

Welcome to the Advisory Board on Midwifery

The Virginia Board of Medicine will hold an electronic meeting of the Advisory Board on Midwifery on **January 29, 2021 at 10:00 A.M.** This meeting will be supported by Cisco WebEx Meetings application.

For the best WebEx experience, you may wish to download the Cisco WebEx Meeting application on your mobile device, tablet or laptop in advance of the meeting. Please note that WebEx will make an audio recording of the meeting for posting

This electronic meeting is deemed warranted under Amendment 28 to HB29 based on that requiring in-person attendance by the Advisory Board members is impracticable or unsafe to assemble in a single location.

Comments will be received from those persons who have submitted an email to william.harp@dhp.virginia.gov no later than 8:00 a.m. on January 28, 2021 indicating that they wish to offer comment. Comment may be offered by these individuals when their names are announced by the chairman.

Whether you are a member of the Advisory Board or a member of the public, you can join the meeting in the following ways.

- **JOIN by WEBEX**

<https://covaconf.webex.com/covaconf/j.php?MTID=m830844d98f6410ccfb31921bf22cbe45>

Meeting number (access code): 178 358 4334

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TECHNICAL DIFFICULTIES: Should you experience technical difficulties, you may call the following number: (804) 339-0627 for assistance. Any interruption in the telephonic or video broadcast of the meeting shall result in the suspension of action at the meeting until repairs are made and public access is restored.

The Board of Medicine and the Freedom of Information Act Council are interested in your evaluation of the electronic experience of this meeting. You can provide comment via the following form **HERE**.

Advisory Board on Midwifery

Virginia Board of Medicine
January 29, 2021
10:00 am

Advisory Board on Midwifery

Board of Medicine

Friday, January 29, 2021 @ 10:00 a.m.

9960 Mayland Drive, Suite 300, Henrico, VA

Electronic Meeting

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A. Review High Risk Pregnancy Disclosures Guidance Document	5 – 73
B. Discuss Guidance Document for Pre-Natal and Post-Natal Screening for Depression	
New Business	
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2. Access to Covid-19 vaccines and PPE for Licensed Midwives -Kim Pekin, CPM	

Announcements:

Next Scheduled Meeting: May 28, 2021 @ 10:00 a.m.

Adjournment

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ADVISORY BOARD ON MIDWIFERY

Minutes

October 9, 2020

Electronic Meeting

The Advisory Board on Midwifery held a virtual meeting on Friday, October 9, 2020 hosted at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia.

MEMBERS PRESENT: Kim Pekin, CPM, Chair
Mayanne Zielinski, CPM
Rebecca Banks, CPM
Natasha Jones, MSC

MEMBERS ABSENT: Ami Keatts, MD

STAFF PRESENT: William L. Harp, MD Executive Director
Michael Sobowale, LLM, Deputy Director, Licensing
Colanthia Morton Opher, Deputy Director, Administration
Jennifer Deschenes, JD, Deputy Director, Discipline
Beulah Baptist Archer, Licensing Specialist

GUESTS PRESENT: Rebecca Bowers-Lanier, Lobbyist
Tammi McKinley, CPM, President of Virginia Midwives Alliance
Nicole Lawter
Ben Traynham, JD, MSV

Call to Order

Kim Pekin called the meeting to order at 10:04 a.m.

Emergency Egress Procedures

Dr. Harp announced the emergency egress instructions.

Roll Call

Roll was called; a quorum was declared.

Approval of Minutes February 7, 2020

Mayanne Zielinski moved to approve the minutes of the February 7, 2020 meeting. Rebecca Banks seconded. By roll call vote, the minutes were approved as presented.

Kim Pekin requested an update on an item from the February 7, 2020 meeting to clarify procedures for reporting and getting death certificates signed in the unfortunate event of a stillbirth. It was suggested in February that an item on this topic be placed in the Board Briefs and emailed to Advisory Board members. Dr. Harp advised that the item will be included in the next Board Briefs that should go out the week of October 13th.

Adoption of the Agenda

Natasha Jones moved to adopt the agenda. The motion was seconded by Mayanne Zielinski. By roll call vote, the agenda was adopted as presented.

Public Comment on Agenda Items (15 Minutes)

Tammi McKinley spoke in support of legalizing medication use within the scope of practice of Midwifery. She also commended the Board of Medicine's commitment to the Advisory Board during the growth of the midwifery profession in Virginia.

NEW BUSINESS

1. Report of Regulatory Actions and 2020 General Assembly

Dr. Harp provided a regulatory update and report of the 2020 General Assembly. He discussed bills that were of interest to members.

In regards to HB42, Kim Pekin inquired about the creation of a guidance document for pre-natal and post-natal screening for depression. Dr. Harp related that the HB42 article in the next Board Briefs will have resources for licensees to help in the evaluation of depression. He suggested that the article be reviewed prior to deciding if a guidance document needs to be created.

Ms. Pekin requested that discussion of a guidance document be placed on the agenda for the next meeting.

2. Review of High-Risk Pregnancy Disclosures Guidance Document

After preliminary discussion, Ms. Pekin requested that this document be placed on the agenda in January 2021. She advised the members to be prepared to discuss any editorial

or substantive changes that may be in order. Dr. Harp reminded the Advisory Board that the guidance document was initially created by an Ad Hoc Committee of the Board of Medicine, and any substantive changes would need to be reviewed by a newly constituted Ad Hoc.

3. Approval of 2021 Meeting Calendar

Kim Pekin moved to approve the proposed 2021 meeting dates for the Advisory Board as presented, and for the Advisory Board to continue to hold virtual meetings beyond COVID-19. Mayanne Zielinski seconded the motion. By roll call vote, members voted to approve the 2021 schedule of meetings and to continue to hold virtual meetings if possible.

Dr. Harp remarked that the Director of the Department of Health Professions, Dr. David Brown, will be made aware of the Advisory Board's request to continue to hold virtual meetings.

4. Election of Officers

Rebecca Banks made a motion for Kim Pekin to continue as Chair. Mayanne Zielinski seconded. Kim Pekin nominated Rebecca Banks as Vice-Chair. Mayanne Zielinski seconded. By roll call vote, Kim Pekin was elected Chair, and Rebecca Banks was elected Vice-Chair.

Dr. Harp reminded the Advisory Board that a member continues in the seat until a successor is appointed. He thanked Ms. Zielinski for her willingness to continue to serve.

Announcements

Ms. Archer provided the licensing report. The Board has a total of 97 licensed midwives, 70 of which are current active with Virginia addresses. There are 27 current active licensees with out-of-state addresses.

Next Meeting Date

Next scheduled meeting date: January 29, 2021, at 10:00 a.m.

Adjournment

With no other business to conduct, Kim Pekin adjourned the meeting at 11:16. a.m.

Kim Pekin, CPM, Chair

William L. Harp, MD
Executive Director

Beulah Baptist Archer, Licensing Specialist

Disclosures by Licensed Midwives for High-Risk Pregnancy Conditions

Virginia Board of Medicine

The Code of Virginia (Law) requires that licensed midwives “disclose to their patients, when appropriate, options for consultation and referral to a physician and evidence-based information on health risks associated with birth of a child outside of a hospital or birthing center.” Regulations for Licensed Midwives specify that:

Upon initiation of care, a midwife shall review the client's medical history in order to identify pre-existing conditions or indicators that require disclosure of risk for home birth. The midwife shall offer standard tests and screenings for evaluating risks and shall document client response to such recommendations. The midwife shall also continually assess the pregnant woman and baby in order to recognize conditions that may arise during the course of care that require disclosure of risk for birth outside of a hospital or birthing center.

The risk factors or conditions that require disclosures are listed in regulation. If any of these conditions or factors are presented, the midwife is to:

- 1) Request and review the client's medical history, including records of the current or previous pregnancies;*
- 2) Disclose to the client the risks associated with a birth outside of a hospital or birthing center; and*
- 3) Provide options for consultation and referral.*

Regulations require that if the risk factors or criteria have been identified that may indicate health risks associated with birth of a child outside a hospital or birthing center, the midwife must provide evidence-based information on such risks and must document in the client record the assessment of all health risks that pose a potential for a high risk pregnancy and, if appropriate, the provision of disclosures and evidence-based information. **The disclosure for intrapartum risk factors should be given to a client at the first prenatal visit.**

For each of the risk factors or conditions identified, this guidance document provides evidence-based information and a format to record in a client's record the disclosure of information and options for consultation and referral.

To access the evidence-based information and disclosure for a particular conditions or risk factor, click on the link in the index below. The midwife may then print the form for that condition or risk factor for presentation and discussion with the client and have the form signed for inclusion in the client record.

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Intrapartum Risk Factors

1. Abnormal fetal cardiac rate or rhythm
2. Active cancer
3. Acute or chronic thrombophlebitis
4. Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)
5. Any pregnancy with abnormal fetal surveillance tests
6. Blood coagulation defect
7. Body Mass Index (BMI) equal to or greater than 30
8. Cardiac disease
9. Chronic obstructive pulmonary disease including asthma
10. Ectopic pregnancy
11. Essential chronic hypertension over 140/90
12. Genital herpes or partner with genital herpes
13. History of hemoglobinopathies
14. HIV positive status with AIDS
15. Inappropriate fetal size for gestation – Macrosomia (Large for gestational age)
16. Inappropriate fetal size for gestation – IUGR (Small for gestational age)
17. Incomplete spontaneous abortion
18. Isoimmunization to blood factors
19. Multiple gestation
20. Persistent severe abnormal quantity of amniotic fluid
21. Platelet count less than 120,000
22. Position presentation other than vertex at term or while in labor
23. Pre-eclampsia/eclampsia
24. Pregnancy lasting longer than 42 completed weeks with an abnormal non-stress test
25. VBAC (vaginal birth after cesarian) previous uterine incision or myomectomy
26. Psychiatric disorders (Mental Health Disorders)
27. Rupture of membranes 24 hours before the onset of labor
28. Seizure disorder requiring prescriptive medication

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29. Severe liver disease -- active or chronic
30. Severe renal disease - active or chronic
31. Significant 2nd or 3rd trimester bleeding
32. Significant glucose intolerance (Preexisting diabetes, gestational diabetes, PCOS)
33. Uncontrolled hyperthyroidism
34. Uterine ablation (endometrial ablation)
35. Uterine anomaly

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Intrapartum Risk Factors

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the *North American Registry of Midwives*).

“If a midwife supports a client’s choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process.” – NARM

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Conditions requiring on-going medical supervision or on-going use of medications

Clients with chronic medical conditions, on prescribed medications, or under medical care for a time-limited problem that coincides with pregnancy should be advised to consult with their treating healthcare providers regarding the impact of these conditions and medications on pregnancy, as well as any impact pregnancy may have on their other diagnosed conditions. Women who choose not to disclose information regarding any medical conditions they have or medications that they are taking may increase their risk of complications.

Current substance abuse (including alcohol and tobacco)

Obstetrical complications of cigarette smoking include:

- Growth restriction (IUGR)
- Spontaneous abortion (miscarriage)
- Sudden infant death syndrome (SIDS)

Alcohol abuse leads to:

- Nutritional deficiencies
- Fetal alcohol syndrome

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In addition to increased risk of preterm labor and baby being small for gestational age, complications resulting from abusing other drugs include:

- Heroin and cocaine consumption result in medical, nutritional and social neglect
- Cocaine and amphetamine cause hypertension, placental abruption
- Intravenous abuse also increases the risk of contracting infectious disease.¹
- Maternal substance use of opioids, benzodiazepines, barbiturates, and alcohol can cause NAS (Neonatal abstinence syndrome).² NAS is a set of drug withdrawal symptoms that affect the central nervous, gastrointestinal, and respiratory systems in the newborn when separated from the placenta at birth.

Documented Intrauterine growth retardation (IUGR)/small for gestational age (SGA) at term

Complications³ for the growth-restricted fetus include:

- Prematurity
- Perinatal morbidity
- Stillbirth

"IUGR is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins."⁴

Suspected uterine rupture

Consequences of uterine rupture:

- There have been no reported maternal deaths due to uterine rupture
- Overall, 14 percent to 33 percent of women will need a hysterectomy when the uterus ruptures
- Approximately 6 percent of uterine ruptures will result in perinatal death
- This is an overall risk of intrapartum fetal death of 20 per 100,000 women undergoing trial of labor after previous cesarean section
- "For term pregnancies, the reported risk of fetal death with uterine rupture is less than 3 percent. Although the risk is similarly low, there is insufficient evidence to quantify the neonatal morbidity directly related to uterine rupture."⁵

Prolapsed cord or cord presentation

Prolapsed cord is a term describing a cord that is passing through the cervix at the same time or in advance of the fetal presenting part. This occurs in approximately 1.4-6.2 per 1000 of pregnancies. Although uncommon, it is considered a true obstetrical emergency most often necessitating a caesarean delivery. Prolapsed cord is associated with other complications of pregnancy and delivery as well.

¹ Pregnancy and substance abuse, G. Fischer, M. Bitschnau, A. Peternell, H. Eder, A. Topitz. Archives of Women's Mental Health. August 1999, Volume 2, Issue 2, pp 57-65.

² Casper, Tammy, and Megan W. Labour. "Identification of the Pregnant Woman Who Is Using Drugs: Implications for Perinatal and Neonatal Care." Journal of Midwifery & Women's Health (2013).

³ Lerner, Jodi P. "Fetal growth and well-being." Obstetrics and gynecology clinics of north America 31.1 (2004): 159-176.

