

Browse Responses

[Filter Responses](#) [Download Responses](#) [View All Responses](#)Displaying 1 of 4 respondents [« Prev](#) [Next »](#) Jump To: 1 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 70.162.41.206**Response Started:** Saturday, May 25, 2013 10:29:52 AM**Response Modified:** Saturday, May 25, 2013 10:39:32 AM**1. What parts of the draft rules do you believe are effective?**Allowing midwives to attend vbac patients

2. How can the draft rules be improved?

DO NOT make GBS + patients transfer care. This would be such a traumatic thing to happen in your third trimester, and is completely unnecessary. There is a protocol already in place by midwives to treat GBS with antibiotics during delivery. So transferring a low risk woman to a hospital for that reason is an outrage. I would have been devastated to transfer to a hospital because I was GBS+, when I had absolutely no other problems with my last pregnancy. I had a beautiful and peaceful homebirth, and a 100% perfect, healthy baby. PLEASE, PLEASE change this section of the rules. It's fine to require the testing, but to risk a woman out of homebirth because of a positive result would be a travesty.

3. Has anything been left out that should be in the rules?No Response

Browse Responses

Filter Responses

Download Responses

Displaying 2 of 4 respondents

« Prev

Next »

Jump To: 2

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 68 2 36 70

Response Started: Monday, May 27, 2013 4:44:00 PM

Response Modified: Monday, May 27, 2013 5:17:35 PM

1. What parts of the draft rules do you believe are effective?

This latest draft I believe is much closer to finding a good balance between regulatory agency's obligation to protect the public and midwives' freedom to practice in the way that they are able to provide the best service to their clients. Overall the standards proposed in the new draft are a reasonable compromise in my opinion. That being said, I do have some suggestions for improvement which I will include below.

2. How can the draft rules be improved?

The trouble with GBS testing is it can be inaccurate. Saying that a woman who tests positive at any time during pregnancy cannot deliver at home is unreasonable. Perhaps there are other measures that can be taken rather than completely eliminating a woman's eligibility for home birth based upon a positive GBS test. The honest truth about consumers is that most who have truly chosen home birth will birth at home regardless of the rules. I'm not agreeing with this choice, but the choice happens. Is it not better for those to have access to professionally trained medical care such as midwifery? If the agency's goal is to protect the health of mothers and babies, I believe it must take this into account. Because the agency cannot tell a woman what to ultimately choose, it's real challenge is to regulate professionals like midwives with this in mind. It has to somehow find a balance between allowing the experts in any given field act through their knowledge and allow them to allow consumers who essentially know far less, make their own health choices with adequate informed consent. I think there are two things really that are up for discussion that have gotten rolled into one thing #1 Regulating the practice of Midwifery in order to ensure public safety, and #2 Patient's Rights. Patients unfortunately have the right to choose whatever they like. I certainly understand that creating rules that make it harder for consumers to make ill-informed choices are necessary. It is a tough balance to strike and tremendously complex. Perhaps the answer then is another level of midwifery licensing. Something of a Master Midwife credential that the consumers can easily distinguish between classes of midwifery care. If there was another level of midwifery certification, perhaps the rules could be a little looser for those who have clearly demonstrated their ability to put the health and safety of mother's and babies first. In the end, everyone is on the same side. Law makers, practitioners, and consumers all want the same thing. Everyone wants the best outcomes for mother and baby while providing the greatest freedom of choice for individual consumers as well as practitioners. I think there is a solution out there that will serve the highest good for all involved. I believe creating a higher tier of midwifery class could be the answer to that. Consumers choosing rookie or lower level midwives will be doing so with the knowledge of the restrictions of their choices in order to ensure that proper protocols are followed by less experienced midwives, which I believe is reasonable and prudent. And consumers choosing a midwife with a higher level of certification can be assured that the more flexible rules are allowed because said midwife has demonstrated her proficiency of care and ability to produce positive outcomes for all. While this may seem like more work than is necessary, it could really be the solution. The trouble with rules is they don't often fit every situation every time. Creating levels of rules allows for the covering of more ground and ensures that more people are protected and cared for.

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

Filter Responses

Download Responses

Displaying 4 of 4 respondents

« Prev

Next »

