# Advisory Board on Midwifery

## Virginia Board of Medicine

## February 7, 2020

## 10:00 a.m.

**Advisory Board on Midwifery**

Board of Medicine

Friday, February 7, 2020 @ 10:00 a.m.

9960 Mayland Drive, Suite 201, Henrico, VA

Training Room 2

**PERIMETER CENTER CONFERENCE CENTER**
**EMERGENCY EVACUATION OF BOARD AND TRAINING ROOMS**
(Script to be read at the beginning of each meeting.)

**PLEASE LISTEN TO THE FOLLOWING INSTRUCTIONS ABOUT EXITING THESE PREMISES IN THE EVENT OF AN EMERGENCY.**

In the event of a fire or other emergency requiring the evacuation of the building, alarms will sound.

When the alarms sound, leave the room immediately. Follow any instructions given by Security staff

## Training Room 2

Exit the room using one of the doors at the back of the room. (**Point**) Upon exiting the doors, turn **LEFT**. Follow the corridor to the emergency exit at the end of the hall.

Upon exiting the building, proceed straight ahead through the parking lot to the fence at the end of the lot. Wait there for further instructions.

---DRAFT UNAPPROVED---

# ADVISORY BOARD ON MIDWIFERY
## Minutes
## May 24, 2019

The Advisory Board on Midwifery met on Friday, May 24, 2019 at the Department of Health Professions, Perimeter Center; 9960 Mayland Drive, Henrico, Virginia, 23233.

| | |
|---|---|
| **MEMBERS PRESENT:** | Kim Pekin, CPM, Chair<br>Maya Gunderson, CPM<br>Natasha Jones, MSC |
| **MEMBERS ABSENT:** | Ami Keatts, M.D.<br>Mayanne Zielinski, CPM |
| **STAFF PRESENT:** | William L. Harp, M.D. Executive Director<br>Elaine Yeatts, DHP Senior Policy Analyst<br>Colanthia M. Opher, Deputy Director, Administration<br>Beulah Baptist Archer, Licensing Specialist |
| **GUESTS PRESENT:** | Rebecca Bowers-Lanier, Lobbyist |

**CALL TO ORDER**

Kim Pekin called the meeting to order at 10:13 a.m.

**EMERGENCY EGRESS PROCEDURES** – Dr. Harp announced the Emergency Egress Procedures.

**ROLL CALL** –Beulah Baptist Archer called the roll, and a quorum was declared.

**APPROVAL OF MEETING MINUTES**

Ms. Opher read the proposed amendment submitted by Mayanne Zielinski to the September 21, 2018 meeting minutes.

Ms. Zielinski request that under Periodic Review – Changes to Guidance Document 85-26, 85-27, that the language be amended to say:

Newborn Screening Results #4 Guidance Document 85-27 – Ms. Zielinski discussed an avenue by which the instructions on what screenings should be offered is disseminated to CPMs.

Maya Hawthorne Gunderson moved to approve the February 2, 2018 and the amended September 21, 2018 minutes. The motion was seconded and carried.

---DRAFT UNAPPROVED---

## ADOPTION OF THE AMENDED AGENDA

Ms. Gunderson moved to approve the amended agenda. The motion was seconded and carried.

## PUBLIC COMMENT ON AGENDA ITEMS

No public comment.

## NEW BUSINESS

1. Legislative Update – Elaine Yeatts

   Ms. Yeatts reviewed the Report of the 2019 General Assembly and provided historical background on the bills that were of interest to the members.

   Ms. Yeatts also provided a brief update on the status of the Board's emergency regulations, APA regulatory actions, and future policy actions.

   Both of these reports were for information only and did not require any action.

2. Regulation Governing the Practice of Licensed Midwives *(for reference only)*

## ANNOUNCEMENTS

Ms. Archer announced that the Board has licensed four (4) midwives since the beginning of the year.

## NEXT MEETING DATE

October 4, 2019 at 10:00 a.m.

## ADJOURNMENT

Ms. Gunderson moved to adjourn the meeting. The motion seconded and carried. The meeting adjourned at 11:10

Kim Pekin, CPM
Chair

William L. Harp, MD
Executive Director

Beulah Baptist Archer
Licensing Specialist

## Report of the 2020 General Assembly

## Advisory Board on Midwifery

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**HB 42 Health care providers; screening of patients for prenatal and postpartum depression, training.**

*Chief patron:* Samirah

*Summary as introduced:*
**Health care providers; screening of patients for prenatal and postpartum depression; training.** Directs the Boards of Medicine and Nursing to adopt regulations requiring licensees who provide primary, maternity, obstetrical, or gynecological health care services to complete a training program on prenatal and postnatal depression in women. Such training program shall include information on risk factors for and signs and symptoms of prenatal and postnatal depression, resources for the treatment and management of prenatal and postnatal depression, and steps the practitioner can take to link patients to such resources. The bill also requires the Board of Medicine to adopt regulations requiring licensees who provide primary, maternity, obstetrical, or gynecological health care services to screen all patients who are pregnant or who have been pregnant within the previous five years for prenatal or postnatal depression or other depression, as appropriate.

11/19/19 House: Prefiled and ordered printed; offered 01/08/20 20100344D
11/19/19 House: Referred to Committee on Health, Welfare and Institutions
01/13/20 House: Impact statement from DPB (HB42)
01/15/20 House: Assigned HWI sub: Health Professions

**HB 188 Health care services; payment estimates.**

*Chief patron:* Levine

*Summary as introduced:*
**Health care services; payment estimates.** Requires hospitals and practitioners licensed by the Board of Medicine to provide a patient or the representative of a patient scheduled to receive a nonemergency procedure, test, or service to be performed by the hospital or practitioner with an estimate of the payment amount for which the patient will be responsible no later than one week after the scheduling of such procedure, test, or service. Currently, only hospitals are required to provide such estimate, and such estimate is required only (i) for elective procedures, tests, or services; (ii) within three days of the procedure, test, or service; and (iii) upon request of the patient or his representative.

