

## **Rights for Homebirth response to Arizona House Bill 2247**

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## INTRODUCTION

Rights for Homebirth is a consumer based nonprofit organization whose mission is to bring awareness of the iniquities in the rules and regulations that govern Licensed Midwives in the state of Arizona. In order to bring this awareness, consumers and proponents of midwifery care decided to rally support to make changes. In July of 2011, consumers gathered to discuss what rule changes were most important to the consumers and what steps needed to be taken to achieve those changes. Vaginal Birth after Cesarean (VBAC), breech birth and twins/multiples were the three topics the consumers chose to focus on.

Consumers met with midwives and representatives from the Department of Health and quickly realized that going through the legislative process was the fastest way to see changes in the rules. Consumers went to action, putting together a rally, marching to the Department, meeting with Director Humble and securing consumers to lobby for HB 2247. After countless hours of meetings and collaboration with Arizona midwives, representatives from the Department of Health, Representatives from the House, Senators, and opposing lobbyists, HB 2247 was passed; allowing the rules and regulations governing licensed midwives to be opened and revised.

Although the rules and regulations “govern” Arizona licensed midwives, they essentially dictate the health care members of the public are able to receive. This was the driving force behind the consumer’s desire to change the rules and regulations. As the rules stand today, a large proportion of potential consumers of homebirth are not able to receive care from Licensed Midwives specifically because of the rules regarding VBAC, breech, and twins/multiples.

Less than 1% of Arizona women give birth at home. This number may be small, but it is powerful. Consumers are requesting that the Department of Health become familiar with available research, understand the importance of informed consent and the consumer’s ability to research available options and make well educated and informed choices.

## INFORMED CONSENT

Informed Consent is the foundation of respect between a care provider and their patient. The American Medical Association says,

Informed consent is more than simply getting a patient to sign a written consent form. It is a process of communication between a patient and physician that results in the patient's authorization or agreement to undergo a specific medical intervention.

In the communications process, you, as the physician providing or performing the treatment and/or procedure (not a delegated representative), should disclose and discuss with your patient:

- The patient's diagnosis, if known;
- The nature and purpose of a proposed treatment or procedure;
- The risks and benefits of a proposed treatment or procedure;
- Alternatives (regardless of their cost or the extent to which the treatment options are covered by health insurance);
- The risks and benefits of the alternative treatment or procedure; and
- The risks and benefits of not receiving or undergoing a treatment or procedure.

In turn, your patient should have an opportunity to ask questions to elicit a better understanding of the treatment or procedure, so that he or she can make an informed decision to proceed or to refuse a particular course of medical intervention.<sup>1</sup>

Based on the AMA stance on informed consent, it is both reasonable and prudent to change the scope of practice to allow Licensed Midwives to attend VBAC births, breech births and births of twins/multiples at home in Arizona. Informed consent given by a Licensed Midwife that would allow the patient to decide to continue care or opt for a hospital birth, is already in line with the current midwifery model of care which focuses on counseling and individualized education.<sup>2</sup>

Midwives are trained specifically to provide individualized care and thoroughly discuss the risks and benefits of all tests, procedures, interventions and special circumstances that arise throughout the pregnancy. Therefore, allowing midwives to attend these births under the informed consent statute would require no further training and would give women who desire to birth out of the hospital an educated and informed option for doing so.

Other states, like Oregon, recognize patients' rights in regard to informed consent and have enacted an Informed Consent and Risk Information Practice Standard that midwives must present to patients desiring a homebirth for breech, multiples, VBAC, and post-date deliveries. The Packet must be signed and maintained in the patient's file. A copy of their Informed Consent Risk and Information Practice standard is available in Appendix A.

<sup>1</sup> American Medical Association. (2012) Informed Consent. Retrieved on May 22, 2012. <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/informed-consent.page>

<sup>2</sup> Midwives Alliance of North America. (2012) Definitions: Midwives Model of Care. Retrieved on May 22, 2012. <http://mana.org/definitions.html>

We, as consumers, would expect and demand that all women are being provided with informed consent regarding their health care so that they may make the decision they feel is right for their circumstance and family. That decision may be to choose a hospital birth with a qualified physician or it may be to birth at home with a qualified midwife.

