Wisconsin Department of Safety and Professional Services
Division of Policy Development
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Tony Evers, Governor
Dan Hereth, Secretary

VIRTUAL/TELECONFERENCE
MIDWIFE ADVISORY COMMITTEE
Virtual, 4822 Madison Yards Way, Madison
Contact: Tom Ryan (608) 266-2112
May 13, 2025

The following agenda describes the issues that the Committee plans to consider at the meeting. At the time of the meeting, items may be removed from the agenda. Please consult the meeting minutes for a record of the actions of the Committee.

AGENDA

12:00 P.M.

OPEN SESSION – CALL TO ORDER – ROLL CALL

A. Adoption of Agenda (1-2)

B. Approval of Minutes of March 18, 2025 (3)

C. Administrative Matters – Discussion and Consideration
1. Department, Staff and Committee Updates
2. Committee Members
   a) Abitz, Leslie C.
   b) Bauer, Korina M.
   c) Guzzardo, Angela I.
   d) Scherer, Kelsey A.
   e) Stevenson, Kaycie Marie

D. Legislative and Policy Matters – Discussion and Consideration

E. Midwifery Survey and Results – Discussion and Consideration (4-5)

F. Administrative Rule Matters – Discussion and Consideration (6-38)
1. Drafting Proposals: SPS 180 to 183, Relating to Licensed Midwives Comprehensive Review
2. Pending and Possible Rulemaking Projects

G. Licensed Midwives – Informed Consent Form – Discussion and Consideration (39-53)

H. Discussion and Consideration of Items Added After Preparation of Agenda:
1. Introductions, Announcements and Recognition
2. Administrative Matters
3. Election of Officers
4. Education and Examination Matters
5. Credentialing Matters
6. Legislative and Policy Matters

7. Administrative Rule Matters
8. Committee Liaison Training and Appointment of Mentors
9. Informational Items

I. Public Comments

ADJOURNMENT

NEXT MEETING: JULY 15, 2025

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MEETINGS AND HEARINGS ARE OPEN TO THE PUBLIC, AND MAY BE CANCELLED WITHOUT NOTICE.

Times listed for meeting items are approximate and depend on the length of discussion and voting. All meetings are held virtually unless otherwise indicated. In-person meetings are typically conducted at 4822 Madison Yards Way, Madison, Wisconsin, unless an alternative location is listed on the meeting notice. In order to confirm a meeting or to request a complete copy of the board's agenda, please visit the Department website at https:\\dsps.wi.gov. The board may also consider materials or items filed after the transmission of this notice. Times listed for the commencement of any agenda item may be changed by the board for the convenience of the parties. The person credentialed by the board has the right to demand that the meeting at which final action may be taken against the credential be held in open session. Requests for interpreters for the hard of hearing, or other accommodations, are considered upon request by contacting the Affirmative Action Officer or reach the Meeting Staff by calling 608-267-7213.

VIRTUAL/TELECONFERENCE
MIDWIFE ADVISORY COMMITTEE
MEETING MINUTES
MARCH 18, 2025

PRESENT: Leslie Abitz, Korina Bauer, Angela Guzzardo, Kayci Marie Stevenson

ABSENT: Kelsey Scherer

STAFF: Tom Ryan, Executive Director; Whitney DeVoe, Legal Counsel; Nilajah Hardin, Administrative Rules Coordinator; Tracy Drinkwater, Board Administration Specialist; and other DSPS Staff

CALL TO ORDER

Korina Bauer, Chairperson, called the meeting to order at 12:00 p.m. A quorum of four (4) members was confirmed.

ADOPTION OF AGENDA

MOTION: Korina Bauer moved, seconded by Leslie Abitz, to adopt the agenda as published. Motion carried unanimously.

APPROVAL OF MINUTES FROM JANUARY 21, 2025

MOTION: Korina Bauer moved, seconded by Leslie Abitz, to approve the minutes of January 21, 2025, as published. Motion carried.

ADJOURNMENT

MOTION: Korina Bauer moved, seconded by Leslie Abitz, to adjourn the meeting. Motion carried unanimously.

The meeting adjourned at 2:11 p.m.

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:	2) Date when request submitted:
Nilajah Hardin, Administrative Rules Coordinator on behalf of Korina Bauer, Chairperson	**05/01/25** Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting

3) Name of Board, Committee, Council, Sections:

Midwife Advisory Committee

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
05/13/25	☒ Yes ☐ No	**Midwifery Survey and Results – Discussion and Consideration**

7) Place Item in:	8) Is an appearance before the Board being scheduled? *(If yes, please complete Appearance Request for Non-DSPS Staff)*	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session	☐ Yes ☒ No	**N/A**

10) Describe the issue and action that should be addressed:

Attachments: Survey Data Spreadsheet

11) Authorization

Nilajah D. Hardin — 05/01/25

Signature of person making this request — **Date**

Supervisor (if required) — **Date**

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — **Date**

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director.
3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

Timestamp	1. How long have you been practicing as a Licensed Midwife in Wisconsin	2. Is your practice primarily urban or rural?	3. Do you work in a group setting with other licensed midwives or other provider types that are caring for birthing people	Do you provide birth services in the home setting or in a free standing birth center?	Are you a member of the Wisconsin Guild of Midwives or other professional midwifery organization	Are you aware of the state appointed WI Advisory Committee for Licensed Midwives?	How did you hear about the committee?	*Are there specific rules in RL 180-183 that have created challenges for your practice?*	*How would you specifically amend the rules to assist your practice?*	What support or resources would be the most helpful	If you have reviewed information with DSPS concerning a case, do you have any feedback about that process?	If there was a case being reviewed by the DSPS team, please indicate provider (s) that would be the experts related to the practice of Licensed Midwives.	Do you believe Wisconsin Licensed Midwives should have their own governing board within the state?	Could you explain your answer further from above about whether or not you see value in Wisconsin Licensed Midwives having their own governing board within the state? What are the pros and cons of it?	Any additional comments or feedback	Please share your contact information if you would like to stay updated on the work of the committee.	The public can join Midwife Advisory Committee Meetings, and we encourage midwives to do so! In each meeting there is time for public comment. Public comment is part of the committee process, and having as much engagement from midwives is imperative. Public comment involves you calling in and stating your comment, but not participating in the meeting or engaging in conversation. Comments should be	Here is the link to meeting dates and the agenda for each meeting: [illegible] Meeting dates for the rest of the year (all at 12 p.m.): March 18, 2025 May 13, 2025 July 15, 2025 September 23, 2025 November 18, 2025
2/24/2025 15:22:36	12	Rural	group practice	homebirth	Wisconsin Guild of Midwives	Yes	Wisconsin Guild of Midwives	none of the rules have created challenges for my practice.		A state appointed midwifery board or committee could be helpful for our growing profession	I have not	Licensed Midwives	yes	a state board or official committee focused on midwifery would be a great resource when there are cases to review, complaints to review and to assist with understanding the overall needs of the midwifery workforce.	Thank you for those that are doing work for the committee			
2/24/2025 15:56:30	8 months	Rural	single practice	both	Wisconsin Guild of Midwives	Yes	Through the Guild	No	I wouldn't.	Better collaboration with medical professionals "within" the system, OBs and Family Med etc.	I have not.	Licensed Midwives	uncertain/need more information	Having a margin control the whole always has its complications. Each of us have differences that may then not be voiced etc. I do not think it would be inherently harmful though, would simply want more information of what that would look like.				
2/24/2025 16:26:23	17 yrs	Not currently active	single practice	Not currently active	Wisconsin Guild of Midwives	Yes	WI Guild of Midwives	Yes	I would like to see the rules to include an option for Licensed Midwives in the state of WI to provide well woman care outside of pregnancy.	NA	NA	Licensed Midwives	yes	The practice of community birth midwifery and training of community birth workers is unique and requires a skill set, critical thinking, and decision making capability that is largely under acknowledged/appreciated by those providing hospital based care due, in part, to the lack of integrated care between home/birth center birth providers, EMS, and hospital based services and personnel. None of the other professions listed above are trained in the same model of care being provided (physiologic birth) or to provide that care in a wide range of venues. Skilled care by community birth workers requires a unique skill set whereby the LM effectively functions as not only the primary care provider but also the EMS, social worker, community outreach specialist, resource coordinator, billing and coding specialist, environmental services crew, etc. Midwives who are trained similarly will be in the best position to provide appropriate	No	No.	Not at this time	
2/24/2025 16:48:58	2006?	Rural	other providers	both	Wisconsin Guild of Midwives	Yes	Midwife friend	Not really	Don't know	State insurance billing	None	Licensed Midwives	uncertain/need more information	Diverse opinions are good/	None			
2/24/2025 17:07:03	13	Urban	single practice	homebirth	Wisconsin Guild of Midwives	Yes	Wisconsin Guild of Midwives	No	I would not amend the rules.	The advisory committee's work is a helpful resource	I do not have any feedback	Licensed Midwives	uncertain/need more information	I would like information about what the responsibilities and benefits of our own governing board would be.			Not at this time.	
2/24/2025 20:32:30	9 years	mix	single practice	homebirth	Wisconsin Guild of Midwives	Yes	WGOM	Transfer after an hour without birth of placenta	Maybe		Cases need to be done in a timely manner.	Licensed Midwives	yes	No one but other LM understand what we do or should be doing.				
2/25/2025 6:51:04	35 years	mix	single practice	both	Wisconsin Guild of Midwives, Other:	Yes	A committee member told me	No	N/A	Guidelines for both LM/CPMs and collaborating MDs or CNMs to make collaborative agreements with each other and/or standing orders guidance.	It was straightforward, but at the time, many years ago, I didn't understand that the letter i received was official, and at first, I thought it was optional. I understood after receiving a second, reminder letter, but at first I didn't realize what it was. Could have been my mindset at the time too, because there had been an unsettling incident involving an apprentice's misdeeds in my practice, and i was shaken by it. The investigation and resolution process was reasonable though.	Licensed Midwives, other	uncertain/need more information	I don't know. On the one hand, I feel that a dedicated board could be well informed of the unique aspects of the profession, distinct from other providers. But would that board become more active than necessary to secure relevance and remain funded? How would it remain educated about the practice of licensed midwifery as a different kind of practice than obstetrics and medicine? Would it require stakeholders to be included or just serve as an administrative group of non-practitioners? It would not be appropriate for it to be a group medical doctors overseeing LMs and home birth, that is important in light of the historic failure of that model in Wisconsin and nationally. What are the expected cost changes? Does a dedicated board mean that WI LM licenses will be significantly more costly?	N/A		The statement provided says, "allow for current technologies...", and i am interested in how this will specifically fit into the Department of Safety and Professional Services' review and update of chapters SPS 180 to 183. Technological advances are accelerating at a rate that can't be kept up with, and midwifery practices (and clients) can be impacted by that in positive and negative ways. I think that technological and information management training is a vital component of all healthcare professions today. I think all healthcare practices need policies around technology uses and best practices. Midwives and midwifery schools are a component of critical infrastructure and are at risk of being targeted by cyber criminals due to the vital role we have in providing essential services, and because our records contain highly sought private health information. I would like to grow towards a model of digital proficiency for all midwives, so that we can keep apace of technological advances without unintentionally increasing risks. Such a framework will require resources because the business model of LMs, being mostly sole proprietorships or small partnerships, cannot sustain successive technological	I am interested as the future unfolds, but currently, i am navigating end of life care for a close family member. Cannot commit just yet.
2/25/2025 10:52:26	Less than 1 year	Urban	group practice	Mostly homebirth, occasional birth suite	Wisconsin Guild of Midwives	Yes	At a Guild Meeting	Being required to transfer a client if the placenta hasn't been delivered at the one hour mark post birth.	A consultation is required at the one hour mark and transfer at two hours post birth.		N/A	Licensed Midwives	yes	I see the need to have a board that actually understands the scope of our practice and what it is out of hospital midwives actually do. A former preceptor of mine was disciplined in a case and it was clear she was being punished for things that it was acceptable according to our rules to do (transfer by car when it would be faster than ambulance etc). I would hope having a governing board would protect us in that regard.	n/a		no	
3/1/2025 20:18:36	7 years	Rural	group practice, One additional part-time, licensed midwife	homebirth	Wisconsin Guild of Midwives	Yes	The Wisconsin Guild of Midwives	Yes, the requirement that a birth assistant also be a temporary permit holder is a huge burden. There are very well qualified and experienced birth assistants who want to remain just that - an assistant - and don't want to have to be enrolled or engaged in a midwifery education in order to be assisting. I also assert that TXA (tranexamic acid) and epinephrine should be in the standard CPM formulary.	If an assistant has no desire to pursue a midwifery education, they should be able to serve as an assistant, providing they maintain their NRP and CPR.	- Collaborative hospital practitioners who are closer than 1.5 hrs from my practice radius. - The ability to use Midwife Rx for straightforward situations that require Rx medications (i.e. antibiotic therapies for UTI or mastitis, prophylactic antivirals for maternal HSV, Progesterone supplementation, etc. - ABR hearing screening access without	I have not.	Licensed Midwives, Nurse Midwives, Family Practice MD with OB privileges	uncertain/need more information	I would need to know more about how the board would function in order to have an opinion on this. I tend to think it could only be an improvement over what currently exists.				
3/3/2025 13:38:56	30+ years, 16 with a WI licenses	mix	single practice	homebirth	Wisconsin Guild of Midwives	Yes	through another midwife	Possibly but mostly no	Do we NEED to have a physician sign standing orders yearly if we don't use/do anything outside of the already listed (SPS182.03(2) "prescription drugs, devices and procedures"	more physicians/OB providers that read/understand our RR/limitations as home birth providers. Having done so, be willing to consult with us for patient safety, and cya for the midwife. The clients have a say in their healthcare and often push back on consults (fear)	I was a proctor for another midwife and the process was SO LONG!! There was poor communication, very little feedback or assistance from DSPS and it was frustrating.	Licensed Midwives, Family Practice MD with OB privileges	uncertain/need more information	first I would say no, not specifically, but I'm not sure exactly what is being asked here. We do have the WGOM, and I wouldn't want there to be any additional expense to WI tax payers for something that can be overseen at the WGOM, or even NARM OR NACPM. BUT, there does need to be BETTER and CLEARER communication from DSPS when complaints made, with the midwife and the WGOM IRC committee, and for there to be quicker resolutions. There absolutely should be LM'S, FP w/OB privileges to review these complaints, not just random state employees who have no idea or correlation to home birth or licensed	I think that the WGOM is an appropriate "governing" group if you will, even though they have no true authority. They can contact, engage with the midwife about the complaint, review the facts, make recommendation or refer to the state for further action IF in fact a rule or law has been violated. All medical professionals should be reviewed by their peers first		I practiced before the law and after. I respect it and adhere to it, as do most LM's	Thank you
3/4/2025 15:38:52	5 years	urban location but mostly serve folks in outlying suburbs and rural areas with urban hospitals as primary transport site	single practice	homebirth	Wisconsin Guild of Midwives	Yes	WGOM	no	Some clarity around what is meant by weeks pregnant would be great (i.e. labor prior to the 37th week gestation - I interpret this to mean anyone in their 37th week, which would be 36 completed weeks gestation. But that should be more clearly stated and with consistent language regarding gestation throughout the rules of practice.)	Not sure that I need any or can think of any at the time	NA - for the next question, I noted other as an expert related to the practice of LMs - other would be Nurse Midwives who practice out of hospital (free standing birth center or home birth)	Licensed Midwives, other	uncertain/need more information	would like to discuss more with peers				
3/5/2025 11:50:04	1 year	mix	group practice	homebirth	Wisconsin Guild of Midwives	Yes	Through my midwife colleague	The most challenging ones (that we get pushback for) are the requirements to consult after 18 hours of SROM with no labor, the requirements to consult after 42 weeks and requiring to transfer for a retained placenta after one hour	Include the ability to prescribe medications for simple things such as Urinary Tract Infections, Bacterial Vaginosis etc. In the case of consulting for SROM, stretch the time for consult to 24 hours. Regarding assistants, remove the requirement that they need to be a student as well. There's many fine people that would be wonderful assistants but have no desire to be a midwife. There could be some requirements in place for assists	Supportive collaborations with physicians,	n/a	Licensed Midwives, Family Practice MD with OB privileges	uncertain/need more information	I think that the Licensed Midwife scope of practice is unique enough that it could certainly benefit from having it's own governing board but I would need more information of what that would look like	Thank you for your work on this!		not at this time but I will definitely try to call in	Thank you!
3/26/2025 12:06:02	2 years	mix	group practice	both	Wisconsin Guild of Midwives	Yes	Through being a member of the Wisconsin Guild of	no	n/a				uncertain/need more information					