12/26/19 House: Prefiled and ordered printed; offered 01/08/20 20100999D
12/26/19 House: Referred to Committee on Health, Welfare and Institutions
01/22/20 House: Assigned HWI sub: Health Professions
01/22/20 House: Impact statement from DPB (HB188)

**HB 471 Health professionals; unprofessional conduct, reporting.**

*Chief patron:* Collins

*Summary as introduced:*
**Health professionals; unprofessional conduct; reporting.** Requires the chief executive officer and the chief of staff of every hospital or other health care institution in the Commonwealth, the director of every licensed home health or hospice organization, the director of every accredited home health organization exempt from licensure, the administrator of every licensed assisted living facility, and the administrator of every provider licensed by the Department of Behavioral Health and Developmental Services in the Commonwealth to report to the Department of Health Professions any information of which he may become aware in his professional capacity that he has determined, in good faith, after investigation, review, or consultation, if and as needed, with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, indicates that there is a reasonable probability that such health professional may have engaged in unethical, fraudulent, or unprofessional conduct. Current law requires information to be reported if the information indicates, after reasonable investigation and consultation with the appropriate internal boards or committees authorized to impose disciplinary action on a health professional, a reasonable probability that such health professional may have engaged in unethical, fraudulent, or unprofessional conduct.

01/21/20 House: Referred from Health, Welfare and Institutions
01/21/20 House: Referred to Committee for Courts of Justice
01/23/20 House: Assigned Courts sub: Civil
01/27/20 House: House subcommittee amendments and substitutes offered
01/27/20 House: Subcommittee recommends reporting with substitute (8-Y 0-N)

**HB 601 Administrative Process Act; review of occupational regulations.**

*Chief patron:* Freitas

*Summary as introduced:*
**Administrative Process Act; review of occupational regulations.** Creates a procedure by which a person may petition an agency to review whether an existing occupational regulation is necessary for the protection or preservation of the health, safety, and welfare of the public and meets other statutorily enumerated criteria. The bill also creates a cause of action whereby any person who is adversely affected or aggrieved by an occupational regulation that such person believes is not necessary for the protection or preservation of the health, safety, and welfare of the public or does not meet other statutorily enumerated criteria may seek judicial review of such regulation. The bill provides that the burden of proof shall be upon the party complaining of the occupational regulation to demonstrate by a preponderance of the evidence that the challenged

occupational regulation on its face or in its effect burdens the entry into or participation in an occupation and, thereafter, the burden shall be upon the agency to demonstrate by a preponderance of the evidence that the challenged occupational regulation is necessary to protect or preserve the health, safety, and welfare of the public and complies with certain other statutorily enumerated requirements. The bill provides that if the court finds in favor of the party complaining of the agency action, the court shall declare the regulation null and void.

01/06/20 House: Prefiled and ordered printed; offered 01/08/20 20100327D
01/06/20 House: Referred to Committee on General Laws
01/24/20 House: Assigned GL sub: Professions/Occupations and Adminstrative Process

**HB 650 Naloxone or other opioid antagonist; possession and administration.**

*Chief patron:* Hope

*Summary as introduced:*
**Naloxone; possession and administration.** Provides that a person who is not otherwise authorized to administer naloxone or other opioid antagonist used for overdose reversal may administer naloxone or other opioid antagonist used for overdose reversal to a person who is believed to be experiencing or about to experience a life-threatening opioid overdose, provided the administration is in good faith and absent gross negligence or willful and wanton misconduct.

01/06/20 House: Prefiled and ordered printed; offered 01/08/20 20104901D
01/06/20 House: Referred to Committee on Health, Welfare and Institutions
01/15/20 House: Assigned HWI sub: Health Professions

**HB 967 Military service members and veterans; expediting the issuance of credentials to spouses.**

*Chief patron:* Willett

*Summary as introduced:*
**Professions and occupations; expediting the issuance of credentials to spouses of military service members.** Provides for the expedited issuance of credentials to the spouses of military service members who are ordered to federal active duty under Title 10 of the United States Code if the spouse accompanies the service member to the Commonwealth or an adjoining state or the District of Columbia. Under current law, the expedited review is provided more generally for active duty members of the military who are the subject of a military transfer to the Commonwealth. The bill also authorizes a regulatory board within the Department of Professional and Occupational Regulation or the Department of Health Professions or any other board in Title 54.1 (Professions and Occupations) to waive any requirement relating to experience if the board determines that the documentation provided by the applicant supports such waiver.

01/24/20 House: Read second time
01/24/20 House: Committee substitute agreed to 20105996D-H1

01/24/20 House: Engrossed by House - committee substitute HB967H1
01/27/20 House: Read third time and passed House (98-Y 0-N)
01/27/20 House: VOTE: Passage (98-Y 0-N)

**HB 982 Professions and occupations; licensure by endorsement.**

*Chief patron:* Webert

*Summary as introduced:*
**Professions and occupations; licensure by endorsement.** Establishes criteria for an individual licensed, certified, or having work experience in another state, the District of Columbia, or any territory or possession of the United States to apply to a regulatory board within the Department of Professional and Occupational Regulation or the Department of Health Professions and be issued an occupational license or government certification if certain conditions are met.

01/07/20 House: Referred to Committee on General Laws
01/15/20 House: Assigned GL sub: Professions/Occupations and Adminstrative Process
01/23/20 House: House subcommittee amendments and substitutes offered
01/23/20 House: Subcommittee recommends reporting with substitute (7-Y 1-N)
01/27/20 House: Impact statement from DPB (HB982)

**HB 1040 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, defined in the bill as an individual, other than a doctor of medicine, osteopathy, chiropractic, or podiatry, who may diagnose, treat, and help prevent diseases using a system of practice that is based on the natural healing capacity of individuals, using physiological, psychological, or physical methods, and who may also use natural medicines, prescriptions, legend drugs, foods, herbs, or other natural remedies, including light and air.

01/07/20 House: Referred to Committee on Health, Welfare and Institutions
01/15/20 House: Assigned HWI sub: Health Professions
01/21/20 House: Impact statement from DPB (HB1040)
01/23/20 House: House subcommittee amendments and substitutes offered
01/23/20 House: Subcommittee recommends reporting with substitute (4-Y 2-N)

**HB 1147 Epinephrine; required in certain public places.**

*Chief patron:* Keam

*Summary as introduced:*
**Epinephrine required in certain public places.** Requires public places to make epinephrine

available for administration. The bill allows employees of such public places who are authorized by a prescriber and trained in the administration of epinephrine to possess and administer epinephrine to a person present in such public place believed in good faith to be having an anaphylactic reaction. The bill also provides that an employee of such public place who is authorized by a prescriber and trained in the administration of epinephrine and who administers or assists in the administration of epinephrine to a person present in the public place believed in good faith to be having an anaphylactic reaction, or is the prescriber of the epinephrine, shall not be liable for any civil damages for ordinary negligence in acts or omissions resulting from the rendering of such treatment.

