Meeting Minutes
SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
Teleconference
July 17, 2018 2:00 p.m. Central

President Debbie Pease called the meeting to order at 2:10 p.m. The roll was called. A quorum was present.

Members of the board in attendance: Debbie Pease, Susan Rooks (via phone), Pat Schwaiger (via phone), and Autumn Cavender-Wilson.

Others in attendance: Tammy Weis**,** SD Board of CPM Exec. Secretary; Justin Williams, DOH; Susan Sporrer, DOH; Tim Engle, SDSMA; Bob Mercer, Reporter; and via phone Evie DeWitt, SD Birth Matters President; Abbie Paulson, Birth Doula; Alaina Kerkhoff, Student CPM; Judy Jones, CPM ND; and Mark East, SDSMA Exec Vice President.

Rooks moved approval of the agenda; seconded by Schwaiger. The board voted by roll call. Pease, Rooks, and Schwaiger voted aye; Cavender-Wilson and McKay absent. **MOTION PASSED**

Pease announced the public hearing on the proposed administrative rules §§20:85:01:01 through 20:85:05:19 was held. Justin Williams served as the hearing officer. Williams called the public hearing to order at 2:15 p.m. See Attachment for the minutes of the public hearing. The public hearing was adjourned at 2:35 p.m.

Schwaiger moved to approve the March 24, 2018 minutes; seconded by Rooks. The board voted by roll call. Pease, Rooks, and Schwaiger voted aye; Cavender-Wilson and McKay absent. **MOTION PASSED**

Pease explained that the Financial Report included expenditures through June30th. Approximately $500 spent since last meeting. There were no questions, the report was filed.

Pease reminded the board that the Complaint Form was to be discussed at this meeting. Schwaiger moved to take that issue up at our next meeting, seconded by Rooks. The board voted by roll call. Pease, Rooks, and Schwaiger voted aye; Cavender-Wilson and McKay absent. **MOTION PASSED**

The board considered the comments received on the proposed rules. Dr. McKay provided written comments on comments received for consideration by the board (see attached).

- South Dakota Birth Matters
  - 20:85:03:01(3) – requested change to required lab work to allow the client to refuse HIV and Hepatitis B testing. The board agreed that informed refusal could be an option as long as client signed a refusal form developed by the board. Motion by Rooks, seconded by Schwaiger to amend 20:85:03:01 (3) with the following language:

    "(3) Failure to obtain minimum lab work of: Blood group, RH antibody screening, hemoglobin, and syphilis by 28 weeks gestation.
    (4) Failure to document:
    (a) lab work for HIV and Hepatitis B around 28 weeks gestation or

(b) a signed HIV and Hepatitis B Informed Refusal Form provided by the board."

The board voted by roll call. Pease, Rooks, and Schwaiger voted aye; Cavender-Wilson and McKay absent. **MOTION PASSED.**

- 20:85:03:02(1) – requested "previous cesarean section" be moved from required physician consultation to recommended physician consultation. requested "previous cesarean section" be moved from required physician consultation to recommended physician consultation. Board members present agreed that the burden imposed on families could outweigh the benefits provided by a required physician consult, especially in areas where it is difficult to find a physician willing to consult with a home birth client. Motion by Rooks, second by Schwaiger to move previous cesarean section from required physician consult to recommended physician consult in 20:85:03:03. The board voted by roll call. Pease, Rooks, and Schwaiger voted aye; Cavender-Wilson and McKay absent. **MOTION PASSED.** McKay objected in comments read at the meeting.

- Requested change in 20:85:03:06 to clarify a midwife's responsibilities during a transport to a hospital and transfer of care. The board agreed the language pertaining to language permitting transport in a private vehicle if it was the most expedient method for transport but believe the language allowing the CPM to continue to provide care if the client refused transport would create a loophole that would prevent enforcement of the rules. Motion made by Schwaiger, seconded by Rooks to amend 20:85:03:06 to add language to read: "Provide necessary emergency stabilization until emergency medical services arrive or transfer is completed with the understanding that transport via private vehicle is an acceptable method of transport if it is the most expedient method for accessing medical services;" and add "pertinent" to the medical records accompanying the mother and/or baby during transport. The board voted by roll call. Pease, Rooks, Schwaiger, Cavender-Wilson voted aye; McKay absent. **MOTION PASSED**

- Abbie Paulson
  - Requested the same changes to required lab testing and previous C-section as SD Birth Matters. No further board action taken.
  - Requested 20:85:03:04 (4) (breech birth) be removed. No changes made.

