California College of Midwives

State chapter ~ American College of Community Midwives

Section One

MODERATE-RISK LABOR & BIRTH ~ Protocols & Criteria for Midwives providing domiciliary birth services in "**Special Circumstances"**

Special circumstances of pregnancy or parturition require special training, special skills and special preparation on the part of the licensed midwife, as well as a willingness by the midwife to take on potentially complicated or litigious legal consequences. It also requires special arrangements and a special informed consent or decline of standard care waiver from the client and her family and a similar willingness on the part of the client's to expose herself to potential complications of unknown severity and the legal consequences of an unpopular choice.

In a perfect world, neither the client nor the midwife would have to make these difficult choices. In the mother-friendly Dutch system, this kind of situation would be resolved by what is called a "relocated home birth", that is, routine physiological management by midwives in a low-tech hospital environment, with immediate access to obstetrical care and surgery. In this integrated system, mothers and babies get the "best of both worlds."

Unfortunately our obstetrical system does not provide this same opportunity due to fear of lawsuits. In the US, doctors and hospital do not offer or even permit the childbearing women to choose physiological management in certain moderate risk situations. At present pregnant women with moderate risk factors are frequently forced to decide between multiple unwanted medical interventions and/or physiologically unnecessary Cesarean surgery *or* to labor at home unattended. However, childbearing women and their unborn or newborn babies are always safer with an experienced professional present than they would be giving birth unattended.

Risk vs. Complication: The *Licensed Midwifery Practice Act of 1993* prohibits providing care to childbearing women with any significant medical *complication*. However, the LMPA is silent about the topic of "*risk*." The scope of practice for California midwives legally defines midwives as being authorized to attend "normal childbirth."

Normal Birth Defined: The term 'normal', as used in the LMPA and the both previous California statutes relative to midwifery, equates with a natural or spontaneous birth process, that is, one *not* requiring the use of any "artificial, forcible or mechanical means." Thus 'normal' would encompass all spontaneous physiological processes characteristic of healthy reproductive biology in healthy childbearing women that can reasonably be expected to lead to normal healthy conclusions.

Criteria for Moderate Risk Circumstances: When client and midwife both agree that the risk-benefit ratio is acceptable, the following criteria must *also* be satisfied in order for the Midwife to provide domiciliary birth services to women with moderate risk circumstances:

Criteria for the Midwife: (per OAL decision by Judge Roman)

1. Must have attended at least 75 births as the primary midwife following licensure
2. Must have advanced training that clearly identifies her experience, skills and comfort to represent an elevated level of professional ability well beyond "entry -level" midwifery
3. Must be current in neonatal resuscitation and have training and skills in emergency or “first-responder” abilities for mother and baby, such as the ALSO (Advanced Life Support in Obstetrics) or equivalent
4. Must have advanced experience via attendance of moderate risk labors at home, hospital or a birth center, with supervised hands-on experience in the specific circumstance that applies to the specific client
5. "Special Circumstances // Moderate-Risk Informed Consent Waiver of Standard Midwifery Advice” must be read, agreed to, signed by the client and retained in the client’s chart a (see samples of Informed Consent/Special Circumstances Decline of Standard Care waivers)

Criteria for the Client:

A. Normal pregnancy with reasonable expectation of the normal birth of a healthy baby:

1. ‘Normal’ is functionally defined as a healthy pregnancy that naturally advances to term with a live, growth-appropriate fetus/fetuses in a vertical lie and which can reasonably to expected to culminate with a spontaneous onset of labor that will progress normally to the spontaneous live birth of a viable neonate, with **conservation of the health of the mother and well-being of the baby being the desired outcome and goal**.

2. ‘Normal’ requires a baby in a longitudinal lie that engages in the pelvis before or during early labor and which establishes its ability to fit by advancing sequentially through the stations of the pelvis in a timely manner while displaying no evidence of significant or persistent fetal distress.

B. Circumstances of fetal demise or fetus with documented lethal untreatable congenital anomalies (incompatible with life such as anencephaly, etc) for which medical care is unable to influence outcome and for whom the parents have declined hospitalization with appropriate informed consent/decline of medical advise waiver.