01/07/20 House: Referred to Committee for Courts of Justice
01/17/20 House: Impact statement from DHCD/CLG (HB1147)
01/22/20 House: Referred from Courts of Justice
01/22/20 House: Referred to Committee on Health, Welfare and Institutions
01/24/20 House: Assigned HWI sub: Health Professions

**HB 1328 Offender medical and mental health information and records; exchange of information to facility.**

*Chief patron:* Watts

*Summary as introduced:*
**Exchange of offender medical and mental health information and records.** Provides that a health care provider who has been notified that a person to whom he has provided services is committed to a local or regional correctional facility must disclose to the person in charge of the facility any information necessary and appropriate for the continuity of care of the person committed. The bill also provides protection from civil liability for such health care provider, absent bad faith or malicious intent.

01/15/20 House: Assigned PS sub: Public Safety
01/23/20 House: Impact statement from DPB (HB1328)
01/23/20 House: Subcommittee recommends reporting with substitute (7-Y 0-N)
01/24/20 House: Reported from Public Safety with substitute (22-Y 0-N)
01/24/20 House: Committee substitute printed 20106592D-H1

**HB 1506 Pharmacists; prescribing, dispensing, and administration of controlled substances.**

*Chief patron:* Sickles

*Summary as introduced:*
**Pharmacists; prescribing, dispensing, and administration of controlled substances.** Authorizes the prescribing, dispensing, and administration of certain controlled substances by a pharmacist, provided that such pharmacist prescribes, dispenses, or administers such controlled substances in accordance with a statewide protocol developed by the Board of Pharmacy in consultation with the Board of Medicine and set forth in regulations of the Board of Pharmacy.

The bill clarifies that an accident and sickness insurance policy that provides reimbursement for a service that may be legally performed by a licensed pharmacist shall provide reimbursement for the prescribing, dispensing, or administration of controlled substances by a pharmacist when such prescribing, dispensing, or administration is in accordance with regulations of the Board of Pharmacy.

01/08/20 House: Presented and ordered printed 20105023D
01/08/20 House: Referred to Committee on Health, Welfare and Institutions
01/15/20 House: Assigned HWI sub: Health Professions

**HB 1649 Health care; decision making, end of life, penalties.**

*Chief patron:* Kory

*Summary as introduced:*
**Health care; decision making; end of life; penalties.** Allows an adult diagnosed with a terminal condition to request and an attending health care provider to prescribe a self-administered controlled substance for the purpose of ending the patient's life in a humane and dignified manner. The bill requires that a patient's request for a self-administered controlled substance to end his life must be given orally on two occasions and in writing, signed by the patient and one witness, and that the patient be given an express opportunity to rescind his request at any time. The bill makes it a Class 2 felony (i) to willfully and deliberately alter, forge, conceal, or destroy a patient's request, or rescission of request, for a self-administered controlled substance to end his life with the intent and effect of causing the patient's death; (ii) to coerce, intimidate, or exert undue influence on a patient to request a self-administered controlled substance for the purpose of ending his life or to destroy the patient's rescission of such request with the intent and effect of causing the patient's death; or (iii) to coerce, intimidate, or exert undue influence on a patient to forgo a self-administered controlled substance for the purpose of ending the patient's life. The bill also grants immunity from civil or criminal liability and professional disciplinary action to any person who complies with the provisions of the bill and allows health care providers to refuse to participate in the provision of a self-administered controlled substance to a patient for the purpose of ending the patient's life.

01/16/20 House: Presented and ordered printed 20104784D
01/16/20 House: Referred to Committee for Courts of Justice
01/23/20 House: Impact statement from VCSC (HB1649)
01/28/20 House: Impact statement from DPB (HB1649)

**HB 1683 Diagnostic medical sonography; definition, certification.**

*Chief patron:* Hope

*Summary as introduced:*
**Diagnostic medical sonography; certification.** Defines the practice of "diagnostic medical sonography" as the use of specialized equipment to direct high-frequency sound waves into an area of the human body to generate an image. The bill provides that only a certified and

registered sonographer may hold himself out as qualified to perform diagnostic medical sonography. The bill requires any person who fails to maintain current certification and registration or is subject to revocation or suspension of a certification and registration by a sonography certification organization to notify his employer and cease using ultrasound equipment or performing a diagnostic medical sonography or related procedure.

01/17/20 House: Presented and ordered printed 20105638D
01/17/20 House: Referred to Committee on Health, Welfare and Institutions
01/22/20 House: Assigned HWI sub: Health Professions

Guidance document: 85-10 Revised: October 22, 2015

# 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 risks 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 risks 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, click on the link in the index below. The midwife may then print the form for that condition or risk 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

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

## 1. 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

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**

Complications[3] 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.

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[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. Arbour. "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 frequency[6] of:

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

**Suspected placental previa**

Pregnancies complicated with placenta previa had significantly higher rates[7] 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

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[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

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[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 system[12]
- 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 exhausted[13]
- 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 result[14]

**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

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[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

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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

## 2. 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***

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**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

Guidance document: 85-10 Revised: October 22, 2015

## 3. ACTIVE CANCER

**Preamble:**

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**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

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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 _____

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

## 4. ACUTE OR CHRONIC THROMBOPHLEBITIS

**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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**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**
- **Hypercoaguable 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:**

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

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife 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 _____

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

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

**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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**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.

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 _____

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.

## 6. 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 Sruveilannce . *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.

## 7. BLOOD COAGULATION DEFECT

**Preamble:**

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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.

## 8. 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.

- 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.

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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## 9. 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.

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 _____

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

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.

Guidance document: 85-10 Revised: October 22, 2015

## 10. CHRONIC OBSTRUCTIVE PULMONARY DISEASE INCLUDING ASTHMA (1)

**Preamble:**

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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

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.glowm.com/section_view/heading/Pulmonary%20Disease%20in%20Pregnancy/item/170#1199

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.

