March 15, 2013
Public Hearing and Possible Work Session HB 2997

Dear Members of the House Committee on Health Care:

My name is Stella Dantas, MD and I am a full time practicing obstetrician and gynecologist in Portland and Beaverton, Oregon. I am also an officer with the American Congress of Obstetricians and Gynecologists (ACOG).

During my 12 years practicing as an OB/GYN, I have worked in a collaborative practice model with CNMs. I have also been on the receiving end of out of hospital birth transfers while working at Providence St. Vincent hospital and years ago at Legacy Emanuel hospital. Given my experience with CNMs (both professionally and personally as both of my births were attended by a midwife) and my experience with the DEM community as a receiving provider for transports, I feel that I am a stakeholder on the out of hospital birth issue and one who is sensitive to all the surrounding complex issues.

I want to thank the work group for all their efforts regarding this bill, the DEMs who are supporting this bill, and The House Health Care Committee for looking at this bill and allowing us to testify.

I fully support mandatory licensure of DEMs and hope that this bill moves forward. However, I have several issues with HB 2997. While I very much appreciate the work that has been done and understand how difficult consensus is to reach on this issue, the Oregon Section of ACOG and I can only support the bill with the following the proposed changes.

1) It needs to be clearly and unequivocally stated that care by a direct entry midwife is a reasonable choice for a healthy pregnant woman **with a low risk pregnancy**. This was the legislative intent when licensure was established in 1993. There is now a published study looking at births occurring in Oregon between 2008 and 2010, using vital statistics data. If one compares planned home births in our state to the appropriate hospital cohort group (meaning intended hospital births limited to those meeting eligibility criteria for home birth in Oregon, the rate of neonatal death was lower in hospital births (0.08% versus 0.26%, P□0.002). We will be able to see more Oregon data when Vitals Statistics publishes its 2013 data, but for now, this suggests that a higher than expected neonatal death rate for planned home birth in Oregon. This alone should be reason to limit it to low risk births in hopes that the neonatal death rate would improve.

2) The exemptions for traditional midwives need to be removed. There are no exemptions for other birth providers with regard to licensure. Also, in our own state in 2013, members of the Followers of Christ Church in Oregon City were charged with second-degree manslaughter and received maximum sentence for failing to seek medical treatment in a premature pregnancy other than an unlicensed midwife. There was no religious exemption for these parents. Why should the practice of direct entry midwifery have a different standard than parents and other birth providers?

3) If there is an exemption, then these providers should
   a. Not be labeled midwives but **birth attendants** and **should be a member** of the religious or cultural group that holds the religious, spiritual or philosophical belief related to the practice of direct entry midwifery
   b. No fee should be allowed to be contemplated, charged or received for this service.
   c. **And any and all** traditional birth attendants thus claiming this exemption **must be required** to disclose to each client on a form adopted by the board by rule the following additions to the bill:
      i. That this person does not have a medical back-up plan or emergency transport plan verified by the State
      ii. That this person may not have sent the client's prenatal records to the back-up system for the birth (hospital, labor and delivery unit, or physician practice).
      iii. All types of midwives who are licensed by the state.

4) Currently the bill states that a direct entry midwife licensed under this section is entitled to payment under the rules of the medical assistance program but this should be changed to **may receive**. There are circumstances in the medical community where care is not eligible for payment unless certain criteria are met. DEMs should be subject to the same scrutiny of payers who want to pay for high quality care.

5) Families who have had a poor outcome should not be traumatized by having to give a deposition to or be compelled to appear before the Board. Other boards do not do this. The bill should state **investigators** may take the depositions of witnesses in the manner provided by law in civil actions and the appearance before the board should be deleted.

6) Tocolytics should not be added to the legend of drugs for DEMs. If a tocolytic is needed, a client needs to be transferred immediately to a facility that can take care of a preterm infant or perform the necessary measures in a situation of fetal distress. The use of tocolytics should not be used to delay transfer of care. I also feel if Group B Streptococcal antibiotic prophylaxis is added to legend drugs, then there should be an educational requirement for training on how to handle anaphylactic shock should a client have a reaction.

Also, I would like to see added to the bill stipulation that:

A. Educational requirements for licensed DEMS that are identical to the International standards
B. Normal birth and pregnancy is defined by the World Health Organization's definition with it's standards for high and low risk: http://www.internationalmidwives.org/Portals/5/2011/DB%202011/MIDWIFERY%20EDUCATION%20PREFACE%20&%20STANDARDS%20ENG.pdf
C. Maternal and newborn conditions requiring physician consultation, referral and transfer of patient care for all stages of pregnancy would be delineated
D. Peer review by the state regulatory agency would be mandatory
E. Failure to facilitate a transfer would have a penalty
F. Specified state record keeping and reporting requirements
G. Low risk would be defined and conditions enumerated in the bill; ones requiring mandatory consultation and facilitation for transfer would be specified
H. Requirement for liability coverage with mandatory reporting of awards, settlements and claims payments (just like doctors have to do when we applying for hospital privileges and licensure).

I believe women should have a choice in birth providers and birth experience. However, I also believe that if the State of Oregon licenses and pays out of hospital birth providers, the state needs to pay attention to the best evidence available to make sure it is providing the safest care and ensuring the most optimal outcomes.

Oregonians trust and believe if their state licenses a provider, the practice is safe. Without these crucial points in the Bill, I do not believe we are being transparent to or ensuring the safety of the public you serve and therefore the Oregon Section of ACOG would not be able to support HB 2997.

Respectfully submitted,
Stella Dantas, MD