Jump To: 4

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 72 201 48 27

Response Started: Tuesday, May 28, 2013 11:28:58 PM

Response Modified: Tuesday, May 28, 2013 11:30:57 PM

1. What parts of the draft rules do you believe are effective?**No Response**

2 How can the draft rules be improved?

Director Humble, Thank you for all the time you and your department have invested into this issue, and for remaining engaged I find myself wondering if all this consternation over the scope of practice guidelines isn't an indicator that the process has "come off the rails" a bit. It would seem to me as an interested observer that the rules are on the right track with regards to licensure. As the state has apparently recognized, there is no reason to duplicate efforts when there is an established national standard and certification process for midwives. Given that, I am puzzled why the department seems to be taking the opposite approach with regards to scope of practice. As I'm sure you are aware, a key component of obtaining and maintaining certification through NARM is developing and maintaining practice guidelines in accordance with current accepted best practices and standards of care. As I believe you've discovered through this process, trying to "legislate" one size fits all guidelines that will cover every midwife and every patient is difficult at best, and potentially detrimental to public health at worst. Given that the state is going to recognize the validity of this national certification, why then wouldn't the rules simply instruct midwives to practice in accordance with those guidelines? In doing so, you could achieve what the "one size fits all" rules never could. Rules that are uniquely tailored to the individual skills, experience, and education of every licensed midwife, address the unique needs of every qualifying mother to be, and that evolve naturally over time as best practices and evidence evolves. Don't get me wrong, it makes sense for the state to draw the boundaries and define what conditions, based on evidence, elevate risk beyond what is acceptable to the greater public health. But in doing so, I believe you need to employ the same standards hopefully used in all situations where individual rights must be compromised for the public good. That restriction should be made as narrow as possible, and implemented by the least restrictive means possible. One doesn't have to look very hard to find this principle at work widely in the laws of this state. As an example, if GBS can be just as effectively treated by IV antibiotics in a co-care arrangement with birth still being attended by the midwife in the home, then the rules should be open enough to allow for that. If midwives have training in administering IV antibiotics, we should be finding ways to provide them with the authorization to do so. If we can find our way back to rules that revolve around the sanctity and co-operative nature of the midwife/mother relationship, brings an outside expert/doctor in to assist in that care when necessary, and reserves direct intervention by the state for cases where there is a clearly demonstrated danger then it would seem to me that we could truly have a document which not only makes everyone happy but could be a national model for how consumers, midwives, doctors, and states can work together toward the best possible quality of maternity care. Rob Smith, Phoenix, AZ

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

Filter Responses

Download Responses

View Summary

Displaying 3 of 4 respondents

« Prev

Next »

Jump To: 3

Go »

Respondent Type: Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 98.167.178.199**Response Started:** Tuesday, May 28, 2013 2:01:00 PM**Response Modified:** Tuesday, May 28, 2013 2:15:40 PM**1. What parts of the draft rules do you believe are effective?**

I like that consultations can be done with a CNM Also, the midwifery advisory committee is a great addition

2. How can the draft rules be improved?

I have an issue with having to transfer care if the mother has a positive culture for GBS There are many ways to treat this at home Hibicencs is a common treatment done during labor. Also, a regiment of probiotics, garlic, vitamin c and grapefruit seed extract are extremely helpful with the treatment of GBS. Another option of course is an injection of Penicillin or IV antibiotics. I think that many home birth parents would be willing to treat at home in order to have a home birth. Midwives are trained to look for GBS infection symptoms in newborns and will be sure to get the baby treated right away There are other risk factors for GBS including a labor that begins before 37 weeks, a high temperature during labor, water being broken for longer than 18 hours In the event of those high risk factors, I believe a midwife would transfer care to prevent infection of GBS to the newborn I would love to see the GBS issue under the "required consultation" section to be sure that parents are aware of the risks of GBS and are given the appropriate treatment options Also, being able to retest should be an option.

3. Has anything been left out that should be in the rules?

I would love for women to be able to refuse tests and still be able to receive care from their midwife Possibly with consultation to know their risks for refusal of a test. Women are able to refuse tests with an OB and don't have to transfer to a high risks OB Isn't it our right as a patient to choose our health care provider and to choose what tests we put ourselves and our babies through?

Browse Responses

Filter Responses

Download Responses

Print Responses

Displaying 12 of 37 respondents

« Prev

Next »

Jump To: 12

Go »

Respondent Type: Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 71 38 109 134**Response Started:** Wednesday, June 5, 2013 11:04:18 PM**Response Modified:** Wednesday, June 5, 2013 11:45:46 PM**1. What parts of the draft rules do you believe are effective?**

The inclusion of VBAC is greatly appreciated!

2. How can the draft rules be improved?

Eliminating the guidelines for labor progression would greatly improve the rules for VBAC clients. Director Humble has stated that he has been using ACOG's practice bulletin for VBAC to determine the rules for VBAC clients. After reading that document, I am unable to find any section that says women should follow a specific rate of dilation in order to qualify to continue their trial of labor. ACOG suggests careful monitoring of the baby's heart rate, the station of the baby, the mother's pain level and vaginal bleeding. These should be indicators of proper progression, rather than a rate of dilation that is not supported by evidence. This rate of progression has been greatly scrutinized in both the medical and midwifery community. We should not have practices that are not evidence based in the rules! Please remove this restriction on VBAC mothers. The labor progress restriction should be removed completely and replaced with more assessments of mom and baby, including assessing heart tones, emotional wellbeing of mother, pain level for mother, station/position of baby, etc. The rate of labor progression could also be replaced with the rate of progression published in research such as, "Contemporary Patterns of Spontaneous Labor with Normal Neonatal Outcomes" by Zhang et al. The study is a multi-site (19) study with an n=62,415. It was published in Obstetrics & Gynecology. The study was recently used by AMCB, the certifying body for ACNM. Removing the current requirements for labor progression is essential. The current requirements are NOT evidence based. The rules should NOT include practices that are completely contrary to normal progression of labor.

