OFFICE OF PROFESSIONAL REGULATION
VERMONT SECRETARY OF STATE
89 Main Street, 3rd Floor, Montpelier, VT 05620
802-828-1505 | sos.vermont.gov/opr

Administrative Rules for Midwives
Effective Date: December 1, 2001

Part 1 General information on Licensure of Midwives

1.1 The Purpose of Licensure

The Director of the Office of Professional Regulation has been given powers by Vermont law to protect the public health, safety, and welfare by setting standards, licensing applicants, and regulating licensed midwives and their practices.

1.2 Laws that Govern Licensure

Licensure is governed by a specific state law that establishes responsibilities for setting standards, issuing licenses, and regulating the profession. The law is the Midwives Act, Title 26, Vermont Statutes Annotated, Chapter 85. In addition, the Director of Professional Regulation is obligated to comply with several other state laws, such as the Administrative Procedure Act (3 V.S.A.801-849), the Open Meeting Law (1 V.S.A. 311- 314), the Access To Public Records Law (1 V.S.A. 315-320), and the Law of Professional Regulation (3 V.S.A. 121-131).

These laws set forth the rights of an applicant, licensed midwife, or member of the public. The complete text of these laws is available at most libraries and town clerks' offices. "Vermont Statutes Online" are also available on the Internet at http://www.leg.state.vt.us. The text of laws and rules governing midwives may be found at http://www.vtprofessionals.org/midwives.

Part 2 Information for Applicants

2.1 Application

Applications and information about licensure requirements are available from the Office of Professional Regulation (Office). An applicant must submit a completed

application form with all supporting documentation and the fee to the Office. The Office reviews applications only after the supporting documentation is received.

2.2 Qualifications for Licensure as a Midwife

To be eligible for licensure as a midwife, an applicant must

(1) have obtained certification as a certified professional midwife (CPM) from the North American Registry of Midwives (NARM),

(2) have earned a high school degree or its equivalent, and

(3) have agreed to practice according to the scope and standards of practice set forth in these rules.

2.3 Right to a Written Decision and Appeal

If the Director of the Office of Professional Regulation (Director) denies an applicant licensure, the Director will give specific reasons in writing and inform the applicant of the right to appeal this decision to an administrative law officer. After giving the applicant an opportunity to present the application and any additional information, the administrative law officer must affirm, reverse, or modify the Director's preliminary decision. Decisions of the administrative law officer may be appealed to the Washington Superior Court.

Part 3 Information for Midwives

3.1 Renewing Licensure Biennially

Licenses renew on a fixed biennial schedule: January 31 of the odd-numbered years. Initial licenses issued within 90 days of the renewal date will not be required to renew or pay the renewal fee. The license will be issued through the next full license period. Applicants issued an initial license more than 90 days prior to the renewal expiration date will be required to renew and pay the renewal fee.

Before the expiration date, the Office will mail a renewal application and notice of the renewal fee. A license will expire automatically if the renewal application and fee are not returned to the Office by the expiration date.

See also Rules 3.3 (continuing education requirements), 3.8 (peer reviews), 3.9 (individual practice data), and 3.10 (CPR certification) for additional license renewal requirements.

3.2 Lapsed Licenses

A license that has lapsed for three years or less will be renewed if the applicant submits the renewal fee, late renewal penalty, and renewal application showing:

(1) That the applicant still meets the eligibility requirements for licensure.

(2) That all requirements for renewal have been met, including continuing education of not less than 20 hours accrued during the two years immediately preceding application for license renewal. See Rule 3.3 (continuing education requirements).

An applicant is not required to pay renewal fees for years during which the license was lapsed.

A license that has lapsed for more than three years for reasons other than professional discipline may be renewed, but only if the applicant files an application for license reinstatement on a form approved by the Director and pays the required fee. An applicant for license reinstatement must show to the Director' s satisfaction:

(1) That the applicant still meets the eligibility requirements for licensure.

(2) That the applicant has met the continuing education requirement of not less than 20 hours accrued during the two years immediately preceding application for license reinstatement.

(3) That no fewer than three persons, including at least one midwife licensed in Vermont, who have knowledge of the applicant's professional activities since the license lapsed recommend and support license reinstatement.

An applicant is not required to pay renewal fees for years during which the license was lapsed.

3.3 Continuing Education Requirements

All midwives licensed and residing in this state must complete a minimum of 20 hours of continuing education during the two-year renewal period and must so certify at the time of license renewal. The continuing education requirement does not apply for the renewal period during which a midwife initially obtained licensure. It will begin with the first full two-year renewal period.

A continuing education program means classes, institutes, lectures, conferences, workshops, midwifery journals, scientific journals, audio- or videotaped presentations, and preceptorships. A program must consist of study covering new, review, experimental, research, and specialty subjects within the scope of practice of midwifery in this state.

Excluded are programs that promote a company, individual, or product and programs whose subject is practice economics.