⁴ Frye, Anne, Holistic Midwifery, Volume I, Labrys Press, Portland, OR, 2006, p. 990

⁵ Guise, Jeanne-Marie, et al. "Vaginal birth after cesarean: new insights." (2010).

Fetal risks:

- Hypoxia
- Stillbirth/death

Suspected complete or partial placental abruption

Placental abruption results from a cascade of pathophysiologic processes ultimately leading to the separation of the placenta prior to delivery. Pregnancies complicated by abruption result in increased frequency⁶ of:

- Low birth weight
- Preterm delivery
- Stillbirth
- Perinatal death

Suspected placental previa

Pregnancies complicated with placenta previa had significantly higher rates⁷ of

- Second-trimester bleeding
- Pathological presentations
- Placental abruption
- Congenital malformations
- Perinatal mortality
- Cesarean delivery
- Apgar scores at 5 minutes lower than 7
- Placenta accreta
- Postpartum hemorrhage
- Postpartum anemia
- Delayed maternal and infant discharge from the hospital

Suspected chorioamnionitis

Chorioamnionitis is a potentially serious complication:⁸

- Chorioamnionitis is a major risk factor in the event of preterm birth, especially at earlier gestational ages, contributing to prematurity-associated mortality and morbidity
- Increased susceptibility of the lung for postnatal injury, which predisposes for bronchopulmonary dysplasia.
- Chorioamnionitis is associated with cystic periventricular leukomalacia, intraventricular hemorrhage and cerebral palsy in preterm infants
- Prenatal inflammation/infection has been shown a risk factor for neonatal sepsis

⁶ Ananth, Cande V., et al. "Placental abruption and adverse perinatal outcomes." *JAMA: the journal of the American Medical Association* 282.17 (1999): 1646-1651.

⁷ Sheiner, E., et al. "Placenta previa: obstetric risk factors and pregnancy outcome." *Journal of Maternal-Fetal and Neonatal Medicine* 10.6 (2001): 414-419.

⁸ Thomas, Wolfgang, and Christian P. Speer. "Chorioamnionitis: important risk factor or innocent bystander for neonatal outcome?." *Neonatology* 99.3 (2010): 177-187.

Pre-eclampsia/eclampsia

Complications of preeclampsia include:

- Eclampsia
- HELLP (hemolysis, elevated liver enzymes, low platelets) syndrome
- Liver rupture
- Pulmonary edema
- Renal failure
- Disseminated intravascular coagulopathy (DIC)
- Hypertensive emergency
- Hypertensive encephalopathy
- Cortical blindness

Maternal complications occur in up to 70% of women with eclampsia and include: ⁹

- DIC
- Acute renal failure
- Hepatocellular injury
- Liver rupture
- Intracerebral hemorrhage
- Cardiopulmonary arrest
- Aspiration pneumonitis
- Acute pulmonary edema
- Postpartum hemorrhage
- Maternal death rates of 0-13.9% have been reported

Fetal complications in preeclampsia are directly related to gestational age and the severity of maternal disease and include increased rates of: ¹⁰

- Preterm delivery
- Intrauterine growth restriction
- Placental abruption
- Perinatal death

Thick meconium stained amniotic fluid without reassuring fetal heart tones and birth is not imminent

Meconium staining of the amniotic fluid is a common occurrence during labor. Although a large proportion of these pregnancies will have a normal neonatal outcome, its presence may be an indicator of fetal hypoxia and has been linked to the development of: ¹¹

- Cerebral palsy

⁹ Norwitz, Errol R., Chaur-Dong Hsu, and John T. Repke. "Acute complications of preeclampsia." *Clinical obstetrics and gynecology* 45.2 (2002): 308-329.

¹⁰ de Souza Rugolo, Ligia Maria Suppo, Maria Regina Bentlin, and Cleide Enoir Petean Trindade. "Preeclampsia: effect on the fetus and newborn." *Neoreviews* 12.4 (2011): e198-e206.

¹¹ Rahman, Shimma, Jeffrey Unsworth, and Sarah Vause. "Meconium in labour." *Obstetrics, Gynaecology & Reproductive Medicine* 23.8 (2013): 247-252.

- Seizures
- Meconium aspiration syndrome

Abnormal auscultated fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones

Sustained abnormal fetal heart rate patterns include bradycardia (abnormally low heart rate) and decelerations in the baby's heart rate. Additionally, tachycardia (abnormally high heart rate) is abnormal, and can also be an indication for the need for further evaluation. Historically, a 30-minute rule from decision-to-incision time for emergent cesarean delivery in the setting of abnormal FHR pattern has existed; however, the scientific evidence to support this threshold is lacking.

Excessive vomiting, dehydration, or exhaustion unresponsive to treatment

- Sufficient fluid intake during labor may prevent hemoconcentration, starvation, and activation of the thrombogenic and fibrinolytic system¹²
- With extreme exhaustion, the chances of fetal distress and non-progressive labor are greatly increased
- Bleeding during or after the placental birth, followed by shock, are much more likely to occur when the woman and her uterus are exhausted¹³
- Maternal exhaustion is diagnosed with a combination of ketonuria, elevated temperature, and elevated pulse. This condition is also known as ketoacidosis, in that the mother's blood becomes abnormally acidic and less able to carry oxygen. Unless this condition is reversed, fetal distress will result¹⁴

Blood pressure greater than 140/90 which persists or rises and birth is not imminent

Women with chronic hypertension are at increased risk of: ¹⁵

- Superimposed preeclampsia (25% risk)
- Preterm delivery
- Fetal growth restriction or demise
- Placental abruption
- Congestive heart failure
- Acute renal failure
- Seizures
- Stroke
- Death

Maternal fever equal to or greater than 100.4°

Fever can indicate infection. Fever in labor is associated with: ¹⁶

- Early neonatal and infant death
- Hypoxia

¹² Watanabe, Takashi, et al. "Effect of labor on maternal dehydration, starvation, coagulation, and fibrinolysis." *Journal of perinatal medicine* 29.6 (2001): 528-534.

¹³ Frye, Anne, *Holistic Midwifery, Volume II*, Labrys Press, Portland, OR, 2004, p. 1055.

¹⁴ Davis, Elizabeth, *Heart and Hands: A Midwife's Guide to Pregnancy and Birth*, Celestial Arts, New York, NY, 2004, p. 141.

¹⁵ Hypertension. 2003; 41: 437-445 Published online before print February 10, 2003, doi: 10.1161/01.HYP.0000054981.03589.E9

¹⁶ PETROVA, Anna, et al. "Association of maternal fever during labor with neonatal and infant morbidity and mortality." *Obstetrics and gynecology* 98.1 (2001): 20-27.

- Infection-related death. These associations were stronger among term than preterm infants
- Meconium aspiration syndrome
- Hyaline membrane disease
- Neonatal seizures
- Assisted ventilation

Labor or premature rupture of membrane (PROM) less than 37 weeks according to due date

Premature rupture of membranes before 37 weeks' gestation (and where there is at least an hour between membrane rupture and the onset of contractions and labor) can have consequences for both the mother and the baby:

Risks to Baby:

- Neurologic injury
- Infection
- Respiratory Distress
- Death
- Increased need for neonatal intensive care services

Maternal Risks:

- Infection
- Prolonged Labor
- C-Section
- Death

Because the out-of-hospital birth setting does not provide for immediate access to medications, surgery, and consultation with a physician, there may be increased risks to mother and/or baby if any of these conditions present during the birth. In some communities, the lack of availability of a seamless, cooperative hospital transfer process adds additional risk during intrapartum transfer.

I understand that the intrapartum risks may not be apparent until labor, and my opportunity for referral to a physician, should I choose that, would be limited to hospital transfer and transfer of care to the physician on call at that facility.

I have received and read this document, discussed it with my midwife, and my midwife has answered my questions to my satisfaction.

Client _____

Date _____

Midwife _____

Date _____

[HOME](#)

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1. ABNORMAL FETAL CARDIAC RATE OR RHYTHM

Preamble:

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“If a midwife supports a client’s choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process.” – NARM

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. **The risks listed below apply to birth in any setting, and are not all-inclusive.** The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of risks related to: Abnormal fetal cardiac rate or rhythm

Fetal rhythm abnormalities (fetal heart rates that are irregular, too fast or too slow):

- occur in up to 2% of pregnancies
- usually identified by the obstetrical clinician who detects an abnormal fetal heart rate or rhythm using a Doppler or stethoscope
- majority have isolated premature atrial contractions which may spontaneously resolve
- sustained tachyarrhythmia (rapid) or bradyarrhythmia (slow) may be of clinical significance
 - may indicate severe systemic disease
 - may have the potential to compromise the fetal circulation
 - May require intensive antepartum and/or neonatal care

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

[HOME](#)

Congenital heart disease: Rhythm abnormalities of the fetus. Lisa K Hornberger, David J Sahn. Heart 2007;93:10 1294-1300 doi:10.1136/hrt.2005.069369

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2. ACTIVE CANCER

Preamble:

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"If a midwife supports a client's choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process." – NARM

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. **The risks listed below apply to birth in any setting, and are not all-inclusive.** The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of risks related to: Active Cancer

Maternal risks:

- maternal infection due to immune suppression,
- deep vein thrombosis and pulmonary embolism during pregnancy and especially after delivery
- hemorrhage at delivery.

Fetal risks:

- Intrauterine growth restriction
- Preterm birth
- Fetal health effects from exposure to maternal medications

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

<http://www.nlm.nih.gov/medlineplus/cancerandpregnancy.html> | J Obstet Gynaecol Can. 2013 Mar;35(3):263-80.

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3. ACUTE OR CHRONIC THROMBOPHLEBITIS

Preamble:

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Deep vein thrombosis (DVT) and pulmonary embolism (PE) are collectively known as venous thromboembolism (VTE). VTE occurs more frequently in pregnant women, with an incidence of 0.5 to 2.0 per 1000 pregnancies, four to five times higher than in the non-pregnant population. The risk for VTE is further elevated in the postpartum period.

The risk for VTE in pregnancy is increased in women with:

- Prior history of VTE
- Advanced maternal age
- Collagen-vascular disease, especially antiphospholipid antibody syndrome
- Obesity (BMI > 30)
- Multiparity
- Hypercoagulable state
- Nephrotic syndrome
- Operative delivery
- Prolonged bed rest
- Hematologic disorders (hemoglobin SS and SC disease, polycythemia, thrombotic thrombocytopenic purpura, paroxysmal nocturnal hemoglobinuria, and some dysfibrinogenemias).
- Maternal medical conditions (diabetes, heart disease, inflammatory bowel disease)
- Smoking
- Preeclampsia

Maternal complications:

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- hypoxemia
- post-phlebitic syndrome
- pulmonary infarction
- death

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Chisholm CA, James AH, Ferguson JE. Thromboembolic disorders. In: Evans AE, Manual of Obstetrics, 8th edition. 2014, Wolters Kluwers Health.

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4. ANEMIA (HEMATOCRIT LESS THAN 30 OR HEMOGLOBIN LESS THAN 10 AT TERM)

Preamble:

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Disclosure of risks related to: Anemia (hematocrit less than 30 or hemoglobin less than 10 at term)

The World Health Organization (WHO) estimates that worldwide, 42% of pregnant women are anemic.¹⁷

Current knowledge indicates that iron deficiency anemia in pregnancy is a risk factor for preterm delivery and subsequent low birth weight, and possibly for inferior neonatal health. Data are inadequate to determine the extent to which maternal anemia might contribute to maternal mortality.¹⁸

...a woman who is already anemic is unable to tolerate blood loss that a healthy woman can.¹⁹

Maternal Risks related to severe or untreated anemia:

- need for blood transfusion(s), resulting from a hemorrhage (significant blood loss) during delivery
- postpartum depression

Fetal/Neonatal Risks related to maternal severe or untreated anemia:

- prematurity
- low-birth-weight
- anemia
- developmental delays

¹⁷ Benoist B, McLean E, Egli I, et al. Worldwide Prevalence of Anaemia 1993-2005. Geneva, Switzerland: World Health Organization; 2008.

¹⁸ Allen, Lindsay H. "Anemia and iron deficiency: effects on pregnancy outcome." The American journal of clinical nutrition 71.5 (2000): 1280s-1284s.

¹⁹ McCormick, M. L., et al. "Preventing postpartum hemorrhage in low-resource settings." International journal of gynecology & obstetrics 77.3 (2002): 267-275.

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

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5. ANY PREGNANCY WITH ABNORMAL FETAL SURVEILLANCE TESTS

Preamble:

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Disclosure of risks related to: Pregnancy with abnormal Fetal Surveillance Tests

There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery (Price, 2014).” Abnormal stress tests at any point in pregnancy are associated with an increased risk of poor outcomes in pregnancy and during labor and delivery. Babies with diagnosed or undiagnosed anomalies are more likely to have abnormal test results requiring specialized care before or after delivery. Antepartum testing results, with regard to the overall clinical picture, should be taken seriously.

Risks to fetus:

- Stillbirth
- Asphyxia
- Fetal Acidosis
- Low Apgar scores
- Respiratory distress
- Surgical delivery
- Meconium Aspiration
- Death

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology* , 55 (3), 722.
Preboth, M. (2000). Practice Guidelines ACOG Guidelines on Antepartum Fetal Surveillance . *Am Fam Physician* .
Price, A. (2014, January). MSN CNM. Assistant Clinical Professor VCUMC. (B. Sheets, Interviewer)
Singh, T. (2008). The prediction of intra-partum fetal compromise in prolonged pregnancy. *Journal of Obstetrics and Gynecology* , 28 (8), 779-782.