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

Filter Responses Download Responses 

Displaying 13 of 37 respondents Jump To: 13

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 70 190 183 31

Response Started: Thursday, June 6, 2013 7:07:52 AM

Response Modified: Thursday, June 6, 2013 7:11:22 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

No Response

3 Has anything been left out that should be in the rules?

The quarterly report - the cm/hr for active labor? Or latent phase as well? Including pushing in that number?

Browse Responses

Filter Responses

Download Responses

Displaying 14 of 37 respondents

« Prev

Next »

Jump To: 14

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 71 223 87 179

Response Started: Thursday, June 6, 2013 10:08:28 AM

Response Modified: Thursday, June 6, 2013 10:12:09 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

This is an article showing the inaccuracies of cervical exams to determine the progress of labor
<http://www.ncbi.nlm.nih.gov/pubmed/7573274?dopt=Abstract&holding=f1000,f1000m,isrcn> When requiring mothers to get these exams please consider that they are being put at higher risks for infections and that they are only at best 50% accurate in determining dilation. There are other more effective methods such as; the Bottom line, vocal sounds, emotional states, bloody show, and smells

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

Filter Responses

Download Responses

Displaying 15 of 37 respondents

« Prev

Next »

Jump To: 15

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 72.200.101.110

Response Started: Thursday, June 6, 2013 8:16:35 PM

Response Modified: Thursday, June 6, 2013 8:26:14 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

I cannot stress how strongly I feel about this! R9-16-111 (pg 25) A midwife only has the ability to suture under Emergency Measures. It is not uncommon for women to tear when birthing their baby. Not all tearing should be considered an emergency! "As discussed in the final Midwifery Scope of Practice Advisory Committee meeting, currently midwives have the authority to suture an episiotomy or tear of the perineum to stop active bleeding under Emergency Measures, R9-16-111 A4. Suturing should be moved from Emergencies Measures to Responsibilities of a Midwife; Scope of Practice, R9-16-108. It is not uncommon for women to tear when birthing their baby. Not all tearing should be considered an emergency. Let us not forget that if this remains in Emergency Measures, EMS would need to be called for every tear that needed suturing. That would be a waste of time and resources for EMS. In some areas, residents are charged for calls to EMS. More importantly, midwives are educated and trained on suturing. There is no reason it should not be in their scope of practice.

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 16 of 37 respondents

[« Prev](#)[Next »](#)

Jump To: 16

[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 75 172 251 87**Response Started:** Friday, June 7, 2013 10:34:20 AM**Response Modified:** Friday, June 7, 2013 10:34:43 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

During the meeting on June 3rd, Director Humble stated that the words, "at a minimum" would be removed from R9-16-115 Including the term "at a minimum" could drastically alter the make up of the committee It is essential that midwives remain in the majority Please remove the words, "at a minimum" from the rules "

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)

Displaying 17 of 37 respondents [« Prev](#) [Next »](#) **Jump To:** 17 [Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 70 176 175 155

Response Started: Sunday, June 9, 2013 10:53:30 AM

Response Modified: Sunday, June 9, 2013 10:54:18 AM

1 What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

Here is some information on how to make consent forms "informed"

http://www.bioedge.org/index.php/bioethics/bioethics_article/10551 Respectfully, Krystyna Bowman Chandler, AZ

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)

Displaying 18 of 37 respondents [« Prev](#) [Next »](#) **Jump To:** 18 [Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 68 109 168 89

Response Started: Tuesday, June 11, 2013 8:20:20 PM

Response Modified: Tuesday, June 11, 2013 8:20:46 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

"Please remove R9-16-109 C1b(iv) Excluding VBAC moms who had a cesarean section due to "failure to progress as a result of cephalopelvic insufficiency" is not based on evidence These rules MUST contain evidence-based practice.

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 19 of 37 respondents [« Prev](#) [Next »](#) Jump To: 19 [Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 174.17.165.155

Response Started: Tuesday, June 11, 2013 8:45:02 PM

Response Modified: Tuesday, June 11, 2013 9:23:57 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

Please remove R9-16-109 C1b(iv): excluding VBAC moms who had a cesarean section due to "failure to progress" During my first pregnancy, I transferred care at 36 weeks pregnant because I lost confidence in my OB's commitment to helping me achieve a natural delivery. That pregnancy went a full 42 weeks, including a long, slow (30+ hours) labor--but ultimately, my baby was born safely and naturally at home. I was thoroughly monitored throughout labor; my baby was never in danger, and I was never in danger. We were simply slower than most. Had I attempted to give birth in a hospital setting, I would have no doubt been pressured into an unnecessary cesarean--thus setting the precedent for any subsequent births I might have--because of my "failure to progress" at the arbitrary pace of 1cm/hour. In truth, my body was not "failing", but working at its own pace. I have since had another baby at home--another slow, healthy, perfectly natural labor. My heart breaks for the countless other slow-laboring mothers who did not transfer to midwifery care like I did, who, under these guidelines, would be held to the absurd "rule" of Friedman's Curve that has been disproved time and time again. It is not the state's responsibility to decide how long a woman may labor--it is the mother's responsibility to choose a care provider that can ascertain when a hospital is necessary, using legitimate indicators of health and well-being, not a stopwatch. I wholeheartedly applaud the decision to support midwives as they attend VBAC mothers who wish to birth at home. The vast majority of the potential VBAC mothers I know want to birth at home because they were diagnosed with "failure to progress" and want a care provider who is patient and will allow her body to work at its own pace. If VBAC mothers are to be given the chance to labor at home like everyone else, let them labor at home...like everybody else!

