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Dear Counselor Ceroalo,

As public health nurses (one of us a licensed midwife), members of the Board of Directors of the New York State Public Health Association, and concerned citizens we are writing to express our strong opposition to the wording of the proposed Birth Center regulations amending 10 NYCRR sections 12.2 and 405.21, and Parts 721, 754 and 795. The increased utilization of [midwifery](#) models of care, including midwife-owned birthing centers (MBC), is a crucial step in addressing the issue of Maternity Care Deserts in New York State (NYS), and the barriers to access to care, inequities, health disparities that they perpetuate. NYS has historically been at the forefront of implementing policies and programs that prioritize support for those in need, and we believe it can set an exemplary standard for the rest of the nation, with comprehensive and evidenced-based regulatory policies for the perinatal system in NYS -- Regional Perinatal Centers (RPCs), Level III hospitals, Level II hospitals, Level I hospitals, and freestanding birth centers, including midwifery-led birth centers.

The utilization of community-based continuity of care models, specifically midwifery models of care, is a well-documented approach to achieving equitable access to high-quality maternal infant care. [Sandal, J. \(et. al. \(2016\)\)](#) reported in the British Medical Journal that the National Institute for Health and Care Excellence (NICE) published an updated guideline in the United Kingdom: "Giving birth in a midwife led birthing unit or at home with the support of a midwife is safer than giving birth in a traditional hospital ward for women with straightforward, low risk pregnancies." The World Health Organization (WHO) made this recommendation in its 2021 [Global Strategic Directions for Nursing and Midwifery 2021-2025 \(2021\)](#): "Universal coverage of midwife-delivered interventions could avert 67% of maternal deaths, 64% of neonatal deaths and 65% of stillbirths (92)". National stakeholders such as the [National Partnership for Women and Families](#), the Biden administration ([Whitehouse Blue Print for Addressing the Maternal Health Crisis](#)), and the [March of Dimes](#) also endorse midwifery models of care, further underscoring the importance and relevance of this approach.

We commend past actions taken by NYS, including the establishment of the [Maternal Mortality](#)

[Task Force](#), as part of its efforts to address racial disparities in maternal morbidity and mortality. However, the wording of the proposed Birth Center regulations amending 10 NYCRR sections 12.2 and 405.21, and Parts 721, 754 and 795 must be revised to assure it aligns with evidenced based protocols and procedures, including those of the [Commission for the Accreditation of Birth Centers](#) (CABC) and [National Fire Protection Association](#) (NFPA) 101 Life Safety Code.

Every NYS family deserves equitable access to high-quality and safe midwifery care, regardless of the healthcare setting they choose - be it hospitals, homes, or midwifery birth centers.

Unfortunately, the current limitations imposed on midwifery care are founded on outdated attitudes, regulations, and policies enforced by the NYSDOH, hindering the expanded utilization and integration of midwifery care into the state's current perinatal system, denying women and newborns the benefits of a care-model known to enhance outcomes, reduce costs, and improve safety and satisfaction.

To truly improve maternal and infant care in NYS, we urgently need accredited and licensed midwifery birth centers (MBC). Moreover, we must ensure that licensed midwives have a place in all care settings - hospitals, birth centers, and homes. While the law had specified coordination between accreditation and licensure, these regulations fall short of fulfilling the law's intended purpose. Furthermore, the collaborative process that was intended to include midwifery stakeholders in creating MBC regulations failed to do so in a continuous and sufficient manner, failing to arrive at a mutually agreed upon proposal ensuring quality and safety.

It is evident that these Regulations do not align with the true spirit of the law as written. Nevertheless, midwives stand firm in our commitment to advocate for all birthing individuals in NYS, striving to make childbirth a more equitable, safe, and better experience for all New Yorkers.