Guidance document: 85-10 Revised: October 22, 2015

## 11. ECTOPIC PREGNANCY (1)

**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.

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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

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.webmd.boots.com/pregnancy/tc/ectopic-pregnancy-complications-of-ectopic-pregnancy

## 12. ESSENTIAL CHRONIC HYPERTENSION (1)

**Preamble:**

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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

Guidance document: 85-10 Revised: October 22, 2015

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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 _____

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

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.

## 13. GENITAL HERPES OR PARTNER WITH GENITAL HERPES

**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***

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**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:**

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[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, microphtalmia),
- 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, encephalomacia),
- 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

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 _____

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

## 14. HISTORY OF HEMOGLOBINOPATHIES

**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***

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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

- 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

## 15. 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.

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 _____

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

[23] http://www.cdc.gov/hiv/risk/gender/pregnantwomen/index.html

Guidance document: 85-10 Revised: October 22, 2015

**Preamble:**

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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.

  - 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.

As required by the regulations for her practice as a Virginia Licensed Midwife, my midwife 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 _____

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

**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***).

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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 Gestation 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

- 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.

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 _____

## 18. INCOMPLETE SPONTANEOUS ABORTION OR INCOMPLETE MISCARRIAGE (10)

**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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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

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.

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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

(10)http://www.acog.org/Resources_And_Publications/Patient_Education_Pamphlets/Files/Early_Pregnancy_Loss

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.

## 19. 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.

Guidance document: 85-10 Revised: October 22, 2015

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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 _____

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.

## 20. MULTIPLE GESTATION

**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.

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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

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.

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

**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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**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

Guidance document: 85-10 Revised: October 22, 2015

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

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 _____

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.

## 22. 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.

- 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

## 23. 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

- 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

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.

## 24. PRE-ECLAMPSIA/ECLAMPSIA

**Preamble:**

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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

American College of Obstetricians and Gynecologists. (2011). *Frequently Aksed 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.

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

**Preamble:**

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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

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

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 _____

Hilder, C. T. (1998). Prolonged Pregnancy: evaluating gestation-specific risks of fetal and infact 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 Sruveilannce . *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.

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

**Preamble:**

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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

- 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

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 _____

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

## 27. 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.

Guidance document: 85-10 Revised: October 22, 2015

Works Cited

Sinclair, C. (2004) A Midwife's Handbook St. Louis, MO: Saunders

Vesga-Lopez O, B.C. (2008) *Psychiatric Disorders in Pregnant and Postpartum Women in the United States,* Archives of General Psychiatry, 65(7) 805-815

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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 _____

## 28. 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

- maternal death

FETAL COMPLICATIONS

- fetal death
- neonatal sepsis

NEONATAL COMPLICATIONS

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

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 _____

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

(7) http://www.nejm.org/doi/full/10.1056/NEJM199611143352013

Guidance document: 85-10 Revised: October 22, 2015

## 29. 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

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 _____

Best practice guidelines for the management of women with epilepsy. Crawford, P., Epilepsia. 2005:46 Suppl 9:117-24.
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.
Management of epilepsy during pregnancy. Battino D., Tomson T. Drugs, 2007:67(18):2727-46.

Guidance document: 85-10 Revised: October 22, 2015

## 30. SEVERE LIVER DISEASE -- ACTIVE OR CHRONIC

**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.

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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.

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 _____

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.

Guidance document: 85-10 Revised: October 22, 2015

## 31. SEVERE RENAL DISEASE -- ACTIVE OR CHRONIC

**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.

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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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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.

Guidance document: 85-10 Revised: October 22, 2015

☐ 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.

## 32. SIGNIFICANT 2ND OR 3RD TRIMESTER BLEEDING

**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.

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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

- Premature Birth
- Anemia
- Hypovolemic Shock
- Stillbirth

American College of Obstetricians and Gynecologists. (2011).*Frequently Asked Questions in Pregnancy: Bleeding During Pregnancy.* ACOG.
Karim, S. e. (1998). Effects of first and second trimester vaginal bleeding on pregnancy outcome.". *JPMA* .
Nielson, E. M. (1991). The Outcome of Prengancies complicated by bleeding during the second trimester. *Surgery, Gynecology, & Obstetrics* .
Oylese, Y. (2010). Third Trimester Bleeding. *Protocols for High Risk Pregnancies* .

## 33. SIGNIFICANT GLUCOSE INTOLERANCE (PREEXISTING DIABETES, GESTATIONAL DIABETES, PCOS)

**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.

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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:

  - hypertensive disorders
  - large for gestational age babies
  - stillbirth
  - abnormal progression of labor
  - cesarean delivery
  - 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
  - hypoglycemia
  - hyperbilirubinemia
  - 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

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 _____

Pre-gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 60, March 2005.
Gestational Diabetes Mellitus. American College of Obstetricians and Gynecologists, Practice Bulletin 137, August 2013.
Landon MB, Gabbe SG. Gestational Diabetes Mellitus. Obstet Gynecol 2011;118:1379-93.

## 34. UNCONTROLLED HYPERTHYROIDISM

**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.

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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

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 _____

(1)http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_--_Obstetrics/Thyroid_Disease_in_Pregnancy

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.

Guidance document: 85-10 Revised: October 22, 2015

## 35. Uterine Ablation (Endometrial ablation)

**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 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 acreta
- Manual/Surgical removal of placenta
- Hemorrhage
- Uterine rupture
- C-Section
- Hysterectomy
- Death

**Fetal Risks:**

- Prematurity
- Death
- Possible increase in anomalies

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 _____

American College of Obstetricians and Gynecologists. (2013).*Frequently Asked Questions: Special Procedures: Endometrial Ablation.* ACOG.
Jenny, S. L. (2006). Pregnancy after endometrial ablation: English literature review and case report . *The Journal of Minimally Invasive Gynecology , 13* (2), 88-91.
Laberge P. (2008, Oct). Serious and deadly complications from pregnancy after endometrail ablation reports and review of the literature. *J Gynecology Obstertics Biological Reproduction (Paris)* .

Guidance document: 85-10 Revised: October 22, 2015

## 36. UTERINE ANOMALY

**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.

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**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.

