



Arizona Association of Midwives
Committee on Legal and Regulatory Concerns
PO Box 80751
Phoenix, AZ 85060

August 31, 2015

Arizona Department of Health Services
Licensed Midwife Advisory Committee
1740 W Adams #203
Phoenix, AZ 85007

On behalf of the Arizona Association of Midwives (AAM) the Committee on Legal and Regulatory Concerns (CLaRC) submits the following narrative and timeline to be included in the annual report of the Arizona Department of Health Services (ADHS) Licensed Midwives Advisory Committee (LMAC). This narrative has been requested by Jenny Schultz LM CPM, LMAC committee member.

In August 2014 the Arizona Association of Midwives formed a special committee to address legal and regulatory concerns pertaining to the practice of midwifery in the State of Arizona. The formation of this committee (CLaRC) was in response to a growing need to improve the Arizona midwifery rules, a sharp increase in ADHS enforcement actions against midwives, and unclear communications with ADHS.

Licensed midwives (LM) in the State of Arizona are committed to providing high quality maternity care to families. It is essential that the Arizona Rules under which Licensed and Certified Professional Midwives practice reflect both the midwifery model of care and current best practices for maternity care providers. Rules that do not meet these standards pose a ***substantial risk to the health and safety of women and babies*** in Arizona.

Despite multiple formal and informal requests from the Arizona Association of Midwives (AAM) and individual midwives to update the antiquated, burdensome and legally uncertain midwifery rules (see attached timeline), ADHS has not made the substantial and relevant changes requested by midwives to ensure health and safety of midwifery clients and their babies. ADHS has placed blame on the long standing governors' moratoriums on rulemaking for their inaction to correct multiple errors within the rules that govern licensed midwives in Arizona.

Additionally, ADHS has referenced the “scope of practice” bill HB2247, which initiated a rules revision process in 2012, as evidence that ADHS has addressed concerns regarding the rules. Unfortunately, this revision process was a missed opportunity for ADHS to bring midwifery rules up to date and to revise the rules to reflect current standards of practice and evidenced based care. The midwives of Arizona, through the AAM, collectively submitted an evidenced-based report to ADHS detailing the ways in which midwifery rules are problematic and unsafe. The midwives who sat on the advisory committee for HB2247 repeatedly attempted to bring this report to the attention of the committee and ADHS. This report was neither referenced nor utilized by ADHS during the process of updating the rules. Therefore the rules, although changed in 2012, continue to be outdated, unsafe and burdensome.

Within the most recent Governor’s Order regarding the internal review of administrative rules (*G.O. 2015-01 issued on January 5, 2015*) the order clearly outlines that each state agency has the ability to request new rule making powers in order “*to prevent a significant threat to the public health, peace or safety.*” As stated above, we feel the rules present a ***substantial risk to the health and safety of women and their newborns.***

Therefore, in an attempt to reduce the risk to health and safety of women and newborns, the Arizona Association of Midwives (AAM) has begun submitting “Petitions for a Rule” to the Arizona Department of Health Services (ADHS) as permitted in Arizona Revised Statutes § 41-1033 (Administrative Procedures Act). Thus far, AAM has submitted a total

of seven petitions addressing some of the most pressing issues within rule. AAM has, through these petitions, requested that the Department exercise its ability to submit a request to the Office of the Governor in order to address problematic midwifery rules. It appears, that as of this date, ADHS has made no such request.

We respectfully request that any submitted petitions and this narrative be included in the LMAC annual report.

Please direct any questions, clarifications or responses to the *Committee for Legal and Regulatory Concerns of AAM* (liaison to the AAM Board of Directors) at the address listed above.

Sincerely,

Committee for Legal and Regulatory Concerns of AAM

AAM Committee on Legal and Regulatory Concerns (CLaRC) Timeline of Events

Below is a brief summary of events and actions taken by the Arizona Association of Midwives (AAM) and AAM CLaRC in an attempt to improve midwifery regulations for the health and safety of midwifery clients.

- June 2012: Midwives submit HB2247 report to ADHS requesting extensive rules changes
- August 2013: AAM submits Sunrise Application for Medication Access
- August 2014: Committee on Legal and Regulatory Concerns (CLaRC) began meeting regularly
- September 2, 2014: Submit letter to ADHS with requesting: audio and slide content from the June 2014 training meeting to be posted to the ADHS website, address the numerous questions posed at the June meeting, provide a fee schedule for enforcement fines,
- November 19, 2014: AAM votes to require MANA STATS submission as a requirement of membership
- December 4, 2014: CLaRC meeting with Carla Berg. Discussed MANA Core Competencies, ICM Core Competencies, Midwifery Model of Care.
- March 5, 2015: CLaRC meeting with Carla Berg/Donald Gibson (See letter/email response)
- May 12, 2015 APA petition for a rule - Continuity of Care*
- May 19, 2015 APA petition for a rule - Blood Pressure*
- May 26, 2015 APA petition for a rule - Definition of Midwifery Services*
- June 2, 2015 APA petition for a rule - Severe Mental Illness*
- June 20, 2015 APA petition for a rule - Gestation Beyond 42 Weeks
- July 10, 2015 APA petition for a rule - PPH Greater than 500ml
- July 14, 2015 APA petition for a rule - Syphilis Testing
- July 21, 2015 APA petition for a rule - Syphilis
- Aug 11, 2015 APA petition for review of agency practice - Syphilis

Department Responses

- June 2014: ADHS hosted a meeting to discuss/clarify midwifery rules with Pragathi as moderator with Tom Salow attending.
- October 8, 2014: ADHS responded to September 2nd letter
- December 8, 2014: ADHS hosts Informal Question and Answer Meeting
- June 23, 2015 to July 1, 2015: ADHS responds to the first four (7)* of the nine (9) APA petitions from 06/23/15 to 08/27/15 with the same form letter stating that “ADHS does not believe that your Letter satisfies the requirements in A.R.S. § 41-1033.” and “ADHS

also believes that the current midwifery rules contain the necessary standards to ‘safeguard the health and safety of the mother and child.’”

CURRENT RULE

A.A.C. R9--16-111. Prohibitive Practice; Transfer of Care

B: A midwife shall not accept for midwifery services **or continue midwifery services** for a client who has or develops any of the following: 1-26 [lists conditions]

1. A previous surgery that involved:
 - a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
 - b. A previous uterine surgery that enters the myometrium;
2. Multiple fetuses
3. Placenta previa or placenta accreta;
4. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
5. Deep vein thrombosis or pulmonary embolism;
6. Uncontrolled gestational diabetes;
7. Insulin-dependent diabetes;
8. Hypertension;
9. Rh disease with positive titers;
10. Active:
 - a. Tuberculosis;
 - b. Syphilis;
 - c. Genital herpes at the onset of labor;
 - d. Hepatitis until treated and recovered, following which midwifery services may resume; or
 - e. Gonorrhea until treated and recovered, following which midwifery services may resume;
11. Preeclampsia or eclampsia persisting after the second trimester;
12. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
13. A persistent hemoglobin level below 10 grams or a **persistent** hematocrit below 30 during the third trimester;
14. A pelvis that will not safely allow a baby to pass through during labor;
15. A serious mental illness;
16. Evidence of substance abuse, including six months prior to pregnancy, to one of the following, evident during an assessment of a client:
 - a. Alcohol,
 - b. Narcotics, or
 - c. Other drugs;
17. Except as provided in R9-16-108(B)(2), a fetus with an abnormal presentation;
18. Labor beginning before the beginning of 36 weeks gestation;
19. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
20. Gestational age greater than 34 weeks with no prior prenatal care;
21. A gestation beyond 42 weeks;
22. Presence of ruptured membranes without onset of labor within 24 hours;
23. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
24. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;
25. A postpartum hemorrhage of greater than 500 millimetres in the current pregnancy; or
26. A non-bleeding placenta retained for more than 60 minutes

PROPOSED RULE

- A.A.C. R9-16-111. Prohibitive Practice; Transfer of Care
- B. A midwife shall not **knowingly** accept for midwifery services or continue midwifery services **without documentation of condition treated and resolved, following which midwifery services may resume;** for a client who has or develops any of the following: 1-26 [lists conditions]
27. A previous surgery that involved:
 - a. An incision in the uterus, except as provided in R9-16-108(B)(1); or
 - b. A previous uterine surgery that enters the myometrium;
 28. Multiple fetuses
 29. Placenta previa or placenta accreta;
 30. A history of severe postpartum bleeding, of unknown cause, which required transfusion;
 31. Deep vein thrombosis or pulmonary embolism;
 32. Uncontrolled gestational diabetes;
 33. Insulin-dependent diabetes;
 34. Hypertension;
 35. Rh disease with positive titers;
 36. Active:
 - a. Tuberculosis;
 - b. Syphilis;
 - c. Genital herpes at the onset of labor;
 - d. Hepatitis until treated and recovered, following which midwifery services may resume; or
 - e. Gonorrhea until treated and recovered, following which midwifery services may resume;
 37. Preeclampsia or eclampsia persisting after the second trimester;
 38. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart;
 39. A persistent hemoglobin level below 10 grams or a **persistent** hematocrit below 30 during the third trimester;
 40. A pelvis that will not safely allow a baby to pass through during labor;
 41. A serious mental illness;
 42. Evidence of substance abuse, including six months prior to pregnancy, to one of the following, evident during an assessment of a client:
 - a. Alcohol,
 - b. Narcotics, or
 - c. Other drugs;
 43. Except as provided in R9-16-108(B)(2), a fetus with an abnormal presentation;
 44. Labor beginning before the beginning of 36 weeks gestation;
 45. A progression of labor that does not meet the requirements of R9-16-108(J)(4), if applicable;
 46. Gestational age greater than 34 weeks with no prior prenatal care;
 47. A gestation beyond 42 weeks;
 48. Presence of ruptured membranes without onset of labor within 24 hours;
 49. Abnormal fetal heart rate consistently less than 120 beats per minute or more than 160 beats per minute;
 50. Presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones;

51. A postpartum hemorrhage of greater than 500 millimetres in the current pregnancy; or
52. A non-bleeding placenta retained for more than 60 minutes

JUSTIFICATION - Midwife-led continuity of care is provided in a multidisciplinary network of consultation and referral with other care providers. This contrasts with medical-led models of care where an obstetrician or family physician is primarily responsible for care. In shared-care models, responsibility is shared between different healthcare professionals. Organizations worldwide and in the United States, such as the Homebirth Summit, have concentrated on shared care during a medical transport which recognizes that midwives have proven competency at medical assessment for conditions which would require a transfer of care or consultation. Once consulted or transferred, within a multidisciplinary network, the optimal care for the woman would be the ability to maintain continuity of care by her midwife once the condition necessitating transfer of care or consultation is resolved.

The midwifery prohibited practice section states that “[a] midwife shall not accept for midwifery services or continue midwifery services for a client who *has or develops* any of the following” twenty-six different health conditions. A.A.C. R9-16-111(B). In the past, this provision was interpreted to allow a midwife to resume care once the health condition had been treated or ceased to exist. Since the writing of the new rules, the Department has taken action against midwives and had opined in a training session that this “Prohibited Practice” section does not allow a midwife to resume care. This position is problematic.

First, interpreting the rules in this way arbitrarily excludes healthy, low-risk women from midwifery services. Many of the health conditions within section 111(B) are not permanent conditions and can be resolved. By interpreting these rules to not allow midwives to resume care, the Department is excluding healthy women from the care providers of their choice.

Second, this interpretation is not consistent with the plain language of the rules. When the Department revisited the midwifery rules in 2013, the Department chose to use the words “*has or develops*.” The Department chose to use these words in the present perfect tense, indicating that a midwife cannot accept or continue care when a client *presently* has one of the twenty-six different conditions. The logical leap that the Department has made is that this section also prohibits care when a client *has had* any of these conditions.

Third, midwives are mandated in A.A.C. R9-108-K to provide postpartum care for the mother *and* the newborn. The interpretation of this rule offered by the Department to immediately terminate all midwifery services when the midwifery client experiences any of the conditions within 111(B) ignores that there are two people the midwife is legally tasked with caring for in the days following birth.

Last, as currently interpreted, these rules do not provide guidance on a midwife’s responsibilities in the event that her patient does not consent to a transfer of care. Both the Arizona Supreme Court and the United States Supreme Court have held that patients have a right to refuse medical treatment, even when that treatment is lifesaving. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 277 (1990); *Rasmussen by Mitchell v. Fleming*, 154 Ariz. 207, 215, 741 P.2d 674, 682 (1987).

The Department of Health has been aware for years that the rules place the midwife in an impossible situation if her client exercises her constitutionally protected right to decline treatment: the midwife must choose between keeping her licence and her ethical responsibility to not abandon her patient. This rule change would provide the midwife with the guidance she needs while still protecting public health and safety.

R9-16-101. 30 Definition of ‘midwifery services’: “*Midwifery services*” means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery or postpartum care.

REFERENCE LIST

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- Midwives Alliance Board. (2011). Core Competencies for Basic Midwifery Practice. Accessed online 05 May 2015. <http://mana.org/pdfs/MANACoreCompetenciesColor.pdf>
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http://www.homebirthsummit.org/wp-content/uploads/2014/03/HomeBirthSummit_BestPracticeTransferGuidelines.pdf

Petition for a Rule Change - Blood Pressure Limits

Submitted to Arizona Department of Health Services on May 19, 2015

Page 1 of 1

CURRENT RULE

A.A.C. R9-16-111 Prohibited Practice; Transfer of Care

B. A midwife shall not accept for midwifery services or continue midwifery services for a client who has or develops any of the following:

12. A blood pressure of 140/90 or an increase of 30 millimeters of Mercury systolic or 15 millimeters of Mercury diastolic over the client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart.

PROPOSED RULE

Remove from Prohibited Practice; Transfer of Care and move to Required Consultation; change limits to as follows: Diastolic blood pressure (dBp) of 90-109 millimeters of mercury or systolic blood pressure greater than or equal to 160 millimeters of mercury taken in two consecutive readings taken at least six hours apart, OR dBp greater than or equal to 110 millimeters of mercury in one single reading warrants **medical consultation**.