We urge the NYSDOH Regulatory Affairs Unit to seriously consider and support the revisions we suggest (See Appendix A) for the proposed Birth Center regulations amending 10 NYCRR sections 12.2 and 405.21, and Parts 721, 754 and 795. Our recommendations are based on evidence supporting midwifery care, which has been well-documented for many, many years now. Studies have consistently shown that midwife-led continuity models of care lead to reduced interventions and increased satisfaction with care, with comparable adverse outcomes for low-risk pregnant individuals compared to other care models. By doing so, NYS can build upon the momentum initiated by the proposals of its [Maternal Mortality Task Force](#) in 2019 and contribute significantly to mitigating the risk of maternity care deserts within its borders. Evidence-based

policies regulating NYS midwifery practice and NYS Birth Centers will be a significant step forward in ensuring equitable and quality care for all pregnant individuals, reducing maternal and neonatal morbidity/mortality rates, and setting an inspiring example for other states facing similar challenges.

Thank you for considering our comments (Appendix A). We hope that together, we can work towards a healthier and more inclusive future for all. We include our contact information below and are available for clarification, consultation, testimony, or any other needs you might have.

Sincerely,

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Appendix A

I. Collaborative Process and Stakeholder Engagement

“Minimizing Adverse Impact: (pg 151). “Additionally, following passing of the Midwifery Birth Center Accreditation Act, the Department engaged with midwifery stakeholders and advocates, including representatives of state and national midwifery organizations, to discuss the proposed regulations with a focus on accreditation and establishment. Following these discussions, the regulations were further revised to clarify requirements and reduce burdensome requirements while still supporting the integration of midwifery birth centers into the perinatal regionalization system and ensuring compliance with national life and safety standards.”

It is deeply concerning to learn about the lack of a genuine collaborative process during the development of the Regulations by the NYSDOH. The limited and brief meetings with the New York State Birth Center Association (NYSBCA) and New York Midwives (NYM) leadership from April 2022 to December 2022, totaling only three 30-minute meetings, are simply insufficient to address such a critical matter that directly impacts the health and well-being of birthing individuals in New York State (NYS).

The absence of significant time and personnel allocated to achieve the goal of creating equitable regulation indicates a disregard for the importance of midwifery care and its potential positive impact on maternal and infant outcomes. By not accepting commentary on the extensive 157-page document, and by keeping different groups in silos without fostering a collaborative, inter-professional discussion with all stakeholders present, the NYSDOH has failed to create an inclusive and well-informed regulatory framework.

The lack of effort to truly integrate midwifery throughout the healthcare system in NYS is disappointing and disheartening. Midwifery care is a proven model that can enhance reproductive choice and provide better access to care for childbearing individuals, especially those in marginalized communities. The continued erasure of midwifery by the state denies families the opportunity to make informed decisions about their reproductive healthcare options.

It is imperative that the NYSDOH takes immediate steps to rectify the shortcomings by reengaging in this process. A comprehensive and inclusive approach that involves all relevant parties, including midwifery stakeholders, is essential to ensure the development of regulations that prioritize the well-being and choices of birthing individuals in NYS. True integration of midwifery throughout the healthcare system can lead to improved outcomes, increased access to care, and a more empowered and informed birthing experience for all New

	<p>Yorkers.</p> <p>We urge the NYSDOH to recognize the significance of midwifery care and to work together with the New York State Birth Center Association, New York Midwives, and other relevant stakeholders in an open and collaborative manner. Let us strive to create a healthcare system that upholds reproductive choice, respects diverse care models, and prioritizes the well-being of families throughout the birthing journey.</p>
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II. National Birth Center Accreditation