# Workgroup on Midwifery and Medications

Board of Medicine
Friday, December 3, 2010, 9:00 a.m.
9960 Mayland Drive, Suite 201
Board Room 4
Richmond, Virginia

---FINAL APPROVED---

# VIRGINIA BOARD OF MEDICINE
## Workgroup on Midwifery and Medications

Friday, December 3, 2010 Department of Health Professions Richmond, VA

**CALL TO ORDER:** The meeting convened at 9:10 a.m.

**MEMBERS PRESENT:**
Karen Ransone, MD, Chair
Deren Bader, CPM, DrPH
Samuel Bartle, MD
Jessica Jordan, CNM
Jane Maddux
Jane Piness, MD
Brynne Potter, CPM

**MEMBERS ABSENT:**

**STAFF PRESENT:**
William L. Harp, MD, Executive Director
Ola Powers, Deputy Executive Director, Licensing
Colanthia Morton Opher, Operations Manager
Beulah Archer, Licensing Specialist
Elaine Yeatts, DHP Policy Analyst

**OTHERS PRESENT:**
Kim Mosny, CPM
Maria Cranford
Marinda Shindler, CMA
Glenda Turner, CMA
Degra Nofsinger, CMA
Ann Hughes, MSV
Peggy Franklin, VSTM
Trinlie Wood
Jennifer Derugen, CMA
Terri Hewitt, CMA
Melanie Gerheart, ACOG

**EMERGENCY EGRESS INSTRUCTIONS**

Dr. Ransone gave verbal emergency egress instructions.

**ROLL CALL**

A quorum was declared.

---FINAL APPROVED---

## INTRODUCTION OF COMMITTEE MEMBERS

The Committee members introduced themselves and spoke to their experience and interest in the charge of the Committee.

## ADOPTION OF THE AGENDA

Dr. Piness moved to adopt the agenda as presented.

## PUBLIC COMMENT

Dr. Ransone acknowledged the public and opened the floor for public comment.

Kim Mosny – spoke in favor of midwives having some type of authority for medications. She would like to see the Committee go beyond whether or not midwives should be able to carry drugs to the practical ways to achieve this.

Maria Cranford – spoke in favor of midwives' ability to possess and administer certain medications.

Degra Nofsinger - spoke in favor of midwives possessing and administering certain medications.

Anne Hughes, representing the Medical Society of Virginia (MSV), stated that MSV was opposed to granting this authority to the midwifery profession until certain issues could be addressed. Ms. Hughes stated that other key elements, such as a relationship between midwife and physician should be taken into consideration, and that authority should not be granted based solely on what other states are doing. Ms. Hughes stated that 2005 was the last time MSV and the midwifery profession had collaborated.

Ms. Potter remarked that since achieving licensure in 2005, the midwifery profession has chosen to work within the processes of the Board of Medicine for any regulatory or statutory changes it believes would be advantageous to midwifery and the citizens of the Commonwealth.

### Charge of the Committee

Dr. Ransone stated that the charge of the Committee was to develop a recommendation that addresses whether the midwifery profession should possess and administer drugs, provide a proposed list of those drugs, and also the mechanism for obtaining this goal. This recommendation would be presented at the Full Board business meeting, February 17, 2011.

### History of Midwifery and Medication in Commonwealth

Ms. Potter provided the Committee with a detailed overview of the current midwifery education and training model; highlighting the distinctions between CPM's and CNM's.

---FINAL APPROVED---

She noted that CNM's have a broader scope of practice, but they do not specialize in out-of-hospital births.

Ms. Potter then fielded questions regarding the pass/fail rate on the North American Registry of Midwives written examination for certification, and the approximate number of live home births and stillborns delivered by CPM's in Virginia over the last five years. Ms. Potter advised that there is no way to accurately account for home births prior to May 2009, since the activity had not been properly captured by the current system of records. She also advised that an accurate account of adverse outcomes was not available. Outcome reviews are currently performed by hospitals; there is no similar review process for CPMs.

The Committee then reviewed and discussed the letter of support from Blue Ridge Emergency Medical Services Council, Inc. Dr. Bartle addressed a few of the comments regarding the low numbers of ALS providers in rural areas. He advised that in the city where training is available, the chances are greater that a level 3 paramedic would be manning an EMS vehicle. EMS providers in rural areas are usually volunteers. Dr. Bartle noted that limited financial resources and limited space on EMS vehicles are also reasons EMS does not carry a vast array of medications.

Dr. Piness stated that the sound bite of this situation is that the hospital and the receiving practitioner/CNM incur significant liability in assuming care from a CPM in emergent situations. CPM's are not required to carry liability insurance, as the physicians on hospital staffs must. She acknowledged that CPM's may have difficulty finding collaborating physicians, given the current situation.

**Midwifery and Other Jurisdictions**

Ms. Potter reported that 24 states have law that recognizes CPMs, however, only 21 grant CPM's authority to carry and administer certain medications. It was noted that Virginia is the only state in which the midwifery profession is licensed by the Board of Medicine. It was also noted that Virginia does not have specific prohibitions on the types of pregnancies CPM's can attempt to deliver.

**Safety and Efficacy Issues:**

Dr. Bader reviewed the handout she prepared on the safety and efficacy of IM Pitocin administered by CPM's at home births. She indicated that the data is limited and somewhat frustrating. She advised that there are no studies that address the frequency of post-partum hemorrhage, but stated that the drug pitocin is commonly used to control or prevent hemorrhage in hospital settings.

Dr. Bader stated that in these instances a CPM would want to avoid transfer of care; however, she did not agree with the statement that hospital births are safer than out-of-hospital births.

---FINAL APPROVED---

Ms. Jordan informed the Committee that she works at a family maternity center on the Northern Neck, and that the closest hospital with a maternity unit is 1.5 hours away. She said transport to the hospital would not be pursued unless the patient continues to hemorrhage after a stabilization attempt with meds at the center.

Dr. Harp reported on his attempts to gather information on midwives and medication and stated that the data was minimal at best. He had spoken at length with the Texas licensing board and had reviewed their disciplinary Orders. There were no Orders that described problems patients had with medications administered by CPM's, but rather that CPM's had given medications without the proper supervision of a physician in accordance with state law.

Dr. Bader noted that during her information gathering, she did not find any disciplinary cases associated with midwifery and medication.

Ms. Potter suggested that the Committee move forward and explore options that would clarify for the Committee as to whether practice of midwifery, in Virginia, would be safer with or without medications.

The Committee agreed that in order to move forward, there needs to be more information and data presented on the issue.

Ms. Jordan suggested that the medication issue should be the focus of the next meeting and that the other issues (protocol, emergency transfer, etc.) can be addressed as they come up.

