Utah Midwives Organization – Guild of Unlicensed Midwives

Standard of Practice

Midwives believe the practice of midwifery to be distinct from the practice of medicine. Midwives deal with essentially normal, healthy, low-risk pregnancy; low-risk labor and delivery that generally begins between 37 and 43 weeks gestation with essentially natural onset. Midwifery is a discipline pertaining to a normal cycle of life, the childbearing years. Midwives base their profession on the **Midwives Model of Care**:

1. Pregnancy, labor, birth and breastfeeding are fundamentally healthy processes.
2. Each woman is unique and her care should be tailored to meet her individual needs.
3. Midwives recognize the emotional and spiritual aspects of childbirth and midwifery care.
4. Midwives should be trained and educated by skilled birth attendants to include, but not limited to: Certified Professional Midwives, Certified Midwives, Certified Nurse Midwives, Licensed Midwives, and Direct-Entry Midwives as well as Perinatologists, Obstetricians and Family Practice Physicians.
5. Midwives should maintain a professional attitude and practice which promotes collegial relationships between midwives, students and physicians.
6. The relationship between midwives and their clients is collaborative in nature.
7. Midwives uphold the right of the woman/family to informed consent and self-determination, within boundaries of safe care.

For the safety of the mother, her baby, and the midwife herself, a midwife must be able to give necessary supervision, care, and advice to women during pregnancy, labor, birth and postpartum, to provide care on her own responsibility. This care may include preventative measures, detection of abnormal conditions in mother and baby, recommendation of natural remedies, procurement of medical assistance, and execution of emergency measures in the absence of medical help.

**Legal Definition of Direct-Entry Midwifery as applies to unlicensed midwifery [Utah Code 58-77-102(8)]**

(8) "Practice of Direct-entry midwifery" means practice of providing the necessary supervision, care, and advice to a client during essentially normal pregnancy, labor, delivery, postpartum, and newborn periods that is consistent with national professional midwifery standards and that is based upon the acquisition of clinical skills necessary for the care of pregnant women and newborns, including antepartum, intrapartum, postpartum, newborn, and limited interconceptual care and includes:

(a) obtaining an informed consent to provide services;
(b) obtaining a health history, including a physical examination;
(c) developing a plan of care for a client;
(d) evaluating the results of client care;
(e) consulting and collaborating with and referring and transferring care to licensed health care professionals, as is appropriate, regarding the care of a client;
(f) obtaining medications, as specified in this Subsection (8)(f), to administer to clients, including: . . . [items listed that are only obtainable by LDEMs]
   (vi) oxygen; . . .
(g) obtaining food, food extracts, dietary supplements, as defined by the Federal Food, Drug, and Cosmetic Act, homeopathic remedies, plant substances that are not designated as prescription drugs or controlled substances, and over-the-counter medications to administer to clients;
(h) obtaining and using appropriate equipment and devices such as Doppler, blood pressure cuff, phlebotomy supplies, instruments, and sutures;
(i) obtaining appropriate screening and testing, including laboratory tests, urinalysis, and ultrasound;
(j) managing the antepartum period;
(k) managing the intrapartum period including:
   (i) monitoring and evaluating the condition of mother and fetus;
(ii) performing emergency episiotomy; and
(iii) delivering in any out-of-hospital setting;
(l) managing the postpartum period including suturing of episiotomy or first and second
degree natural perineal and labial lacerations, . . .
(m) managing the newborn period including:
   (i) providing care for the newborn, including performing a normal newborn
       examination; and
   (ii) resuscitating a newborn;
(n) providing limited interconceptual services in order to provide continuity of care
    including:
   (i) breastfeeding support and counseling;
   (ii) family planning, limited to natural family planning, . . .; and
   (iii) Pap smears, where all clients with abnormal results are to be referred to an
        appropriate licensed health care provider; and
(o) executing the orders of a licensed health care professional, only within the education,
    knowledge, and skill of the Direct-entry midwife.

