Midwives' Association of Washington State

Indications for Discussion, Consultation, and Transfer of Care
In Home or Birth Center Midwifery Practice

1. Introduction

Professional members of the Midwives' Association of Washington State (MAWS) include Licensed Midwives (LMs)[1] and Certified Nurse Midwives (CNMs). In the home or birth center setting LMs and CNMs (herein referred to as 'Midwives') work interdependently with one another and with other health care practitioners to promote the optimal health and safety of low-risk parents and babies during the normal childbearing cycle. Midwives engage in an ongoing risk screening process that begins at the initial visit and continues through the completion of care. In providing care, midwives take into account their clinical judgment and expertise, clients' own values and informed choice, relevant state laws and regulations, the standards for practice and core competencies for basic midwifery care provided by their professional organizations, relevant 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 philosophy of care.

During pregnancy, labor, or postpartum, risk factors or complications can develop. This document provides a list of conditions that a 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 are advised to 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. MAWS recognizes that there are variations in practice specialty and professional members may hold different licenses or qualifications that hold them to a different standard of care than those outlined in this document. (These practitioners may include but are not limited to CNMs, ARNPs, and NDs). 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 clients. Its purpose is to enhance safety and promote midwives' accountability to their clients, to one another, to other health care practitioners, and to the general public. MAWS reviews this document periodically 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 newborn without unduly restricting midwifery practice.

[1] Licensed midwifery, as defined in RCW 18.50, is an autonomous profession. 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.

2. Definitions:

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

A discussion refers to a situation in which the midwife seeks information from a colleague about a clinical situation, presenting a management plan for feedback.

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, virtually**,** by phone, fax, or e-mail.

2.1.4 Discussion may include review of relevant patient records.

2.1.5 Discussion may include requests for prescription medication based on clinical signs or symptoms and/or laboratory results.

2.1.6 Discussion should be documented by the midwife in their 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 their 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[2].

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

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

2.2.2 A consultation can involve the physician providing advice and information, and/or providing care to the client or newborn, and/or prescribing treatment for the client 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 a physician by phone or other similar means. The midwife should document this request for advice in the client's records and discuss the consultant's advice with the client.

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 should be fully documented by the midwife in their records, including the consultant's name, date of referral, and the consultant's findings, opinions, and recommendations. The midwife should 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, 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.

2.4 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.

3.1 PRE-EXISTING CONDITIONS

- Discussion
    - Family history of significant genetic disorders, hereditary disease, or congenital anomalies
    - History of preterm birth (Laughen et al., 2014)
    - History of IUGR/FGR
    - History of severe antepartum or postpartum hemorrhage (Ruiter, 2019)
    - History of preeclampsia with severe features or HELLP syndrome (Sibai et al., 1991).
    - History of placental abruption without clear etiology (Rasmussen et al., 2000).
    - History of gestational diabetes requiring oral antihyperglycemic agents or insulin (Getahun et al., 2010).
    - No prenatal care prior to the third trimester (Linard et al., 2018).
    - Previous unexplained neonatal mortality or stillbirth
    - History of bariatric (weight loss) surgery (Guelinckx et al., 2009)
    - History of cesarean birth: Please refer to MAWS VBAC Guidelines

- Consultation
    - Age <16 years (World Health Organization, 2004).
    - Absent prenatal care at term (Linard et al., 2018).
    - History of seizure disorder (Viale et al., 2015).
    - History of eclampsia (Sibai et al., 1992).
    - History of uterine surgery other than cesarean birth, including myomectomy
    - Significant history of or current medical conditions that may affect pregnancy or are exacerbated by pregnancy, including:
        - Cardiovascular
        - Renal
        - Hepatic
        - Neurological
        - Gastrointestinal
        - Endocrine (excluding controlled mild hypothyroidism)
        - Pulmonary, including severe asthma (Källén et al, 2000)
        - HIV infection
        - Systemic rheumatic diseases (previously known as collagen vascular diseases)
        - Significant hematological disorders or coagulopathies
        - Severe chronic autoimmune disorder
    - Significant acute/active infection, including hepatitis B virus (HBV) or tuberculosis (Sobhy et al., 2017)

- Current or recent diagnosis of cancer requiring chemotherapy
- History of 3 consecutive early pregnancy losses (excluding clients who present to care with viable pregnancy at gestation >14wks and beyond previous miscarriage) (Jauniaux et al., 2006)
- History of ≥2 consecutive prior second-trimester pregnancy losses or extremely preterm births (MRC/RCOG Working Party on Cervical Cerclage, 1993; Vousden et al., 2015)
- Significant uterine anomalies
- Chronic hypertension (Bateman et al., 2012)
- History of postpartum hemorrhage requiring transfusion
- History of placenta accreta spectrum (Sentilhes et al., 2010).