Programs offered by the following organizations, agencies, or institutions are approved by the Director for continuing education credit:

(1) The American College of Nurse Midwives.

(2) The Midwives Alliance of North America.

(3) A midwifery school or program accredited by the Midwives Education Accreditation Council.

(4) North American Registry of Midwives (NARM)

(5) The Vermont Medical Society or the American Medical Association (programs which qualify for Category I credit).

(6) The Vermont Midwives Alliance when accredited by any other approved organization, agency or institution.

(7) The National Health Service Corps.

(8) The American College of Obstetricians and Gynecologists.

(9) The American Association of Nurse Practitioners.

(10) International Board of Lactation Consultants

A course will be approved for the hours the provider assigns to the course. All other programs will be evaluated and may be eligible for credit if they meet the following criteria and comply with other provisions of these rules: the material is relevant to a midwifery practice (presenting a modality used by midwives), and the sponsoring organization is credible (able to verify attendance and course content).

No more than ten hours will be credited in a single subject area towards the 20-hour biennial continuing education requirement. No more than five hours will be granted for informal study or self-study of midwifery or scientific journals, audio- or videotaped presentations, or preceptorships.

The amount of credit to be allowed for correspondence and formal individual study programs (including taped study programs) will be that which is recommended by the program sponsor. Licensees claiming credit for such correspondence or formal individual study courses are required to obtain evidence of satisfactory completion of the course from the program sponsor. Credit will be allowed in the renewal period in which the course is completed.

A licensee residing in another jurisdiction who has met the continuing education requirements for the current biennial renewal period in that jurisdiction will be deemed by the Director to have met the continuing education requirements for license renewal in Vermont, provided that the other jurisdiction's requirements are reasonably equivalent to those in Vermont. A licensee who holds a current certification as a CPM from the NARM will also be deemed by the Director to have met the continuing education requirements for license renewal in Vermont, provided that NARM's continuing education requirements are reasonably equivalent to those in Vermont.

At the time of license renewal, each licensee must certify on the official renewal form that he or she has complied with the continuing education requirements. The Office may randomly audit licensees to ensure compliance. A licensee who is audited will be notified in writing by the Office and will be required to produce written documentation verifying successful completion of the 20 hours of continuing education during the two-year period at issue. A licensee must maintain such written documentation for a period of three years following the renewal period at issue.

The Director may require a licensee who cannot produce such documentation to develop and complete a specific corrective action plan within 90 days, prior to renewal.

3.4 Continuing Education Program Approval

An educational activity will be eligible for approval as satisfying the continuing education requirements of these rules if it has significant intellectual and practical content directed at increasing the professional competence of midwives, and the activity consists of classroom-style instruction, educational seminars, or self-directed study with substantial written material available, whether conducted by live speakers, lecturers, panel members, video or audiotape presentation, or in written format. If the educational activity consists of classroom-style instruction or seminar, it must be conducted in a classroom or similar setting with a group of not fewer than three individuals. If the educational activity consists of a scientific journals, each journal article for which credit is sought must provide for a written examination and answer sheet, to be completed and mailed to the journal for correction and grading.

The activity may be approved by the Director upon a written request for approval. The name of the activity, the number of credits requested, and the names of the instructors and sponsors must be clearly indicated in the written request. Application may be filed by the sponsoring agency or group, or by any participant. Application for advance approval must be filed at least 120 days before the educational activity has commenced. All applications for approval

must be filed within 30 days after the activity is completed. The Director will assign a maximum number of credit hours to each approved activity.

The Director may refuse to approve or may limit the number of hours to be accredited for any activity if the Director finds the activity:

(1) Is not eligible for accreditation pursuant to the criteria set forth above;
(2) Is sponsored by an individual or group lacking the ability or intention to produce a continuing education activity of sufficiently high quality to improve or maintain a midwife's professional competence; or
(3) Is not offered in a sufficiently organized fashion or under otherwise adequate circumstances to fulfill the objectives of these rules.

When the Director has approved an activity, the sponsor may so state, including the number of credits for which the activity has been approved.

3.5 Change of Name or Address

A licensee is responsible for notifying the Office promptly in writing if the licensee changes name, mailing address, or business address. For purposes of these rules, all initial licensure or renewal applications, notices, or other correspondence mailed to a licensed midwife by the Director or the Office at the licensed midwife's address on file with the Office will be considered as having been received by the licensed midwife.

3.6 Unprofessional Conduct

Licensed midwives may be disciplined for unprofessional conduct under 26 V.S.A. 4188 and 3 V.S.A. 129a. In addition, 3 V.S.A. 129(a)(6) provides a ground for discipline in this state if a licensee or applicant has been disciplined in another jurisdiction for any offense which would constitute unprofessional conduct in Vermont.

3.7 Complaint Procedure

The Office has a published procedure for receiving, investigating, and acting on complaints of unprofessional conduct. Copies of the procedure are available from the Office.

