

**Midwifery Rulemaking Comments  
January 9 through March 20, 2013**

<b>Has anything been left out that should be in the rules?</b>	
I am very concerned about the requirement that at home mid-wives require a "back-up" physician. It has been communicated to me that this is an impossibility, therefore rendering home-birth midwives to be practicing illegally without a "back-up" physician. Women must be allowed to make informed decisions regarding their health and the health of their babies, free from government intrusion. Women who choose homebirth, under the care of a qualified, experienced midwife, must have their rights protected. Any requirements that inhibit the practice of qualified, experienced, licensed midwives should be stricken from the draft rules.	Wed, Mar 20, 2013 8:48 PM
<b>How can the draft rules be improved?</b>	
The proposed section requiring a backup physician for midwives needs to be taken off.	Tue, Mar 19, 2013 9:29 PM
<b>How can the draft rules be improved?</b>	
Take out the section stating a physician is needed at a birth	Tue, Mar 19, 2013 7:28 PM
<b>Has anything been left out that should be in the rules?</b>	
102a states a physician needs to be at a birth, which would create unnecessary assistance with the midwifery practice attending the birth.	Tue, Mar 19, 2013 7:28 PM
<b>What parts of the draft rules do you believe are effective?</b>	
Section R9-16-108 B - that a licensed midwife may perform a vaginal delivery after C-section, delivery with multiple gestation, or delivery of a baby in breech position.	Tue, Mar 19, 2013 6:58 PM
<b>How can the draft rules be improved?</b>	
Section R9-16-102 A.e-f should be struck from the rules. If it remains this rule would make it impossible to practice home-birth in the state of Arizona and, as a consumer, I desire the ability to make my own choices about the risk I will assume in giving birth.	Tue, Mar 19, 2013 6:58 PM

**Midwifery Rulemaking Comments  
January 9 through March 20, 2013**

<b>Has anything been left out that should be in the rules?</b>	
Not that I am aware of.	Tue, Mar 19, 2013  6:58 PM
<b>How can the draft rules be improved?</b>	
The proposed section on requiring a backup physician. Please do not make midwifery illegal by maintaining that requirement!	Tue, Mar 19, 2013  3:45 PM
<b>How can the draft rules be improved?</b>	
Director, I agree a women can choose to have anyone present at her birth that she wishes. However, some women would like to choose to have a licensed professional present who is supportive of normal, non-interventive birth, yet is capable of detecting potential complications and refers to EMERGENCY care as appropriate without having a physician dictate any form of control in the matter. That is exactly where a licensed midwife fits into the picture. The fact is, OB's have a toolbox full of interventions to assist in rare birthing circumstances and/or complications, however, in today's practice, these interventions are being implemented far too often as "control" measures because of fear. This is perpetuated in the way the current draft rules are written by requiring a midwife to have a back-up physician sign for her license. This is equivalent to requiring an individual who wishes to get a driver's license to have an ER physician agree to take care of them in the event of a car crash! PLEASE ensure that those requirements are REMOVED in their ENTIRETY to preserve women's freedom to have whom she wishes to be present at her birth, as you assert a woman has. Thank you.	Tue, Mar 19, 2013  10:09 AM
<b>How can the draft rules be improved?</b>	
With all due respect to ADHS, from a layman's point of view, the spirit of HB2247 was intended to *reduce* regulatory burden placed upon midwives and *update* the Scope Of Practice. From what I see so far, there is a spirit out there that is exactly the opposite. In fact, the 2/5/13 draft includes language that not only increases regulatory burden, but could in reality put a complete halt to midwifery practice. First, a physician will *never* sign a legal consent agreeing to accept clients who fall outside a midwife's scope of practice, nor should they. This puts an unnecessary legal liability upon a physician, and furthermore effectively puts them in control of the licensing process because without their signature, a midwife can not obtain a license to practice. That language MUST be removed!	Tue, Mar 19, 2013  7:09 AM