- Transfer
  - Any serious medical condition associated with increased risk status for client or fetus, for example:
    - Cardiac disease
    - Renal disease with failure
    - Insulin-dependent diabetes mellitus
    - Uncontrolled asthma
    - Significant hemolytic disease
  - Alloimmunization with an antibody known to cause hemolytic disease of the newborn (Moise & Argoti, 2012)
  - Any other condition or situation based on the midwife's clinical judgement

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3.2 ANTEPARTUM CONDITIONS

- Discussion
    - Significant abnormal ultrasound finding
    - Significant abnormal laboratory finding
    - ≥42 0/7 weeks with reassuring fetal surveillance (either NST with AFI or BPP) (Alfirevic & Walkinshaw, 1995)
    - Low-lying placenta at term (Vergani et al., 2009)
    - Multiple gestation if co-managing prenatal care (transfer if not co-managing)

- Consultation
    - Diagnosis of a notifiable condition, including sexually transmitted infections
    - Significant abnormal Pap (Perkins et al., 2020)
    - Significant abnormal breast/chest mass, thickening, or significant asymmetry
    - Fetal demise after 14 weeks gestation
    - Significant vomiting unresponsive to treatment within the midwife's scope of practice
    - Severe anemia unresponsive to treatment within the midwife's scope of practice
    - Primary or non-primary first episode genital Herpes Simplex Virus (HSV) infection during the third trimester (Wald et al., 1995)
    - Significant vaginal bleeding
    - Hemoglobinopathy
    - Thrombosis
    - Thrombocytopenia: Low platelet count <100,000/μL (Myers, 2012)
    - Non-reassuring fetal surveillance
    - Presentation other than cephalic at 37 weeks
    - Significant uterine or placental abnormalities
    - Funic (cord) presentation (Ezra et al., 2003)
    - Polyhydramnios or oligohydramnios (Dashe et al., 2018; Pilliod et al., 2015; Shrem et al., 2016).
    - Significant infection, the treatment of which is beyond the midwife's scope of practice**,** including, but not limited to:
        - Urinary tract infection unresponsive to treatment within the midwife's scope of practice (Smaill et al., 2019)
        - Pyelonephritis (Hill et al., 2005; Wing et al., 2014)
        - Acute Hepatitis B (HBV) infection
    - Gestational hypertension (August, 2021; Barton et al., 2001)
    - Chronic hypertension (Panaitescu et al., 2017)
    - Teratogenic exposure, including medications or significant drug or alcohol substance use

- Gestational diabetes requiring management with oral antihyperglycemics (American Diabetes Association, 2007)
- Pain that persists, worsens, and/or is unresponsive to treatment within the midwife's scope of practice

- Transfer
  - Ectopic pregnancy
  - Molar pregnancy
  - Premature prelabor rupture of membranes (PPROM)
  - Persistent/unresolved intrauterine growth restriction (IUGR)/FGR
  - Multiple gestation if not co-managing prenatal care
  - Preeclampsia, eclampsia, HELLP (August, 2021; Koopmans et al., 2009; Panaitescu et al., 2017)
  - Placenta previa at term (ACOG, 2019)
  - Alloimmunization with an antibody known to cause hemolytic disease of the newborn
  - Clinically significant placental abruption (Mei & Lin, 2018)
  - Venous thromboembolic disease (deep vein thrombosis and/or pulmonary embolism) (Bates et al., 2018)
  - Cardiac or renal disease with failure
  - Gestational diabetes requiring management of insulin to achieve euglycemia (Ryan & Al-Agha, 2013)
  - Known fetal anomaly or condition that requires physician management during or immediately after delivery
  - ≥43 0/7 weeks gestation
  - Any other condition or situation based on the midwife's clinical judgement

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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 their clinical judgment and expertise in such situations, activate EMS as appropriate, and transport as able.

- Discussion
    - Labor dystocia (Simkin & Ancheta, 2017)
    - Prolonged rupture of membranes (ROM) (≥48 hours without active labor) (Bond et al., 2017; Hannah et al., 1996; Pintucci et al., 2014)
- Consultation
    - Hypertension (≥140 systolic and/or ≥90 diastolic, two readings four hours apart)
- Transfer
    - Significant labor dystocia unresponsive to treatment (Simkin & Ancheta, 2017)
    - Active labor before 37 0/7 weeks (Stewart & Barfield, 2019)
    - Previously undiagnosed non-cephalic presentation including breech, transverse lie, oblique lie, or compound presentation
    - Previously undiagnosed multiple gestation
    - Suspected chorioamnionitis (intraamniotic infection)
    - Thick or particulate meconium-stained amniotic fluid (in the absence of imminent birth) (Bhat & Roa, 2008; Bhutani, 2008; Hiersch et al., 2014; Hiersch et al., 2017)
    - Persistent non-reassuring fetal heart rate pattern
    - Exhaustion unresponsive to rest and hydration
    - Abnormal bleeding
    - Suspected placental abruption
    - Suspected uterine rupture
    - Unstable vital signs, including but not limited to:
        - Persistent fever (≥100.4°F/38°C orally) despite thermoregulation efforts (Banjeree et al., 2004; Higgins et al., 2014)
        - Severe hypertension (≥160 systolic or ≥110, one reading)
    - Suspected preeclampsia (i.e. hypertension with signs of end-organ dysfunction) (Lowe et al., 2009; Waugh et al., 2004)
    - Seizure
    - ROM ≥72 hours (Bond et al., 2017; Hannah et al., 1996; Pintucci et al., 2014)