3.8 Peer Reviews

A midwife licensed in this state must participate in at least four separate peer review meetings evaluating the midwife's practice during each two-year renewal period as a condition of license renewal. Peer reviews must be conducted in peer review meetings or in conjunction with professional organization meetings. Each peer review must be conducted by at least two other licensed midwives who

have no personal, professional, or financial interest in the birth being reviewed. Peer reviews of the licensed midwife's practice must include but not be limited to process of care, outcome data, referral patterns, and discussion of specific cases and obtaining feedback and suggestions regarding care. Attendance at peer review sessions must be documented in writing on report forms approved by the Director and must be made available to the Director as required.

In addition to the four peer reviews required during each two-year renewal period, a licensed midwife must request and participate in peer review in the following specific situations:

(1) When there has been a death, significant morbidity to client or child, or transfer to hospital.

(2) When the midwife has acted outside the standards set forth in these rules.

Attendance at any peer review session conducted regarding a specific situation listed in paragraph (1) or (2) above must be documented in writing on report forms approved by the Director and must be filed with the Director within 30 days of the peer review session. Reports filed under paragraphs (1) or (2) above will be kept confidential by the Director, unless they result in the filing of charges of unprofessional conduct.

3.9 Individual Practice Data

As a condition of license renewal, a midwife licensed in this state must submit to the Office, on a form approved by the Director, individual practice data covering each two-year renewal period. Information must not include any data that would identify the client. Such individual practice data must include, at a minimum, the following information about each home birth attended during the renewal period:

(1) Client demographics.

(2) Previous pregnancies.

(3) Present pregnancy concerns.

(4) Prenatal care.

(5) Reasons why client stopped using midwife for primary care before labor at term began.

(6) Reasons why home birth was not or could not have been initiated or was outside midwife's home birth protocol.

(7) Intended and actual place of birth and gestational age.

(8) Encouragement, induction, and augmentation.

(9) Birth data.

(10) Hospital or birth center procedures.

(11) Transport from planned home or birth center birth
.
(12) Complications of labor and delivery.

(13) Perineal, labial, cervical, and vaginal trauma.

(14) Newborn data
.
(15) Immediate neonatal complications.

(16) Infant's health problems in first six weeks
.
(17) Infant in hospital in first six weeks.

(18) Infant died in first six weeks of life.

(19) Client's health and stay in hospital.

(20) Postpartum care, breastfeeding, and health by six weeks.

3.10 CPR Certification

A midwife licensed in this state must show proof of current cardiopulmonary resuscitation certification for adults and newborns and for neonatal resuscitation as a condition of initial issuance of license and of license renewal. The Director will accept courses in external cardiopulmonary resuscitation which are approved by the Vermont Heart Association or the American Red Cross and courses in neonatal resuscitation approved by the American Academy of Pediatrics (AAP).

3.11 Student Midwives in Training and Assistants

When providing midwifery care, student midwives in training and assistants must be under the direct on-site supervision of a licensed midwife.

3.12 Informed Consent

Before accepting a client for care, a licensed midwife must first obtain written informed consent.

Informed consent must be shown by a written statement, in a form prescribed by the Director and signed by the licensee and the client to whom care is to be given, in which the licensee certifies that full disclosure of the following information has been made and acknowledged by the client:

(1) The midwife's educational background and credentials.

(2) Whether the midwife has professional liability insurance coverage.

(3) A description of the procedures, benefits and risks of home birth, primarily those conditions that may arise during delivery.

(4) The fact that the client has been advised to consult with a physician at least once during the pregnancy.

(5) A copy of the written plan for consultation and for emergency transfer and transport of client and newborn required by Rule 3.14 (written plan for consultation and for emergency transfer and transport).

(6) A copy of the written plan for non-emergency transfer and transport of client and newborn.

(7) The address and telephone number of the Office of Professional Regulation where complaints may be filed.

The signed informed consent form must be filed in the client's record, and a copy must be provided to the client. Throughout the care process, the midwife must continue to inform the client and obtain consent.

3.13 Scope and Practice Standards

Role of the Midwife: The midwife is a person who provides well-woman care, support and education to healthy women during the childbearing cycle, including normal pregnancy, labor, childbirth and the postpartum period. Midwifery care emphasizes education, health promotion, shared responsibility, and mutual participation in decision making. The midwife works with each client and the client's family to identify their unique physical, social, cultural, and emotional needs. When the care required extends beyond the midwife's abilities, the

midwife continues involvement and arranges for consultation, referral, and collaboration with appropriate health care providers.

Prenatal Care:

(A) Information: Each midwife must present to each client accurate information conforming to the requirements of Rule 3.12 (informed consent) and also including but not limited to:

(1) Financial charges for services.

(2) Services the midwife provides, advantages and disadvantages of home birth, legal status of midwifery in Vermont, mutual expectations, and responsibilities of the client and the client's family.

(3) Values and ethics of practice.