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p><b>How can the draft rules be improved?</b></p> <p>RE: R9-16-111. A,2 Midwives should not be carrying or using oxygen. There is sufficient evidence to support the use of room air as an optimal choice in resuscitation, if the need arises. Oxygen is a volatile substance and should not be transported frequently if it is not absolutely required. It is an added risk to birth, in a home environment. If women or babies require medical assistance, they should be transported by ambulance. Room air, again, has been shown as optimal in beginning resuscitation. Reference for consideration:  <a href="http://circ.ahajournals.org/content/122/16_suppl_2/S516.full">http://circ.ahajournals.org/content/122/16_suppl_2/S516.full</a>  <a href="http://www.medscape.com/viewarticle/558124_4">http://www.medscape.com/viewarticle/558124_4</a> <a href="http://lib.bioinfo.pl/paper:12537311">http://lib.bioinfo.pl/paper:12537311</a> B. Pitocin Usage Pitocin should not be administered in the home environment. There are risks to administration of Pitocin, which could only be handled in a hospital environment, with appropriate technology and staff. These risks include: <a href="http://www.rxlist.com/pitocin-side-effects-drug-center.htm">http://www.rxlist.com/pitocin-side-effects-drug-center.htm</a>  <a href="http://www.aafp.org/afp/2007/0315/p875.html">http://www.aafp.org/afp/2007/0315/p875.html</a> A midwife should be trained in normal birth and should be able to identify the need for medical intervention. There is more risk to using these drugs at home, than to not have them at all. There are alternatives that can be used while waiting for transport. I also believe that other drugs, such as misoprostol, should not be considered for use at home. Reference considerations: *  <a href="http://www.ncbi.nlm.nih.gov/pubmed/230905332">http://www.ncbi.nlm.nih.gov/pubmed/230905332</a>.<a href="http://www.who.int/bulletin/volumes/87/9/08-055715/en/index.html">http://www.who.int/bulletin/volumes/87/9/08-055715/en/index.html</a> * <a href="http://www.rxlist.com/cytotec-drug/warnings-precautions.htm">http://www.rxlist.com/cytotec-drug/warnings-precautions.htm</a>  *<a href="http://www.who.int/bulletin/volumes/87/9/08-055715/en/index.html#4">http://www.who.int/bulletin/volumes/87/9/08-055715/en/index.html#4</a>.  *<a href="http://onlinelibrary.wiley.com/doi/10.1111/aogs.12065/abstract">http://onlinelibrary.wiley.com/doi/10.1111/aogs.12065/abstract</a> *  <a href="http://www.ncbi.nlm.nih.gov/pubmed/20494730">http://www.ncbi.nlm.nih.gov/pubmed/20494730</a> *  <a href="http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61923-1/abstract">http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61923-1/abstract</a>  *<a href="http://medcitynews.com/2012/08/study-says-cytotec-for-postpartum-bleeding-should-not-be-on-who-drug-list/">http://medcitynews.com/2012/08/study-says-cytotec-for-postpartum-bleeding-should-not-be-on-who-drug-list/</a> *<a href="http://www.helium.com/items/2144176-side-effects-of-misoprostol">http://www.helium.com/items/2144176-side-effects-of-misoprostol</a>  *<a href="http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=5880">http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=5880</a></p>	<p>Sat, Feb 16, 2013</p> <p>8:52 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>the change to CPM as licensing/education evaluation</p>	<p>Sat, Feb 10, 2013</p> <p>4:16 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>these rules should be made with the whole state in mind. the majority of the state has small rural communities that are under served as far as maternal care goes. These people know that they are not near to quick medical care and choose to live there anyway. I have been working with a few other midwives that do rural births. We do a few things differently than practicing in cities including transfer sooner rather than wait out something that may resolve on its own . We carry and use IV which are crucial to prevent hypovolemic shock in a mom who has hemorrhaged and is preventive of more severe consequences .We also care very large oxygen tanks for the same reason- we have done so for the past 15 years. In that time we have had cause to call out the helicopter once but know how to do so including getting GPS coordinates for the best landing area ahead of time or using the local landing pad at the fire department. None of this works well with having a designated doctor back-up for each client because in an emergency we really want to utilize the larger system developed by the state. It was my understanding that part and parcel with centralizing trauma care/ and high level NICU units , money is not spent supporting staff and high level experts at rural hospitals but rather the rural units transfer in to the larger hospitals- so there are a few small town hospitals that provide some delivery services and can stabilize a laboring mom or neonate but because of nursery provisions and staffing the level of care a client needs is higher than they can provide so they are transferred to the</p>	<p>Sat, Feb 10, 2013</p> <p>4:16 PM</p>