- Alaina Kerkhoff
  - Requested the same change for previous C-section as SD Birth Matters. No changes made.

- Judy Jones
  - Requested removal of 20:85:05:06 (8)(b). Board agreed this language is covered under SDCL 36-9C-22 (2). Motion by Rooks, seconded by Schwaiger to removed 20:85:05:06 (8)(b). The board voted by roll call. Pease, Rooks, Schwaiger, and Cavender-Wilson voted aye; McKay absent. **MOTION PASSED**

- South Dakota State Medical Association
  - Rules allow CPM to care for mother-baby unit with a history of problems relating to pregnancy which is prohibited by statute. Board reaffirmed position that statute

permits CPMs to provide care for low risk pregnancy as determined by ongoing assessment throughout pregnancy. No changes made.

- 20:85:03:01(1)(a) Placental abnormality – requested that section be amended to prohibit care for patient with placental abnormality. The Board reaffirmed their position that women with placental abnormalities should not be cared for by CPMs and that this is already covered in the rules in these places: 20:85:03:01(1)(a) (1) (2) (3), 20:85:03:02 (16) (28), 20:85:03:04 (2)(11)(17). No changes made.
- 20:85:03:01(1)(u) – questioned how a CPM will detect suspected or diagnosed congenital fetal anomaly. The board reaffirmed their position from the May 24th meeting. No changes made.
- 20:85:03:01(1)(x) – asked that this read "any infection at time of delivery". The board noted the changes made to this rule at the request of SDSMA at the May 24th meeting and reaffirmed the position that "any infection" is too broad. No changes made.
- 20:85:03:01(1)(y) – requested "diagnosed" intrauterine growth restriction be changed to "suspected". Motion by Cavender-Wilson, seconded by Rooks to change "Diagnosed" to "Suspected" in 20:85:03:01 (l) (y). The board voted by roll call, Pease, Rooks, Schwaiger, and Cavender-Wilson voted aye, McKay absent. **MOTION PASSED**
- 20:85:03:02(1) – A woman with a previous cesarean section should deliver in a facility with capability to perform C-section within 10 minutes. Proposed rule does not adequately protect mother and baby. No change made.
- 20:85:03:06 – required transport information should include reason for transport. The board agrees and the "reason for transport" is included on the transport forms required under 20:85:03:06. No changes made.
- 20:85:03:07 – recordkeeping requirement should be 20 years. Motion by Schwaiger, seconded by Rooks to change recordkeeping requirement from 10 to 20 years. The board voted by roll call, Pease, Rooks, Schwaiger, and Cavender-Wilson voted aye, McKay absent. **MOTION PASSED**
- 20:85:03:08 – requirement for CPM to be certified in neonatal resuscitation. The board reaffirmed position that neonatal resuscitation is required as part of NARM certification and recertification which is required for licensure in South Dakota. No changes made.
- 20:85:03:10(6) – requirement to report services and outcomes should be extended to the standard postpartum period which is defined as 42 days after birth. The rules define the postpartum period as 6 weeks which is the equivalent to 42 days. No changes made.

Motion made by Schwaiger, seconded by Rooks to adopt the Proposed Rules §§ 20:85:01:01 through 20:85:05:19 as amended. The board voted by roll call, Pease, Rooks, and Schwaiger, Cavender-Wilson voted aye; McKay absent. **MOTION PASSED**

The floor was opened for the public to address the Board. There were no comments

There were no announcements.

The next meeting will be September 27th from 1-5 (central) via teleconference. Future meeting will be held the third Thursday in March and September with time and location to be determined.

Schwaiger moved to adjourn, seconded by Rooks. The board voted by roll call. Pease, Rooks, Schwaiger, and Cavender-Wilson voted aye; McKay absent. **MOTION PASSED.** The meeting was adjourned at 4:12 p.m.

SOUTH DAKOTA BOARD OF CERTIFIED PROFESSIONAL MIDWIVES
MINUTES OF PUBLIC HEARING

The South Dakota Board of Certified Professional Midwives (Board) convened a public hearing at 2:10 p.m. on Tuesday, July 17, 2018, at the Health Laboratory Building, Large Conference Room, 615 East Fourth Street, Pierre, South Dakota. The purpose of the hearing was to conduct a public hearing to consider proposed rules numbered 20:85:01:01 through 20:85:05:19.