- ROM ≥18 hours with no prophylactic antibiotics in GBS-positive or GBS-unknown individuals (Oddie & Embleton, 2002; Schuchat et al., 2000; Verani et al., 2010)
- Umbilical cord prolapse
- Significant allergic response
- Herpes simplex virus (HSV) lesions or prodromal symptoms in the genital region at the onset of labor or ROM (Brown et al., 2003; Workowski & Bolan, 2015)
- Client's stated desire to transfer to hospital-based care
- Any other condition or situation based on the midwife's clinical judgement

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3.4 POSTPARTUM CONDITIONS (BIRTHING PERSON)

- Consultation
    - Significant infection unresponsive to treatment within the midwife's scope of practice, including but not limited to:
        - Urinary tract infection
        - Mastitis (including breast/chest abscess)
        - Wound infection
    - Fever, defined as oral temperature ≥100.4°F (38°C), unresponsive to treatment
    - Diagnosis of a notifiable condition, including sexually transmitted infections
    - Retained products of conception, unresolved subinvolution, or prolonged or excessive lochia
    - Persistent bladder or rectal dysfunction (Bharucha et al., 2005; Bø, 2012)
    - Mild hypertension (Sibai, 2012)
    - Significant abnormal Pap (Perkins et al., 2020)
    - Significant breast/chest lump presumed unrelated to lactation
    - Significant postpartum depression or other mood disorders (O'hara & McCabe, 2013; Yildiz et al., 2017)

- Transfer
    - Persistent unstable vital signs
    - Significant postpartum hemorrhage unresponsive to treatment and/or signs/symptoms of persistent hypovolemic shock unresponsive to treatment (ACOG, 2017; Lyndon et al., 2015)
    - 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 or enlarging hematoma
    - Seizure
    - Suspected endometritis
    - Anaphylaxis
    - Persistent uterine prolapse
    - Uterine inversion
    - Severe hypertension or signs/symptoms of preeclampsia (Al-Safi et al., 2011; Kuklina et al., 2011; Sibai et al., 2006)
    - Eclampsia
    - Signs of postpartum psychosis (Sit et al., 2006)
    - Any condition for which the midwife's clinical judgement is that ongoing clinical monitoring is appropriate beyond routine midwifery postpartum care.

- Birthing person and/or support person(s) demonstrate or express inability to competently monitor birthing person well-being in the home setting
- Any other condition or situation based on the midwife's clinical judgement

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3.5 NEWBORN CONDITIONS

It is recommended that parents establish a relationship with a pediatric provider before the baby is born. It is strongly recommended that all parents be advised to establish care with a pediatric provider by 2 weeks of age. The following conditions warrant contact sooner.

- Discussion
    - Loss of greater than 10% of birth weight, persistent poor weight gain, or failure to regain birth weight by 2 weeks of age

- Consultation
    - Clinically significant abnormal newborn exam findings
    - Low birth weight newborn (<2500 g = 5 lbs 8 oz)
    - Significant clinical evidence of prematurity
    - Suspicion of or significant risk of neonatal infection
    - Symptomatic hypoglycemia OR persistent hypoglycemia, in the presence of risk factors, that is unresponsive to treatment within the midwife's scope of practice (Adamkin, 2011)
    - Total Bilirubin (TB) or Transcutaneous Bilirubin (TcB) level persistently in the high intermediate-risk zone (Maisels et al., 2009; Riskin et al., 2008)
    - Positive critical congenital heart disease screening (CCHD)
    - No meconium passed by 48 hours of age (Tabbers et al., 2014)
    - No void by 24 hours of age (Vuohelainen et al., 2008)

- Transfer
    - Seizure
    - Jaundice observed in the first 24 hours of life (Maisels et al., 2009)
    - TB or TcB level in the high-risk zone (Maisels et al., 2009)
    - Persistent respiratory distress
    - Persistent central cyanosis or pallor
    - Persistent temperature instability
    - Significant bruising, petechiae or purpura
    - Apgar score ≤6 at ten minutes of age
    - Major congenital anomalies affecting well-being
    - Birth injury requiring medical attention
    - Any condition for which the midwife's clinical judgement is that ongoing clinical monitoring is appropriate beyond routine midwifery newborn care
    - Any other condition or situation based on the midwife's clinical judgement

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