

MINUTES

UTAH

Direct Entry Midwife Administrative Rules Committee March 19, 2009

Room 464 – 4th Floor –3 p.m.
Heber Wells Building
Salt Lake City, UT 84111

CONVENED: 3:13 pm

ADJOURNED: 5:05 pm

Bureau Manager:
Secretary:

Laura Poe
Katherine Klotovich-Wilson
Shirlene Kimball

Conducting:

Suzanne Smith, LDEM

Board Members Present:

Holly Richardson, LDEM (arrived at 3:30 p.m.)
Heather Johnson, LDEM
Suzanne Smith, LDEM
Stephen Lamb, MD
Catherine Wheeler, MD (arrived at 3:20 p.m.)
Deborah Ellis, CNM

Guests:

Pam Udy, Int'l Cesarean Awareness Network

TOPICS FOR DISCUSSION

DECISIONS AND RECOMMENDATIONS

ADMINISTRATIVE BUSINESS:

January 15, 2009

Dr. Wheeler made a Motion to approve the minutes as corrected. Ms. Ellis seconded the Motion. All Committee members in favor.

Reviewed draft informed consent language submitted by Dr. Lamb:

Overall, Committee members agreed with the language developed by Dr. Lamb as Key Elements to be Included in Informed Consent for VBAC (see attached). After reviewing the minutes of the last meeting, Dr. Lamb indicated an element or standard was left off the list. He proposed the following additional element: Risks associated with TOLAC when the type of uterine scar is unknown are greater than when the uterine scar is known to be low transverse. Committee members agreed to the additional language.

Ms. Smith suggested that element #5 was not clear as written. She questioned why a uterine rupture after a

failed TOLAC at home would automatically be worse than a rupture after a failed TOLAC in a hospital. Dr. Wheeler indicated the risks or complications are not necessarily based on the setting, but the time it takes to respond to a complication with medical equipment, etc. The risks were to the mother and baby and were inherently linked to the accessibility to acute care should a complication arise. After further discussion, it was determined to re-write element #5 to read: If a complication occurs from a TOLAC outside of a hospital setting, the risk to mother and baby may be higher due to the inherent delay in access to hospital care.

Committee members discussed that the elements for an extended informed consent for VBAC should include the likely chance of having a successful vaginal delivery. The only research study found by committee members regarding deliveries in other than a hospital setting, was a 2004 birth center study. Nothing specific to home birth was found. The statute language indicates the Rule should be based on research. Dr. Wheeler suggested the addition of an element addressing transfer and vaginal delivery rate. Committee members agreed to the following ninth element. A 2004 national birth center study revealed women who attempt TOLAC in a birth center setting have an overall transfer rate of 24% and a vaginal delivery rate of 87%.

A tenth element for the informed consent for VBAC was suggested regarding success rate. The language agreed to was: A woman with no previous vaginal birth and two previous c-sections for documented failure to progress has a very low vaginal delivery success rate.

Ms. Poe suggested creating a new section in the Rule to address the elements or standards that would need to be included in an expanded informed consent. The times when the extended informed consent must be used will be specified in Section 601 under the applicable bucket and condition. Committee members agreed that an unknown uterine incision type would be placed under waivable transfer provided the client signs an extended informed consent including the

elements listed in Section 602.

Dr. Wheeler made a Motion to approve the ten key elements or standards for informed consent for VBAC as discussed and amended. Ms. Johnson seconded the Motion. All Committee members were in favor of the Motion.

Red cell isoimmunization

Dr Lamb expressed concern that the current Rule only addresses Rh factor and not other red cell isoimmunizations. Dr. Lamb suggested that any isoimmunization with an anti-body known to cause erythroblastosis fetalis require a mandatory consult. If the anti-body titre is greater than 1:8, then a mandatory transfer would be required.

Other common conditions

Ms. Smith asked if there were any other common conditions that had not be addressed in the proposed Rule draft that should be discussed. Dr. Lamb stated he was comfortable with the draft and he believed that there was no need for further discussion.

Consulting physician

Ms. Smith has addressed a specific LDEM's concern about consulting options and she feels this issue has been addressed at this time. Any further concerns would be addressed by the LDEM Board and the issue did not require Rule language.

Informed refusals

Ms. Smith understood this issue to have come from the public. Ms Udy thanked the Committee members for their willingness to listen to her concerns. She is still concerned with some of the items that have been included in the mandatory transfer bucket. The way in which the Rule is written, does not allow a parent to make an informed refusal and still maintain the services of an LDEM. The Rule would require the LDEM to terminate midwifery care. Ms. Poe stated that Ms. Udy was correct in that a parent, after having been thoroughly informed of the risks involved in a specific situation may want to continue with a home delivery, but cannot utilize the services of an LDEM because the parent cannot waive law and Rule governing LDEM practice. Ms. Richardson stated that a parent may chose to refuse transfer, but that would not change the action of the LDEM who must terminate midwifery care. Ms. Smith stated that just because the LDEM terminates care, it doesn't mean

the patient will follow the recommendation of the LDEM and transfer care to a physician.

Data collection

Dr Wheeler asked if there are some events that would trigger an evaluation of care practices to determine if things could be done differently. As a physician, any adverse event is reviewed by peers. She also wanted to know under what circumstances a formal review would be conducted and when the review go public. Ms. Poe said that any disciplinary action against a licensee would be public. Ms. Poe explained that she is not aware of any type of peer review or third party review of LDEMs. However, Ms. Richardson informed the committee that there is a mandatory peer review process for DEMs. If the Division received a complaint against an LDEM, an investigation may be conducted, and if warranted, disciplinary action could be taken. Investigative information is protected and not available to the public. However, a petition which is a charging document that initiates the disciplinary process, or a Stipulation and Order which is an agreement between a licensee and the Division to an agreed upon resolution such as probation, are public documents.

Ms. Ellis indicated her employment within the Department of Health is to monitor perinatal mortality. There is a committee that reviews the information, and those meetings are not open to the public. Information is gathered through vital records. She would be willing to look into including LDEMs in their review. She believes the Committee is a good forum to review sentinel events and near misses. Ms. Ellis stated the Department of Health does not have enforcement authority in these situations. The information is obtained as part of the Department's health surveillance responsibilities.

Ms. Richardson would like to have an LDEM available for this committee at the Department of Health. She would also like to know what other sentinel events are brought to Ms. Ellis' attention.

Ms. Poe suggested that this issue be brought up during the next meeting, which will be April 2, 2009 at 3:00 p.m.

April 2, 2009
Date Approved

(ss) Suzanne Smith
Suzanne Smith, Co-chair

April 2, 2009
Date Approved

(ss) Laura Poe
Laura Poe, Bureau Manager, Division of Occupational &
Professional Licensing