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>central hospitals. I ask that the distance from a hospital that would actually be taking care of a rural client be taken into consideration. In these cases naming a doctor is also not useful because the whole trauma/perinatal care situation is that staff is there waiting for emergent transfers all the time already. So waiting for a named doctor to care for an emergency or for urgent needed care is just wasting time and endangering mom or baby.</p>	
<p><b>Has anything been left out that should be in the rules?</b></p>	<p>Sat, Feb 10, 2013 4:16 PM</p>
<p>What is left out is the ability to administer the medications that we have already been administering- like Rh immune globulin both prenatally and postpartum, as well as vitamin K shots. if there is a distance from a hospital requirement it may be applicable for higher risk births like VBAC, breeches and twins. Although if c-sections continue to increase and become 50% or greater of the birthing population then distance from the hospital for VBAC may not be as big of an issue because those same women have a higher risk of pregnancy rupture or placenta abruption and so provisions will need to be made by the community health and emergency services as to how these events will be managed for the general population not just for midwife clients. Also there needs to be some statement about the ability of students to perform midwifery tasks under supervision.</p>	
<p><b>Has anything been left out that should be in the rules?</b></p>	<p>Mon, Jan 14, 2013 9:38 PM</p>
<p>I APPOLOGIZE FOR MY STATEMENT ABOUT QUALIFICATIONS. I DID NOT SEE THE NEW AND IMPROVED FORM. IT CERTAINLY IS AN IMPROVEMENT AND I CONGRATULATE THE AUTHORS FOR THAT. IT CONTINUES, HOWEVER, TO BE INADEQUATE TRAINING FOR THE SCOPE OF PRACTICE THAT IS BEING REQUESTED. ESPECIALLY "B1,2,3 ... THESE ARE DELIVERIES DONE UNDER THE MOST CAREFULLY MANAGED CONDITIONS BY THE VERY QUALIFIED OBSTETRICIANS. AND FOR THE SAFETY OF THE MOTHER AND CHILD I WOULD ESTIMATE THAT AT LEAST 75% OF EACH OF THOSE DELIVERIES ARE BY CSECTION ... BECAUSE STATISTICS INDICATE IT IS THE SAFEST FOR THE BABY AND MOTHER.</p>	
<p><b>What parts of the draft rules do you believe are effective?</b></p>	<p>Mon, Jan 14, 2013 9:22 PM</p>
<p>EFFECTIVE FOR WHAT? ARE YOU INTERESTED IN BEING "EFFECTIVE" FOR INCREASING THE SCOPE OF PRACTICE FOR THE MIDWIFE? OR ARE YOU TRYING TO BE EFFECTIVE FOR INCREASING THE SAFETY OF THE MOTHER AND THE UNBORN CHILD? THESE ARE DEFINITELY CONFLICTING GOALS.</p>	
<p><b>How can the draft rules be improved?</b></p>	<p>Mon, Jan 14, 2013 9:22 PM</p>
<p>AFTER READING "B" 1,2,3 I THINK THINGS SHOULD GO BACK TO THE DRAWING BOARD. DO YOU REALLY THINK THERE ARE MANY OBSTETRICIANS IN PRIVATE PRACTICE THAT WILL AGREE WITH THE RESPONSIBILITIES ... OR HOSPITALS THAT WILL AGREE? MY GUESS IS YOU MIGHT FIND A FEW WHO WILL DO MOST OF THE MONITORING. THE LEAST THAT YOU SHOULD DO IS GET THE OPINION OF THE ACOG DISTRICT OF OB/GYN AND THE PHOENIX COUNCIL OF OB/GYN</p>	

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p><b>Has anything been left out that should be in the rules?</b></p> <p>THIS DRAFT IS SO FLAWED IT SHOULD BE RE WRITTEN. THERE ARE SO MANY CONTRADICTIONS AND CONFUSING RULES I DON'T SEE HOW ANYONE WILL QUALIFY. FROM BRIEFLY READING THE REQUIREMENTS TO BE A CERTIFIED MIDWIFE I AM AMAZED HOW FEW QUALIFICATIONS ARE NECESSARY. I AM EMBARRASSED TO ADMIT IT TOOK ME COLLEGE, MEDICAL SCHOOL, INTERNSHIP AND RESIDENCY TO DO WHAT A HIGH SCHOOL GRADUATE IS ALLOWED TO DO WITH A LITTLE ON THE JOB TRAINING AND A COUPLE OF LETTERS OF RECOMMENDATION.</p>	<p>Mon, Jan 14, 2013</p> <p>9:22 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>for instance: instead of stating 'pitocin' stating any hemoragic drug would enable midwives to provide the best possible care regardless of new scientific discoveries. I believe that there is no need for an OB to sign off on breech/vbac, if the wording was changed so that the women could still make up their mind regardless of the recomendation made rather than leaving that decision in the hands of the OB.</p>	<p>Mon, Jan 14, 2013</p> <p>8:11 PM</p>
<p><b>Has anything been left out that should be in the rules?</b></p> <p>regardless of breech reasons the women should still be able to use a midwife at home. along with women who have had more than 5 births prior.</p>	<p>Mon, Jan 14, 2013</p> <p>8:11 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>I believe that I should have the right to choose my healthcare provider regardless of certain situations including; vbac, breech position and multiple births.</p>	<p>Mon, Jan 14, 2013</p> <p>5:54 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>Planned home birth is an example of ideology replacing proven clinical facts. The state has no place in advocating in any way a step backwards in womens health. As a strong supporter of midwife care I feel there is proven benefit in having Midwifery practiced in close affiliation to all services a fully staffed hospital can provide. John W Hesser MD</p>	<p>Mon, Jan 14, 2013</p> <p>5:06 PM</p>
<p><b>Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?</b></p> <p>16-108 E.1.f. Client should have the right to refuse 1-hour blood glucose test. E.2.d. Client should have the right to refuse vaginal examinations. E.2.d. &amp; E.2.e. Arbitrary time limits should not be placed on dilation and stages. 16-109 A.1. Mothers with previous Cesareans or uterine surgery should have the right to chose care with a licensed midwife. A.14. Mothers with multiple gestation in current pregnancy should have the right to chose care with a licensed midwife. A.16. A mother should have the right to remain under care of a licensed midwife if she goes past 42 weeks, if the midwife evaluates the baby and is confidant of the health of the child and placenta. 116-10 A.4. Primagravida older than 45. A.7. Should not place limits on weight gain without addressing pre-pregnancy health</p>	<p>Mon, Jan 14, 2013</p> <p>3:26 PM</p>

