

Midwifery Scope of Practice Comments

April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Please read the report supplied by the midwives in 2012 for input on the rules changes. There is a link to it on your webpage. http://www.azdhs.gov/als/midwife/documents/reports/midwifery-scope-of-practice-report-licensed-midwives.pdf</p>	<p>Tues Apr 23 2013</p> <p>11:28AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>AZ Midwifery Scope of Practice (with footnotes) 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: Page 1 of 9 a. OB/prenatal panel⁶; b. Urinalysis; c. Sexually transmitted infection (STI) testing⁷; 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.). 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). 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.). 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. 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) 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). 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</p>	<p>Tues Apr 23 2013</p> <p>11:27AM</p> <p>Continued please scroll down.</p>

Midwifery Scope of Practice Comments

April 17 through April 23 2013

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 AZ Midwifery Scope of Practice (with footnotes) Page 2 of 9 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 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). 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. 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." Removed, "...recommended based upon examination or history" as this is obviously what recommendations will be based on. 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).. 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. Previously read, "The midwife shall initially determine if the client is in labor and the appropriate course of action to be taken by." 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. 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. AZ Midwifery Scope of Practice (with footnotes) Page 3 of 9 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. 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." Reworded

Midwifery Scope of Practice Comments

April 17 through April 23 2013

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). 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 multigravidas 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). Interventions required at certain clinical situations. Moved from emergency measures. See Gruenberg, B. (2008), 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. 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) Added "...requiring immediate care."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). Emergency Procedures needed in the case of retained placenta or placental fragments and/or postpartum hemorrhage. See Gruenberg (2008). AZ Midwifery Scope of Practice (with footnotes) Page 4 of 9 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). 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). 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); 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.. 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. replaced, "Providing instruction and

Midwifery Scope of Practice Comments

April 17 through April 23 2013

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.. 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). AZ Midwifery Scope of Practice (with footnotes) 4. The condition of the mother and newborn shall be re-evaluated between 24 and 72 hours of delivery and includes the following: Page 5 of 9 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; 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). Rh immunoglobulin administration for Rh negative mothers to prevent RH isoimmunization. See Moise, 2012. Vitamin K injection for newborns to prevent vitamin K deficiency bleeding. See Adame and Carpenter, 2009. Antibiotic eye prophylaxis for newborns to prevent complications resulting from infections of gonorrhea or chlamydia. See Darling and McDonald, 2010. 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); Chelmow (2011); Jerbi et al (2006) 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). IV fluids can be invaluable aids in dehydration, as well as fluid volume replacement in the case of postpartum hemorrhage. See Gruenberg 2008 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) 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). AZ Midwifery Scope of Practice (with footnotes) 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; Consultation 8 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; Page 6 of 9 Necessary for NNR and CPR. See AAP/AHA (2011); Gruenberg 2008; American National Red Cross (2006). International standards for midwifery, other states. See ICM (2010)“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) Epinephrine is a

Midwifery Scope of Practice Comments

April 17 through April 23 2013

necessary pharmacological agent to treat anaphylaxis while awaiting emergency transport. Especially important if midwives are going to offer antibiotic therapy. See Gruenberg, B. (2008). 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. "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. The requirement for quarterly reports 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. 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 situation is actually a consultation to obtain antibiotic therapy and there is no need for transfer. AZ Midwifery Scope of Practice (with footnotes) 2. A positive HIV test; 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 lesion at the onset of labor; 11. Active hepatitis; 12. Active gonorrhea; 13. Active syphilis; 14. Pulmonary embolism; 15. Pregnancy induced hypertension (PIH) preeclampsia, eclampsia; 16. Failure to auscultate fetal heart tones by 22 weeks gestational age; 17. Page 7 of 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. Moved from R9-16-109. Required Consultation A. 1. "Chronic" has been added to hypertension to avoid transfer of care for situational hypertension that may be on record. "Heart disease" has been replaced with "Cardiac disease" to reflect medical terminology. "Rh disease with positive titers" has been replaced with Rh isoimmunization to reflect medical terminology. "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. A portion of R9-16-108. Prohibited Practice; Transfer of Care A. 4. - diseases in this list have been separated for clarity. A portion of R9-16-108. Prohibited Practice; Transfer of Care A. 3. - diseases in this list have been separated for clarity. Previously R9-16-108. Prohibited Practice; Transfer of Care A. 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. AZ Midwifery Scope of Practice (with footnotes) 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. 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 Page 8 of 9 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). This replaces R9-16-108. Prohibited Practice; Transfer of Care A. 13, "Prematurity or labor beginning before 36 weeks