(4) Choices regarding prenatal lab testing, including but not limited to sexually transmitted diseases, blood type and antibody screen, hematocrit, HIV, rubella, gestational diabetes screening, Group B Strep, urinalysis.

(5) Information regarding community well child care resources available to client and baby.

(B) History and Physical Assessment: At the initiation of prenatal care, a health and personal history must be completed. History taking is an interactive process during which the midwife and the client focus upon emotional, philosophical, and social responses of the client and her family to health issues and problems, as well as on the details of the events themselves. It is also an opportunity for mutual education. This history must include:

(1) Past medical history, including gynecological and previous pregnancy histories.

(2) Relevant family history.

(3) Social history.

(4) Current pregnancy history.

(5) Physical assessment.

(C) On-going Prenatal Care: The purpose of on-going prenatal care is to promote the health of the client and baby, screen for problems, develop a relationship between family and midwife which create the trust and compatibility important to

good labor support, exchange information pertinent to the childbearing cycle of the individual client and empower the client with trust in the birthing capabilities of her body. Prenatal visits should occur not less than

(1) every four weeks through 32 weeks,

(2) every two weeks until 36 weeks, and

(3) weekly thereafter.

This care includes:

(1) Education and self-care: diet, exercise, enhancement of emotional and physical environment, birth preparation, breast feeding preparation.

(2) Evaluation of maternal nutrition, blood pressure, fetal heart tones, fetal growth, position and presentation of the baby.

(3) Baseline weight; abnormal weight gain or loss.

(4) Screening for signs and symptoms of edema, bleeding, headache, visual disturbances, or unusual vaginal discharge.

(5) Discussion of any recent illnesses, symptoms, social or emotional problems, diet, supplements, reading suggestions, exercise, rest and sleep requirements, sexuality, nipple and perineal preparation, partner's role, birth preparation, newborn care, parenting, and transport arrangements.

(6) Obtaining appropriate lab testing.

(7) Use of aseptic techniques and universal health precautions.

(D) Record Keeping: Each midwife must keep accurate records and make them available as provided in Rule 3.15 (record keeping and report requirements). Records must otherwise be kept confidential.

(E) Birth Preparation: If prenatal course is normal and home birth is planned, the following preparations must be made and are the midwife's responsibility:

(1) Alert parents to signs of complications that necessitate immediate contact with midwife as well as signs of labor and when to call.

(2) Be on call or make specific arrangements for on-call coverage with another licensed health care professional whose scope of practice includes birth.

(3) Arrange for assistance from another licensed midwife or trained assistant to attend the birth, unless declined by the family.

(4) Make a home visit before the 37th week of pregnancy.

(5) Maintain appropriate equipment for assessing maternal, fetal, and newborn well-being; carry oxytocic drugs (Rule 3.16), supplies to maintain asepsis, and emergency resuscitation equipment.

(6) Midwife must:

(a) Have an accessible phone.

(b) Have transportation readily available.

(c) Make appropriate arrangements for consultation and for emergency and non-emergency transfer and transport of client and newborn.

(7) Midwife insures that parents will:

(a) Have all necessary supplies on hand several weeks prior to due date.

(b) Have adequate light, heat, water, cleanliness, and accessibility.

(c) Post phone numbers of midwives, ambulance or rescue squad, hospital, and consulting physicians.

(d) Make child care arrangements for siblings.

(e) Arrange for help after the birth.

(F) Discontinuation of Services: During prenatal care the midwife must evaluate a client and her baby and determine continuing appropriateness for home birth and midwifery services. All concerns must be shared with the client and documented in the chart. In addition to circumstances outlined in Rule 3.14.1, it is the right of the midwife to refuse or discontinue service. Before refusing or discontinuing service, the midwife must notify the client in writing, provide the client with names of other licensed maternity care practitioners, and offer to provide copies of medical records promptly, regardless of whether copying costs have been paid by the client.

Labor, Birth, and Immediate Postpartum:

(A) Labor: During labor and birth, the midwife must use all of the resources available to the midwife to assure and enhance the well-being of the client and

baby. The midwife recognizes that emotional and spiritual well-being are essential to normal healthy labor and birth and must offer a full spectrum of support.

(1) When the midwife arrives, the midwife must determine well-being of presentation of the baby, client's energy, attitude and ability to cope with labor.

(2) When indicated, the midwife must perform a vaginal exam to assess progress of labor and position and presentation of the baby.

(3) When the membranes rupture, the midwife must check for meconium, signs of maternal or fetal infection, and cord prolapse.

(4) The midwife must continue to assess the progress of labor and the well-being of client and baby.

(5) The midwife must observe aseptic technique and use universal health precautions.

(B) Care of the Client: The midwife must:

(1) Use the home environment as a valuable resource in helping the client go through labor as comfortably as possible.

(2) Assure adequate nutrition and fluid intake throughout labor.

(3) Periodically assess well-being of the client and the fetus in relation to the progress of labor.

(4) Provide support and encouragement to the client during the birth process.

(5) Assist the client with the delivery of the placenta.