In addition to the importance of informed consent, Arizona policymakers should consider the National Bill of Patients' Rights. At the core of a patient's rights is the right to receive care from a responsible care provider, who shares all relevant information with the patient and guarantees the patient the right to make the final decision about treatment.

According to the National Bill of Patients' Rights, patients also have the right to refuse medical treatment, even if it's recommended by a physician.<sup>3</sup> We acknowledge that many Obstetricians would advise against VBAC, breech or multiples births at home, however we maintain that "every woman has the right to refuse the physician's recommendation and choose her birth setting from the full range of safe options available in her community, on the basis of complete, objective information about benefits, risks and costs of these options."<sup>4</sup>

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<sup>3</sup> Annas, G. (March 1998) A National Bill of Patients' Rights. *New England Journal of Medicine* 1998; 338:695-700.

<sup>4</sup> Childbirth Connection. (2012) The Rights of Childbearing Women. Retrieved May 22, 2012.

[http://www.childbirthconnection.org/pdfs/rights\\_childbearing\\_women.pdf](http://www.childbirthconnection.org/pdfs/rights_childbearing_women.pdf)

## VAGINAL BIRTH AFTER CESAREAN (VBAC)

### **1. A definition of the problem and why a change in scope of practice is necessary including the extent to which consumers need and will benefit from practitioners with this scope of practice.**

In 2010, 27.6% of all babies born in Arizona were delivered by cesarean. 10.5% were repeat cesarean deliveries, almost double the amount of repeat cesarean deliveries from 2000. Meanwhile, the rate of VBAC in Arizona drastically declined 73.3 % from 22.1% in 2000 to 5.9% in 2010<sup>5</sup>

The current rate of cesarean delivery in Arizona is unacceptable according to the World Health Organization. In *Monitoring Emergency Obstetric Care: A Handbook*, published by the World Health Organization in 2009, it specifically states,

#### *Minimum and maximum acceptable levels*

Both very low and very high rates of cesarean section can be dangerous, but the optimum rate is unknown. Pending further research, users of this handbook might want to continue to use a range of 5–15% or set their own standards.

Earlier editions of this handbook set a minimum (5%) and a maximum (15%) acceptable level for cesarean section. Although WHO has recommended since 1985 that the rate not exceed 10–15% (125), there is no empirical evidence for an optimum percentage or range of percentages, despite a growing body of research that shows a negative effect of high rates (126-128). It should be noted that the proposed upper limit of 15% is not a target to be achieved but rather a threshold not to be exceeded.<sup>6</sup>

Clearly, Arizona's current cesarean birth rate of 27.6% is well over the proposed guidelines of 10-15%.

The number of primary cesareans has also been at a steady rise since 2000, with 13.2% primary cesareans in 2000 to 17.1% in 2010. With an increase in primary cesareans and a decline in VBAC, the number of total cesareans will continue to rise as demonstrated by the birth statistics in Arizona showing 18.9% total cesareans in 2000 to 27.6% total cesareans in 2010.<sup>7</sup>

The National Institutes of Health (NIH) has voiced concerns that the rising cesarean rate in relation to the declining VBAC rate might reflect the barriers set in place by state regulations, maternity care providers, hospitals and insurance providers.

<sup>5</sup> *Arizona vital statistics 2010*. 1B Natality: Maternal characteristics and newborn health. Page 30. Retrieved May 8, 2012. <http://www.azdhs.gov/plan/report/ahs/ahs2010/pdf/text1b.pdf>

<sup>6</sup> World Health Organization. *Monitoring Emergency Obstetric Care: A Handbook*. (2009) [http://whqlibdoc.who.int/publications/2009/9789241547734\\_eng.pdf](http://whqlibdoc.who.int/publications/2009/9789241547734_eng.pdf)

<sup>7</sup> *Arizona vital statistics 2010*. 1B Natality: Maternal characteristics and newborn health. Page 30. Retrieved May 8, 2012. <http://www.azdhs.gov/plan/report/ahs/ahs2010/pdf/text1b.pdf>

“We are concerned about the barriers that women face in gaining access to clinicians and facilities that are able and willing to offer trial of labor. Given the low level of evidence for the requirement for “immediately available” surgical and anesthesia personnel in current guidelines, we recommend that the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists reassess this requirement with specific reference to other obstetric complications of comparable risk, risk stratification, and in light of limited physician and nursing resources. Health care organizations, physicians, and other clinicians should consider making public their trial of labor policies and VBAC rates, as well as their plans for responding to obstetric emergencies. We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor.