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6. BLOOD COAGULATION DEFECT

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Disclosure of risks related to: Blood coagulation defect

Hereditary thrombophilia, or predisposition to thrombosis, ranges from the common (Factor V Leiden heterozygosity, present in 1-15% of pregnant women) to the rare (antithrombin deficiency occurring in 0.02%). The risk of deep vein thrombosis or pulmonary embolism (collectively known as venous thromboembolism or VTE) ranges from 0.1-7% of pregnancies. The maternal medical history determines the management during pregnancy, which can include anticoagulation with injections of heparin throughout the pregnancy and post-partum period.

The presence of one of these disorders may contribute to the risk of obstetric complications as well, including:

- IUGR
- preeclampsia
- stillbirth
- Frequent fetal surveillance is recommended in most cases, as well as timed delivery in the last week before the estimated date of delivery.

Alternatively, disorders of maternal hemostasis (such as von Willebrand disease) increase the risk of blood loss at delivery, and as hereditary disorders also increase the risk for abnormal bleeding in the newborn.

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Inherited Thrombophilia in Pregnancy. Practice Bulletin 138, November 2013. American College of Obstetricians and Gynecologists.

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7. BODY MASS INDEX (BMI) EQUAL TO OR GREATER THAN 30

Preamble:

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Disclosure of risks related to: Body Mass Index (BMI) equal to or greater than 30

Obesity is defined as having a BMI of 30 or higher. The number of obese women in the United States has increased greatly during the past 25 years. Obesity has also become a major health concern for pregnant women. More than one half of pregnant women are overweight or obese.

Risks of Obesity Include:

- Birth defects – Babies born to obese mothers have an increased risk of having birth defects, such as heart defects and neural tube defects.
- Macrosomia – In this condition, the baby is larger than normal. This can increase the risk of the baby being injured during birth. For example, the baby’s shoulder can become entrapped after the head is delivered. Macrosomia also increases the risk of cesarean birth.
- Preterm Birth – Problems associated with a mother’s obesity may mean that the baby will need to be delivered early. Preterm infants have an increased risk of health problems, including breathing problems, eating problems, and developmental and learning difficulties later in life.
- Stillbirth – The risk of stillbirth increases the higher the mother’s BMI.
- High Blood Pressure
- Preeclampsia – Preeclampsia is a serious illness for both the woman and her baby. Although gestational hypertension is the most common sign of preeclampsia, this condition affects all organs of the body. The kidneys and liver may fail. In rare cases, stroke can occur. The fetus is at risk of growth problems and problems with the placenta. It may require early delivery, even if the baby is not fully grown. In severe cases, the woman, baby, or both may die.

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- Gestational Diabetes – High blood glucose (sugar) levels during pregnancy increase the risk of having a very large baby and a cesarean delivery. Women who have had gestational diabetes have a higher risk of having babies diabetes in the future, as do their children.
- Challenges in Prenatal Care – Obesity can make it more difficult for the midwife to assess fetal position and fetal growth.
- Challenges in Labor Management – Obesity can create challenges in moving the woman quickly in the event of an emergency during the birth, and can make auscultation of fetal heart tones more difficult.

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Date _____

Midwife _____

Date _____

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8. CARDIAC DISEASE

Preamble:

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Disclosure of risks related to: Cardiac Disease

Most women tolerate the cardiovascular changes of pregnancy without difficulty. Pregnancy in a patient with significant cardiac disease is associated with significant risk. Despite occurring in only 0.2-4% of pregnancies, cardiac disease is associated with up to 30% of maternal deaths. A pregnant patient with cardiac disease will benefit from the coordinated care of a multidisciplinary team including perinatologists, cardiologists and anesthesiologists. In particular, adults with repaired congenital heart disease may pose complex management scenarios. They may require specialized cardiac monitoring during labor and birth, and some cardiac conditions are associated with a high enough risk of labor complications that cesarean is recommended.

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Nanda S, Nelson-Piercy C, Mackillop L. Cardiac disease in pregnancy. Clin Med 2012;12:553-560.

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9. CHRONIC OBSTRUCTIVE PULMONARY DISEASE INCLUDING ASTHMA (1)

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Asthma affects approximately 4% to 6% of adults of all ages and is one of the most common medical conditions complicating pregnancy.

RISKS

- Preterm birth
- Decreased birth weight
- Increased neonatal and maternal death

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Client _____ Date _____

Midwife _____ Date _____

(1) http://www.glowm.com/section_view/heading/Pulmonary%20Disease%20in%20Pregnancy/item/170#1199

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10. ECTOPIC PREGNANCY (1)

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Today, about 1 in 50 pregnancies is ectopic. An ectopic pregnancy occurs when a fertilized egg grows outside of the uterus most commonly in the tube. As the pregnancy grows, it can rupture (burst). If this occurs, it can cause major internal bleeding. This can be life threatening and needs to be treated with surgery.

RISKS

- Fallopian tube damaged, leading to an increased likelihood of having another ectopic pregnancy in the future.
- Ruptured ectopic pregnancy (when the fallopian tube splits) and severe internal bleeding, which can lead to shock.
- Death

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

(1) <http://www.webmd.boots.com/pregnancy/tc/ectopic-pregnancy-complications-of-ectopic-pregnancy>

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11. ESSENTIAL CHRONIC HYPERTENSION (1)

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Elevated blood pressure, systolic >140 or diastolic >90 or both, that predates conception or is diagnosed before 20 weeks of gestation.

MATERNAL RISKS

- Preterm delivery
- Placental abruption
- Preeclampsia
- Eclampsia
- Seizures
- Maternal congestive heart failure
- Acute renal failure
- Death

FETAL RISKS

- Fetal growth restriction
- Fetal death

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As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

(1) http://www.nhlbi.nih.gov/health/public/heart/hbp/hbp_preg.htm

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12. GENITAL HERPES OR PARTNER WITH GENITAL HERPES

Preamble:

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“If a midwife supports a client’s choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process.” – NARM

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. **The risks listed below apply to birth in any setting, and are not all-inclusive.** The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of Risks Related to: Genital Herpes

Because of its serious and potentially lethal risks to the fetus and neonate, pregnant women and their partners should be tested for **HSV - Herpes Simplex Virus** (HSV1 & HSV2).

In women with a previous diagnosis of genital herpes, cesarean delivery to prevent neonatal HSV infection is not indicated if there are NO genital lesions at the time of labor. In an effort to reduce cesarean deliveries performed for the indication of genital herpes, the use of oral acyclovir or valacyclovir near the end of pregnancy to suppress genital HSV recurrences has become increasingly common in obstetric practice. Several studies with small sample sizes suggest that suppressive acyclovir therapy during the last weeks of pregnancy decreases the occurrence of clinically apparent genital HSV disease at the time of delivery, with an associated decrease in cesarean delivery rates for the indication of genital HSV. **However, because viral shedding still occurs (albeit with reduced frequency), the potential for neonatal infection is not avoided completely, and cases of neonatal HSV disease in newborn infants of women who were receiving antiviral suppression recently have been reported.**²⁰

Genital HSV, especially in primary infections, may be dangerous to the neonate if infected during delivery, as it can cause a severe neonatal disease.²¹

Risks of HSV infection to the fetus include:

²⁰ Kimberlin, David W., et al. "Guidance on management of asymptomatic neonates born to women with active genital herpes lesions." *Pediatrics* 131.2 (2013): e635-e646.

²¹ Meytal Avgil, Asher Ornoy, Herpes simplex virus and Epstein-Barr virus infections in pregnancy: consequences of neonatal or intrauterine infection, *Reproductive Toxicology*, Volume 21, Issue 4, May 2006, Pages 436-445, ISSN 0890-6238, <http://dx.doi.org/10.1016/j.reprotox.2004.11.014>.

- intrauterine fetal demise (the death of the fetus while in the uterus)
- skin scars (cutaneous manifestations),
- ophthalmologic findings (chorioretinitis, microphthalmia),
- neurological involvement (causing brain damage)

The clinical presentation of infants with neonatal HSV infection, that is almost invariably symptomatic and frequently lethal, is a direct reflection of the site and extent of viral replication.²²

Risks of HSV infection to the neonate (newborn) include:

- death
- neurologic (brain) damage (intracranial calcifications, microcephaly, seizures, encephalomalacia),
- growth restriction,
- psychomotor development impairment
- skin vesicles or scarring,
- eye lesions resulting in vision loss and/or blindness (chorioretinitis, microphthalmia, cataracts),
- hearing loss and/or deafness

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

²² Anzivino, Elena, et al. "Herpes simplex virus infection in pregnancy and in neonate: status of art of epidemiology, diagnosis, therapy and prevention." *Virology* 6.1 (2009): 1-11.

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13. HISTORY OF HEMOGLOBINOPATHIES

Preamble:

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Disclosure of risks related to: History of hemoglobinopathies

Hemoglobinopathies include sickle cell disease and its variants as well as alpha and beta thalassemia. The involvement of a multidisciplinary team including perinatologists, hematologists and anesthesiologists can allow for development of a plan to screen for and manage complications.

Maternal risks include:

- cerebral vein or deep vein thrombosis
- anemia and vaso-occlusive crisis
- pneumonia
- pyelonephritis
- transfusion
- pregnancy induced hypertension
- postpartum infection, sepsis, and systemic inflammatory response syndrome
- cesarean delivery

Fetal risks include:

- preterm birth and its consequences including low birth weight
- intrauterine growth restriction
- abruption placentae
- stillbirth

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- genetic risk assessment is also recommended for individuals identified as carriers for hemoglobinopathy, as they may be at risk to have affected offspring.

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Villers, Margaret S., et al. "Morbidity associated with sickle cell disease in pregnancy." *American journal of obstetrics and gynecology* 199.2 (2008): 125-e1.
 Naik, Rakhi P., and Sophie Lanzkron. "Baby on board: what you need to know about pregnancy in the hemoglobinopathies." *ASH Education Program Book 2012.1* (2012): 208-214.
 John C. Morrison and Marc R. Parrish. "Sickle Cell Disease and Other Hemoglobinopathies" *Protocols for High-Risk Pregnancies* (2010): 158-159.
 American College of Obstetricians and Gynecologists, *Practice Bulletin 78, "Hemoglobinopathy in Pregnancy,"* January 2007

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14. HIV POSITIVE STATUS WITH AIDS

Preamble:

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Disclosure of risks related to: HIV positive status with AIDS

HIV transmission from mother to child during pregnancy, labor and delivery, or breastfeeding is known as perinatal transmission and is the most common route of HIV infection in children. When HIV is diagnosed before or during pregnancy, perinatal transmission can be reduced to less than 1% if appropriate medical treatment is given, the virus becomes undetectable, and breastfeeding is avoided.²³

Recommended medical treatment includes antiretroviral medication taken throughout pregnancy and during labor, regular monitoring of the maternal viral load, cesarean delivery for viral load > 1000 copies/mL, and initiation of antiretroviral medication for the newborn shortly after birth.

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

15. INAPPROPRIATE FETAL SIZE FOR GESTATION – MACROSOMIA (LARGE FOR GESTATIONAL AGE)

²³ <http://www.cdc.gov/hiv/risk/gender/pregnantwomen/index.html>

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – Macrosomia (Large for Gestational Age)

Macrosomia (meaning *big body*), is arbitrarily defined as a birth weight of more than 4,000 g (8 lb, 13 oz). Also known as *large for gestational age*, fetal macrosomia complicates more than 10 percent of all pregnancies in the United States.²⁴

Risks to the mother related to macrosomia include:

- increased risk of uterine rupture after previous cesarean section or other uterine surgery;
- increased likelihood of induction at or before 40 weeks;
- increased likelihood of an operative delivery: forceps, vacuum, or cesarean section;
- trauma to vagina and/or perineum; including perineal and/or vulvar lacerations, 3rd or 4th degree episiotomy, short or long-term urinary or fecal incontinence;
- increased blood loss and/or postpartum hemorrhage,
- damage to the coccyx (tailbone)

Risks to the baby related to macrosomia at the time of birth include:

- shoulder dystocia (the baby gets stuck at the shoulders after the delivery of the head), which may result in trauma to the baby including:
 - broken clavicle (collar) bone(s);
 - brachial plexus injury, temporary or permanent nerve damage (sensory and motor) to either one or both shoulders, arms, and hands;
 - cerebral palsy;
 - hypoxia, resulting in permanent brain damage;
 - death.
- injuries related to operative delivery (forceps, vacuum, or cesarean section) including:
 - bruising and/or injury to the scalp, head and/or face;

²⁴ MARK A. ZAMORSKI, M.D., M.H.S.A., and WENDY S. BIGGS, M.D., University of Michigan Medical School, Ann Arbor, Michigan. Am Fam Physician. 2001 Jan 15;63(2):302-307.

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- temporary weakness in the facial muscles (facial palsy);
- external eye and/or ear trauma;
- broken clavicle (collar) bone(s);
- brachial plexus injury (see description above);
- cerebral palsy;
- skull fracture;
- bleeding within the skull;
- seizures;
- lacerations (during cesarean section) to the baby's presenting part
- immature lungs and breathing problems, if the due date has been miscalculated and the infant is delivered before 39 weeks of gestation;
- need for special care in the neonatal intensive care unit (NICU);

Risks to the newborn related to macrosomia and later childhood risks:

- higher than normal blood sugar level (impaired glucose tolerance);
- childhood obesity (research suggests that the risk of childhood obesity increases as birth weight increases);
- metabolic syndrome (a group of conditions: increased blood pressure, a high blood sugar level, excess body fat, abnormal cholesterol levels; that occur together, increasing the risk of heart disease, stroke and diabetes later in life.