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

Filter Responses

Download Responses

Summary

Displaying 20 of 37 respondents

« Prev

Next »

Jump To: 20

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 72 223 2 84

Response Started: Tuesday, June 11, 2013 11:36:58 PM

Response Modified: Tuesday, June 11, 2013 11:45:01 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

I would like to voice concern on the inclusion of labor management as indicated in R9-16-108 K(4) Ensuring the health of mother and baby is the primary concern of the Department of Health, and of every mother and care provider I understand the inclusion of labor management guidelines under the assumption that this will improve safety and well being of both mother and baby. What is most important in regard to the safety and well being of mother and baby is that baby presents reassuring heart tones, mother maintains a normal blood pressure, blood loss is monitored and also that progress of labor is being made. With that understanding in mind, I suggest that the department revise R9-16-108 K(4) and instead focus on the health and well being of mother and baby through frequent doppler and blood pressure checks, which provides more accurate information than progress of dilation as to whether or not the labor is progressing normally The midwifery model of care is such that a midwife recognizes the various stages of labor based on a mother's behavior and physiological signs in addition to consensual vaginal exams. Removing the technical language that requires a specific number of centimeters of progress per hour will allow the new Scope of Practice to reflect current recommendations that Friedman's Labor Curve be revised In a survey published on PubMed it was reported that, "87.6% of nurse managers responding to the survey believed that Friedman's Labor Curve should be revised to meet the needs of current patient populations " The midwifery model of care is appropriate under this recommendation as it provides unique training and one on one care with a patient that allows progress of labor to be monitored and evaluated patient to patient Please revise R9-16-108 K(4)a-b: Omit the specifications for labor progress and replace them with requirements that a midwife should assess mother and baby to detect reassuring heart tones, maternal blood pressure, maternal blood loss and progression of labor Quote from - Cesario, S K "Reevaluation of the Friedman's Curve: A Pilot Study" Journal for Obstetric, Gynecological and Neonatal Nursing U S National Library of Medicine, Dec 2004 Retrieved from: <http://www.ncbi.nlm.nih.gov/pubmed/15561659>

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#)[Download Responses](#)

Displaying 21 of 37 respondents

[« Prev](#)[Next »](#)

Jump To: 21

[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 24 251 62 253**Response Started:** Wednesday, June 12, 2013 7:08:53 AM**Response Modified:** Wednesday, June 12, 2013 7:21:32 AM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

First, I would like to acknowledge, and express my appreciation for, the many many hours spent by the health department staff and the members of the committee in working toward an increased scope of practice and update in rules for midwifery in Arizona. I think many positive changes have been made. A few changes I think would improve the rules further are to: 1) strike "at a minimum" from the sentence introducing the advisory committee (R9-16-115) and add a sentence stating that midwives must always make up the majority of this committee. I know adding a pediatrician was considered during the last meeting. I want to add to that discussion that it could be a pediatrician who is an MD, DO, or ND or it could be a family practice physician who is an MD, DO, or ND. Regardless of the type of children's doctor added, another LM must be added to maintain the balance of and LM dominated committee. 2) add a specification that each advisory committee member must have significant experience with out of hospital birth-the people on this committee need to understand what midwives do, what their training is, and how home birth works. Please don't assume that if a transfer of care or consult is not REQUIRED it won't happen. When the need arises, midwives do a great job of providing informed consent and recommending transfers of care and consultations with other providers. Lengthy discussion between families and midwives are the norm and decisions are made based on the specifics of the particular situation. Transfers and consultation DO happen when necessary. This should be viewed as a positive indication that midwives are doing their jobs safely. Transfers don't need to be mandated.

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

Filter Responses Download Responses 

Displaying 22 of 37 respondents Jump To: 22

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 24 251 62 253

Response Started: Wednesday, June 12, 2013 7:21:39 AM

Response Modified: Wednesday, June 12, 2013 7:23:00 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

Please keep in mind that nobody has her baby's best interest and safety in mind more than a mother. Moms want safe, healthy pregnancies, births, and babies

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#) [Download Responses](#) [Print Responses](#)

Displaying 23 of 37 respondents [« Prev](#) [Next »](#) **Jump To:** 23 [Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 70 190 183 31

Response Started: Wednesday, June 12, 2013 7:52:54 AM

Response Modified: Wednesday, June 12, 2013 7:59:36 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

No Response

3. Has anything been left out that should be in the rules?

I work in some underserved areas and would like to be able to offer prenatal care for women who would not otherwise get prenatal care. Many of these women may not be good home birth candidates but should still receive prenatal care, I would like to be able to provide that care. Is there a way to allow for this in the current rules rewrite?