We are concerned that medical-legal considerations add to, and in many instances exacerbate, these barriers to trial of labor. Policymakers, providers, and other stakeholders must collaborate in developing and implementing appropriate strategies to mitigate the chilling effect the medical-legal environment has on access to care.”<sup>8</sup>

ACOG did in fact reassess their guidelines on VBAC and TOLAC (trial of labor after cesarean) following the 2010 NIH Conference and revised their statement on having a staff “immediately available” to perform an emergency cesarean. The guidelines now state,

“Women and their physicians may still make a plan for a TOLAC in situations where there may not be “immediately available” staff to handle emergencies, but it requires a thorough discussion of the local health care system, the available resources, and the potential for incremental risk.”<sup>9</sup>

We are requesting that Arizona follow the example of ACOG and remove barriers to evidence-based health care options by changing the current scope of practice for Licensed Midwives in Arizona to allow VBAC mothers to birth at home.

An independent panel, convened by the NIH, confronted a troubling fact that pregnant women currently have limited access to clinicians and facilities able and willing to offer a trial of labor after previous cesarean delivery because of so-called VBAC bans. Many, even those at low risk for complications in a trial of labor, are not offered this option. The panel affirmed that a trial of labor is a reasonable option for many women with a prior cesarean delivery. They also urged that current VBAC guidelines be revisited, malpractice concerns be addressed, and additional

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<sup>8</sup> National Institutes of Health. (March 2010) NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights. Retrieved May 9, 2012. <http://consensus.nih.gov/2010/vbacstatement.htm>

<sup>9</sup> The American Congress of Obstetricians and Gynecologists. (July 2010) Ob Gyns Issue Less Restrictive VBAC Guidelines. Retrieved May 9, 2012. [http://www.acog.org/About\\_ACOG/News\\_Room/News\\_Releases/2010/Ob\\_Gyns\\_Issue\\_Less\\_Restrictive\\_VBAC\\_Guidelines](http://www.acog.org/About_ACOG/News_Room/News_Releases/2010/Ob_Gyns_Issue_Less_Restrictive_VBAC_Guidelines)

research undertaken to better understand the medical and non-medical factors that influence decision making for women with previous cesarean deliveries.<sup>10</sup>

A press release issued by the National Institutes of Health regarding the panel's findings had the following to say,

"Declining VBAC rates and increasing cesarean delivery rates over the last 15 years would seem to indicate that planned repeat cesarean delivery is preferable to a trial of labor. But the currently available evidence suggests a very different picture: a trial of labor is worth considering and may be preferable for many women," said Dr. F. Gary Cunningham, panel chair, and chair of obstetrics and gynecology at the University of Texas Southwestern Medical Center at Dallas.

Rigorous research shows that a trial of labor is successful in nearly 75 percent of cases, and maternal mortality is actually lower for women who have a trial of labor, regardless of whether they end up delivering vaginally or by cesarean, though those women who have an unsuccessful trial of labor and undergo a repeat cesarean delivery experience higher morbidity than those who have a successful VBAC.

In light of their assessment of VBAC's relative safety, the panel urged professional societies to revisit existing VBAC guidelines, in particular, the recommendation for "immediate availability" of surgical and anesthesia personnel as prerequisites for offering a trial of labor; two recent surveys of hospital administrators found that 30 percent of hospitals had stopped offering trial of labor or providing VBAC services because they could not meet this standard, creating a serious barrier to that option.

There's still a lot we don't know about which women will be successful in having a VBAC, but we believe it's essential that women's desires and preferences be respected throughout the decision making process," said Dr. Cunningham.<sup>11</sup>

The findings from the NIH are applicable to our current situation in Arizona, particularly in Northern Arizona where VBAC bans or de facto bans exist at local area hospitals. Women desiring a VBAC must travel many hours to Phoenix in hopes to receive a TOLAC or they are forced to have an unnecessary cesarean at their local hospital. It is unacceptable to have barriers in place that force a woman into having unnecessary major abdominal surgery. Allowing Licensed Midwives to attend VBAC births at home would allow women in Northern Arizona to have a safe and reasonable option for a VBAC birth.