<p>Section 795.11 - pg 135 states: “The Department may enter into collaborative agreements with one or more accreditation agencies to provide that such an agency’s accreditation survey can be used in lieu of a survey by the Department”</p>	<p>In collaboration with the Hudson Valley Hospital Center (Cortlandt, NY), Andréa Sonenberg, with her midwife colleagues established the first freestanding childbearing center in the Hudson Valley (1994). To assure the highest quality and safety of mothers and newborns, we sought accreditation by the American Association of Birth Centers (1994). The hospital administration and Board of Trustees understood and agreed that this was a critically essential step to take.</p> <p>Accreditation was the foundation for the 2022 Midwifery Accreditation Act, it is perplexing that the NYSDOH chose to overlook this crucial aspect. It is noteworthy that in a joint statement, both the American College of Nurse-Midwives (ACNM) and The American College of Obstetricians and Gynecologists (ACOG) support the accreditation of birth centers, with Commission for the Accreditation of Birth Centers (CABC) being the only accrediting agency using the national AABC Standards for Birth Centers in its process.</p> <p>It is concerning that the current regulations make accreditation optional for midwifery birth centers (MBCs). Without an agency listed for accrediting MBCs, leaves a critical gap in the oversight of safety and quality. We strongly advocate for the use of the CABC accreditation mechanism, as a means to ensure high-quality MBC services.</p> <p>Accrediting and licensing all MBCs would not only allow inclusion in the regional perinatal care system but also guarantee maintenance of ongoing learning and adherence to evidence-based birth center practices.</p> <p>Extensive research consistently demonstrates that accredited birth centers are the safest environments</p>
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for childbirth. [Sandal, J. \(et. al. \(2016\)\)](#) By making accreditation optional, the current regulations undermine a recognized mechanism that ensures safety and quality standards for families receiving care by these essential care facilities. For licensed midwives (LMs) opening midwifery birth centers, adhering to the highest national standards through accreditation reflects their commitment to providing a safe and high-quality choice for childbearing families across NYS.

In the early 1990's, the Hudson Valley Hospital Center Medical Board, Administration, and Board of Trustees all recognized that being a pioneer in offering a birth center care option was neither feasible nor safe without the expert input of its midwives. The lack of midwifery expertise at the NYSDOH is extremely concerning. By removing a mandate for accreditation, the regulations diminish the involvement of midwifery experts in facilities where midwives are the experts in care provision. This approach neglects the evidence and research rooted in midwifery care and birth center practices, leading to the exclusion of invaluable knowledge and perspectives. This is a step backwards from an insightful, pioneering NYS health system of three decades ago!

As professionals in the midwifery field, it is crucial to have the autonomy to define our scope, processes, policies, and systems within the profession. Disregarding accreditation represents a level of professional disrespect and policing that is unacceptable.

Harmonizing NYS regulations with CABC accreditation standards establishes the highest benchmark for ensuring quality and safety in birth centers, prioritizing the well-being of women and childbearing individuals. It is essential that there is consistency in standards across the perinatal system in NYS and that all its regulatory and policy initiatives related to perinatal care align with this primary goal.

We urge there be action to reform the persistent culture of resistance and the failure to embrace equity. The inclusion of CABC accreditation must be a requirement for all NYS birth centers; it is a crucial and essential step in the right direction.

	<p>In conclusion, We firmly support the incorporation of accreditation by CABC as a mandatory requirement for all birth centers in NYS. Ensuring quality and safety should remain the priority of all efforts to regulate and improve perinatal care in our state.</p>
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III. Meeting Facility Standards

SUMMARY OF EXPRESS TERMS: “The proposed regulations also reflect New York State’s requirements for the establishment of midwifery led birth centers, which includes physical plant standards, 2 compliance with National Fire Protection Association (NFPA) 101 Life Safety Code, Facility Guidance Institute (FGI) requirements for Birth Centers, and ADA Standards for Accessible Design” (Pg 1-2)

It is disheartening to learn that the information and concerns shared by midwifery birth center stakeholders have not been adequately addressed and have been obfuscated by the legal department at the DOH. We strongly urge that the "limited" birth center category align with current national standards to ensure the highest quality of care.

The DOH's imposition of compliance modifications beyond the current guidelines is concerning, as it significantly increases start-up costs for midwifery birth centers. Given that most MBCs will likely be minority and/or women-owned enterprises (MWBE), these onerous architectural requirements can lead to the exclusion of small minority and women-owned businesses from opening MBCs. This is a classic example of a 'structural bias,' qualifying as a discriminatory practice.

