Maryland
Hospital Association

House Bill 351 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Position: *Oppose*
February 22, 2023
House Health & Government Operations Committee

MHA Position
On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in opposition of House Bill 351.

In 2015, the Maryland General Assembly passed House Bill 9, which offered a path to licensure for direct-entry midwives (DEM). MHA and other stakeholders agreed to restrictions to ensure home births are as safe as possible. One condition was to limit the scope of practice by not including vaginal births after a cesarean section (C-section), also known as VBACs or home birth after C-section (HBAC). As a member of the Direct-Entry Midwife Advisory Committee since its inception, MHA respects a woman's autonomy and personal decisions about her health, and strives to ensure safe care for delivering mothers and their babies. We value the work that DEMs provide for low-risk women wanting a home birth. The basis of our opposition is allowing for a home birth after C-section.

The American College of Obstetrics and Gynecologists (ACOG) states prior C-section deliveries are an **"absolute contraindication to planned home birth."**[1]

Safety Concerns for Mom and Baby
A trial of labor after a cesarean delivery (TOLAC) is a strategy to reduce the rate of cesarean births.[2] Research indicates TOLAC can reduce maternal morbidity for current and future pregnancies, but a failed TOLAC is associated with higher morbidity than a scheduled repeat C-section.[3] ACOG recommends a TOLAC happen in "facilities with trained staff and the ability to begin an emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care."[4] A 2017 study found higher rates of poor outcomes for infants born via VBAC in out-of-hospital settings.[5] Uterine rupture, compared with other complications commonly associated with a TOLAC has been shown to correlate with the largest increase in maternal and neonatal morbidity.[6] The rate of uterine rupture is estimated to be 15 to 30 times higher for women choosing TOLAC compared to a

[1] The American College of Obstetricians and Gynecologists. (April, 2017). "Planned Home Birth."
[2] Togioka, B. and Tonismae, T. (July 1, 2021). "Uterine Rupture."
[3] Ibid.
[4] Ibid.
[5] Tilden EL, Cheyney M, Guise J-M, et al. (2017). "Vaginal birth After Cesarean: Neonatal Outcomes and United States Birth Setting"
[6] Togioka, B. and Tonismae, T. (July 1, 2021). "Uterine Rupture."

repeat C-section.[7] **Although rare, when a uterine rupture occurs, immediate surgical intervention is required to prevent catastrophic harm to mom and baby.** Additionally, studies have found higher rates of intrapartum and neonatal death in areas without an integrated system and collaboration with the receiving hospital, which could delay intrapartum transport.[8]

Safe Support for TOLAC and VBAC in Hospitals

There is a safe way to have a TOLAC in Maryland. Hospitals across the state allow for TOLACs and VBACs. VBAC rates with no complications range from 8.8 to 34.4 per 100 births in Maryland—compared to 14.2 per 100 births nationwide.[9,10] Almost all of Maryland's 32 birthing hospitals allow for TOLACs and VBACs. However, certain resources must be available 24/7, including anesthesiologist, obstetrician, and pediatrician coverage. Some hospitals require 24/7 neonatologist coverage or a surgical assistant or second physician to be available in case a C-section is required.

Additionally, there are patient criteria considered before recommending a TOLAC. Although the exact details vary by hospital, care provider, and patient, common criteria for why a patient might not be recommended for a TOLAC in the hospital include:

- More than two previous C-sections
- Patients who had a C-section less than 18 months prior
- Patients with a prior T-shaped incision or other trans-fundal uterine surgery
- Patients with a contracted pelvis
- Medical or obstetric complications that preclude vaginal delivery
- Patients with a history of previous uterine rupture
- Patients with a history of myomectomy

Need for Collaboration with Direct Entry Midwives

Many Maryland hospitals employ or credential certified nurse midwives, which supports a cooperative and collaborative relationship. For women laboring with the assistance of a certified nurse midwife in the hospital, an obstetrician and surgical team is available if an adverse event occurs. This critical relationship does not exist between DEMs and hospitals. **When every second counts, having these relationships and immediate access can mean the difference between a catastrophic outcome and a healthy mom and baby.** Additionally, the credentialling process allows for quality review and ongoing professional practice evaluation. We need to build the relationship between hospitals and DEMs where there is a seamless transfer of care and robust quality review. This relationship does not exist today. The data reporting process for births attended by a DEM are self-reported and mailed to the Board of Nursing.[11] There is more the state could do to bolster this critical dataset.

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[7] Ibid.
[8] The American College of Obstetricians and Gynecologists. (April, 2017). "Planned Home Birth."
[9] Maryland Health Care Commission. (n.d.) "Maryland Quality Reporting Data: Maternity Services."
[10] National Center for Health Statistics, National Vital Statistics System, Natality. (August, 2022). "Data Brief 442 Births in the United States, 2021."
[11] Maryland Board of Nursing. (November 16, 2022). "FY 2022 Report from the Committee as Required by Health Occupations Article, Title 8, Section 8-6C-12(a)(10), Annotated Code of Maryland."

Hospitals are available 24/7 to assist in emergencies and help when there are adverse outcomes for home births. It would be unimaginable to expand DEM scope to include such a high-risk birth, especially without quick access to the resources needed to rapidly intervene.

For the safety of birthing mothers and their babies, we strongly recommend an ***unfavorable*** report on HB 351.

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