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<sup>10</sup> National Institutes of Health. (March 2010) NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights. Retrieved May 9, 2012. <http://consensus.nih.gov/2010/vbacstatement.htm>

<sup>11</sup> National Institutes of Health. (March 2010) NIH News: Panel Questions "VBAC Bans," Advocates Expanded Delivery Options for Women. Retrieved May 9, 2012. <http://www.nih.gov/news/health/mar2010/od-10.htm>

## The Patients' Rights

Consumers have the right to receive care from a health care provider who shares all relevant information with the patient and guarantees the patient the right to make the final decision about treatment. The patient must be able to trust the healthcare provider to act honestly and in the patient's best interests. Only provisions that honor and reinforce a healthcare provider-patient relationship based on trust, deserve to be designated patients' rights.

The patient has a right to informed participation in all decisions involving his or her health care, including a clear, concise explanation, in lay terms, of all proposed treatments, the reasonable medical alternatives (whether or not they are covered by the insurance plan), the risks of death and serious complications associated with each alternative (including no treatment), likely problems of recuperation, and the probability of a successful outcome (including the physician's experience with the treatment and its outcomes).<sup>12</sup>

The National Bill of Patients' Rights are applicable to our current request that it be within Licensed Midwives regulations to attend VBAC at home. The patient has the right to participate in all decisions, including where to birth, given that the patient has been informed of all alternatives, risks, complications and probability of a successful outcome.

In the NIH consensus it is stated, "When trial of labor and elective repeat cesarean delivery are medically equivalent options, a shared decision-making process should be adopted and, whenever possible, the woman's preference should be honored."<sup>13</sup> This would also include honoring a woman's preference as to where she gives birth, given full informed consent.

The current rules on VBAC for Licensed Midwives in Arizona denies women their right to choose their birth setting, even when they have been informed of the risks and benefits and would choose to VBAC at home.

By denying Licensed Midwives the ability to care for women desiring a VBAC, women who choose to VBAC at home are left to deliver unassisted by a healthcare provider, which inherently puts both mother and baby at a greater risk of morbidity. Alternatively, the birthing mother may also feel forced to birth in the hospital because no other safe options are available. Denying Licensed Midwives authorization to attend a VBAC at home monopolizes the setting for which a woman may choose a safe delivery. Women are forced into birthing at a hospital or unassisted at home. It unethical for women to be forced into specific birthing environments, with undesired care providers. The rules must be changed to ensure that women's health care rights are being upheld.

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<sup>12</sup> Annas, G. (March 1998) A National Bill of Patients' Rights. *New England Journal of Medicine* 1998; 338:695-700.

<sup>13</sup> National Institutes of Health. (March 2010) NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights. Retrieved May 9, 2012. <http://consensus.nih.gov/2010/vbacstatement.htm>

**2. The available evidence-based research that demonstrates that the interested current practitioners are competent to perform the proposed scope of practice.**

If a woman with a prior cesarean(s) is healthy and low risk, meaning she doesn't have a condition that would otherwise be labeled high risk and unsuitable for a homebirth, a Licensed Midwife is fully competent in managing her care. With a VBAC patient, the main concern is uterine rupture. Signs of uterine rupture such as decrease in fetal heart rate, excessive vaginal bleeding or maternal hypotension would be recognized by a Licensed Midwife as an abnormal condition of labor and the patient would then be transferred to a hospital. Assessing uterine rupture is already part of a midwives training.

Licensed Midwives are fully competent and capable of caring for a VBAC patient upon completion of their licensure since there is no special set of skills required for caring for a woman with a previous uterine incision. Assessing uterine rupture is already part of a midwives training.

## VAGINAL BIRTH FOR BREECH AND TWINS/MULTIPLES

### 1. A Definition of the problem and why an increase in the scope of practice is necessary, including the extent to which consumers need, and will benefit from, practitioners with the increased scope of practice

Consumers of midwifery care have limited options in regard to vaginal breech birth and vaginal birth of multiples. Finding a care provider in a hospital willing to attend a vaginal birth for breech or multiples is extremely difficult. Current midwifery regulations make it nearly impossible for midwives to attend breech births. In addition, current regulations make it illegal for midwives to attend births of twins/multiples. Because of these significant restrictions, consumers are provided with limited options for care, forcing many to choose between receiving care they do not want or not having a health care attendant present. Consumers have an inherent human right to make educated choices regarding their health care. Evidence-based options must be available in all birth settings and a variety of care providers should be permitted to be considered as options.