Additionally, the use of dated NFPA (2012), FGI (2018), and architectural standards, which are more stringent than the evidence-based national standards of CABC, is unnecessary and may create unnecessary barriers for MBCs. If CABC standards do not specify a particular building standard, it implies that it does not impact the safety of perinatal clients. Therefore, adopting the "most stringent" language for requirements that are not evidence-based can further hinder the establishment of MBCs in New York.

What we truly need are safe and current standards that promote high-quality, evidence-based birth centers to thrive across New York. Embracing the latest evidence-based practices and aligning with the national standards of CABC will not only ensure the safety of perinatal clients but also create a supportive environment for the successful operation of midwifery birth centers.

It is essential that the DOH listens to the concerns of midwifery birth center stakeholders and experts

and takes immediate action to address these issues. By collaboratively working together, we can foster an environment that promotes equitable access to the highest quality maternity care, which enhances the well-being of families across New York State.

IV. The Integration of Midwifery Birth Centers into the Regional Perinatal Center (RPC) System

... is crucial for ensuring the health and safety of women and families in New York State (NYS), according to esteemed national organizations such as ACOG, ACNM, and AABC, as well as international experts such as [National Institute for Health and Care Excellence \(NICE\)](#). We strongly urge the revised regulations to prioritize the inclusion of midwifery birth centers as an integral part of the overall healthcare system, rather than categorizing them as an 'alternative' option.

In alignment with these professional organizations, we firmly endorse the incorporation of accredited birth centers into the RPC system, and we request that this integration is explicitly reflected in the NYS perinatal regulations. Accredited birth centers play a vital role in creating a more inclusive and functional RPC system.

The ultimate objective of establishing an RPC system is to ensure and enhance access to care by strengthening and defining relationships among healthcare facilities within a region. Central to a robust RPC system is the development of collaborative partnerships between hospitals of varying levels of care in proximate regions. This strategic approach guarantees that every maternity-serving facility, including midwifery birth centers and Level 1, 2, and 3 facilities, have the necessary personnel and resources to handle unexpected obstetric emergencies. It also ensures that risk assessment is applied judiciously, and that collaboration, consultation, and referral systems are readily available when needed. These collaborative relationships enhance the safety and quality of care for all women and birthing individuals across all levels of care, providing support for circumstances that require higher-level resources.

At the Hudson Valley Hospital Center (HVHC) - Birth Cottage, we were only a driveway away from the hospital's emergency room entrance. Non-emergent transfers were made via the family's car, with the midwife following. Emergent transfers were made via ambulance, which was in such close proximity, that the transfer occurred within minutes. As HVHC was a primary hospital, air-flight protocols were also in place in the event of a more critical medical need for a med-flight transfer to the closest tertiary hospital, ~20 miles away. The gradation of transfer capabilities ensured the highest safety of birth center care of the mother, newborn and family.

Integrating midwifery birth centers into the RPC system ensures a comprehensive and cohesive approach to maternity care in New York State. This integration will enable seamless collaboration between birth centers and hospitals of all levels of service, optimizing the resources available to provide the best possible care for pregnant individuals at any level of need. Moreover, it will foster a supportive environment for midwifery birth centers to thrive as an essential maternity service of the broader healthcare system, offering women and families diverse and evidence-based care options.

In conclusion, we strongly advocate for the integration of midwifery birth centers into the Regional Perinatal Center system, as it will lead to improved access to quality care, enhance safety measures, and promote better health outcomes for women, birthing individuals, and newborns in New York State. By working in partnership to create a truly integrated and collaborative perinatal care system, all New York growing families are ensured to receive the care and support they need throughout their birthing journey.