State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and title of person submitting the request:	2) Date when request submitted:
Nilajah Hardin **Administrative Rules Coordinator**	**05/01/25** **Items will be considered late if submitted after 12:00 p.m. on the deadline date which is 8 business days before the meeting**

3) Name of Board, Committee, Council, Sections:

Midwife Advisory Committee

4) Meeting Date:	5) Attachments:	6) How should the item be titled on the agenda page?
05/13/25	☒ Yes ☐ No	**Administrative Rule Matters – Discussion and Consideration** **1. Drafting Proposals: SPS 180 to 183, Relating to Licensed Midwives Comprehensive Review** **2. Pending or Possible Rulemaking Projects**

7) Place Item in:	8) Is an appearance before the Board being scheduled? *(If yes, please complete **Appearance Request** for Non-DSPS Staff)*	9) Name of Case Advisor(s), if required:
☒ Open Session ☐ Closed Session	☐ Yes ☒ No	**N/A**

10) Describe the issue and action that should be addressed:

Attachments:

1. SPS 180 to 183 Redlined Code Text
2. Updated Adjacent State Analysis
3. WI Department of Health Services Birth Data

Copies of current Department Rule Projects Can be Viewed Here:
https://dsps.wi.gov/Pages/RulesStatutes/PendingRules.aspx

11) Authorization

Nilajah D. Hardin — 05/01/25

Signature of person making this request — **Date**

Supervisor (if required) — **Date**

Executive Director signature (indicates approval to add post agenda deadline item to agenda) — **Date**

Directions for including supporting documents:

1. This form should be attached to any documents submitted to the agenda.
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3. If necessary, provide original documents needing Board Chairperson signature to the Bureau Assistant prior to the start of a meeting.

Chapter SPS 180

AUTHORITY AND DEFINITIONS

SPS 180.01 Authority. SPS 180.02 Definitions.

Note: Chapter RL 180 was renumbered chapter SPS 180 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

SPS 180.01 Authority. The rules in chs. SPS 180 to 183 are adopted under the authority of ss. 227.11 (2) and 440.08 (3), Stats., and subch. XIII of ch. 440, Stats.

SPS 180.02 Definitions. As used in chs. SPS 180 to 183 and in subch. XIII of ch. 440, Stats.:

(1) "Administer" means the direct provision of a prescription drug or device, whether by injection, ingestion or any other means, to the body of a client.

(1m) "Automated external defibrillator" has the meaning given in s. 440.01 (1) (ad), Stats.

(2) "Client" means a woman who obtains maternity care provided by a licensed midwife.

(3) "Consultation" means discussing the aspects of an individual client's circumstance with other professionals to assure comprehensive and quality care for the client, consistent with the objectives in the client's treatment plan or for purposes of making adjustments to the client's treatment plan. Consultation may include history-taking, examination of the client, rendering an opinion concerning diagnosis or treatment, or offering service, assistance or advice.

(3m) "Defibrillation" has the meaning given in s. 440.01 (1) (ag), Stats.

(4) "Department" means the department of safety and professional services.

(5) "Direct supervision" means immediate on-premises availability to continually coordinate, direct and inspect at first hand the practice of another.

(7) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, 42 USC 1320d et seq.

(8) "Licensed midwife" means a person who has been granted a license under subch. XIII of ch. 440, Stats., to engage in the practice of midwifery.

(9) "Practice of midwifery" means providing maternity care during the antepartum, intrapartum, and postpartum periods consistent with the standards of practice set forth in ch. SPS 182.

(10) "Temporary permit" means a credential granted under s. SPS 181.01 (4), to an individual to practice midwifery under the direct supervision of a licensed midwife pending successful completion of the requirements for a license under s. SPS 181.01 (1).

(11) "Ventricular fibrillation" has the meaning given in s.440.01 (1) (i), Stats.

Chapter SPS 181

APPLICATIONS FOR LICENSURE, RENEWAL OF LICENSES AND TEMPORARY PERMITS

SPS 181.01 Applications.

Note: Chapter RL 181 was renumbered chapter SPS 181 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

SPS 181.01 Applications. (1) LICENSES. An individual who applies for a license as a midwife shall apply on a form provided by the department. An applicant who fails to comply with a request for information related to the application, or fails to meet all requirements for the license within 120 calendar days from the date of filing shall file a new application and fee if licensure is sought at a later date. The application shall include all of the following:

(a) The fee specified in s. 440.03 (9), Stats.

(b) Evidence satisfactory to the department of one of the following:

1. That the applicant holds a valid certified professional midwife credential granted by the North American Registry of Midwives or a successor organization.
2. That the applicant holds a valid certified nurse-midwife credential granted by the American College of Nurse Midwives or a successor organization.
3. That the applicant holds a valid certified nurse-midwife or midwife credential granted by the American Midwifery Certification Board or a successor organization.

(c) That the applicant, subject to ss. 111.321, 111.322 and 111.335, Stats., does not have an arrest or conviction record. An applicant who has a pending criminal charge or has been convicted of any crime or ordinance violation shall provide the department with all information requested relating to the applicant's pending criminal charge, conviction or other offense, as applicable. The department may not grant a midwife license to a person convicted of an offense under s. 940.22, 940.225, 944.06, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.06, 948.07, 948.075, 948.08, 948.09, 948.095, 948.10, 948.11 or 948.12, Stats.

(d) Evidence satisfactory to the department that the applicant has current proficiency in the use of an automated external defibrillator achieved through instruction provided by an individual, organization, or institution of higher education approved under s. 46.03 (38), Stats., to provide the instruction.

Note: Instructions for applications ~~Applications~~ for licensure as a midwife are available ~~from the Department of Safety and Professional Services, Division of Professional Credential Processing, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708-8935, or from~~ on the department's website at: http://dsps.wi.gov.

(1m) RECIPROCITY FOR SERVICE MEMBERS, FORMER SER- VICE MEMBERS, AND SPOUSES OF SERVICE MEMBERS OR FORMER SERVICE MEMBERS. A reciprocal

midwife license shall be granted to an applicant who is a service member, former service member, or the spouse of a service member or former service member as defined in s. 440.09 (1), Stats., if the department determines that the applicant meets all of the requirements under s. 440.09 (2), Stats. Subject to s. 440.09 (2m), Stats., the department may request verification necessary to make a determination under this subsection.

Note: Instructions for applications~~Application forms~~ are available on the department's website at http://dsps.wi.gov ~~https://dsps.wi.gov/pages/Home.aspx, or by request from the Department of Safety and Professional Services, P.O. Box 8935, Madison, WI 53708, or call (608) 266-2112~~.

(2) RENEWAL OF LICENSES. **(a)** Except for temporary permits granted under sub. (4), the renewal date for licenses granted un- der subch. XIII of ch. 440, Stats., is July 1 of each even-numbered year.

(b) Renewal applications shall be submitted to the department on a form provided by the department and shall include the renewal fee specified in s. 440.08 (2) (a) 46w., Stats.

(c) At the time of renewal of a license under par. (b), a li- censed midwife shall submit proof satisfactory to the department of all of the following:

1. The licensee holds a valid certified professional midwife credential from the North American Registry of Midwives or a successor organization, or a valid certified nurse-midwife credential from the American College of Nurse Midwives or a successor organization.
2. The licensee has current proficiency in the use of an auto- mated external defibrillator achieved through instruction pro- vided by an individual, organization, or institution of higher education approved under s. 46.03 (38), Stats., to provide the instruction.

(3) LATE RENEWAL OF LICENSES. A licensed midwife who fails to renew a license by the renewal date may renew the license by submitting an application on a form provided by the department and satisfying the following requirements:

(a) If applying less than 5 years after the renewal date, satisfy the requirements under sub. (2), and pay the late renewal fee specified in s. 440.08 (3), Stats.

(b) If applying 5 years or more after the renewal date, satisfy the requirements under sub. (2); pay the late renewal fee specified in s. 440.08 (3), Stats., and submit proof of one or more of the following, as determined by the department to ensure protection of the public health, safety and welfare:

1. Successful completion of educational course work.
2. Successful completion of the national examination required by the North American Registry of Midwives for certification as a certified professional midwife or successful completion of the national examination required by the American College of Nurse Midwives for certification as a certified nurse-midwife.

(4) TEMPORARY PERMITS. **(a)** Application. An applicant seeking a temporary permit shall apply on a form provided by the department. An applicant who fails to comply with a request for information related to the application, or fails to meet all requirements for a permit within 120 calendar days from the date of filing shall submit a new application and fee if a permit is sought at a later date. The application shall include all of the following:

1. The fee specified in s. 440.05 (6), Stats.
2. Evidence satisfactory to the department of all of the following:
   a. The applicant is actively engaged as a candidate for certification with the North American Registry of Midwives or a successor organization; or is currently enrolled in the portfolio evaluation process program through the North American Registry of Midwives or a successor organization, or a certified professional midwife educational program accredited by the Midwifery Education Accreditation Council.
   b. The applicant has received a written commitment from a licensed midwife to directly supervise the applicant's practice of midwifery during the duration of the temporary permit.
   c. The applicant is currently certified by the American Red Cross or American Heart Association in neonatal resuscitation.
   d. The applicant is currently certified by the American Red Cross or American Heart Association in adult cardiopulmonary resuscitation.
   e. The applicant has attended at least 5 births as an observer.
   f. The applicant, subject to ss. 111.321, 111.322 and 111.335, Stats., does not have an arrest or conviction record. An applicant who has a pending criminal charge or has been convicted of any crime or ordinance violation shall provide the department with all information requested relating to the applicant's pending criminal charge, conviction or other offense, as applicable. The department may not grant a temporary permit to a per- son convicted of an offense under s. 940.22, 940.225, 944.06, 944.15, 944.17, 944.30, 944.31, 944.32, 944.33, 944.34, 948.02, 948.025, 948.06, 948.07, 948.075, 948.08, 948.09, 948.095, 948.10, 948.11 or 948.12, Stats.

Note: Instructions for applications ~~Applications~~ are available ~~from the Department of Safety and Professional Services, Division of Professional Credential Processing, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708-8935, or from~~ on the department's website at: http://dsps.wi.gov.

(b) Duration of permit. 1. The duration of a temporary permit is for a period of 3 years or until the permit holder ceases to be currently registered or actively engaged as a candidate for certification as specified in par. (a) 2., whichever is shorter.

2. A licensed midwife with a written commitment to supervise the holder of a temporary permit shall notify the department immediately of a termination of the supervisory relationship.