Ms. Potter moved that another meeting be set to identify areas of concern and develop a plan for legislative change that will increase safety and access to necessary medications or home-birthing women and their newborns. The motion was seconded and carried unanimously.

With no other business to conduct, the meeting adjourned at 11:20 p.m.

Karen Ransone, MD, Chair

William L. Harp, M.D.
Executive Director

Colanthia M. Opher
Recording Secretary

# Workgroup on Midwifery and Medications

Board of Medicine
Friday, February 4, 2011, 9:00 a.m.
9960 Mayland Drive, Suite 201
Board Room 1
Richmond, Virginia

--- FINAL APPROVED ---

# VIRGINIA BOARD OF MEDICINE
## Workgroup on Midwifery and Medications

Friday, February 4, 2011 Department of Health Professions Richmond, VA

**CALL TO ORDER:** The meeting convened at 9:43 a.m.

**MEMBERS PRESENT:**
Karen Ransone, MD, Chair
Sam Bartle, MD
Jessica Jordan, CNM
Jane Piness, MD
Brynne Potter, CPM

**MEMBERS ABSENT:**
Deren Bader, CPM, DrPH
Jane Maddux

**STAFF PRESENT:**
William L. Harp, MD, Executive Director
Ola Powers, Deputy Executive Director, Licensing
Colanthia Morton Opher, Operations Manager
Elaine Yeatts, DHP Policy Analyst

**OTHERS PRESENT:**
Kim Mosny, CPM, CMA
Jen Chendea
Michelle Stille
Kerri Park
Maria Cranford, CMA
Meredith Anderson, CMA
Gina Bass
Samantha Kiser
Sara Krivanec
Jason Ford
Peggy Franklin
Leah Paul, CMA
Misty Ward, CMA
Ashley Larsen
Kimberly Smith, RN
Kate McKinney
Peggy Byler, CPM, CMA
Kiera Wells
Tara Thessen
Pamela Pilch
Collin Wood
Becky Banks
JoAnne Lind
Adrienne Ownby

--- FINAL APPROVED ---

Glenda Turner
Marinda Shindler
Trinlie Wood
Freeda Cathcart
Becky Bowers-Lanier
Nicole Linh-Tu
Melanie Gerheart, ACOG
Ann Hughes, MSV

**EMERGENCY EGRESS INSTRUCTIONS**

Dr. Ransone gave verbal emergency egress instructions.

**ROLL CALL**

A quorum was declared.

**ADOPTION OF THE AGENDA**

Dr. Piness moved to adopt the agenda as presented.

Dr. Harp informed the Work Group that the Advisory Board on Midwifery respectfully requested that Leslie Payne be allowed to substitute as a voting member of the Work Group in Dr. Bader's absence.

After discussion, the Work Group voted 3-2 that Ms. Payne would be invited to participate if needed.

**PUBLIC COMMENT**

Dr. Ransone acknowledged the public and opened the floor for public comment.

Ms. Mosny – spoke in favor of midwives being able to carry standard medications.

Jin Chendea – spoke in favor of midwives being able to carry standard medications.

Michelle Stillie - spoke in favor of midwives being able to carry standard medications.

Kerri Park - spoke in favor of midwives being able to carry certain medications.

Mary Anderson_ - spoke in favor of midwives being able to carry certain medications.

Gina Bass - spoke in favor of midwives being able to carry certain medications.

Freda Cathcart – citizen member of the Advisory Board on Midwifery requested that the Work Group invite a consumer to be on the panel as a voting member. Ms. Cathcart

stated that, based on the minutes from the previous meeting, the question should not be whether or not midwives should be granted the privilege to possess and administer certain drugs, but how it can be accomplished.

Dr. Ransone asked for a show of hands of all in support of midwives having access to medication. She then asked if anyone wished to speak in opposition to midwives having access to medication.

Ann Hughes, speaking on behalf of the Medical Society of Virginia, reminded the Work Group that through the seven years of testimony that resulted in licensure, the response the midwifery profession had to the language that prohibited them from possessing medications was that they were perfectly safe to practice without medications.

Melanie Gerheart – spoke in opposition to the granting of this authority.

The floor was then closed for public comment.

**Midwifery Practice in Virginia**

Ms. Potter gave a PowerPoint presentation that provided an outline on the relationship of midwifery and medication. It also covered the history and culture of midwives and medication, challenges with collaboration, and models for consultation. In addition, she distributed a book authored by Christa Craven entitled Pushing for Midwives, which chronicles the efforts for licensure of midwives in Virginia.

Ms. Potter provided the Work Group with the available data for 2010 home births including the available statistics on transfer of care in emergent situations.

Ms. Potter briefly highlighted other clinical controversies: VBACs, vaginal breeches, twin births, and elective induction. She stated that liability concerns impact the care of women with complicated clinical situations. Perceived pressure pushes some clinicians and systems of care to make decisions with the primary aim of avoiding liability rather than supporting a healthy childbirth and honoring women's informed choices.

Ms. Potter offered the following options for the Work Group's discussion and consideration:

Option 1: Prescriber Relationship
Option 2: Controlled Substance Registration
Option 3: The Colorado Model – Limited Prescriptive Authority
Option 4: Do Nothing – Status Quo

After the presentation, the following issues/concerns were discussed:

Transfer by private vehicles versus EMS

The Work Group agreed that use of a private vehicle delays necessary care especially with distance being an issue, since care begins when EMS arrives. Ms. Potter responded by saying that it has not been encouraging to use EMS, and that the difficulties with this issue have been brought to the attention of the Board.

The American College of Obstetricians and Gynecologists Issues Opinion on Planned Home Births (ACOG)

Dr. Piness provided a copy of ACOG's statement, released January 20, 2011 in which it states "Although the College does not support planned home births given the published medical data, it emphasizes that women who decide to deliver at home should be offered standard components of prenatal care, including Group B Strep screening and treatment, genetic screening, and HIV screening. Dr. Piness pointed out that this part of the published opinion did not address the use of medications. She added that ACOG has a stronger definition of "low-risk" than the Board has come up with in the past.

Ms. Potter noted that the opinion supports the cultural divide, and she contests it.