JUSTIFICATION

140/90 and a rise of 30/15 as limits set in current rule do not reflect standard of care. A definition of hypertension in pregnancy due to a relative rise in blood pressure has a high false positive rate in pregnancy, due to the variability of blood pressure at certain stages of gestation, thus this criterion is no longer endorsed. Current guidelines for standard of care by all major obstetric and midwifery organizations define the point at which blood pressure during pregnancy warrant further evaluation as defined above in the proposed rule. Further, current guidelines recommend expectant management and medical consultation rather than immediate transfer of care. Midwives are experts in pregnancy education, spending at average an hour with patients, to discuss lifestyle and diet changes as well as relative risk of hypertension and its associated diseases to both the mother and fetus. With consultation and continued midwifery care, the woman is receiving the best possible anticipatory guidance and monitoring.

A.A.C. R9-16-111 (B) 8. already establishes a diagnosis of hypertension as prohibited practice and A.A.C. R9-16-111 (B) 11 already establishes a diagnosis of preeclampsia or eclampsia as prohibited practice. A rise in blood pressure alone is not justification for termination of care. Medical consultation serves the purpose of screening to rule out the diagnoses of hypertension and preeclampsia.

REFERENCE LIST

ACOG Committee on Obstetric Practice. (2015). *Emergent Therapy for Acute - Onset, Severe Hypertension During Pregnancy and the Postpartum Period*. Committee Opinion No 623.

ACOG Task Force on Hypertension in Pregnancy. (2013). *Hypertension in Pregnancy*. *Obstetrics & Gynecology*, Vol 122, No 5, November 2013.

Canadian Hypertensive Disorders of Pregnancy Working Group. (2014). *Diagnosis, Evaluation, and Management of the Hypertensive Disorders of Pregnancy: Executive Summary*. *J Obstetrics Gynaecol Can* 2014; (5): 416-438.

HDP CPG Working Group. Association of Ontario Midwives. (2012). *Hypertensive Disorders of Pregnancy*. Available online:

http://www.ontariomidwives.ca/images/uploads/guidelines/No15_CPG_HDP_062612.pdf. (Clinical Practice Guideline No. 15).

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<https://www.nice.org.uk/guidance/cg62/resources/guidance-antenatal-care-pdf>

CURRENT RULE

A.A.C. R9-16-101. 30 "Midwifery services" means health care, provided by a midwife to a mother, related to pregnancy, labor, delivery, and postpartum care.

PROPOSED RULE

"Midwifery services" means health care, provided by a midwife, related to pregnancy, labor, delivery, and postpartum care. This care includes preconception counseling, well-woman care, preventative care, the promotion of normal birth, the detection of complications in pregnancy and the newborn, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

JUSTIFICATION

Midwifery practice according to AWONN is the "...independent management of women's healthcare, focusing on pregnancy, childbirth, the postpartum period, care of the newborn and the family planning and gynecological care. The core of midwifery practice contains health promotion, management of normal birth, assessment and detection of complications, and referral as needed." The certified and licensed midwife in Arizona has demonstrated competency via a national certification and state exam. Licensed midwives have worked in partnership with women to give the necessary support, clinical care and recommendations pertaining to health promotion, reproductive health and wellness, care of the newborn and the carrying out of emergency measures if needed since Arizona enacted regulations in the 1970s. In addition, national and international standards for education, training, competency and credentialing of midwives include the midwifery services outlined above. Midwives are recognized as experts in normal birth and wellness care globally and are held to a set of professional standards and ethics that require the midwife to consult or refer to another healthcare provider when the needs for care exceed the competency of the midwife.

REFERENCE LIST

Association of Women's Health, Obstetric and Neonatal Nursing. (2012). *Midwifery Position Statement*. Accessed online 5/16/15 at

https://www.awhonn.org/awhonn/content.do?name=07_PressRoom/07_PositionStatements.htm

International Confederation of Midwives. (2011). *ICM International Definition of the Midwife*. Accessed online 05/16/15 at

<http://www.internationalmidwives.org/assets/uploads/documents/Definition%20of%20the%20Midwife%20-%202011.pdf>

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Medical Board of California. (2014). *Practice Guidelines for California Licensed Midwives*. Accessed online 05/16/15 at http://www.mbc.ca.gov/Licensees/Midwives/midwives_practice_guidelines.pdf.

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State of Vermont. (2015). *The Vermont Statutes Online. Title 26: Professions And Occupations. Chapter 85: Midwives*. Accessed online 05/16/15 at <http://legislature.vermont.gov/statutes/fullchapter/26/085>

Petition for a Rule Change - Serious Mental Illness

Submitted to the Arizona Department of Health Services 06/02/15

by the Arizona Association of Midwives Legal and Regulatory Committee

Page 1 of 2

CURRENT RULE

R9-16-111. Prohibited Practice; Transfer of Care

B. A midwife shall not accept for midwifery services or continue midwifery services for a client who has or develops any of the following:

15. A serious mental illness;

A.A.C R9-16-101

44. "Serious mental illness" means a condition in an individual who is eighteen years of age or older and who exhibits emotional or behavioral functioning, as a result of a mental disorder as defined in A.R.S. § 36-501 that:

- a. Is severe and persistent, resulting in a long-term limitation of their functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation; and b. Impairs or substantially interferes with the capacity of the individual to remain in the community without supportive treatment or services of a long-term or indefinite duration

For reference:

A.R.S. § 36-501

24. "Mental disorder" means a substantial disorder of the person's emotional processes, thought, cognition or memory. Mental disorder is distinguished from:

- (a) Conditions that are primarily those of drug abuse, alcoholism or intellectual disability, unless, in addition to one or more of these conditions, the person has a mental disorder.*
- (b) The declining mental abilities that directly accompany impending death.*
- (c) Character and personality disorders characterized by lifelong and deeply ingrained antisocial behavior patterns, including sexual behaviors that are abnormal and prohibited by statute unless the behavior results from a mental disorder.*

PROPOSED RULE

Eliminate A.A.C. R0-16-111 (B) 15 and A.A.C R9-16-101 44.

JUSTIFICATION

Within healthcare ethics and standard of care, individuals are expected to make medical decisions on their own behalf unless they are legally incompetent to do so. Major obstetric organizations recommend that pregnant patients with SMI be provided the same treatment options as the general population as long as they demonstrate decision making capacity. The presence of a possible or diagnosed SMI does not remove this right. Many mental health organizations have made great strides towards removing the stigma and discrimination associated with mental illness. Prohibiting individuals with SMI from obtaining midwifery care unless they have been proven legally incompetent is discriminatory.

According to the National Alliance on Mental Illness (NAMI), severe mental illness includes "major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder." One out of every six women will experience unstable mental health during their childbearing years, with depression being most common. Women with depression have been noted to enter midwifery care at disproportionate rates and midwifery organizations encourage midwives to integrate care of women with depression into their practices. Midwifery care has been shown to improve postnatal outcomes for women with chronic clinical depression.

Petition for a Rule Change - Serious Mental Illness

Submitted to the Arizona Department of Health Services 06/02/15

by the Arizona Association of Midwives Legal and Regulatory Committee

Page 1 of 2

Further, midwives are not mental health professional and therefore are not trained in the identification and diagnosis of mental disorders, serious mental illness, or severe psychiatric illness. The rule and definition as provided, A.A.C. R0-16-111 (B) 15 and A.A.C R9-16-101 44, places the responsibility on the midwife to determine whether the midwifery client has a “*substantial disorder of the person's emotional processes, thought, cognition or memory.*”

Other disease and illness processes listed within AAC R9-106 as prohibited practice or consultation (for example, seizure disorder, heart disease, kidney disease, blood disease, active tuberculosis, etc.), that are recognized as outside of the scope of practice of midwifery care do not contain the expectation that the midwife identify and diagnose the condition. Rather, the expectation is that if the midwifery client presents with a history of these conditions or reports a current diagnosis of these conditions, the midwife will the appropriately consult or transfer care. By defining SMI in A.A.C. and not defining other diseases and illnesses, the implied expectation is that the midwife understand, identify and diagnose. This is an unreasonable expectation.

REFERENCE LIST

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Petition for a Rule Change - Gestation beyond 42 weeks

Submitted to Arizona Department of Health Services on June 30, 2015

by The Arizona Association of Midwives Legal and Regulatory Committee

Page 1 of 2

CURRENT RULE

R9-16-111. Prohibited Practice; Transfer of Care

21. A gestation beyond 42 weeks;

PROPOSED RULE

R9-16-112. Required Consultation

A. A midwife shall obtain a consultation at the time a client is determined to have any of the following during the current pregnancy:

A gestation beyond 42 weeks;

JUSTIFICATION

Pregnancy that goes beyond 42 weeks gestation or 294 days, by definition, is based on a 28 days menstrual cycle. Discrepancies in pregnancy dating are well known. Methods used to calculate due dates, including use of the LMP, conception date, ultrasound after 12 weeks gestation are all subjective. Research suggests that the only method of accurate pregnancy dating is an early ultrasound in the embryonic stage. Many midwifery clients do not obtain or wish for an early first trimester ultrasound.

There are many confounding factors that have an effect on the length of gestation for certain individuals. For example, ovulation is often delayed in breastfeeding individuals; pharmaceuticals being taken by individuals may impact hormonal function; people who practice extreme dieting, exercise or suffer from malnutrition often exhibit longer (or shorter) gestations and there is evidence to suggest that patients tend to follow previous pregnancy patterns and will carry pregnancies longer if they have done so in the past. Additionally, midwives understand the psycho-social condition of pregnancy may explain why some individuals may not be emotionally able to enter into labor if experiencing trauma or an unwillingness to experience birth.

Current research clearly demonstrates that although there is an increased risk of stillbirth as pregnancy progresses beyond 37 weeks gestation, there is no clear indication that medical management via induction methods reduces that risk when compared to expectant management for people who remain pregnant beyond 41 weeks. The increased risks of potentially unneeded medical intervention are well documented as significant hormonal “benefit” of entering into spontaneous labor rather than undergoing induction of labor.

Often, post dates pregnancy is incorrectly correlated with postmaturity syndrome, or an issue with placental sufficiency, which is not confined to infants with a gestation of more than 40 weeks. This distinction is critical as a pregnancy that is prolonged is markedly different than a pathological condition that is often unrelated to the gestational duration. Midwives are trained to identify risk factors for post date pregnancies which may be cause for concern and, in collaboration with a consulting physician, assess best plan for positive outcome. Additionally, mortality rates in postdate infants are often related to congenital malformations.

Moving “gestation beyond 42 weeks” to consultation allows the midwife to work collaboratively with the medical community and serve the midwifery client for the best possible outcomes. If the midwifery client is being monitored with expectant management including advanced ultrasound scans and non-stress tests, she may safely deliver at home or in a birth center if she so desires after a thorough informed consent process. Conversely, if medical management is determined to be a more appropriate approach to care, the client could still maintain collaborative care with her midwife and physician as well as return to the midwife for postpartum care following a hospital birth.

REFERENCE LIST

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Petition for a New Rule - Postpartum Hemorrhage greater than 500 ml

Submitted to Arizona Department of Health Services on 07/10/15

by The Legal and Regulatory Committee of the Arizona Association of Midwives

Page 1 of 3

PROPOSED NEW RULE

A midwife may continue care for a midwifery client with a “postpartum hemorrhage of greater than 500 milliliters in the current pregnancy” as stated in R9-16-111 B 25 if the following criteria are met in the postpartum period:

- a. The hemorrhage responds to treatments available in the out of hospital setting and is well controlled
 - i. The client is alert and oriented
 - ii. The client is not experiencing syncope greater than one occurrence
 - iii. The client's blood pressure remains within normal limits of between 90/60 and 140/90; or,
- b. The client has been discharged from physician care following a transfer of care for hemorrhage

JUSTIFICATION

Currently available prevention and treatment options for postpartum hemorrhage have been found to be effective at improving maternal outcomes. Midwives undergo rigorous training in assessing risk factors for postpartum hemorrhage. Midwives regularly implement prenatal care plans that reduce identified risks. Midwives in out of hospital birth practices do not provide care to clients with known risk factors for postpartum hemorrhage such as those with: multiple gestation, preeclampsia, chorioamnionitis, and polyhydramnios. Similarly, patients planning an out of hospital birth do not undergo interventive procedures known to increase rates of hemorrhage such as: medical labor augmentation, assisted delivery techniques (vacuum or forceps), and cesarean delivery. Postpartum hemorrhage affects 1-3% of postpartum patients. The most common cause of postpartum hemorrhage is uterine atony which respond well to current standards of practice for a licensed midwife.

There is no single accepted definition of postpartum hemorrhage in the United States. A blood loss of 500mL following vaginal birth and 1000mL following cesarean birth are commonly used for diagnosis even though current research suggests average blood loss may be greater. Visual estimation of blood loss is notoriously inaccurate, often over-estimating total blood loss, and has been found to be of little clinical use. It is important to note that a blood loss volume of 500mL is somewhat arbitrary and fails to take into consideration the individual's starting blood volume and may be irrelevant to the client's hemodynamic state. Likewise, a decrease in hematocrit levels by 10% has also been used for diagnosis, but similarly may not represent the current hematological state of the client and some individuals may suffer a postpartum hemorrhage with lower blood losses.

Two health and safety advantages of the proposed rule changes include: supporting continuity of care for the client and expanding the definition of postpartum hemorrhage to allow for assessment and treatment of signs and symptoms of postpartum hemorrhage rather than basing transfer of care upon an arbitrary and often inaccurate numerical estimated measurement. Midwives are trained and capable of assessing signs and symptoms that would indicate impending hypovolemic shock or a hemorrhage that is not responding well to treatment. Midwifery clients exhibiting concerning symptoms or presenting with a poorly controlled hemorrhage would appropriately be transferred to the hospital while those midwifery clients who have a postpartum hemorrhage greater than 500mL yet remain stable would be permitted to remain home under the care of their midwife.

Petition for a New Rule - Postpartum Hemorrhage greater than 500 ml

Submitted to Arizona Department of Health Services on 07/10/15

by The Legal and Regulatory Committee of the Arizona Association of Midwives

Page 1 of 3

Supporting continuity of care for clients through treatment of postpartum hemorrhage is of great value to the client, as continuity of care has been shown to decrease maternal morbidity and mortality. In a shared-care, midwife-led model, continuity of care is provided in a multidisciplinary network of consultation and referral with other care providers. In shared-care models, responsibility is shared between different healthcare professionals. Organizations worldwide and in the United States, such as the Homebirth Summit, have concentrated on shared care during a medical transport which recognizes that midwives have proven competency at medical assessment for conditions which would require a transfer of care or consultation. Once consulted or transferred, within a multidisciplinary network, the optimal care for the woman would be the ability to maintain continuity of care by her midwife. Therefore even if a transfer is necessitated for treatment of postpartum hemorrhage once the condition is resolved the client should be given the opportunity return to her midwife for postpartum care.