3. Upon termination of a supervisory relationship, the temporary permit shall be automatically suspended until the permit holder obtains another written supervisory commitment that complies with par. (a) 2. b.
4. The department may in its discretion grant renewal of a temporary permit. Renewal shall be granted only once and for a period of no more than 3 years. A permit holder seeking renewal of a temporary permit shall submit documentation that satisfies the requirements for an initial permit under par. (a).

Note: The North American Registry of Midwives may be contacted at ~~5257 Rosestone Dr., Lilburn, GA 30047~~ P.O. Box 420, Summertown, TN 38483, 1−888−842−4784, https://narm.org/. The American College of Nurse−Midwives may be contacted at ~~8402 Colesville Road, Suite 1550, silver spring, MD 20910~~ 409 12th Street SW, Suite 600, Washington, DC 20024-2188, (240) 485−1800, https://www.midwife.org/.

Chapter SPS 182

STANDARDS OF PRACTICE

SPS 182.01 Standards. SPS 182.02 Informed consent.
SPS 182.03 Practice.

Note: Chapter RL 182 was renumbered chapter SPS 182 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

SPS 182.01 Standards. Licensed midwives shall comply with the standards of practice of midwifery established by the National Association of Certified Professional Midwives.

Note: The standards of the National Association of Certified Professional Midwives are set forth in ch. SPS 183 Appendix I. The National Association of Certified Professional Midwives may be contacted at 234 Banning Road, Putney, VT 05346, (866) 704-9844, https://www.nacpm.org/.

SPS 182.02 Informed consent. (1) DISCLOSURE OF INFORMATION TO CLIENT. A licensed midwife shall, at an initial consultation with a client, provide a copy of the rules promulgated by the department under subch. XIII of ch. 440, Stats., and disclose to the client orally and in writing on a form provided by the department all of the following:

(a) The licensed midwife's experience and training.

(b) Whether the licensed midwife has malpractice liability insurance coverage and the policy limits of the coverage.

(c) A protocol for medical emergencies, including transportation to a hospital, particular to each client.

(d) A protocol for and disclosure of risks associated with vaginal birth after a cesarean section.

(e) The number of babies delivered and the number of clients transferred to a hospital since the time the licensed midwife commenced practice of midwifery.

(f) A statement that the licensed midwife does not have the equipment, drugs or personnel available to perform neonatal resuscitations that would normally be available in a hospital setting.

(g) A list of intravenous medications and their associated risks that may be used during or after birth. These medications may include:

1. Tranexamic Acid.
2.

Note: Forms are available ~~from the Department of Safety and Professional Services, Division of Professional Credential Processing, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708-8935, or from~~ on the department's website at: http://dsps.wi.gov.

(1m) DISCLOSURE OF INFORMATION BY TEMPORARY PERMIT HOLDER. A temporary permit holder shall inform a client orally and in writing that the temporary permit holder may not engage in the practice of midwifery unless the temporary permit holder practices under the direct supervision of a licensed midwife.

(2) ACKNOWLEDGEMENT BY CLIENT. A licensed midwife shall, at an initial consultation with a client, provide a copy of the written disclosures required under sub. (1), to the client and obtain the client's signature acknowledging that she has been in- formed, orally and in writing, of the disclosures required under sub. (1).

SPS 182.03 Practice. (1) TESTING, CARE AND SCREENING. A licensed midwife shall:

(a) Offer each client routine prenatal care and testing in accordance with current American College of Obstetricians and Gynecologists guidelines.

(b) Provide all clients with a plan for 24 hour on-call availability by a licensed midwife, certified nurse-midwife or licensed physician throughout pregnancy, intrapartum, and 6 weeks postpartum.

(c) Provide clients with labor support, fetal monitoring and routine assessment of vital signs once active labor is established.

(d) Supervise delivery of infant and placenta, assess newborn and maternal well being in immediate postpartum, and perform Apgar scores.

(e) Perform routine cord management and inspect for appropriate number of vessels.

(f) Inspect the placenta and membranes for completeness.

(g) Inspect the perineum and vagina postpartum for lacerations and stabilize.

(h) Observe mother and newborn postpartum until stable condition is achieved, but in no event for less than 2 hours.

(i) Instruct the mother, father and other support persons, both verbally and in writing, of the special care and precautions for both mother and newborn in the immediate postpartum period.

(j) Reevaluate maternal and newborn well being within 36 hours of delivery.

(k) Use universal precautions with all biohazard materials.

(L) Ensure that a birth certificate is accurately completed and filed in accordance with state law.

(m) Offer to obtain and submit a blood sample in accordance with the recommendations for metabolic screening of the newborn.

(n) Offer an injection of vitamin K for the newborn in accordance with the indication, dose and administration route set forth in sub. (3).

(o) Within one week of delivery, offer a newborn hearing screening to every newborn or refer the parents to a facility with a newborn hearing screening program.

(p) Within 2 hours of the birth offer the administration of antibiotic ointment into the eyes of the newborn, in accordance with state law on the prevention of infant blindness.

(q) Maintain adequate antenatal and perinatal records of each client and provide records to consulting licensed physicians and licensed certified nurse-midwives, in accordance with HIPAA regulations.

(2) PRESCRIPTION DRUGS, DEVICES AND PROCEDURES. A licensed midwife may administer the following during the practice of midwifery:

(a) Oxygen for the treatment of fetal distress.

(b) Eye prophylactics – 0.5% erythromycin ophthalmic ointment or 1% tetracycline ophthalmic ointment for the prevention of neonatal ophthalmia.

(c) Oxytocin, or pitocin, as a postpartum antihemorrhagic agent.

(d) Methyl-ergonovine, or methergine, for the treatment of postpartum hemorrhage.

(e) Vitamin K for the prophylaxis of hemorrhagic disease of the newborn.

(f) RHo (D) immune globulin for the prevention of RHo (D) sensitization in RHo (D) negative women.

(g) Intravenous fluids for maternal stabilization – 5% dextrose in lactated Ringer's solution (D5LR), unless unavailable or impractical in which case 0.9% sodium chloride may be administered.

(h) In addition to the drugs, devices and procedures that are identified in pars. (a) to (g), a licensed midwife may administer any other prescription drug, use any other device or perform any other procedure as an authorized agent of a licensed practitioner with prescriptive authority.

Note: Licensed midwives do not possess prescriptive authority. A licensed mid- wife may legally administer prescription drugs or devices only as an authorized agent of a practitioner with prescriptive authority. For physicians and advanced practice nurses, an agent may administer prescription drugs or devices pursuant to written standing orders and protocols.

Note: Medical oxygen, 0.5% erythromycin ophthalmic ointment, tetracycline ophthalmic ointment, oxytocin (pitocin), methyl-ergonovine (methergine), injectable vitamin K and RHo (D) immune globulin are prescription drugs. See s. SPS 180.02 (1).

(3) INDICATIONS, DOSE, ADMINISTRATION AND DURATION OF TREATMENT. The indications, dose, route of administration and duration of treatment relating to the administration of drugs and procedures identified under sub. (2) are as follows:

Medication	Indication	Dose	Route of Administration	Duration of Treatment
Oxygen	Fetal distress	Maternal: 6-8 L/minute Infant: 10-12 L/minute 2-4 L/minute	Mask Bag and mask Mask	Until delivery or transfer to a hospital is complete 20 minutes or until transfer to a hospital is complete
0.5% Erythromycin Ophthalmic Ointment Or 1% Tetracycline Ophthalmic Ointment	Prophylaxis of Neonatal Ophthalmia	1 cm ribbon in each eye from unit dose package 1 cm ribbon in each eye from unit dose package	Topical Topical	1 dose
Oxytocin (Pitocin) 10 units/ml	Postpartum hemorrhage only	10-20 units, 1-2 ml	Intramuscularly only	1-2 doses
Methyl-ergonovine (Methergine) 0.2 mg/ml or 0.2 mg tabs	Postpartum hemorrhage only	0.2 mg	Intramuscularly Orally	Single dose Every 6 hours, may repeat 3 times Contraindicated in hypertension and Raynaud's Disease
Vitamin K 1.0 mg/0.5 ml	Prophylaxis of Hemorrhagic Disease of the Newborn	0.5-1.0 mg, 0.25-0.5 ml	Intramuscularly	Single dose
RHo (D) Immune Globulin	Prevention of RHo (D) sensitization in RHo (D) negative women	Unit dose	Intramuscularly only	Single dose at any gestation for RHo (D) negative, antibody negative women within 72 hours of spontaneous bleeding. Single dose at 26-28 weeks gestation for RHo (D) negative, antibody negative women and Single dose for RHo (D) negative, antibody negative women within 72 hours of delivery of RHo (D) positive infant, or infant with unknown blood type
5% dextrose in lactated Ringer's solution (D5LR), unless unavailable or impractical in which case 0.9% sodium chloride may be administered	To achieve maternal stabilization during uncontrolled post-partum hemorrhage or anytime blood loss is accompanied by tachycardia, hypotension, de-creased level of consciousness, pallor or diaphoresis	First liter run in at a wide-open rate, the second liter titrated to client's condition	IV catheter 18 gauge or greater (2 if hemorrhage is severe)	Until maternal stabilization is achieved or transfer to a hospital is complete

(4) CONSULTATION AND REFERRAL. **(a)** A licensed midwife shall consult with a licensed physician or a licensed certified nurse-midwife providing obstetrical care, whenever there are significant deviations, including abnormal laboratory results, relative to a client's pregnancy or to a neonate. If a referral to a physician is needed, the licensed midwife shall refer the client to a physician and, if possible, remain in consultation with the physician until resolution of the concern.

Note: Consultation does not preclude the possibility of an out-of-hospital birth. It is appropriate for the licensed midwife to maintain care of the client to the greatest degree possible, in accordance with the client's wishes, during the pregnancy and, if possible, during labor, birth and the postpartum period.

(b) A licensed midwife shall consult with a licensed physician or certified nurse-midwife with regard to any mother who presents with or develops the following risk factors or presents with or develops other risk factors that in the judgment of the licensed midwife warrant consultation:

1. Antepartum.
   a. Pregnancy induced hypertension, as evidenced by a blood pressure of 140/90 on 2 occasions greater than 6 hours apart.
   b. Persistent, severe headaches, epigastric pain or visual disturbances.
   c. Persistent symptoms of urinary tract infection.
   d. Significant vaginal bleeding before the onset of labor not associated with uncomplicated spontaneous abortion.
   e. Rupture of membranes prior to the 37th week gestation.
   f. Noted abnormal decrease in or cessation of fetal movement.
   g. Anemia resistant to supplemental therapy.
   h. Fever of 102° F or 39° C or greater for more than 24 hours.
   i. Non-vertex presentation after 38 weeks gestation.
   j. Hyperemisis or significant dehydration.
   k. Isoimmunization, Rh-negative sensitized, positive titers, or any other positive antibody titer, which may have a detrimental effect on mother or fetus.
   L. Elevated blood glucose levels unresponsive to dietary management.
   m. Positive HIV antibody test.
   n. Primary genital herpes infection in pregnancy.
   o. Symptoms of malnutrition or anorexia or protracted weight loss or failure to gain weight.
   p. Suspected deep vein thrombosis.
   q. Documented placental anomaly or previa.
   r. Documented low lying placenta in woman with history of previous cesarean delivery.
   s. Labor prior to the 37th week of gestation.
   t. History of prior uterine incision.
   u. Lie other than vertex at term.

v. Multiple gestation.
w. Known fetal anomalies that may be affected by the site of birth.
x. Marked abnormal fetal heart tones.
y. Abnormal non-stress test or abnormal biophysical profile.
z. Marked or severe poly- or oligo-dydramnios.
za. Evidence of intrauterine growth restriction.
zb. Significant abnormal ultrasound findings.
zc. Gestation beyond 42 weeks by reliable confirmed dates.

2. Intrapartum.
a. Rise in blood pressure above baseline, more than 30/15 points or greater than 140/90.
b. Persistent, severe headaches, epigastric pain or visual disturbances.
c. Significant proteinuria or ketonuria.
d. Fever over 100.6° F or 38° C in absence of environmental factors.
e. Ruptured membranes without onset of established labor after 18 hours.
f. Significant bleeding prior to delivery or any abnormal bleeding, with or without abdominal pain; or evidence of placental abruption.
g. Lie not compatible with spontaneous vaginal delivery or unstable fetal lie.
h. Failure to progress after 5 hours of active labor or following 2 hours of active second stage labor.
i. Signs or symptoms of maternal infection.
j. Active genital herpes at onset of labor.
k. Fetal heart tones with non-reassuring patterns.
L. Signs or symptoms of fetal distress.
m. Thick meconium or frank bleeding with birth not imminent.
n. Client or licensed midwife desires physician consultation or transfer.

3. Postpartum.
a. Failure to void within 6 hours of birth.
b. Signs or symptoms of maternal shock.
c. Febrile: 102° F or 39° C and unresponsive to therapy for 12 hours.
d. Abnormal lochia or signs or symptoms of uterine sepsis.
e. Suspected deep vein thrombosis.
f. Signs of clinically significant depression.

(c) A licensed midwife shall consult with a licensed physician or licensed certified nurse-midwife with regard to any neonate who is born with or develops the following risk factors:

1. Apgar score of 6 or less at 5 minutes without significant improvement by 10 minutes.
2. Persistent grunting respirations or retractions.
3. Persistent cardiac irregularities.
4. Persistent central cyanosis or pallor.
5. Persistent lethargy or poor muscle tone.
6. Abnormal cry.
7. Birth weight less than 2300 grams.

