

Midwifery Scope of Practice Comments April 10 through April 16 2013

<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>The following sections are redundant as they are required through NARM for obtaining or maintaining CPM status. Including them INCREASES the regulatory burden on the state and the applicant. These sections should only apply to LM licensees who predate the 1999 requirement for maintain CPM status. R9-16-102. A. Application for Initial Licensure A. 4. a. and b. R9-16-103. Renewal. A. 1. f. R9-16-104. Administration. D. 1. a. and c. R9-16-105. Continuing Education</p>	<p>Mon Apr 15 2013</p> <p>7:10 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>I am very saddened by the way the Draft rules are going. It seems a step backward for the midwives. They have submitted their own draft rules and those have not been taken into consideration. The LMs know what they need to practice safer and more efficiently, not the doctors, hospital based CNMS or UofA. Please have a private meeting between AZDHS and the licensed midwives so they can have a chance to explain themselves, how they do things and what will best help them move forward. After all this is said and done, the relationship between AZDHS and midwives will still be there and dont you want to find a happy middle ground between the two,so we can assure honest communication for the future.</p>	<p>Mon Apr 15 2013</p> <p>9:26 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>The midwife report shall be submitted to the Department within 30 calendar days following the termination of midwifery services---is it a quarterly or a monthly? Can the AZDHS really keep up with 400--700 individual correspondences throughout the year. Wouldnt it be better to leave them as quarterlies--let the midwives keep all the records on the clients for any births happening in that quarter and turn them in on the appropriate times, like we do now. If we have to send in correspondence after each birth--within 30 days- the AZDHS will be getting alot of work--To me it makes more sense on both sides--to allow the quarterly to remain a quarterly--easier to keep track 4 times a year --rather than constantly.</p>	<p>Mon Apr 15 2013</p> <p>9:20 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-110. why does it have to be a written consultation? Doctors dont always have time to write something up for us.Sometimes I do a telephone consult--and then I chart it.--Isnt that good enough? For instance in the case History of stillbirth, premature labor, or parity greater than 5; Why would a healthy homebirth client have to go in and see a doctor for any of those reasons--just because you had a stillbirth or previous premature labor--doesnt mean they are gonna have it again. ALso when consulting for parity greater than 5 a doctor--always says --so what? Please strike this from the rules.</p>	<p>Mon Apr 15 2013</p> <p>9:08 AM</p>

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<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Women are given the choice to kill their unborn children, sometimes inhumanly, but you want to take away our right to choose to give our bodies a trial of labor? Makes no sense!</p>	<p>Sat Apr 13 2013</p> <p>12:54 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>In every other area of medicine, patient autonomy is given the utmost respect. Women are smart, and when presented with comprehensive, unbiased, complete information and options they will make the best decision for themselves. It may not be the decision you or I would make. It is her decision, and no one else's. I implore the board to support Arizona women's autonomy when deciding with whom and where they choose to birth.</p>	<p>Fri Apr 12 2013</p> <p>9:13 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Under the sections on vbac and multiples, the exclusion of women who have had a previous breech presentation or a previous multiple gestation is inappropriate. Barring certain rare maternal anomalies that would be detected via ultrasound, these are not necessarily repeating situations.</p>	<p>Fri Apr 12 2013</p> <p>3:32 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-109 B(5). It states that a midwife shall not perform a VBAC for a client who: "Had a pervious Cesarean section for any of the following indications: (a) failure to dilate; or (b) Cephalopelvic insufficiency. I believe this should be removed, it is a woman right to choose what she does with her body and baby, any choices she makes should be her own and NOT dictated to her by any 'powers that be'. Also 6 per 10,000 deaths due to amniocentesis versus that for a perinatal mortality due to uterine rupture while attempting a VBAC 3 per 10,000. Lets tell physicians to stop performing amniocentesis they are more dangerous, this is the same logic used here to limit midwives.</p>	<p>Fri Apr 12 2013</p> <p>1:00 PM</p>