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- Decline consultation with a physician regarding my risk factors.

Client _____

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16. INAPPROPRIATE FETAL SIZE FOR GESTATION – IUGR (SMALL FOR GESTATIONAL AGE)

Preamble:

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Disclosure of Risks Related to: Inappropriate Fetal Size for Gestation – IUGR (Small for Gestational Age)

IUGR (Intrauterine Growth Restriction) is a serious problem, regardless of why the baby is small. About 20% of stillborn babies are IUGR, and perinatal mortality for growth-restricted infants may be 6 to 10 times higher than for those of normal size. Most IUGR stillbirths occur after the 36th week of pregnancy and before labor begins.²⁵

Risks to the baby related to IUGR, known as Small for Gestational Age:

- low birth weight (LBW);
- difficulty handling the stresses of vaginal delivery;
- decreased oxygen levels (hypoxia);
- hypoglycemia (low blood sugar);
- low resistance to infection;
- low APGAR scores (a test given immediately after birth to evaluate the newborn's physical condition and determine need for special medical care);
- meconium aspiration (inhalation of stools passed while in the uterus), which can lead to breathing problems, lung surfactant dysfunction, chemical pneumonitis, and persistent pulmonary hypertension;
- trouble maintaining body temperature (hypothermia);
- abnormally high red blood cell count;
- admission to NICU;
- long-term growth problems;
- intrauterine fetal demise (fetal death prior to labor);

²⁵ Frye, Anne, *Holistic Midwifery, Volume I*, Labrys Press, Portland, OR, 2006, p. 990

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- stillbirth (fetal death during labor or birth).

Risks to the mother related to IUGR:

- increased stress related to fetal monitoring and surveillance (serial ultrasounds and non-stress testing);
- premature labor;
- premature birth (delivery of the fetus before 37 weeks gestation);
- induction and early delivery, before 40 weeks;
- cesarean section.

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

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17. INCOMPLETE SPONTANEOUS ABORTION OR INCOMPLETE MISCARRIAGE (10)

Preamble:

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Spontaneous abortion also known as early pregnancy loss refers to a miscarriage that happens before 20 weeks of gestation and is seen in 13% to 20% of all diagnosed pregnancies. Incomplete spontaneous abortion occurs when some tissue is retained in the uterus. Medication or a procedure may be needed to remove the tissue.

STILLBIRTH OR INTRAUTERINE FETAL DEMISE (IUFD)

Fetal death that happens after 20 weeks of gestational age is called stillbirth and has a rate of 3.2 per 1000 births. Medical intervention is needed for delivery.

MATERNAL FETAL RISKS OF EARLY OR LATE FETAL LOSS

- Infection
- Hemorrhage
- Maternal coagulopathy
- Gestational trophoblastic disease
- Rh isoimmunization

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

(10)[http://www.acog.org/Resources And Publications/Practice Bulletins/Committee on Practice Bulletins -- Obstetrics/Management of Stillbirth](http://www.acog.org/Resources%20And%20Publications/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Obstetrics/Management%20of%20Stillbirth)

(10)[http://www.acog.org/Resources And Publications/Patient Education Pamphlets/Files/Early Pregnancy Loss](http://www.acog.org/Resources%20And%20Publications/Patient%20Education%20Pamphlets/Files/Early%20Pregnancy%20Loss)



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18. ISOIMMUNIZATION TO BLOOD FACTORS

Preamble:

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Disclosure of risks related to: Isoimmunization to blood factors

Pregnant women with a negative Rh blood type (O-, A-, B-, AB-) or with other atypical antibodies have significant fetal and neonatal risk factors. Clinical manifestations of RhD haemolytic disease (HDN) range from asymptomatic mild anemia to hydrops fetalis or stillbirth associated with severe anemia and jaundice.²⁶

Risks to the baby related to maternal isoimmunization include:

- destruction of fetal red blood cells (hemolysis);
 - mild to moderate hemolysis manifests as increased indirect bilirubin (red cell pigment).
 - severe hemolysis leads to red blood cell production by the spleen and liver.
- severe anemia;
- hepatic circulatory obstruction (portal hypertension);
- placental edema, interfering with placental perfusion;
- ascites (accumulation of fluid in the abdominal cavity);
- hepatomegaly (swelling of the liver);
- increased placental thickness;
- polyhydramnios (increased amniotic fluid);
- hydrops (fetal heart failure);
- anasarca (extreme generalized edema);
- effusions (abnormal accumulation of fluid);
- intrauterine fetal demise (fetal death);
- stillbirth.

²⁶ Urbaniak, S. J., and M. A. Greiss. "RhD haemolytic disease of the fetus and the newborn." *Blood reviews* 14.1 (2000): 44-61.

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19. MULTIPLE GESTATION

Preamble:

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Disclosure of risks related to: Multiple gestation

Maternal risks:

- Anemia
- Hemorrhage
- Preeclampsia
- Gestational diabetes
- Cesarean delivery

Fetal risks:

- Twin-to-twin transfusion syndrome (TTTS) in monochorionic twins
- Vanishing twin/death of one fetus
- Congenital anomalies
- Hydramnios
- Preterm birth
- Malpresentation
- Small for gestational age
- Umbilical cord prolapse
- Neonatal intensive care unit admission

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Guidance document: 85-10

Revised: October 22, 2015

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Rao, Anita, Shanthi Sairam, and Hassan Shehata. "Obstetric complications of twin pregnancies." *Best Practice & Research Clinical Obstetrics & Gynaecology* 18.4 (2004): 557-576.

Spellacy, W. N. "Antepartum complications in twin pregnancies." *Clinics in perinatology* 15.1 (1988): 79-86.

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20. PERSISTENT SEVERE ABNORMAL QUANTITY OF AMNIOTIC FLUID (OLIGOHYDRAMNIOS AND POLYHYDRAMNIOS)

Preamble:

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Disclosure of risks related to: Persistent severe abnormal quantity of amniotic fluid

Oligohydramnios (decreased amniotic fluid) may be caused by fetal anomalies (bladder outlet obstruction, renal agenesis), premature rupture of the membranes, or placental insufficiency occurring de novo or as a consequence of maternal conditions such as hypertension.

Maternal risks:

- antepartum hospitalization
- induction of labor
- cesarean delivery

Fetal risks:

- pulmonary hypoplasia (underdevelopment of the lungs)
- limb contractures
- abnormal fetal heart rate patterns
- acidosis
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- stillbirth or neonatal death

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Polyhydramnios (increased amniotic fluid) is most commonly idiopathic (no identifiable cause) but may be seen in maternal diabetes (especially uncontrolled or with large for gestational age fetus) and with fetal anomalies (diaphragmatic hernia, intestinal obstruction).

Maternal risks:

- cesarean delivery
- post-partum hemorrhage

Fetal risks:

- malpresentation
- neonatal intensive care unit admission
- need for surgical intervention if anomalies present
- neonatal hypoglycemia
- stillbirth and neonatal death

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____ Date _____

Midwife _____ Date _____

Shanks, Anthony, et al. "Assessing the optimal definition of oligohydramnios associated with adverse neonatal outcomes." *Journal of Ultrasound in Medicine* 30.3 (2011): 303-307.

Magann EF, Sandlin AT, Ounpraseuth ST. Amniotic fluid and the clinical relevance of the sonographically estimated amniotic fluid volume: oligohydramnios. *J Ultrasound Med* 2011;30:1573-85.

Moore, Thomas R. "Abnormal Amniotic Fluid Volume." *Protocols for High-Risk Pregnancies* (2010): 399.

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21. PLATELET COUNT LESS THAN 120,000

Preamble:

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Disclosure of risks related to: Platelet count less than 120,000

Platelet disorders in pregnancy include those that are time-limited to pregnancy (gestational thrombocytopenia, HELLP syndrome) and those that may pre-date or be newly diagnosed during the pregnancy (idiopathic thrombocytopenic purpura (ITP), thrombotic thrombocytopenic purpura (TTP)). With the exception of gestational thrombocytopenia, all of these platelet disorders place the mother at increased risk for blood loss and need for transfusion.

Gestational thrombocytopenia: occurs in 7-8% of pregnancies and accounts for 70-80% of cases of thrombocytopenia in pregnancy, typically diagnosed in the third trimester, rarely associated with platelet counts below 70,000, not associated with increased risks of bleeding in the mother or fetus, platelet counts return to normal after delivery.

It is important to differentiate gestational thrombocytopenia from more serious platelet disorders:

- ITP: chronic disorder associated with:
 - fluctuating platelet counts that may be lower than 50,000
 - need for steroid or immune globulin treatment and platelet transfusion to avoid excess blood loss at delivery, particularly surgical delivery.
- TTP: acute or chronic disorder generally associated with:
 - severe thrombocytopenia of 20,000 or less
 - hepatic impairment
 - renal impairment
 - CNS impairment
 - increased risk of death for both mother and fetus.

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- HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of preeclampsia, and characterized by:
 - thrombocytopenia
 - elevated liver enzymes
 - hemolytic anemia
 - potential for severe maternal illness including:
 - liver failure
 - hepatic subcapsular hematoma
 - excess maternal blood loss
 - seizure
 - maternal death
 - preterm birth
 - intrauterine growth restriction
 - fetal death

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Gernsheimer T, James AH, Stasi R. How I treat thrombocytopenia in pregnancy. *Blood* 2013;121:38-47.

Thrombocytopenia during pregnancy. Importance, diagnosis and management. Boehlen F. *Hamostaseologie*. 2006 Jan;26(1):72-4

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22. POSITION PRESENTATION OTHER THAN VERTEX AT TERM OR WHILE IN LABOR

Preamble:

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Presentation Risks

Non-vertex presentations occur in less than 4% of all pregnancies. This would include breech, brow, face, transverse lie, and compound presentations. Non-vertex presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine abnormalities. These associations would increase risk to the mother/baby in addition to the actual risks associated with non-vertex delivery.

C-section has become the standard mode of delivery for babies in non-vertex positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-vertex presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal position cannot be rotated.

Disclosure of risks related to: Position presentation other than vertex at term or while in labor:

Risks to Babies:

- Low APGAR scores
- Ruptured organs (kidney, liver)
- Neck Trauma
- Genital edema
- Prematurity
- Cord Prolapse
- Respiratory distress
- Stillbirth

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Revised: October 22, 2015

- Head entrapment
- Edema to face and skull
- Tracheal damage
- Increased NICU admission rates
- Shoulder/arm trauma
- Hip and leg trauma
- Intracranial hemorrhage
- Death

Maternal Risks:

- C-section
- Prolonged/Dysfunctional labor
- Placenta abruption
- Increased risk of deep lacerations

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Client _____

Date _____

Midwife _____

Date _____

de Leeuw, J. (2002). Mortality and early morbidity for abdominal and vaginal deliveries in breech presentation. *Journal of Obstetrics and Gynaecology*, 22 (2), 127-139.
Tidy, C. R. (2010). *patient.co.uk/doctor/malpresentations*. Retrieved from patient.co.uk.

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23. PRE-ECLAMPSIA/ECLAMPSIA

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Disclosure of risks related to Pre-eclampsia:

Pre-eclampsia is a leading cause of death in pregnant women and occurs in 5% of all pregnancies. The management of pre-eclampsia may require medication and monitoring unavailable in an out of hospital setting.

Maternal Risks:

- Hypertension leading to brain injury
- Liver Failure
- Kidney Failure
- HELLP syndrome
- Clotting problems (DIC)
- Pulmonary edema
- Seizure (Eclampsia)
- Stroke
- Placental Abruption
- C-section
- Death

Fetal Risks:

- Small for gestational age (IUGR)
- Premature Birth
- Stillbirth

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Client _____

Date _____

Midwife _____

Date _____

American College of Obstetricians and Gynecologists. (2011). *Frequently Asked Questions: Pregnancy: High Blood Pressure During Pregnancy*. ACOG.
Cunningham, C. L. (2010). *Williams Obstetrics* (23rd Edition ed.). New York, NY: McGraw-Hill.
Frye, A. (1998). *Holistic Midwifery* (Vol. 1). Portland, OR: Labry's Press.

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24. PREGNANCY LASTING LONGER THAN 42 COMPLETED WEEKS WITH AN ABNORMAL STRESS TEST

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Pregnancy is considered to be postdates at 42 weeks of gestation. There is limited research available to outline the risks of a pregnancy continuing beyond 42 weeks *with* an abnormal stress test. Current medical standard of practice is that beginning at 41 weeks, a non-stress test (NST) be combined with other indicators of fetal well-being, i.e., amniotic fluid index (AFI) or biophysical profile (BPP). There is no benefit in continuing a pregnancy at or post term after fetal surveillance is found to be non-reassuring. The recommendation is delivery. (Price, 2014)

Maternal Risks:

- Oligohydramnios
- Medical induction
- C-section
- Prolonged labor
- Complicated delivery such as: Shoulder dystocia

Fetal Risk

- Large size leading to risks associated with macrosomia
- uteroplacental insufficiency
- Asphyxia
- Infection
- Neonatal acidemia

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- Low Apgar
- Birth Injury
- Stillbirth
- Postmaturity/Dysmaturity syndrome
- Fetal distress
- Meconium Aspiration
- Death

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Hilder, C. T. (1998). Prolonged Pregnancy: evaluating gestation-specific risks of fetal and infant mortality. *BJOG* .
O'Neill, E. T. (2012). Antepartum evaluation of the fetus and fetal well-being. *Clinical Obstetrics and Gynecology* , 55 (3), 722.
Preboth, M. (2000). Practice Guidelines ACOG Guidelines on Antepartum Fetal Surveillance . *Am Fam Physician* .
Price, A. (2014, January). MSN CNM. Assistant Clinical Professor VCUMC. (B. Sheets, Interviewer)
Singh, T. (2008). The prediction of intra-partum fetal compromise in prolonged pregnancy. *Journal of Obstetrics and Gynecology* , 28 (8), 779-782.