8. Jitteriness or seizures.
9. Jaundice occurring before 24 hours or outside of normal range.
10. Failure to urinate within 24 hours of birth.
11. Failure to pass meconium within 48 hours of birth.
12. Edema.
13. Prolonged temperature instability.
14. Significant signs or symptoms of infection.
15. Significant clinical evidence of glycemic instability.
16. Abnormal, bulging, or depressed fontanel.
17. Significant clinical evidence of prematurity.
18. Medically significant congenital anomalies.
19. Significant or suspected birth injury.
20. Persistent inability to suck.
21. Diminished consciousness.
22. Clinically significant abnormalities in vital signs, muscle tone or behavior.
23. Clinically significant color abnormality, cyanotic, or pale or abnormal perfusion.
24. Abdominal distension or projectile vomiting.
25. Signs of clinically significant dehydration or failure to thrive.

(5) TRANSFER. **(a)** Transport via private vehicle is an acceptable method of transport if it is the most expedient and safest method for accessing medical services. The licensed midwife shall initiate immediate transport according to the licensed midwife's emergency plan; provide emergency stabilization until emergency medical services arrive or transfer is completed; accompany the client or follow the client to a hospital in a timely fashion; provide pertinent information to the receiving facility and complete an emergency transport record. The following conditions shall require immediate physician notification and emergency transfer to a hospital:

1. Seizures or unconsciousness.
2. Respiratory distress or arrest.
3. Evidence of shock.
4. Psychosis.
5. Symptomatic chest pain or cardiac arrhythmias.
6. Prolapsed umbilical cord.
7. Shoulder dystocia not resolved by Advanced Life Support in Obstetrics (ALSO) protocol.
8. Symptoms of uterine rupture.
9. Preeclampsia or eclampsia.
10. Severe abdominal pain inconsistent with normal labor.
11. Chorioamnionitis.
12. Clinically significant fetal heart rate patterns or other manifestation of fetal distress.
13. Presentation not compatible with spontaneous vaginal delivery.
14. Laceration greater than second degree perineal or any cervical.
15. Hemorrhage non-responsive to therapy.

16. Uterine prolapse or inversion.
17. Persistent uterine atony.
18. Anaphylaxis.
19. Failure to deliver placenta after one hour if there is no bleeding and fundus is firm.
20. Sustained instability or persistent abnormal vital signs.
21. Other conditions or symptoms that could threaten the life of the mother, fetus or neonate.

(b) A licensed midwife may deliver a client with any of the complications or conditions set forth in par. (a), if no physician or other equivalent medical services are available and the situation presents immediate harm to the health and safety of the client; if the complication or condition entails extraordinary and unnecessary human suffering; or if delivery occurs during transport.

(6) PROHIBITED PRACTICES. A licensed midwife may not do any of the following:

(a) Administer prescription pharmacological agents intended to induce or augment labor.

(b) Administer prescription pharmacological agents to pro- vide pain management.

(c) Use vacuum extractors or forceps.

(d) Prescribe medications.

(e) Provide out-of-hospital care to a woman who has had a vertical incision cesarean section.

(f) Perform surgical procedures including, but not limited to, cesarean sections and circumcisions.

(g) Knowingly accept responsibility for prenatal or intra- partum care of a client with any of the following risk factors:

1. Chronic significant maternal cardiac, pulmonary, renal or hepatic disease.
2. Malignant disease in an active phase.
3. Significant hematological disorders or coagulopathies, or pulmonary embolism.
4. Insulin requiring diabetes mellitus.
5. Known maternal congenital abnormalities affecting childbirth.
6. Confirmed isoimmunization, Rh disease with positive titer.
7. Active tuberculosis.
8. Active syphilis or gonorrhea.
9. Active genital herpes infection 2 weeks prior to labor or in labor.
10. Pelvic or uterine abnormalities affecting normal vaginal births, including tumors and malformations.
11. Alcoholism or abuse.
12. Drug addiction or abuse.
13. Confirmed AIDS status.
14. Uncontrolled current serious psychiatric illness.
15. Social or familial conditions unsatisfactory for out-of- hospital maternity care services.
16. Fetus with suspected or diagnosed congenital abnormalities that may require immediate medical intervention.

Chapter SPS 183
GROUNDS FOR DISCIPLINE

SPS 183.01 Disciplinary proceedings and actions.

Note: Chapter RL 183 was renumbered chapter SPS 183 under s. 13.92 (4) (b) 1., Stats., Register November 2011 No. 671.

SPS 183.01 Disciplinary proceedings and actions.

(1) Subject to the rules promulgated under s. 440.03 (1), Stats., the department may reprimand a licensed midwife or deny, limit, suspend, or revoke a license or temporary permit granted under subch. XIII of ch. 440, Stats., if the department finds that the applicant, temporary permit holder, or licensed midwife has engaged in misconduct. Misconduct comprises any practice or behavior that violates the minimum standards of the profession necessary for the protection of the health, safety, or welfare of a client or the public. Misconduct includes the following:

(a) Submitting fraudulent, deceptive or misleading information in conjunction with an application for a credential.

(b) Violating, or aiding and abetting a violation, of any law or rule substantially related to practice as a midwife. A certified copy of a judgment of conviction is prima facie evidence of a violation.

Note: Pursuant to s. SPS 4.09, all credential holders licensed by the department need to report a criminal conviction within 48 hours after entry of a judgment against them. The department form for reporting convictions is available on the department's website at http://dsps.wi.gov.

(c) Having a license, certificate, permit, registration, or other practice credential granted by another state or by any agency of the federal government to practice as a midwife, which the granting jurisdiction limits, restricts, suspends, or revokes, or having been subject to other adverse action by a licensing authority, any state agency or an agency of the federal government including the denial or limitation of an original credential, or the surrender of a credential, whether or not accompanied by findings of negligence or unprofessional conduct. A certified copy of a state or federal final agency decision is prima facie evidence of a violation of this provision.

(d) Failing to notify the department that a license, certificate, or registration for the practice of any profession issued to the mid- wife has been revoked, suspended, limited or denied, or subject to any other disciplinary action by the authorities of any jurisdiction.

(e) Violating or attempting to violate any term, provision, or condition of any order of the department.

(f) Performing or offering to perform services for which the midwife is not qualified by education, training or experience.

(g) Practicing or attempting to practice while the midwife is impaired as a result of any

condition that impairs the midwife's ability to appropriately carry out professional functions in a manner consistent with the safety of clients or the public.

(h) Using alcohol or any drug to an extent that such use im- pairs the ability of the midwife to safely or reliably practice, or practicing or attempting to practice while the midwife is impaired due to the utilization of alcohol or other drugs.

(i) Engaging in false, fraudulent, misleading, or deceptive behavior associated with the practice as a midwife including advertising, billing practices, or reporting, falsifying, or inappropriately altering patient records.

(j) Discriminating in practice on the basis of age, race, color, sex, religion, creed, national origin, ancestry, disability or sexual orientation.

(k) Revealing to other personnel not engaged in the care of a client or to members of the public information which concerns a client's condition unless release of the information is authorized by the client or required or authorized by law. This provision shall not be construed to prevent a credential holder from cooperating with the department in the investigation of complaints.

(L) Abusing a client by any single or repeated act of force, violence, harassment, deprivation, neglect, or mental pressure which reasonably could cause physical pain or injury, or mental anguish or fear.

(m) Engaging in inappropriate sexual contact, exposure, gratification, or other sexual behavior with or in the presence of a client. For the purposes of this paragraph, an adult shall continue to be a client for 2 years after the termination of professional services. If the person receiving services is a minor, the person shall continue to be a client for the purposes of this paragraph for 2 years after termination of services, or for one year after the client reaches age 18, whichever is later.

(n) Obtaining or attempting to obtain anything of value from a client without the client's consent.

(o) Obtaining or attempting to obtain any compensation by fraud, misrepresentation, deceit or undue influence in the course of practice.

(p) Offering, giving or receiving commissions, rebates or any other forms of remuneration for a client referral.

(q) Failing to provide the client or client's authorized representative a description of what may be expected in the way of tests, consultation, reports, fees, billing, therapeutic regimen, or schedule, or failing to inform a client of financial interests which might accrue to the midwife for referral to or for any use of ser- vice, product, or publication.

(r) Failing to maintain adequate records relating to services provided a client in the course of a professional relationship.

(s) Engaging in a single act of gross negligence or in a pattern of negligence as a midwife, or in other conduct that evidences an inability to apply the principles or skills of midwifery.

(t) Failing to respond honestly and in a timely manner to a request for information from the department. Taking longer than 30 days to respond creates a rebuttable presumption that the response is not timely.

(u) Failing to report to the department or to institutional supervisory personnel any violation of the rules of this chapter by a midwife.

(v) Allowing another person to use a license granted under subch. XIII of ch. 440, Stats.

(w) Failing to provide direct supervision over a temporary permit holder while the permit holder is engaging in the practice of midwifery.

(2) Subject to the rules promulgated under s. 440.03 (1), Stats., the department shall revoke a license granted under subch. XIII of ch. 440, Stats., if the licensed midwife is convicted of any of the offenses specified in s. 440.982 (2), Stats.

(3) Subject to s. 440.982, Stats., no person may engage in the practice of midwifery the person has been granted a license or a temporary permit to practice midwifery under subch. XIII of ch. 440, Stats., or granted a license to practice as a nurse-midwife under s. 441.15, Stats.

(4) Subject to s. 440.981, Stats., no person may use the title "licensed midwife" unless the person has been granted a license to practice midwifery under subch. XIII of ch. 440, Stats., or granted a license to practice as a nurse-midwife under s. 441.15, Stats.

Chapter SPS 183
APPENDIX I
ESSENTIAL DOCUMENTS OF THE NATIONAL ASSOCIATION OF CERTIFIED PROFESSIONAL MIDWIVES

Contents

I. Introduction
II. Philosophy
III. The NACPM Scope of Practice
IV. Standards for NACPM Practice
V. Endorsement Section

Gender references: To date, most NACPM members are women. For simplicity, this document uses female pronouns to refer to the NACPM member, with the understanding that men may also be NACPM members.

I. Introduction

The Essential Documents of the NACPM consist of the NACPM Philosophy, the NACPM Scope of Practice, and the Standards for NACPM Practice. They are written for Certified Professional Midwives (CPMs) who are members of the National Association of Certified Professional Midwives.

- They outline the understandings that NACPM members hold about midwifery.
- They identify the nature of responsible midwifery practice.

II. Philosophy and Principles of Practice

NACPM members respect the mystery, sanctity and potential for growth inherent in the experience of pregnancy and birth. NACPM members understand birth to be a pivotal life event for mother, baby, and family. It is the goal of midwifery care to support and empower the mother and to protect the natural process of birth. NACPM members respect the biological integrity of the processes of pregnancy and birth as aspects of a woman's sexuality.

NACPM members recognize the inseparable and interdependent nature of the mother-baby pair.

NACPM members believe that responsible and ethical midwifery care respects the life of the baby by nurturing and respecting the mother, and, when necessary, counseling and educating her in ways to improve fetal/infant well-being.

NACPM members work as autonomous practitioners, recognizing that this autonomy makes possible a true partnership with the women they serve, and enables them to bring a broad range of skills to the partnership.

NACPM members recognize that decision-making involves a synthesis of knowledge, skills, intuition and clinical judgment.

NACPM members know that the best research demonstrates that out-of-hospital birth is a safe and rational choice for healthy women, and that the out-of-hospital setting provides optimal opportunity for the empowerment of the mother and the support and protection of the normal process of birth.

NACPM members recognize that the mother or baby may on occasion require medical consultation or collaboration.

NACPM members recognize that optimal care of women and babies during pregnancy and birth takes place within a net- work of relationships with other care providers who can provide service outside the scope of midwifery practice when needed.

III. Scope of Practice for the National Association of Certified Professional Midwives

The NACPM Scope of Practice is founded on the NACPM Philosophy. NACPM members offer expert care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. NACPM members work with women and families to identify their unique physical, social and emotional needs. They inform, educate and support women in making choices about their care through informed consent. NACPM members provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period. NACPM members are trained to recognize abnormal or dangerous conditions needing expert help outside their scope. NACPM members each have a plan for consultation and referral when these conditions arise. When needed, they provide emergency care and support for mothers and babies until additional assistance is available. NACPM members may practice and serve women in all settings and have particular expertise in out-of-hospital settings.

IV. The Standards of Practice for NACPM Members

The NACPM member is accountable to the women she serves, to herself, and to the midwifery profession. The NACPM Philosophy and the NACPM Scope of Practice are the foundation for the midwifery practice of the NACPM member. The NACPM Standards of Practice provide a tool for measuring actual practice and appropriate usage of the body of knowledge of midwifery.

Standard One: The NACPM member works in partnership with each woman she serves. The NACPM member:

- Offers her experience, care, respect, counsel and support to each woman she serves
- Freely shares her midwifery philosophy, professional standards, personal scope of practice and expertise, as well as any limitations imposed upon her practice by local regulatory agencies and state law
- Recognizes that each woman she cares for is responsible for her own health and well-being
- Accepts the right of each woman to make decisions about her general health care and her pregnancy and birthing experience
- Negotiates her role as caregiver with the woman and clearly identifies mutual and individual responsibilities, as well as fees for her services

- Communicates openly and interactively with each woman she serves
- Provides for the social, psychological, physical, emotional, spiritual and cultural needs of each woman
- Does not impose her value system on the woman
- Solicits and respects the woman's input regarding her own state of health
- Respects the importance of others in the woman's life.