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)Displaying 24 of 37 respondents [« Prev](#) [Next »](#) **Jump To:** 24 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 174 26 53 168**Response Started:** Wednesday, June 12, 2013 9:29:27 AM**Response Modified:** Wednesday, June 12, 2013 9:30:35 AM**1. What parts of the draft rules do you believe are effective?**

No Response

2. How can the draft rules be improved?

Please revise the rules regarding delayed implementation for VBAC and breech births. In the committee meeting, Director Humble mentioned that he is open to changing this time frame. Please revise the rules to read January, 2014

3. Has anything been left out that should be in the rules?

Please remove R9-16-109 C1b(iv) Excluding VBAC moms who had a cesarean section due to "failure to progress as a result of cephalopelvic insufficiency" is not based on evidence. These rules MUST contain evidence-based practice

Browse Responses

 Displaying 25 of 37 respondents

 Jump To: 25

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 70 171 195 12

Response Started: Wednesday, June 12, 2013 3:44:28 PM

Response Modified: Wednesday, June 12, 2013 4:28:09 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

Dear Director Humble and Team, These are my concerns and suggestions for the most recent proposed midwifery rules • Please allow midwives to attend VBAC and breech births during this next year as part of their training The advisory committee, along with creating informed consents/refusal documents, can create some sort of training program. There needs to be a concrete plan • Although I think it is completely unnecessary, if there is to be calls to the hospitals regarding a woman in labor, I fully support the proposed idea that the hospital set the standard for these calls, whether or not they require them and what their requirements are • It only makes sense that the requirement age be the same as the NARM standards • Freidman's curve is terribly outdated and VBAC or not, needs to be removed. Here are some studies regarding the need for these times constraints to be expanded <http://www.ncbi.nlm.nih.gov/pubmed/15561659> - <http://www.sciencedirect.com/science/article/pii/S000293780200248X> • "Failure to dilate as a result of cephalopelvic insufficiency" - this phrase is all too frequently blamed for 'unsuccessful' vaginal births, usually due to interventions and lack of patience on the part of the care provider This still eliminates a large majority of women who are prime candidates for having a VBAC • "Age <16 and >40years." No physician will be able to tell whether or not these women will have difficulties in labor If the mother is healthy, she should be able to have a homebirth Age discrimination is not acceptable • Parity greater than 5 No physician will be able to tell whether or not these women will have difficulties in labor If the mother is healthy, she should be able to have a homebirth • "Failure to gain 12 pounds by the beginning of 30 weeks gestation or gaining more than 8 pounds in any two-week period during pregnancy" Women come in all shapes and sizes The Institute of Medicine makes recommendations on pregnancy weight gain based off of the pregnant woman's weight Weight gain recommendations for an underweight woman vary greatly from an overweight woman Midwives receive training on nutrition and diet They can provide the necessary information to assist women with proper weight gain. This rule could be changed to read, "failure to maintain healthy weight gain". However, I believe it should be stricken completely • "Excessive vomiting or continued vomiting after 20 weeks"- should be stricken • "Fever of at least or greater than 100.4 twice at 24 hours apart" Mothers often get sick The requirements are too restrictive • As discussed in the final Midwifery Scope of Practice Advisory Committee meeting, currently midwives have the authority to suture an episiotomy or tear of the perineum to stop active bleeding under Emergency Measures, R9-16-111 A4 Suturing should be moved from Emergencies Measures to Responsibilities of a Midwife; Scope of Practice, R9-16-108 It is not uncommon for women to tear when birthing their baby Not all tearing should be considered an emergency Let us not forget that if this remains in Emergency Measures, EMS would need to be called for every tear that needed suturing That would be a waste of time and resources for EMS In some areas, residents are charged for calls to EMS. More importantly, midwives are educated and trained on suturing There is no reason it should not be in their scope of practice • The proposed rules use the wording for member make-up "at a minimum" I request that "minimum" be removed to avoid ambiguity or risk losing majority Physician(s) should have significant experience with OUT OF HOSPITAL midwifery services The member of the public must have "significant experience" There is no reason the physician and CNM should not be held to the same standard Thank you for your excellent work on these rules, it is greatly admired and appreciated I hope to see continued improvements! Cheyanne Gastelum, Licensed Midwife

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#)[Download Responses](#)

Displaying 26 of 37 respondents

[« Prev](#)[Next »](#)

Jump To: 26

[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 174 17 126 171**Response Started:** Wednesday, June 12, 2013 4:41:24 PM**Response Modified:** Wednesday, June 12, 2013 4:51:31 PM**1. What parts of the draft rules do you believe are effective?**

Having VBACs at home be contingent upon any mention of cephalopelvic disproportion is not evidence based. This is a subjective, catch all diagnosis often made when other factors could be present that led to the cesarean. I myself turned to midwifery care when I was informed by my OBGYN, before I was ever pregnant, that she had been attending births for 20 years and I would never be able to vaginally birth a baby due to the small size of my pelvis. When I questioned that, my OB said if I had a premature, less than 5lb baby, I *might* be able to birth vaginally. I was told if I ever got pregnant I needed to just schedule my c-section as soon as I had a due date. I found that devastating and began researching other options, which culminated in me hiring a homebirth midwife when I got pregnant and vaginally delivering my 7 lb 6 oz daughter. I am so glad I had resources and support available that pointed out just how inaccurate pelvimetry can be.