Pharmacology Training

Dr. Piness stated that currently the professions granted prescribing authority in Virginia are required to complete 1 year face-to-face pharmacology training. Those professions include MDs, DOs, PAs, and NPs; the current CPM educational model does not meet this standard. In addition to the unease she expressed about the liability aspect of transfers, she was very concerned about granting access to medications that have multiple purposes and could cause an unintended outcome.

Members of the Work Group also expressed some concern about the storage of drugs and the disposal of unused drugs. The latter was a huge concern since there is a known illegal market for misoprostol.

The Work Group went on to discuss some issues addressed in Ms. Potter's presentation and concluded that the following issues are those that need to be addressed:

- Education required for prescriptive authority
- Continuing education relative to medications
- Care for the infant after birth
- Liability for all providers incurred with providing services
- Recordkeeping guidelines

Dr. Harp addressed the comments from both sides of the issue. He said there are three main issues inherent in the discussion: medication, supervision, and high risk conditions of pregnancy. An additional issue may be the impediment that liability represents. The supervision issue cannot be solved by this Work Group, and neither

can the issue of liability, since the governing law is Section 8.01 of the Code of Virginia. The two remaining issues are medications and high-risk conditions. Some may think even if midwives have medications, it will not change the outcome of the high-risk deliveries; some may think that midwives with medications may take on more high-risk patients than they do presently. The decision as to whether or not midwives should be granted the authority should be driven by data, and should take into consideration the risks to the public, not the risk to practitioners.

Dr. Harp advised that the Virginia Board of Medicine did not have a lot of data available on the use of medications by midwives, since midwives cannot use meds. What information the Board did find from other states indicated that midwives had not been disciplined because of a standard of care misuse of medications. There had been issues of the use of medication without invoking required physician supervision. He noted that in the few years that Virginia has been licensing midwives, the disciplinary hearings have not involved medications, but rather the decisions to attempt home birth with high-risk pregnancies. The Board understands the complex issues of a mother's right to choose but, the real question comes down to will medications make midwifery practice safer or not.

Ms. Yeatts walked through each of the options presented in Ms. Potter's presentation. She said that the entire regulatory context should be considered as the Work Group moves forward. She pointed out that it is rare to find a state that has zero requirements for collaboration, referral and treatment of high-risk patients. Virginia is the only one that has such a wide-open scope of practice, and it is difficult to look at it in isolation because there are states in which access to medications is integral to the other practice parameters, such as supervision and limits on high-risk home birthing. She advised that the options all seem doable but she is not sure that having a controlled substance registration is the way to go. She said that the Board of Pharmacy may be highly uncomfortable with issuing a registration without the licensee having a safe place for storage and inspection. She pointed out that the midwifery community always has the option to approach your legislators to introduce legislation for 2012 Session of the General Assembly.

In response, Ms. Potter stated that in trying to positively affect the cultural divide between the physicians and CPM's, the preferred course would be to work cooperatively with the Board of Medicine rather than to seek legislative change.

After further discussion, Dr. Piness moved that a meeting be convened prior to the June full Board meeting. Information that should be reviewed at that meeting includes education necessary for access/administration of medications, protocols for the use of medications, recordkeeping, and Board of Pharmacy issues (storage, inspection, wastage).

With no other business to conduct, the meeting adjourned at 12:38 p.m.

--- FINAL APPROVED ---

Karen Ransone, MD, Chair

William L. Harp, M.D.
Executive Director

Colanthia M. Opher
Recording Secretary

# Workgroup on Midwifery and Medications

Board of Medicine
Thursday, May 5, 2011, 10:00 a.m.
9960 Mayland Drive, Suite 201
Board Room 3
Richmond, Virginia

--- FINAL APPROVED ---

# VIRGINIA BOARD OF MEDICINE
## Workgroup on Midwifery and Medications

Thursday, May 5, 2011 Department of Health Professions Richmond, VA

**CALL TO ORDER:** The meeting convened at 10:25 a.m.

**MEMBERS PRESENT:**
Karen Ransone, MD, Chair
Jessica Jordan, CNM
Jane Piness, MD
Brynne Potter, CPM

**MEMBERS ABSENT:**
Samuel Bartle, MD
Jane Maddux

**STAFF PRESENT:**
William L. Harp, MD, Executive Director
Colanthia Morton Opher, Operations Manager
Elaine Yeatts, DHP Policy Analyst
Dianne Reynolds-Cane, MD, DHP Director
Arne Owens, DHP, Chief Deputy

**OTHERS PRESENT:**
Becky Bowers-Lanier, CMA
Ann Hughes, MSV
Degra Nofsinger, CPM, CMA
Marinda Shindler, CMA
Glinda Turner, CMA
Sara Krivanec
Kim Mosny, CPM, CMA
Leslie Payne, CPM
Pamela Pilch, JD, LCLE
Melanie Gerheart, ACOG

## EMERGENCY EGRESS INSTRUCTIONS

Dr. Ransone gave verbal emergency egress instructions.

## ROLL CALL

A quorum was declared.

## ADOPTION OF THE AGENDA

Dr. Piness moved to adopt the agenda as presented. The motion was seconded and carried unanimously.

--- FINAL APPROVED ---

## PUBLIC COMMENT

Dr. Ransone acknowledged the public and opened the floor for public comment.

Ann Hughes, speaking on behalf of the Medical Society of Virginia, advised that this issue was discussed by MSV's Executive Committee. MSV's chief concern was that of adequate training in pharmacology for health care providers that would be given access to medications.

Melanie Gerheart, representing the Virginia Section of the American College of Obstetrics and Gynecology, advised that the Section shared MSV's concern.

There were no other comments. The floor was then closed for public comment.

## Midwifery Practice in Virginia

Ms. Potter began her presentation with an overview of the discussion that occurred at the February 2011 meeting of the Workgroup.

She distinguished the main issues discussed as those directly related to medication and those indirectly related to the medication issue.

Ms. Potter suggested two goals for this meeting: 1) the development of a recommendation to the Full Board for further work on guidance documents addressing risk analysis and informed consent by CPM's drawing upon resources from both ACOG and NARM, and 2) a full address of the lack of access to medications.

## Access to Medications

Ms. Potter highlighted several benefits of midwives being dually regulated by the Virginia Department of Health (VDH) and the Board of Medicine.

She noted that VDH has a history with permitted and "granny" midwives as well as available transport for emergencies with EMS. Ms. Potter proposed that VDH could facilitate relationships at the community level between midwives and the public health structures, collect data on the use of medication by midwives, and serve as a bridge builder among provider systems to optimize public safety.