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Petition for a New Rule - Postpartum Hemorrhage greater than 500 ml

Submitted to Arizona Department of Health Services on 07/10/15

by The Legal and Regulatory Committee of the Arizona Association of Midwives

Page 1 of 3

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Petition for a Rule Change - SYPHILIS TESTING

Submit to the Arizona Department of Health Services July 14, 2015

by The Arizona Association of Midwives Legal and Regulatory Committee

Page 1 of 2

CURRENT RULE

A.A.C. R9-16-108. Responsibilities of a Midwife; Scope of Practice

I. During the prenatal period, the midwife shall:

1.Until October 1, 2013, schedule or arrange for the following tests for the client within 28 weeks gestation:

f. Syphilis as required in A.R.S. § 36-693;

3. As of October 1, 2013, except as provided in R9-16-110, ensure that the tests in section (I)(1) are completed by the client within 28 weeks gestation;

A.R.S. § 36-693 Blood tests required; pregnant women; umbilical cord at delivery; definition

A. A physician shall at the time of the first prenatal examination, after a diagnosis of pregnancy, take or cause to be taken a sample of the blood of the woman and submit it to an approved laboratory for a standard serological test for syphilis. If the woman has not had a serological test prior to delivery, a sample of blood from the umbilical cord shall be taken at delivery for examination.

B. Any other person permitted by law to attend pregnant women but not permitted to take blood samples shall cause a sample of the blood of each pregnant woman attended by him to be taken under the direction of a duly licensed physician of medicine and surgery as required by subsection A. The physician shall have the sample submitted to an approved laboratory for a standard serological test for syphilis.

C. For the purpose of this section "standard serological test" means a test for syphilis approved by the director and made at a laboratory approved by the director to make such tests. A laboratory test required by this section shall be made by the state laboratory without charge.

PROPOSED RULE

A.A.C. R9-16-108. Responsibilities of a Midwife; Scope of Practice

I. During the prenatal period, the midwife shall:

1.Until October 1, 2013, schedule or arrange for the following tests for the client within 28 weeks gestation:

f. Syphilis

3. As of October 1, 2013, except as provided in R9-16-110, ensure that the tests in section (I)(1) are completed by the client within 28 weeks gestation;

JUSTIFICATION

Removing "Syphilis as required in A.R.S. § 36-693" and replacing it with "Syphilis" as another declinable laboratory test better fits the midwifery licensing rules in Arizona as well as the midwifery model of care. Autonomous, informed choice for midwifery clients consenting or declining certain testing without fear of losing their care provider is central to midwifery care.

Beyond the right to informed choice, citing A.R.S. § 36-693 in midwifery rules is an error as midwives do not meet the descriptions stated in the statute. Midwives are not physicians as described in A.R.S. § 36-693 A, nor are they "any other person permitted by law to attend pregnant women but not permitted to take blood samples" as described in A.R.S. § 36-693. Phlebotomy or at minimum the ability to order

Petition for a Rule Change - SYPHILIS TESTING

Submit to the Arizona Department of Health Services July 14, 2015

by The Arizona Association of Midwives Legal and Regulatory Committee

Page 2 of 2

laboratory tests is part of licensed midwives training, standard of practice and expectations as outlined in rule. Licensed midwives are independent care providers and do not operate under a physician's license or supervision.

If interpretation of the statute is that all midwifery clients must obtain physician consultation for syphilis testing, this is both cost prohibitive and nearly unobtainable. If it is determined that midwives are not permitted to take blood samples, this poses a serious health risk to mothers and babies. Newborn metabolic screening and routine laboratory testing is considered part of routine midwifery care.

REFERENCE LIST

ACOG. (2007). Ethical decision making in obstetrics and gynecology. ACOG Committee Opinion No. 390. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2007;110:1479–87. Reaffirmed 2013.

Arizona Revised Statute. A.R.S. § 36-693 Blood tests required; pregnant women; umbilical cord at delivery; definition

Petition for a Rule Change- Syphilis

Submit to the Arizona Department of Health Services July 21, 2015

by The Arizona Association of Midwives Legal and Regulatory Committee
Page 1 of 1

CURRENT RULE

A.A.C. R9-16-111 Prohibited Practice; Transfer of Care

B. A midwife shall not accept for midwifery services or continue midwifery services for a client who develops any of the following:

- 10. Active b. Syphilis

PROPOSED RULE:

A.A.C. R9-16-112. Required Consultation

A. A midwife shall obtain a consultation at the time a client is determined to have any of the following during the current pregnancy:

- 26. A positive test result for: d. Syphilis;

JUSTIFICATION

- Midwifery scope of practice includes routinely assessing gestational age of the fetus.
- Effective treatment of syphilitic infection in women in less than 20 weeks gestation is achievable; Fetal ultrasonographic abnormalities and treatment failure are rare because the infection can only pass through a fully mature placenta.
- Effective treatment of syphilitic infection is monitored through screening and documentation of a four-fold decrease in titer reactivity. Lab results obtained from the infectious disease specialists may be assessed and addressed by the midwife in routine prenatal checkups. Thoughtful interpretation of results prevents the unnecessary transfer of VDRL positive mothers.
- Women at an increased risk for exposure- those with multiple sex partners, history of STIs, or living in a community with a high prevalence of syphilis- should be rescreened during the third trimester.
- If an especially large, thick, and pale placenta is observed postpartum (indicative of congenital syphilis) midwife will make referral to a pediatric provider skilled in infectious disease for full evaluation.
- Neonates born to women who have been effectively treated for syphilis during gestation will be referred to a pediatric provider skilled in infectious disease for full evaluation.

REFERENCE LIST

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Petition for a Review of Existing Agency Practice pursuant to Arizona Revised Statute
Section 41-1033

Submitted to the Arizona Department of Health Services 8/10/2014
by the Arizona Association of Midwives Legal and Regulatory Committee

REVIEW OF EXISTING AGENCY PRACTICE

This petition requests review of an existing agency practice that constitutes a rule. Specifically, the Department of Health has interpreted A.R.S. § 36-693 and developed a rule outside of the rulemaking process.

According to the midwifery rules “during the prenatal period, a midwife shall ... schedule or arrange the following tests for the client within 28 weeks gestation ... (f) Syphilis as required by § 36-693.” R9-16-108(l)(1)(f).

On August 3, 2015, Thomas Salow the Branch Chief in the Department of Health Division of Licensing, announced a new agency interpretation of section 36-693. Mr. Salow testified that the agency has interpreted A.R.S. § 36-693 to mean that a midwife is a “person permitted by law to attend pregnant women but not permitted to take blood samples.”

Specifically in 2015C-MDW-0244-DHS, at 52:00 minutes into the hearing, Mr. Salow and the defense attorney have the following exchange:

Attorney: Is it the departments position than that [the midwife] is "any other person permitted by law to attend pregnant women but not permitted to take blood."

Mr. Salow: Correct.

Further, on cross examination, Mr. Salow testified that, under the Department’s interpretation of the statute, midwives are obligated “cause a sample of the blood of each pregnant woman attended by him to be taken under the direction of a duly licensed physician of medicine and surgery” because they are “not permitted to take blood.”

The Department of Health has served at least two Notices to Assess Civil Penalties or Suspend Licenses based on this interpretation of the statute.

REQUEST TO REVIEW PRACTICE JUSTIFICATION

The assertion that a midwife is “not permitted to take blood samples” is a statement of general applicability that implements and interprets state statute. Further, that midwives have to “cause a sample of the blood of each pregnant woman attended by him to be taken under the direction of a duly licensed physician of medicine and

surgery” is a generally applicable interpretation of statute. Both of these interpretations were promulgated outside of both the Administrative Procedures Act and the exempt rulemaking pursuant to HB 2247.

This interpretation is problematic because midwives had no notice of this change in interpretation. In Arizona, there is no legislative framework or licensing system for taking blood samples or phlebotomy. Accordingly, any citizen is permitted to “take a blood sample.” Further, a “duly licensed physician of medicine and surgery” is no longer a license or title available to doctors in Arizona. According, no midwife can comply with the Department’s interpretation of the statute.

Last, the interpretation that a syphilis test is “required by § 36-693” is problematic in that the Department cannot constitutionally compel a pregnant woman to receive medical care against her will, nor can the Department threaten to withhold prenatal care if she does not consent. A.R.S. § 36-114.

The interpretation of § 36-693 was promulgated outside of the rulemaking process and purports to be applicable to all midwives. As such, the Arizona Association of Midwives asks Department to review its existing practice of fining midwives for violating its interpretation of the statute and engage in rulemaking surrounding the interpretation of § 36-693.

Arizona Midwives Response to House Bill 2247
To: Department of Special Licensing, Department of Health Services
Submitted June, 2012

Included in this report:

- Introductory Report
- AZ Midwifery Rules and Regulations
- AZ Midwifery Scope of Practice (no footnotes)
- AZ Midwifery Scope of Practice (with footnotes)
- AZ Midwifery Expansion of Practice
- References

In early February, 2012, midwives and student midwives from across the state of Arizona began a collective effort to address the rules rewrite mandated by HB2247. A total of eight meetings were conducted in a public meeting room at the Phoenix Public Library every two weeks, widely advertised in the midwifery community, and open to all licensed midwives and students pursuing licensure. Input was also considered when submitted via email or by proctor for those unable to physically attend the meetings.

It became apparent, early in the public meetings to address HB2247, that the Arizona midwifery community's objective was to focus on sections R9-16-106 through R9-16-111, as these are the sections that govern the day to day practice and care that midwives provide to their clients. Realizing that HB2247 also requires rewrite consideration for the process of licensure, the group respectively and collectively agreed that the Certified Professional Midwife (CPM) credential or equivalent is acceptable, entrusting the Arizona Department of Health Services, Department of Special Licensing to develop a fair and efficient licensing and testing procedure. Focusing on the scope of practice portion of R9-16 Chapter One, each item that affects the midwives' abilities to provide quality, up to date, evidenced-based care to midwifery clients in the state of Arizona was analyzed, line by line. At the conclusion of the public meetings, three documents were developed for the State's consideration.

The first document, titled "**AZ Midwifery Rules and Regulations**" represents our ideal regulatory guidelines. The scope of practice will be removed from rule and replaced by a general guideline similar to that which governs other health care providers, simply emphasizing the need for the midwife to follow current international standard of care, considering both the midwife's education and experience and the client's situation. This approach acknowledges the midwife as a professional, independent health care practitioner, assumes that holding a CPM or equivalent license ensures proper initial education and ongoing continuing education, and allows the midwife to develop practice guidelines that reflect her level of training, experience, and expertise. It allows for flexibility for each individual midwife, but also allows midwives as whole, in Arizona, to adapt their practice to the current midwifery model of care.

The second document, titled "**AZ Midwifery Scope of Practice**" is meant to be a living document, separate from rule or statute. Scope of practice written into regulation restricts the midwife's ability to update her care according to new evidence. Considering that the last significant update to this scope of practice via regulation occurred years ago, this risk is significant. This document brings Arizona's rules up to the current standard of practice within the US midwifery model, and our intention is that it be reviewed by the Advisory Committee and kept up to date by the proposed Advisory Council. The version submitted here is footnoted to reflect the ways in which current rule would effectively change, to provide ease of information retrieval for the Advisory Committee.

The third document, titled “**AZ Midwifery Expansion of Practice**,” fulfills the portion of HB2247 requiring the presentation of evidence to support any requests for the expansion of practice. All references noted in the requests for the expansion of practice are cited for the Advisory Committee's consideration, and will be printed upon request.

There are some central themes to these documents that Arizona Department of Health Services is asked to consider foundational to the rules rewrite process. The midwives of Arizona request the following:

1. Addition of Midwifery Advisory Council. An ongoing volunteer **Midwifery Advisory Council** is adopted to create a more informed regulatory Department. The current process of simple rules enforcement focuses on whether the midwife can follow the written rules, as opposed to recognizing that the midwife can make sound, up to date, evidenced based care decisions specific to each midwifery client she encounters. The Midwifery Advisory Council would be composed of Arizona licensed midwives and midwifery consumers. From an educated, peer review perspective, and inclusive of consumers as important stakeholders, responsibilities would include: reviewing current evidence, evaluating complaints, advising the Department on all future rules and statute changes, processing disciplinary actions, interpreting the rules, and assisting the Department in staying current on research and statistics. Five midwives would sit on the council, duly representing all Arizona midwives and ensuring an objective and intimate working group. Random rotation is important so that objectivity is maintained, and, therefore, all LMs have the opportunity and responsibility to sit on the council.

2. Change in the Licensure Process. Adopt a **national licensure process, a provisional student license, a temporary license for out of state midwives operating in Arizona, and the ability to assume inactive status**. The Certified Professional Midwife (CPM) credential is a nationally accredited credential in which the education, monitoring, and decision making processes are driven by Evidenced-Based Practice and Informed Consent and which specializes in out of hospital birth. A national licensing standard in Arizona will assist coalescing US midwifery as a whole, will provide the midwife the opportunity to obtain and maintain licensure through a more objective process, and will significantly reduce regulatory and financial burden on the State. Provisional student licenses serve to protect the preceptor, the student, the department of health, and the client. Temporary licensure for out of state midwives greatly increases midwifery care access to women on the borders of Arizona. An inactive status with the ability to renew without repeating the initial licensure process reflects the licensing process of other health care providers.

3. Removal from rule all restrictions to pharmaceuticals, equipment and procedures necessary for providing quality care. The rapidly changing and evolving research in women's health care makes the restricting of the innovations and tools a midwife may use unrealistic and often dangerous. For example, Arizona law currently disallows midwives to utilize one of the field drugs of choice, Misoprostol, for postpartum hemorrhage. In addition, the practical exam offered by the state requires the student to demonstrate many manipulative maneuvers for addressing shoulder dystocia; yet Arizona midwives are only permitted by law to "rotate the shoulders to the oblique." The midwives ask that the state allow all pharmaceuticals, equipment and procedures **relevant** to midwifery care to be utilized by midwives without specifics set in rule. A formulary can be kept up to date by the Advisory Council.