Unprofessional Conduct
Conduct by a midwife which is likely to deceive, defraud, or injure clients, or which results from conscious
disregard for the health and welfare of the client under the midwife’s care.
1. Knowingly and/or consistently failing to accurately document a client’s condition, responses, progress or
   other information obtained during care. This includes failing to make, destroying, omitting, or falsifying
   entries in records pertaining to midwifery care.
2. Failure to respect a client’s privacy and/or confidentiality, except when necessary in urgent care of the
   client.
3. Performing or attempting midwifery techniques or procedures which are outside the midwife’s scope of
   practice.
4. Failing to give care in a reasonable and professional manner.
5. Maintaining a client load which exceeds the midwife’s ability to provide personalized care.
6. Leaving a client intrapartum or immediate postpartum without providing adequate care for the mother and
   baby.
7. Delegating midwifery care or responsibilities to a person who lacks the ability or knowledge to perform the
   function or responsibility in question.
8. Manipulating or affecting a client’s decision by withholding or misrepresenting information, in violation of
   the client’s right to make informed choices in her health care.
9. Holding herself out as being something she is not, especially regarding licensure and the privileges
    licensure entails.

Standards for Midwifery Practice

Skills
Midwives desire to provide a safe and satisfying birth experience for the family unit. Necessary skills of a
practicing midwife include the ability to:
1. Provide care and education to the woman and her family during the childbearing years
2. Assess, monitor, and manage antenatal, intrapartum, postpartum, and neonatal periods
3. Identify and assess deviations from normal and respond appropriately to those deviations
4. Maintain proficiency in lifesaving measures, including maternal and neonatal resuscitation, by regular
   review, study, practice and certification
5. Be able to appropriately manage emergency situations, such as shoulder dystocia, hemorrhage, etc. by
   regular review, study and practice, and scenario role playing.

Equipment
Midwives should have available for their immediate use:
1. Equipment to assess and maintain maternal, fetal and newborn wellbeing, including, but not limited to: fetal doppler and/or fetoscope, sphygmomanometer, stethoscope, oxygen, adult and infant pulse oximeter, ambu-bag, etc.
2. Equipment and supplies to maintain cleanliness, asepsis and sterility.
3. Equipment and supplies to resuscitate a newborn and mother

Records
Midwives should keep accurate records of maternal, fetal, and neonatal care for each client. Midwives must file birth certificates in accordance with state law.

Medical Back-Up
Midwives recognize that there are certain conditions when medical consultation is advisable. Each midwife should be prepared to obtain consultation, make referral and arrange transport as necessary. Available resources for referrals should be discussed with each client prenatally.

Screening
Midwives should generally use risk factor assessments for initial screening and, periodically throughout the course of care, to determine continuing eligibility status. It is the right and responsibility of the midwife to refuse or discontinue her services, and to make appropriate referrals when she considers it necessary for the safety of the mother, baby, or herself.

Informed Disclosure and Consent
Midwives should have every client sign an Informed Disclosure form before the midwife provides any midwifery care to the client. This disclosure should include all information the client would require to make an informed decision regarding her choice of care provider and should include statements about:
1. her philosophy of practice
2. her education and training
3. number of years of service as primary midwife and approximate number of births attended as primary midwife and assistant
4. her experience with complications
5. her legal status regarding licensure
6. that she cannot legally acquire, carry, or administer prescription maternal or neonatal medications, with the exception of oxygen

Informed Consent for Specific Situations
In addition, informed consent should be signed by the client for specific situations encountered during the prenatal, labor, birth, postpartum and neonatal periods, when the client has been informed of the unique characteristics and/or risk factors inherent in their situation but desires to remain under the care of the midwife. Such situations include, but are not limited to: Rh negative status, gestational diabetes, diabetes mellitus not controlled by diet, positive Group Beta Strep status, VBAC, twins, breech, and the refusal of Vitamin K and eye ointment.

Continuing Education
Midwives are committed to continually updating their knowledge and skills pertinent to maternity and neonatal care. Suitable topics include, but are not limited to:
1. midwifery management in the antepartum, intrapartum, postpartum, and neonatal periods
2. risk assessment
3. early recognition of potential problems
4. midwifery management of emergency situations
5. ethics
6. nutrition
7. medicolegal concerns
8. cultural awareness
9. childbirth education
10. holistic health care
Continuing education may be obtained through organized courses, conferences, area midwifery meetings, or other means.