ADVANCED MIDWIFERY SKILLS ~ For Specific Circumstances in Moderate Risk Parturition in Domiciliary Setting (list is not exhaustive)

A. All moderate risk labor situations call for the highest level of fetal monitoring with intermittent auscultation at a minimum of q 20 minutes in active labor, q ten minutes in second stage and q 5 minutes while actively pushing; alternative method - episodic or continuous electronic fetal monitoring

B. A moderate risk labor calls for a high level of emergency transport plans, including less than 30 minutes to a tertiary care hospital which offers 24/7 in-house obstetrical and anesthesia coverage with access to a fully staffed operating room and other services such as lab and blood banking.

C. Criteria and guidelines for physiological management of a Vaginal Breech birth (per OAL decision by Judge Roman)

1. Gestational age >36 ½ weeks, <41 ½ weeks
2. Frank breech position with head flexed
3. Pelvis adequate for fetal size
4. Sonogram to rule out anomalies associated with breech presentation
5. Distance to hospital less than 30 minutes
6. Psycho-social aspects conducive to cooperation during labor and delivery
7. Signed informed consent for topic-specific, moderate-risk decline of medicalization
8. Once *active* labor begins, progress must be straightforward
9. Highest level of fetal monitoring with intermittent auscultation, episodic or continuous electronic fetal monitoring

D. Criteria and guidelines for physiological management Vaginal Twin Birth

(based on the model identified by the OAL decision)

1. Gestational age – within 36 hours of 37 weeks completed weeks of pregnancy
2. First baby's head in the pelvis
3. Distance to hospital less than 30 minutes
4. Signed informed consent for topic-specific moderate-risk decline of medicalization
5. Once *active* labor begins, progress must be straightforward
6. Highest level of fetal monitoring with intermittent auscultation, episodic or continuous electronic fetal monitoring.
7. After birth of the first twin, the second baby should deliver promptly -- ideally within 30 minutes, outside limit 2 hours, with highest level of fetal monitoring during this period, at least every 5 minutes or continuous electronic fetal monitoring.

E. Criteria and guidelines for physiological management vaginal post-term labor and birth (based on the model identified by the OAL decision)

1. Adequate amniotic fluid by ultrasound or palpation q 3-4 days starting at 41 ½ weeks
2. NST by EFM or FHTs for 10-20 minutes, reactive outcome with good variability
3. Normal fetal movement & responsiveness
4. Begin at 41 weeks to explain risks associated with >42 weeks, such as increase in problems for babies due to placental insufficiency, sutures becoming hard, macrosomia, etc.
5. Discuss castor oil/ herbal induction at 42 weeks if and/or obstetrical referral
6. Biophysical profile at 42 weeks
7. Distance to hospital less than 30 minutes
8. Signed informed consent / topic-specific moderate-risk decline of medicalization
9. Once *active* labor begins, progress must be straightforward
10. After rupture of membranes, no evidence of meconium beyond very light "tea-staining"
11. Highest level of fetal monitoring with intermittent auscultation, episodic or continuous electronic fetal monitoring

F. Criteria and guidelines for physiological management of post-cesarean vaginal birth (based on the model identified by the OAL decision)

1. Documentation of one low transverse incision without serious post-op morbidity/infection
2. Strong recommendation for greater than 18 months between births
3. Adequate pelvis for size of baby
4. Distance to hospital less than 30 minutes
5. Discuss ultrasound exam in last 3rd trimester to determine thickness of low uterine segment (note: Cochrane date base has not established the efficacy of this diagnostic procedure)
6. Signed informed consent / topic-specific special circumstances decline of medicalization (see special circumstances VBAC informed consent for other VBAC-specific criteria)
7. Once *active* labor begins, progress must be straightforward
8. Highest level of fetal monitoring with intermittent auscultation, episodic or continuous electronic fetal monitoring

========== **Expectant Management of PROM** ==========

G. **Criteria and guidelines for pre-labor rupture of membranes** (**PROM**) – Expectant Management of spontaneous rupture of amniotic membranes (SROM) *without* spontaneous onset of labor (SOOL) from the 18th to the 48th hour in GBS negative mothers:

1. Most pregnant women experience spontaneous onset of labor within 12 hours of SROM. Published studies on PROM at term document SOOL within 24 hours in 70% of pregnant women and by 48 hours in 90% of such cases. Based on scientific opinion, expectant management is an acceptable alternative to induction when the mother is apyrexic (no fever), fluid is clear and the fetal heart rate evaluation is normal. The following criteria and guidelines apply:

    a) 37 completed weeks of pregnancy w/o other clinically significant factors
    b) mother afebrile with normal pulse rate
    c) normal FHT baseline with normal variability and no clinically significant decels
    d) amniotic fluid without odor, blood or meconium (beyond light "tea-staining")
    e) informed consent discussion and topic-specific decline of medicalization waiver
    f) mother agrees to monitor her temperature and pulse every 4 hours during while awake
    g) instructions to parents to contact the midwife if any change in parameters
    h) on-going assessment of situation by the midwife as indicated
    i) discuss castor oil/ herbal induction at 24 hours and/or obstetrical referral

2. Transfer of care for:

a) clinically-significant elevation of maternal or fetal pulse rate
b) maternal fever of 100.6
c) foul-smelling amniotic fluid
d) frank blood or meconium (beyond light or "tea-stained", non-particulate fluid)
e) failure to establish progressive labor by 48 hours
a. client's desire for medical management or midwife's unwillingness/inability to continue managing expectantly at home

H. Criteria and guidelines for risk-based management of PROM in mother whose GBS status is unknown or is positive:

1. The midwife shall initiate a general informed consent discussion regarding GBS in pregnancy and the specific difference between screening-based protocols and risk-based protocols, including the provision of printed educational resource such as the synopsis of current CDD guidelines, ACOG's client brochure on GBS or evidence-based information from other sources.

2. If mother is known to be GBS+, discuss possible plan for hospitalization @ 18 hours to receive prophylactic IV antibiotics

3. If mother is known to be GBS+, discuss physician referral for outpatient regime of prophylactic PO antibiotics (Kaiser, UCSF)

4. Risk-based Criteria & Guidelines for PROM with unknown or positive GBS status:
   a. no history of previous baby born with early-onset GBS infection
   b. no history of urinary tract infection with Group B bacteria in previous or current pregnancy
   c. 37 completed weeks of pregnancy w/o other clinically significant factors
   d. mother afebrile with normal pulse rate as compared to pulse prenatally
   e. normal FHT baseline with normal variability and no clinically significant decels
   f. amniotic fluid without odor, blood or meconium (beyond light "tea-staining")
   g. mother agrees to monitor her temperature and pulse every 4 hours during waking
   h. client reads, agrees to and signs a topic-specific decline of medicalization waiver
   i. instructions to parents to contact the midwife if any change in parameters
   j. on-going assessment of situation by the midwife as indicated
   k. discuss castor oil/ herbal induction at 12 -18 hours

5. **Transfer of care for**:
   a. clinically-significant elevation of maternal or fetal pulse rate
   b. maternal fever of 100.6
   c. foul-smelling amniotic fluid
   d. frank blood or meconium (beyond light or "tea-stained", non-particulate fluid)
   e. failure to establish progressive labor by 48 hours
   f. client's desire for medical management or midwife's unwillingness/inability to continue managing expectantly at home

========== **Works-in-progress ~** emergency protocol ==========

I. Umbilical Cord Prolapsed ~ After contacting paramedics and while awaiting emergency transport, insert a Foley catheter into the mother's bladder and fill retention balloon with 30 cc sterile water. Then instill of 500 cc sterile solution into the bladder, clamp catheter & tape to mother's leg. Once the bladder is filled and the catheter secured, **check the fetal heart rate**. If it returns to normal and remains WNR, the mother may remain in a supine position (instead of knee-chest position) on the stretcher while being transported by EMTs to the hospital. **Rationale:** Since the bladder and uterus share a membranous attachment, a full bladder mechanically elevates the baby up out of the pelvis, relieving the pressure on the cord which had been trapped between the baby's head and the mother's pubic bone. Relieving that pressure permits fetal blood circulation to be reestablished.