4. Respect for Informed Consent. The midwives request the removal of the current legal requirement to discontinue providing services to women who exhibit certain conditions during the course of her care with the midwife. Our belief is that women, once given the opportunity to discuss the risks and benefits of home birth, in her particular situation, and with true informed consent, have the capability of deciding how and where they would like to birth, and with which care provider. Having a midwife present at birth, regardless of risk factors, is a much safer option than choosing an unassisted birth due to legal restrictions. This change respects a woman's choice.

Please consider the attached, "**AZ Midwifery Rules and Regulations**," "**AZ Midwifery Scope of Practice**," and "**AZ Midwifery Expansion of Practice**" and accompanying references as HB2247 is implemented. The midwifery community appreciates the opportunity for this long-overdue update, and looks forward to working with the advisory committee in the coming months as the new rules governing midwifery care in Arizona are shaped.

Midwifery Licensing

Full License to practice midwifery in the State of Arizona will be granted to all persons that have:

1. Successfully completed their educational process to become a Certified Professional Midwife (CPM credential) or equivalent.
2. Passed the State of Arizona written exam covering the current rules and regulations outlined for the practice of Midwifery in the State of Arizona.
3. Pays the initial license fee of \$25.

Provisional License shall be provided to all students of midwifery who meet the following criteria:

1. Is 18 years of age or older
2. Holds a High School Diploma or High School Equivalency Diploma
3. Is currently trained in adult and neonatal resuscitation
4. Holds a signed Letter of Commitment from a Preceptor

Temporary License shall be provided to out of state midwives working with a woman in the state of Arizona.

This temporary license will include all of the privileges of a standard license, but will be limited in the duration of the licensing period.

Lapse of License for Inactivity will be permitted and be reinstated upon fulfillment of:

1. Current CPM or equivalent - which includes CEUs and current training in adult and neonate resuscitation
2. Payment of the additional fee of twenty dollars (\$20) for reinstatement of license.

Rights of the Licensed Midwife

The license to practice midwifery authorizes the holder of the license to attend women in childbirth, provide prenatal, intrapartum, and postpartum care, family-planning, well woman care, as well as care of the newborn and infant. The midwife also has an important task in health counseling and education, not only for the woman, but also within the family and the community. This work can involve antenatal education and preparation for parenthood and may extend to woman's health, sexual or reproductive health, and child care.

Responsibilities of a Licensed Midwife:

1. Pay an initial license fee of \$25 for the license period of 2 years
2. Pay a biannual renewal fee of \$25.00
3. Keep current CPM or equivalent
4. Keep current training in adult and neonatal resuscitation
5. Complete and maintain a record for every client
6. Report client outcomes to the statistics project outlined by the Arizona Department of Health.

7. File Birth Certificate, Death Certificates, or Stillbirth Certificate with the State of Arizona Vital Records according to their outlined rules
8. Provide to all clients, in writing, an Informed Choice and Disclosure statement
9. Compose and maintain Practice Guidelines reflecting current evidenced-based care and experience
10. Provide care for women and newborns as outlined in her individual Practice Guidelines and in the AZ Midwifery Scope of Practice written and maintained by the Advisory Council including but not limited:
 - a.Prenatal care and counseling, intrapartum care and support, postpartum care and counseling, well-woman care and newborn care;
 - b.Performing minor interventions and emergency measures as necessary;
 - c.Buying, possessing and administering all medications and supplies pertaining to midwifery and necessary to maintain mother, fetus, newborn and infant in a healthy state and to deter risk factors;
 - d.Make available to all clients any testing necessary to assess the health of mother and fetus;
 - e.Referral of the woman or the baby to a higher level of care if complications arise which require interventions that are beyond the midwife's competency; and
 - f.Provides collaborative care to women not considered to be low risk, within the guidelines of a physician.

AZ Midwifery Scope of Practice

The AZ Midwifery Scope of Practice will provide general guidelines for the practice of midwifery in the state of Arizona. This document is meant to be separate from rule in order to be easy to maintain, keep current and evidenced-based.

Advisory Council

1. The Advisory Council shall consist of five (5) licensed midwives and two (2) consumers who have experience in out of hospital birth. Advisory Council members serve for a maximum period of two (2) year terms on a staggered rotation.
2. The five licensed midwives serving on the Advisory Council will be drawn by random selection. Midwives may decline sitting on the advisory council.
3. The Advisory Council will be convened and available to the Department for the following:
 - a. maintain and update AZ Midwifery Scope of Practice document
 - b. questions, discussion, review and recommendation to the Department on the validity of any complaint and any further course of action regarding the complaint; and
 - c. recommendation for peer review

- d. any policy change or rule updates in regards to all things concerning midwifery and out of hospital births.

Complaint Procedures

1. A person, government, or private entity may submit a written complaint to the Department charging a licensee or license applicant with a violation of statute or rules, and specifying the grounds for the complaint.
2. Complaints must be in writing, and shall be filed on the proper complaint form prescribed by the Department. The Department form shall contain a release of medical records statement, to be signed by the complainant or the client if the complainant is not the client.
3. Upon receipt of the written complaint form, the Department shall
 - a. Log the complaint and assign it a complaint number.
 - b. Send a copy of the complaint to the licensee complained about for a written response within 20 calendar days.
 - c. Upon receipt of the licensee's written response, both complaint and response shall be considered by the Advisory council of the Department for appropriate action including dismissal of complaint, investigation or a finding of reasonable cause of violation of a statute or rule.
 - d. The Department shall notify both complainant and licensee of the determination made by the advisory council.
4. If a reasonable cause violation determination is made by the advisory council, the disciplinary process shall follow ARS 36-756.
5. The advisory council shall review anonymous complaints to determine whether appropriate investigative or disciplinary action may be pursued or whether the matter may be dismissed for lack of sufficient information.

Responsibilities of the Licensed Midwife

- A. A midwife provides care to any client desiring midwifery services, respecting the woman's right to self-determination.
- B. A midwife utilizes universal measures to protect against blood born pathogens.
- C. A midwife both initially and periodically thereafter assesses a client's condition.
- D. A midwife informs clients, both orally and in writing, of the midwife's scope of practice including the risks and benefits of out of hospital birth. A written informed consent is obtained from the client upon beginning midwifery care.
- E. Initial care & care during the prenatal period is provided as follows unless a written refusal by the client is obtained.
 - 1. The following tests shall be scheduled or ordered during the first visit:
 - a. OB/prenatal panel;
 - b. Urinalysis;
 - c. Hematocrit, hemoglobin, or complete blood count;
 - d. Sexually transmitted infection (STI) testing;
 - e. Glucose screening test for diabetes; and
 - f. Other cultures or blood work as appropriate.
 - 2. Prenatal visits are conducted as appropriate and may include,:
 - a. The taking of weight, blood pressure, and assessment of edema;
 - b. Assessment of fetal growth, heart tones, movement and position;
 - c. Referral of a client as for ultrasound or other studies; and
 - d. Administration or recommendation of Rh immunoglobulin drug.
- F. Care during the intrapartum period shall be provided as follows unless a written refusal by the client is obtained:
 - 1. The midwife initially assesses,:
 - a. Contraction pattern;
 - b. The status of membranes, and;
 - c. Evaluating the presence of bloody show;
 - d. Fetal movement.
 - 2. During labor, the condition of the mother and fetus is assessed. Care includes the following:
 - a. Initial and periodic assessment of maternal well being;
 - b. Initial and periodic assessment of fetal heart tones as appropriate for stage of labor or more often if indicated, and;

- c. Ongoing assessment of labor progress, and;
 - d. Performing amniotomy, episiotomy, or maneuvers of the fetus to expedite delivery as needed;.
3. After delivery of the newborn, care includes the following:
- a. Apgar score assessment;
 - b. Physical assessment of the newborn for any abnormalities requiring immediate care;
 - c. Delivery of the placenta, assessment for signs of separation, frank or occult bleeding and examination of the placenta;
 - d. Manual exploration of the uterus and manual removal of the placenta as needed.
4. Abnormal or emergency situations are evaluated, and if not resolved, consultation or intervention sought.

G. A midwife provides the following care during the postpartum period, unless a written refusal is obtained from the client:

- 1. During the immediate postpartum period, care of the mother includes:
 - a. Ongoing assessment of maternal well being;
 - b. Assisting the mother to urinate;
 - c. Evaluating the perineum for tears, and repair as needed;
 - d. Assisting with maternal and infant bonding;
 - e. Assisting with initial breast feeding;
 - f. Providing postpartum instructions for mother and baby; and
 - g. Recommending and/or administering Rh immunoglobulin as necessary.
- 2. During the immediate postpartum period, care of the newborn includes:
 - a. Newborn physical exam;
 - b. Recommend and/or administer eye prophylaxis and vitamin K.
- 3. Abnormal or emergency situations are evaluated, and if not resolved, consultation or intervention sought.
- 4. The condition of the mother and newborn shall be re-evaluated between 24 and 72 hours of delivery and includes the following:
 - a. Assessment of maternal well being;
 - b. Assessment of newborn well being, and;
 - c. Recommend and/or perform newborn screening.

H. The midwife shall file a birth certificate.

I. A midwife may purchase, possess and administer the following:

1. Rh immunoglobulin;
2. Vitamin K;
3. Ophthalmic preparations for Newborn Eye Care;
4. Uterotonic and Anti-hemorrhagic Medications;
5. Medical Oxygen;
6. IV fluids;
7. Suturing and Repair Materials and Equipment;
8. Local Anesthetic;
9. Antibiotics;
- 10 Family Planning Medications and Devices;
11. Resuscitation Medications and Devices;
12. Immunizations;
13. Nitrous Oxide;
14. Epinephrine;
15. Nutritional Supplementation;
16. Any other medication prescribed by a medical professional for obstetrical care; and
17. Any supplies or equipment necessary to administer any of the above.

Record-keeping and Report Requirements

- A. A midwife establishes, maintains and validates a record of the care provided for each client.
- B. A midwife shall make records available to other health care providers engaged in the care and treatment of the client upon receipt of a written records release.
- C. A midwife collects statistic pertaining to the midwife's practice and provides the state with periodic summaries of these statistics.

Prohibited Practice; Transfer of Care; Consultation

- A. The midwife shall obtain consultation to obtain a recommendation for treatment, referral, or transfer of care at the time any client is determined to have any of the following circumstances or conditions during the current course of care:
 1. A persistent, chronic or uncontrolled disease process that may have a negative impact on the well-being of the mother or fetus;
 2. Testing positive for HIV;

3. Insulin-dependent diabetes
4. Chronic hypertension
5. Cardiac disease
6. Rh isoimmunization
7. Renal failure
8. Active tuberculosis
9. Deep vein thrombophlebitis
10. Primary genital herpes simplex infection in the first trimester or active genital herpes lesions at the onset of labor;
11. Active hepatitis
12. Active gonorrhea
13. Active syphilis;
14. Pulmonary embolism;
15. PIH, preeclampsia, eclampsia;
- 16.. Failure to auscultate fetal heart tones by 22 weeks gestational age;
17. Abnormally decreased fetal movement;
18. Premature birth prior to 36 weeks gestation;
19. A gestation beyond 42 weeks;
20. An abnormal progression of labor;
21. Persistent, abnormal fetal heart rates;
22. A postpartum hemorrhage which does not respond to treatment methods available to the midwife;
23. Lacerations of the vulva or birth canal that require repair above the midwife's abilities, or;
24. Expressed wishes of the client or family.

B. A midwife shall obtain consultation to obtain a recommendation for treatment, referral, or transfer of care at the time any newborn demonstrates any of the following conditions:

1. Birth weight less than 2000 grams;
2. Congenital anomalies;
3. An irregular heartbeat;
4. Persistent poor muscle tone;
5. Lethargy, irritability, or poor feeding;
6. Failure to urinate or pass meconium in the first 24 hours of life;
7. A hip examination which results in a clicking or incorrect angle;

8. Skin rashes not commonly seen in the newborn;
9. Temperature persistently above 99.6° or below 97.6° F.
10. Pale, blue, or gray color after 10 minutes;
11. Excessive edema;
12. Respiratory distress.

Responsibilities of the Licensed Midwife

- A. A midwife provides care to any client desiring midwifery services, respecting the woman's right to self-determination.¹
- B. A midwife utilizes universal precautions to protect against blood born pathogens.²
- C. A midwife both initially and periodically thereafter assesses a client's condition.³
- D. A midwife informs clients, both orally and in writing, of the midwife's scope of practice, including the risks and benefits of out of hospital birth. A written informed consent is obtained from the client upon beginning midwifery care.⁴
- E. Initial care and care during the prenatal period is provided as follows, unless a written refusal by the client is obtained:⁵
 - 1. The following tests shall be scheduled or ordered during the first visit:
 - a. OB/prenatal panel⁶;
 - b. Urinalysis;
 - c. Sexually transmitted infection (STI) testing⁷;

¹ Previously read "A midwife shall provide care only to clients determined to be low risk." Our belief is that women, once given the opportunity to discuss the risk and benefits of home birth in her particular situation and with true informed consent, has the capability of deciding how and where she would like to birth, and with which care provider. Having a midwife present at birth, regardless of risk factors, is a much better option than choosing an unassisted birth due to legal restrictions. This change respects women's choice. See McAra-Couper, Jones and Smythe (2012); Pamela Laufer-Ukeles (2011); Childbirth Connection (n.d.).

² Previously read, "A midwife shall maintain all instruments used for delivery in an aseptic manner and other birthing equipment and supplies in clean and good condition." A knowledge of universal measures to prevent the spread of blood-born pathogens is, a standard in health care industry, is common knowledge and practice among licensed midwives and is a skill required for application for the CPM credential.. See NARM (2011).

³ Removed, "... in order to establish the client's continuing eligibility to receive midwifery services." Midwives can and do make recommendations to transfer to a physician or hospital for medical management when the client's situation warrants, and oftentimes the client will heed that advice.. However, as stated before, a care provider is better than no care provider and a midwife should not be forced by rule to abandon care if a woman chooses not to transfer care. See McAra-Couper, Jones and Smythe (2012); Pamela Laufer-Ukeles (2011); Childbirth Connection (n.d.).

⁴ Removed, "the required tests and potential risks to a newborn if refused, and the need for written documentation of client's refusal; the use of a physician or medical facility for the provision of emergency consultation or services; midwife facilitation of the transfer of care to the physician or medical facility; and the midwife's termination of care should certain medical conditions arise or the client refuses intervention." Medical procedures must be offered on an informed consent, therefore, requiring tests, consultations or termination of care does not respect the informed consent process or the woman's right to choice. See McAra-Couper, Jones and Smythe (2012); Pamela Laufer-Ukeles (2011) about informed consent.