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25. VBAC (VAGINAL BIRTH AFTER CESARIAN) PREVIOUS UTERINE INCISION OR MYOMECTOMY (8)

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Because the uterine scar for most caesarian sections is low on the uterus, women who undergo TOLAC (trial of labor after cesarean), are able to give birth vaginally 60–80% of the time. But if problems arise during TOLAC, the baby may need to be born by emergency cesarean delivery. Because uterine rupture can be sudden and unexpected labor outside of a hospital can delay delivery and increase the risk of injury and death for both mother and baby in an emergency. Some surgery for fibroids can result in a similar risk for uterine rupture. An unknown type of prior uterine scar is a contraindication for TOLAC so review of prior surgical records is essential part of the evaluation.

RISKS

Maternal risks

- Maternal hemorrhage
- Infection
- Thromboembolism
- Placenta accreta
- Death
- Emergency hysterectomy

Fetal risks

- Hypoxic Ischemic Encephalopathy
- Stillbirth

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- Perinatal death
- Neonatal death
- Respiratory morbidity
- Transient tachypnea
- Hyperbillirubinemia

The probability that a woman attempting TOLAC will achieve VBAC depends on her individual combination of factors.

Selected Clinical Factors Associated with Trial of Labor after Previous Cesarean Delivery Success

Increased Probability of Success

- Prior vaginal birth
- Spontaneous labor

Decreased Probability of Success

- Recurrent indication for initial cesarean delivery (labor dystocia)
- Increased maternal age
- Non-white ethnicity
- Gestational age greater than 40 weeks
- Maternal obesity
- Preeclampsia
- Short interpregnancy interval
- Increased neonatal birth weight

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

(8) <http://www.webmd.com/baby/tc/vaginal-birth-after-cesarean-vbac-risks-of-vbac-and-cesarean-deliveries>

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26. PSYCHIATRIC DISORDERS (MENTAL HEALTH DISORDERS)

Preamble:

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Clients with mental health issues such as:

- Depression
- Panic/anxiety
- Obsessive-compulsive traits
- Schizophrenia

should be counseled about the stresses of pregnancy and the postpartum period. Clients who are taking psychiatric medication should be made aware that some potential for birth defects may exist and are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

Risks associated with pregnancy and psychiatric disorders include:

- Poor maternal health
- Poor outcomes for babies including poor fetal growth and development
- Maternal psychiatric medication side effects
- Increased potential for some birth defects

Clients who are taking psychiatric medication are advised to discuss the risks and benefits of continuing their drugs during pregnancy with their provider.

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Guidance document: 85-10

Revised: October 22, 2015

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As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

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27. RUPTURE OF MEMBRANES 24 HOURS BEFORE THE ONSET OF LABOR (7)

Preamble:

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“If a midwife supports a client’s choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process.” – NARM

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The risk of prolonged rupture of membranes is chorioamnionitis. The risk increases with the delay between rupture of membranes and delivery.

MATERNAL COMPLICATIONS

- cesarean delivery
- endomyometritis
- wound infection
- pelvic abscess
- bacteremia
- postpartum hemorrhage
- postpartum hemorrhage
- bacteremia most commonly involving GBS

Rarely

- septic shock
- disseminated intravascular coagulation
- adult respiratory distress syndrome

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- maternal death

FETAL COMPLICATIONS

- fetal death
- neonatal sepsis

NEONATAL COMPLICATIONS

- perinatal death
- asphyxia
- early onset neonatal sepsis
- septic shock
- pneumonia
- intraventricular hemorrhage
- cerebral palsy

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

(7) <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3008318/>

(7) <http://www.neim.org/doi/full/10.1056/NEJM199611143352013>

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28. SEIZURE DISORDER REQUIRING PRESCRIPTIVE MEDICATION

Preamble:

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Disclosure of risks related to: Seizure disorder requiring prescriptive medication

Most pregnancies are uneventful in women with epilepsy, and most babies are delivered healthy with no increased risk of obstetric complications in women. When controlled, there does not appear to be an increased risk for intrauterine growth restriction, preeclampsia, preterm birth or stillbirth compared to women without seizure disorder.

Fetal risks:

- With uncontrolled seizures:
 - Intrauterine growth restriction
 - Preterm birth
 - Stillbirth
- Some medications are associated with an increased risk of birth defects

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

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McPherson JA, harper LM, Odibo AO, et al. Maternal seizure disorder and risk of adverse pregnancy outcomes. *Am J Obstet Gynecol* 2013;208:378.e1-5.
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29. SEVERE LIVER DISEASE -- ACTIVE OR CHRONIC

Preamble:

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Disclosure of risks related to: Severe liver disease -- active or chronic

Liver disease occurs in approximately 3% of pregnancies. It may be chronic or occurring coincident with pregnancy, such as viral hepatitis or drug-induced hepatotoxicity, or pregnancy specific such as HELLP syndrome, intrahepatic cholestasis of pregnancy or acute fatty liver of pregnancy.

Severe liver disease:

- is usually acute in onset
- can be life-threatening to the mother
- associated with a high risk of stillbirth
- If hypertension has preceded the onset of HELLP syndrome, fetal growth restriction may also be present.

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Liver Disease in Pregnancy, Cleveland Clinic Disease Management Project, Jamilé Wakim-Fleming, August 10, 2010.
Joshi D, James A, Quaglia A et al. Liver Disease in Pregnancy. Lancet 2010;375:594-605.

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30. SEVERE RENAL DISEASE -- ACTIVE OR CHRONIC

Preamble:

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Disclosure of risks related to: Severe Renal Disease — Active or Chronic

Renal disease is associated with increased risks of both maternal and fetal adverse outcomes. These risks, which rise with the severity of preexisting renal disease, include:

Maternal:

- Hypertension
- abruptio placentae
- deterioration of renal function including permanent end-stage renal failure;

Fetal:

- Intrauterine growth restriction
- abruptio placentae
- stillbirth

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- Consult with a physician regarding my risk factors.

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Guidance document: 85-10

Revised: 2-7-2020

- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Williams DJ, Davison JM. Renal Disorders. In: Creasy & Resnick's Maternal-Fetal Medicine, Principles and Practice. 6th edition, 2009: Saunders Elsevier.

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31. SIGNIFICANT 2ND OR 3RD TRIMESTER BLEEDING

Preamble:

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Significant 2nd or 3rd trimester bleeding is often associated with potentially serious conditions, including placenta previa, placenta abruption, and vasa previa.

Medical management and ultrasound is indicated to rule out and/or monitor potentially serious conditions associated with significant bleeding.

Maternal Risk Factors:

- C-section
- Hemorrhage
- Anemia
- Hypovolemic Shock
- Death
- Coagulation Defects (DIC)
- Damage to Kidneys and Brain

Fetal Risk Factors:

- Poor fetal growth (IUGR)
- Birth Defects

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- Premature Birth
- Anemia
- Hypovolemic Shock
- Stillbirth

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

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Karim, S. e. (1998). Effects of first and second trimester vaginal bleeding on pregnancy outcome." *JPMA* .
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32. SIGNIFICANT GLUCOSE INTOLERANCE (PREEXISTING DIABETES, GESTATIONAL DIABETES, PCOS)

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Disclosure of risks related to: Significant glucose intolerance

Pre-gestational diabetes mellitus (Type 1 or Type 2) affects approximately 1% of pregnancies, with an incidence rising with the incidence of type 2 diabetes in younger adults. Gestational diabetes is diagnosed in 5-7% of pregnancies.

Risk factors for GDM: occurs more commonly in women with a family history of diabetes, prior personal history of glucose intolerance including prior gestational diabetes, obesity, and maternal age over 25.

Maternal risks:

- Hypertension
- Antepartum hospitalization
- Induction of labor
- Cesarean delivery
- Uncontrolled diabetes may result in:
 - kidney damage
 - retinopathy resulting in vision loss
 - peripheral nerve damage.

Fetal risks:

- Even when controlled, pre-gestational diabetes is associated with an increased risk of miscarriage and major congenital anomalies. This risk rises with poorer control around the time of conception.
- Throughout pregnancy, diabetes is associated with increased risks of:

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- o hypertensive disorders
- o large for gestational age babies
- o stillbirth
- o abnormal progression of labor
- o cesarean delivery
- o shoulder dystocia with resultant brachial plexus injury
- Due to these risks, more frequent ultrasound examinations and antepartum testing of fetal well-being ~~are prescribed~~ may be indicated.
- In the newborn period
 - o hypoglycemia
 - o hyperbilirubinemia
 - o polycythemia

Timing of delivery:

- Pre-gestational diabetes, and uncontrolled gestational diabetes: between 37 and 39 weeks, individualized
- Controlled gestational diabetes: between 39 and 41 weeks, individualized

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

Pre-gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 60, March 2005.
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 Landon MB, Gabbe SG. Gestational Diabetes Mellitus. *Obstet Gynecol* 2011;118:1379-93.

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33. UNCONTROLLED HYPERTHYROIDISM

Preamble:

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Hyperthyroidism occurs in 0.2% of pregnancies; Graves' disease accounts for 95% of these cases.

The signs and symptoms of hyperthyroidism include nervousness, tremors, tachycardia, frequent stools, excessive sweating, heat intolerance, weight loss, goiter, insomnia, palpitations, and hypertension.

RISKS

- Premature delivery
- Severe preeclampsia
- Heart failure
- Maternal death
- Low birth weight
- Fetal death
- Abnormal thyroid function in the newborn

Thyroid storm is a medical emergency and occurs in 1% of pregnant patients with hyperthyroidism and can be triggered by infection, labor or delivery.

RISKS

- Shock
- Stupor
- Coma

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- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

(1)[http://www.acog.org/Resources And Publications/Practice Bulletins/Committee on Practice Bulletins --
Obstetrics/Thyroid Disease in Pregnancy](http://www.acog.org/Resources%20And%20Publications/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Obstetrics/Thyroid%20Disease%20in%20Pregnancy)

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34. UTERINE ABLATION (ENDOMETRIAL ABLATION)

Preamble:

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Disclosure of risks related to Uterine Ablation (Endometrial Ablation):

Endometrial Ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research and the maternal and fetal complications are poorly defined.

Maternal Risks:

- Miscarriage
- Placenta accreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-Section
- Hysterectomy
- Death

Fetal Risks:

- Prematurity
- Death
- Possible increase in anomalies

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- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

American College of Obstetricians and Gynecologists. (2013). *Frequently Asked Questions: Special Procedures: Endometrial Ablation*. ACOG.
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A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

35. UTERINE ANOMALY

Preamble:

The Midwives Model of Care® recognizes the client/patient as the primary decision maker in all aspects of her care and respects her autonomy. This is supported within a model of well-informed, shared decision-making in order to achieve optimal clinical outcomes. Disclosure of risks is an integral part of the informed consent process, as outlined by NARM (the North American Registry of Midwives).

“If a midwife supports a client’s choices that are outside of her Plan of Care, she must be prepared to give evidence of informed consent. The midwife must also be able to document the process that led to the decision and show that the client was fully informed of the potential risks and benefits of proceeding with the new care plan. It is the responsibility of the midwife to provide evidence-based information, clinical expertise, and when appropriate, consultation or referral to other providers to aid the client in the decision making process.” – NARM

Licensed midwives are trained experts in the management of low-risk pregnancy and birth outside of the hospital. Certain conditions may present increased risk to mother and/or baby. The risks listed below apply to birth in any setting, and are not all-inclusive. The condition/risk factor listed may require medications and treatments outside of the scope of practice of Virginia Licensed Midwives and, thus may necessitate consultation with a physician, additional testing, and careful consideration for the appropriateness of birth in an out-of-hospital setting. Some conditions in pregnancy should be optimally managed and supported by a multidisciplinary team that may include midwives, obstetricians, perinatologists, family physicians, psychologists, social workers, and spiritual advisors.

Disclosure of risks related to: Uterine anomaly

Women with a uterine anomaly (uterine septum, unicornuate uterus, bicornuate uterus, uterine didelphys) are at risk for

- PTB (preterm birth)
- Fetal presentation other than vertex
- Hemorrhage
- Retained placenta
- Kidney malformation

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife has discussed this information with me and has provided me with options for consultation and referral to a physician for the risk factors she has indicated apply to me. I have decided to:

- Consult with a physician regarding my risk factors.
- Decline consultation with a physician regarding my risk factors.

