MIDWIFERY SCOPE OF PRACTICE DRAFT RULES COMMENTS

PAGE:

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

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1. Simplifies the licensure process in keeping with national standards and reducing administrative burden on the state	Thu, Jan 10, 2013 5:20 PM	Find

AnsweredQuestion	**1**
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2 Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?

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1. 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. & 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.	Mon, Jan 14, 2013 3:27 PM	Find

AnsweredQuestion	**8**
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2. Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?

	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 and weight of mother.		
2.	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	Mon, Jan 14, 2013 11:27 AM	Find
3.	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.	Mon, Jan 14, 2013 11:15 AM	Find

AnsweredQuestion 8

SkippedQuestion 1

2 Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?

4. 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	Mon, Jan 14, 2013 11:11 AM	Find

AnsweredQuestion **8**

SkippedQuestion **1**

2 Should the scope of practice for midwives (highlighted in the draft) be changed? If so, how?

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

5. This is a section that I have a problem with: Thu, Jan 10, 2013 8:23 PM Find

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 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

6. 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 Thu, Jan 10, 2013 6:58 PM Find

AnsweredQuestion 8

SkippedQuestion 1

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	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.		
7.	The clause about having an order to suture a perineal tear is more restrictive than the previous rules	Thu, Jan 10, 2013 5:20 PM	Find
8.	R9-16-104 C 1 : Needs to be changed to say deaths related to maternity care R9-16-108 E 1 F : It is not practical to order the 24-28 blood glucose test on the initial visit. E 2 D : Should say physician's or CNM's orders E 3 : Should say fetoscope or doppler F 1 d&e : Normal progress of labor may not follow this guideline and this time frame should not be used F 2 f : Change ketone testing to every 2-4 hours or as needed. G 1 a: Should say vital signs and massage, not vitals signs with massage G 4 c: There are other labs available for newborn screens besides AZ State Lab. R9-16-109 A 15 : (No prenatal care before 34 weeks) This woman may be at risk for unattended home birth. This should be deleted or moved to required consultation. A 16 : Post 42 weeks. Move to required consultation R9-16-110 A 3: remove parity greater than 5. 12: Should say unexplained fever B 8: should be changed to jaundice within 24 hours A 15: Should say 3rd degree or greater R9-16-111 B: This is not an adequate protocol and will endanger lives Needs to be changed to antihemorrhagics according to the standard of care	Sat, Dec 22, 2012 11:06 PM	Find

AnsweredQuestion **8**

SkippedQuestion **1**

3 How can the draft rules be improved?

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1. As an advocate for women's health, and a physician who has run a training program for obstetricians for 7 years, this document worries me profoundly. I believe it represents a risk to public health.

   Obstetrics is very much about forseeing danger and avoiding it Breech deliveries, vaginal births after C-sections, and twin deliveries can quickly become complicated. That these complications will occur is a suprise to no one experienced in obstetrics At that time, the safety of the mother and the baby will depend on expertise, teamwork, and resources that are not available outside a healthcare setting.

   Licensing individuals to supervise births whose forseeable complications they cannot manage is irresponsible It demeans the women of Arizona, their children, and the families who depend on them. Any health department that considers it must fullfill their commitment to understand the public health issues at hand, and the liability that would follow from putting the health of Arizona's women and children at risk I strongly urge the department to not make this change

   I am happy to discuss the issue with interested parties I can be reached at rbrady2@chw edu or at 602 406-3517.

   Regards,

   Michael Brady, MD, FACOG
   Residency Program Director
   Phoenix Integrated Resdiency in Obstetrics and Gynecology
   Maricopa Integrated Health System and
   St Joseph's Hospital and Medical Center

   Clinical Assistant Professor of Obstetrics and Gynecology,
   University of Arizona College of Medicine

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AnsweredQuestion	**3**
SkippedQuestion	**6**

3 How can the draft rules be improved?

	Assistant Professor of Obstetrics and Gynecology Creighton University School of Medicine		
2.	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	Thu, Jan 10, 2013 6:58 PM	Find
3.	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	Thu, Jan 10, 2013 5:20 PM	Find

AnsweredQuestion	**3**
SkippedQuestion	**6**

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

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AnsweredQuestion	**1**
SkippedQuestion	**8**