Peer Review
Midwives recognize that their activities, professional and otherwise, have an impact on their colleagues and clients. They have the right and responsibility to advise one another in a confidential, professional, non-punitive, and educational manner. The UMO, is a "covered entity" under Utah Code Title 26 Chapter 25 - Confidential Information Release. As such, the UMO is instituting and will have available quarterly peer review. The Unlicensed Midwife Guild of the UMO encourages midwives to take advantage of the regionally available UMO peer review or to utilize another such community peer review mechanism to review cases as needed. Review situations include cases of transfer of care, transports or other complications that may arise.

Practice Guidelines
Each midwife should develop practice guidelines for her services which meet the needs of her client, baby, and their family; and which reflect national professional midwifery standards. (See Guidelines for Midwifery Practice below)

Apprentice Training
A midwife should apprentice with a skilled, experienced senior midwife. Before acquiring an apprenticeship, the student midwife should demonstrate a basic knowledge of midwifery and be trained and competent in resuscitation. She should continue to work as an apprentice until she progresses to the point that she and her mentor believe she is competent and/or she meets qualifications for board certification.

Midwife Assistants at Birth
Whenever possible, each midwife should have an assistant in attendance at every birth. It is recommended that the assistant be a midwife, senior apprentice, or a qualified birth assistant. The assistant should be able to demonstrate a basic knowledge of midwifery, be able to assist with common complications, and be trained and competent in resuscitation. Routinely attending births without a qualified assistant is discouraged.

Guidelines for Midwifery Practice

Prenatal Care

1. On the first visit/interview, the midwife discusses Informed Disclosure before continuous care is provided. The Informed Disclosure should be signed and returned upon agreement to provide/receive ongoing services.

2. Maternal health history should be discussed with the client at the initial appointment and include obtaining client’s health, reproductive and family medical history, and discussing possible implications to the current pregnancy. Such topics should include, but are not limited to:
   A. family history of significant genetic disorders, hereditary disease, or congenital anomalies
   B. history of pre-term birth (< 36 weeks)
   C. history of IUGR
   D. history of severe postpartum hemorrhage
   E. history of severe pre-eclampsia or HELLP
   F. history of gestational diabetes requiring oral hypoglycemic or insulin
   G. no prenatal care prior to third trimester
   H. BMI > 35
   I. history of lap band, gastroplasty or other bariatric (weight loss) surgery
   J. previous unexplained neonatal mortality or stillbirth

3. The midwife and client should develop a transfer of care plan in case of complication or emergency.

4. The midwife should see the client at least once every 4 weeks during her first and second trimesters, every two weeks beginning at 28 weeks, and weekly from 36 weeks until the birth.

5. At prenatal visits, the midwife should check, when appropriate, the client’s:
   a. general health
   b. weight
c. blood pressure
d. pulse
e. urinalysis
f. fundal height
g. fetal heart tones
h. fetal presentation
i. fetal activity
j. maternal nutrition
k. maternal exercise
l. maternal psychosocial well-being
m. laboratory and diagnostic tests

5. In the case of an Rh negative mother, the midwife should thoroughly discuss the possibility of Rh isoimmunization and use of Rhogam with the client. The client should accept the responsibility of acquiring Rhogam through a licensed health care provider. The midwife should follow-up with the client regarding her acquisition and administration of Rhogam and document such in the client’s chart.

6. The midwife should maintain an individual chart for each woman in her care. The completed chart should include data, observations and notes from prenatal visits, laboratory and diagnostic test results, record of consultations with other health providers, labor and delivery record, postpartum record and newborn records.

