

# SCHWARTZ, METZ & WISE, P.A.

ATTORNEYS

20 WEST STREET  
ANNAPOLIS, MARYLAND 21401

TEL: 410-244-7000

FAX: 410-269-5443

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: February 11, 2015

RE: **OPPOSE** – House Bill 9 – *Maryland Home Birth Safety Act*

---

On behalf of MedChi, the Maryland State Medical Society (MedChi), the American Congress of Obstetricians and Gynecologists, Maryland Section (MDACOG), the Maryland Chapter of the American Academy of Pediatrics (MDAAP), and the Maryland Chapter of the American College of Emergency Physicians (MDACEP), we oppose House Bill 9.

House Bill 9, in different iterations, has been before this Committee for the past several years. During this past interim, a broad range of stakeholders, including the above named organizations, met extensively to try to come to a consensus on the myriad of issues that are essential to establishing a regulatory framework, for both home birth and the licensure of certified professional midwives (CPM), referred to in the bill as “direct-entry midwives,” that minimize the risk to women and their newborns should women choose to assume the risk of home birth. Despite the concerted effort of all parties involved, the bill as introduced 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.

Prior to this hearing, a meeting of the stakeholders was held. A request was made to provide suggested amendments and/or identification of issues that require additional amendment or clarification. The above named organizations identified a list of 26 issues/deficiencies that remain unacceptable and need further work. While some of the issues identified are technical and relate to drafting deficiencies, others are substantive and must be resolved before consideration of removing opposition to the bill can be contemplated. Examples of this legislation’s continued deficiencies include, but are not limited to, permitting VBACs (vaginal birth after cesarean); failure to clearly define and delineate appropriate limits on the scope of services that can be provided to both the pregnant woman and her newborn after birth, including a failure to adequately define low risk in a manner that clearly limits the cases that a CPM may accept; failure to clearly define the requirements for informed consent, transfer protocols, and other critical components of a framework of care that is both transparent and collaborative; reliance on a committee under the Board of Nursing to develop recommended regulations on scope of practice and informed consent that does not include representation by physicians and other stakeholders necessary to appropriately define these critical elements of a regulatory structure; failure to address the mechanism for ensuring newborn screening is done in a timely manner and associated fees

are paid; insufficient data collection and outcome analysis; reliance on MANA statistics for data reporting when those statistics have proven problematic in other states; liability language that may not adequately protect health care practitioners and institutions should care be transferred due to adverse events prior to, during or post delivery that are attributable to omissions by the midwife; and concerns about the proposed education requirements, especially in the period prior to 2017.

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.

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 9 begins to address these issues in a manner absent from previous iterations of the legislation, noted deficiencies remain, both in terms of clarity and specificity. The bill still falls short with respect to many of the basic tenets reflected in MDACOG’s opinion.

A woman’s choice to assume the risk of a home birth has implications not only for the health and well-being of the mother but also, and more critically, the health and well-being of the newborn. A child’s risk of dying is highest in the newborn period. The newborn period is possibly the most tenuous in a human’s lifetime. Of the nearly 4 million babies who are born alive annually in the United States, approximately 1% die within the first 24 hours, 1% die within the first 25 hours, 1% die within the first week, and 1% die within the first year. An infant experiences a greater risk of death during the first 7 days of life than at any other time during the next 65 years. Therefore, the statutory provisions regarding newborn care must be narrowly and carefully delineated. House Bill 9 reflects significant improvements in the provisions related to newborn care but areas in need of further clarification and delineation remain.

House Bill 9, despite concerted efforts by stakeholders to address the concerns raised in previous years, fails in its present iteration to meet the General Assembly’s commitment to expand access while ensuring quality and patient protection. Passage of House Bill 9 without further significant amendment will jeopardize the health and lives of our pregnant women and their newborns. An unfavorable report is requested.

**For more information call:**

Pamela Metz Kasemeyer  
Joseph A. Schwartz, III  
J. Steven Wise

Danna L. Kauffman  
(410) 244-7000