⁵ Added, "...unless a written refusal by the client is obtained." Informed consent has become the norm in health care. Only the client has the right to choose or refuse care, procedures or testing. The midwife's part in this choice is to offer and educate. See McAra-Couper, Jones and Smythe (2012); Pamela Laufer-Ukeles (2011)

⁶ Previously read, "Blood type, including ABO and Rh, with antibody screen." These items are included in a standard OB/Prenatal blood panel in addition to RPR, HbAsg, Rubella and CBC. See Sonora Quest (2012); LabCorp (2012); QuestDiagnostics (2012).Repeat HNH or CBC should be offered as clinically indicated. See USPSTF (2006).

⁷ Previously read, "Syphilis, gonorrhea, and chlamydia testing, unless a written refusal for gonorrhea or chlamydia testing is obtained from the client." Routine STI testing extends beyond these specific tests, is constantly evolving, and is offered to all midwifery clients on a STI risk assessment basis. Written refusal is permitted via 106 E. See National Institute for Health and Clinical Excellence (2007) One on one interventions to reduce transmission of sexually transmitted infection (STI's) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups. London: National Institute for Health and Clinical Excellence. and Williams J. Blood tests for maternal wellbeing: Testing for sexually transmitted infections in

- d. Glucose screening test for diabetes¹; and
 - e. Other cultures or blood work as appropriate.
2. Prenatal visits are conducted as appropriate and may include:
- a. The taking of weight, blood pressure, and assessment of edema²;
 - b. Assessment of fetal growth, heart tones, movement and position³;
 - c. Referral of a client as for ultrasound or other studies⁴; and
 - d. Administration or recommendation of Rh immunoglobulin drug⁵.
- F. Care during the intrapartum period shall be provided as follows, unless a written refusal by the client is obtained⁶:
1. The midwife initially assesses^{7,8}:
 - a. Contraction pattern⁹;
 - b. The status of membranes¹⁰;
 - c. Evaluating the presence of bloody show; and
 - d. Fetal movement¹¹.
 2. During labor, the condition of the mother and fetus is assessed. Care includes the following¹²:

pregnancy. *Pract Midwife*, 2011; Feb;14(2):36-41

¹ There are many valid methods of screening for gestational diabetes, and these tests are constantly evolving. Currently, the 1 hour PGS, 3 hour PGS, and A1C are used according to risk assessment for the particular client. GDM screening is not appropriate for all clients. See USPSTF (2008).

² Removed “urinalysis for protein, nitrites, glucose and ketones” - See Alto (2005); Berger (2005); Gribble et al (1995); Mayburry and Waugh (2004); Murray et al (2012); Siddique et al (2012); Waugh (2004) on UA dipsticks accuracy and usefulness in prenatal care. Wording “assessment of the lower extremities for swelling” was changed to “assessment of edema” to reflect medical language.

³ Previously read, “Measurement of the fundal height and listening for fetal heart tones and, later in the pregnancy, feeling the abdomen to determine the position of the fetus.”

⁴ Removed, “...recommended based upon examination or history” as this is obviously what recommendations will be based on.

⁵ Previously read, “Recommendation of administration of the drug RhoGam to unsensitized Rh negative mothers after 28 weeks, or any time bleeding or invasive uterine procedures are done, or midwife administration of RhoGam under physician's written orders.” RhoGam is a name brand drug and there are multiple Rh immunoglobulins available. Specification of when to administer should follow standard of care and clinical judgement. Written orders are no longer a common practice. See USPTF (2004).

⁶ Added, “...unless a written refusal by the client is obtained.” Informed consent has become the norm in health care. Only the client has the right to choose or refuse care, procedures or testing. The midwife’s part in this choice is to offer and educate.

⁷ Previously read, “The midwife shall initially determine if the client is in labor and the appropriate course of action to be taken by.”

⁸ Removed, “d. Reviewing with the client the need for an adequate fluid intake, relaxation, activity, and emergency management; and e. Deciding whether to go to client's home, remain in telephone contact, or arrange for transfer of care or consultation.” This is normal intrapartum counseling and care decisions.

⁹ Previously read, “Assessing the interval, duration, intensity, location, and pattern of the contractions”

¹⁰ Previously read, “Determining the condition of the membranes, whether intact, ruptured, and the amount and color of fluid.”

¹¹ This section was added as a common standard of care as part of a midwifery intrapartum care assessment.

- a. Initial and periodic assessment of maternal well being¹;
 - b. Initial and periodic assessment of fetal heart tones as appropriate for stage of labor or more often if indicated²;
 - c. Ongoing assessment of labor progress³;
 - d. The performance of amniotomy, episiotomy, or maneuvers of the fetus to expedite delivery as needed⁴.
3. After delivery of the newborn, care includes the following⁵:
- a. Apgar score assessment⁶;
 - b. Physical assessment of the newborn for any abnormalities requiring immediate care⁷;
 - c. Delivery of the placenta, assessment for signs of separation, frank or occult bleeding and examination of the placenta⁸;
 - d. Manual exploration of the uterus and manual removal of the placenta as needed⁹.

¹² Previously read, “During labor, the condition of the mother and fetus shall be assessed upon initial contact, every half hour in active labor until completely dilated, and every 15 to 20 minutes during pushing, after the bag of water has ruptured or until the newborn is delivered. Care shall include the following” Removed time frames for assessment.

¹ Replaces, “a. Checking of vital signs every 2 to 4 hours and an initial physical assessment of the mother;”, “f. Maintenance of proper fluid balance for the mother throughout labor as determined by urinary output and monitoring urine for presence of ketones, at least every 2 hours; and” and “g. Assisting in support and comfort measures to the mother and family.”

² Reworded from, “Assessment of fetal heart tones every 30 minutes in active first stage labor, and every 15 minutes during second stage, following rupture of the amniotic bag or with any significant change in labor patterns.” Removed time frames, intermittent auscultation time frames vary greatly depending on clinical situation, there exist no evidence as to the ideal frequencies of IA . See ACNM (2010); Devane et al (2012).

³ Replaces “c. Periodic assessment of contractions, fetal presentation, dilation, effacement, and position by vaginal examination; d.Determination of the progress of active labor for primiparas by determining if dilation occurs at an average of 1 cm/hr until completely dilated, and a second stage not to exceed 2 hours; e.Determination of a normal progress of active labor for multigravidae by determining if dilation occurs at an average of 1.5 to 2 cm/hr until completely dilated, and a second stage not to exceed 1 hour.” Friedman’s Curve has long been a subject of dispute. Recent research suggests that normal labor progress may be much longer than thought for the past 50 years. See Neal et al (2010); Zhang (2010).

⁴ Interventions required at certain clinical situations. Moved from emergency measures. See Gruenberg, B. (2008),

⁵ Removed “c.Inspection of the mother's perineum for lacerations.” Within the midwifery model of care, except in the case of unexplained bleeding (covered under section F4), immediate inspection of the perineum affords no long term improvement in outcome and is more appropriately done after the immediate postpartum period. See Pregazzi 2002.

⁶ Previously read, “a.Assessment of the newborn at 1 minute and 5 minutes to determine the Apgar scores.” Apgars are poor predictors of long term morbidity and are at times additionally done at 10, or 20 minutes when needed. See ACOG (2006)

⁷ Added “...requiring immediate care.”

⁸ Replaces “d. Delivery of the placenta within 40 minutes during which time the midwife shall assess for signs of separation, frank or occult bleeding, examine for intactness, and determine the number of umbilical cord vessels.” Normal physiologic third stage is currently defined as 60 minutes. See NICE (2007) . Gross examination of the placenta includes ‘intactness’ and ‘number of umbilical cords.’and is a skills expectation for obtaining the CPM credential. See NARM CIB (2011).

⁹ Emergency Procedures needed in the case of retained placenta or placental fragments and/or postpartum hemorrhage. See Gruenberg (2008).

4. Abnormal or emergency situations are evaluated, and if not resolved, consultation or intervention sought¹⁰.

G. A midwife provides the following care during the postpartum period, unless a written refusal is obtained from the client¹¹:

1. During the immediate postpartum period, care of the mother includes:

- a. Ongoing assessment of maternal well being²;
- b. Assisting the mother to urinate³;
- c. Evaluating the perineum for tears, and repair as needed⁴;
- d. Assisting with maternal and infant bonding;
- e. Assisting with initial breast feeding⁵;
- f. Providing postpartum instructions for mother and baby⁶; and
- g. Recommending and/or administering Rh immunoglobulin as necessary⁷.

2. During the immediate postpartum period, care of the newborn includes:

- a. Newborn physical exam;
- b. Recommendation and/or administration of eye prophylaxis and/or vitamin K.

3. Abnormal or emergency situations are evaluated, and if not resolved, consultation or intervention sought.

¹⁰ Previously read, “4.The responsibility of the midwife shall include recognition of and response to any situation requiring immediate intervention.” Certain abnormal or emergency situations may be safely handled at home by a qualified health care provider. Others require transfer to a medical care facility. The licensed midwife is trained in making this assessment and responding appropriately. See Gruenberg, B. (2008),

¹¹ Added, “...unless a written refusal by the client is obtained.” Informed consent has become the norm in health care. Only the client has the right to choose or refuse care, procedures or testing. The midwife’s part in this choice is to offer and educate. See Judith McAra-Couper, Marion Jones and Liz Smythe. (2012). Pamela Laufer-Ukeles. (2011).

² replaced: “a. Taking of vital signs of the mother with external massage of the uterus and evaluation of bleeding every 15 to 20 minutes for the first hour and every half hour for the second hour;” Maternal well-being assessment is central to midwifery training, is comprehensive and not limited to simple clinical rounds. The licensed midwife performs rounds as needed as well as incorporates other indicators of maternal well being. See NARM CIB (2011).

³ replaced “b.Assisting the mother to urinate within 2 hours following the birth”; Postpartum urinary retention is not considered abnormal until 6 hours postpartum. See Groutz (2008); Rizvi (2006);

⁴ replaced “c.Evaluating the perineum for tears, bleeding, or blood clots;” The addition of the legal ability to repair is necessary. The language stating assessment of the perineum for ‘bleeding’ and ‘blood clots’ does not reflect clinical maternity practice..

⁵ removed “...instructing the mother in the care of the breast, and reviewing potential danger signs, if appropriate;” as this is obvious and integrated when needed.

⁶ replaced, “Providing instruction and support to the family to ensure adequate fluid and nutritional intake, rest, and type of exercise allowed, normal and abnormal bleeding, bladder and bowel function, appropriate baby care, and any danger signals with appropriate emergency phone numbers;” The midwife develops and communicates comprehensive postpartum instructions which includes these instructions..

⁷ replaced “g. Recommending the drug RhoGam or administering it, under written physician's orders, to an unsensitized Rh-negative mother who delivers an Rh-positive newborn. Administration shall occur not later than 72 hours after birth.” Written physician’s orders is not possible nor needed if midwives are able to obtain and administer rh immunoglobulin. RhoGam is a brand name and there are many Rh immunoglobulins available. Protocol on when and whom to administer to does not need be in regulation as it is part of midwifery training. See NARM CIB (2011); USPSTF (2004).

4. The condition of the mother and newborn shall be re-evaluated between 24 and 72 hours of delivery and includes the following:

- a. Assessment of maternal well being;
- b. Assessment of newborn well being, and;
- c. Recommendation and/or performance of newborn screen.

H. The midwife shall file a birth certificate.

I. A midwife may purchase, possess and administer the following¹:

1. Rh immunoglobulin²;
2. Vitamin K³;
3. Ophthalmic preparations for Newborn Eye Care⁴;
4. Uterotonic and Anti-hemorrhagic Medications⁵;
5. Medical Oxygen⁶;
6. IV fluids⁷;
7. Suturing and Repair Materials and Equipment⁸;
8. Local Anesthetic⁹;
9. Antibiotics¹⁰;
10. Family Planning Medications and Devices¹¹;

¹ Creating a pharmacology list within rule will allow midwives to obtain needed medications without the requirement of having a prescription or standing orders, both of which are difficult to obtain. Current medical practice and liability prevents physicians from willingly writing prescriptions for individuals who are not their clients and standing orders is no longer a common practice. The medications and medication types listed are standard of care in obstetrics and midwifery practices. See NM (2008); MHRA (2012). WAC (2012).

² Rh immunoglobulin administration for Rh negative mothers to prevent RH isoimmunization. See Moise, 2012.

³ Vitamin K injection for newborns to prevent vitamin K deficiency bleeding. See Adame and Carpenter, 2009.

⁴ Antibiotic eye prophylaxis for newborns to prevent complications resulting from infections of gonorrhea or chlamydia. See Darling and McDonald, 2010.

⁵ Uterotonic Medications are utilized in 3rd and 4th stages of labor to prevent and/or treat postpartum hemorrhage. See WHO (2009); Alfirevic et al (2007); Chelnow (2011); Jerbi et al (2006)

⁶ Medical oxygen is utilized for the treatment of maternal shock, non-reassuring fetal heart tones, and in some cases of neonatal resuscitation. See AAP/AHA (2011); Gruenberg 2008; American National Red Cross (2006).

⁷ IV fluids can be invaluable aids in dehydration, as well as fluid volume replacement in the case of postpartum hemorrhage. See Gruenberg 2008

⁸ Suturing is a common need for birthing women. Currently, midwives trained in suturing may have to transfer for routine repair because of the lack of a legal access to repair equipment. See Gruenberg 2008; Frye (2010)

⁹ Local anesthetic is necessary for repair. See Gruenberg 2008; Frye (2010)

¹⁰ Antibiotics are common tx for infection during the maternity period such as UTIs in pregnancy and for intrapartum prophylaxis of Group B Beta hemolytic Streptococcus (GBS) per current CDC guidelines. See Smaill 2009; CDC (2010)

¹¹ International standards for midwifery. See ICM (2010).

11. Resuscitation Medications and Devices¹;
12. Immunizations²;
13. Nitrous Oxide³;
14. Epinephrine⁴;
15. Nutritional Supplementation;
16. Any other medication prescribed by a medical professional for obstetrical care; and
17. Any supplies or equipment necessary to administer any of the above.