Ms. Potter also suggested that VDH establish a formulary and protocol for administration, storage, and disposal of medications, that VDH grant access to certain medications to a midwife that presents proof of licensure and any additional training requirements, that VDH hold quarterly meetings with qualified CPM's to submit reports and obtain supplies, and that VDH serve as the repository for medication usage forms for possible investigation or review by the Board of Medicine.

--- FINAL APPROVED ---

Becky Bowers-Lanier with CMA indicated that this matter had been presented to Dr. Remley at VDH.

Ms. Yeatts stated that the ability to have a profession governed by two agencies is not an option nor is it feasible, plus there is no statutory requirement for VDH to adopt such a regulatory structure. She asked if consideration had been given to moving the midwifery licensing statutes in Title 54.1 to VDH's Title 32.1, thereby giving VDH complete jurisdiction over the profession.

Ms. Potter advised that the option for VDH to regulate the midwifery profession had been historically pursued at the General Assembly, but the consensus was that health care providers belonged at the Department of Health Professions.

Ms. Potter then presented a newborn and maternal medication protocol. She indicated that in NARM's job description there are no specific training requirements. However, Ms. Potter did provide, as an example, medication training based on the curriculum required by the Oregon Health Licensing Agency.

Ms. Potter proposed that, if allowed access, midwives be required to maintain an inventory of the medications for three years with predetermined information including but not limited to the name of the drug, the client to which is was administered, and the date and place of disposal. She stated that the records would be kept on business premises and available for inspection upon request by VDH or the Board of Medicine.

Ms. Potter noted that the mechanics to reach this goal would be to amend the following:

§ 54.1-2957.9. Regulation of the practice of midwifery.

The Board shall adopt regulations governing the practice of midwifery, upon consultation with the Advisory Board on Midwifery. The regulations shall (i) address the requirements for licensure to practice midwifery, including the establishment of standards of care, (ii) be consistent with the North American Registry of Midwives' current job description for the profession and the National Association of Certified Professional Midwives' standards of practice, ~~except that prescriptive authority~~ and (iii) - *shall provide for licensed midwives to possess and administer certain controlled substances pursuant to a standing protocol issued by the Commissioner of Health or his designee, according to 54.1-3408 and 32.1…*

Ms. Potter emphasized that this language would not be giving midwives prescriptive authority.

§ 54.1-3408. Professional use by practitioners

§54.1-3408. ___ Pursuant to a standing protocol issued by the Commissioner and in accordance with policies and guidelines established by the Board of Health pursuant to [32.1___], the Commissioner shall authorize midwives licensed under §54.1-2957.9 who

have received training in the use of standard newborn and obstetric medications (including emergency medications) to possess and administer those controlled substances, according to the protocol.

§32.1 ____. The Commissioner shall issue a standard protocol, and the Department shall issue policies and guidelines governing the possession and administration of certain standard newborn and obstetric medications (including emergency medications) by midwives licensed under §54.1-2957.9. The policies, protocols and procedures shall include such requirements as may be necessary to ensure midwife competency, which may include continuing education and/or testing.

Ms. Potter concluded her presentation by asking the Workgroup to consider the following options:

- The Workgroup recommend to the Full Board a change to the CPM scope of practice regarding medications via the proposed mechanisms, with possible amendments after further consultation with VDH representatives.

- The Workgroup recommend to the Full Board that this or another Workgroup continue to meet to address possible regulatory changes that reflect clarification of issues related to risk assessment, consultation, and informed consent.

- Or, do nothing at this time.

Dr. Piness complimented Ms. Potter on her presentation, but stated that the issue of midwives and medication is not a simple, straightforward one.

Dr. Piness expressed concern with regard to written protocols, pointing out that they do not take the place professional judgment, but at the same time, imply that there is no need for it *[professional judgment]*. She reiterated her concern regarding high-risk pregnancies and indicated that NARM does not provide definitions that distinguish "low risk" from "high risk" pregnancies. Another one of her concerns is that with access to medication by midwives, there might be a delay in an infant's visit to his/her own health care provider.

Ms. Yeatts noted that there is a reluctance to assign risk levels. In Oregon there is a list of absolute risks, and if the mother fits into one of the absolute risk categories, midwives are not allowed to perform the delivery at home. Comparing Oregon's scope to Virginia's is like apples and oranges. In Virginia there is no statutory or regulatory prohibition regarding clients that a midwife might serve. Under ideal circumstances, medications in a low risk client would probably have a favorable outcome. With a high risk situation, that may not be the case.

After a brief recess, the meeting reconvened.

--- FINAL APPROVED ---

Dr. Ransone asked "where to go from here". After, some discussion, the Workgroup agreed that the VDH option is probably not viable.

Ms. Potter offered the option of limited prescriptive authority. She asked that authority be granted under the Board of Medicine with the midwife bearing all liability as long as there was adequate pharmacology training to everyone's comfort level.

Dr. Bader advised that the Shenandoah University Nurse Midwife curriculum offers a semester pharmacology course that is accredited by the American College of Nurse Midwives Accreditation Commission for Midwifery Education. She advised that CMA had approached Shenandoah and was told that a pharmacology training program suitable for midwives could be developed.

Dr. Ransone advised that she did not think that the recommendations presented by Ms. Potter today would be accepted by the Full Board without some consideration of the high risk issue.

The Workgroup requested that Ms. Potter and Dr. Bader gather additional data that could inform the Board about the demographics of midwifery clients in Virginia, as well as anecdotal data regarding cases in which medications would have been beneficial.

Dr Harp and Dr. Bader will seek to identify states that are similarly situated to Virginia in which midwives have some authority with medications to learn of problems that have occurred. The goal would be to have two states join the Workgroup by conference call.

Dr. Harp praised the Workgroup for what it has accomplished to date and encouraged Ms. Potter and Dr. Bader stay the course. He suggested the next meeting might be time to include a representative from the Board of Pharmacy in the Workgroup's discussion.

The Workgroup requested that the next meeting not take place before the fall.

With no other business to conduct, the meeting adjourned at 12:38 p.m.

Karen Ransone, MD, Chair

William L. Harp, M.D.
Executive Director

Colanthia M. Opher
Recording Secretary

# Discuss Procedures for Stillbirth Deaths At Home or in a Birth Center.