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TO: The Honorable Peter A. Hammen, Chair
Members, House Health & Government Operations Committee
The Honorable Ariana Kelly

FROM: Pamela Metz Kasemeyer
Joseph A. Schwartz, III
J. Steven Wise
Danna L. Kauffman

DATE: March 11, 2014

RE: **OPPOSE** – House Bill 1211 – *State Board of Nursing – Midwives – Licensing and Regulation*

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On behalf of MedChi, the Maryland State Medical Society (MedChi), the American Congress of Obstetricians and Gynecologists, Maryland Section (MDACOG), and the Maryland Chapter of the American Academy of Pediatrics (MDAAP), we oppose House Bill 1211.

House Bill 1211, in different iterations, has been before this Committee for the past few years. While House Bill 1211 attempts to address some of the deficiencies previously identified in deliberations on this issue, the bill continues to reflect education and practice standards that will place women and their newborns at risk if CPMs are licensed under the conditions reflected in the legislation.

For example, the academic standards for CPMs which are reflected in this legislation – known in some states as licensed or direct entry midwives – are remarkably lower than the academic standards for training and certification of physicians as well as for certified nurse-midwives. CPMs, by their lack of training and lack of hospital-based experience, are the least qualified to attend a home birth, especially if there is no requirement for them to work collaboratively with hospital-based obstetrical care providers or under state practice guidelines. Inadequately trained midwives should not be permitted to order laboratory tests, perform surgeries (episiotomies) or surgical repair (vaginal/cervical lacerations), and provide medications (i.e., antibiotics for infections, ocytocin or methergine to stop postpartum hemorrhage) all of which are authorized in the legislation.

Additional examples of this legislation's continued deficiencies include, but are not limited to, a lack of appropriate limits on the scope of services that can be provided to both the pregnant woman and her child after birth, failure to define low

and high risk in a manner that limits the cases that a CPM may accept, continues to permit VBACs, includes medication administration and care of the newborn that cannot be supported by their level of education and training, and a lack of required consultation with trained health care professionals at critical junctures in the course of pregnancy or when issues arise that a CPM cannot appropriately manage.

The named organizations support the collaborative practice model of care, the maternity care team, and integrated systems of care with established criteria and provision for emergency intrapartum transport. At any time during pregnancy and the birth process women may encounter complications requiring a change of provider or setting. Therefore, an integrated care system must facilitate timely communication and transfer or collaborative management of care. An integrated system depends on appropriately trained and certified practitioners at all levels, open communication and transparency, ongoing performance evaluation, use of evidence-based guidelines, and patient education. None of these critical system protections are recognized by CPMs. In fact, House Bill 1211 specifically prohibits requirements for collaborative practice.

Should women choose to assume the risk of home birth, it should be attended by appropriately trained health care providers in a transparent continuum of care under practice guidelines which attempt to make birth as safe as possible in that setting for the best possible outcome for mother and child. The home birth attendant must have a system in place where consultation with hospital-based and privileged consultants can confer expeditiously throughout the pregnancy and delivery to guarantee safe and expeditious transfer of care and transport to a hospital for care if necessary. The American College of Obstetrics and Gynecologists Committee on Obstetrics Practice issued an opinion on "Planned Home Birth" in February 2011 which further discusses critical issues relative to home births. That statement is attached for your reference. While House Bill 1211 has attempted to narrow the scope of practice and include certain requirements for improved communication between midwives and accepting facilities should a transfer be required, the bill still ignores, rejects or prohibits many of the basic tenets reflected in MDACOG's opinion and is completely counter to this basic premise of good obstetric practices.

This General Assembly has historically been committed to ensuring access to care. It has responded to issues regarding professional licensure and certification that acknowledge legitimate training, experience and education to ensure the State has a robust workforce to meet the growing demand for high quality health care services. To that end, over the last few years, this General Assembly has revised the

collaborative practice requirements for certified nurse midwives (CNMs) to facilitate access to their services and most recently proposed regulations to further facilitate CNM practice. The physician community has largely supported those efforts and continues to support those professionals who serve in collaboration with physicians throughout Maryland.

House Bill 1211, despite efforts to address some of the concerns raised in previous years, continues to run counter to the General Assembly's commitment to expand access while ensuring quality and patient protection. Passage of House Bill 1211 will jeopardize the health and lives of our pregnant woman and their newborns by legitimizing the services of undertrained and inexperienced individuals who wish to provide obstetrics care without receiving the necessary knowledge, skills and experience to do so. An unfavorable report is requested.

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