Standard Two: Midwifery actions are prioritized to optimize well-being and minimize risk, with attention to the individual needs of each woman and baby.
The NACPM member:

- Supports the natural process of pregnancy and childbirth
- Provides continuous care, when possible, to protect the integrity of the woman's experience and the birth and to bring a broad range of skills and services into each woman's care
- Bases her choices of interventions on empirical and/or research evidence, verifying that the probable benefits outweigh the risks
- Strives to minimize technological interventions
- Demonstrates competency in emergencies and gives priority to potentially life-threatening situations
- Refers the woman or baby to appropriate professionals when either needs care outside her scope of practice or expertise
- Works collaboratively with other health professionals
- Continues to provide supportive care when care is transferred to another provider, if possible, unless the mother declines
- Maintains her own health and well-being to optimize her ability to provide care.

Standard Three: The midwife supports each woman's right to plan her care according to her needs and desires. The NACPM member:

- Shares all relevant information in language that is understandable to the woman
- Supports the woman in seeking information from a variety of sources to facilitate informed decision-making
- Reviews options with the woman and addresses her questions and concerns
- Respects the woman's right to decline treatments or procedures and properly documents her choices
- Develops and documents a plan for midwifery care together with the woman
- Clearly states and documents when her professional judgment is in conflict with the decision or plans of the woman
- Clearly states and documents when a woman's choices fall outside the NACPM member's legal scope of practice or expertise
- Helps the woman access the type of care she has chosen
- May refuse to provide or continue care and refers the woman to other professionals if she deems the situation or the care requested to be unsafe or unacceptable
- Has the right and responsibility to transfer care in critical situations that she deems to be unsafe. She refers the woman to other professionals and remains with the woman until the transfer is complete.

Standard Four: The midwife concludes the caregiving partnership with each woman responsibly. The NACPM member:

- Continues her partnership with the woman until that partnership is ended at the final postnatal visit or until she or the woman ends the partnership and the midwife documents same
- Ensures that the woman is educated to care for herself and her baby prior to discharge from midwifery care
- Ensures that the woman has had an opportunity to reflect on and discuss her childbirth experience
- Informs the woman and her family of available community support networks and refers appropriately.

Standard Five: The NACPM member collects and records the woman's and baby's health data, problems, decisions and plans comprehensively throughout the caregiving partnership. The NACPM member:

- Keeps legible records for each woman, beginning at the first formal contact and continuing throughout the caregiving relationship
- Does not share the woman's medical and midwifery records without her permission, except as legally required
- Reviews and updates records at each professional contact with the woman
- Includes the individual nature of each woman's pregnancy in her assessments and documentation
- Uses her assessments as the basis for on-going midwifery care
- Clearly documents her objective findings, decisions and professional actions
- Documents the woman's decisions regarding choices for care, including informed consent or refusal of care
- Makes records and other relevant information accessible and available at all times to the woman and other appropriate persons with the woman's knowledge and consent
- Files legal documents appropriately.

Standard Six: The midwife continuously evaluates and improves her knowledge, skills and practice in her endeavor to provide the best possible care. The NACPM member:

- Continuously involves the women for whom she provides care in the evaluation of her practice
- Uses feedback from the women she serves to improve her practice
- Collects her practice statistics and uses the data to improve her practice
- Informs each woman she serves of mechanisms for complaints and review, including the NARM peer review and grievance process
- Participates in continuing midwifery education and peer review
- May identify areas for research and may conduct and/or collaborate in research
- Shares research findings and incorporates these into midwifery practice as appropriate
- Knows and understands the history of midwifery in the United States
- Acknowledges that social policies can influence the health of mothers, babies and families; therefore, she acts to influence such policies, as appropriate.

V. Endorsement of Supportive Statements

NACPM members endorse the Midwives Model of Care ({ 1996-2004 Midwifery Task Force), the Mother Friendly Childbirth Initiative ({ 1996 Coalition for Improving Maternity Services) and the Rights of Childbearing Women ({ 1999 Maternity Center Association, Revised 2004). For the full text of each of these statements, please refer to the following web pages.

Midwives Model of Care (MMOC)-http://www.cfmidwifery.org/Citizens/mmoc/define.aspx

Mother Friendly Childbirth Initiative (MFIC) -http://www.motherfriendly.org/MFCI/

Rights of Childbearing Women - http://www.maternitywise.org/mw/rights.html

Comparison with rules in adjacent states:

Illinois: The Illinois Department of Financial and Professional Regulation is responsible for the licensure and regulation of the practice of midwifery in Illinois, with input from the Illinois Midwifery Board. The Illinois Department is also responsible for the promulgation of rules to implement certain sections of the Illinois Licensed Certified Professional Midwife Practice Act. This Act contains requirements for applications, licensure, renewal, informed consent, consultation, referrals, and discipline for licensed certified professional midwives. As outlined in Section 45 of the Act, each applicant for a license must hold a valid professional midwife certification granted by the North American Registry of Midwives, a current cardiopulmonary resuscitation certification, and an active status as a neonatal resuscitation provider. Additionally, each applicant needs to submit proof of successful completion of a postsecondary midwifery education program accredited by the Midwife Education and Accreditation Council, successfully complete a licensure examination from the Illinois Department, and be at least 21 years old [225 Illinois Compiled Statutes ch. 64 s. 45]. In Illinois, a Licensed Certified Professional Midwife may administer oxygen, eye prophylactics, oxytocin, Pitocin, or misoprostol, methylergonovine or methergine, vitamin K, Rho (D) immune globulin, intravenous fluids, antibiotics, ibuprofen and lidocaine, among other drugs via the methods specified in the statute while performing the practice of midwifery. Additional medications, agents, or current evidence-based obstetric guidelines may be approved by the Illinois Department by rule [Illinois Compiled Statutes ch. 64 s. 70]. A licensed certified professional midwife is prohibited from providing care outside of a hospital to individuals who have had a previous cesarean section [Illinois Compiled Statutes ch. 64 s. 85].
The Illinois Administrative Code further outlines requirements for licensed certified professional midwives. These rules include requirements for continuing education, midwife assistants, recordkeeping, adverse occurrences, and unprofessional conduct, among other topics. The additional medications specified by rule that can be administered by a Licensed Certified Professional Midwife include tranexamic acid, hemabate, penicillin, ampicillin, cefazolin, clindamycin, and acetaminophen [Illinois Administrative Code Title 68 Chapter VII Part 1345].

Iowa: The Iowa Board of Nursing, with input from the Midwifery Advisory Council, is responsible for the licensure and regulation of the practice of midwifery in Iowa. Chapter 148I of the Iowa Code includes statutory requirements for licensure, adoptions of rules, and the composition of the Midwife Advisory Council. An applicant for licensure as a midwife needs to submit evidence of a high school diploma or equivalent, current certification as a Certified Professional Midwife from the North American Registry of Midwives, successful completion of an educational program accredited by the Midwifery Education Accreditation Council, and that they are at least 21 years of age. Additionally, the Iowa Board shall adopt rules to regulate midwifery that are based on the rules of the National Association of Certified Professional Midwives and the North American Registry of Midwives. In Iowa, a licensee may administer oxytocin, misoprostol, methylergonovine, intravenous fluids, vitamin K , antibiotic eye prophylaxis, oxygen, intravenous antibiotics for group B streptococcal prophylaxis, Rho (D) immune globulin, local anesthetic, epinephrine and other drugs consistent with the practice of Midwifery as approved by the Iowa Board [Iowa Code ch. 148I].
The Iowa Administrative Code includes the rules for regulation of midwifery, as well as further requirements for licensed midwives. The rules for midwife practice in Iowa require that each

licensee shall comply with the practice standards of the National Association of Certified Professional Midwives. Other areas listed include requirements for delegation, testing and drugs, discipline, and telehealth. The additional drugs specified by rule and approved by the Iowa Board that licensees may administer in Iowa include pyridoxine, terbutaline, and nifedipine [Iowa Administrative Code 655 Ch. 16]. In Iowa, a Certified Professional Midwife must consult with a Licensed Physician or a Certified Nurse Midwife if their client has risk factors, including history of uterine incision [Iowa Administrative Code 655 Ch. 16 s. 16.3 (6) b.].

Michigan: The Michigan Department of Licensing and Regulatory Affairs and the Michigan Board of Licensed Midwifery are responsible for the licensure and regulation of the practice of midwifery in Michigan. Act 368 Article 15 Part 171 of the Michigan Compiled Laws includes the regulations for midwifery in Michigan, among several other occupations. Some of the requirements in this part include those for licensure, renewal, transfer of care, informed consent, and duties of the Michigan Board. Each applicant for licensure as a midwife needs to have successfully completed an education program accredited by the Midwifery Education and Accreditation Council, have a current credential as a Certified Professional Midwife from the North American Registry of Midwives or an equivalent, and have successfully completed and examination provided by the Michigan Department. The Michigan Department and Board are also responsible for promulgation of rules for midwifery on licensure, continuing education, processes to obtain informed consent, protocols for transfer of care, among other areas [Michigan Compiled Laws ss. 333.17101-333.17123
The rules also outline requirements for pre-licensure education, consultation, referral, emergency transfer of care, administration of prescription medications, and prohibited conduct. In Michigan, a licensed midwife who has pharmacology training and a standing prescription order from a health professional with prescription authority may administer prophylactic vitamin K, antihemorrhagic agents (including tranexamic acid), local anesthetic, oxygen, prophylactic eye agents, prophylactic Rho (D) immunoglobulin, agents for group B streptococcus prophylaxis, intravenous fluids excluding blood products, antiemetics, and epinephrine via the methods outlined in the rules [Michigan Administrative Rules R 338.17101-338.17141]. A Certified Professional Midwife in Michigan is prohibited from caring for patients with certain risk factors including history of previous uterine rupture [Michigan Administrative Rules R 338.17136].

Minnesota: The Minnesota Board of Medical Practice is responsible for the licensure and regulation of traditional midwifery in Minnesota with input from the Advisory Council of Traditional Midwifery. Chapter 147D of the Minnesota Statutes includes requirements for licensure, practice, informed consent, consultation, discipline, and make-up of the Advisory Council. To qualify for a license in traditional midwifery, each applicant needs to submit a diploma from an approved education program, a copy of a current credential from the North American Registry of Midwives as a Certified Professional Midwife, evidence of current certification in adult and infant cardiopulmonary resuscitation, a medical consultation plan, and documentation of practical experience through an apprenticeship or similar supervised practice setting. In Minnesota, a licensed traditional midwife may obtain and administer vitamin K, RhoGAM treatment, postpartum antihemorrhagic drugs, local anesthetic, oxygen, and prophylactic eye agents [Minnesota Statutes ch. 147D]. A licensed traditional midwife in Minnesota may only provide care to clients who are expected to have a normal pregnancy, labor, and delivery [Minnesota Statutes ch. 147D s. 147D.05 Subd. 1 (a)].

Intended Home Births Occurring in Wisconsin, 2011-2022, by Attendant Title and Previous Cesarean Section Indicated

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics
Counts under 5 are suppressed for confidentiality and indicated X, but are included in totals.
Totals also include "Unknown" attendant title and "Unknown" previous c-section.

	2011					2011 Total	2012					2012 Total	2013					2013 Total
Previous C-Section Reported	CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife	
No	53	521	7	73	510	1165	28	578	8	62	544	1220	28	612	8	73	546	1270
Yes	X	24		6	21	54	X	21		X	19	44		28		5	21	54
Total	56	545	7	79	531	1219	29	599	8	66	563	1266	28	640	8	78	567	1324

	2014					2014 Total	2015					2015 Total	2016					2016 Total	2017					2017 Total
Previous C-Section Reported	CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	DO or MD	Licensed Midwife	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife	
No	30	689	10	64	559	1353	45	X	732	61	546	1385	60	704	X	44	525	1337	45	769	61	435	1310	
Yes	X	23		X	21	47	X		28	6	32	68	X	33		X	27	64	X	38	5	17	61	
Total	31	713	10	66	580	1401	47	X	760	68	578	1454	62	737	X	47	555	1406	46	807	67	454	1374	

	2018					2018 Total	2019					2019 Total	2020					2020 Total
Previous C-Section Reported	CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife	
No	29	942	X	77	396	1445	20	1042	X	68	417	1551	14	1114	X	70	451	1653
Yes		35		X	13	49	X	42		X	8	53		43		X	12	58
Total	29	977	X	80	413	1500	22	1085	X	71	427	1609	14	1158	X	76	466	1718

	2021					2021 Total	2022					2022 Total	2023					2023 Total	2024					2024 Total	Grand Total
Previous C-Section Reported	CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife		CNM	Licensed Midwife	DO or MD	Other	Other Midwife		
No	17	1278	X	82	506	1886	38	1189	X	71	548	1848	52	1213	X	68	586	1900	72	1350	X	79	649	2154	21477
Yes		60		X	9	73	X	45			8	56	X	58		X	13	75	X	58		X	13	74	830
Total	17	1340	X	87	516	1963	41	1237	X	72	558	1910	54	1276	X	72	582	1985	73	1416	X	82	664	2239	22368

All Births Occurring in Wisconsin, 2011-2022, by Attendant Title and Previous Cesarean Section Indicated

Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics
Counts under 5 are suppressed for confidentiality and indicated X, but are included in totals.
Totals also include "Unknown" attendant title and "Unknown" previous c-section.

