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February 28, 2023

To: The Honorable Melony Griffith, Chair, Senate Finance Committee

Re: Letter of Concern- Senate Bill 376 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Dear Chair Griffith:

I am writing to provide feedback on Senate Bill 376 regarding the practice expansion for licensed direct-entry midwives. Specifically, my comments address the proposal to allow direct-entry midwives to provide management of trial of labor and vaginal delivery at home for women who have had a previous c-section.

The Maryland Patient Safety Center has worked diligently over the past 17 years to improve the safety of healthcare in our state. We have led collaboratives to improve all aspects of healthcare safety, including those involving pregnancy, delivery, and newborn care. Our c-section collaborative was successful in reducing – and maintaining reduction in- primary c-sections for Maryland women. Our neonatal abstinence syndrome (NAS) collaborative was successful in reducing transfer of babies with NAS to a higher level of care, allowing them to stay with their mothers. Currently, we are leading the statewide implementation of B.I.R.T.H. Equity Maryland with the aim of eliminating disparities and preventable maternal morbidity and mortality by educating non-obstetric providers on the impact of bias and urgent maternal warning signs.

As the Director of Perinatal and Neonatal Quality and Patient Safety at the Maryland Patient Safety Center and a doctorally prepared registered nurse with over 25 years' experience I am passionate about advocating for the provision of safe care for birthing people. Recognizing the increasing rates of severe maternal morbidity and mortality, and the significant disparities in outcomes that exist, the Maryland Patient Safety Center created my position so that as an organization we can focus on supporting and creating systems of safe care for birthing people in the State of Maryland. I have significant concern over the safety of offering a trial of labor and vaginal birth after c-section (VBAC) at home and therefore I feel it necessary to voice my concern over the potential increase in avoidable neonatal and maternal harm that might result.

As an organization, we support birthing people's right to make an informed decision about their delivery, and believe planned home births can be carried out safely among low-risk women. However, a history of c-section is considered a high-risk factor. A trial of labor after cesarean increases a birthing person's risk of uterine rupture and other complications which are unpredictable, this is why the American College of Obstetricians and Gynecologists (2017) has stated that prior cesarean deliveries are an "absolute contraindication to planned home birth". Subsequently, as the Director of Perinatal and Neonatal Quality and Patient Safety at the state-designated patient safety center, I do not endorse Senate Bill 376 to allow direct-entry midwives

to manage a trial of labor and vaginal delivery at home for women who have had a previous c-section. Nor would I endorse this practice by any other practitioner.

A (2015) study by Cox et al. found that women attempting home VBAC were significantly more often transferred to the hospital than those who did not have a prior cesarean (18% vs 7%, $p < 0.001$). Additionally, women with a prior cesarean who had a home birth had a higher proportion of blood loss, maternal postpartum infections, uterine rupture, and neonatal intensive care unit admissions than those without a prior cesarean. In this study, five neonatal deaths (4.75/1,000) occurred in the prior cesarean group compared with 1.24/1,000 in multiparas without a history of cesarean ($p = 0.015$). Although other studies may support that some birthing people may be eligible for planned home birth after c-section, determining which patients with a history of c-section are most at risk for complications remains challenging. Subsequently, it is safest to proceed with a trial of labor after c-section in a hospital setting where there is immediate access to emergent cesarean section if necessary.

The rate of spontaneous rupture of the uterus after a trial of labor is approximately .5-.9%. Although rare, consequences can be devasting. Spontaneous rupture of the uterus during labor, requires an emergency c-section to save the life of the baby and possibly the mother. In these cases, time is of the essence, and a delay of more than a few minutes to deliver the baby and address any maternal hemorrhage which resulted from the rupture can be devastating. That is why I believe, a trial of labor after cesarean should occur only at a hospital with the resources required for emergency c-section – an obstetrician, and anesthesiologist, a trained operating room staff on site and ready to proceed, and the facilities, equipment, and supplies (most importantly blood for transfusion) immediately available. Obviously, these resources are not available in the home – the time it takes to transfer to a hospital that can manage this event may result in the death of both mother and baby.

To ensure access to safe and respectful maternity care, which promotes access to trial of labor after cesarean and VBAC, legislators should instead focus on developing policies which support hospital VBAC, promotes collaboration between direct entry midwives and hospital providers so that women across the state can easily access VBAC in the hospital setting with the support of their direct entry midwife.

Thank you for allowing me the opportunity to express my concerns regarding Senate Bill 376.

Sincerely,

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Committee Opinion No. 697: Planned Home Birth. Obstetrics & Gynecology 129(4):p e117-e122, April 2017. | DOI: 10.1097/AOG.0000000000002024

ACOG Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. Obstetrics & Gynecology 133(2):p e110-e127, February 2019. | DOI: 10.1097/AOG.0000000000003078

Cox, K. J., Bovbjerg, M. L., Cheyney, M., & Leeman, L. M. (2015). Planned Home VBAC in the United States, 2004-2009: Outcomes, Maternity Care Practices, and Implications for Shared Decision Making. *Birth (Berkeley, Calif.)*, *42*(4), 299–308. https://doi.org/10.1111/birt.12188