Hearing Officer: Justin L. Williams, Legal Counsel, South Dakota Department of Health, 600 East Capitol Avenue, Pierre, SD.

Persons in Attendance:

(1) Debbie Pease, President, Board of Certified Professional Midwives;
(2) Susan Rooks, Board Member, Board of Certified Professional Midwives (appeared telephonically);
(3) Pat Schwaiger, Board Member, Board of Certified Professional Midwives (appeared telephonically);
(4) Tamera Weis, Executive Secretary, Board of Certified Professional Midwives;
(5) Judy Jones, Certified Professional Midwife, Irene, SD (appeared telephonically);
(6) Abbie Paulson, Birth Doula (appeared telephonically);
(7) Alaina Kerkhove, midwifery student, Coleman, SD (appeared telephonically);
(8) Evie DeWitt, Chair, South Dakota Birth Matters (appeared telephonically);
(9) Tim Engel, attorney for South Dakota State Medical Association;
(10) Mark East, Vice President, South Dakota State Medical Association (appeared telephonically);
(11) Bob Mercer, journalist
(12) Susan Sporrer, South Dakota Department of Health

Exhibits:

(A) Letter dated July 12, 2018 from Evie DeWitt, Chair, South Dakota Birth Matters;
(B) Letter dated July 11, 2018 from Alaina Kerkhove, midwifery student, Coleman, SD;
(C) Email / Letter dated July 1, 2018 from Judy Kay Jones, CPM, Irene, SD;
(D) Letter dated July 10, 2018 from Abbie Paulson, Birth Doula;
(E) Letter dated July 10, 2018 from Christopher Dietrich, President, South Dakota State Medical Association

Proponent Testimony:

1. Debbie Pease testified on behalf of the Board. Ms. Pease testified that the Legislature overwhelmingly supported and passed in a Bill in 2017 allowing for the creation of the Board of Professional Midwives. Much work has gone into these draft rules which outline definitions, requirements for licensure, disciplinary procedures and processes, and outlines the

scope of practice of professional midwives, including conditions requiring consultation and transfer of care.

Ms. Pease thanked the members of the Board and the Department of Health for all the assistance and effort put into seeking to balance the safety of mothers and newborn babies while also respecting the autonomy of those families seeking the services of a professional midwife. She stated it is impossible to satisfy all interested parties on all the issues covered by these rules. However, the Board feels the work up to this point strikes a balance in this regard. Ms. Pease stated similar rules are working well in neighboring states of Wyoming, Montana, and Minnesota and there is every expectation they will work well in South Dakota. The Board is looking forward to finalizing the rules and to begin licensing Certified Professional Midwives in South Dakota for families who have been asking for this service in the state for many years.

2. Evie DeWitt testified on behalf South Dakota Birth Matters. Ms. DeWitt thanked the Board and the Department of Health for their substantial work and effort on creating these draft rules. Birth Matters supports the rules as written, but asked the Board to consider some proposed changed outlined in written testimony previously submitted to the Board for consideration.

3. Abbie Paulson testified in her personal capacity as a birth doula. Ms. Paulson thanked everyone involved in researching and writing the rules. Ms. Paulson is in favor of the rules as currently written, but asked the Board to consider a few additional changes as outlined in the written testimony which she previously submitted.

4. Judy Jones testified in her personal capacity as a Certified Professional Midwife. Ms. Jones testified that she has been a Certified Professional Midwife for over 30 years. She has some issues with a few sections of the current draft rules, specifically regarding the prohibition on a CPM advising others in Section 20:85:05:06(8)(b). Ms. Jones appreciates all the work and effort put in these draft rules and respectfully asked the Board to consider her proposed changes in the written testimony previously provided.

5. Alaina Kerkhove testified in her personal capacity. She asked the Board to consider the proposed amendments to the draft rules outlined in her written testimony. Specifically, she believes a woman who previously had a cesarean section should not be required to first obtain a consultation with a physician before seeking to use the services of a Certified Professional Midwife. Ms. Kerkhove believes a previous cesarean section should be moved to the section containing conditions for which a consultation shall be recommended, rather than the section for which a consultation of a physician is required. She thanked the Board for all the hard work done.