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>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); McPheeter et al (2005) Previously R9-16-108.Prohibited Practice; Transfer of Care A. 16. Previously R9-16-109.Required Consultation. A. 16. 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). 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. 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. Previously R9-16-108.Prohibited Practice; Transfer of Care A. 22. 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. AZ Midwifery Scope of Practice (with footnotes) 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 Page 9 of 9 14 Previously R9-16-109.Required Consultation B.11. Previously R9-16-109.Required Consultation B.13. Previously R9-16-109.Required Consultation B.14. Previously R9-16-109.Required Consultation B.15. Previously R9-16-109.Required Consultation B.16. Previously R9-16-108.Prohibited Practice; Transfer of Care E. 2. Previously R9-16-108.Prohibited Practice; Transfer of Care E. 3. Previously R9-16-108.Prohibited Practice; Transfer of Care E. 5.</p>	
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>IT IS VITAL THAT THE ADVISORY COMMITTEE BE COMPRISED BY A MAJORITY OF LICENSED MIDWIVES IN ORDER TO MAINTAIN THE MIDWIFERY MODEL OF CARE. PLEASE CHANGE THE MAKE UP TO ENSURE THIS. D. The director of the Department shall select the following midwifery advisory committee members: 1. Two midwives who are licensed according to Title 36, Chapter 6, Article 7 of the Arizona Revised Statutes; 2. Two public members who have used or who have significant experience with midwife services; 3. One physician who is licensed according to Title 32, Chapter 13, of the Arizona Revised Statutes or one physician who is licensed according to Title 32, Chapter 17, of the Arizona Revised Statutes, and who has experience in obstetrics; and 4. One nurse midwife who is licensed and certified according to Title 32, Chapter 15 of the Arizona Revised Statut</p>	<p>Tues Apr 23 2013</p> <p>11:25AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-112. Midwife Report A. A midwife shall complete a midwife report for each client in a format provided by the Department that includes the following: IF QUARTERLY REPORTS ARE GOING TO BE MAINTAINED, PLEASE DE-IDENTIFY THEM. A CHART NUMBER IS JUST AS</p>	<p>Tues Apr 23 2013</p> <p>11:21AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>EFFECTIVE AND DOES NOT VIOLATE PATIENT PRIVACY LAW. ADDITIONALLY, PLEASE MAKE IT A REQUIREMENT THAT MIDWIVES TELL THEIR CLIENTS ABOUT THIS REPORT AND GIVE THE CLIENTS THE OPTION TO NOT HAVE THEIR INFORMATION SHARED WITH THE STATE. PLEASE CONSIDER REMOVING QUARTERLY REQUIREMENT AND REPLACING WITH REQUIREMENT TO SUBMIT TO MANASTATS. REQUIRING QUARTERLIES IS A POOR METHOD OF REGULATION AND DATA COLLECTION AS HAS BEEN DEMONSTRATED. SUBMISSION TO MANASTATS WOULD ALLOW ARIZONA TO TRACK ALL LMs STATISTICS. QUARTERLIES DO NOT IN ANY WAY INCREASE SAFETY FOR CLIENTS OR ENSURE THAT LMs ARE FOLLOWING REGULATION. A MIDWIFERY BOARD IS NEEDED.</p>	
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation B. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time any newborn demonstrates any of the following conditions: 8. Yellowish-colored skin within 48 hours; (NML PHYSIOLOGIC JAUNDICE CAN OCCUR BETWEEN 24 AND 48 HOURS, PLEASE CHANGE TO WITHIN 24 HOURS; ALSO PLEASE CHANGE TO JAUNDICE RATHER THAN YELLOWISH-COLORED SKIN)</p>	<p>Tues Apr 23 2013</p> <p>11:16AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: 17. An unengaged head at 7 centimeters dilation in active labor; MAY OR MAY NOT BE ABNORMAL. MULTIPS??? PLEASE REMOVE.</p>	<p>Tues Apr 23 2013</p> <p>11:14AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: 15. Second degree or greater lacerations of the birth canal; HOW ABOUT CHANGING TO LACERATIONS BEYOND THE ABILITY OF THE MIDWIFE TO REPAIR. SOME MAY BE ABLE TO REPAIR 3RD DEGREE, OTHERS MAY NOT BE ABLE TO REPAIR 1ST DEGREE.</p>	<p>Tues Apr 23 2013</p> <p>11:13AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: 13. Effacement or dilation of the</p>	<p>Tues Apr 23 2013</p> <p>11:12AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>cervix, greater than a fingertip, accompanied by contractions, prior to the beginning of 36 weeks gestation; THIS IS ALL MULTIPS. PLEASE REMOVE.</p>	