7. During the third trimester, for a client planning a home birth, the midwife should make a home visit and discuss issues relating to the birth plan including:
   a. facilities at home
   b. adequate heating and cooling
   c. necessary supplies
   d. those invited to the birth
   e. the father’s preparation
   f. preparation and care of siblings
   g. signs of labor
   h. when and how to contact the midwife
   i. inclement weather policy/plan
   j. unassisted/precipitous birth without the midwife
   k. review of complication/emergency transfer of care plan

8. The midwife may recommend that the client and her partner to take prenatal and birth classes.

9. During prenatal care, conditions may be identified that contraindicate home birth. Except in emergency situations, a midwife should not assume or continue primary responsibility for a woman when the following conditions present:
   a. thrombosis
   b. pulmonary embolism
   c. previous cesarean section without a low transverse uterine incision
   d. Rh sensitization (Rhesus isoimmunization) or other isoimmunization known to cause hemolytic disease of the newborn
   e. active tuberculosis
   f. ectopic or molar pregnancy
   g. congenital abnormality that affects childbearing
   h. addiction to alcohol or drugs
   i. primary outbreak of HSV2
   j. active syphilis, gonorrhea, HIV, AIDS, or other STI’s
   k. unresolved cardiac or renal disease
   l. prolapsed cord (current pregnancy only)
   m. placental abnormalities or abruption
   n. insulin-dependent diabetes mellitus or gestational diabetes requiring management with medication (excepting situations of consultation in lieu of transfer if co-managing metformin with a physician)
   o. mono-mono twin gestation
p. discordant twins
q. footling or kneeling breech
r. uncontrolled hypertension
s. confirmed Pre-eclampsia, Toxemia or HELLP syndrome
t. Partial and Complete Previa

10. During the course of prenatal care, conditions may arise that may require additional care and/or consultation. Conditions which may require consultation include:
   a. blood pressure of 140/90
   b. unusual edema beyond the limits of normal water retention
   c. severe, persistent headaches, epigastric pain, or visual disturbances
   d. absence of reliable and normal weight gain
   e. persistent proteinuria
   f. persistent glucosuria or other signs and symptoms of diabetes
   g. bacterial vaginosis
   h. urinary tract infection or pyelonephritis
   i. severe anemia
   j. platelets ≤ 105,000/µL
   k. signs of progressive, preterm labor (before 37 weeks) or history of cervical cerclage
   l. suspected postmaturity
   m. abnormal or lack of fetal heart tones
   n. marked decrease or cessation of fetal movements
   o. abnormal vaginal bleeding before the onset of labor
   p. (preterm and/or) premature rupture of membranes
   q. suspected malpresentation
   r. no prenatal care before 37 weeks
   s. suspected macrosomia
   t. suspected IUGR or SGA
   u. polyhydramnios or oligohydramnios
   v. mono-di or di-di twin gestation
   w. frank or complete breech presentation
   x. unresolved anemia
   y. symptoms of preeclampsia or HELLP
   z. marginal placenta previa

11. The midwife should acquaint the client with the increased risk of the following conditions and have a signed Informed Consent form on file for the following:
   a. previous cesarean section or other known uterine surgery
   b. presentation other than vertex
   c. multiple gestation

12. The midwife should counsel any client who exhibits an unusual or abnormal condition regarding risk factors for either herself and/or her baby. The midwife should encourage parents to make a responsible decision in conjunction with other health care providers.

**Labor and Delivery**

1. During the labor and delivery, the midwife should:
   a. monitor the condition of the mother
   b. monitor the condition of baby, including fetal heart tones and fetal presentation
   c. assist in coaching the mother when needed
   d. prepare equipment for birth
   e. facilitate birth
   f. visually evaluate newborn immediately upon birth, with more proactive assessment as needed
   g. appropriately respond to issues with newborn
   h. assist with placental delivery
   i. manage any third stage maternal bleeding
j. inspect the placenta, membranes, and cord vessels
k. inspect mother for lacerations and advise proper care and/or repair
l. examine and assess newborn

2. The midwife should inform the client and her family of the risks involved if the following circumstances arise during labor. The midwife may also need to consult with another health care provider and/or transport the client to the hospital, depending on the condition.
   a. signs and symptoms of preeclampsia
   b. maternal respiratory distress
   c. prolonged rupture of membranes (>72 hours with GBS- status or >18 hours with GBS+ or unknown GBS status)
   d. unforeseen malpresentation
   e. unforeseen multiple babies
   f. fetal distress when the birth is not yet imminent
   g. abnormal amount of bleeding prior to delivery
   h. signs of maternal shock or allergic reaction
   i. signs of placental abruption
   j. moderate or thick meconium
   k. suspected uterine rupture
   l. maternal seizure
   m. maternal fever (≥100.4 F) that persists for >1 hr
   n. signs of chorioamnionitis, including, but not limited to, fetal tachycardia, maternal tachycardia, uterine tenderness, purulent or malodorous amniotic fluid
   o. maternal blood loss of more than 4 cups/1000 cc with or after delivery
   p. retained placenta, placental fragments, or membranes
   q. unexplained, persistent pain
   r. prolapsed cord
   s. signs of placental abnormalities