Opponent Testimony:

1. Tim Engel testified on behalf of the South Dakota State Medical Association. Mr. Engel asks the Board to refer back to the written testimony previously provided by the South Dakota State Medical Association and asks the proposed changes be considered. The Medical Association has some concern about draft rule 20:85:03:03, specifically regarding "low risk" pregnancy, which is defined in SDCL 36-9C-1(6) to be "a pregnancy that is anticipated to be problem free…" The Medical Association believes the entirety of draft rule 20:85:03:03 is not consistent with or allowed by the enabling statutes in SDCL Chapter 36-9C.

2. Mark East testified on behalf on the South Dakota State Medical Association. Mr. East reinforced Mr. Engel's previous testimony and added the Medical Association has a concern regarding draft rule 20:85:03:01(1)(u). That subsection mentions a suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth. The Medical Association asserts this diagnosis would require the use of an ultrasound which the Certified Professional Midwife is not qualified or allowed to use.

Adjournment: 2:35 p.m.

Respectfully submitted,

Dated: July 18, 2018

Justin L. Williams

Exhibit A

July 12, 2018

RE: Board of Certified Professional Midwives Draft Administrative Rules

Dear CPM Board:

Thank you for the opportunity to provide comments on the Board of Certified Professional Midwives draft administrative rules. The families of South Dakota Birth Matters are eagerly awaiting the time when families in South Dakota who choose to have their babies in an out of hospital setting, will have access to skilled midwives to assist them. We greatly appreciate all the work the Board has done so far and respectfully ask for their consideration of the following suggestions to improve the rules:

1. Proposed 20:85:03:01 (3) is a significant change from the last draft of rules adding three STD's to the required lab work and removing the option for informed refusal. According to the SD Department of Health the average number of cases in the general population of South Dakota between 2007 and 2016 was 25.8 cases of syphilis, 58.8 cases of Hepatitis B, and 30.4 cases of HIV/AIDS. Due to the low incidence of these diseases in the general population, we request clients in low risk populations be given the ability to give informed refusal.We understand that syphilis testing is mandated by SDCL 34-23-10, but recommend HIV and Hepatitis B removed from the mandatory testing. We suggest the following changes:
    a. Amend 20:85:03:01 (3) to read "Failure to obtain minimum lab work of: blood group type, RH antibody screening, hemoglobin, and syphilis by 28 weeks gestation."
    b. Utilize the language used for lab work in the last draft to apply to these STD tests:
        i. "Failure to document the following: a) prenatal lab work that includes HIV and Hepatitis B by 28 weeks, or b) signed refusal of these tests from client;" (this would be a new subsection (4) and the following numbers would need to be adjusted)
2. Proposed 20:85:03:02 (1) requires a doctor's visit for every client that has had a previous cesarean section. We see very little benefit, if any, to balance the burden of time and expense that this requirement is going to impose on families, especially moms that have already successfully had a VBAC. We recommend that "Previous cesarean section;" be removed from 20:85:03:02 (1) (consultation required) and instead included under 20:85:03:03 (consultation shall be recommended).
3. Proposed 20:85:03:06 explains the midwife's responsibilities during a transport to a hospital and transfer of care. We agree with everything stated in this section but believe it can be improved by borrowing some language from the proposed Michigan rules for licensed midwives. We suggest the following revisions of 20:85:03:06 (underlined designates new language):

20:85:03:06 **Emergency transport and transfer plan.** When facilitating a transport and transfer of care:

1) The certified professional midwife shall:
    a. Notify the hospital when transport is initiated;

b. Provide necessary emergency stabilization until emergency medical services arrive or transfer is completed with the understanding that transport via private vehicle is an acceptable method of transport if it is the most expedient method for accessing medical services;
c. Accompany the client to the hospital, if feasible, or communicate by telephone with the hospital if the certified professional midwife is unable to be present; and
d. Ensure that transfer of care is accompanied by the client's pertinent medical records and the transport form prescribed by the board.

2) The certified professional midwife may:
   a. Continue to provide care to a client with any of the complications or conditions set forth in these rules under the following circumstances:
      i. If no appropriate health professional or other equivalent medical services are available;
      ii. If delivery occurs during transport;
      iii. If the client refuses to be transported to the hospital; or
      iv. If the transport entails futility, or extraordinary and unnecessary human suffering.
   b. Remain in consultation with the appropriate health professional after a transfer is made; and
   c. If authorized by the client and approved by the hospital, be present during the labor and childbirth, and care may return to the midwife upon discharge.