Row Labels	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	Grand Total
CNM	**5342**	**5272**	**5357**	**5808**	**5784**	**5868**	**5921**	**6090**	**6040**	**6065**	**6257**	**6493**	**6789**	**7048**	**84134**
N	5168	5097	5164	5585	5577	5650	5708	5864	5787	5855	5993	6220	6468	6706	80842
Y	173	173	187	217	197	213	204	211	234	210	254	264	307	303	3147
DO	**5853**	**5642**	**6021**	**6300**	**6424**	**6418**	**6370**	**6756**	**7594**	**7728**	**8437**	**8429**	**8534**	**8285**	**98791**
N	5051	4861	5097	5294	5406	5300	5269	5618	6349	6470	7006	7010	7128	6801	82660
Y	788	772	911	1001	1010	1043	1072	1109	1221	1252	1421	1408	1389	1468	15865
Licensed Midwife	**684**	**756**	**834**	**978**	**992**	**1003**	**1111**	**1304**	**1472**	**1533**	**1722**	**1638**	**1700**	**1881**	**17608**
N	646	722	789	944	942	948	1059	1252	1416	1467	1640	1578	1620	1773	16796
Y	38	34	45	33	50	55	52	52	55	65	79	57	74	79	768
MD	**54723**	**54630**	**53432**	**53114**	**52811**	**52304**	**50762**	**49258**	**47288**	**44374**	**44474**	**42555**	**41766**	**41467**	**682958**
N	47741	47214	46019	45328	44837	44535	42841	41431	39455	37158	37338	35626	34698	34340	578561
Y	6815	7299	7267	7616	7846	7635	7790	7690	7669	7168	7062	6842	6980	6901	102580
Other	**94**	**82**	**93**	**86**	**81**	**69**	**96**	**129**	**113**	**129**	**143**	**130**	**122**	**137**	**1504**
N	83	78	87	81	74	65	84	119	109	118	136	123	112	127	1396
Y	10	X	X	X	6	X	6	5	X	5	6	X	6	5	69
Other Midwife	**537**	**571**	**572**	**583**	**579**	**557**	**459**	**413**	**430**	**469**	**525**	**560**	**586**	**670**	**7511**
N	516	552	551	562	547	527	439	396	420	454	515	550	570	654	7253
Y	21	19	21	21	32	27	18	13	8	12	9	8	13	13	235
Grand Total	**67235**	**66958**	**66320**	**66874**	**66674**	**66225**	**64721**	**63955**	**62948**	**60304**	**61560**	**59812**	**59502**	**59497**	**892585**

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 697 • April 2017
(Reaffirmed 2020)

(Replaces Committee Opinion Number 669, August 2016)

Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Joseph R. Wax, MD, and William H. Barth Jr, MD.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

INTERIM UPDATE: This Committee Opinion is updated as highlighted to reflect a limited, focused change in the presentation of data regarding perinatal mortality in planned home births.

Planned Home Birth

ABSTRACT: In the United States, approximately 35,000 births (0.9%) per year occur in the home. Approximately one fourth of these births are unplanned or unattended. Although the American College of Obstetricians and Gynecologists believes that hospitals and accredited birth centers are the safest settings for birth, each woman has the right to make a medically informed decision about delivery. Importantly, women should be informed that several factors are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes. These factors include the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education, or physician practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals. The Committee on Obstetric Practice considers fetal malpresentation, multiple gestation, or prior cesarean delivery to be an absolute contraindication to planned home birth.

Recommendations

- Women inquiring about planned home birth should be informed of its risks and benefits based on recent evidence. Specifically, they should be informed that although planned home birth is associated with fewer maternal interventions than planned hospital birth, it also is associated with a more than twofold increased risk of perinatal death (1–2 in 1,000) and a threefold increased risk of neonatal seizures or serious neurologic dysfunction (0.4–0.6 in 1,000). These observations may reflect fewer obstetric risk factors among women planning home birth compared with those planning hospital birth. Although the American College of Obstetricians and Gynecologists (the College) believes that hospitals and accredited birth centers are the safest settings for birth, each woman has the right to make a medically informed decision about delivery.
- Women should be informed that several factors are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes. These factors include the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education, or physician practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals.
- The Committee on Obstetric Practice considers fetal malpresentation, multiple gestation, or prior cesarean delivery to be an absolute contraindication to planned home birth.

In the United States, approximately 35,000 births (0.9%) per year occur in the home (1). Approximately one fourth of these births are unplanned or unattended (2). Among women who originally intend to give birth in a hospital or those who make no provisions for professional care during childbirth, home births are associated with high rates of perinatal and neonatal mortality (3). The relative risk versus benefit of a planned home birth, however, remains the subject of debate.

High-quality evidence that can inform this debate is limited. To date, there have been no adequate randomized clinical trials of planned home birth (4). In developed

countries where home birth is more common than in the United States, attempts to conduct such studies have been unsuccessful, largely because pregnant women have been reluctant to participate in clinical trials that involve randomization to home or hospital birth (5, 6). Consequently, most information on planned home births comes from observational studies. Observational studies of planned home birth often are limited by methodological problems, including small sample sizes (7–10); lack of an appropriate control group (11–15); reliance on birth certificate data with inherent ascertainment problems (2, 16–18); reliance on voluntary submission of data or self-reporting (7, 12, 14, 15, 19); limited ability to distinguish accurately between planned and unplanned home births (16, 20); variation in the skill, training, and certification of the birth attendant (14–16, 21); and an inability to account for and accurately attribute adverse outcomes associated with antepartum or intrapartum transfers (8, 16, 22). Some recent observational studies overcome many of these limitations, describing planned home births within tightly regulated and integrated health care systems, attended by highly trained licensed midwives with ready access to consultation and safe, timely transport to nearby hospitals (7, 8, 10, 11, 16, 19, 23–28). However, these data may not be generalizable to many birth settings in the United States where such integrated services are lacking. For the same reasons, clinical guidelines for the intrapartum care of women in the United States that are based on these results and are supportive of planned home birth for low-risk term pregnancies also may not currently be generalizable (29). Furthermore, no studies are of sufficient size to compare maternal mortality between planned home and hospital birth and few, when considered alone, are large enough to compare perinatal and neonatal mortality rates. Despite these limitations, when viewed collectively, recent reports clarify a number of important issues regarding the maternal and newborn outcomes of planned home birth when compared with planned hospital births.

Women planning a home birth may do so for a number of reasons, often out of a desire to avoid medical interventions and the hospital atmosphere (30). Recent studies have found that when compared with planned hospital births, planned home births are associated with fewer maternal interventions, including labor induction or augmentation, regional analgesia, electronic fetal heart rate monitoring, episiotomy, operative vaginal delivery, and cesarean delivery (Table 1). Planned home births also are associated with fewer vaginal, perineal, and third-degree or fourth-degree lacerations and less maternal infectious morbidity (18, 27, 31, 32). These observations may reflect fewer obstetric risk factors among women planning home births compared with those planning hospital births. Parous women comprise a larger proportion of those planning out-of-hospital births (27, 32). Compared with nulliparous women, parous women collectively experience significantly lower rates of obstetric intervention, maternal morbidity, and neonatal morbidity and mortality, regardless of birth location. Those planning home births also are more likely to deliver in that setting than nulliparous women (15, 27, 33). For these reasons, recommendations regarding the intrapartum care of healthy nulliparous and parous women may differ outside of the United States (29). Also, proportionately more home births are attended by midwives than planned hospital births, and randomized trials show that midwife-led care is associated with fewer intrapartum interventions (34).

Strict criteria are necessary to guide selection of appropriate candidates for planned home birth. In the United States, for example, where selection criteria may not be applied broadly, intrapartum (1.3 in 1,000) and neonatal (0.76 in 1,000) deaths among low-risk women planning home birth are more common than expected when compared with rates for low-risk women planning hospital delivery (0.4 in 1,000 and 0.17 in 1,000, respectively), consistent with the findings of an earlier meta-analysis (15, 31, 33). Additional evidence from the United States shows that planned home birth of a breech-presenting fetus is associated with an intrapartum mortality rate of 13.5 in 1,000 and neonatal mortality rate of 9.2 in 1,000 (15). United States data limited to

Table 1. Maternal Events Associated With U.S. Planned Out-of-Hospital Births Versus Hospital Births ⇦

Event	Planned Out-of-Hospital Birth (Events per 1,000 births)	Planned Hospital Birth (Events per 1,000 births)	Adjusted Odds Ratio	95% CI
Labor induction	48	304	0.11	0.09–0.12
Labor augmentation	75	263	0.21	0.19–0.24
Operative vaginal delivery	10	35	0.24	0.17–0.34
Cesarean delivery	53	247	0.18	0.16–0.22
Blood transfusion/hemorrhage	6	4	1.91	1.25–2.93
Severe perineal lacerations	9	13	0.69	0.49–0.98

Abbreviation: CI, confidence interval.

Data from Snowden JM, Tilden EL, Snyder J, Quigley B, Caughey AB, Cheng YW. Planned out-of-hospital birth and birth outcomes. N Engl J Med 2015;373:2642–53.

singleton-term pregnancies demonstrate a higher risk of 5-minute Apgar scores less than 7, less than 4, and 0; perinatal death; and neonatal seizures with planned home birth, although the absolute risks remain low (Table 2) (17, 18, 32).

Although patients with one prior cesarean delivery were considered candidates for home birth in two Canadian studies, details of the outcomes specific to patients attempting home vaginal birth after cesarean delivery were not provided (24, 25). In England, women planning a home trial of labor after cesarean delivery (TOLAC) exhibited fewer obstetric risk factors, were more likely to deliver vaginally, and experienced similar maternal and perinatal outcomes compared with those planning an in-hospital TOLAC (35). In contrast, a recent U.S. study showed that planned home TOLAC was associated with an intrapartum fetal death rate of 2.9 in 1,000, which is higher than the reported rate of 0.13 in 1,000 for planned hospital TOLAC (36, 37). This observation is of particular concern in light of the increasing number of home vaginal births after cesarean delivery (38). Because of the risks associated with TOLAC, and specifically considering that uterine rupture and other complications may be unpredictable, the College recommends that TOLAC be undertaken in facilities with trained staff and the ability to begin an emergency cesarean delivery within a time interval that best incorporates maternal and fetal risks and benefits with the provision of emergency care.

The decision to offer and pursue TOLAC in a setting in which the option of immediate cesarean delivery is more limited should be considered carefully by patients and their health care providers. In such situations, the best alternative may be to refer patients to facilities with available resources. Health care providers and insurers should do all they can to facilitate transfer of care or comanagement in support of a desired TOLAC, and such plans should be initiated early in the course of antenatal care (39).

Recent cohort studies reporting comparable perinatal mortality rates among planned home and hospital births describe the use of strict selection criteria for appropriate candidates (23–25). These criteria include the absence of any preexisting maternal disease, the absence of significant disease arising during the pregnancy, a singleton fetus, a cephalic presentation, gestational age greater than 36–37 completed weeks and less than 41–42 completed weeks of pregnancy, labor that is spontaneous or induced as an outpatient, and that the patient has not been transferred from another referring hospital. In the absence of such criteria, planned home birth is clearly associated with a higher risk of perinatal death (15, 26, 40). The Committee on Obstetric Practice considers fetal malpresentation, multiple gestation, or prior cesarean delivery to be an absolute contraindication to planned home birth.

Another factor influencing the safety of planned home birth is the availability of safe and timely intrapartum transfer of the laboring patient. The reported risk of needing an intrapartum transport to a hospital is 23–37% for nulliparous women and 4–9% for multiparous women. Most of these intrapartum transports are

Table 2. Adverse Perinatal Events Associated With U.S. Planned Home Births Versus Hospital Births ⇦

Event	Planned Home Birth (Events per 1,000 Births)	Hospital Birth (Events per 1,000 Births)	Odds Ratio	95% CI
5-minute Apgar score				
<7	24.2*	11.7*	2.42*	2.13–2.74*
	23†§	18†	1.31†	1.04–1.66†
<4	3.7*	2.43*	1.87*	1.36–2.58*
	6†§	4†	1.56†	0.98–2.47*
0	1.63‡	0.16†	10.55‡	8.62–12.93‡
Neonatal seizures (or serious neurologic dysfunction‡)	0.58*	0.22*	3.08*	1.44–6.58*
	0.86‡	0.22†	3.80†	2.80–5.16†
	1.3†§	0.4†	3.60†	1.36–9.50†
Perinatal mortality (fetal death and neonatal mortality)	3.9†§	1.8†	2.43†	1.37–4.30†

Abbreviation: CI, confidence interval.

*Cheng YW, Snowden JM, King TL, Caughey AB. Selected perinatal outcomes associated with planned home births in the United States. Am J Obstet Gynecol 2013;209:325.e1–8.

†Snowden JM, Tilden EL, Snyder J, Quigley B, Caughey AB, Cheng YW. Planned out-of-hospital birth and birth outcomes. N Engl J Med 2015;373:2642–53.

‡Grunebaum A, McCullough LB, Sapra KJ, Brent RL, Levene MI, Arabin B, et al. Apgar score of 0 at 5 minutes and neonatal seizures or serious neurologic dysfunction in relation to birth setting. Am J Obstet Gynecol 2013;209:323.e1–6.