Client _____

Date _____

Midwife _____

Date _____

A Work Group comprised of members of the Board of Medicine and the Advisory Board on Midwifery has developed this information to assist licensed midwives in satisfying the requirements of Code Section 54.1-2957.9(iv), which requires midwives to disclose to their patients options for consultation and referral to a physician and evidence-based information on health risks associated with the birth of a child outside of a hospital. This information does not constitute medical advice, diagnosis, opinion or treatment. Individuals should consult a qualified health care provider for advice regarding a medical condition.

Report of the 2021 General Assembly Session

January 20, 2021

HB 1737 Nurse practitioners; practice without a practice agreement.

Chief patron: Adams, D.M.

Summary as introduced:

Nurse practitioners; practice without a practice agreement. Reduces from five to two the number of years of full-time clinical experience a nurse practitioner must have to be eligible to practice without a written or electronic practice agreement.

HB 1747 Clinical nurse specialist; licensure of nurse practitioners as specialists, etc.

Chief patron: Adams, D.M.

Summary as introduced:

Clinical nurse specialist; licensure; practice. Provides for the licensure of nurse practitioners as clinical nurse specialists by the Boards of Medicine and Nursing and provides that a nurse practitioner licensed as a clinical nurse specialist shall practice pursuant to a practice agreement between the clinical nurse specialist and a licensed physician. The bill requires the Boards of Medicine and Nursing to jointly issue a license to practice as a nurse practitioner in the category of a clinical nurse specialist to an applicant who is an advance practice registered nurse who has completed an advanced graduate-level education program in the specialty category of clinical nurse specialist and who is registered by the Board of Nursing as a clinical nurse specialist on July 1, 2021.

HB 1769 Health care providers, certain; licensure or certification by endorsement.

Chief patron: Freitas

Summary as introduced:

Certain health care providers; licensure or certification by endorsement. Requires the Board of Medicine to issue a license or certificate by endorsement to an applicant who holds a valid, unrestricted license or certificate under the laws of another state, the District of Columbia, or a United States territory or possession with which the Commonwealth has not established a reciprocal relationship upon endorsement by the appropriate board or other appropriate

authority of such other state, the District of Columbia, or United States territory or possession and a determination by the Board of Medicine that the applicant's credentials are satisfactory to the Board of Medicine and the examinations and passing grades required by such other board or authority are fully equal to those required by the Board of Medicine.

HB 1795 Counseling, Board of; licensure of professional counselors without examination.

Chief patron: Cole, M.L.

Summary as introduced:

Board of Counseling; licensure of professional counselors without examination. Requires the Board of Counseling to issue a license as a licensed professional counselor without examination to a person who has applied for such a license and who satisfies all other education, experience, and fitness to practice requirements set forth in regulation and who, in the judgment of the Board, is qualified to practice professional counseling.

HB 1815 Marijuana; legalization of cultivation, manufacture, sale, possession, and testing, penalties.

Chief patron: Heretick

Summary as introduced:

Marijuana; legalization of cultivation, manufacture, sale, possession, and testing; penalties. Establishes a regulatory scheme for the regulation of marijuana cultivation facilities, marijuana manufacturing facilities, marijuana testing facilities, and retail marijuana stores by the Board of Agriculture and Consumer Services. The bill also grants localities the authority to enact ordinances establishing additional licensing requirements for marijuana establishments located within such locality and allows the home cultivation of marijuana for personal use under certain circumstances. The bill imposes a tax on retail marijuana and retail marijuana products sold by a retail marijuana store at a rate of 9.7 percent (for a total sales tax of 15 percent) and provides that 67 percent of the revenues collected from the tax be deposited into the general fund and 33 percent of the revenues be deposited into a "Retail Marijuana Education Support Fund" to be used solely for purposes of public education. Finally, the bill establishes several new criminal penalties related to marijuana; as well as modifies some existing criminal penalties.

HB 1817 Certified nurse midwives; practice.

Chief patron: Adams, D.M.

Summary as introduced:

Practice of certified nurse midwives. Eliminates the requirement that certified nurse midwives practice pursuant to a practice agreement and provides that certified nurse midwives shall practice in accordance with regulations of the Boards of Medicine and Nursing and consistent with the Standards for the Practice of Midwifery set by the American College of Nurse-Midwives and shall consult and collaborate with and refer patients to such other health care providers as may be appropriate for the care of the patient.

HB 1913 Career fatigue and wellness in certain health care providers; programs to address, civil immunity.

Chief patron: Hope

Summary as introduced:

Programs to address career fatigue and wellness in certain health care providers; civil immunity. Expands civil immunity for health care professionals serving as members of or consultants to entities that function primarily to review, evaluate, or make recommendations related to health care services to include health care professionals serving as members of or consultants to entities that function primarily to address issues related to career fatigue and wellness in health care professionals licensed, registered, or certified by the Boards of Medicine, Nursing, or Pharmacy, or in students enrolled in a school of medicine, osteopathic medicine, nursing, or pharmacy located in the Commonwealth. The bill contains an emergency clause.

EMERGENCY

HB 1953 Licensed certified midwives; definition of practice, licensure, report.

Chief patron: Gooditis

Summary as introduced:

Licensed certified midwives; licensure; practice. Defines "practice of licensed certified midwifery" and directs the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife. The bill also directs the Department of Health Professions to convene a workgroup to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals. The Department shall report its findings and conclusions to the Governor and the General Assembly by November 1, 2021.

HB 1959 Medication abandonment and increasing patient medication adherence; options for reducing rates.

Chief patron: Fowler

Summary as introduced:

Study; Health Professions Subcommittee of the Committee on Health, Welfare and Institutions; options for reducing rates of medication abandonment and increasing patient medication adherence; report. Directs the Health Professions Subcommittee of the Committee on Health, Welfare and Institutions to study options for reducing the rates of medication abandonment and increasing patient medication adherence, including the feasibility of permitting health plans and pharmacy benefits managers to make available in real time to enrollees and their health care providers, upon request of such health care provider made at the time a prescription drug is prescribed to an enrollee, information regarding the actual cost and any benefits of the prescription drug and any health insurance coverage related to the prescription drug.

HB 1987 Telemedicine; coverage of telehealth services by an insurer, etc.

Chief patron: Adams, D.M.

Summary as introduced:

Telemedicine. Clarifies that nothing shall preclude coverage of telehealth services by an insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; a corporation providing individual or group accident and sickness subscription contracts; or a health maintenance organization providing a health care plan for health care services. The bill requires the Board of Medical Assistance Services to amend the state plan for medical assistance to provide for payment of medical assistance for remote patient monitoring services provided via telemedicine for certain high-risk patients, and provides for the establishment of a practitioner-patient relationship via telemedicine for the prescribing of Schedule II through VI controlled substances.

HB 1988 Cannabis oil; processing and dispensing by pharmaceutical processors.

Chief patron: Adams, D.M.

Summary as introduced:

Board of Pharmacy; pharmaceutical processors; processing and dispensing cannabis oil.

Effects numerous changes to the processing and dispensing of cannabis oil by pharmaceutical processors in the Commonwealth. The bill defines the term "designated caregiver facility" and allows any staff member or employee of a designated caregiver facility to assist with the possession, acquisition, delivery, transfer, transportation, and administration of cannabis oil for any patients residing in the designated caregiver facility. The bill allows written certifications for use of cannabis oil to include an electronic practitioner signature. The bill removes the requirement that a cannabis dispensing facility undergo quarterly inspections and instead requires that inspections occur no more than once annually and allows pharmaceutical processors to remediate cannabis oil that fails any quality testing standard. The bill requires pharmaceutical processors to maintain evidence of criminal background checks for all employees and delivery agents of the pharmaceutical processor. The bill directs the Board of Pharmacy to promulgate regulations implementing the provisions of the bill and regulations creating reasonable restrictions on advertising and promotion by pharmaceutical processors by July 1, 2021.

HB 2005 Disposition of the remains of a decedent; persons to make arrangements for funeral.

Chief patron: Sickles

Summary as introduced:

Disposition of the remains of a decedent; persons to make arrangements for funeral and disposition of remains. Establishes an order of priority for persons who have the right to make arrangements and otherwise be responsible for a decedent's funeral and the disposition of his remains, provided that any such person is 18 years of age or older and of sound mind. The bill sets out, among other things, the circumstances under which such persons forfeit the right to make arrangements and otherwise be responsible for a person's funeral and the disposition of his remains and sets out assertions that a person seeking to exercise the right to make such arrangements must attest to in a signed written statement to be delivered to the funeral service establishment. Any funeral service establishment, funeral service establishment manager of record, funeral service licensee, funeral director, embalmer, registered crematory, registered crematory owner, registered crematory manager of record, or certified crematory operator that relies upon such a written statement shall be immune from civil or criminal liability for any act, decision, or omission in connection with following such person's direction related to the decedent's funeral and the disposition of his remains, unless such act, decision, or omission resulted from willful neglect or bad faith. The bill sets out rights of funeral service establishments when there is a dispute regarding the arrangements of a decedent's funeral or

his remains or the identity of any persons who have the right to make arrangements for the decedent. The bill specifies that the provisions do not apply to cemeteries or cemetery companies.

HB 2039 Physician assistant; eliminates certain requirement for practice.

Chief patron: Rasoul

Summary as introduced:

Practice as a physician assistant. Eliminates the requirement that a physician assistant enter into a practice agreement with a single patient care team physician or patient care team podiatrist and provides that a patient care team physician or patient care team podiatrist shall not be liable for the actions or inactions of a physician assistant for whom the patient care team physician or patient care team podiatrist provides collaboration and consultation. The bill also makes clear that a student physician assistant shall not be required to be licensed to engage in acts that otherwise constitute practice as a physician assistant, provided that the student physician assistant is enrolled in an accredited physician assistant education program.

HB 2044 Naturopathic doctors; Board of Medicine to license and regulate.

Chief patron: Rasoul

Summary as introduced:

Naturopathic doctors; license required. Requires the Board of Medicine to license and regulate naturopathic doctors. The practice of naturopathic medicine is defined in the bill as (i) a system of primary health care for the prevention, diagnosis, and treatment of human health conditions, injury, and disease and (ii) the use of both naturopathic and traditional medical therapies to promote or restore whole patient health. The bill also establishes the Advisory Board on Naturopathic Medicine to assist the Board of Medicine in formulating regulations related to the practice of naturopathic medicine.

HB 2061 VIIS; any health care provider in the Commonwealth that administers immunizations to participate.

Chief patron: Willett

Summary as introduced:

Virginia Immunization Information System; health care entities; required participation.

Requires any health care provider in the Commonwealth that administers immunizations to

participate in the Virginia Immunization Information System (VIIS) and report patient immunization history and information to VIIS. Under current law, participation in VIIS is optional for authorized health care entities. The bill has a delayed effective date of January 1, 2022.

HB 2079 Pharmacists; initiation of treatment with and dispensing and administering of drugs and devices.

Chief patron: Rasoul

Summary as introduced:

Pharmacists; initiation of treatment; certain drugs and devices. Expands provisions governing the initiation of treatment with and dispensing and administering of drugs and devices by pharmacists to allow the initiation of treatment with and dispensing and administering of drugs, devices, and controlled paraphernalia to persons 18 years of age or older, in accordance with protocols developed by the Board of Pharmacy in collaboration with the Board of Medicine and the Department of Health, and of (i) vaccines included on the Immunization Schedule published by the Centers for Disease Control and Prevention; (ii) tuberculin purified protein derivative for tuberculosis testing; (iii) controlled substances for the prevention of human immunodeficiency virus, including controlled substances prescribed for pre-exposure and post-exposure prophylaxis pursuant to guidelines and recommendations of the Centers for Disease Control and Prevention; and (iv) drugs, devices, controlled paraphernalia, and other supplies and equipment available over-the-counter, covered by the patient's health carrier when the patient's out-of-pocket cost is lower than the out-of-pocket cost to purchase an over-the-counter equivalent of the same drug, device, controlled paraphernalia, or other supplies or equipment. The bill requires any pharmacist who administers a vaccination pursuant to clause (i) to report such administration to the Virginia Immunization Information System. The bill also (a) requires the Board of Pharmacy, in collaboration with the Board of Medicine and the Department of Health, to establish protocols for the initiation of treatment with and dispensing and administering of drugs, devices, and controlled paraphernalia by pharmacists in accordance with the provisions of the bill by November 1, 2021; (b) requires the Board of Pharmacy, in collaboration with the Board of Medicine, to adopt regulations within 280 days of the bill's enactment to implement the provisions of the bill; and (c) requires the Board of Pharmacy to continue the work group composed of equal number of representatives of the Boards of Pharmacy and Medicine and other stakeholders to provide recommendations regarding the

developing of protocols for the initiation of treatment with and dispensing and administering of certain drugs and devices by pharmacists to persons 18 years of age or older.

HB 2116 Declared states of emergency, certain; funeral service licensees designated as essential workers.

Chief patron: Mugler

Summary as introduced:

Certain declared states of emergency; essential workers; funeral service licensees; emergency. Provides that in any case in which the Governor has declared a state of emergency related to a communicable disease of public health threat, funeral service licensees shall be considered essential workers and shall be included in any group afforded priority with regard to (i) access to personal protective equipment and (ii) administration of any vaccination against such communicable disease of public health threat during such emergency. The bill contains an emergency clause.

EMERGENCY

HB 2218 Pharmaceutical processors; permits processors to produce & distribute cannabis products.