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<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>This is absurd and illogical. There is no evidence that a VBAC birth attended by a trained midwife is any more of a risk than a VBAC birth by a trained physician, especially in the cases of "failure to progress" and CPD. Both of these "conditions" are a labor by labor experience and just because they might have arisen in a first birth that led to a Cesarean doesn't mean they will arise in a VBAC. ACOG even states that they are not reason to prevent a woman from trying labor and delivery vaginally. Also, there are no increased risks in a VBAC birth, just different risks. All forms of birth hold risks. And as long as a trained, sound and competent provider (be it a midwife, obstetrician or a family practitioner) attend the birth, then risks can be handled and navigated as they arise for the safety of the mother and baby. I urge that this law doesn't get passed, otherwise you will force several mothers to make the decision to free birth or midwives to practice illegal for basic human rights that we are entitled to. Otherwise, you might just be putting these mothers and babies at risk of not having sound prenatal and delivery care if they are forced to choose the birth they want versus the birth they do not want.</p>	<p>Fri Apr 12 2013</p> <p>12:14 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Please consider this TRUE information taken from below (link) http://americanpregnancy.org/labornbirth/vbac.html f you have experienced a cesarean delivery, you are not alone. In November 2005, the Centers for Disease Control and Prevention reported the national cesarean birth rate was the highest ever at 29.1%—more than a quarter of all deliveries. If you desire to try a vaginal delivery after having had a cesarean, you should be encouraged by knowing that 90% of women who have undergone cesarean deliveries are candidates for VBAC. Statistically, the highest rate of VBAC involves women who have experienced both vaginal and cesarean births and given the choice, have decided to deliver vaginally. In most published studies, 60-80%—roughly 3 to 4 out of 5—women who have previously undergone cesarean birth can successfully give birth vaginally. After reading the following information and discussing the possibility with your health care provider, you should be able to make an informed decision about the option of VBAC. VBAC and the Risk of Uterine Rupture: The greatest concern for women who have had a previous cesarean is the risk of uterine rupture during a vaginal birth. According to the American College of Obstetricians and Gynecologists (ACOG), if you had a previous cesarean with a low transverse incision, the risk of uterine rupture in a vaginal delivery is .2 to 1.5%, which is approximately 1 chance in 5001. Some studies have documented increased rates of uterine rupture in women who undergo labor induction or augmentation. You should discuss the possible complications associated with induction with your health care provider. Recently, ACOG stated that VBAC is safer than a repeat cesarean, and VBAC with more than one previous cesarean does not pose any increased risk.² If you were given the following reasons for a previous cesarean and are considering a repeat cesarean, you might consider discussing the following with your health care provider: Dystocia: Dystocia refers to a long and difficult labor due to slow cervical dilation, a small pelvis, or a big baby. Many women who are given this reason for previous cesareans, deliver vaginally the next time around and tend to give birth to a larger baby than their first! ACOG states that the effects [or difficulties] of labor with a baby more than 8 ¾ lbs have not been substantiated. There is not evidence that a large baby requires a cesarean. The pelvis and the baby's head are not rigid structures and both mold and change shape to allow birth. During labor there are certain techniques that a woman can use to help open up the pelvis, thus allowing the birth of a large baby. For example, squatting increases the outlet of the pelvis by 10%. Genital Herpes: For many years, because of the risk of passing herpes to the baby during delivery, women with a history of herpes almost always delivered by cesarean. Physicians would examine cultures in the last weeks of pregnancy and if they found active virus, would schedule a cesarean. Today, ACOG has determined and recommended that unless there is a visible lesion at the time of</p>	<p>Fri Apr 12 2013</p> <p>11:55 AM</p>