§Includes planned birth center and home births.

for lack of progress in labor, nonreassuring fetal status, need for pain relief, hypertension, bleeding, and fetal malposition (27, 41, 42). The relatively low perinatal and newborn mortality rates reported for planned home births from Ontario, British Columbia, and the Netherlands were from highly integrated health care systems with established criteria and provisions for emergency intrapartum transport (23–25). Cohort studies conducted in areas without such integrated systems and those where the receiving hospital may be remote, with the potential for delayed or prolonged intrapartum transport, generally report higher rates of intrapartum and neonatal death (6, 9, 11, 15, 22). Even in regions with integrated care systems, increasing distance from the hospital is associated with longer transfer times and the potential for increased adverse outcomes. However, no specific thresholds for time or distance have been identified (43, 44). The College believes that the availability of timely transfer and an existing arrangement with a hospital for such transfers is a requirement for consideration of a home birth. When antepartum, intrapartum, or postpartum transfer of a woman from home to a hospital occurs, the receiving health care provider should maintain a nonjudgmental demeanor with regard to the woman and those individuals accompanying her to the hospital.

A characteristic common to those cohort studies reporting comparable rates of perinatal mortality is the provision of care by uniformly highly educated and trained certified midwives who are well integrated into the health care system (23–25, 27). In the United States, certified nurse–midwives and certified midwives are certified by the American Midwifery Certification Board. This certification depends on the completion of an accredited educational program and meeting standards set by the American Midwifery Certification Board. In comparison with planned out-of-hospital births attended by American Midwifery Certification Board-certified midwives, planned out-of-hospital births by midwives who do not hold this certification have higher perinatal morbidity and mortality rates (18). At this time, for quality and safety reasons, the College specifically supports the provision of care by midwives who are certified by the American Midwifery Certification Board (or its predecessor organizations) or whose education and licensure meet the International Confederation of Midwives Global Standards for Midwifery Education. The College does not support provision of care by midwives who do not meet these standards.

Although the College believes that hospitals and accredited birth centers are the safest settings for birth, each woman has the right to make a medically informed decision about delivery (45). Importantly, women should be informed that several factors are critical to reducing perinatal mortality rates and achieving favorable home birth outcomes. These factors include the appropriate selection of candidates for home birth; the availability of a certified nurse–midwife, certified midwife or midwife whose education and licensure meet International Confederation of Midwives' Global Standards for Midwifery Education, or physician practicing obstetrics within an integrated and regulated health system; ready access to consultation; and access to safe and timely transport to nearby hospitals.

For More Information

The American College of Obstetricians and Gynecologists has identified additional resources on topics related to this document that may be helpful for ob-gyns, other health care providers, and patients. You may view these resources at www.acog.org/More-Info/PlannedHomeBirth.

These resources are for information only and are not meant to be comprehensive. Referral to these resources does not imply the American College of Obstetricians and Gynecologists' endorsement of the organization, the organization's website, or the content of the resource. The resources may change without notice.

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State of Wisconsin
Department of Safety & Professional Services

AGENDA REQUEST FORM

1) Name and Title of Person Submitting the Request: Whitney DeVoe, Board Counsel			2) Date When Request Submitted: 05/01/25 Items will be considered late if submitted after 4:30 p.m. and less than: ▪ 10 work days before the meeting for Medical Board ▪ 14 work days before the meeting for all others
3) Name of Board, Committee, Council, Sections: **Midwife Advisory Committee**			
4) Meeting Date:	5) Attachments: ☐ Yes ☒ No	6) How should the item be titled on the agenda page? Licensed Midwives – Informed Consent Form – Discussion and Consideration	
7) Place Item in: ☒ Open Session ☐ Closed Session ☐ Both	8) Is an appearance before the Board being scheduled? ☐ Yes (Fill out Board Appearance Request) ☒ No	9) Name of Case Advisor(s), if required:	
10) Describe the issue and action that should be addressed: **Discussion and consideration of updates to DSPS form #2795 related to informed consent.**			
11) Authorization Whitney DeVoe — Signature of person making this request Supervisor (if required) Executive Director signature (indicates approval to add post agenda deadline item to agenda)			05/01/25 — Date Date Date
Directions for including supporting documents: 1. This form should be attached to any documents submitted to the agenda. 2. Post Agenda Deadline items must be authorized by a Supervisor and the Policy Development Executive Director. 3. If necessary, Provide original documents needing Board Chairperson signature to the Board Admin Specialist prior to the start of a meeting.			

Revised 10/12

Wisconsin Department of Safety and Professional Services

Office Location: 4822 Madison Yards Way
Madison, WI 53705
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LicensE Portal: https://license.wi.gov/
Email: dsps@wisconsin.gov
Website: http://dsps.wi.gov

DIVISION OF PROFESSIONAL CREDENTIAL PROCESSING

LICENSED MIDWIVES – INFORMED CONSENT FORM

Last Name	**First Name**	**MI**	**Former / Maiden Name(s)**
Address (number street, city, state, zip code)			**Daytime Telephone Number**
			___ - ___ - ____

TRAINING: List location, type of training (self-study, apprenticeship, direct-entry school, nurse midwifery school) and dates of attendance.

Facility Name, City, State	**Type of Training**	**Dates**	
		From (month/year)	**To (month/year)**
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____
		__ / ____	__ / ____

CERTIFICATION: List name and address of certifying body, date of certification and type of certification.

Name and City/State of Certifying Body	**Type of Certification**	**Date of Certification**
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____
		__ / __ / ____

MIDWIFE EXPERIENCE:

1.	Total number of births attended:	
2.	Number of home births as primary/managing midwife:	
3.	Number of home births as primary assistant to the midwife:	
3.	Number of years in practice as primary midwife:	
4.	Number of births as doula/hospital support:	
5.	Number of clients transferred to a hospital since commencement of practice of midwifery:	

MALPRACTICE LIABILITY INSURANCE:

Do you have malpractice liability insurance coverage? ☐ Yes ☐ No List policy limits of coverage (if applicable):

Wisconsin Department of Safety and Professional Services

MEDICAL EMERGENCIES:
The following is my protocol for handling medical emergencies, including transportation to a hospital. Attach additional sheets if necessary.

VAGINAL BIRTH AFTER CESAREAN SECTION (VAC):
The following is my protocol for disclosure of risks associated with vaginal birth after a cesarean section. Attach additional sheets if necessary.

DISCLOSURE RELATING TO NEONATAL RESUSCITATIONS:
Licensed midwives do not have the equipment, drugs or personnel available to perform neonatal resuscitations that would normally be available in a hospital setting.

COPY OF DEPARTMENT RULES PROVIDED TO CLIENT: As required under Wis. Admin. Code § SPS 182.02(1), I certify that on this date I provided a copy of the Department's rules pertaining to the practice of midwifery to the client. **(List client name below.)**

Printed Name of Midwife	**WI License Number**
Signature of Midwife (If unable to provide a digital signature print and sign form.)	**Date**
	/ /

ACKNOWLEDGEMENT BY CLIENT: I acknowledge that I have received the oral and written disclosures required under Wis. Admin. Code § SPS 182.02.

Printed Name of Client	
Signature of Client (If unable to provide a digital signature print and sign form.)	**Date**
	/ /

Information

regarding

VAGINAL BIRTH AFTER CESAREAN SECTION

What is VBAC?

VBAC stands for Vaginal Birth After Cesarean, which is exactly what it sounds like - pushing a baby out through the birth canal (vagina) after having given birth by cesarean section. Some folks think that the VBAC term applies only to the first vaginal birth following a cesarean. In actuality, the VBAC label applies to every intended vaginal birth following the cesarean. In other words, if someone's first baby was born by cesarean, and their second baby was a successful VBAC, their third vaginal birth (and any after that) will similarly be VBACs.

Some important abbreviations that you'll run into in this article and as you further research this topic via other resources:

- VBAC (Vaginal birth after cesarean)
- HBAC (Home birth after cesarean)
- TOLAC (Trial of labor after cesarean)
- VBA2C (Vaginal birth after 2 cesareans)
- C/S (Cesarean section)
- PRCS (Planned repeat cesarean section)

Please understand that this handout is simply a jumping-off point for the research that we implore each family to do as they investigate their birthing options.

What's the big deal about VBAC?

Let's start by understanding that when a baby is born surgically (by cesarean section), the doctor needs to make an incision first through the skin and fat layers of the lower abdomen, at which point the layers of abdominal muscles are essentially stretched apart.

Through that newly-created opening, another incision is made into the uterus, which is the large, balloon-like muscle in which the baby grows and develops. The baby is then pulled out through this incision, followed by the placenta soon after. Afterward, the incisions to the uterus and then to the skin are sutured (sewn) back together and allowed to heal.

The medical world has learned a lot over the years about how to do cesarean sections in a way that encourages the strongest healing - considerations like where and how to make

the incision into the uterus, as well as how to repair it after the birth. However, the fact still remains that there will forever be scar tissue there, making that spot weaker than the rest of the muscle of the uterus - this is where the extra risks and considerations come into play for pregnancies and births following a cesarean section.

That scarred portion of the uterus increases the possibility of some complications with the placenta, as well as a severe complication called uterine rupture, both of which we'll discuss in more detail. It's due to these elevated risks that pursuing a VBAC should be a very thoughtful decision for every family - one that they make on a basis of individual risk-assessment and with evidence-based information that's current and thorough.

It used to be the case that once a mother had a cesarean section, it was considered too dangerous to attempt a VBAC. She would have planned repeat cesarean sections (PRCS) for the rest of her childbearing years. However, we now understand more about how to improve the likelihood of a successful VBAC, and we also understand that each C/S a woman undergoes brings more risk to her future childbearing years. Even the conservative American College of Obstetricians and Gynecologists (ACOG) now recommends encouraging a "trial of labor after cesarean" (TOLAC) for most women, though they assert the birth should take place in a hospital.

What are the major benefits of VBAC?

Many of the benefits of pursuing a VBAC boil down to avoiding the risks and the challenges that come along with major abdominal surgery. Of course, none of the following are guaranteed, but are statistically likely:

- ***Shorter recovery after birth.*** Pushing a baby out vaginally is hard work - especially if it's someone's first time! However, the recovery afterward tends to be much easier than recovery from a surgical birth. A C/S is major abdominal surgery and the recovery is no joke.
- ***Microbiome benefits for baby***. A baby who is born vaginally is exposed to all sorts of helpful bacteria on their trip through the birth canal. Those bacteria colonize the infant's gut, which leads to improved immune function and reduces the risk of various autoimmune disorders and other long-term health consequences for the child. Babies born by cesarean miss out on this beneficial bacterial exposure and we're only now beginning to understand the long-term impacts.

- ***Reducing the increased risks of repeat cesareans.*** It's important to understand that some of the risk factors associated with a cesarean section actually accumulate, or build up, with each additional C/S. In other words, with each additional cesarean section that a woman undergoes, she carries more risk into future pregnancies and births. For couples desiring a large family, this can be a significant problem, especially if the cesarean is early in her childbearing years.

- ***Avoiding the immediate risks of surgery.*** As with any surgery, there are risk factors to consider. A C/S puts someone at higher risk of:
    - Elevated blood loss
    - Infection of uterus, bladder, or incision *(20x greater risk than following vaginal birth)*
    - Hematoma, which is a burst blood vessel inside your body
    - Blood clots *(Doubles the risk compared to natural birth)*
    - Accidental injury to internal organs *(Most likely after multiple cesareans or during an emergency C/S)*
    - Accidental injury to the baby *(Most likely during an emergency C/S)*
    - Anesthesia complications *(More likely during an emergency C/S)*
    - Allergic reaction to medications
    - Delayed/impaired bowel function
    - Extended hospital stay
- ***Decreased cost.*** This is deliberately last on the list of benefits because it should not be the first consideration, safety should always be our primary concern. However, we can't ignore the fact that it's usually MUCH cheaper to have a vaginal birth than to undergo a cesarean. A recent three-year study showed that American families pay, on average, approximately $19,000 more per birth for an uncomplicated cesarean section than for an uncomplicated vaginal birth.

What are the major risks of VBAC?

Uterine rupture - As discussed earlier, with every cesarean birth in a woman's history, there remains a scar on the uterus. The vast majority of times, that scar heals well and remains strong, but it's true that the scarred portion remains weaker than the rest of the muscle of the uterus. The stresses of full-term pregnancy, and then of labor and birth, can be a real test of that scar tissue.

Once a cesarean is in a person's history, the most feared complication of a subsequent pregnancy and birth is uterine rupture. Uterine rupture is when the uterus tears open, usually at the site of the scar. In the event of a rupture, doctors must work quickly to first deliver the baby so they do not suffer from oxygen deprivation which can cause brain damage or death. Doctors must then try to repair the uterus in order to stop the mother's blood loss.

Most times, uterine repair is possible, though sometimes the damage is extensive enough that the uterus can not be saved and must be removed altogether (called a hysterectomy). Transfusion(s) of blood products may be necessary to overcome the mother's blood loss. These are time-sensitive emergencies and the closer that mother and baby are to an operating room, the better the outcome will likely be.

Uterine rupture can happen to anyone, but is EXTREMELY rare for someone who has never had a uterine surgery. Reported rates of uterine rupture vary a bit from one study to the next, but are approximately:

- **0.006%** for someone with an unscarred uterus *(no history of C/S)*
- **0.3%** for someone who's having a planned repeat cesarean section (PRCS)
- **0.5%** for someone who's having a trial of labor after cesarean section (TOLAC) that is allowed to progress naturally *(without medications to start labor or speed it up)*
- **1%** for someone who's having a TOLAC and is given pitocin *(a medication given through one's IV to start or speed up labor)*
- **1.4%** for someone who's having a TOLA2C (trial of labor after 2 cesareans) that is allowed to progress naturally *(without medications to start labor or speed it up)*
- **2%** for someone who's having a TOLAC and is given prostaglandins *(a medication sometimes used to soften the cervix in preparation for labor)*
- **6%** for someone who's having a TOLAC and is given misoprostol *(a medication sometimes used to to start or speed up labor)*

I know these numbers seem low - it's true that uterine rupture is rare. However, when it does occur, it can be a life-threatening emergency for mother and baby and every family deserves to know and understand the risks.

