The Honorable Shane Pendergrass
Chair, House Health and Government Operations Committee
House Office Building, Room 241
Annapolis, MD 21401

In Support of House Bill 66
Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

January 26, 2022

Dear Honorable Shane Pendergrass,

I am writing in strong support of bill HB66 - giving licensed direct-entry midwives the ability to care for clients who have had a cesarean birth in the past.

As a birth worker, doula and future midwife, I have supported numerous birthing people attempting a VBAC in a hospital setting. Very few of those attempting a trial of labor after cesarean were successful in having a VBAC. All my experience and education considered, the obstacles that the hospital environment and obstetric care provided for my clients were simply insurmountable. Labor augmentation measures, hospital protocols (not all of which are evidence based) and providers unwilling to take the time to monitor and support VBAC patients are all barriers that have prevented those who chose trial of labor after cesarean to achieve their safe and effective VBAC. Interestingly, I have only supported one VBAC hopeful client who actually went on to have a successful VBAC in the hospital and I attribute this success to the fact that she actually stayed home until her baby was well on its way thus eliminating unnecessary provider and protocol induced obstacles. It would have been preferable for her to have been attended by a trained medical professional capable of anticipating and managing potential VBAC complications rather than stay home alone. Unfortunately, this is what limiting access does - leaves people to choose unsafe situations rather than almost certain repeat cesarean.

As an experienced birth assistant in out of hospital environments and future CPM, it is overwhelmingly clear to me that CPMs possess the education, fortitude and temperament necessary to provide the appropriate care and monitoring needed for VBAC patients to safely succeed in out of hospital settings. Evidence suggests that the risk of uterine rupture is higher in a hospital setting, potentially because labor augmentation often creates potential complications for those attempting trial of labor after cesarean. Simply put, with proper education and training, birthing people attempting a VBAC who are otherwise low-risk and appropriate for out of hospital birth should have access to out of hospital VBAC birth under the care of trained certified professional midwives. Continuing to limit the scope of practice of CPMs by prohibiting them to provide services and care for VBAC clients greatly limits birthing people and their full autonomy in choosing the best and safest provider for their desired birthing situation.

Thank you for taking the time to read this. I look forward to hearing that you and your colleagues have given this safe choice back to the families of Maryland.

Kind regards,

M. Disney

Michelle Disney

Birth Assistant, Doula, Student Midwife