"Section 795.5, Section i) 3) (pg 124): is amended to read as follows: Midwifery birth center director and

As described above, in the Hudson Valley Hospital Center Birth Cottage model, midwifery birth centers

medical consultants. The operator shall appoint a midwifery birth center director who: ensures that the midwifery birth center has: transfer agreements with one or more perinatal [centers] care hospitals which are geographically close, affiliated with the midwifery birth center's RPC

(MBCs) should be recognized as Level 0 facilities within the overall healthcare system, leading to their integration throughout New York State's healthcare systems. This integration would involve a shared responsibility for safe transfers across the Regional Perinatal Center (RPC) system. It is crucial that the responsibility for facilitating and enforcing transfer agreements between the midwifery birth center and the receiving hospital is jointly undertaken by the RPC, rather than solely relying on the MBC-midwife clinical director.

HVHC was unique in understanding the scope and services provided by the Birth Cottage and the midwives. To ensure successful and safe births, it is essential to foster respectful transfers through established affiliations and protocols between facilities. The AABC's national standards emphasize the importance of establishing consultation, collaboration, and referral systems in each birth center to meet the needs of pregnant individuals and infants.

ACOG also advocates that collaborating receiving hospitals should openly accept transfers. The decision to transfer a patient should not be solely based on guidelines but should also consider the healthcare provider's judgment of the severity of illness and the balance between the need for higher-level care and the risks associated with moving the individual out of their community.

For a truly safe and effective perinatal system in NYS, respectful collaboration must be promoted at every level of care, including midwifery birth centers. By embracing this collaborative approach and honoring the reproductive choices of all birthing individuals, the perinatal system is one that prioritizes quality, safety, accessibility, and personalized care.

In conclusion, recognizing MBCs as Level 0 facilities and integrating them throughout the healthcare system, while ensuring respectful collaborations and transfer agreements, will contribute to building the safest perinatal system in NYS—one that values and respects the diverse choices of all individuals during the birthing process.

V. Language

Language indeed matters, and it should be used accurately and with the intention of fostering a culture of safety, quality, and respect for childbearing individuals. In the draft regulations, there are several places where outdated and inaccurate language is used, and we believe it is essential to address these issues.

Firstly, the term "licensed nurse-midwife" should be removed, as it is inaccurate and non-existent. The correct term is "[licensed midwife](#)," and this should be consistently used throughout the regulations.

Secondly, the use of the term "deliveries" to describe the process of childbirth is outdated and disempowering. The power of childbirth must lie with the birthing person. More empowering and person-centered language should be used, such as "birth" or "humans give birth." This shift in language reflects a focus on the person who is birthing and centers their agency in the birthing process.

Furthermore, when referring to the setting of the birthing process, the term "birthing rooms" should be used instead of "delivery rooms," and the phrase "labor and birth" should be preferred over "labor and delivery." These changes emphasize the central role of the birthing person rather than the clinician in the birthing process.

The concept of informed decision-making should be underscored, recognizing that the ultimate decision-maker is the childbearing individual, who receives information and guidance from their clinical provider(s). This acknowledges the autonomy and agency of the birthing person while being supported by their healthcare providers.

In the regulations, the term "Midwifery/Obstetric patients" is used to refer to all birthing people. While it is commendable to use degendered language by adopting "Obstetric Patients" instead of "Maternity Patients," it is important to note that not all birthing people are obstetric patients. To avoid generalizations and to acknowledge the distinct practices of midwifery and obstetrics, the term "Midwifery/Obstetric patients" may be more suitable.

Finally, in defining the relationships between medical professionals and midwives, the agreed-upon terms of "Consultation, Collaboration, and Referral," as put forth by ACOG and ACNM, should be used. These terms encompass the various ways in which midwives interact and partner with medical professionals, whether in-hospital or out-of-hospital settings. These terms highlight the collaborative nature of the relationships. The use of consistent and agreed-upon terminology enhances clarity and understanding.

In conclusion, using accurate and empowering language in the regulations is vital to reflect a culture that values safety, quality, and respect for childbearing individuals. Adopting the correct terminology and centering the agency of birthing people in the language will contribute to a more inclusive and respectful perinatal care system in New York State.