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: 9. Greater than 1+ sugar, ketones, or protein in the urine on two consecutive visits; ROUTINE SCREENING OF URINE IS NOT CURRENT EVIDENCED BASED PRACTICE!!! http://www.ncbi.nlm.nih.gov/pubmed/17465289</p>	<p>Tues Apr 23 2013</p> <p>11:11AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: 6. Refusal of Rh blood work or treatment; Refusal of medical treatments is a client right. Requiring that they then speak to another care provider is a violation of that right.</p>	<p>Tues Apr 23 2013</p> <p>11:10AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: 5. Failure to auscultate fetal heart tones by the beginning of 22 weeks gestation; This may only require ULS examination. Can we include ULS as a consultation? Radiologist is a physician, after all.</p>	<p>Tues Apr 23 2013</p> <p>11:09AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. Required Consultation A. A midwife shall obtain a consultation to receive a written recommendation from a physician for treatment, referral, or transfer of care at the time a client is determined to have any of the following during the current pregnancy: Please modify R9-16-110. Required Consultation to allow for consultation from physicians, CNMs, and CPMs. There are situations where consultation with a physician specifically may not be needed such as referral for antibiotic therapy.</p>	<p>Tues Apr 23 2013</p> <p>11:08AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Please consider removing R9-16-109. Prohibited Practice; Transfer of Care. Wording requires immediate transfer of care, even when it would be dangerous to do so. Additionally, there are conditions on this list that may or may not increase risk depending on the situation. It would be far more appropriate to move all of R9-16-109. Prohibited Practice; Transfer of Care to R9-16-110. Required Consultation in order to evaluate each case individually.</p>	<p>Tues Apr 23 2013</p> <p>11:05AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-109. Prohibited Practice; Transfer of Care E. A midwife shall not perform any operative procedures except as provided in R9-16-111. Please make the following changes in parenthesis. R9-16-111 - 3. Midline episiotomy to expedite the delivery during fetal distress; (episiotomy should not be restricted to midline. mediolateral is often more appropriate. please reword to simply say episiotomy.) 4. Suturing of episiotomy or tearing of the perineum to stop active bleeding, following administration of local anesthetic, contingent upon consultation or standing orders of physician; (please remove requirement for consultation or standing orders - restrictive, and increases risk especially when suturing must be done to control hemorrhage) 5. Release of shoulder dystocia by rotating the shoulders into one of the oblique diameters of the pelvis; and (allow for whatever maneuvers are needed. this may include removing posterior or anterior arm, maternal position changes, rubins 1 and 2, etc. restricting maneuvers to only rotation in to the oblique increases risk) 6. Manual exploration of the uterus for control of severe bleeding. (please add manual removal of placenta, necessary emergency procedure)</p>	<p>Tues Apr 23 2013</p> <p>11:02AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-109. Prohibited Practice; Transfer of Care 1. Has more than one fetus; (restricts twins to vertex/vertex eliminating half) 5. Had a previous unsuccessful vaginal delivery or other demonstration of an inadequate maternal pelvis; (previous unsuccessful vag deliver could be for a variety of factors including things that do not indicate current ability to birth.) 7. Had a previous delivery with multiple gestation. (has no bearing on current risk)</p>	<p>Tues Apr 23 2013</p> <p>10:54AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-109. Prohibited Practice; Transfer of Care C. A midwife shall not perform a vaginal delivery with multiple fetuses for a client who: 2. Has twins who are less than 37 weeks gestation or more than 41 weeks gestation; (twins often come early and our scope allows for 36 week - why the difference?) 3. Has either twin not presenting in a vertex position; (half of all twins will not present in vertex/vertex; allowing breech singletons for primips but excluding second twin breeches does not make sense. second twin breeches are far less dangerous.) 8. Had a previous delivery of a fetus in a breech presentation. (how does this affect current risk)</p>	<p>Tues Apr 23 2013</p> <p>10:53AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>The following sections will eliminate access for the majority of women seeking VBAC out of hospital. Please remove them; it is obvious the intent of these sections is not about client safety in current birth but rather about restricting access to TOLAC and out of hospital VBAC. #5CPD or failure to dilate with previous births do not increase risks associated with TOLAC. They may increase rates of transfer to hospital, but should not exclude TOLAC at home. #6 and 7 "any complication"? this would include things like allergic reaction to a medication or iatrogenic mistakes such as a nicked bladder. Again, how does this protect current birth process? #8 or #9 previous multiples or previous breech? multiples and breeches are highly likely to be born by c-sec. how does previous multiples or breech increase risk for current singleton vertex presentation? R9-16-109. Prohibited Practice; Transfer of Care B. A midwife shall not perform a vaginal delivery after prior Cesarean section for a client who: 5. Had a previous Cesarean section for any of the following indications: a. Failure to dilate; or b. Cephalopelvic insufficiency; 6. Had complications during a previous vaginal delivery after a Cesarean section; 7. Had a Cesarean section with complications, including uterine infection; 8. Had a previous delivery with multiple fetuses; or 9. Had a previous delivery of a fetus in a breech presentation.