Ohio State Medical Association

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Opponent Testimony to the Ohio House Children and Human Services Committee
Ohio State Medical Association
HB 537 – Midwives
Presented by Monica Hueckel, VP, Ohio State Medical Association
and Lisa Bohman Egbert, MD, FACOG
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Chair White, Vice Chair Salvo, Ranking Member Lett, and members of the House Children and Human Services Committee, my name is Monica Hueckel and I am here on behalf of the Ohio State Medical Association (OSMA), the state's oldest and largest professional organization representing Ohio physicians, medical residents, and medical students. We would like to thank the committee for the opportunity to testify regarding our concerns with House Bill 537 today.

OSMA generally supports the licensing of all midwives providing maternity care in Ohio, and appreciate many aspects of this legislation, such as the inclusion of informed consent for the patient/clients, liability protections, inclusion of adverse outcome reporting, language around pre-registering intended home birth with nearest hospital, and requirements around physician consult and referral. These provisions are critical to the goal of helping Ohio families have favorable birth outcomes.

However, we have outstanding concerns with HB 537, including:

Licensing

- Under HB 537, certified midwives would be licensed by the Ohio Board of Nursing; however, licensed midwives would be licensed by the Ohio Department of Commerce. This is concerning because this is not a typical agency that licenses healthcare providers, and may not have the appropriate staff to ensure proper patient safety guardrails are in place. For consistency, safety, and quality, we believe that both certified and licensed midwives should be licensed by the Ohio Board of Nursing.
- HB 537 includes language that qualifies individuals holding a current, valid license from another state, but not all states have included robust, appropriate educational requirements in their own licensing programs. We are very concerned that if this language remains in HB 537, this legislation would allow for less qualified midwives to be licensed in Ohio.
- We also question why the bill makes reference to traditional midwives, yet does not require them to be licensed. This is extremely concerning as licensing is an important method of providing oversight.

Collaboration Agreements

- While we are grateful for the inclusion of a provision in the bill which requires certified midwives to have collaboration agreements with licensed physicians, to alleviate additional patient safety concerns, this requirement must also be applied to all midwives in Ohio, including licensed and traditional midwives.

Reporting Requirements

- We believe language should be included in HB 537 which would require annual reporting from the Board of Nursing related to cases in which the midwife provided services when the intended place of birth at the onset of care was in a facility or setting other than a hospital. The annual report would include information such as the number of live births attended as a midwife and the number of cases of and descriptions of any complications resulting in the morbidity or mortality of a maternal patient or newborn, including those intended home births which were transferred to a hospital or other emergency setting. This would mirror language which was included in HB 496 from the 134th General Assembly.

Religious Exemptions

- Our organizations believe that to respect the diverse religions and cultures of Ohioans while also maintaining safety precautions for those seeking maternal care, the religious exemption for the practice of midwifery should be written in a manner similar to the existing religious exemptions that apply to freestanding birthing centers.

Scope of Practice

- HB 537 does not define "high-risk" deliveries, which should always be performed at facilities that can address emergency situations and perform emergency deliveries should the need arise. In order to maintain safe maternal care, the scope of practice of all midwives licensed in HB 537 should be limited to normal, low-risk pregnancy and newborn care. For patient safety, home birth standards should be on par with level one maternal care.

With me today is Dr. Lisa Bohman Egbert, a physician obstetrician who will now go into more detail about concerns with high-risk deliveries, but I would be happy to help with answering any questions the committee may have at the end. Thank you for your attention to my remarks today and as always, OSMA appreciates the opportunity to be a meaningful contributor to the legislative process.

Thank you Chair White and members of the Committee. My name is Dr. Lisa Bohman Egbert, and I am a longtime member and past president of the Ohio State Medical Association. As a soloist in private practice in general obstetrics and gynecology for over 27 years in Dayton, Ohio, I personally cared for thousands of obstetric patients, from their first positive pregnancy test, at all of their prenatal visits, to delivering their babies and caring for them post-partum. I managed their general gynecologic well-woman care as well.

As Monica said, I would like to provide some additional clinical perspective on HB 537 as a physician obstetrician regarding high-risk births.

It is extremely concerning that HB 537 would allow home births to include vaginal births after cesarean (VBAC), now more accurately called trial of labor after cesarean (TOLAC), birth of twins, and breech births. While we maintain that hospitals and accredited birth centers remain the safest settings for birth, each birthing patient has the right to make a medically informed decision about their delivery. Part of that medically informed decision is being empowered with the knowledge about factors which greatly reduce perinatal mortality risks and help achieve positive home birth outcomes. This includes appropriate selection of lower risk candidates for home birth.

The American College of Obstetricians and Gynecologists Committee on Obstetric Practice considers VBAC, birth of twins, or breech births to be an absolute contraindication to planned home birth. Because of the distinct and serious risks associated with these deliveries, we strongly recommend that these births occur in accredited facilities or hospitals, with trained staff, that can promptly perform emergency cesarean delivery to avoid needless maternal and fetal risk. There are simply too many predictable and significant complications, including life-threatening concerns, which can arise from these circumstances. These cases require specific medical attention by trained personnel within a narrow time interval to avoid catastrophic consequences. Sometimes, there are no warning signs of these potentially catastrophic outcomes, except those which can only be detected with resources and personnel available to patients in hospitals and accredited care facilities, such as use of continuous fetal heart monitoring.

There is an increased risk of uterine rupture in patients who labor after one or more cesarean births. This is a rare but dangerous and even life-threatening complication for both the laboring patient and the baby, which occurs when the uterus opens at the previous cesarean scar. Fortunately, uterine rupture is, with quick surgical intervention and resuscitation, survivable for most women and babies, but such urgent intervention is only possible in an accredited facility or hospital. The American College of Nurse Midwives has stated that it is "safest to have a VBAC in a hospital so you and your baby can be monitored during labor."[1] At my hospital, for the safety of both the mom and the baby, we do not even allow a trial of labor after cesarean to occur without having an obstetrician present and available onsite for the duration of the labor.

Additionally, HB 537 includes language that allows a patient to refuse referral from a midwife to a more appropriate setting for trial of labor after a cesarean, birth of twins, or breech births. We appreciate a patient's right to choose, but this legislation must account for how to handle this situation and what a midwife will do if they no longer feel comfortable and able to continue with the maternity care of a patient who refuses to be referred.

It is imperative that high risk deliveries take place in settings which are equipped to handle the specific and heightened needs of these patients, including operative delivery if necessary. As an obstetrician and a mother who survived two very high-risk pregnancies, including the birth of my twins, I believe the provisions in HB 537 regarding these deliveries pose an absolutely unacceptable risk to patients and move Ohio in the wrong direction for maternal and fetal health outcomes.

Thank you for your consideration of our concerns about this legislation today. We would be happy to answer any questions from the committee at this time.

[1] American College of Nurse Midwives. (2016). "Birth Options after Having a Cesarean." https://doi.org/10.1111%2Fjmwh.12583