### BREECH BIRTH

Term breech births account for approximately 3-4% of all births in the United States, the majority are currently delivered by cesarean section.

Under the current rules, midwives must consult with a physician in order to continue care for breech birth. While consultation with a physician is not necessarily negative, the problem lies in the current standard of practice in the medical community. The American Congress of Obstetricians and Gynecologists has recommended that breech births be accomplished via cesarean section. Because of this, physicians are not being trained how to attend these births. Because of the lack of training and the misinterpretation of certain studies, attending vaginal breech birth has, unfortunately, become a lost skill in the medical community. In recent years, evidenced based research has been published and has swayed international organizations, such as the Society of Obstetricians and Gynecologists of Canada to reverse their recommendations. "The evidence is clear that attempting a vaginal delivery is a legitimate option in some breech pregnancies," said Dr. André Lalonde, Executive Vice-President of the Society of Obstetricians and Gynecologists of Canada (¶ 5).<sup>14</sup>

As explained in the section on VBAC, the excessive rates of cesarean section are unacceptable and reflect performance of cesareans that are not always medically necessary. Advising that all breech deliveries be accomplished through cesarean section not only lacks credible evidence, but it increases the extreme cesarean section rate and the very real risks that are associated with abdominal surgery. It also takes away the consumer's inherent right to make choices regarding her health care.

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<sup>14</sup> Society of Obstetricians and Gynecologists of Canada (June 17, 2009) No more automatic C-section for breech births, says Ob/Gyn Society. Retrieved 2012-06-15. [http://www.sogc.org/media/advisories-20090617a\\_e.asp](http://www.sogc.org/media/advisories-20090617a_e.asp)

The Term Breech Trial research study created an international movement among the obstetric communities to move to elective cesarean section, before the onset of labor, for breech birth.<sup>15</sup> In recent years, new and reliable research has been completed, which attests to the immediate and long term safety of vaginal breech birth when performed by an appropriately trained professional. New research has also exposed significant flaws within the way the Term Breech Trial was conducted.<sup>16, 17, 18, 19, 20, 21, 22, 23</sup>

Goffinet's study of 8,105 pregnant women delivering singleton fetuses in breech presentation at term concluded that, "In places where planned vaginal delivery is a common practice and when strict criteria are met before and during labor, planned vaginal delivery of singleton fetuses in breech presentation at term remains a safe option that can be offered to women"(p. 1003).<sup>24</sup> Uotila states, "Selective vaginal breech deliveries may be safely undertaken in units having a tradition of vaginal breech deliveries"(p. 578).<sup>25</sup> Doyle reports, ". . . vaginal breech delivery remains a viable option in selected patients" (p. 325).<sup>26</sup> Licensed midwives 'specialize' in vaginal birth. That is what they are trained to do. It's it their 'tradition'.

As consumers, we understand that there are many variations and variables to take into consideration when assessing the safety of vaginal breech birth. We understand that each variation comes with its own individualized risks. We ask that all available research be considered and the voice of the public be heard when forming the rules on breech birth. We ask that special consideration be put on the consumer's right to self-determination and our ability to make well informed choices.

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<sup>15</sup> Hannah, M. E., Hannah, W. J., Hewson, S. A., Hodnett, E. D., Saigal, S., Willan, A. R. (2000). Planned Caesarean Section Versus Planned Vaginal Birth for Breech Presentation at Term: A Randomised Multicentre Trial. *The Lancet*, 356, 1375-1383.

<sup>16</sup> Hauth J.C., & Cunningham F.G. (2002). Vaginal breech delivery is still justified. *Obstetrics and Gynecology*, 99, 1115-6.

<sup>17</sup> Van Roosmalen J., & Rosendaal, F. (2002). There is still room for disagreement about vaginal delivery of breech infants at term. *BJOG: an International Journal of Obstetrics and Gynaecology*, 109, 967-969.

<sup>18</sup> Kotaska, A. (2004). Inappropriate use of randomized trials to evaluate complex phenomena: Case study of vaginal breech delivery. *BMJ*, 329, 1039-1042.

<sup>19</sup> Keirse, M.J. (2002). Evidence-based childbirth only for breech babies? *Birth*, 29(1), 55-59.