2. How can the draft rules be improved?

Remove mention of CPD as a disqualifying factor for home VBACs.

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

[Filter Responses](#)
[Download Responses](#)

 Displaying 27 of 37 respondents
 [« Prev](#)
[Next »](#)
 Jump To: 27
 [Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 75 172 132 84

Response Started: Wednesday, June 12, 2013 10:37:40 PM

Response Modified: Wednesday, June 12, 2013 10:45:13 PM

1 What parts of the draft rules do you believe are effective?

VBAC and breech births will become options for women.

2. How can the draft rules be improved?

"Primary Cesarean Delivery in the United States" by Boyle, et al, was published on June 5th 2013 by ACOG. I strongly encourage the department to carefully evaluate this study. The proposed rules have several issues that are addressed by this study. <http://www.ncbi.nlm.nih.gov/pubmed/23743454> Here are a couple excerpts that I believe apply DIRECTLY to our rules. Boyle states, "In a previous analysis of Consortium on Safe Labor data, Zhang et al concluded that 6 cm should be considered the start of the active phase of labor. In our cohort, 42.6% of primiparous women and 33.5% of multiparous women underwent a primary cesarean delivery for failure to progress when the cervix was dilated less than 6 cm. From this we deduce that waiting longer for labor to progress could have a major effect on decreasing the primary cesarean delivery rate." "Of women in our study with prolonged second stage diagnosed, 20.5% were delivered in less than 3 hours (for primiparous women) and in less than 2 hours (for multiparous women) from the time of complete dilation. Only 1.1% of these women were given a trial of operative vaginal delivery. This supports the idea that conservatively managing the second stage of labor, by allowing adequate time and encouraging operative vaginal delivery, when appropriate, also may have a major effect on decreasing the primary cesarean delivery rate." "Chief among these are decreasing the number of cesarean deliveries performed for failure to progress by using 6 cm as the cut-off for active labor when assessing failure to progress and conservatively managing the second stage of labor by allowing adequate time and encouraging operative vaginal delivery, when appropriate." "These statements, go hand-in-hand with my concerns with the current rules regarding labor progression for VBAC and breech births. The current proposed rules on labor progress are NOT evidence based. Please consider the Zhang study (referenced in the Boyle study), if labor progression requirements must stay in the rules. I recognize that Director Humble stated in the last meeting that he does not want to base labor progression on one study, but that is what is being proposed right now. VBAC and breech births must follow a labor progression based off a study done in the 50s that has been refuted time and time again and may very well be the cause for many unnecessary cesarean sections. Zhang's study is referenced throughout much of the current literature.

3. Has anything been left out that should be in the rules?

Women who have had a prior successful VBAC should be able to have a VBAC at home.

Browse Responses

[Filter Responses](#) [Download Responses](#) [Print Responses](#)Displaying 28 of 37 respondents [« Prev](#) [Next »](#) Jump To: 28 [Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 75 172 132 84**Response Started:** Wednesday, June 12, 2013 10:45:44 PM**Response Modified:** Wednesday, June 12, 2013 10:47:13 PM**1. What parts of the draft rules do you believe are effective?****No Response**

2. How can the draft rules be improved?

"Primary Cesarean Delivery in the United States" by Boyle, et al, was published on June 5th 2013 by ACOG I strongly encourage the department to carefully evaluate this study. The proposed rules have several issues that are addressed by this study <http://www.ncbi.nlm.nih.gov/pubmed/23743454> In Boyle's study, Table 2 on page 5 shows that failure to progress or cephalopelvic disproportion make up 35.4% of all cesarean sections I encourage you to following the recommendations made by ICAN, which were made in their recent letter to the Department (letter attached) ICAN stated, "Regarding R9-16-109C(1)iv: A collection of data released last week by the American College of Obstetricians and Gynecologists, found that Failure to Progress (FTP) and Cephalopelvic Insufficiency (CPD) are THE most common reasons for a primary cesarean section, accounting for 35.4% of primary cesarean births. This number is a striking contradiction to the medical research that proclaims true CPD occurs in 1 of every 250 births, 0.4% This leaves us to conclude that the diagnosis of Failure to Progress as a result of Cephalopelvic Insufficiency is being massively overdiagnosed and should hold no weight as to whether or not a woman with this diagnosis can vaginally birth subsequent babies. Furthermore, the American College of Nurse Midwives states that "more than 65% of women who were previously diagnosed with CPD were able to deliver vaginally in subsequent pregnancies " Again, I would like to encourage the Department to REMOVE this restriction from the rules.