(6) If abnormal bleeding occurs respond appropriately.

(C) Immediate Care of the Newborn: Following birth the midwife must:

(1) Maintain a warm environment for the newborn.

(2) Assess the newborn and provide appropriate care.

(3) Continue to evaluate newborn vital signs.

(4) Encourage and support breast feeding.

(5) Conduct a newborn exam and make a referral if necessary.

(6) Administer eye prophylaxis and vitamin K, unless declined by client and documented by midwife in chart.

(D) Immediate Postpartum Care: Following the birth, the midwife must remain with client and baby until both are stable and secure, and at least two hours have passed since the birth. During this time the midwife must perform the following and document in the chart:

(1) Observe the client's general well-being.

(2) Assess the amount of maternal bleeding, size and consistency of the uterus, and take maternal blood pressure and pulse if indicated.

(3) Examine the client's perineum and vagina and repair lacerations when appropriate.

(4) Assess the client's ability to urinate.

(5) Inspect the umbilical cord, placenta, and membranes.

(6) Assess the client's ability to ambulate and take nutrition.

(E) Instructions: Before leaving, the midwife must discuss with the client and must leave with the client information about:

(1) Normal amount of bleeding and appropriate size and consistency of uterus.

(2) Perineal care and hygiene.

(3) Rest and nutrition requirements of the client.

(4) Signs of a healthy baby and care of the newborn.

(5) Breast/bottle feeding.

(6) Indications that warrant contacting the midwife or consulting a physician.

Follow-up Care:

(A) Visits: Recommended follow-up visits are on the first and third day, one week, three weeks and six weeks or as needed. Phone consultation when necessary. During these visits the midwife must assess the client for:

(1) Over-all well-being.

(2) Status of breast feeding.

(3) Uterine involution, amount and color of lochia, and condition of the perineum.

(4) Vital signs when indicated.

(5) Bowel and urinary continence and output.

(6) Nutritional status and amount of rest.

(7) Emotional status.

(B) Baby Care: The midwife must observe the baby during this period for and document the observations in the chart:

(1) Over-all well-being.

(2) Ability to nurse.

(3) Jaundice.

(4) Activity level, respirations, heart rate, color and body temperature maintenance.

(5) Weight

(6) Bowel movements and urination.

(7) Condition of cord.

(8) Condition of eyes.

(9) Obtain specimens for newborn screening.

(10) Encourage and facilitate referral to a child health care provider for ongoing well-baby services.

(C) Final Visit: A four-to-six-week final check-up is encouraged. At this visit the midwife must:

(1) Make inquiries concerning bleeding, condition of perineum, breast feeding, family adjustment, sexual activity, and bowel and urinary output and continence.

(2) Discuss client's return to fertility/family planning.

At the final visit, the midwife may:

(1) Perform a pelvic exam, including a pap smear.

(2) Obtain a hematocrit or hemoglobin.

(3) Perform a breast exam.

(4) Obtain other labs as needed, with abnormal findings referred to a physician for consult.

3.14 Written Plan for Consultation and for Emergency Transfer and Transport

The licensed midwife recognizes that there are certain conditions when medical consultations or transfers, or both, are advisable.

Each licensed midwife must develop a written plan

(1) for consultation with physicians (M.D. or D.O.) and other health care providers and

(2) for emergency transfer and for transport of an infant or a client, or both, to an appropriate health care facility. The written plan must be submitted to the Director on an approved form with the initial license application and with every subsequent license renewal.

3.14.1 History of Disorders or Situations for Which Midwives Must Not Assume or Continue to Take Responsibility

If a history of any of the following disorders or situations is found to be present at the initial interview or if any of the following disorders or situations becomes apparent through history, examination, or laboratory report as prenatal care proceeds, the midwife must not assume or continue to take responsibility for the client's pregnancy and birth care.

For clients already under care, it is the responsibility of the midwife to arrange for orderly transfer of care to a licensed M.D. or D.O.

(1) Diabetes mellitus

(2) Hyperthyroidism currently treated by medication

(3) Uncontrolled hypothyroidism

(4) Epilepsy with seizures or anti-epileptic drug use during the previous 12 months

(5) Coagulation disorders

(6) Chronic pulmonary disease

(7) Heart disease in which there are arrhythmias or murmurs except when, after evaluation, it is the opinion of an M.D. or D.O. that midwifery care may proceed

(8) Hypertension including pregnancy-induced hypertension (PIH)

(9) Renal disease

(10) Rh sensitization with positive antibody titer, except as in R. 3.14.2 below.

(11) Previous caesarean delivery, except as in R. 3.14.2.1 below.

