Midwives' Association of Washington State
INDICATIONS FOR DISCUSSION, CONSULTATION, AND TRANSFER OF CARE IN AN OUT-OF-HOSPITAL MIDWIFERY PRACTICE

1. INTRODUCTION:

Licensed midwifery, as defined in RCW 18.50, is an autonomous profession. Licensed midwives work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk mothers and babies during the normal childbearing cycle. When there are significant deviations from normal during the pregnancy, labor, or postpartum period, licensed midwives are required by law in Washington State (RCW 18.50.010) to consult with a physician regarding the client's care.

Licensed midwives engage in an ongoing screening process that begins during the initial visit and continues through the completion of care in the postpartum period. In providing care, licensed midwives take into account their client's own informed choices, the state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, the midwifery and medical literature, the settings in which they practice, the collaborative relationships they have with other health care practitioners and area hospitals, and their clinical judgment, expertise, and philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a licensed midwife may encounter in practice for which discussion, consultation, or transfer of care is indicated. The list is representative but not exhaustive. Other circumstances may arise where the licensed midwife believes discussion, consultation, or transfer of care to be necessary.

Professional members of the Midwives' Association of Washington State (MAWS) discuss, consult, and/or transfer care of their clients according to this document and in accordance with the MAWS document *Position Statement: Shared Decision-Making*. In addition, new clinical procedures may be undertaken in accordance with the MAWS document *Mechanism for Introducing Expanded Clinical Procedures into Midwifery Practice.* MAWS members should discuss the scope and limitations of midwifery care with clients and refer to these documents as necessary.

This document should be used as a screening tool to distinguish between low-risk and higher-risk maternal and newborn clients. Its purpose is to enhance safety and promote licensed midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MAWS reviews this document every two years and revises it as necessary in order to reflect the most current evidence available and to insure that the parameters identified promote the safety of mother and infant without unduly restricting midwifery practice. To that end, in writing this document MAWS has sought guidance from midwifery documents from countries with well functioning, integrated midwifery systems (Canada, the Netherlands, and Australia).

2. DEFINITIONS:

2.1 DISCUSSION WITH ANOTHER MIDWIFE, AN ARNP, OR A PHYSICIAN

A discussion refers to a situation in which the midwife seeks advice or information from a colleague about a clinical situation, presenting her management plan for feedback.[1]

2.1.1 It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.

2.1.2 Discussion should occur in a timely manner soon after the clinical situation is discovered.

2.1.3 Discussion may occur in person, by phone, fax, or e-mail.

2.1.4 Discussion may include review of relevant patient records.

2.1.5 Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.

2.1.6 Discussion should be documented by the midwife in her records. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.

2.1.7 Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

2.2 CONSULTATION WITH A PHYSICIAN

A consultation refers to a situation in which the midwife, using her professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a physician competent to give advice in the relevant field. The consultant will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the consultation.

2.2.1 It is the midwife's responsibility to initiate a consultation and to communicate clearly to the consultant that she is seeking a consultation.

2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the woman/newborn, and/or prescribing treatment for the woman or newborn.

2.2.3 In the case of an in-person consultation, the midwife should expect that the consultant will promptly communicate findings and recommendations to the client and the referring midwife after the consultation has taken place.

2.2.4 Where urgency, distance, or climatic conditions do not allow an in-person consultation with a physician when it would otherwise be appropriate, the midwife should seek advice from the physician by phone or other similar means. The midwife should document this request for advice in her records and discuss the consultant's advice with the client.

[1] A MAWS member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions which are within her scope of practice.

2.2.5 It is the midwife's responsibility to provide all relevant medical records to the consultant, including a written summary of the client's history and presenting problem, as appropriate.

2.2.6 Consultation must be fully documented by the midwife in her records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife must then discuss the consultant's recommendations with the client.

2.2.7 After consultation with a physician, care of the client and responsibility for decision-making, with the informed consent of the client, either continues with the midwife, is shared collaboratively by the midwife and the consultant,[2] or transfers completely to the consultant. Transfer or sharing of care should occur only after dialogue and agreement among the client, the midwife, and the consultant.

2.3 TRANSFER TO A PHYSICIAN OR OTHER QUALIFIED HOSPITAL-BASED PROVIDER

When care is transferred permanently or temporarily from the midwife to a qualified hospital-based provider, the receiving practitioner assumes full responsibility for subsequent decision-making, together with the client. For guidance about intrapartum transfers, see also the MAWS document *Planned Out-of-Hospital Birth Transport Guideline*.

[2] During such collaborative care the consultant may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within her scope of practice. It is the midwife's responsibility to maintain explicitly clear communication between all parties regarding which health professional has primary responsibility for which aspects of the client's care. In addition to any verbal dialogue regarding client care, the midwife should confirm the management plan in writing, and both the client and consultant should receive a copy.