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

Filter Responses

Download Responses

Displaying 29 of 37 respondents

« Prev

Next »

Jump To: 29

Go »

Respondent Type: Normal Response**Collector:** New Link (Web Link)**Custom Value:** empty**IP Address:** 75 172 132 84**Response Started:** Wednesday, June 12, 2013 10:47:28 PM**Response Modified:** Wednesday, June 12, 2013 10:55:55 PM**1. What parts of the draft rules do you believe are effective?**

Breech birth is now available without consultation.

2. How can the draft rules be improved?

In a very recent study published by ACOG on June 5, 2013 Boyle et al state, "Among women in our cohort who had a cesarean delivery for suspected fetal macrosomia, 97.3% of neonates had a birth weight of less than 5,000 g. The American College of Obstetricians and Gynecologists does not recommend offering a cesarean delivery until the suspected fetal weight is more than 4,500 g in diabetic women and more than 5,000 g in nondiabetic women. Our findings highlight the well-described limitations of antenatal diagnosis of estimated fetal weight, both clinical and ultrasonographic." <http://www.ncbi.nlm.nih.gov/pubmed/23743454> With these recommendations in mind, I would ask that you remove the rule regarding estimated fetal weight, R9-16-109D2b. In ACOG's Committee Opinion on Breech Delivery from 2006, their opinion does NOT include estimated weight restrictions. "In light of the recent publications that further clarify the long-term risks of vaginal breech delivery, the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice issues the following recommendations: The decision regarding the mode of delivery should depend on the experience of the health care provider. Cesarean delivery will be the preferred mode of delivery for most physicians because of the diminishing expertise in vaginal breech delivery. Obstetricians should offer and perform external cephalic version whenever possible. Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management. In those instances in which breech vaginal deliveries are pursued, great caution should be exercised, and detailed patient informed consent should be documented. Before embarking on a plan for a vaginal breech delivery, women should be informed that the risk of perinatal or neonatal mortality or short-term serious neonatal morbidity may be higher than if a cesarean delivery is planned." Please REMOVE R9-16-109D2b. There is a great deal of research to show that estimating fetal weight is inaccurate.

3. Has anything been left out that should be in the rules?

In the current rules, LMs are able to attend breech births if they consult with a doctor. If there is delayed implementation for VBAC and breech, that means breech births will not be available for the next year. Consumers will be LOSING access to care for the next year. This brings me great concern. I believe that delayed implementation should NOT be part of the rules. However, if it is, I believe that these births (especially breech, since this is current rule) should be attended with consultation.

Browse Responses

 Displaying 30 of 37 respondents

 Jump To: 30

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*
IP Address: 75 172 132 84

Response Started: Wednesday, June 12, 2013 11:01:58 PM

Response Modified: Wednesday, June 12, 2013 11:07:53 PM

1 What parts of the draft rules do you believe are effective?

 Allowing VBAC and breech

2. How can the draft rules be improved?

Please revise the rules regarding delayed implementation for VBAC and breech births. In the committee meeting, Director Humble mentioned that he is open to changing this time frame. If there must be a delay at all, please revise the rules to read January, 2014. Delaying implementation at all seems rather arbitrary. The department has not indicated what education and training experiences will be given to LMs during this delayed implementation period for VBAC and breech birth. How will LMs gain more experience if they are unable to attend these births? If the department is allowing CPMs to attend these births, why delay the implementation? Midwives who already have their CPM should have the skills necessary to attend these births. Delaying implementation does not make sense. In years to come, as soon as a midwife attains her CPM she will be qualified to attend these births. Why are the current CPMs not given the same respect? Delaying implementation is restricting access to care. These mothers have been waiting anxiously to have more opportunities available to them. Delaying implementation leaves these moms with limited choices for another year. Please do not delay implementation. Consumers are waiting for more access to quality care. Please remove the delayed implementation as it is apparent that a delay will not increase the safety of these births.

3. Has anything been left out that should be in the rules?

 No Response

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 31 of 37 respondents

[« Prev](#)[Next »](#)

Jump To: 31

[Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 68.227.228.83

Response Started: Friday, June 14, 2013 7:17:04 PM

Response Modified: Friday, June 14, 2013 7:18:14 PM

1. What parts of the draft rules do you believe are effective?**No Response**

2. How can the draft rules be improved?

Eliminating the guidelines for labor progression would greatly improve the rules for VBAC clients. Director Humble has stated that he has been using ACOG's practice bulletin for VBAC to determine the rules for VBAC clients. After reading that document, I am unable to find any section that says women should follow a specific rate of dilation in order to qualify to continue their trial of labor. ACOG suggests careful monitoring of the baby's heart rate, the station of the baby, the mother's pain level and vaginal bleeding. These should be indicators of proper progression, rather than a rate of dilation that is not supported by evidence. This rate of progression has been greatly scrutinized in both the medical and midwifery community. We should not have practices that are not evidence based in the rules! Please remove this restriction on VBAC mothers. The labor progress restriction should be removed completely and replaced with more assessments of mom and baby, including assessing heart tones, emotional wellbeing of mother, pain level for mother, station/position of baby, etc. The rate of labor progression could also be replaced with the rate of progression published in research such as, "Contemporary Patterns of Spontaneous Labor with Normal Neonatal Outcomes" by Zhang et al. The study is a multi-site (19) study with an n=62,415. It was published in Obstetrics & Gynecology. The study was recently used by AMCB, the certifying body for ACNM. Removing the current requirements for labor progression is essential. The current requirements are NOT evidence based. The rules should NOT include practices that are completely contrary to normal progression of labor. Lesley McKinley