(12) Indications that the fetus has died in utero and there is evidence of DIC or infection

(13) Premature labor (gestation less than 36 weeks)

(14) Multiple gestation

(15) Breech presentation at 38 weeks or after

(16) Transverse lie or other abnormal presentations at 38 weeks or after

(17) Placenta previa or abruption

(18) Preeclampsia

(19) Severe anemia, defined as hemoglobin less than 10

(20) Uncommon diseases and disorders such as Addison's disease, Cushing's disease, systemic lupus erythematosus, anti-phospholipid syndrome, scleroderma, rheumatoid arthritis, periarteritis nodosa, Marfan's syndrome, and other systemic and rare diseases and disorders.

(21) AIDS/HIV

(22) Hepatitis A, B, C, D, E, F, G, and Non A-G

(23) Acute Toxoplasmosis infection, where the client is currently symptomatic

(24) Acute Rubella infection, where the client is currently symptomatic

(25) Acute Cytomegalovirus infection, where the client is currently symptomatic

(26) Acute Parvovirus infection, where the client is currently symptomatic

(27) Drug abuse or continued alcohol use either daily or binge behavior into the second trimester

(28) Thrombosis

(29) Inflammatory bowel disease that is not in remission

3.14.2 Situations or Conditions Requiring Consultation

If the following situations or conditions are present or become apparent during prenatal care, the midwife must consult with a licensed M.D. or D.O, must document such consultation and the consultant's recommendations, and must document discussion of the consultation with the client.

(1) Significant mental disease such as depression, bipolar disorder, schizophrenia, and other conditions which impair the ability of the client to participate effectively in her care or which require current use of psychotropic drugs to control the condition

(2) Postmaturity (gestational age greater than 42 weeks)

(3) Second or third trimester bleeding

(4) Herpes simplex virus, primary infection or active infection at time of delivery

(5) Continued daily tobacco use into the second trimester

(6) Intermittent use of alcohol into the second trimester

(7) Asthma

(8) Gestational diabetes, diet controlled

(9) History of genetic problems, or intrauterine death after 20 weeks gestation, or stillbirth due to a situation which might recur

(10) Previous uterine surgery including myomectomy, LEEP, cone biopsy

(11) Abnormal Pap smear (greater than ASCUS)

(12) Past obstetrical problems, including but not limited to uterine abnormalities, placental abruption, significant congenital anomalies, placenta accreta and incompetent cervix

(13) Possible ectopic pregnancy

(14) Inflammatory bowel disease, in remission

(15) Tuberculosis

(16) thyroid test numbers are normal

(17) Morbid obesity (body mass index (BMI) greater than 34 at initial pregnancy visit)

(18) Rh sensitization with positive antibody titer

(19) Breech presentation between 35 and 38 weeks

(20) Transverse lie or other abnormal presentation between 35 and 38 weeks

(21) Premature rupture of membranes at 37 weeks or less, unless the client has been shown to be GBS (group B strep) negative by rectovaginal swab or the midwife is following CDC guidelines. See Appendix B.

3.14.2.1 Previous Cesarean Delivery

The following requirements must be met for vaginal birth after cesarean (VBAC). In addition, prenatal consultation is advised when available.

(1) The midwife must consult with a licensed M.D. or D.O. to ascertain that the client had only one documented previous lower uterine segment cesarean section with uterine closure of more than one layer.

(2) There must be at least 18 months from the client's cesarean to the due date of the current pregnancy.

(3) The client must obtain ultrasound documentation to determine that the location of the placenta is not previa or is not low and anterior.

(4) Signed informed consent must be present in the client's chart. See Appendix A.

(5) The midwife must perform fetal auscultation at least every 15 minutes during active labor and more frequently if necessary and at least every five minutes during the second stage of labor and more frequently if necessary.

(6) The birth site must be located within 30 minutes transport time from a hospital emergency room.

(7) Two licensed midwives must be present during the birth.

(8) No labor induction or augmentation of any kind must be done, including use of any chemical or herbal medication or nipple stimulation.

(9) Pre-admission forms must be completed for the client before labor, for the hospital to which the client may possibly be transferred.

(10) Prenatal records for the client must be sent before labor to the back-up system for the birth (hospital, labor and delivery unit, or physician practice).

No later than one year from the effective date of these rules or earlier upon written request, the Director, in consultation with the advisor appointees and the Commissioner of Health, will review current scientific research on vaginal birth

after cesarean (VBAC), for the purpose of seeking amendment of this rule to reflect current scientific research findings, provided the Director concludes after consultation that amendment is necessary.

3.14.3 Conditions Requiring Facilitation of Transfer, if Possible or Consultation

If the following conditions become apparent during the labor, birth, or immediate postpartum period, the midwife must facilitate transfer to a hospital setting if time allows. If transfer is not possible, the midwife must consult with a licensed M.D. or D.O. to determine whether and when transfer may become advisable:

(1) Unforeseen malpresentation

(2) Unforeseen multiple fetuses

(3) Non-reassuring fetal heart rate or pattern including but not limited to tachycardia, bradycardia, significant change in baseline, persistent late or severe variable decelerations

(4) Client request

(5) Prolapsed cord

(6) Uncontrolled maternal hemorrhage or retained placenta

(7) Signs of fetal or maternal infection

(8) Client with a fourth degree laceration or a laceration beyond the midwife's repair ability

(9) Apgar of less than seven at 10 minutes

(10) Obvious congenital anomalies

(11) Infants with persistent central cyanosis

(12) Infants with persistent grunting and retractions

(13) Infants with abnormal vital signs

(14) Gross or thick meconium staining

Decision-making Conflicts:

Pre-natal, Birth Not Imminent: If a client chooses to give birth at home in a situation deemed higher- risk or potentially more complicated by the midwife or prohibited by these rules, the midwife must refer the client and her family to alternative care providers. The midwife must cease to take responsibility for the client's pregnancy care no later than one week after providing the referral.