</p>	<p>Tues Apr 23 2013</p> <p>10:50AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE CHANGE TO 60 MINUTES R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 20. A nonbleeding placenta retained more than 40 minutes; and</p>	<p>Tues Apr 23 2013</p> <p>10:38AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE CHANGE TO "ABNORMAL FETAL HEART RATES" AND REMOVE 120-160. HEAD COMPRESSION CAUSES NORMAL FHR BELOW 120. ABNORMAL FHR CAN EXIST BETWEEN 120 AND 160. R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 17. Abnormal fetal heart rate of below 120 beats per minute or above 160 beats per minute;</p>	<p>Tues Apr 23 2013</p> <p>10:38AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE CHANGE TO 36 HOURS TO REFLECT CURRENT STANDARD OF CARE R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 16. Presence of ruptured membranes without onset of labor within 24 hours;</p>	<p>Tues Apr 23 2013</p> <p>10:36AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE move to CONSULTATION R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 14. Gestational age greater than 34 weeks with no prior prenatal care; 15. A gestation beyond 42 weeks;</p>	<p>Tues Apr 23 2013</p> <p>10:36AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE correct "BLOW" TO BELOW R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 8. A persistent hemoglobin level blow 10g or a hematocrit below 30 during the third trimester;</p>	<p>Tues Apr 23 2013</p> <p>10:35AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE REMOVE: R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 7. A blood pressure of 140/90 or an increase of 30mm Hg systolic or 15mm Hg diastolic over client's lowest baseline blood pressure for two consecutive readings taken at least six hours apart; PLEASE MOVE 7 TO CONSULTATION.</p>	<p>Tues Apr 23 2013</p> <p>10:34AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE REMOVE: R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 4. Insulin-dependent diabetes, AND blood disease, UNCONTROLLED DIABETES IS HIGHER RISK, INSULIN-DEPENDENT AND CONTROLLED MAY OR MAY NOT BE. PERHAPS CONSULT? BLOOD DISEASE MAY OR MAY NOT BE HIGH RISK, PERHAPS CONSULT?</p>	<p>Tues Apr 23 2013</p> <p>10:34AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE REMOVE: R9-16-109. Prohibited Practice; Transfer of Care A. A midwife shall not accept for midwifery services a client who has or continue services for a client that develops any of the following: 1. A previous uterine surgery, except as provided in R9-16-108(B)(1) THIS REQUIREMENT WILL EXCLUDE ALL WOMEN WHO HAVE HAD UTERINE OR CERVICAL SURGERIES THAT DO NOT INCREASE RISK SUCH AS D&C FOR TAB, COLPOSCOPY, ETC.</p>	<p>Tues Apr 23 2013</p> <p>10:31AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE REMOVE: EXTERNAL MASSAGE OF THE UTERUS - may not be appropriate BLEEDING, BLOOD CLOTS - perineum blood clots??? AND REVIEWING POTENTIAL DANGER SIGNS - danger signs of breastfeeding? M. A midwife shall provide the following services during the postpartum period: 1. During the 2 hours after delivery of the placenta, care of the client shall include: a. Taking of vital signs of the client and 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; b. Assisting the client to urinate within 2 hours following the birth; c. Evaluating the perineum for tears, BLEEDING, BLOOD CLOTS; d. Assisting with maternal and infant bonding; e. Assisting with initial breast feeding, instructing the client in the care of the breast, AND REVIEWING POTENTIAL DANGER SIGNS, if appropriate; f. Providing instruction to the family about adequate fluid and nutritional intake, rest, and the types of exercise allowed, normal and abnormal bleeding, bladder and bowel function, appropriate baby care, signs and symptoms of postpartum depression, and any danger signals with appropriate emergency phone numbers; g. Document any drugstaken by the client in the client's record to an unsensitized Rh-negative client who delivers an Rh-positive newborn;</p>	<p>Tues Apr 23 2013</p> <p>10:30AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>b. Apply erythromycin optic ointment or other preparation to each of the newborn's eyes in accordance with A.A.C. R9-6-332; and PLEASE ADD UNLESS REFUSED</p>	<p>Tues Apr 23 2013</p> <p>10:27AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>g. Document any drugs taken by the client in the client's record to an unsensitized Rh-negative client who delivers an Rh-positive newborn; PLEASE REMOVE THIS FROM "1. During the 2 hours after delivery of the placenta, care of the client shall include:" Standard of care is to administer Rh immunoglobulin within 72 hours of delivery - not 2 hours. 