## Midwifery Rulemaking Comments January 9 through March 20, 2013

and weight of mother.	
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>Midwives being required to inform clients of risks and benefits of any and all procedures, treatments, tests, etc. Home visits prior to 36 weeks to determine the safety of the home. There is a definite need for regulation to keep everyone involved safe and healthy, but when the requirements limit a midwife's ability to practice, the consumers/ clients are hurt in the process.</p>	<p>Mon, Jan 14, 2013</p> <p>2:43 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>By listening to the voices of the midwives and consumers! We should have a right to choose how and where we deliver our babies, not have it dictated to us by the state. The government already has it's hands so far in our pockets and now, under a false banner of "safety regulations" they want to dip even further by taking away our "alternative" birthing options. Please consider our basic rights as women to CHOOSE the place and process for our labor and delivery!</p>	<p>Mon, Jan 14, 2013</p> <p>2:43 PM</p>
<p><b>Has anything been left out that should be in the rules?</b></p> <p>A licensed midwife SHOULD NOT be penalized if a client makes and informed decision to refuse any and all recommendations, tests, or treatments. This is the RIGHT of the client, and not the FAULT of a midwife.</p>	<p>Mon, Jan 14, 2013</p> <p>2:43 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>Draft rules are conflicting</p>	<p>Mon, Jan 14, 2013</p> <p>2:42 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>The restrictions of home birth for "normal patients" (singleton, vertex, no medical complications, no prior uterine surgery including cesarean delivery) are sound.</p>	<p>Mon, Jan 14, 2013</p> <p>1:18 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>Requiring a physician counsel every potential home birth candidate seems excessive.</p>	<p>Mon, Jan 14, 2013</p> <p>1:18 PM</p>
<p><b>Has anything been left out that should be in the rules?</b></p> <p>I would suggest changing "transfer for thick meconium" to "presence of any meconium" as what is seen in labor does not always reflect the degree of meconium at birth. Presence of a neonatal attendant</p>	<p>Mon, Jan 14, 2013</p>

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>who can intubate/ aspirate meconium below cords/ directly observe that neonate may be the safest route to achieve what everyone wants, which is a healthy baby.</p>	<p>1:18 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>get rid of the practice guidelines and create a midwifery board- consult with EMS about the transfers</p>	<p>Mon, Jan 14, 2013 12:52 PM</p>
<p><b>Has anything been left out that should be in the rules?</b></p> <p>administration of vitamin K to newborns- not just documentation administration of Rh immune globulin in need be- not just documentation pitocin if administered for a hemorrhage should be given as needed not 30 min apart- hemorrhage is a time sensitive thing a second shot 30 minutes later is not supported by evidence. the lab tests allowed do not meet current standard pregnancy panels and there has been a problem in the past when the labs changed ownership they would not process midwife client labs because they were not allowed to do all the labs they ran- there may be a write up or a letter to the lab companies in your files that show what was done by the office to allow labs to be done.</p>	<p>Mon, Jan 14, 2013 12:52 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>I can't believe we're going to let licensed midwives do VBACs. This is wreckless and dangerous. The response to the question, "What do you do when a complication arises?" only to be answered with "Dial 911, and request transport." is amazing. As a non-healthcare related professional, I can dial 911 but it doesnt mean the AZ DHS should allow it?</p>	<p>Mon, Jan 14, 2013 11:34 AM</p>
<p><b>How can the draft rules be improved?</b></p> <p>More information is needed regarding the dangers of VBACs.</p>	<p>Mon, Jan 14, 2013 11:34 AM</p>
<p><b>Has anything been left out that should be in the rules?</b></p> <p>More should be left out.</p>	<p>Mon, Jan 14, 2013 11:34 AM</p>
<p><b>Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?</b></p> <p>No. It seems dangerous to allow this without more statistics and information regarding the dangers of at home VBACs. The response to the question, "What would you do in case of a complication during a VBAC?" at the December 17th meeting was avoided for quite some time and finally answered with, "I'd dial 911 and request transport." This is scary if you don't live next door to a hospital.</p>	<p>Mon, Jan 14, 2013 11:26 AM</p>
<p><b>Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?</b></p>	