Birth Imminent: If the birth is imminent, the midwife must not leave the client until the ambulance has arrived.

3.15 Record Keeping and Report Requirements

A licensed midwife must establish and maintain a record of the care provided and data gathered for each client. Each client's record must contain the following information, as applicable:

(1) Client identification sheet, including name, address, date of birth, next of kin, spouse or other designated person, directions to the client's home, telephone number, and marital status.

(2) Health history sheet including pre-existing conditions or surgeries, previous pregnancies, physical examination, nutritional status, and a written assessment of risk factors with a plan to transfer care to an M.D. or D.O. when risk factors that require termination of the agreement are present.

(3) Progress notes of all encounters with the midwife and other health care consultants, in chronological order, documenting any actions, guidance, and consultations, with copies if appropriate.

(4) Laboratory and diagnostic reports.

(5) Written informed consent on the approved form, which is signed by the client.

(6) Evidence of medical evaluation and physician visits, consisting of either a report signed by the physician, a copy of the medical and physician notes, or other documentation received from the physician or medical provider.

(7) Documentation of all medications administered to the client.

(8) A date for each entry in the prenatal record and the postpartum record, and a date and time for each entry in the labor record. Each entry must be initialed or signed by the midwife. If initials are used, the midwife must also sign on the same page.

A licensed midwife must make records available upon request to the client, to the client's representative, to other health care providers engaged in the care and treatment of the client, for peer reviews required by Rule 3.8 (peer reviews), or upon request by the Director for periodic quality review. For other persons or entities, information in the client's record may be released by the midwife only

with the written consent of the client, legal guardian, or as otherwise provided by law.

3.16 Protocol and Formulary for Drug and Equipment Use

A licensed midwife may purchase and use the legend devices listed below which are deemed integral to providing safe care to the public.

(1) Dopplers

(2) Syringes

(3) Needles

(4) Phlebotomy Equipment

(5) Sutures

(6) Urinary catheters

(7) Intravenous equipment

(8) Amnihooks

(9) A DeLee type mucous traps

(10) Equipment and supplies listed in the American heart Association Cardiopulmonary Resuscitation Guidelines and the American Academy of Pediatrics Neonatal Resuscitation Guidelines for the administration of oxygen

(11) Diaphragms and cervical caps for postpartum women

A licensed midwife may obtain (by purchase or by prescription written by a Vermont-licensed MD or DO) and administer the legend drugs listed in Table A, for the purposes listed in that table. The routes of administration listed in the table are the only approved routes.

Abbreviations used to define the routes of administration are defined as follows:

PO = by mouth

IM = intramuscular

IV = intravenous

SQ = subcutaneous

Topical = applied to skin

Blow-by = oxygen blown at the nose and mouth

The client's records must contain documentation of all medications administered.

A licensed midwife may administer any other medication prescribed by a licensed physician (MD or DO) for a specific client and with the intent that the licensed midwife administer the medication. The licensed midwife must administer such medication consistent with the scope of midwifery practice as defined in Rule 3.13 (scope and practice standards).

(A) The 24 credit hours earned during each two-year period must be obtained from educational activities which follow the guidelines for acceptable course content as described by the American Registry of Radiologic Technologists (ARRT) and the Nuclear Medicine Technologist Certification Board (NMTCB).

(B) During any biennial renewal period, the Board may randomly audit licensees to ensure compliance with continuing education rules. A licensee who is audited will be notified in writing by the Board and will be required to produce written documentation showing successful completion of 24 hours of continuing education during the two-year period at issue.