Recordkeeping and Report Requirements

- A. A midwife establishes, maintains and validates a record of the care provided for each client⁵.
- B. A midwife shall make records available to other health care providers engaged in the care and treatment of the client upon receipt of a written records release.⁶
- C. A midwife collects statistics pertaining to the midwife's practice and provides the state with periodic summaries of these statistics.⁷

Prohibited Practice; Transfer of Care; Consultation⁸

- A. The midwife shall secure consultation to obtain a recommendation for treatment, referral, or transfer of care at the time any client is determined to have any of the following circumstances or conditions during the current course of care:
 1. A persistent, chronic or uncontrolled disease process that may have a negative impact on the well-being of the mother or fetus⁹;

¹ Necessary for NNR and CPR. See AAP/AHA (2011); Gruenberg 2008; American National Red Cross (2006).

² International standards for midwifery, other states. See ICM (2010)

³ "Gas and Air," a combination of nitrous oxide and oxygen is a common and relatively safe method of pain control utilized commonly by British midwives. See ACNM (2010)

⁴ Epinephrine is a necessary pharmacological agent to treat anaphylaxis while awaiting emergency transport. Especially important if midwives are going to offer antibiotic therapy. See Gruenberg, B. (2008).

⁵ Previously, rule specified what was to be kept in records. There exists a standard of obstetric charting that midwives adhere to, making the regulation of chart contents in AZ rule unnecessary. Additionally, Electronic Health Records are being adopted by more and more midwives and other health care providers.

⁶ "upon request by the Department for periodic quality review" has been removed. With the establishment of an advisory board and peer review, the necessity for the Department to audit random records will be removed.

⁷ The requirement for quarterlies has been removed, leaving the reporting process more open to adaptation. MANAstats and yearly (monthly, quarterly) summaries were methods considered for reporting. Having the sole method of reporting and the form required written into rule is bureaucratically cumbersome and does not allow for adaptation as standards of practice shift and change.

⁸ Combining 108 and 109 to "to obtain a recommendation for treatment, referral, or transfer of care" covers conditions that may at times require simply a consultation and at other times a transfer of care. For example, the previous version of section 108 had "active gonorrhea until treated and recovered, following which midwife care may resume;" this situations is actually a consultation to obtain antibiotic therapy and there is no need for transfer.

2. A positive HIV test¹;
3. Insulin-dependent diabetes;
4. Chronic hypertension;²
5. Cardiac disease;³
6. Rh isoimmunization;⁴
7. Renal failure;⁵
8. Active tuberculosis;⁶
9. Deep vein thrombophlebitis;⁷
10. Primary genital herpes simplex infection in the first trimester or active genital herpes lesion at the onset of labor;⁸
11. Active hepatitis;⁹
12. Active gonorrhea;
13. Active syphilis;¹⁰
14. Pulmonary embolism;¹¹
15. Pregnancy induced hypertension (PIH) preeclampsia, eclampsia;¹²
- 16.. Failure to auscultate fetal heart tones by 22 weeks gestational age;¹³

⁹ The addition of this statement covers disease processes which may not be specifically mentioned here but yet still may risk a woman out of an out of hospital birth. This allows the midwife greater flexibility in risk assessment.

¹ Moved from R9-16-109. Required Consultation A. 1.

² “Chronic” has been added to hypertension to avoid transfer of care for situational hypertension that may be on record.

³ “Heart disease” has been replaced with “Cardiac disease” to reflect medical terminology.

⁴ “Rh disease with positive titers” has been replaced with Rh isoimmunization to reflect medical terminology.

⁵ “Kidney disease” has been replaced here with “renal failure.” Kidney disease may be manageable within midwifery care depending on the situation. The midwife may decide to risk out or collaborate with another health care provider.

⁶ A portion of R9-16-108.Prohibited Practice; Transfer of Care A. 4. - diseases in this list have been separated for clarity.

⁷ A portion of R9-16-108.Prohibited Practice; Transfer of Care A. 3. - diseases in this list have been separated for clarity.

⁸ Previously R9-16-108.Prohibited Practice; Transfer of Care A. 9.

⁹ A portion of R9-16-108.Prohibited Practice; Transfer of Care A. 5. - diseases in this list have been separated for clarity. The phrase, “until treated and recovered, following which midwife care may resume” has been removed because this treatment would be the purpose of the consultation to begin with and therefore is redundant.

¹⁰ A portion of R9-16-108.Prohibited Practice; Transfer of Care A. 4. - diseases in this list have been separated for clarity.

¹¹ A portion of R9-16-108.Prohibited Practice; Transfer of Care A. 3. - diseases in this list have been separated for clarity.

¹² This replaces R9-16-108.Prohibited Practice; Transfer of Care A. 7 and R9-16-109. Required consultation A 8. Training for midwifery licensure includes recognizing the S/S of these diseases. See NARM CIB (2010).

¹³ Previously R9-16-109.Required Consultation A. 5.

17. Abnormally decreased fetal movement;¹
 18. Premature birth prior to 36 weeks gestation;²
 19. A gestation beyond 42 weeks;³
 20. An abnormal progression of labor;⁴
 21. Persistent, abnormal fetal heart rates;⁵
 22. A postpartum hemorrhage which does not respond to treatment methods available to the midwife;⁶
 23. Lacerations of the vulva or birth canal that require repair above the midwife's abilities, or;⁷
 24. Expressed wishes of the client or family.⁸
- B. A midwife shall secure consultation to obtain a recommendation for treatment, referral, or transfer of care upon presentation of the newborn with any of the following conditions:⁹
1. Birth weight less than 2000 grams;¹⁰
 2. Congenital anomalies;¹¹
 3. Irregular heartbeat;¹²
 4. Persistent poor muscle tone;¹³

¹ Previously R9-16-109.Required Consultation. A. 11. "Symptoms of decreased fetal movement" Fetal movement varies so it must be specified that this is an abnormal decrease in fetal movement to warrant a consultation. See Winje et al (2011).

² This replaces R9-16-108.Prohibited Practice; Transfer of Care A. 13, "Prematurity or labor beginning before 36 weeks gestation." Premature labor does not necessarily result in premature birth and may be managed and birth successfully postponed while the client remains under the care of the midwife. Reliable testing measures, such as ffn exist to reassure the clinician and the client that premature labor has been successfully halted. See Chao et al . (2011); CHANDIRAMANI (2011); McPheeet et al (2005)

³ Previously R9-16-108.Prohibited Practice; Transfer of Care A. 16.

⁴ Previously R9-16-109.Required Consultation. A. 16.

⁵ Previously R9-16-108.Prohibited Practice; Transfer of Care A. 18. The text, "Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute" has been replaced with "persistent, abnormal fetal heart rate." This statement more accurately encompasses situations where the heart rate may fall within 120-160 bpm yet still be abnormal such as declining baselines or sinusoidal rhythms. See ACNM (2010).

⁶ Replaces R9-16-108.Prohibited Practice; Transfer of Care A. 20., "A postpartum hemorrhage of greater than 500cc in the current pregnancy." The midwife has management skills available to her that may make transport for PPH unneeded.

⁷ Replaces R9-16-109.Required Consultation. A. 15."Second degree or greater lacerations of the birth canal." Midwives possess differing levels of suturing abilities and provide repair that is within their level of training.

⁸ Previously R9-16-108.Prohibited Practice; Transfer of Care A. 22.

⁹ Combining 108 and 109 to "to obtain a recommendation for treatment, referral, or transfer of care" covers conditions that may at times require simply a consultation and at other times a transfer of care.

¹⁰ Previously R9-16-108.Prohibited Practice; Transfer of Care E. 1..

¹¹ Combination of R9-16-108.Prohibited Practice; Transfer of Care E.4. and R9-16-109.Required Consultation B.2.

¹² Previously R9-16-109.Required Consultation B.5.

¹³ Previously R9-16-109.Required Consultation B.6.

5. Lethargy, irritability, or poor feeding;¹⁴
6. Failure to urinate or pass meconium in the first 24 hours of life;²
7. Hip examination which results in a clicking or incorrect angle;³
8. Skin rashes not commonly seen in the newborn;⁴
9. Temperature persistently above 99.6° or below 97.6° F.⁵
10. Pale, blue, or gray color after 10 minutes;⁶
11. Excessive edema;⁷
12. Respiratory distress.⁸

¹⁴ Previously R9-16-109.Required Consultation B.11.

² Previously R9-16-109.Required Consultation B.13.

³ Previously R9-16-109.Required Consultation B.14.

⁴ Previously R9-16-109.Required Consultation B.15.

⁵ Previously R9-16-109.Required Consultation B.16.

⁶ Previously R9-16-108.Prohibited Practice; Transfer of Care E. 2.

⁷ Previously R9-16-108.Prohibited Practice; Transfer of Care E. 3.

⁸ Previously R9-16-108.Prohibited Practice; Transfer of Care E. 5.

This document address these expansions of practice as requested by HB2247 by defining the problem, presenting evidence-based research that supports midwifery care in these situations, and discussing potential negative impact resulting from the changes. These requested changes should not prohibit entry into midwifery practice for individuals who have achieved the national licensure CPM credential. There are situations in which the newly licensed midwife will, according to practice ethics and professional guidelines, seek collaboration with more experienced care providers for assistance with more complex cases.

There are many changes requested in the document titled, “AZ Midwives Scope of Practice 9with footnotes)” that are not addressed here, due to the fact that those changes do not pertain to the expansion of practice. These changes are reflected in the footnotes of the document.

There are certain women who are risked out of home birth in Arizona, either because of a history of certain medical conditions or the development thereof during pregnancy. In addition to the general topics addressed below such as language updates, the right for the woman to have agency in her health care decisions, and the need for collaboration between midwives and the medical community – there are specific areas of R9-16-108 and R9-16-109 that the midwifery community wishes to address. The topics below are highlighted in this document.

LANGUAGE SHIFTS***INFORMED CHOICE FOR MIDWIFERY CARE******COMBINING TRANSFER OF CARE, PROHIBTED, and CONSULTATION******BLOOD DISEASE and ANEMIA******PELVIS******NO PRIOR CARE and TIMING OF CARE******HISTORY of POSTPARTUM HEMMORHAGE OR CURRENT PPH******VBAC AND OTHER UTERINE SURGERIES******MULTIPLES******BREECH******PREMATURE LABOR******UNDERSERVED POPULATIONS – MINORS, SMI, 'UNSAFE' LOCATION, ADDICTS******LABOR MANAGEMENT******PREMATURE RUPTURE OF MEMBRANES (PROM)******PLACENTA******PROCEDURES***

MEDICATIONS**LANGUAGE SHIFTS**

The majority of the suggested changes that you see in the AZ Midwives Scope of Practice (with footnotes) are not expansions of practice and are not further discussed here. These changes are discussed in footnotes. The midwifery community feels that these changes in language are necessary in order to respect the trained and licensed AZ midwife as an independent and qualified health care provider. Midwifery licensing at the state and national level requires years of study and skill development. These language shifts serve to:

1. bring AZ Rule to current standard of care within the midwifery model;
2. change the language of the rule to reflect medical terminology;
3. remove redundant statements;
4. remove language that assumes no training prior to midwifery licensure.

INFORMED CHOICE FOR MIDWIFERY CARE

Reflected throughout the AZ Midwives Scope of Practice document, there is an expectation for informed choice for midwifery care including a true informed consent process, the right for women to choose midwifery care and home birth, and a right for the client to refuse any procedures, tests, or transfer of care. The rationale for this change is that the midwifery model holds great respect for the woman's right to self-determination as well as her agency and ability to make their own care decisions. This self-determination can be as simple as declining a blood test to choosing to birth with a midwife at home even with risk factors. The position of the North American Registry of Midwives (NARM), which provides the Certified Professional Midwife (CPM) credential, is that of shared decision making and informed consent. Further, midwifery care is a human right. The informed consent process ensures collaborative care between the midwife and the client. The client is thereby fully informed of the midwife's education, training, experience and skill set and all risks and benefits of choosing a certain plan of care.

Current literature is beginning to reflect the phenomenon of 'unassisted births' or 'free births' where women choose to birth out of hospital without a care provider present. Although, some women may genuinely wish to have no care provider at birth, many are choosing this route due to legal limits placed upon care providers in their area. It is possible to obtain numbers of these 'unassisted births' utilizing vital statistics by sampling the number of out of hospital births registered by the parents rather than a health care provider or other entity. With current Arizona rules, there are many situations that legally risk women out of having a midwife present at their birth: multiples, breech presentation (effectively), and VBAC are the 'hot' topics brought forward by consumers at the onset of HB2247. These regulated 'risks' prevent many women from choosing a homebirth, which is likely the intent of the regulation. However, these regulated 'risks' also force many women to choose to birth unassisted.

There is always the potential, that by giving women with risk factors the right to choose out of hospital birth with a midwife, that women may unwisely choose this option and therefore put themselves or their child at risk. However, at this time, it remains the right of the woman to choose her level of involvement in health care including prenatal, intrapartum, and postpartum care. Women experiencing any of the situations restricted by Arizona rule may legally choose to birth at home, unattended. It is the midwives who are restricted from providing these women with any level of care. Releasing restrictions on midwives to attend these women will ensure that there will be a health care provider present, rather than an 'unassisted birth' due to legal limitations.

Childbirth Connection. (no date). The Rights of Childbearing Women. New York. Available online at

http://www.childbirthconnection.org/pdfs/rights_childbearing_women.pdf

Hickman, A. (2010). Born (not so) free: Legal limits on the practice of unassisted childbirth or free-birthing in the united states. *Minnesota Law Review*, 94(5), 1651.

Laufer-Ukeles, P. (2011). Reproductive Choices and Informed Consent: Fetal Interests, Women's Identity, and Relational Autonomy. *American Journal of Law & Medicine*, 37 (2011): 567-623

McAra-Couper, J., Jones, J. and Smythe, L. (2012). Caesarean-section, my body, my choice: The construction of informed choice' in relation to intervention in childbirth. *Feminism Psychology* February 2012 vol. 22 no. 1 81-97

Miller, A. C. (2009). Midwife to myself": Birth narratives among women choosing unassisted homebirth. *Sociological Inquiry*, 79(1), 51-74. 00272.x

NARM. (2012a). Informed Consent. Position Statement on Shared Decision Making and Informed Consent. Available online at <http://narm.org/accountability/informed-consent/>.