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>In the practice of OB/GYN we would never allow a delivery at home for VBAC, Multiples, or Breech. In fact, we require a physician in house 24 hours a day to ensure safety for these events, which typically need a response time of under 15 minutes to have the baby delivered, impossible with a home birth. Why would there be different standards of care. In addition, Midwives have rarely had consultation with a physician and do not ask of acceptance of care when transferring a patient. They put them in an ambulance and send them, leaving us to pick up the pieces, again an impossible situation. If asked, I would refuse acceptance of these patients, and I would encourage all of my counterparts to do the same. Since I run several hospitalist programs this would include most hospitals in Phoenix. Midwives need to have a partner/consultant who is an OB for the entire pregnancy, who will then assume care when problems arise. This is the only way this can work. I will fight this to the bitter end as most all OBs will. It is not appropriate to "play" with obstetrics and then expect me to fix it all when things go wrong, especially when most of these patients refuse any suggestions that we make. I will not practice in this type of environment. If you want OBs here to leave for other states to practice, you should fix this.</p>	<p>Mon, Jan 14, 2013  11:14 AM</p>
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<p><b>Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?</b></p> <p>3 Years ago on January 6th 2010, my first son Tyler was born at home with a licensed midwife attending. The labor and birth was quick and easy with no complications. Another home birth with the same licensed midwife was planned for my second pregnancy. However, following the onset of labor, it was determined by my midwife that my baby had turned into a breech presentation. After consulting with my midwife I made the informed decision to transfer to the hospital where it was confirmed via ultrasound that the baby was in a double footling breech presentation. A cesarean section was recommended and on December 27th 2012, my second son Maxwell was born at Verde Valley Medical Center via cesarean. Current state law prevents me from attempting future births at home with my midwife, who is my maternal caregiver of choice. Additionally, most hospitals available to me throughout the state will not allow me to have a vaginal birth after cesarean at all. I feel this represents a clear restriction on my inherent right to choose what happens to my body and baby. As with all major surgeries, a cesarean section carries with it the risk of many complications above and beyond those normally experienced during labor and delivery. A previous cesarean is not necessarily a contraindication for future vaginal deliveries, and in fact carries very little risk above and beyond a labor carried out with no previous cesarean. However, the decision to birth at home with a licensed midwife in attendance or have a cesarean section is a false dichotomy. In many circumstances the mother may opt for a normal birth with no attendance by a care provider rather than have major abdominal surgery forced upon her. The decision is then between laboring alone at home or with a licensed midwife, of which the latter is provably safer for mother and child. Any restriction placed upon my midwife limiting the care she can provide translates directly to limiting my choices and the choices of all mothers she serves in what level of care they wish to experience. Such restrictions should be avoided when possible, and only enacted if necessary. Current state law, in my estimation, legislates unnecessary and non-trivial restrictions upon my choices of how I should labor and deliver with any future children I might have.</p>	<p>Mon, Jan 14, 2013  11:10 AM</p>
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<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>Distance to hospital is delineated.</p>	<p>Mon, Jan 14, 2013  10:50 AM</p>
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<p><b>How can the draft rules be improved?</b></p> <p>It needs to be explored whether a malpractice carrier would cover a physician performing</p>	
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## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>consultations and completing the form regarding a home vbac -- notwithstanding the legal disclaimers. I do not believe it is in the public health's interest in the State of Arizona to allow for home VBAC, multifetal deliveries or breech deliveries. Distance to hospital should be shortened to 10 miles. There should be provisions added in statute limiting a physician provider's liability when taking over the care of a VBAC, breech or multifetal delivery under emergency circumstance; or the licensed midwife's liability carrier needs to provide for such liability coverage according to local custom -- ie 3 million per occurrence.</p>	<p>Mon, Jan 14, 2013  10:50 AM</p>
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<p><b>3. Has anything been left out that should be in the rules?</b></p> <p>Licensed midwives should have BLS certification and neonatal resuscitation skills and these skills need to be documented through current certification. What are the consequences of violating the rules?</p>	<p>Mon, Jan 14, 2013  10:50 AM</p>
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<p><b>How can the draft rules be improved?</b></p> <p>B. Except as provided in R9-16-109(B), (C) or (D), a midwife may perform: 1. A vaginal delivery after prior Cesarean section; 2. A delivery with multiple gestation; or 3. A delivery of a fetus in a breech presentation. This is absurd to allow a woman carrying multiples to be delivered outside of a hospital. This is not only incredibly dangerous for the mother but also for the babies. Being a mother of twins I would NEVER even consider this an option due to the high rate of complications that do occur when carrying multiples. Please reconsider this and protect the babies who do not have a voice on this issue.</p>	<p>Mon, Jan 14, 2013  10:31 AM</p>
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<p><b>How can the draft rules be improved?</b></p> <p>R9-16-108 (C)1--"Ensure that a client consults with a physician (refer to ARS) who has a medical specialty in obstetrics and gynecology;" This requirement, including all the information on the "Draft Physician Consultation for At-Home Delivery", will NEVER work in our current maternity care system. Finding a physician who would be willing to meet for a consultation for a homebirth will most likely prove to be very difficult. The document on the department's website entitled: "State of Washington Advisory Committee" talks about transferring care and liability issues. It states... Liability Issues (pg 9) Hospitals and physicians will want to consult their legal counsel; however, it is our understanding that the professional liability insurance companies who provide obstetricians and gynecologists with professional liability insurance ask that their insureds not form formal, written consultation agreements with licensed midwives, which might be interpreted as the "loaning" of the physician's liability policy limits to the licensed midwife. It is our further understanding that these companies do cover their insureds when their insureds are assigned to emergency obstetrical call as a condition of hospital privileges, and are then asked to care for any woman brought into the hospital for obstetrical care, including those women being transported who have been under the care of a licensed midwife."Regardless of what rules or statutes say/imply regarding liability, doctors are not going to do consultation because their liability insurance companies are advising against such things. ACOG's position is that ALL births are safest in the hospital. That being said, finding an OB/GYN willing to consult when their liability insurance and their professional organization advise against homebirth, will be virtually impossible. Assuming a physician is willing to do a consult, it is very likely that the consulting physician will be opposed to VBAC, multiples or breech at home. From a consumer standpoint, a physician consultation is just another road block to achieving our desired birth experience in a setting and with a provider that we believe is the safest option. As a consumer, I am unable to see the benefit of the consultation. The consultation document the physician is supposed to fill out will not detect information about the patient that the midwife and client do not already know. The consultation document states that the OB/Gyn will "explain the</p>	<p>Sun, Jan 13, 2013  4:01 PM</p>
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## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>potential risks, adverse outcomes, and alternatives to a home birth associated with their specific condition..." I, as a consumer, do NOT understand why I have to have a go to a care provider to gather information that I am MORE than capable of gathering myself and discussing with the care provider of MY choice, a Licensed Midwife. Attaining information and providing my consent or refusal is something that should be done with MY health care provider, not with a physician who will not be part of my care. In R9-16-108 (3)h it states that "the client may decide to proceed with an at-home deliver, regardless of the physician consultation". This does not state whether or not the client will be able to continue on with the care of their licensed midwife. The proposed rules suggest that the midwife would be able to continue care even the physician does not recommend homebirth. Although this will make homebirth an accessible option, it makes the consultation pointless. As consumers of homebirth, we know that physicians who support homebirth are few and far between. We recognize that if this proposed rule becomes part of the rules, we will be forced to meet with physicians, who fundamentally disagree with our choices. This will lead to feelings of patronizing superiority. Many women seeking a VBAC at home do so because of poor experiences with their hospital birth that ended in a Cesarean Section. For some, this consultation can be far beyond their comfort level. Also, the consultation is an increased cost for the client in the way of co-pays or out of pocket expenses for those without insurance. The bottom line is that this consultation does NOTHING. Licensed Midwives are more than capable of accessing and discussing EVERY piece of the consultation document. I do not need and do not want the opinion of a physician who, I know, will not agree with my course of action.</p>	
<p><b>Has anything been left out that should be in the rules?</b></p> <p>There was NO mention of informed consent or refusal with regards to VBAC, multiples or breech. Texas' Informed choice and disclosure and VBAC waiver form are wonderful templates we can work from. I should be able to, with my licensed midwife, go over these forms and make an informed decision regarding my health care. All procedures in the rules should provide the consumer the opportunity to refuse. A general statement of "the midwife shall document refusal" would suffice.</p>	<p>Sun, Jan 13, 2013 4:01 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>The rules are extensive and mirror what is expected in licensed facilities, but can't possibly be achieved in a home environment. Draft rules for licensed midwives at their core should focus on establishing that the patient is LOW RISK, as such suitable for a home birth. These rules suggest that by their creation one can achieve a safe home delivery of a HIGH RISK patient. Do we really want to establish rules that support obstetrical practice at home by providers with uncertain training that we wouldn't except in our primary obstetrical centers. I don't believe ANY of these rules are effective. I do believe that these rules will lead to unsafe practices with limited to NO enforcement.</p>	<p>Sun, Jan 13, 2013 1:50 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>At the heart of this discussion we need to eliminate all HIGH RISK prenatal care and deliveries from the care of those providers that are not properly trained. We also need to acknowledge that such deliveries shouldn't occur in facilities that are not prepared to handle the expected and predictable complications. I think the rules should have clear consequences for those providers that fail to follow ALL these provisions to the letter. I also think all of the down stream providers who will be forced into the service of rescuing these dire outcomes should be protected from the liability attendant to the poor outcomes that they will be obligated to participate in.</p>	<p>Sun, Jan 13, 2013 1:50 PM</p>