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#) [Download Responses](#) [View Summary](#)

Displaying 32 of 37 respondents [« Prev](#) [Next »](#) **Jump To:** 32 [Go »](#)

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 68 227 228 83

Response Started: Friday, June 14, 2013 7:19:18 PM

Response Modified: Friday, June 14, 2013 7:20:10 PM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

During the meeting on June 3rd, Director Humble stated that the words, "at a minimum" would be removed from R9-16-115. Including the term "at a minimum" could drastically alter the make up of the committee. It is essential that midwives remain in the majority. Please remove the words, "at a minimum" from the rules. Lesley McKinley

3. Has anything been left out that should be in the rules?

No Response

Browse Responses

Displaying 33 of 37 respondents

Jump To: 33

Respondent Type: Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 68 227 228 83**Response Started:** Friday, June 14, 2013 7:22:09 PM**Response Modified:** Friday, June 14, 2013 7:23:08 PM**1. What parts of the draft rules do you believe are effective?**No Response

2. How can the draft rules be improved?

Please revise the rules regarding delayed implementation for VBAC and breech births. In the committee meeting, Director Humble mentioned that he is open to changing this time frame. Please revise the rules to read January, 2014 or earlier if possible. So many mothers have been anxiously awaiting this expansion of scope. Please don't exclude the women who are pregnant now. Lesley McKinley

3. Has anything been left out that should be in the rules?No Response

Browse Responses

Filter Responses

Download Responses

Displaying 34 of 37 respondents

« Prev

Next »

Jump To: 34

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: empty

IP Address: 70 57 103 70

Response Started: Saturday, June 15, 2013 1:45:05 PM

Response Modified: Saturday, June 15, 2013 1:59:34 PM

1. What parts of the draft rules do you believe are effective?**No Response**

2. How can the draft rules be improved?

The new rules for midwives being able to attend VBAC and breech births should be implemented sooner: January 2014 instead of July. That is still plenty of time for midwives get prepared. If a cesarean section was due to "failure to dilate as a result of cephalopelvic insufficiency", the women should still be able to have a home birth. CPD is often over-diagnosed or misdiagnosed. As discussed in the final Midwifery Scope of Practice Advisory Committee meeting, currently midwives have the authority to suture an episiotomy or tear of the perineum to stop active bleeding under Emergency Measures, R9-16-111 A4. Suturing should be moved from Emergency Measures to Responsibilities of a Midwife; Scope of Practice, R9-16-108. It is not uncommon for women to tear when birthing their baby. Not all tearing should be considered an emergency. Let us not forget that if this remains in Emergency Measures, EMS would need to be called for every tear that needed suturing. That would be a waste of time and resources for EMS. In some areas, residents are charged for calls to EMS. More importantly, midwives are educated and trained on suturing. There is no reason it should not be in their scope of practice. Here is a recent Dutch study on the safety of home births:
<http://www.parentherald.com/articles/1445/20130614/planned-home-birth-safer-hospital-new-study-finds.htm>

3. Has anything been left out that should be in the rules?**No Response**

Browse Responses

[Filter Responses](#)[Download Responses](#)[View Summary](#)

Displaying 35 of 37 respondents

[« Prev](#)[Next »](#)

Jump To: 35

[Go »](#)**Respondent Type:** Normal Response**Collector:** New Link (Web Link)**Custom Value:** *empty***IP Address:** 24 255 35 89**Response Started:** Sunday, June 16, 2013 7:10:47 AM**Response Modified:** Sunday, June 16, 2013 7:12:54 AM**1. What parts of the draft rules do you believe are effective?**No Response

2. How can the draft rules be improved?No Response

3. Has anything been left out that should be in the rules?

New bad twist, the local place in Tucson that we have been sending babies to that does newborn hearing screening is not taking our clients because they say it is out side our scope to send babies in for the hearing screening. Can this be clarified please?

Browse Responses

Filter Responses

Download Responses

New Responses

Displaying 37 of 37 respondents

« Prev

Next »

Jump To: 37

Go »

Respondent Type: Normal Response

Collector: New Link (Web Link)

Custom Value: *empty*

IP Address: 24 255 35 89

Response Started: Sunday, June 16, 2013 8:10:13 AM

Response Modified: Sunday, June 16, 2013 8:14:20 AM

1. What parts of the draft rules do you believe are effective?

No Response

2. How can the draft rules be improved?

No Response

3. Has anything been left out that should be in the rules?

On the newborn screening, there are 2 tests currently that are not included in our "scope" because of the wording of the rules- maybe just the term newborn screening- so beyond the blood-spot tests, there is a pulse ox screening and the hearing screening. These are usually done soon after birth and should be included in our scope ..