3. In the event that a client is transferred to a hospital, the midwife should do everything in her power to facilitate a smooth transition into the hospital system, including:
   a. preparing and delivering the UWNQC Provider-to-Provider Transfer form to the receiving provider
   b. remaining with her client in the role as support and advocate
   c. providing a triage/case report to on duty medical personnel
   d. providing a copy of the client’s complete chart
   e. completing the UWNQC survey following the transport.

Postpartum
1. The midwife is responsible for providing care after the birth to ensure that mother and baby remain stable.
2. After a thorough examination of the newborn, the midwife may recommend that the parents contact their pediatrician, family physician or licensed naturopathic physician to arrange for neonatal examination.
3. For an Rh negative mother, the midwife should obtain a specimen of cord blood, or see that specimen is obtained in a medical laboratory. If the baby’s blood type is positive, an antibody screen should be performed on the mother’s blood and the midwife should ensure that Rhogam is administered by a licensed provider, within 72 hours.
4. The midwife should make at least two visits during the first week after birth, to monitor the mother’s and baby’s well-being. The midwife is responsible for ensuring that:
   a. The baby is stable, alert, and establishing a healthy pattern of waking, feeding, and sleeping, and that the cord is healing properly
   b. The mother’s lochia is normal, her fundus firm, she is afebrile without other signs of infection, is voiding and stooling properly, is successfully breastfeeding, and is getting adequate rest and support
5. The midwife should provide the client with information concerning routine postpartum care of herself and her baby, including breastfeeding information, perineal care, and care of the baby’s umbilical area.
6. The midwife shall instruct the parents regarding the law concerning newborn metabolic screening and newborn hearing screening and advise clients on methods to obtain screenings if not provided by the midwife.
7. The CCHD POX (pulse ox) screening is to be done approximately 24 hours of age, and repeated at 3 days if first is abnormal. If the result continues to be abnormal, referral should be made.
8. The midwife shall file the birth certificate.
9. The midwife should see mother and baby at approximately two, as well as four to six weeks postpartum, to ensure well-being.
10. In the following postpartum newborn problems, the midwife should assist the parents in consulting with an appropriate health care provider:
   a. persistent low APGAR
   b. obvious newborn anomaly
   c. persistent grunting respiration, retractions, or nasal flaring
   d. cardiac irregularities
   e. persistent pale, cyanotic, or gray color
   f. abnormal cry
   g. lethargy
   h. inability to feed well, urinate or have a bowel movement.
   i. persistent abnormal temperature, either low or high
   j. unusual jaundice within the first 24 hours, or jaundice which is unresponsive to treatment
   k. any other questionable/concerning condition
11. The midwife should be alert to any maternal postpartum condition that would require consultation.

**Code for Ethical Midwifery Practice**

**Client Rights**
An ethical midwife will respect the personal rights of her clients:
1. The right to be treated with respect and dignity, without prejudice.
2. The right to informed consent regarding her care, with access to relevant information upon which to base decisions.
3. The right to freedom from coercion in decision-making.
4. The right to accept or refuse treatment.
5. The right to full disclosure of the costs of her care.
6. The right to know who will participate in her care and to obtain additional consultation of her choice.
7. The right to absolute confidentiality except where this right is preempted by law.

**Midwife Rights**
A midwife recognizes the importance of respect for her own rights as a care provider:
1. The right to refuse care to clients with whom no midwife/client relationship has been established.
2. The right to discharge clients from her care, provided adequate referral to another care provider is extended.
3. The right to receive honest, relevant information from clients upon which to base care.
4. The right to receive reasonable compensation for services rendered.
5. The right to refuse care if the client acts irresponsibly, in any way that would cause the client to become high risk.
6. The right to refuse care if terms of the contract between client and midwife are not adhered to.