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Midwifery Scope of Practice Committee
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Comments on HB 2247 for the Arizona Department of Health Services
Midwifery Scope of Practice Advisory Committee

Thank you for the opportunity to comment on the proposed revision of Administrative Code R9-16-106 through R9-16-111, Licensing of Midwifery. This statement is made on behalf of the Arizona Affiliate of the American College of Nurse-Midwives (ACNM), whose members are Certified Nurse-Midwives (CNMs) practicing in the State of Arizona. We offer these comments in a spirit of collegiality. They reflect a commitment to the health and welfare of the women and families of the state of Arizona

SUPPORT FOR CHOICE OF PROVIDER

Although the Rules under revision do not directly affect CNMs, we strongly support a woman's right to choose the provider best suited to provide the birth experience she desires. Furthermore, we wish to acknowledge the important services provided by Licensed Direct-Entry Midwives in this state. As midwives who both work with and receive transfers from LM practices, we regard ourselves and our clients as relevant stakeholders.

SUPPORT FOR HOMEBIRTH

The Arizona Affiliate of ACNM whole-heartedly supports a woman's right to choose home birth. Expert advisory panels in several nations, including the US, recommend that a woman's informed choice of place of birth be respected. Clinical practice must be guided by research. Scientific evidence strongly demonstrates that planned home birth under established selection criteria is a safe alternative to hospital birth. Indeed, recent cohort studies indicate that planned home births are

associated with lower rates of cesarean birth, perineal trauma, and medical interventions than hospital births, with similar perinatal outcomes. 1-15

COMMENTS ON RISK ASSESSMENT FOR HOME BIRTH

The goal of risk assessment in home birth midwifery is to determine the relative safety of birth settings for each woman. Safety has been the primary focus of home birth research, and investigators in the US and around the world have reported excellent perinatal outcomes for planned home births. 1, 4, 5, 8-11, 16-21

Countries such as Sweden and The Netherlands, and the United Kingdom have demonstrated optimal perinatal outcomes in the home setting, using clear, standardized risk criteria for selection of the birth environment. The course of action with respect to consultation and transfer for common obstetric events is understood by all parties and strictly followed. 10, 11, 17, 21-23

The United States, however, does not have universal guidelines for midwives, physicians, or hospitals regarding home birth practice. Therefore, risk assessment must be based on the evidence to date and continuing dialogue between the midwife, consultant(s), and the woman seeking a home birth. 21, 24-27

Evidence suggests that certain medical conditions and obstetric complications require hospital resources to promote optimal outcomes during childbirth. Although the majority of medical literature is based on outcomes in the hospital setting (where management may differ from home birth), the potential catastrophic risks of selected conditions (e.g., VBAC, breech, and multiples) must be recognized even if the evidence base is limited. 13, 14, 27, 29-32

With this in mind, the Arizona Affiliate of ACNM respectfully suggests careful review of the proposed Risk Criteria with particular attention paid to the guidelines followed by countries with optimum home birth outcomes.

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The Arizona Affiliate of ACNM would like to offer the following specific comments on the Arizona Midwives Response to House Bill 2247:

Introductory Report:

We support the addition of a volunteer Midwifery Advisory Council allowing for peer review and the inclusion of consumers as important stakeholders. However, the composition of the proposed Council is limited to a narrow perspective. We suggest looking at the Advisory Council in the New Mexico Department of Public Health, which has an equal number of Licensed Midwives and Certified Nurse-Midwives, a physician (Obstetrician or Family Practice Physician practicing Obstetrics), a consumer who has used Licensed Midwife services, the Maternal Child Health Bureau Chief and state health department staff.

Changing the licensing process to requiring the Certified Professional Midwife (CPM) credential could be of value. However, the majority of CPMs have applied for the

credential through the Portfolio Evaluation Process (PEP), which is an apprenticeship program. No degree or diploma is required. We would support licensure based on the other primary pathway to the CPM credential, which is an accredited formal education. Please see “Comparison of CNMs, CMs, and CPMs” and the “ACNM Position Statement on Midwifery Certification in the United States” attached to these comments.