3. INDICATIONS:

3.1 PRE-EXISTING CONDITIONS AND INITIAL HISTORY

Discussion:

- family history of significant genetic disorders, hereditary disease, or congenital anomalies
- history of pre-term birth (< 36 weeks)
- history of IUGR
- history of severe postpartum hemorrhage
- history of severe pre-eclampsia
- history of gestational diabetes

Consultation:

- history of uterine surgery, including: myomectomy, hysterotomy, or prior cesarean birth
- current or significant history of cardiovascular disease, renal disease, hepatic disorders, neurological disorders, severe gastrointestinal disease
- current or significant history of endocrine disorders (excluding controlled mild hypothyroidism)
- pulmonary disease/active tuberculosis/asthma if severe
- collagen-vascular diseases
- significant hematological disorders
- current or significant history of cancer
- history of cervical cerclage
- history of 3 consecutive spontaneous abortions
- significant uterine anomalies
- essential hypertension
- history of eclampsia or HELLP
- previous unexplained neonatal mortality or stillbirth
- isoimmunization with an antibody known to cause hemolytic disease of the newborn
- history of postpartum hemorrhage requiring transfusion
- current severe psychiatric illness
- no prenatal care prior to third trimester
- current or history of epilepsy

Transfer:

- absent prenatal care at term
- any serious medical condition, for example: cardiac disease, renal disease with failure, insulin-dependent diabetes mellitus, or uncontrolled asthma

3.2 ANTEPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- significant abnormal ultrasound finding
- well-controlled gestational diabetes
- persistent size/dates discrepancies

Consultation:

- significant abnormal Pap
- significant abnormal breast lump
- pyelonephritis
- ectopic pregnancy
- molar pregnancy
- thrombosis
- fetal demise after 14 weeks gestation
- persistent anemia, unresponsive to treatment
- primary herpes infection
- significant vaginal bleeding
- premature pre-labor rupture of membranes (PPROM)
- isoimmunization, hemoglobinopathies
- persistent abnormal fetal heart rate or rhythm
- significant placental abnormalities
- documented intrauterine growth restriction
- unresolved polyhydramnios or oligohydramnios
- significant infection the treatment of which is beyond the midwife's scope of practice
- 42 completed weeks with reassuring fetal surveillance
- presentation other than cephalic at 37 weeks

Transfer:

- multiple gestation
- persistent transverse lie, oblique lie, or breech presentation
- persistent hypertension, HELLP, pre-eclampsia, or eclampsia
- placenta previa at term
- clinically significant placental abruption
- cardiac or renal disease with failure
- uncontrolled gestational diabetes
- known fetal anomaly or condition that requires physician management during or immediately after delivery

3.3 INTRAPARTUM CONDITIONS

In certain intrapartum situations, the midwife may need to act immediately and transport may not be the most prudent course of action in that moment. It is expected that the midwife will use her clinical judgment and expertise in such situations, access 9-1-1 if appropriate, and then transport if and when it becomes necessary.

Discussion:

- arrested active phase of labor (>6 hours of regular, strong contractions without any significant change in cervix and/or station and/or position)
- arrested 2nd stage of labor (>3 hours of active pushing without any significant change)
- prolonged rupture of membranes (>48 hours)

Transfer:

- labor before 37 weeks
- transverse lie, oblique lie, or breech presentation
- multiple gestation
- sustained maternal fever (>100.4 F) or other evidence of maternal infection
- moderate or thick meconium
- persistent non-reassuring fetal heart rate pattern
- maternal exhaustion unresponsive to rest/hydration
- abnormal bleeding during labor
- suspected placental abruption
- suspected uterine rupture
- persistent hypertension
- pre-eclampsia
- maternal seizure
- ROM >72 hours or ROM >18 hours with unknown GBS status and no prophylactic antibiotics or GBS+ and no prophylactic antibiotics
- prolapsed cord or cord presentation
- significant allergic response
- active genital herpes in vaginal, perineal or vulvar area in labor or after ROM
- client's clear desire for pain relief or hospital transport

3.4 POSTPARTUM CONDITIONS

Discussion:

- urinary tract infection unresponsive to treatment
- mastitis unresponsive to treatment
- subinvolution

Consultation:

- breast abscess
- retained products/unresolved subinvolution
- sustained hypertension
- significant abnormal Pap
- postpartum depression

Transfer:

- significant postpartum hemorrhage unresponsive to treatment, with or without sustained maternal vital sign instability or shock
- retained placenta (>1 hour or active bleeding and manual removal unsuccessful)
- lacerations beyond midwife's ability to repair
- unusual or unexplained significant pain or dyspnea
- significant hematoma
- endometritis
- postpartum psychosis
- maternal seizure
- anaphylaxis
- persistent uterine prolapse or inversion

3.5 NEWBORN CONDITIONS

It is strongly recommended that all newborns be seen by an appropriate pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

Discussion:

- low birth weight infant (< 2500 gm = 5 lbs 8 oz)
- loss of greater than 10% of birth weight

Consultation:

- persistent cardiac arrhythmias or murmurs
- significant clinical evidence of prematurity
- failure to thrive
- hypoglycemia
- significant jaundice in first 24 hours or pathologic jaundice at any time

Transfer:

- seizure
- persistent respiratory distress
- persistent central cyanosis or pallor
- persistent temperature instability
- persistent hypoglycemia
- Apgar score less than 7 at five minutes of age and not improving
- major apparent congenital anomalies
- birth injury requiring medical attention