Thompson, JB. (2004). A Human Rights Framework for Midwifery Care. *J Midwifery Womens Health* 2004;49:175–181

Vowel, L. (2011). "Do it yourself" births prompt alarm. *CMAJ : Canadian Medical Association Journal = Journal De l'Association Medicale Canadienne*, 183(6), 648-650. doi:10.1503/cmaj.109-3820

Vedam, S., Goff, M. and Nolan, V. (2007). Closing the Theory–Practice Gap: Intrapartum Midwifery Management of Planned Homebirths. *J Midwifery Womens Health* 2007;52:291–300

Vedam, S. (2012). In Search of a Common Agenda for Planned Home Birth in America. *The Journal of Perinatal Education*, Volume 21, Number 2, 2012, pp. 67-71(5)

COMBINING TRANSFER OF CARE, PROHIBTED, and CONSULTATION

Currently, R9-16-108 Prohibited Practice; Transfer of Care and R9-16-109 Required Consultation outline various restrictions on eligibility for beginning or continuing midwifery care. The first section is comprised of conditions

that require immediate transfer of care for women or neonates. This requirement of immediate transfer of care sets up two potentially inappropriate and dangerous situations. The first is that conditions currently listed under R9-16-108 may or may not require immediate medical intervention, depending on the individual circumstance. Secondly, the current language of rule requires the midwife to not “knowingly continue to provide care” and “immediately transfer care” to any clients who develops any of these conditions. This regulation is potentially dangerous in situations where the midwife must continue to provide care while awaiting transport to a higher level care facility, such as in the case of postpartum hemorrhage or newborn respiratory distress.

The second section contains items requiring consultation in order to continue providing care. Some of these considerations, such as in the case of signs and symptoms of preeclampsia are better address by transferring care. Combining these sections into one where “the midwife shall obtain consultation to obtain a recommendation for treatment, referral, or transfer of care at the time any client is determined to have any of the following circumstances or conditions during the current course of care” allows the midwife, other care providers and the client to work together to develop a care plan based on shared decision making and allows the midwife to continue to provide care in emergency situations while awaiting higher level of care.

Evidence to support this change includes the importance of collaboration between the medical community and the midwifery community for best outcomes and the absolute value of risk assessment in pregnancy. The World Health Organization attests that normal pregnancies can develop complications and that complicated pregnancies can result in a normal intrapartum and postpartum period.

Downe, S, Kenny Finlayson, K. and Fleming, A. (2010) Creating a Collaborative Culture in Maternity Care.

Journal of Midwifery & Women's Health. 250 Volume 55, No. 3, May/June 2010

Schmied, V., Mills, A., Kruske, S., Kemp, L., Fowler, C. and Homer, C. (2010), The nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *Journal of Clinical Nursing*, 19: 3516–3526. doi: 10.1111/j.1365-2702.2010.03321.x

Skinner, JP. and Foureur, M. (2010) Consultation, Referral, and Collaboration Between Midwives and Obstetricians: Lessons From New Zealand, *Journal of Midwifery & Women's Health*, Volume 55, Issue 1, January–February 2010, Pages 28-37.

WHO. (1996). Care in normal birth; a practical guide. The World Health Organization. Department of Reproductive Health and Research

History of "blood disease" is prohibited practice under R9-16-108. Blood disease is a broad term that includes dozens of subsets. Some of these would certainly risk out a woman from home birth, such as uncontrolled hemophilia. However, others may be successfully treated and/or managed within midwifery care such as iron-deficiency anemia.

Anemia is addressed in R9-16-108 as "A persistent hemoglobin level below 10g or a hematocrit below 30 during the third trimester." The intent of this rule is likely to prevent some of the complications historically associated with anemia in pregnancy. However, current evidenced-based research suggests mild or moderate acquired anemia is not reliable as a causal factor of poor pregnancy outcomes. It is rather as a correlation possibly associated with socioeconomic, nutritional and ethnic variations. Current recommendations for acquired anemia, even at moderate levels, are simply to provide supplementation (and medication in the rare case of parasitic infection). Even this therapeutic treatment is controversial as it may, dependent on the type of supplementation, cause more harm than benefit. Severe anemia is associated with poor maternal outcomes, mainly heart failure, and fetal outcomes at the level of 6g/dl or less and should be immediately addressed with transfusion.

American College of Obstetricians and Gynecologists. (2008). ACOG practice bulletin no. 95: Anemia in pregnancy. *Obstetrics and Gynecology*, 112(1), 201-207.

Lee, A. and Okam, M. (2011). Anemia in Pregnancy. *Hematology/Oncology Clinics of North America* - Volume 25, Issue 2

Revez L, Gyte GML, Cuervo LG, Casasbuenas A. (2011). Treatments for iron-deficiency anemia in pregnancy. *Cochrane Database of Systematic Reviews* 2011, Issue 10. Art. No.: CD003094.

PELVIS

R9-16-108 lists "a pelvis that will not safely allow a baby to pass through during labor" as a transfer of care or prohibited practice. The midwifery community agrees that out of hospital birth, indeed vaginal birth, should not be attempted if the pelvis will not allow the baby to pass through. Unfortunately, there are no medically reliable, evidenced-based methods of assessing pelvis adequacy prior to labor. Pelvimetry is no longer considered a good predictor of cephalopelvic disproportion (CPD); there is a poor correlation between any type of pelvimetry (XRAY, MRI, CT, clinical) and labor outcomes. Similarly, a history of CPD does not indicate that there will be CPD in the current intrapartum period. Performing pelvimetry and knowledge of previous diagnosis of CPD is actually shown to negatively impact vaginal delivery rates.

- Catling-Paull, C., Johnston, R., Ryan, C., Foureur, M. J. and Homer, C. S. E. (2011), Clinical interventions that increase the uptake and success of vaginal birth after caesarean section: a systematic review. *Journal of Advanced Nursing*, 67: 1646–1661.
- Maharaj, D. (2010). Assessing cephalopelvic disproportion: Back to the basics. *Obstetrical & Gynecological Survey*, 65(6), 387-395.
- Pattinson RC, Farrell EME. (1997) Pelvimetry for fetal cephalic presentations at or near term. *Cochrane Database of Systematic Reviews* 1997, Issue 2. Art. No.: CD000161.

NO PRIOR CARE and TIMING OF CARE

R9-16-108 currently prohibits midwives from providing care for women with a, “gestational age greater than 34 weeks with no prior prenatal care.” This rule prevents women seeking late prenatal care from accessing midwifery care, possibly alienating the 3-5% of pregnant women in Arizona who seek care late in their pregnancy. Further, recent evidence has suggested that our long held notion that early and often prenatal care improved outcomes was flawed. Rather, women who were already lower risk due to socioeconomic conditions were more likely to seek early and quality prenatal care.

R9-16-106 currently reads “Prenatal visits shall be conducted at least every 4 weeks until 28 weeks gestation, every 2 weeks from 28 weeks until 36 weeks gestation, and weekly thereafter, …” Research is now suggesting that a reduced and modified prenatal visit schedule is appropriate for most women, focusing on quality of visits and contact at key times in pregnancy. Currently, the recommended prenatal visit schedule is between 7 and 9 total visits. This recommendation is evolving with research, so removing the frequency and timing of visits from rule allows for adaptation to current evidence and care practices.

ADHS. (2012). Arizona Health Status and Vital Statistics 2010. 1B. Natality: Maternal Characteristics and Newborn's Health. Available online at <http://www.azdhs.gov/plan/report/ahs/ahs2010/pdf/text1b.pdf>

Moos, M.-K. (2006), Prenatal Care: Limitations and Opportunities. *Journal of Obstetric, Gynecologic, & Neonatal Nursing*, 35: 278–285. doi: 10.1111/j.1552-6909.2006.00039.x

Phelan ST. (2008). Components and timing of prenatal care. *Obstet Gynecol Clin North Am*- 01-SEP-2008; 35(3): 339-53, vii

HISTORY of POSTPARTUM HEMMORHAGE OR CURRENT PPH

“A history of severe postpartum bleeding, of unknown cause, which required transfusion;” is currently listed as a prohibition of midwifery care AZ under R9-16-108. Similarly, “A postpartum hemorrhage of greater than 500cc

in the current pregnancy” is cause for transfer of care. Cases of PPH generally have a known cause, mainly uterine atony which is effectively treated in most cases by the use of uterotonic medications. New research is pointing to placental pathology as the root of the relatively high incidence of PPH in humans as compared to other mammals. Further, PPH is not a diagnosis, but rather an event noted on the client's medical history and the current standard of 500ml as a postpartum hemorrhage is being called into question. Measured blood loss at vaginal births often exceeds this number and some authors note that more than half of all deliveries would be classified as having a PPH using 500ml measured blood loss. A history of PPH of any cause is noted, in current medical literature, as a risk factor for future PPH. Midwives generally have the tools and training to treat PPH, while awaiting transport as needed. Training on emergency measures such as the management of PPH are required for licensure under the CPM credential.

- Abrams, E. T., & Rutherford, J. N. (2011). Framing postpartum hemorrhage as a consequence of human placental biology: An evolutionary and comparative perspective. *American Anthropologist*, 113(3), 417-430.
- Callaghan, W. M., Kuklina, E. V., & Berg, C. J. (2010). Trends in postpartum hemorrhage: United states, 1994-2006. *American Journal of Obstetrics and Gynecology*, 202(4), 353.e1-353.e6.
- NARM (2011) North American Registry of Midwives. Certified Professional Midwife: Candidate Information Booklet. Available online at <http://narm.org/wp-content/uploads/2011/02/cib.pdf>.
- Oyelese, Y., & Ananth, C. V. (2010). Postpartum hemorrhage: Epidemiology, risk factors, and causes. *Clinical Obstetrics and Gynecology*, 53(1), 147-156.
- Su, C. W. (2012). Postpartum hemorrhage. *Primary Care: Clinics in Office Practice*, 39(1), 167-187.
- Vedam, S., Goff, M. and Nolan, V. (2007). Closing the Theory–Practice Gap: Intrapartum Midwifery Management of Planned Homebirths. *J Midwifery Womens Health* 2007;52:291–300

VBAC AND OTHER UTERINE SURGERIES

R9-16-108 currently mandates that, “A previous Cesarean section or other known uterine surgery;” is prohibited practice for AZ midwives. This rule is not in alignment with current evidence. The most recent research available places the risks of morbidity and mortality for VBAC labors at or below that of primiparous women or Elective Repeat Cesarean. Primiparous women have the same level of risk for morbidity to mother and baby as VBAC women. VBAC decreases risk of intrapartum complications, especially when compared to women with multiple repeat cesareans. The potential risks that do exist for women attempting a vaginal birth after multiple cesareans, after non-favorable surgery technique, or after a previous cesarean that was performed prior to 36 weeks must be acknowledged. These risks can be mitigated by careful screening of operative records and the informed consent process.

- Cahill, AG et al. (2006) Is vaginal birth after cesarean (VBAC) or elective repeat cesarean safer in women with a prior vaginal delivery? *American Journal of Obstetrics and Gynecology* (2006) 195, 1143–7
- Erez et al. (2012). Remote prognosis after primary cesarean delivery: the association of VBACs and recurrent cesarean deliveries with maternal morbidity. *International Journal of Women's Health* 2012;4 93–107
- Rozen, G., Ugoni, AM., Sheehan, PM. (2011) A new perspective on VBAC: A retrospective cohort study. *Women and Birth* (2011) 24, 3—9

MULTIPLES

“Multiple gestation in the current pregnancy;” are currently prohibited practice/transfer of care under Arizona rule. There is no argument among the midwifery or obstetric populations that multiple pregnancies and births carry higher risks than that of singletons. At 40 weeks, neonatal mortality rates are 6 times higher for multiples than for singletons. Malpresentation of the second twin as well as death due to hypoxia and asphyxiation are real risks in twin births. What is still in question is the difference in outcomes between twin births at home and those in the hospital. Unfortunately, only one study has directly compared these groups and it was too small scale (1000 women for each group) to get information about the rare complications that can occur regardless of birthplace. Twin births account for only 1-2% of all deliveries so without statistical extrapolation we need tens of thousands of births to observe these complications in clinical settings, and therefore their outcomes. The techniques required for twin births such as assessing fetal presentation, immediate cord clamping, frequent fetal monitoring, and breech extraction are techniques in which midwives are trained. The increased risk to twin birth at home is likely mainly related to proximity to a medical facility if external version or cesarean delivery of the second twin is required. These issues can be part of the informed consent process where the midwife ensures that the client knows the increased risks associated with being out of hospital.

- Carroll, M. (2006). Vaginal Delivery of Twins. *CLINICAL OBSTETRICS AND GYNECOLOGY*. Volume 49, Number 1, 154–166.
- Kahn, B. (2003). Prospective Risk of Fetal Death in Singleton, Twin, and Triplet Gestations: Implications for Practice. *Obstet Gynecol* 2003;102:685–92.
- Leonard, L. (2002). Prenatal Behavior of Multiples: Implications for Families and Nurses. *JOGNN*, 31, 248–255; 2002.
- Smith et al. (2007). Birth Order of Twins and Risk of Perinatal Death Related to Delivery in England, Northern Ireland, and Wales, 1994-2003: Retrospective Cohort Study. *BMJ: British Medical Journal*, Vol. 334, No. 7593 (Mar. 17, 2007), pp. 576-578

Smulian, JC. et al. (2004). Twin Deliveries in the United States Over Three Decades: An Age-Period-Cohort Analysis. *Obstet Gynecol* 2004;104:278–85.

BREECH

Current rule requires a consultation for any non-vertex presentation. Consumers in Arizona have expressed a desire to be able to have a skilled attendant present for home delivery of a baby in breech presentation. With the accumulation of evidence now showing that long term risks for healthy neonates are similar between vaginal delivery and cesarean section, requiring a consultation puts undue burden on the client who must attempt to gain approval from a medical community that believes breech deliveries to be abnormal.

For the past decade or more, the medical model for breech presentation was to schedule a cesarean prior to labor onset. The recommendation for cesarean as the preferred method of delivery for breech presentation was largely based on the Term Breech Trial, conducted in 2000. This trial has since been heavily criticized for methodology, and for the resulting rising maternal mortality rate among women having cesareans for breech presentation as per the recommendation.