VI. Integrating Midwifery in all settings

Midwifery. A midwife or nurse-midwife licensed in the state of New York, at minimum, with privileges at the hospital shall serve as the chief of midwifery services. Facilities that do not employ or utilize midwifery staff are exempt from this requirement. (Level I pg 66; Level II pg 75, Level III, pg 82; RPC, pg 91)

The exclusion and erasure of midwifery practice and leadership in hospital settings, as indicated in the regulations, is deeply concerning. The phrase "Facilities that do not employ or utilize midwifery staff are exempt from this requirement" appears in all sections at every hospital level, effectively excluding midwifery services from these facilities. This exclusion restricts reproductive choice and autonomy, and it knowingly disregards a proven

model of care that has been shown to improve maternal health outcomes.

For true access and integration of midwifery care in New York State (NYS), three critical elements need to be addressed:

1. Midwifery Services at all birth facilities: It is essential that NYS ensures the availability of midwifery services at all birth facilities. Midwives play a vital role in providing safe, evidence-based care and must be recognized as essential members of the healthcare team.

2. Access to admitting privileges: Midwives should have admitting privileges at hospitals, enabling them to provide comprehensive care to their clients throughout the birthing process. This is essential to uphold birthing individuals' reproductive choice and ensure continuity of care.

3. Inclusion and full participation of Chiefs of Midwifery Service: To promote true integration and recognition of midwifery care, Chiefs of Midwifery Service should be included and fully engaged in decision-making processes within hospital settings.

Given the worsening maternal mortality rates in the United States, it is imperative that NYS embraces systemic changes and learns from countries with full integration of midwifery, which have demonstrated better maternal health outcomes. As a state committed to reproductive freedom and choice, it is impossible to justify the exclusion of a proven public health solution that can significantly improve maternal health outcomes.

Access to full-scope midwifery care and the freedom to choose one's birth setting are matters of personal choice and autonomy. Every birthing individual deserves the option to choose a midwife, regardless of their medical needs. Midwives work collaboratively with physicians and other healthcare colleagues, providing holistic and individualized care for their clients.

Unfortunately, hospitals in NYS and across the country continue to discriminate against midwives, hindering their inclusion and autonomy. If the NYSDOH is genuinely dedicated to achieving birth care equity, the regulations must reflect that. The NYSDOH must take decisive action to highlight and

	<p>support midwifery access and inclusion throughout these policies. By recognizing and promoting midwifery care, NYS can take a significant step towards improving maternal health outcomes, ensuring reproductive choice, and creating a more inclusive and equitable perinatal care system for all individuals.</p>
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VII. Maternal Mortality Warning Signs

<p>Section 405.21 Perinatal services. (f) Postpartum care of [mother] midwifery or obstetric patient; 4), ii. (pg 39) states: The hospital shall provide to the [mother] patient instructions in self-care and caring for [herself and her] the baby. Topics to be covered shall include but not be limited to: [to] self-care, nutrition, breast examination, exercise, signs of perinatal depression, infant care including taking temperature, feeding, bathing, diapering, infant growth and development, neonatal, infant and childhood vaccines, and parent-infant relationships.</p> <p>Section 405.21 Perinatal services. (c) B. Intrapartum Services. Part 4 Delivery and Childbirth – which should say Childbirth and Birth of the Placenta Part 1c. states: "Accurate methodology to qualitatively and quantitatively assess for blood loss."</p>	<p>The absence of patient education on evidence-based maternal morbidity and mortality warning signs in the current regulations is deeply concerning. Education on recognizing major postpartum complications, such as infection, preeclampsia/hypertension, hemorrhage, and postpartum depression, is crucial in preventing and addressing these issues promptly. By providing specific teaching on how to identify warning signs sooner, care providers can play a significant role in preventing and mitigating potential complications.</p> <p>Given the alarming rates of maternal mortality, particularly among Black and Brown birthing individuals at 2-8 times the rate of White birthing individuals, it is even more critical to include evidence-based patient education on warning signs in the regulations. This step represents an opportunity to improve the quality and safety of care for those most at risk.</p> <p>Eyeballing or making estimates of blood loss, which are qualitative blood loss measuring methods, are not evidence-based standards of care. Research has shown that humans tend to underestimate blood loss, leading to delays in response time and an increased risk of complications such as blood transfusions, ICU admissions, and maternal mortality and morbidity. To ensure best practices and prevent further blood loss or massive hemorrhage, healthcare facilities should adopt quantitative blood loss measurements, which provide real-time measurements and more accurate information.</p> <p>Mandating the use of quantitative blood loss measurements in all hospital labor and birthing units, birthing centers, and midwife birthing centers is vital to the health and safety of birthing individuals in NYS. Additionally, ensuring that all these facilities</p>
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	<p>have hemorrhage carts consistent with the provider's scope of practice will further enhance the readiness to respond to potential emergencies and improve outcomes.</p> <p>The inclusion of evidence-based patient education on maternal mortality warning signs, along with the adoption of quantitative blood loss measurements and the provision of appropriate hemorrhage carts, represents crucial steps in prioritizing the health and safety of birthing individuals in NYS. These measures will contribute to reducing maternal mortality rates and addressing health disparities among vulnerable populations. As we work towards creating a more equitable and inclusive perinatal care system, it is essential that we utilize evidence-based practices to improve outcomes for all birthing individuals.</p>
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VII. Decentralize Transfers – Include all levels of care