<sup>20</sup> Menticoglou, S.M. Why vaginal breech delivery should still be offered. *Journal of Obstetrics and Gynecology Canada*, 28, 380-385.

<sup>21</sup> Glezerman M. (2006). Five years to the term breech trial: the rise and fall of a randomized controlled trial. *American Journal of Obstetrics and Gynecology*, 194, 20-25.

<sup>22</sup> Lawson, GW. The term breech trial: Ten years on:Primum non nocere?

<sup>23</sup> Pradhan, P., Mohajer, M., Deshpande, S. (2005). Outcome of term breech births: 10-year experience at a district general hospital. *BJOG: an International Journal of Obstetrics and Gynaecology*, 112, 218-222.

<sup>24</sup> Goffinet, F., Carayol, M., Foidart, J.M, Alexander, S., Uzan, S., Subtil, D., et. al. (2006). Is planned vaginal delivery for breech presentation at term still an option? Results of an observational prospective survey in France and Belgium. *American Journal of Obstetrics and Gynecology*, 194, 1002-11

<sup>25</sup> Uotila, J., Tuimala, R., & Kirkinen, P. (2005). Good perinatal outcome in selective vaginal breech delivery at term. *Acta Obstetricia Et Gynecologica Scandinavica*, 84, 578-583.

<sup>26</sup> Doyle, N.M., Riggs, J.W., Ramin, S.M, Sosa, M.A., & Gilstrap, L.C. (2005). Outcomes of term vaginal breech delivery. *American Journal of Perinatology*, 22(6), 325-328.

## BIRTH OF TWINS/MULTIPLES

As of 2009, the CDC reported that twin births made up 2.65% of all births in Arizona and multiples made up 0.15% of all Arizona births.<sup>27</sup>

One of the largest concerns, in regards to birth of twins/multiples, is the position of the babies at the time of delivery. Although, The American Congress of Obstetricians and Gynecologists does not have a statement suggesting cesarean section for the birth of all twins/multiples, many women *are* having cesarean sections for the birth of their twins/multiples. As with breech birth, it is extremely difficult to find a care provider to attend a vaginal birth of twins/multiples. Being that one of the biggest concerns is breech presentation, medical professionals are resorting to the skills they do have and performing cesarean sections when faced with one or more breech babies. What is a mom, pregnant with twins/multiples, who is searching out a vaginal birth supposed to do? She is currently hard-pressed to find a medical care provider who will allow her to deliver vaginally and she is unable to have a licensed midwife attend a homebirth. Is she required to forgo the health care that she desires because physicians lack the skills and midwives, who do possess the skills, are currently unable to attend these births?

Research continues to be done to show that vaginal birth for twin/multiples should be a valid option. "...practitioners should continue to use clinical judgment and experience to inform their decisions regarding the optimal mode of delivery of term twins" (p. 563).<sup>28</sup> Alexander, et. al, state that, "... an attempt at vaginal delivery should not be avoided due to the fear of an unexpected cesarean delivery of the second twin"(p. 751).<sup>29</sup>

Historically, midwives and physicians have delivered twins vaginally with little technical or medical support. Many obstetricians have lost the intention or capability to actively deliver twins/multiples.<sup>30</sup>

The consumers are aware that there are many variables to consider when assessing the safety of vaginal birth for twins/multiples. We strongly encourage the department to closely examine each variable while taking into account all of the supportive evidence based research.

We stand firm on the notion that informed consent plays a major role in vaginal breech birth and vaginal birth for twins/multiples. Women have an intrinsic right to choose their specific health care options, especially when given informed consent after having gaining an understanding of the potential risks.

"... what is the magnitude of risk to the fetus of a TOL [Trial of Labor] and how should we balance it against the increased immediate and future risk of cesarean section to the mother and

<sup>27</sup> Center for Disease Control. (November 3, 2012). National Vital Statistic Report. 60(1). Birth:Final data for 2009. Retrieved 2012-6-5. [http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60\\_01\\_tables.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_01_tables.pdf)

<sup>28</sup> Armson, B.A., O'Connell, C., Persad, V., Joseph, K.S., Young, D., & Basket, T. (2006, September). Determinants of Perinatal Mortality and Serious Neonatal Morbidity in the Second Twin. *Obstetrics and Gynecology*. 108(3). 556-564.