Table A

Legend	Indication	Dose	Route of Administration	Duration of Treatment	Comments
Oxygen	Administered to mother for fetal distress		Blow-by or mask		
.05%Erythromycin Ophthalmic Ointment	Ophthalmia neonatorum	1cm ribbon in each eye from unit dose package			
Oxytocin 10 units/ml	Postpartum hemorrhage	10 units	IM only	1-2 doses	
Methyl-ergonovine .02 mg/ml or .02 mg tabs	Postpartum hemorrhage	0.2 mg	IM or PO	3-4 times daily for 30 days	Do not use in patients with Raynaud's Disease or high blood pressure
Vitamin K 2 mg/ml	Prophylaxis of Hemorrhagic Disease of the Newborn	0.5 ml 1 ml	IM PO	Single Dose	Infants with active bleeding must be referred to a licensed physician (MD or DO)

RH (D) Immune Globuilin	Prevention of RH (D) Sensitization in RH (D) negative women	Unit dose	IM only	Single dose at 26-28 weeks gestation for RH(D) negative, antibody negative women And single does given within 72 hours of delivery of RH (D) positive infant	May administer an additional dose approx.. 12 weeks after the initial dose if delivery is not imminent
Lidocaine HCl Injection 0.5 or 1% And Lidocaine HCl and epinephrine injection 0.5 or 1%	Local anesthetic for use during postpartum repair of lacerations, tears or episiotomy	Maximum 50 ml	Percutaneous infiltration only		
Epinephrine HCl 1:1000 solution	Treatment for post-exposure prevention of severe allergic reactions	0.3	SQ or IM	Every 10-15 minutes until EMT arrives	Administer first dose then immediately contact emergency services by telephoning 911
Measles, mumps, and rubella vaccine	Prevention of Rubella in susceptible women in the immediate postpartum period	Unit dose	SQ only	Single Dose	Must comply with vaccine management and immunization registry requirements of the Vermont

					Department of Health. Recommend following the CDC Advisory Committee on Immunization Practices schedule.
5% Dextrose in Ringer=s Lactate, or Ringer=s Lactate	To prevent or correct dehydration complicating labor and delivery	Consult with licensed MD or DO for dose	IV		
Misoprostol	Postpartum hemorrhage	800mcg	Mucosal, oral	1 dose	Postpartum use only. If hemorrhage uncontrolled, must transfer per 3.14.3(6).
First line antibiotic prophylaxis (does not include Vancomycin)	Positive GBS status	Per CDC guidelines	IV	Per CDC guidelines at onset of labor	Allergies and susceptibilities will guide non-PCN antibiotic choice. Where first line antibiotics are not indicated, physician consult required.

					Standard informed consent and patient counseling required.
Tdap vaccine	Third trimester booster for pregnant woman Partner, anytime during pregnancy	Unit dose	IM	One dose	For partner, too. Must comply with vaccine management and immunization requirements of the Vermont Department of Health. Recommend following the CDC Advisory Committee on Immunization Practices schedule.
Influenza seasonal vaccine	Annual vaccination	Unit dose	IM	One dose	Must comply with vaccine management and immunization requirements of the Vermont

					Department of Health. Recommend following the CDC Advisory Committee on Immunization Practices schedule.
Hepatitis B vaccine	Postpartum for neonate	Unit dose	IM	One dose	Must comply with vaccine management and immunization requirements of the Vermont Department of Health. Recommend following the CDC Advisory Committee on Immunization Practices schedule.

All Purpose Nipple Ointment (“triple nipple cream”)	Postpartum nipple injury		Topical		

Appendix A

Informed Consent For Out-Of-Hospital Vaginal Birth After Cesarean (VBAC)

1. I have thought about the danger to my baby and to me of uterine rupture (my uterus tearing open), which may result in permanent brain damage, heavy bleeding, or in the death of my baby and/or me.

Client's initials _____

2. I understand and agree to:

1, My having had only one previous cesarean, and that the scar is across the lower part of my uterus.

2. That there will be more than 18 months from my cesarean to this pregnancy=s due date.

3. An ultrasound to find out where my placenta is attached to my uterus.

4. Birth place will be 30 minutes or less from an operating room.

Client's initials _____

3. I agree to go to the hospital if:

1. I request it.

2. There are any symptoms or evidence of uterine rupture (my uterus tearing open).

3. There are any other medical reasons.

Client's initials _____

4.I have had the chance to have all my questions asked and answered.

All the choices of where and how to have my birth have been explained to me and I have been told all of the dangers and advantages of having a planned home VBAC.

Client's initials _____

5.In authorizing to attend and assist me in this procedure, I understand that she will be assisted by another licensed midwife and possibly by other health care professionals as she considers necessary in my care. I agree to their participation in my care.

Client's initials _____

6. I agree to obtain a copy of the operative report of my past Cesarean section for my health care provider.

Client's initials _____

7. I agree that I will complete pre-admission forms prior to my possible transfer to a hospital.

Client's initials _____

8. I agree that a copy of my current midwifery records may be sent to a hospital prior to my possible transfer there.

Client's initials _____

Client's Statement

I have read or have had read to me the above information and I understand it.I have discussed my options with my licensed midwife. I have had all my questions answered and I have received all the information I need to make an informed choice.

I want to attempt VBAC

_____ _____

(Client's Signature) (Date and Time)

_____ _____

(Witness's Signature) * (Date and Time)

_____ _____

(Midwife's Signature) (Date and Time)

* The witness must not be the client's spouse, attending midwife or person acting under the direction or control of the attending midwife, or any other person who has at the time of the witnessing any personal, professional, or financial interest in the birth.

Effective date: December 1, 2001