<p>Section 795.11, b) (pg 135) “Additional operational requirements for New York State midwifery birth centers shall include affiliation agreements with designated Regional Perinatal Centers; patient transfer agreements with those facilities and/or other designated birthing hospitals; and the implementation of quality improvement protocols related to their integration with a regional perinatal care system, as described in sections 795.2, 795.4, and 795.9 of this Part, respectively. “</p>	<p>The proposed regulations' requirement for all transfers to occur using the RPC transfer center within a designated geographic area raises valid concerns about centralization. While the intention may be to streamline the transfer process, there are potential issues with this approach.</p> <p>Timely transfers between affiliates within the perinatal system are critical in cases of urgent medical issues. In such situations, transferring to the closest and higher level of care is often the safest course of action, saving critical, potentially lifesaving, time. Introducing an additional party and communication, such as the RPC transfer center, could potentially delay communication and decision-making, which may have serious, if not life threatening, consequences for the health and safety of the birthing individuals.</p> <p>On the other hand, when transferring for non-emergent issues to a higher level of care, involving the RPC consultation may not be necessary. This could lead to unnecessary delays in transferring patients when a direct midwife-to-midwife communication would suffice for smooth transfers. In our birth center at HVHC, the midwives had admitting privileges at both the Birth Cottage and the hospital, so the midwife would accompany the patient to the hospital, if transfer was indicated. If</p>
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the midwife had a second patient laboring at the birth center, she would call the midwife on second-call to meet the patient at the hospital, ensuring continuity of care and a positive patient experience.

Moreover, it is essential to recognize that transferring from midwifery care clients who are coming from home or birth centers often prefer to be transferred to other midwifery services. This preference is based on the continuity of care and familiarity with midwifery perspectives and practices. Facilitating direct communication between midwives in such cases can improve the overall transfer experience and ensure a seamless transition of care.

It is crucial to acknowledge the historical discrimination and underestimation of midwifery scope of practice by many RPCs. Granting decision-making power to RPCs for all transfers could perpetuate biases and undermine efforts to promote midwifery care and integration. Decades of discrimination cannot be undone simply by giving authority to RPCs, which may not fully appreciate or understand the scope and value of midwifery care.

In conclusion, while the intention of centralizing transfers may be to streamline the process, there are potential drawbacks and concerns to consider. Timely and appropriate transfers are essential in ensuring optimal care and safety for birthing individuals. Recognizing the preferences of clients and facilitating direct midwife-to-midwife communication when appropriate can enhance the transfer experience. Additionally, a collaborative approach that acknowledges the value of midwifery care and addresses historical discrimination is crucial to creating an equitable and inclusive perinatal care system.