Maryland
Hospital Association

Senate Bill 376 - Health Occupations - Licensed Direct-Entry Midwives - Previous Cesarean Section

Position: *Oppose*
February 28, 2023
Senate Finance 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 Senate Bill 376.

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. 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. It is the location, not the provider that is the issue.

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

Risk of Death for Mom and Baby with Home Birth After C-Section
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] Ibid.
[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]

MHA opposes SB 376 because having a VBAC at home is a known risk. There is not enough time to transfer to a hospital in the event of a uterine rupture. The results can result in the death of or significant injury to mom and baby.

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. All but two 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. The reason a hospital would not allow for a TOLAC or VBAC is if these resources cannot be provided. These resources are essential for ensuring access to an operating room within minutes if an adverse event, like a uterine rupture, were to occur. Even though the risk of uterine rupture may be low on an individual basis, statewide policy should focus on the population-level where studies have shown a 1% risk of uterine rupture with VBACs.[9]

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 & Improved Data Oversight and Accountability

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 for the low-risk births within the current scope. This relationship does not exist today. The data reporting process for births attended by a DEM are

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[7] Ibid.

[8] The American College of Obstetricians and Gynecologists. (April, 2017). "Planned Home Birth."

[9] Togioka, B. and Tonismae, T. (July 1, 2021). "Uterine Rupture."

self-reported, de-identified and mailed to the Board of Nursing.[10,11] The current data collection process does not provide the transparency and opportunity for case review that we have with other providers attending births in the hospital. More needs to be done to provide oversight, accountability and tracking of this data. There is no way to track individual DEMs who may be transferring a high number of patients or having poor outcomes consistently. More oversight is needed to ensure accountability since DEMs are licensed by the state 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 SB 376.

For more information, please contact:
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[10] 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
[11] Maryland Board of Nursing. "Maryland Data Collection Form,".