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<p>birth, a vaginal birth is acceptable. Fetal Distress: If the life of the baby is at risk from fetal distress or other complication, there is little doubt that most mothers will consider a cesarean delivery. According to the Centers for Disease Control and Prevention, 9% of cesarean deliveries in 1991 were due to fetal distress. Fetal heart rate monitoring to detect fetal distress can be a routine part of the VBAC procedure.</p>	
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>http://americanpregnancy.org/labornbirth/vbac.html</p>	<p>Fri Apr 12 2013 11:47 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Previous c-sec caused by failure to dilate is not a sufficient reason for a midwife to be disallowed to perform a VBAC. Every pregnancy is different.</p>	<p>Fri Apr 12 2013 8:19 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>R9-16-109 B(5). It states that a midwife shall not perform a VBAC for a client who: "Had a previous Cesarean section for any of the following indications: (a) failure to dilate; or (b) Cephalopelvic insufficiency. This is unreasonable. It is unknown if this diagnosis was premature, given to cover an induction of a woman not yet ready to labor, in a bed under the influence of epidural and unable to move (therefore unable to assume optimum birthing positions) or simple impatience. I have, many times, assisted a previous VBAC mother who was diagnosed "failure to progress" who did progress with patience, and mothers diagnosed with Cephalopelvic insufficiency who delivered babies up to 2 pounds larger than their previous child because of either baby position or ability to move.</p>	<p>Fri Apr 12 2013 7:12 AM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>I think it will be a great benefit to mothers and babies to allow midwives to be able to attend more births at home. As far as the proposed rules on VBACs, I believe not allowing mothers to birth at home because their previous c-section was for failure to dilate or Cephalopelvic insufficiency will rule out far too many women and is totally ridiculous. Those reasons are used far too often, seemingly as a catch-all. Is there fear that those situations will occur again during labor? Even if they did happen again, to me they don't seem like medical emergencies. And midwives have many methods for getting labor going and many positions to try to help open up the pelvis. These are exactly the women who are likely to labor better at home with a midwife than in a hospital. Please reconsider eliminating these restrictions. (I have had a VBAC myself in a hospital.)</p>	<p>Fri Apr 12 2013 6:15 AM</p>

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<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>The following should be stricken: "A midwife shall provide services during the intrapartum period as follows: 1. Notification to the emergency room charge nurse of the hospital identified in subsection (E)(1)(a) when the client: a. Begins labor; and b. Ends labor;" ~~~~~ This will create unnecessary stress for the charge nurse. The charge nurse may go through shift change before the delivery occurs. Charge nurses have plenty to do without taking a call from a home birth midwife except in the event of an emergency. ~~~~~ It should read: The midwife will notify a charge nurse from the labor and delivery department at the closest hospital when when a laboring woman, postpartum woman or newborn baby are being prepared for transport due to an emergency situation. The midwife will provide all of the statistical information so the charge nurse can prepare for their arrival. A description of the maternal outcome; age, gravida/para 4. If applicable, the newborn's: a. Date of birth; b. Gender; c. Weight; d. Length; e. Head circumference; f. Designation of average, small or large for gestational age; g. Apgar score at 1 minute; h. Apgar score at 5 minutes; i. Existence of complications; j. Description of complications; if applicable; k. Length of travel time before arrival l. Method of transport information The midwife shall accompany the mother and/or baby to the closest hospital and remain until such time as the hospital staff has assumed care and mother and baby are stable or a care plan has been established. The hospital staff shall work in collaboration with the midwife to provide the best possible outcome in compliance with the parents wishes if at all possible keeping everyone safe.</p>	<p>Thur Apr 11, 2013 10:39 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Midwives should assess and be allowed to suture 1st degree tears after administering a local anesthetic if otherwise left open can cause discomfort to the mother or possible infection.</p>	<p>Thur Apr 11, 2013 9:58 PM</p>
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>Preventing VBACs for clients who were given cesarean sections due to "failure to dilate" or "cephalopelvic insufficiency" is not to the benefit of mothers seeking a better outcome for their next birth. These two diagnoses are used far more commonly than they should be, based on research. An average first time mother will be in labor for around twenty four hours, although this does vary widely. In many hospitals, mothers are given only twelve hours to dilate to completion before induction methods are used, which have been shown to stall or slow labor due to increased pain and confinement to the bed, usually lying flat on their backs so as not to disrupt the IV lines. This laboring position causes the pelvic opening to become smaller, effectively causing the second diagnosis on this list. Once labor has slowed down or stalled, the obstetrician is likely to diagnose failure to dilate, and intervene with a cesarean section. In most cases, had the mother been allowed to labor on her own, in many different positions, the labor would have progressed and been completed without surgery. As for cephalopelvic disproportion, this diagnosis is also far more common than it should be. According to the American College of Nurse Midwives, CPD is diagnosed in 1 of 250 pregnancies. But, strangely enough, according to the American Journal of Public Health, 65% of women who were diagnosed with this disorder went on to birth vaginally with no complications due to CPD in subsequent pregnancies. There is plenty of evidence showing that this condition is wildly overdiagnosed, although there have been no official studies done to show the true statistic. In my opinion, the overdiagnosis of these two conditions tells me that the majority of hospitals and obstetricians lack a fundamental asset for birth: patience. This is something that midwives have in</p>	<p>Thur Apr 11, 2013 9:49 PM</p>