2 hour requirements without ability for the midwife to administer and without time to wait for NB type and screen to return from lab will require ALL Rh negative parents to transfer to hospital postpartum for Rh immunoglobulin administration.</p>	<p>Tues Apr 23 2013</p> <p>10:27AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>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; and Please change to within 60 MINUTES. No additional risk.</p>	<p>Tues Apr 23 2013</p> <p>10:24AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>REMOVE REQUIREMENT TO MONITOR KETONES IN LABOR. f. Maintenance of proper fluid balance for the client throughout labor as determined by urinary output and monitoring urine for presence of ketones, at least every 2 hours; and Appropriate when dehydration is suspected. Not appropriate or standard of care for routine monitoring.</p>	<p>Tues Apr 23 2013</p> <p>10:23AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>REMOVE 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; and Determination of a normal progress of active labor for multigravidas 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).</p>	<p>Tues Apr 23 2013</p> <p>10:20AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>d. Determination of the progress of active labor for primiparas by determining if dilation occurs at an average of 1 centimeter per hour until completely dilated, and a second stage not to exceed 2 hours; e. Determination of a normal progress of active labor for multigravidas by determining if dilation occurs at an average of 1.5 to 2 centimeters per hour 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).</p>	<p>Tues Apr 23 2013</p> <p>10:19AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>PLEASE REMOVE L. A midwife shall provide services during the intrapartum period as follows: 1. Notification to the emergency room charge nurse of the hospital identified in subsection (E)(1)(a) when the client: a. Begins labor; and b. Ends labor; As a midwife, I am willing to make these phone calls. A client has the right to privacy and may not wish info to be shared with local hospital without consent. Local hospitals in metropolitan areas are TOO BUSY to field these calls and take action in them. Charge nurses are busy and are unlikely to modify behaviors because of a phone call about normal labor and birth. They want to know when we need them. I do not notify to the local hospital each time I get in my car because of risk of a car accident. I understand the intent of the department with this addition is to build bridges, but believe this action will actually serve to further alienate LMs from many hospital OB wards. Perhaps requiring this only for rural communities that are a certain distance from an OB hospital???</p>	<p>Tues Apr 23 2013</p> <p>10:18AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>5. Conduct a visit to the client's home before the end of 35 weeks gestation to ensure that the birthing environment is appropriate for birth and that a working telephone or citizen's band radio is available Please change to 5. Conduct a visit to the client's home before the end of 35 weeks gestation OR PRIOR TO BIRTH FOR CLIENTS BEGINNING CARE AFTER 35 WEEKS GESTATION to ensure that the birthing environment is appropriate for birth and that a working telephone (REMOVE CB RADIO - OUTDATED)</p>	<p>Tues Apr 23 2013</p> <p>10:12AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>3. If applicable, refer a client for: c. A follow-up ultrasound at 35-36 weeks gestation to confirm fetal presentation and estimated fetal weight for a breech pregnancy; approx 25% of fetuses are breech at 35-36 weeks and only 3-4% will present breech at birth. Referring 1/4 of all midwifery clients for an ULS to confirm breech and then managing them as if they are a planned breech is inappropriate. EFW by ULS are off by 1-2 pounds. This requirement combined with the weight requirements for breech delivery out of hospital will eliminate most options for breech out of hospital delivery.</p>	<p>Tues Apr 23 2013</p> <p>10:10AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>f. One-hour blood glucose screening test for diabetes, between 24 and 28 weeks gestation; PLEASE change to: f. Glucose screening test for diabetes There are many valid methods of screening for gestational diabetes, and these tests are constantly evolving. Currently, the 1 hour PGS, 2 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).</p>	<p>Tues Apr 23 2013</p> <p>10:07AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>d. Document in the client record: i. Any time bleeding or invasive uterine procedures are done; and ii. Any drug taken by an unsensitized Rh negative client after the beginning of 28 weeks gestation; PLEASE change to: d. Document in the client record: i. Any time bleeding OCCURS or invasive uterine procedures are done; and ii. Any RH IMMUNOGLOBULIN drug taken by an unsensitized Rh negative client after the beginning of 28 weeks gestation; bleeding is not "done" and "any drug" without specified relation to Rh would include things like OTC meds.