Placenta complications - The placenta is a flat, disc-shaped organ that develops during pregnancy and is attached to the inside of the mother's uterus. Its job is to pass oxygen and nutrients from the mother's blood stream, through the umbilical cord, and to the baby. In order to sustain the baby, the placenta has to remain attached to the uterus throughout the entirety of pregnancy, labor, and birth. However, after the baby is born, the placenta is *designed to detach from where it's stuck on the inside of the uterus* and pass out of the birth canal.

The more C/Ss that a person has had, the more likelihood there is to be troubles with the placenta, specifically with its ability to detach and be born after the birth. It might attach too deeply to the uterus, a condition called ***placenta accreta***. This is an exceedingly rare complication for women who have never had a uterine surgery, but one that will be experienced by approximately 1 out of 1,229 who have previously had a cesarean (based on a 2023 nation-wide study). The rate of placenta accreta increases with every C/S as follows:

- 0.31% chance after 2 C/Ss
- 0.57% after 3 C/Ss
- 2.13% after 4 C/Ss
- 2.33% after 5 C/Ss
- 6.74% after 6 C/Ss

Another possible complication is the placenta attaching over the cervix, which is the part of the uterus that must open up to let a baby be born through the birth canal. This condition is called placenta previa and can quickly threaten the lives of both mother and baby due to blood loss, which in many cases can be severe. Sometimes placenta previa and accreta happen at the same time and that can be a particularly dangerous situation!

Both of these placenta complications, while uncommon, can cause significant blood loss - the type that can quickly become a life-threatening emergency. Medications can be necessary to slow the bleeding, but the mother may require an emergency operation to remove the placenta in order to fix the problem. In dire circumstances, surgeons may even need to remove the uterus altogether. Depending on the situation, mother and/or baby may need a transfusion(s) of blood products if the blood loss was severe.

After reading about those possible complications, why do folks want a VBAC?

It's important to understand that the post-cesarean risks are NOT contained to just VBACs - there are potentially severe risks associated with repeat C/S as well. In other words, a repeat surgical birth is not an "easy-out". As mentioned before, the risks of repeat C/S accumulate with each additional surgery, so with every birth, *more risk* is actually being borne by the mother. The main risks that tend to increase with each additional cesarean are:

- ***Placenta accreta*** (the placenta attaching too deeply to the uterine wall)
- ***Placenta previa*** (the placenta attaching over the cervix)
- ***Uterine rupture*** (the uterus rupturing)
- ***Hernia*** (a weakening of the abdominal muscles possibly allowing abdominal tissues and organs to protrude through)
- ***Adhesions*** (bands of abnormal, fibrous tissue developing between abdominal organs. Their presence can contribute to future complications including infertility, ectopic pregnancy, abdominal and pelvic pain, and difficulty with future abdominal surgeries.)

Considering a VBAC?

Discuss your childbearing history with your provider, including:

1. Number of prior cesareans or other uterine surgeries (example: fibroid removal, D&C, biopsy, etc.)
2. Reason for the prior C/S
3. Amount of time that will have passed between the C/S and the next birth
4. Location and type of uterine scar
5. Any post-cesarean complications that occurred

Evaluate the birthing location and emergency response time. If you're considering birthing out-of-hospital (home birth or birth center), what is the emergency transport plan? How long will it take to access higher-level medical care if needed? The severe complications of VBAC are, admittedly, rare. However, when they do occur, minutes matter. If you're birthing in a hospital, check into their resources; for example, do they have 24/7 anesthesia in case a quick cesarean is needed? Everyone's birthing situation is different and you need to make sure that you're familiar with and comfortable with the option that you're selecting.

Ask about the VBAC success rate of the provider/institution that you're considering. Some institutions and providers have better VBAC success rates than others. Inquire about the experience, outcomes, and rates of complications for that specific practice.

Risk factors preventing VBAC

Things that would make a VBAC too risky include:

A history of vertical C/S incision - The safest uterine incision for a C/S is normally just above the pubic bone - a low, transverse line between 6 and 9 inches long. In cases of challenging or emergency cesareans, a vertical incision - up and down, right on the mother's midline - may have been necessary (other possibilities are an inverted-J or -T shape incision). These incisions leave someone at much higher risk of uterine rupture and VBAC should not be attempted.

A short interval between a person's cesarean birth and their desired VBAC - 18 months is minimum (24 months is preferred) in order to ensure good healing of the prior uterine incision.

A history of prior rupture - If someone has had a uterine rupture that was repaired, they are at a much higher risk of rupture for future pregnancies, even after it is healed.

A history of other uterine surgeries - There are other uterine procedures aside from cesarean section that may cause weakness similar to a cesarean. This is not an automatic risk-out, however, it's important to discuss any surgery (examples: fibroid removal, D&C, biopsies, etc.) with your care provider so that you can get a proper and accurate evaluation of your risk.

The presence of any other factor that makes natural birth unsafe - There are other conditions, for example, some malformations of the growing baby, or a maternal problem like an untreated herpes (viral) infection that would make any natural birth (not just a VBAC) too high-risk.

Tips for a successful VBAC:

- ***Strive for at least 24 months between the C/S and the next birth.*** As stated earlier, this gives the uterine scar time to heal and strengthen. A short interval between the cesarean and a next pregnancy causes a higher risk of uterine rupture.
- ***Allow labor to start up and progress naturally.*** Inducing labor or using medications to keep labor progressing puts an unusual amount of stress on the uterus and increases the risk of uterine rupture. In most VBAC situations, allowing things to progress naturally is safest!
- ***Having already had a successful vaginal birth or VBAC*** increases the success rate. It doesn't matter if your vaginal birth was before or after your cesarean - the fact that your body has pushed out a baby at least once before means the odds of doing so again are high! Again, the following statistics will vary from one institution to the next, but: having never had a prior natural birth, a woman has a 63% VBAC success rate. If a woman has already had one baby naturally, the VBAC success rate jumps up to about 87%.
- ***Select a care provider and birth setting that you feel comfortable with***. When a mother is comfortable with her care team and her environment, the odds of a successful VBAC go up because the body responds to the labor process more effectively. As a result, less medications and interventions are needed and it's easier to stay in a safe zone.
- ***Understand that your labor will be monitored more closely.*** Both of the major possible complications of VBAC can occur without much in the way of symptoms, so it will be more important that your care providers monitor maternal vitals and baby's heart rate more closely than they likely would for a "normal" labor and birth.
- ***Be willing to change your birthing plans.*** If risk factors over the course of pregnancy or labor/birth would change, the setting and/or method of birth may have to change as well. Early warning signs should be acted upon in a conservative way so that mother and baby both have a safety net underneath them in the event it's needed.

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Informed Consent

for

VAGINAL BIRTH AFTER CESAREAN SECTION

I, _____ understand and appreciate that a major tenet of midwifery care is the ability to retain my own decision making. I also understand that it means I bear an increased burden to inform myself and take responsibility for my care decisions. By initialing next to each of the statements that follow, I affirm that:

(Print full name)

- I have read and given careful consideration to the information and options given to me by Windy Hill Midwifery, LLC (WHM)
- I have had time to research the topic from different sources and ask questions
- I am making a fully-informed decision

Regarding my VBAC:

In the event of a non-emergent transport or transfer of care, my preferred provider and location are:

_____ _____

(Provider Name) *(Provider Location)*

☐ *(Initials)* I realize that in a time-sensitive situation, transport will be to the closest location that provides birthing services, which in my situation, is: _____ *(Hospital)*

☐ *(Initials)* I understand that my care team will monitor my labor more frequently and I agree to give prompt and serious consideration to any concern that develops over the course of labor, as well as to subesquent recommendations from my care team.

☐ *(Initials)* I understand the risks and benefits of Vaginal Birth after Cesarean. Furthermore, I understand the risks and benefits of VBAC in an out-of-hospital setting. I realize that the provision of emergency interventions such as cesarean section, transfusions of blood products, etc, will be delayed compared to birthing in a hospital.

Client Signature: _____ Date: ___/___/_____

Primary VBAC/TOLAC

MIDWIFERY CONSENT FORM

We support a client's right to self-determination.

Therefore, we support clients who would like to attempt to have a VBAC (vaginal birth after cesarean) or what is referred to as 'trial of labor after cesarean' (TOLAC). We believe that in most cases, TOLAC is a safe option for families. Because TOLAC does carry some increased risk, we want to make sure that you fully understand the risks and benefits and are choosing this option knowing how a TOLAC is different from other births.

To reduce unnecessary risk, we only take the lowest risk clients desiring a TOLAC at home with the following criteria:

- No more than one previous cesarean birth.
- Surgical records demonstrating a low, transverse surgical scar from your cesarean birth.
- An ultrasound record from this current pregnancy showing that your placenta is not lying across your cesarean scar.
- Minimum 18 months between your cesarean birth and your current due date.
- You must be willing to allow extra monitoring of you and the baby during your labor and birth.
- You must be willing to transport to the hospital at the request of the midwife if she feels anything about your labor or birth is straying from a normal course.

Current ACOG Standards for VBAC/TOLAC

"In keeping with past recommendations, most women with one previous cesarean delivery with a low- transverse incision are candidates for and should be counseled about VBAC and offered a TOLAC [trial of labor after cesarean]." [1]

TOLAC Counseling on Benefits and Risks

Both a repeat cesarean and a trial of labor after cesarean (TOLAC) carry risks including: maternal hemorrhage, infection, operative injury, blood clots, hysterectomy, and death.

Risks of a TOLAC:

The need for a repeat/emergency cesarean. Most maternal injury that occurs during a TOLAC happens when a repeat cesarean becomes necessary after the TOLAC does not proceed to a normal birth. A successful VBAC has fewer complications than an elective repeat cesarean while a TOLAC that ends in cesarean has more complications than an elective repeat cesarean.

Uterine rupture.

The risk of uterine rupture during a TOLAC is low–between 0.5% and 0.9%.[2] If a uterine rupture occurs, it is an emergency. A uterine rupture can lead to emergency surgery, blood transfusions, hysterectomy, and in extreme cases even death to a client and/or baby. However, the extreme of a neonatal demise happens in only 3-6% of cases where there is a uterine rupture. This makes the overall risk of a serious adverse outcome in a primary TOLAC very low.

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[1] (Humphry, Laura. New VBAC Guidelines. ACOG Today, August 2010.)

[2](Guise Jm, Eden K, Emeis C, Denman MA, Marshall B, Fu Rr, et al. 2010. "Vaginal birth after cesarean:new insights. ." Evid Rep Technol Assess (Full Rep) 1-397.)

Benefits of VBAC:

- Approximately 60-80% of appropriate candidates who attempt TOLAC will be successful with a VBAC.
- A VBAC avoids major abdominal surgery, lowers the risk of hemorrhage and infection, and shortens postpartum recovery. It may also help folks avoid the possible future risks of having multiple cesareans such as hysterectomy, bowel and bladder injury, transfusion, infection, and abnormal placenta conditions (such as placenta previa and placenta accreta). [3]
- Easier bonding and breastfeeding initiation postpartum.

Risks Associated with Elective Repeat Cesarean Section

Risks to the baby:

- Increased risk of neonatal respiratory distress syndrome (RDS)
- Increase in persistent pulmonary hypertension
- Increased risk of physician caused prematurity
- 0.5 %-1.5% chance of laceration by the surgeon's scalpel [4]

Risks to the pregnant person:

- Increased risk of postpartum infection
- Increased risk of hemorrhage, transfusions, ureter or bowel injury, incisional endometriosis
- Increased risk of re-hospitalization due to infection, gallbladder disease, surgical wound complications, cardiopulmonary conditions, thromboembolic conditions, and appendicitis
- Longer hospital stay
- Increased risk of hysterectomy in both the current and future pregnancies
- Increased maternal death rate
- Higher rates in subsequent pregnancies of placental abnormalities such as placenta previa or accreta
- Higher rates of secondary infertility, miscarriage, and ectopic pregnancy [5]

Benefits of Elective Repeat Cesarean:

- Convenience of scheduling the birth
- Avoidance of a labor that may result in a repeat cesarean
- Decreased risk of uterine rupture [6]

Further Reading:

VBAC Facts: http://vbacfacts.com/
iCAN http://www.ican-online.org/vbac-education-project
ACOG https://www.acog.org/Womens-Health/Vaginal-Birth-After-Cesarean-VBAC
ACOG Practice Bulletin on VBAC: https://www.ncbi.nlm.nih.gov/pubmed/20664418

[3] (Bennet S, Bourret K, Meuser A. "Vaginal Birth after Previous Low-Segment Caesarean Section" Clinical Practice Guidelines.Vol 14. (2010): 13-18)
[4] (IBID: 12)
[5] (IBID: 12)
[6] (Guise Jm, Eden K, Emeis C, Denman MA, Marshall B, Fu Rr, et al. 2010. "Vaginal birth after cesarean:new insights. ." Evid Rep Technol Assess (Full Rep) 1-397.)

Please use this space below to declare, in your own words, your choice to pursue a TOLAC in the community setting and your understanding of the risks and benefits of your choice:

Your Choice:

I have had all my questions regarding the risks and benefits of a TOLAC clearly explained to me. I am pursuing a TOLAC as a matter of personal preference. I know that a repeat elective Cesarean Section is an option available to me, but I am choosing to attempt a VBAC instead.

Client Name	Client Signature	Date
Witness Name	Witness Signature	Date
Midwife Name	Midwife Signature	Date