AZ Midwifery Rules and Regulations:

We support the composition and maintenance of Practice Guidelines reflecting evidence-based care and the provision of an Informed Choice and Disclosure statement including the risks and benefits of home birth. We would suggest adding group B strep (GBS) testing to the list of scheduled tests. Of concern is the request for “maneuvers of the fetus to expedite delivery.” It is not clear what this means and we would not support external cephalic versions or the use of vacuum extractors in the home setting.

The Midwives of North America (MANA) competencies, which are used for the basis of the CPM exam include prenatal, intrapartum and post partum care as well as normal newborn care. Well woman care, family planning and infant care are not currently included in the MANA competencies and should not be included in the LM scope of Practice.

AZ Midwifery Scope of Practice:

We support a written informed consent that includes a mutually agreed upon transfer plan, delineating the responsibilities of the midwife as well as the woman and her family. Last, the term insulin-dependent diabetic should be changed to medication dependent diabetic as many gestational diabetics are now treated with oral agents.

Creating a pharmacy list within rule to allow LMs to obtain required medication seems appropriate. We would support Rhogam, Vitamin K, Ophthalmic preparation for newborn eye care, uterotonics, medical oxygen, suturing and repair materials and equipment and local anesthetics. We find the request for antibiotics, family planning medications and devices, nitrous oxide and “any other medication prescribed by a medical professional for obstetrical care” particularly concerning due to the lack of standardized pharmacology course work or continuing education.

AZ Midwifery Expansion of Practice:

We strongly support interdisciplinary collaborative care between all health care providers and the right of the woman to have agency in her health care decisions. But, we cannot support the idea of sanctioning provision of home birth services to any but low risk clients as we stated above. Indications outside the low-risk category would include clients with non-cephalic presentations, multiple gestations and VBACs. VBACs are particularly troubling, as women in many areas of the state do not have access to hospitals allowing or more importantly encouraging trial of labor after cesarean section (TOLAC). We strongly encourage the state to look at ways to improve these services in hospitals for all women in Arizona.

Home birth services should only be offered to women between 37 completed weeks and 41 completed weeks of gestation. They should not be offered to minors without parental permission, those women with severe mental illness, substance-addicted women or those living in an unsafe location for delivery.

There is evidence that intermittent auscultation of fetal heart tones in labor is safe. However, we respectfully disagree that there is no evidence as to the ideal frequencies of intermittent auscultation and suggest the Committee should look at the Association of Women's Health Obstetric and Neonatal Nurses (AWHONN) and American College of Obstetricians and Gynecologists (ACOG) guidelines for those recommendations.

We also agree that labor should not be managed based on Friedman's curve, but managed based on the well being of the mother and baby, along with assessment of progress of labor and careful ongoing risk assessment. Presence of thick and/or particulate meconium should require transfer of care.

The transfer of care for women who have spontaneous rupture of membranes without the onset of labor within 24 hours is appropriate. This is especially true for women who are GBS positive and for those whose GBS status is not known. For these women, CDC guidelines recommend starting antibiotics within 18 hours after rupture of membranes.

We agree that potentially life saving maneuvers such as supra-pubic pressure, Woods maneuver, delivering the posterior arm and fracturing of the clavicle for relieving shoulder dystocia should be included in the LM scope of practice. Manual removal of the placenta should not be included. We also respectfully disagree that medial lateral episiotomy is favored in situations requiring episiotomy and would favor limiting the LM scope of practice to midline episiotomies. Women with lacerations greater than the 2nd degree should be transferred for the repair.

Again, thank you for the opportunity to express our opinion regarding the proposed revisions to Administrative Code R9-16-106 through R9-16-111, as related to HB 2247.

Respectfully submitted,

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