</p>	<p>Tues Apr 23 2013</p> <p>10:04AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>a. The taking of weight, urinalysis for protein, nitrites, glucose and ketones, blood pressure, and assessment of the lower extremities for swelling Please remove requirement for UA dipsticks “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. Please change wording “assessment of the lower extremities for swelling” to “assessment of edema” to reflect medical language.</p>	<p>Tues Apr 23 2013</p> <p>10:01AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>K. A midwife shall provide initial services and services during the prenatal period as follows: please change to K. Initial care and care during the prenatal period is provided as follows, unless a written refusal by the client is obtained. 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)</p>	<p>Tues Apr 23 2013</p> <p>9:58AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>H. Subsections(B) and (K)(3) are effective July 1, 2014 Why the delay? Either your midwives are qualified or they are not. There is no new training that will be made available within the next year.</p>	<p>Tues Apr 23 2013</p> <p>9:56AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>F. A midwife shall implement the emergency care plan if: 1. Any of the conditions in R9-16-110 occur and are applicable to labor Think you meant r9-16-109</p>	<p>Tues Apr 23 2013</p> <p>9:55AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-108. Responsibilities of a Midwife; Scope of Practice C. 1. g. The midwife's notification to the client regarding termination of services if certain medical conditions arise or the client refuses intervention; 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.).</p>	<p>Tues Apr 23 2013</p> <p>9:54AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-108. Responsibilities of a Midwife; Scope of Practice A. A midwife shall provide services only to a client determined to be low risk Please change to: A. A midwife provides care to any client desiring midwifery services, respecting the woman's right to self-determination. 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.).</p>	<p>Tues Apr 23 2013</p> <p>9:52AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Section R9-16-104. B needs to be removed entirely from the proposed rules. Requiring an agreement from a physician to assume care will greatly restrict access to midwifery for parents in Arizona as physicians are no longer willing to be formal backups for licensed out-of-hospital midwives. ACOG is publicly opposed to home birth. Requiring a midwife to specify which hospital she will transfer care to in emergency situations ahead of birth places parents and babies at risk as the safest transport may be the closest hospital. In emergency transports, EMS is often notified, the attending on call physician assumes care, and the parent/baby is transported to the closest appropriate hospital. As a midwife, I will not restrict hospital choice at the expense of the parent/baby dyad.</p> <p style="text-align: right;">R9-</p> <p>16-104. Administration B. A midwife shall: 1. Notify the Department in writing within 30 calendar days after: a. The name of the hospital to which the midwife plans to send a client who needs services outside a midwife's scope of practice changes; or b. The name of the physician who agrees to assume care for a client who needs services outside a midwife's scope of practice changes; and 2. Provide to the Department, as applicable: a. The name of the new hospital to which the midwife plans to send a client who needs services outside a midwife's scope of practice; or b. For each new physician who agrees to assume care for a client who needs services outside a midwife's scope of practice: i. The name of each new physician; and ii. A letter from each new physician agreeing to assume care for a client who needs services outside a midwife's scope of practice.</p>	<p>Tues Apr 23 2013</p> <p>9:45AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>as a vbac mother, I would like to have the freedom (just as every other birthing mother does) to birth where and with whom I chose. vbacs have been proven to be just as safe if not safer than a repeat cesarean. a midwife should be allowed to attend a home birth vbac mother, assuming she has no complications. my first child was born by cesarean, and my second was a vbac with absolutely no complications. yet I still had to deliver at the hospital, couldn't even deliver at the birth center which is next door to the hospital should I have needed a doctor's help. I deserve the same rights as every other birthing woman when it comes to my prenatal care and delivery choices!</p>	<p>Thur 18, 2013</p> <p>10:23 AM</p>