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p><b>Has anything been left out that should be in the rules?</b></p> <p>The rules as they are written demand that these patients and their licensed midwives consult with Obstetrical physicians who in essence will back them up. I urge DHS to determine if there are ANY such providers. A combination of medical liability insurance and fundamental concerns about such practice will preclude any such role. There is also no mechanism for physician compensation for such incredible risk taking. Finally, where and what are the sanctions, consequences for those licensed midwives that proceed without the emergency action plan. For those of us in the Obstetrical community who have been the recipients of these disasters, what are our options when these patients are emergently brought to our institutions. Invariably we are forced to rescue unwilling and unappreciative patients/providers from their own poor decision making and then subject to the medical legal liability when things don't work out as they desire.</p>	<p>Sun, Jan 13, 2013</p> <p>1:50 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>A vaginal delivery after prior Cesarean section; A delivery with multiple gestation; or A delivery of a fetus in a breech presentation. These deliveries are all high risk. I think it is well within a midwife's scope of practice to perform these deliveries provided the deliveries take place in a hospital and under the guidance and physical presence of a licensed obstetrician. There is too high a risk that these deliveries could become surgical emergencies that put both the mother and baby at risk of death. There needs to be an obstetrician and operating room readily available in the case that complications arise. Allowing these deliveries to take place in any other circumstance would amount to medical malpractice.</p>	<p>Sun, Jan 13, 2013</p> <p>6:04 AM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>R9-16-108 C.6 R9-16-111 A. and B. R9-16-112 C</p>	<p>Sat, Jan 12, 2012</p> <p>4:17 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>R9-16-108 C.3.e.f.g.h A physician does not need to be involved to approve/disapprove a clients choice for a home birth. This choice should be between a client and her midwife and arrangements can be made (separately from this decision) for back-up medical care. Remove these criteria. R9-16-109 A 16. should be changed to 72 hours with the presence of clear or lightly tinted pink fluid. R9-16-109 B. 4 a.b. - Failure to progress is the most common reason cited for a c-section and far more often than should be, is the reason cited for the unnecessary c-sections that are quite often the "failure to wait" aka Dr. error! Remove these criteria. A midwife should make the decision whether to accept a VBAC based on each individual client and her real reason/experience for the c-section. R9-16-109 C. 3. 6. D. 1 The second twin commonly presents breech and this is ok as the first will make open the birth canal. In some cases the second twin will turn vertex once the first twin is birthed. A mother should not be denied the home birth she desires for her twins due to a previous c-section. Remove these criteria. R9-16-109 D. 5 If a woman has had a prior vaginal delivery she should be allowed to birth her breech vaginally at home regardless of any prior c-sections. Amend this criteria requiring at least one previous vaginal delivery but not banning previous c-sections.</p>	<p>Sat, Jan 12, 2012</p> <p>4:17 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>There are multiple portions where the wording is such that midwives may "recommend" or "document" something (RhoGam, Pitocin, Vitamin K, etc.) but it does not say she may carry or</p>	