<sup>29</sup> Alexander, J., Leveno, K, Rouse, D, Landon, M., et al. (2008, Oct) Cesarean Delivery for the Second Twin. *American College of Obstetricians and Gynecologists*. 112. p. 748-752.

<sup>30</sup> Arabin, B & Kyvernitakis, i. (2011, October) Vaginal Delivery of the second nonvertex twin: Avoiding a poor outcome when the presenting part is not engaged. 118(2). 950-954.

her future children?"(p. 559)<sup>31</sup> This is the question that an informed consumer should ask regarding all aspects of care, particularly when the alternative care is a cesarean section. Consumers should have the ability to engage in an open dialog with their care provider about more than one option for care. They should have the ability to birth in their desired location, with their desired care provider, based off of research and informed consent. The consumer should be able to seek out a care provider who is knowledgeable and skilled in vaginal breech birth and birth of twins/multiples. Midwives should have the legal ability to attend births which they have the skills to attend, so that women can have access to evidence-based care. The current regulations preclude these options in some cases and significantly inhibit a mother's ability to pursue them.

No one should be forced into birthing in an undesired location, with an undesired care provider, in a mode of delivery that is unwanted. Women should be given options as they choose the appropriate care for themselves and their unborn child. Consumers should gather research regarding breech birth and twins/multiples. They should interview midwives to assess their skill level. They should be autonomous and make informed decisions. Opening up the rules to include breech birth and twins/multiples would create much needed options for women to choose from.

Changes are being made at an international level regarding breech birth, which will inherently affect the way birth practices surrounding the delivery of twins/multiples are handled at a national level. Several other states already allow midwives to legally attend vaginal breech birth and vaginal birth for twins/multiples. As consumers, we ask that the state of Arizona takes the initiative and change the rules and regulations to allow midwives to legally attend the births of twins/multiples and breech.

## **2. The available evidence-based research that demonstrates that the interested current practitioners are competent to perform the proposed scope of practice.**

The American Congress of Obstetricians and Gynecologists recommends that the health care provider's experience should determine the mode of delivery when a breech baby is presenting.<sup>32</sup> This recommendation could also be applied to delivery of twins/multiples. Because of the lack of training for vaginal breech birth, physicians are choosing to perform cesarean sections because that is all they know. Licensed Midwives, on the other hand, have a different perspective on breech birth and a birth of twins/multiples. It is seen as a variation of normal, which should be attended with special skills.

Licensed Midwives come from a broad spectrum of knowledge. Not all midwives have the same training. However, they must all pass the same test to become a midwife. A midwife should attend the birth of a mother delivering twins/multiples or a breech baby based off of her

<sup>31</sup> Kotaska, A., Menticoglou, S., & Gagnon, R. (2009). Vaginal delivery of breech presentation: Clinical practice guideline. Retrieved 2012-06-15. <http://www.sogc.org/guidelines/documents/gui226CPG0906.pdf>

<sup>32</sup> American College of Gynecology. (July 2006) Committee opinion: Mode of term singleton breech delivery. Retrieved 2012-6-10. [http://www.acog.org/Resources\\_And\\_Publications/Committee\\_Opinions/Committee\\_on\\_Obstetric\\_Practice/Mode\\_of\\_Term\\_Singleton\\_Breech\\_Delivery](http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Mode_of_Term_Singleton_Breech_Delivery)

experience. Consumers should be afforded the right to search out a care provider who is experienced.

The Certified Professional Midwife (CPM) test, administered through The North American Registry of Midwives (NARM), tests on vaginal birth for breech and twins/multiples. In order to answer those test questions, a midwife must have practical knowledge. As the department moves towards adopting the CPM test, the question becomes, why are midwives not able to practice the content they are being tested on?

The midwifery didactic is based on a long list of resources, including many books.<sup>33</sup> These books all cover breech and twin deliveries. Within each of the MEAC (Midwifery Education Accreditation Council) accredited schools, these deliveries are thoroughly covered. Nearly every midwifery conference has sessions on these deliveries, keeping midwives up to date on the latest research and skills. There are also many conferences solely dedicated to breech birth and twins/multiples. Midwives can receive hands on training in schools of midwifery, clinics and while working in other states and countries where it is legal to attend births of multiples and breech birth. Midwives should not be mandated to attend a breech birth and birth of twins/multiples. However, consumers should be permitted to seek out midwives who have the proper training and skills necessary to safely and legally accommodate these forms of birth.