Chief patron: Hayes

Summary as introduced:

Pharmaceutical processors; cannabis products. Permits pharmaceutical processors to produce and distribute cannabis products other than cannabis oil. The bill defines the terms "botanical cannabis," "cannabis product," and "usable cannabis." The bill requires the Board of Pharmacy to establish testing standards for botanical cannabis and botanical cannabis products, establish a registration process for botanical cannabis products, and promulgate emergency regulations to implement the provisions of the bill. The bill allows the Board of Pharmacy to assess and collect a one-time botanical cannabis regulatory fee from each pharmaceutical processor, not to exceed \$50,000, to cover costs associated with the implementation of the provisions of the bill, including costs for new personnel, training, promulgation of regulations and guidance documents, and information technology.

HB 2220 Surgical technologist; certification, use of title.

Chief patron: Hayes

Summary as introduced:

Surgical technologist; certification; use of title. Provides that that no person shall hold himself out to be a surgical technologist or use or assume the title of "surgical technologist" or "certified surgical technologist" unless such person is certified by the Board of Medicine; currently, a person must be registered with the Board of Medicine to use the title "registered surgical technologist." The bill also (i) adds a requirement that an applicant whose certification is based on his holding a current credential as a certified surgical technologist from the National Board of Surgical Technology and Surgical Assisting also demonstrate that he has successfully completed an accredited surgical technologist training program and (ii) provides that the Board of Medicine may certify a person who has practiced as a surgical technologist at any time in the six months prior to July 1, 2021, provided that he registers with the Board of Medicine by December 31, 2021.

HB 2241 Unborn child protection from dismemberment abortion; penalties.

Chief patron: LaRock

Summary as introduced:

Unborn child protection from dismemberment abortion; penalties. Prohibits the practice of dismemberment abortion, which is defined in the bill as meaning to, with the purpose of causing the death of an unborn child, purposely dismember a living unborn child and extract him one piece at a time from the uterus through the use of clamps, grasping forceps, tongs, scissors, or any other instrument that, through the convergence of two rigid levers, slice, crush, or grasp a portion of the unborn child's body to cut or rip such portion of the unborn child's body. The term does not include an abortion that uses suction to dismember the body of an unborn child by sucking fetal parts into a collection container, but it does include an abortion in which a dismemberment abortion is used to cause the death of an unborn child but suction is subsequently used to extract fetal parts after the death of the unborn child. The bill provides that a person who purposely performs a dismemberment abortion is guilty of a Class 4 felony. A cause of action is also created for injunctive relief and civil damages. An exception is made when a dismemberment abortion is necessary to prevent serious health risk to the unborn child's mother.

HB 2259 Governor; issuance of licenses to persons denied by regulatory board.

Chief patron: Scott

Summary as introduced:

Professions and occupations; licensure by Governor. Provides that the Governor may issue a license of the kind granted by a regulatory board under the Department of Professional and Occupational Regulation or the Department of Health Professions to any person whose application for such license to such board has been denied.

HB 2272 Naturopathic doctors; Department of Health Professions to amend its regulations.

Chief patron: Fowler

Summary as introduced:

Department of Health Professions; naturopathic doctors. Directs the Department of Health Professions to amend its regulations to require that a person complete a four-year accredited doctoral program in naturopathy and pass the naturopathy examination administered by the Virginia Naturopathic Doctors Association in order to use the title "Naturopathic Doctor" or "ND." The bill requires the Department to collaborate with the Virginia Naturopathic Doctors Association to draft and implement regulations related to the scope of practice of naturopathic doctors in the Commonwealth.

HJ 531 Interstate Medical Licensure Compact; Joint Com. on Health Care to study advisability of joining.

Chief patron: Helmer

Summary as introduced:

Study; Joint Commission on Health Care; advisability of the Commonwealth's joining the Interstate Medical Licensure Compact; report. Directs the Joint Commission on Health Care to study the advisability of the Commonwealth's joining the Interstate Medical Licensure Compact (the Compact), including the legal effects of joining of the Compact in the Commonwealth and possible positive and negative outcomes resulting from the adoption of the Compact, and develop recommendations as to whether the Commonwealth should join the Compact. The Joint Commission on Health Care shall complete its work by November 30, 2021, and submit an executive report of its findings and conclusions no later than the first day of the 2022 Regular Session of the General Assembly.

SB 1107 Medical malpractice; limitation on recovery.

Chief patron: Stanley

Summary as introduced:

Medical malpractice; limitation on recovery. Eliminates the cap on the recovery in actions against health care providers for medical malpractice where the act or acts of malpractice occurred on or after July 1, 2021.

SB 1115 Industrial hemp; increases maximum THC concentration.

Chief patron: Peake

Summary as introduced:

Industrial hemp; increase maximum THC concentration. Increases the maximum tetrahydrocannabinol (THC) concentration in industrial hemp from the maximum allowed by federal law to the maximum allowed by federal law or one percent, whichever is greater. The bill expands the definition of "hemp product" to include raw materials of any part of the plant *Cannabis sativa* and omits from such definition the requirement that the product be otherwise lawful.

SB 1167 Nursing, Board of; licensure or certification by endorsement for members of the U.S. military.

Chief patron: Kiggans

Summary as introduced:

Board of Nursing; licensure or certification by endorsement for members of the United States military. Permits the Board of Nursing to issue licenses and certifications by endorsement for registered nurses, licensed practical nurses, and certified nurse aides who hold a similar or equivalent license or certification from the medical corps of a branch of the United States military.

SB 1178 Genetic counseling; repeals conscience clause.

Chief patron: Ebbin

Summary as introduced:

Genetic counseling; conscience clause. Repeals the conscience clause for genetic counselors who forgo participating in counseling that conflicts with their deeply held moral or religious beliefs, provided that they inform the patient and offer to direct the patient to the online directory of licensed genetic counselors maintained by the Board of Medicine. The law being repealed also prohibits the licensing of any genetic counselor from being contingent upon participating in such counseling.

SB 1187 Physical therapy; extends time allowed for a therapist to evaluate and treat patients.

Chief patron: Hashmi

Summary as introduced:

Department of Health Professions; practice of physical therapy. Extends from 30 days to 60 days the time allowed for a physical therapist who has completed a doctor of physical therapy program approved by the Commission on Accreditation of Physical Therapy Education or who has obtained a certificate of authorization to evaluate and treat patients after an initial evaluation without a referral under certain circumstances. The bill also provides that after discharging a patient a physical therapist shall not perform an initial evaluation of a patient without a referral if the physical therapist has performed an initial evaluation of the patient for the same condition within the immediately preceding 60 days.

SB 1189 Occupational therapists; licensure.

Chief patron: Hashmi

Summary as introduced:

Licensure of occupational therapists; Occupational Therapy Interjurisdictional Licensure Compact. Authorizes Virginia to become a signatory to the Occupational Therapy Interjurisdictional Licensure Compact. The Compact permits eligible licensed occupational therapists and occupational therapy assistants to practice in Compact member states provided they are licensed in at least one member state. The bill has a delayed effective date of January 1, 2022, and directs the Board of Medicine to adopt emergency regulations to implement the provisions of the bill. The Compact takes effect when it is enacted by a tenth member state.

SB 1192 Naturopathic doctors; Department of Health Professions to amend its regulations.

Chief patron: Kiggans

Summary as introduced:

Department of Health Professions; naturopathic doctors. Directs the Department of Health Professions to amend its regulations to require that a person complete a four-year accredited doctoral program in naturopathy and pass the naturopathy examination administered by the Virginia Naturopathic Doctors Association in order to use the title "Naturopathic Doctor" or "ND." The bill requires the Department to collaborate with the Virginia Naturopathic Doctors Association to draft and implement regulations related to the scope of practice of naturopathic doctors in the Commonwealth.

SB 1205 Career fatigue and wellness in certain health care providers; programs to address, civil immunity.

Chief patron: Barker

Summary as introduced:

Programs to address career fatigue and wellness in certain health care providers; civil immunity. Expands civil immunity for health care professionals serving as members of or consultants to entities that function primarily to review, evaluate, or make recommendations related to health care services to include health care professionals serving as members of or consultants to entities that function primarily to address issues related to career fatigue and wellness in health care professionals licensed, registered, or certified by the Boards of Medicine, Nursing, or Pharmacy, or in students enrolled in a school of medicine, osteopathic medicine, nursing, or pharmacy located in the Commonwealth. The bill contains an emergency clause.

EMERGENCY

SB 1218 Naturopathic doctors; license required.

Chief patron: Petersen

Summary as introduced:

Naturopathic doctors; license required. Requires the Board of Medicine to license and regulate naturopathic doctors. The practice of naturopathic medicine is defined in the bill as (i) a system of primary health care for the prevention, diagnosis, and treatment of human health conditions, injury, and disease and (ii) the use of both naturopathic and traditional medical therapies to promote or restore whole patient health. The bill also establishes the Advisory Board on Naturopathic Medicine to assist the Board of Medicine in formulating regulations related to the practice of naturopathic medicine.

SB 1268 Disposition of the remains of a decedent; persons to make arrangements for funeral.

Chief patron: Deeds

Summary as introduced:

Disposition of the remains of a decedent; persons to make arrangements for funeral and disposition of remains. Establishes an order of priority for persons who have the right to make

arrangements and otherwise be responsible for a decedent's funeral and the disposition of his remains, provided that any such person is 18 years of age or older and of sound mind. The bill sets out, among other things, the circumstances under which such persons forfeit the right to make arrangements and otherwise be responsible for a person's funeral and the disposition of his remains and sets out assertions that a person seeking to exercise the right to make such arrangements must attest to in a signed written statement to be delivered to the funeral service establishment. Any funeral service establishment, funeral service establishment manager of record, funeral service licensee, funeral director, embalmer, registered crematory, registered crematory owner, registered crematory manager of record, or certified crematory operator that relies upon such a written statement shall be immune from civil or criminal liability for any act, decision, or omission in connection with following such person's direction related to the decedent's funeral and the disposition of his remains, unless such act, decision, or omission resulted from willful neglect or bad faith. The bill sets out rights of funeral service establishments when there is a dispute regarding the arrangements of a decedent's funeral or his remains or the identity of any persons who have the right to make arrangements for the decedent. The bill specifies that the provisions do not apply to cemeteries or cemetery companies.

SB 1320 Licensed certified midwives; definition of practice, licensure, report.

Chief patron: Lucas

Summary as introduced:

Licensed certified midwives; licensure; practice. Defines "practice of licensed certified midwifery" and directs the Boards of Medicine and Nursing to establish criteria for the licensure and renewal of a license as a certified midwife. The bill also directs the Department of Health Professions to convene a workgroup to study the licensure and regulation of certified nurse midwives, certified midwives, and certified professional midwives to determine the appropriate licensing entity for such professionals. The Department shall report its findings and conclusions to the Governor and the General Assembly by November 1, 2021.

SB 1333 Pharmaceutical processors; permits processors to produce & distribute cannabis products.

Chief patron: Lucas

Summary as introduced:

Pharmaceutical processors; cannabis products. Permits pharmaceutical processors to produce

and distribute cannabis products other than cannabis oil. The bill defines the terms "botanical cannabis," "cannabis product," and "usable cannabis." The bill requires the Board of Pharmacy to establish testing standards for botanical cannabis and botanical cannabis products, establish a registration process for botanical cannabis products, and promulgate emergency regulations to implement the provisions of the bill. The bill allows the Board of Pharmacy to assess and collect a one-time botanical cannabis regulatory fee from each pharmaceutical processor, not to exceed \$50,000, to cover costs associated with the implementation of the provisions of the bill, including costs for new personnel, training, promulgation of regulations and guidance documents, and information technology.

training, promulgation of regulations and guidance documents, and information technology.

SB 1406 Marijuana; legalization of simple possession; penalties.

Chief patron: Ebbin, Lucas

Summary as introduced:

Marijuana; legalization of simple possession; penalties. Eliminates criminal penalties for possession of marijuana for persons who are 21 years of age or older. The bill also modifies several other criminal penalties related to marijuana and provides for an automatic expungement process for those convicted of certain marijuana-related crimes. The bill establishes a regulatory scheme for the regulation of marijuana cultivation facilities, marijuana manufacturing facilities, marijuana testing facilities, marijuana wholesalers, and retail marijuana stores by the Virginia Alcoholic Beverage Control Authority, renamed as the Virginia Alcoholic Beverage and Cannabis Control Authority. The bill imposes a tax on retail marijuana, retail marijuana products, and marijuana paraphernalia sold by a retail marijuana store, as well as non-retail marijuana and non-retail marijuana products at a rate of 21 percent and provides that localities may by ordinance levy a three percent tax on any such marijuana or marijuana products. The bill provides that net profits attributable to regulatory activities of the Authority's Board of Directors pursuant to this bill shall be appropriated as follows: (i) 40 percent to pre-kindergarten programs for at-risk three and four year olds, (ii) 30 percent to the Cannabis Equity Reinvestment Fund, established in the bill, (iii) 25 percent to substance use disorder prevention and treatment programs, and (iv) five percent to public health programs. The bill creates the Cannabis Control Advisory Board, the Cannabis Equity Reinvestment Board, and the Cannabis Public Health Advisory Council. The bill has a delayed effective date of January 1, 2023, with provisions for the Authority's Board of Directors to promulgate regulations for the implementation of the bill and for implementation of the automatic expungement process to begin in due course. In addition, the bill establishes three work groups to begin their efforts in due course: one focused on public health and safety issues, one focused on providing resources for teachers in elementary and secondary schools, and one focused on college-aged individuals. See S. B. 1406 PDF text: <https://lis.virginia.gov/000/CannabisBill.pdf>

SB 1408 Joint Commission on Health Care; sunset.