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>administer those things. Many, if not most, obstetricians will not provide a la carte services to home birth women. Therefore, the wording needs to be changed to include carrying and administering these recommended items. Also, please remove the brand names. Generic names such as anti immunoglobulin D, or anti-hemorrhagics would be more appropriate. Since vaginal breech is allowed at home, the inclusion of breech in a twin delivery as being prohibited makes no sense. The limitations on VBAC to prohibit women who were diagnosed as failure to progress, failure to dilate, or cephalopelvic disproportion from attempting a home birth is inappropriate. Just because these issues may have been seen in one pregnancy does not indicate that it will happen in another. An example coming to mind is a woman who's child had a birth defect and the defect caused cephalopelvic disproportion due to an unusually large head. The next pregnancy is likely to not feature this complication, but the wording in the document would disqualify her. The wording for vaginal exams needs to include the ability for the woman to decline the exam. This is a procedure that many woman are not willing to accept and requiring it is tantamount to assault. There needs to be space made for women to opt out. For that matter, all of these requirements needs to allow for woman to opt out. The midwife should require and educate about why the requirements are there, but space should be made so that the woman may opt out of any treatment for herself or her child without requiring that the midwife discontinue care. Suturing and administration of antihemorrhagics and administration of Vit K should not be contingent on physician orders. Most obstetricians will not provide those orders. It will be a road block to home birthing women receiving timely treatment. An example is a woman who was taken to the hospital for suture, and the on call doc said, and I quote, "I don't work with midwives," refused to suture, and she was placed in a room and made to wait 6 more hours for a doc to come in who would suture her. Real event. Actually happened. If women having twins are to be allowed, then they need to have to same time frame allowed as other birthing women. In the State of Arizona, 36 is the beginning of acceptable home birth. Requiring 37 weeks for twins is unnecessarily restrictive. The language for consult for womn with previous stillbirth needs to include the phrase "of unknown origin." Better yet would be to remove the need for consult for women with previous stillbirth, preterm labor, and parity greater than 5. I'm a woman who has experienced all of those and have gone on to have 4 very healthy successful home births. The doctor visit was an extra expense from my pocket, and a waste of my valuable time and that of the doctor. Gestation greater than 34 weeks should not be a prohibition on home birth. The health of both mother and fetus can be quickly determined later than 34 weeks. "Previous uterine surgery" if far too vague. It can be taken to mean any of a number of common Ob/Gyn procedures that have no impact on a woman's pregnancy or birth. "Abnormal presentation" is also not necessarily a cause to send a woman for a consult. Informed consent from the midwife would be appropriate, but again, it would be a waste of valuable time for the doctor and the woman. Most babies will correct themselves by the time labor begins. I am unaware of any research that shows that uterine infection after a c-section is a significant rupture risk for a future pregnancy. A non-bleeding placenta may take longer than 40 minutes to deliver. If the woman is stable and not bleeding, I would highly recommend giving up to 2 hours postpartum for the placenta to deliver. Women should be allowed to refuse STD screenings of all types. It is their right to determine the course of their health care.</p>	<p>Fri, Jan 11, 2013  10:28 AM</p>
<p><b>Has anything been left out that should be in the rules?</b></p> <p>Allowing for women to refuse or decline any treatment, recommendation, or referral that they deem inappropriate for themselves.</p>	<p>Fri, Jan 11, 2013  10:28 AM</p>
<p><b>Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?</b></p> <p>This is a section that I have a problem with: R9-16-108 B. Except as provided in R9-16-109(B), (C) or (D), a midwife may perform: 1. A vaginal delivery after prior Cesarean section; 2. A delivery with multiple gestation; or 3. A delivery of a fetus in a breech presentation. C. Prior to providing care to a</p>	<p>Thur, Jan 10, 2013</p>