The consumers are aware that not all midwives have equal training. They recognize that, as consumers, they must be educated in their decisions regarding their health care. If they choose a homebirth with a pregnancy that is unique or uncommon, such as vaginal birth for breech or twins/multiples, the consumers must have the ability make informed choices with regards to their health care and obtain their desired care.

There are many intricacies when assessing the safety of breech and twins/multiples. We understand that some variations carry greater risk to both mother and baby. We recognize that much discussion and research will need to be had in order to ascertain the safety of each variation. As consumers, we ask that the Department continues to take our right to choose our health care into consideration. Our goal is to expand our options to evidence-based health care. This goal will be accomplished by increasing the scope of practice to include VBAC, breech and twins/multiples to be born at home under the care of a Licensed Midwife.

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**3. The extent to which an increase in the scope of practice may harm the public, including the extent to which an increased scope of practice will restrict entry into the practice of midwifery.**

Increasing the scope of practice to allow midwives to attend VBAC, breech births and births of twins/multiples will not harm the public. Rather, it will allow more opportunity for health care choices. If the consumers were requesting that all midwives be mandated to accept these births, it would restrict entry into the practice of midwifery. However, that is not what we are asking. We are asking that consumers have the opportunity to seek out midwives who are experienced in these births, and employ them as their health care provider.

## APPENDIX A

### Oregon Bulletin

April 1, 2012

#### Oregon Health Licensing Agency, Board of Direct Entry Midwifery, Chapter 332

**Rule Caption:** Extend implementation date of risk information packets to July 1, 2012.

**Adm. Order No.:** DEM 1-2012(Temp)

**Filed with Sec. of State:** 3-1-2012

**Certified to be Effective:** 4-12-12 thru 9-30-12

**Notice Publication Date:**

**Rules Amended:** 332-025-0120

**Subject:** Amend OAR 338-025-0120 to extend the implementation date for risk information packets to be given to clients by licensed direct entry midwives (LDM). Beginning on July 1, 2012 an LDM must provide risk information regarding out-of-hospital birth, malpresentation birth (breech), multiple gestations (twins), vaginal birth after cesarean (VBAC), and births exceeding 42 weeks gestation (post-dates) to clients, as prescribed by the Oregon Health Licensing Agency (Agency) and published on the Agency Website.

**Rules Coordinator:** Samantha Patnode—(503) 373-1917

#### 332-025-0120

#### Informed Consent and Risk Information Practice Standards

- (1) Informed consent means the consent obtained following a thorough and easily understood explanation of the information to the mother or mother's guardian.
- (2) The explanation must be both verbal and written.
- (3) An LDM must document the verbal explanation and the written informed consent process in the client's record. Informed consent information must include the following:
  - (a) Definition of procedure or process;
  - (b) Benefits of procedure or process;
  - (c) Risk(s) of procedure or process;
  - (d) Description of adverse outcomes;
  - (e) Risk of adverse outcomes; and
  - (f) Alternative procedures or processes and any risk(s) associated with them.
- (4) An LDM must obtain mother's dated signature acknowledging she has received, reviewed, and understands the information, and has made an informed choice.
- (5) Beginning on July 1, 2012, each LDM must provide risk information as published on the agency's website [www.Oregon.gov/OHLA](http://www.Oregon.gov/OHLA), and obtain informed consent for the following circumstances:

- (a) Out-of-hospital birth;
- (b) Vaginal birth after cesarean (VBAC);
- (c) Breech;
- (d) Multiple gestations; and
- (e) Pregnancy exceeding 42 weeks gestation.

Stat. Auth.: ORS 487.485 & 676.615

Stats. Implemented: ORS 687.425, 687.480, 687.485, 676.606 & 676.607

Hist.: DEM 6-2010, f. 12-30-10, cert. ef. 1-1-11; DEM 2-2011(Temp), f. & cert. ef. 5-19-11 thru 11-15-11; Renumbered from 332-025-0080 by DEM 5-2011, f. & cert. ef. 9-26-11; DEM 6-2011(Temp), f. 10-14-11, cert. ef. 10-15-11 thru 4-11-12; DEM 1-2012(Temp), f. 3-1-12, cert. ef. 4-12-12 thru 9-30-12