Chief patron: Barker

Summary as introduced:

Joint Commission on Health Care; sunset. Repeals the sunset provision for the Joint Commission on Health Care.

SB 1424 Funeral service establishments; manager of record.

Chief patron: Cosgrove

Summary as introduced:

Funeral service establishments; manager of record. Defines "manager of record" as a person who manages and handles all operations of a licensed funeral service establishment and sets out the conditions under which a funeral service licensee or a funeral director may serve as a manager of record. The bill requires that funeral service establishments employ a full-time manager of record.

SB 1446 Practice of medicine and other healing arts; provision of litigation assistance.

Chief patron: Surovell

Summary as introduced:

Practice of medicine and other healing arts; provision of litigation assistance. Requires practitioners of medicine and other healing arts to provide litigation assistance to treated patients and their attorneys. Such litigation assistance includes providing a legal consult fee schedule upon request, scheduling and participating in meetings with a treated patient's attorney upon request, participating in trial or de bene esse depositions as needed, and providing a written estimate of the cost of the patient's medical services related to the litigation.

ADDENDUM

High Risk Pregnancy Disclosure Recommended Updates

The following revisions and updates have been recommended by Kim Pekin, CPM and Becky Banks, CPM:

Documents 1 through 6, no recommended updates.

(Kim Pekin) Document 7. Body Mass Index (BMI) Equal to or Greater than 30

There is a strikethrough on the second page “higher risk of having ~~babies~~ diabetes in the future.” Recommend removing strikethrough and the underline in the word “diabetes.”

There are no references cited on this disclosure. Recommendation to reference this journal article that includes most of the claims in the HRP Disclosure:

Bhattacharya, Sohinee, et al. "Effect of Body Mass Index on pregnancy outcomes in nulliparous women delivering singleton babies." *BMC public Health* 7.1 (2007): 168.

(Kim Pekin) 9. Chronic Obstructive Pulmonary Disease Including Asthma

The citation is incorrect. Correct citation is:

Leighton, B, Fish, J, *Glob. libr. women's med.*, (ISSN: 1756-2228) 2008; DOI 10.3843/GLOWM.10170

(Kim Pekin) 10. Ectopic Pregnancy

Reference no longer online. Recommend this citation:

Sivalingam VN, Duncan WC, Kirk E, *et al*, Diagnosis and management of ectopic pregnancy, *Journal of Family Planning and Reproductive Health Care* 2011;**37**:231-240.

(Kim Pekin) 11. Essential Chronic Hypertension

Citation no longer works. Recommend this citation:

Bramham, Kate, et al. "Chronic hypertension and pregnancy outcomes: systematic review and meta-analysis." *Bmj* 348 (2014).

(Becky Banks) 12. Genital Herpes

Suggest adding an extra paragraph detailing the difference in infection rate between primary/first-episode (nonprimary), vs recurrent, vis a vis:

“Accurate classification is particularly important because a newly acquired infection (primary or nonprimary first-episode) near the time of delivery is a major risk for transmission to the neonate.”

“In two case series of women cultured on admission and subsequently found positive, the frequency of neonatal infection ranged from 31% to 44% for primary and first-episode, and 1 to 3% in recurrent.”

“Use of invasive fetal monitoring and preterm birth increase risk of neonatal infection in patients with viral shedding.”

Brown ZA, Wald A, Morrow RA, Selke S, Zeh J, Corey L. Effect of serological status and cesarean delivery on transmission rates of herpes simplex virus from mother to infant. *JAMA*. 2003;289(2):203.

Need a page break after #14 (HIV/AIDS)

(Kim Pekin) 17. Incomplete Spontaneous Abortion or Incomplete Miscarriage

Links no longer work. Change references to:

Metz, Torri D., et al. "Obstetric care consensus# 10: management of stillbirth:(replaces practice bulletin number 102, March 2009)." *American journal of obstetrics and gynecology* 222.3 (2020): B2-B20.

American College of Obstetricians and Gynecologists' Committee on Practice Bulletins—Gynecology. "ACOG Practice Bulletin No. 200: Early Pregnancy Loss." *Obstetrics and gynecology* vol. 132,5 (2018): e197-e207. doi:10.1097/AOG.0000000000002899

(Becky Banks) 18. Isoimmunization

Suggested, or similar:

Widespread use of anti-D immune globulin for prevention of D has decreased the risk of isoimmunization. Routine treatment includes prophylactic dosage at 28 weeks of gestation and after delivery of a D-positive newborn. Testing for Rh typing should be performed with every pregnancy because revisions in lab procedures may present as a change in the Rh blood type.

Sandler SG, Li W, Langeberg A, Landy HJ. New laboratory procedures and Rh blood type changes in a pregnant woman. *Obstet Gynecol*. 2012;119(2 Pt 2):426.

(Becky Banks) 21. Platelet Count

It is suggested that the section regarding HELLP syndrome in this consent document be duplicated including reference in #23

(Becky Banks) 22. Position Presentation other than vertex [should this be struck and replaced with cephalic?]

Non-vertex presentations occur in less than 4% of all pregnancies. This would include breech, brow [vertex, non-cephalic]; face [vertex, non-cephalic], transverse lie, and compound presentations. Non-vertex (should we change this to non-cephalic?) presentations are associated with congenital abnormalities of the baby, multiple pregnancies, placenta previa, and uterine anomalies. These associations would (strike this out, replace with may) increase risk to the mother/baby in addition to the actual risks associated with non-vertex delivery.

C-section has become the standard mode of deliveries for babies in non-vertex positions. Physicians and midwives may not have adequate training in the vaginal delivery of non-vertex presentations further increasing the risk of injury or death to both mother and baby. A transverse presentation is considered incompatible with vaginal delivery. Posterior, Brow, and Face presentations are associated with complicated delivery and increased maternal and/or fetal complications and may require C-section if the fetal position cannot be rotated.

(suggested new paragraph) " There are efforts being made internationally to bring back training for vaginal breech birth to be available in all settings, especially under specific practice guidelines and with a trained provider, including efforts to gather research regarding training with models in subsequent clinical practice."

Fischbein and Freeze BMC Pregnancy and Childbirth (2018) 18:397

Hereafter would follow the risks as listed and other references.

(Becky Banks) 23. Pre-Eclampsia/Eclampsia

HELLP syndrome: an acute condition occurring in up to 2% of pregnancies, usually seen in the setting of pre-eclampsia, and characterized by:

- thrombocytopenia
- elevated liver enzymes
- hemolytic anemia
- potential for severe maternal illness including: liver failure, hepatic subcapsular hematoma, excess maternal blood loss, seizure, maternal death, preterm birth, intrauterine growth restriction, fetal death.

reference is #21, ICD on platelet count

(Kim Pekin) 25. VBAC

The article referenced in the disclosure is not a peer reviewed journal article. I recommend these references:

Asakura H, Myers SA. More than one previous cesarean delivery: a 5-year experience with 435 patients. *Obstet Gynecol* 1995;85:924–9.

Cahill AG, Tuuli M, Odibo AO, Stamilio DM, Macones GA. Vaginal birth after cesarean for women with three or more prior caesareans: assessing safety and success. *BJOG* 2010;117:422–7.

Caughey AB, Shipp TD, Repke JT, Zelop CM, Cohen A, Lieberman E. Rate of uterine rupture during a trial of labor in women with one or two prior cesarean deliveries. *Am J Obstet Gynecol* 1999;181:872–6.

Chauhan SP, Magann EF, Carroll CS, Barrilleaux PS, Scardo JA, Martin JN Jr. Mode of delivery for the morbidly obese with prior cesarean delivery: vaginal versus repeat cesarean section. *Am J Obstet Gynecol* 2001;185:349–54.

Development Maternal-Fetal Medicine Units Network. *Obstet Gynecol* 2006;108:12–20.

Flamm BL, Newman LA, Thomas SJ, Fallon D, Yoshida MM. Vaginal birth after cesarean delivery: results of a 5-year multicenter collaborative study. *Obstet Gynecol* 1990;76:750–4.

Gregory KD, Korst LM, Fridman M, Shihady I, Broussard P, Fink A, et al. Vaginal birth after cesarean: clinical risk factors associated with adverse outcome. *Am J Obstet Gynecol* 2008;198:452.e1–10; discussion 452.e10–2.

Landon MB, Spong CY, Thom E, Hauth JC, Bloom SL, Varner MW, et al. Risk of uterine rupture with a trial of labor in women with multiple and single prior cesarean delivery. National Institute of Child Health and Human Development Maternal-Fetal Medicine Units Network. *Am J Obstet Gynecol* 2005;193:1016–23.

Lavin JP, Stephens RJ, Miodovnik M, Barden TP. Vaginal delivery in patients with a prior cesarean section. *Obstet Gynecol* 1982;59:135–48.

Macones GA, Cahill A, Pare E, Stamilio DM, Ratcliffe S, Stevens E, et al. Obstetric outcomes in women with two prior cesarean deliveries: is vaginal birth after cesarean delivery a viable option? *Am J Obstet Gynecol* 2005;192:1223–8.

McMahon MJ, Luther ER, Bowes WA Jr, Olshan AF. Comparison of a trial of labor with an elective second cesarean section. *N Engl J Med* 1996;335:684-95.

Miller DA, Diaz FG, Paul RH. Vaginal birth after cesarean: a 10-year experience. *Obstet Gynecol* 1994;84:255-8.

Signore, Caroline, and Catherine Y. Spong. "Vaginal birth after cesarean: new insights manuscripts from an NIH consensus development conference, March 8-10, 2010." *Seminars in perinatology*. Vol. 34. No. 5. NIH Public Access, 2010.

Tahseen S, Griffiths M. Vaginal birth after two caesarean sections (VBAC-2)-a systematic review with meta-analysis of success rate and adverse outcomes of VBAC-2 versus VBAC-1 and repeat (third) caesarean sections. *BJOG* 2010;117:5-19. (Meta-analysis)

(Kim Pekin) 27. Rupture of Membranes 24 Hours Before the Onset of Labor

The links really should include the journal articles referenced, rather than the hyperlink to the PubMed article. Recommended references:

Association of Ontario Midwives, Management of Prelabour Rupture of Membranes at Term, Clinical Practice Guideline 13, May 2014.

Gunn G, Mishell D, Morton D. Premature rupture of the fetal membranes. *Am J Obs Gyne* 1970 Feb;106(3):469.

Hannah ME, Ohlsson A, Wang EE, Matlow A, Foster GA, Willan AR, et al. Maternal colonization with group B Streptococcus and prelabour rupture of membranes at term: the role of induction of labor. TermPROM Study Group. *Am.J.Obstet.Gynecol.* 1997 Oct;177(4):780-785.

Seaward PG, Hannah ME, Myhr TL, Farine D, Ohlsson A, Wang EE, et al. International Multicentre Term Prelabour Rupture of Membranes Study: evaluation of predictors of clinical chorioamnionitis and postpartum fever in patients with prelabour rupture of membranes at term. *American Journal of Obstetrics & Gynecology* 1997 Nov;177(5):1024-1029.

Tita, Alan T N, and William W Andrews. "Diagnosis and management of clinical chorioamnionitis." *Clinics in perinatology* vol. 37,2 (2010): 339-54. doi:10.1016/j.clp.2010.02.003

Umans-Eckenhansen, M. A., and Harrie N. Lafeber. "Prolonged rupture of membranes and transmission of the human immunodeficiency virus." *The New England journal of medicine* 335.20 (1996): 1533-1534.

(Kim Pekin and Becky Banks) 33. Uncontrolled Hyperthyroidism

Updated references:

Casey, Brian M., and Kenneth J. Leveno. "Thyroid disease in pregnancy." *Obstetrics & Gynecology* 108.5 (2006): 1283-1292.

American Thyroid Association (ATA): Guidelines of the American Thyroid Association for the Diagnosis and Management of Thyroid Disease During Pregnancy and Postpartum (2017). Topic 112934, Version 7.0

(Becky Banks) #34 Uterine Ablation (Endometrial Ablation):

Recommend updated statement:

Endometrial Ablation is a procedure accompanied by sterilization or the strong recommendation for continuous contraception. Pregnancy after ablation is rare and therefore there is little research, and the maternal and fetal complications are poorly defined. General recommendations are pregnancy is contra-indicated once endometrial ablation has been performed.

Maternal risks:

- Miscarriage
- Ectopic pregnancy
- Placenta accreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-section
- Hysterectomy
- Death

Fetal Risks:

- Prematurity
- Death
- Possible increase in anomalies
- Malpresentation

(Kim Pekin and Becky Banks) 35. Uterine Anomaly

Citation missing. Should be:

Hua M, Odibo AO, Longman RE, et al. Congenital uterine anomalies and adverse pregnancy outcomes. Am J Obstet Gynecol 2011;205:558.e1-5

Recommended update:

The frequency of uterine anomaly is unknown, but appears to be about 3 to 8 percent in an unselected population. Women with a uterine anomaly (uterine septum, unicornuate or bicornuate uterus, uterine didelphys) are at risk for:

- PTB (preterm birth)
- Fetal presentation other than vertex
- Hemorrhage
- Retained placenta
- Kidney malformation
- Miscarriage
- Restricted fetal growth
- Unusual presentation
- Cesarean delivery
- Pregnancy-associated hypertension

Laufer, M, DeCherney, A. Congenital Uterine Anomalies: Clinical Manifestations and Diagnosis, Dec 2019.