Midwifery Scope of Practice Comments April 17 through April 23 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Birth is a normal, healthy event for most women and women retain the right of autonomy over their own bodies. No one should be able to tell women where or with whom they can give birth. Midwives are a vital part of the maternity care team and stand to reduce the cost of maternity care for everyone, states included. Keep midwives around. In fact, get more of them and encourage women to make informed choices about their births!</p>	<p>Thur 18, 2013</p> <p>10:07 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Giving birth is a natural normal event in women's lives. People that are scared of this event and feel the need to "manage" it have no business being a part of birth. Trust, relaxation, and knowledge are the things that women need to have successful births, not fear, denial, and uncertainty. Midwives are a wanted & needed group of women, that many many women in AZ WILL seek out. Expanding their scope of practice to include VBAC, breech and other births would be a very good step in the right direction for Arizona's mothers. ~Anita</p>	<p>Thur, Apr 18, 2013</p> <p>9:39 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>I want a homebirth VBAC next time and I want it LEGALLY!!</p>	<p>Thur, Apr 18, 2013</p> <p>8:58 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Please read and go over the documents that the midwives put together correcting language and errors of the draft.</p>	<p>Wed, Apr 17, 2013</p> <p>1:18 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>I understand the need for a bridge in the community between midwives and ob/gyn's but this needs to happen at a time when there is not stress already on each party. Socials, tea partyies, community get together s' of any type, where the atmosphere is calm and impressionable, is where we will see most change in attitudes and stigma. There is even a chance for knowledge sharing at these times. A phone call to the hospital for a labor notification is really only needed when there is foresight in a transfer or when a transfer is actually happening.</p>	<p>Wed, Apr 17, 2013</p> <p>1:12 PM</p>

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R9-16-109 B(5). states that a midwife shall not perform a VBAC for a client who: "Had a previous Cesarean section for any of the following indications: (a) failure to dilate; or (b) Cephalopelvic insufficiency." These two disqualifications must be removed if VBAC is to be made accessible to Arizona women and families at home. These are made the official diagnosis for a vast majority of c-sections regardless of other factors effecting a woman's labor...(impatient staff, emotional state of mother, poor birthing environment, long labor, presentation of baby etc..) It is unwise of us to make these or other such factors a black mark on a woman's record. Please remove these and trust the midwives of Arizona to examine each potential client's history fully and view her past and present medical/physical/emotional situation. Trust the midwives' abilities to make accurate assessments and recommendations. I feel that some members of the Advisory Board are under the unfortunate impression that midwives will try to do the unthinkable and let birthing women enter into unsafe and unfavorable situations if not regulated more stringently. This is not so. Please, please, please trust the midwives to help their clients make the best and safest decisions for themselves and their babies. Do not take the option from them all at once, regardless of individual situation. Make VBAC accessible to women who want to deliver at home under the care of Licensed Midwives. Thank you.

Wed, Apr
17, 2013

12:43 AM