The PREMODA study, among others completed since the 2000 Term Breech Trial, shows similar risks of maternal and neonatal morbidity and mortality between vaginal vertex deliveries and vaginal breech deliveries in certain situations, with the exception of Apgar scores which have no association with long term outcomes. Even with studies that suggest a higher neonatal morbidity and mortality rate for vaginal breech delivery, the same studies show a higher rate of maternal morbidity and mortality among planned cesareans. Some women are good candidates for a vaginal breech deliveries, most notably having a term, average sized baby in complete or frank breech position. Midwives have preserved the knowledge of practice of attending breech birth and obstetric societies internationally have stated that the woman has the right to choose her birthplace and birth provider even when faced with a breech delivery.

Goffinet, F et al. (2006) .Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium .American Journal of Obstetrics and Gynecology (2006) 194, 1002–11

Hofmeyr GJ, Hannah M, Lawrie TA. Planned caesarean section for term breech delivery. *Cochrane Database of Systematic Reviews* 2003, Issue 2. Art. No.: CD000166.

- Kotaska et al (2009). SOGC Clinical Practice Guidline. Vaginal delivery of breech presentation. No. 226, June 2009. *International Journal of Gynecology and Obstetrics* 107 (2009) 169–176
- Lawson, G. W. (2012). The term breech trial ten years on: Primum non nocere? *Birth*, 39(1), 3-9.
- Pradhan, P., Mohajer, M, Deshpande, S. (2005). Outcome of term breech births: 10-year experience at a district general hospital. *BJOG: an International Journal of Obstetrics and Gynaecology*. February 2005, Vol. 112, pp. 218–222.
- Uotila, J., et al .(2005). Good perinatal outcome in selective vaginal breech delivery at term. *Acta Obstet Gynecol Scand* 2005: 84: 578–583

PREMATURE LABOR

“Prematurity or labor beginning before 36 weeks gestation.” Premature labor does not necessarily result in premature birth and may be managed and birth successfully postponed while the client remains under the care of the midwife. In fact, in recent literature, most cases of perceived premature labor result in discharge from the hospital due to failure to diagnose active labor. Current research of active labor suggests that progression prior to 6cm can be much slower than previously believed, suggesting that the latent phase of labor is quite long. This gives reassurance that contractions plus cervical change, especially in a multiparous woman, does not necessarily mean that birth is imminent. Reliable testing measures, such as fFN exist to reassure the clinician and the client that premature labor has been successfully halted. Training in the use of fFN would be beneficial to new midwives and is widely available. Potential harm to the public includes the risk of premature birth in an out of hospital setting, with the resulting incidence of respiratory distress syndrome.

- Chandiramani, M., Di Renzo, G. C., Gottschalk, E., Helmer, H., Henrich, W., Hoesli, I., & ... Shennan, A. (2011). Fetal fibronectin as a predictor of spontaneous preterm birth: a European perspective. *Journal Of Maternal-Fetal & Neonatal Medicine*, 24(2), 330-336.
- Chao et al . (2011). The Diagnosis and Natural History of False Preterm Labor. VOL. 118, NO. 6, DECEMBER 2011 Natural History of False Preterm Labor 1307
- McPheeeter et al (2005) The epidemiology of threatened preterm labor: A prospective cohort study. *American Journal of Obstetrics and Gynecology* (2005) 192, 1325–30
- Zhang (2010). Contemporary patterns of spontaneous labor with normal neonatal outcomes. *Obstetrics and Gynecology*. 116(6): 1281

UNDERSERVED POPULATIONS – MINORS, SMI, 'UNSAFE' LOCATION, ADDICTS

Midwives are a safety net for many poor and vulnerable women. Excluding these women from midwifery care assumes that the medical model of intensive testing and screening for women at risk will improve outcomes. In reality, midwives achieve better outcomes with at risk women due to the midwifery model of care which includes personalized care, social services resources, and referral.

MINORS

In Arizona, there exists no explicit statute that restricts a minor's ability to obtain prenatal care. Restricting access to midwifery care by requiring parental consent carries rule too far. Minors, even young teens, are believed to have better outcomes in midwifery care as compared to traditional obstetric care.

SMI

R9-16-108 restricts midwifery care for those with “severe psychiatric illness evident during assessment of client's preparation for birth, or a history of severe psychiatric illness in the six-month period prior to pregnancy.”

According to the National Alliance on Mental Illness (NAMI), severe mental illness includes “major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post traumatic stress disorder (PTSD) and borderline personality disorder.” One out of every six women will experience unstable mental health during their childbearing years, with depression being most common. Women with depression have been noted to enter midwifery care at disproportionate rates and midwifery organizations encourage midwives to integrate care of women with depression into their practices. Midwifery care has been shown to improve postnatal outcomes for women with chronic clinical depression.

'UNSAFE'

“Women without safe location for delivery” is also addressed in R9-16-108 Prohibited Practice; Transfer of Care. Women living in disparate housing situations have also been shown to benefit from midwifery care. Midwifery training includes assessing and setting up the birthing room(s), and the home visits that midwives provide allow an opportunity prenatally to offer counseling to ready the birthing environment. Midwifery care benefits women living in lower socioeconomic conditions more than traditional obstetric care does.

ADDICTS

“Addiction to alcohol, narcotics, or other drugs;” Babies born to addicted mothers have risks of preterm birth, low birth weight, neonatal abstinence syndrome (withdrawal), and developmental delays. Research has shown that in many cases correction the associative factors of addiction such as housing status, nutrition, smoking, stress, etc can greatly improve maternal and fetal outcomes. Women with addictions are unlikely to seek traditional obstetric

care as they often view it as inaccessible or dangerous. Midwives can be a valuable part of a comprehensive team that offers care for the woman with an addiction, establish a relationship of respect and trust that may influence behavior, and further, can offer a 'case management' style of care complete with resources and referrals. Midwives, especially those who have obtained additional training in addiction, improve outcomes for women and babies as compared to traditional obstetrical outcomes.

Bick, D. (2003). Strategies to Reduce Postnatal Psychological Morbidity The Role of Midwifery Services.

Review Article. *Dis Manage Health Outcomes* 2003; 11 (1): 11-20

Cox, K. (2008). Midwifery and Health Disparities: Theories and Intersections. *Journal of Midwifery & Women's Health*. Volume 54, Issue 1, January–February 2009, Pages 57–64.

Economidoy, E. (2012). Caring for substance abuse pregnant women: The role of the midwife. *Health Science Journal*, 2012 Jan-Mar; 6 (1): 161-9

Gutteridge, K. (2007), Making a Difference. *RCM Midwives*. Volume 10 No.4 April 2007

Guttmacher Institute. (2012). State Policies in Brief: Minors' Access to Prenatal Care. Available online at http://www.guttmacher.org/statecenter/spibs/spib_MAPC.pdf.

Hepburn Mary, Substance abuse in pregnancy, *Current Obstetrics & Gynaecology* 2004;14: 419-425

Miles, J. (2007). Methadone-exposed newborn infants: outcome after alterations to a service for mothers and infants. *CHILD CARE HEALTH DEV*, 2007 Mar; 33(2): 206

Raisler, J. (2005). Midwifery Care of Poor and Vulnerable Women, 1925–2003. *J Midwifery Womens Health* 2005;50:113–121

Sanders, L. B. (2006). Assessing and managing women with depression: A midwifery perspective. *Journal of Midwifery and Women's Health*, 51(3), 185-192.

Wooster, E. (2007). Supporting mental health. *RCM Midwives*. Volume 10 No.4 April 2007

LABOR MANAGEMENT

Labor management is outlined in R9-16-106, F, 2. This section of midwifery rule concerns frequency of maternal and fetal assessment including fetal heart tones, maternal vital signs and internal examinations. Fetal heart tones are assessed by intermittent auscultation, typically using a hand-held Doppler. Intermittent auscultation time frames vary greatly depending on clinical situation; there exists no evidence as to the ideal frequencies of intermittent auscultation. Removing time frames allows the midwife to adjust dependent on clinical situation. Similarly, maternal vital signs may be necessary more or less often than every 2-4 hours. Labor progress assessed by internal exams, is based upon Friedman's curve. Friedman's Curve has long been a subject of dispute. Recent research suggests that normal labor progress may be much longer than thought for the past 50 years, and may

follow uneven patterns that include plateaus, cervical reversals, and uneven dilation. These labor patterns are not associated with negative maternal or fetal outcomes.

Included in labor management is the assessment of amniotic fluid quality including the “Presence of thick meconium, blood-stained amniotic fluid,” currently a transfer of care under R9-106-108. Blood-stained amniotic fluid is of clinical significance with amniocentesis, but is difficult to diagnose during the intrapartum period due to bleeding from cervical change (“bloody show”). Management of labor when meconium staining of the fluid is present is a subject of debate. Some current research shows that meconium staining is a poor indicator of fetal outcome, although it is a good indicator of higher levels of intervention and lower apgar scores. Neonatal resuscitation recommendations now include minimal interventions for the management of the baby born with meconium stained fluid, with no mention of differing management than the newborn without meconium staining.

ACNM. (2010). Intermittent Auscultation for Intrapartum Fetal Heart Rate Surveillance. *Journal of Midwifery & Women's Health*. Volume 55, No. 4.

Alfirevic Z, Devane D, Gyte GML. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database of Systematic Reviews* 2006, Issue 3. Art. No.: CD006066.

Duhan, N., Anshu Paul, Urmila Duhan, & Anjali. (2010). Meconium staining of amniotic fluid-A poor indicator of fetal compromise.. *JK Science*, 12(4), 184-186.

Jaynes et al (2012). Intrapartum Care the Midwifery Way: A Review. *Prim Care Clin Office Pract* 39 (2012) 189–206

Kattwinkel, J., Neonatal Resuscitation Textbook, 6th Edition. American Academy of Pediatrics - American Academy of Pediatrics (2011) - Paperback -328 pages - ISBN 1581104987

Laughon SK, Branch DW, Beaver J, et al. (2012). Changes in labor patterns over 50 years. *Am J Obstet Gynecol* 2012;206:419.e1-9.

Neal et al (2010). What is the Slowest-Yet-Normal Cervical Dilation Rate Among Nulliparous Women With Spontaneous Labor Onset?. *JOGNN*, 39, 361-369; 2010.

Vedam, S., Goff, M. and Nolan, V. (2007). Closing the Theory–Practice Gap: Intrapartum Midwifery Management of Planned Homebirths. *J Midwifery Womens Health* 2007;52:291–300

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Current AZ rule requires transfer of care for the “Presence of ruptured membranes without onset of labor within 24 hours.” Although, most (60-80%) women will spontaneously enter labor within 24 hours, may will not. There is good evidence that the medical management of labor (hospitalization and repeat vaginal exams) may be the cause of infection, rather than the prolonged rupture of membranes. Expectant management for 72 to 96 hours is considered reasonable and not statistically associated with higher levels of infection. Additionally, prenatal infection is believed to be a major cause of PROM, suggesting that infection may exist prior to rupture of membranes. Expectant midwifery management with limited internal exams yields good outcomes.

Dare, MR., P. Middleton, C.A. Crowther, V.J. Flenady, B. Varatharaju. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more), Cochrane Database Syst Rev (2006) Jan 25;(1):CD005302

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PLACENTA

“A nonbleeding placenta retained more than 40 minutes;” is currently listed as a transfer of care under R9-16-108. This transfer of care would be for the purposes of manual removal of a retained placenta. Normal physiologic third stage is currently defined as 60 minutes and policies for the timing for manual removal of placenta vary greatly, as reflected in one large scale study of 14 European nations. There is currently insufficient research as to the optimal timing for manual removal. Although we know that retained placenta and postpartum hemorrhage co-occur, research does not show whether this is correlation or causation. In the absence of postpartum hemorrhage, expectant management of third stage and therapies alternative to manual removal should be considered, as manual removal carries certain risks. Risk to the client is the extended retention of the placenta resulting in complications.

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PROCEDURES

Certain procedures, routine and emergent are necessary for providing quality up to date care for midwifery clients. These include ability to perform shoulder dystocia maneuvers, amniotomy, episiotomy, manual exploration of the uterus, manual removal of the placenta, and suturing. Current rule restricts some of these procedures to emergency management and excludes others all together. This section will review the midwifery management of these procedures. All of these procedures are required knowledge for the CPM credential.

Shoulder dystocia maneuvers include a variety of internal and external manipulations that are performed in a systematic way to encourage birth of stuck shoulders. These steps are reflected in the AZ practical exam as well as the NARM candidate information booklet as essential knowledge for the licensed midwife. However, current AZ rule only allows moving the shoulders into the oblique diameter to correct a shoulder dystocia. This excludes essential and potentially life saving maneuvers including supra-pubic pressure, Woods maneuver, removal of posterior arm, fracturing of the clavicle, etc.

Amniotomy is not currently allowed within AZ rule. The ability to perform an amniotomy is an essential and recognized tool for the progression of active labor, and can be useful for assessing amniotic fluid when there exists a suspicion of meconium or blood stained fluids. Amniotomy is used sparingly in the midwifery model, as it does carry some risk including malpresentation cord compression or prolapse, rapid decent, and infection.

Episiotomy is currently allowed in AZ rule under emergency measures, however the rule specifies a midline episiotomy. Midline episiotomy is associated with severe perineal lacerations, and a mediolateral episiotomy is favored in situations requiring episiotomy.

Manual exploration and manual removal of the placenta are occasionally necessary steps to controlling postpartum hemorrhage. Manual exploration is currently permitted under AZ rule, but manual removal of the placenta is not explicitly allowed.

Suturing, under current rule, is explicitly limited to “Suturing of episiotomy or tearing of the perineum, to stop active bleeding, following administration of local anesthetic, contingent upon physician consultation or standing orders of physician” and requires consultation for “Second degree or greater lacerations of the birth canal.”

Standing orders has already been discussed as an unobtainable option. There are cases in which active bleeding is not present, yet suturing is still required for health and well-being of the mother. Some midwives have the training and experience to be qualified to suture many varieties of lacerations; being forced to transfer for repairs not related to active bleeding or that are greater than a second degree laceration of the perineum puts undue burden on

the client. Midwives who are not qualified may elect to transfer to a medical care facility or call in a qualified care provider.

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MEDICATIONS

Creating a pharmacology list within rule will allow midwives to obtain required medications without the necessitating a prescription or standing orders, both of which are difficult to obtain. Current medical practice and liability prevents physicians from willingly writing prescriptions for individuals who are not their clients and standing orders is no longer a common practice. The medications and medication types listed are standard of care in obstetrics and midwifery practices.

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