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<p>droves. If the legality of a midwife attending out of hospital births for women who have previously been diagnosed with these conditions is taken away, the likelihood that they will successfully complete a VBAC is much, much smaller. Birth is a spiritual, physiological, difficult journey, and without a care provider who believes in her body and her birth, a woman's ability to birth on her own is greatly diminished. Midwives believe in the power of birth. We believe in our clients. But most importantly, we are trained and educated to recognize problems such as these when they arise and transport to a hospital for treatment. In the case of failed dilation, in most cases the situation is not an emergency one, provided that the baby's heart tones are healthy and the mother's vitals are strong. There is almost always time to get to the hospital with no damage to mother or child. I say mostly because, as always in medical situations, there are cases which fall outside the norm. They are rare, but I would like to point out that the instances of fetal and maternal death IN a hospital are not so different from those at a planned home birth attended by a trained midwife. According to a study performed by the Faculty of Health Sciences, Midwifery Education Program, Department of Obstetrics and Gynecology, McMaster University, Hamilton, Canada, no difference was shown between home and hospital births for perinatal and neonatal mortality or serious morbidity: "2.4% vs 2.8%; relative risk [RR], 95% confidence intervals [CI]: 0.84 [0.68-1.03]". In this particular study, conducted between 2003-2006, no maternal deaths were reported in either group. I would also like to point out that these midwives had the respect and support of the health system, hospitals, and obstetricians, rather than being segregated from them and criminalized. The conclusions, straight from the source: "Midwives who were integrated into the health care system with good access to emergency services, consultation, and transfer of care provided care resulting in favorable outcomes for women planning both home or hospital births." And so, MY conclusion is that the criminalization of midwives is not the answer to healthier, positive outcomes for birth. Rather, the acceptance of their knowledge and passion for birthing women should be encouraged and supported by the medical community. Birth is a process which cannot be rushed, and although medical intervention can be used to improve outcomes, that is not what they are achieving at the moment. Despite medical advances, the maternal mortality rate in the USA has doubled in the past 25 years. We rank 50th in the world for maternal mortality. That means 49 other countries - including Kuwait, Canada, Lithuania, Qatar, the Czech Republic, and Estonia - have LESS maternal deaths than the USA (statistics provided by the CIA). We also rank 50th in infant mortality, according to the same source. So we need to change something. Many of the countries who rank higher than us accept midwives as excellent care providers for low risk birthing mothers, and in order to move up that list we must do the same. Thank you.</p>	
<p>The Department is soliciting public comment on the Midwifery Scope of Practice. Please be mindful that comments received will be posted in their entirety unless redacted due to inappropriate content. Please provide your comments or concerns below:</p> <p>just sharing a nice PDF decision making tool for VBAC from Canada- http://www.powertopush.ca/wp-content/uploads/2010/05/Best-Birth-Clinic-VBAC-Patient-Info-Booklet-with-BC-Data_web.pdf</p>	<p>Wed Apr 10, 2013 7:18 PM</p>