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<p>client requiring a delivery specified in subsection (B), a midwife shall: 1. Ensure that a client consults with a physician (refer to ARS) who has a medical specialty in obstetrics and gynecology; ..... I live in Northern Arizona. There is one doctor close to retirement who supports midwifery in all of Sedona, Verde Valley and the tri-city area of Prescott, Prescott Valley and Chino Valley. I would hate that the fate of my birth be decided by a medical community that disdains midwifery, nor would I have the resources to travel through out Arizona to find a physician who might support my right to choose to birth with a midwife. I would like the option to homebirth even if I fall within this subsection: 1. A vaginal delivery after prior Cesarean section; 2. A delivery with multiple gestation; or 3. A delivery of a fetus in a breech presentation.</p>	<p>8:22 PM</p>
<p><b>Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?</b></p> <p>In the section Prohibited Practice; Transfer of Care - 1) I disagree that a midwife shall not accept for care a previous Cesarean section. There is scientific proof as well as a documented history of women both nationally and internationally who have had successful home births after Cesarean sections. If the choice of home birth is not an option after Cesarean section, you are limiting a woman's choice as where to birth as well as creating a resistance to any kind of emergency hospital birth. 2) I am also in disagreement with the forced transfer of care after 42 weeks. It depends on the health of the mother and the fetus as 40 week gestation is just an average, some women go early and some go late. It doesn't mean that 42 weeks + 3 days requires medical intervention. In the section Required Consultation, I disagree that a primigravida older than 40 needs medical consultation. I think the midwife has the experience to determine whether the health of the mother warrants medical consultation or not regardless of the (advanced) age.</p>	<p>Thur, Jan 10, 2013</p> <p>6:57 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>They need to be based on scientific evidence and not on what is in the financial interests of OB/Gyn current practices. Women's rights to choose need to be considered and valued.</p>	<p>Thur, Jan 10, 2013</p> <p>6:57 PM</p>
<p><b>What parts of the draft rules do you believe are effective?</b></p> <p>Simplifies the licensure process in keeping with national standards and reducing administrative burden on the state</p>	<p>Thur, Jan 10, 2013</p> <p>5:20 PM</p>
<p><b>How can the draft rules be improved?</b></p> <p>The requirement for written emergency hospital plan is based on client location more than a formal agreement. In areas where a supportive physician does not exist this could be a barrier to legal home birth and encourage unassisted. A formal arrangement might also exist with a ND or CNM who has ob back up Most physicians are not wiling to put a formal arrangement in writing, even when supportive philosophically because of fears of litigation</p>	<p>Thur, Jan 10, 2013</p> <p>5:20 PM</p>

## Midwifery Rulemaking Comments January 9 through March 20, 2013

<b>Has anything been left out that should be in the rules?</b>	
<p>A statement that the client can waive the state recommendation upon signed informed consent</p>	<p style="text-align: right;">Thur, Jan 10, 2013  5:20 PM</p>
<b>What parts of the draft rules do you believe are effective?</b>	
<p>Gives more choices to moms of vbac twins and breech Some confusing language is eliminated</p>	<p style="text-align: right;">Thur, Jan 10, 2013  5:07 PM</p>
<b>How can the draft rules be improved?</b>	
<p>The language of the physician consult could easily prohibit women from accessing a home birth as it may difficult to find an ob willing to do that. Also eliminates a CNM or ND or DO/family practice option, which might restrict access in some communities. Laboratory tests should be offered first visit but some women choose to decline or have previous records that would suffice. Many women choose to decline weight checks. Twins often present vertex and breech. Would the rules for breech apply in this situation or are multiples only allowed vertex vertex? An alternative to the 28 week 1 hour should be offered for glucose. If a woman waives the ultrasounds would she Be waiving her right to vbac at home? Many women conceive and vbac in under 18 months. What are their choices? Can they sign an informed consent with increased risk oris it prohibited practice</p>	<p style="text-align: right;">Thur, Jan 11, 2013  5:07 PM</p>
<b>How can the draft rules be improved?</b>	
<p>The current draft states that a woman can't have a VBAC home birth if she has had a previous uterine surgery. Quite clearly a woman seeking a VBAC has had a previous uterine surgery (her prior c-section), so this section really needs to be revised. It also outlines failure to progress and failure to dilate as reasons why a woman would not be eligible for a future home birth VBAC. As long as a woman is low risk throughout her current pregnancy, she should not be precluded from having an HBAC based on the circumstances of previous pregnancies. Additionally, it is insulting to me as a woman to have to seek out the permission of an MD to have a home birth. I am capable of making my own decisions regarding my healthcare, and if I choose a midwife as my care provider, I should not be forced into any further examination or consultation with any additional providers. Midwives should be responsible for screening out high risk women, without oversight from an obstetrician. Lastly, in accordance with the current standard of care to address postpartum hemmorrhage, midwives should be allowed to carry cytotec and methergine in addition to the already allowed pitocin. It is imperative that midwives be allowed to administer these life saving drugs in the event it is necessary.</p>	<p style="text-align: right;">Wed, Jan 9, 2013  9:37 PM</p>