Thank you for your consideration of these recommendations. The families of South Dakota Birth Matters have been working for access to Certified Professional Midwives for a long time, and we are very grateful for all your efforts to assure this happens soon. We support the rules in their current form, but hope that you will consider our recommended changes to make them even better.

Sincerely,

Evie DeWitt

Chair, South Dakota Birth Matters

318 E 4th Ave, Mitchell, SD 57301

evieladonna@gmail.com

605-630-8699

Exhibit B

July 11, 2018

Alaina Kerkhove
46816-225th St
Colman, SD 57017
alainababies@yahoo.com

South Dakota Certified Professional Midwives Board
SD Department of Health
600 East Capital Ave
Pierre, SD 57501

Re: Board of Certified Professional Midwives Draft Administrative Rules

To Whom It May Concern:

I would like to start out by thanking you for taking the time to carefully consider the rules and regulations for the CPM scope of practice. I imagine it has been a monumental task determining the scope for the CPM's that will practice in our state. I feel the Certified Professional Midwifery Board has put together a great set of rules. While I believe the rules and regulations are overwhelmingly appropriate for our state I would like to suggest a change. I appreciate the opportunity to have my voice heard on this matter.

I am a writing today as a mother, grandmother, former doula, and current midwifery student enrolled in a MEAC accredited program. I am excited for the rules and regulations to be completed. This summer I had to leave South Dakota and my family in order to do my summer clinicals in New York. I look forward to the time when I will be able to work with preceptors right here in South Dakota.

I would request that consult required for previous cesarean section 20:85:03:2(1) be moved to the recommended consult section20:85:03:03. I have looked into the concern that a woman who has had a cesarean delivery is at an increased risk of having the placenta implant to the scar. The studies I found did not show an increased risk of placenta adherence to the cesarean scar. I have included two of the studies at the end of the letter. Please, allow families and care providers to determine if a consult is right for their personal history.

Thank you for your consideration of my suggestions.

Sincerely,

Alaina Kerkhove

Naji, O., Daemen, A., Smith, A., Abdallah, Y., Bradburn, E., Giggens, R., Chan D.C., Stalder, C., Ghaem-Maghami, S., Timmerman, D., Bourne, T. (2012). Does the presence of a cesarean section scar influence the site of placental implantation and subsequent migration in future pregnancies: a prospective case-control study. *Ultrasound Obstet Gynecol*(5):557-61. doi: 10.1002/uog.11133. retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/22323094

Pirjani, R., Seifmanesh, F., Tehranian, A., Hosseini L., Heidari, R., Ghajar, A., Sepidarkish, M. (2017). Placental implantation and migration following a previous caesarean section scar. *Aust N Z J Obstet Gynaecol* (1):115-117. doi: 10.1111/ajo.12555. Epub 2016 Nov 11. Retrieved from: https://www.ncbi.nlm.nih.gov/pubmed/27861702

Exhibit C

Emailed to Debbie and Ashley on July 1, 2018

Debbie. & Ashley and other board members,

Thank you for reconsidering some of the rules you are making for SD CPMs. I still Ibelieve you need to consider some of the changes I suggested in my previous letter. Otherwise some families will simply go out of state to be able to have the type of birth they desire.

I implore you again to reconsider section 20:85:05:06 (6). Thank you for realizing you only have authority over people in SD. However. There is still a problem with restricting a CPM from giving advise to others. You would prevent a CPM from advising families having an unattended birth or the Amish who plan to have only a grandmother who has attended other births. If they call with a question a CPM cannot even advise them of simple things to do in the birth or even to advise them to go in to the hospital. That would be advising them.

I also question if this restriction of free speech does not restrict the first amendment free speech rights. Speech is different than actions.

Please again reconsider this.

For Healthy Moms & Babes,

Judy Kay Jones, CPM, ND

Exhibit D

7-10-18

South Dakota Department of Health

600 East Capitol Avenue

Pierre, South Dakota 57501

RE: Board of Certified Professional Midwives Draft Administrative Rules

Dear Midwifery board:

Thank you for taking the time to review my suggestions for some small changes to the drafted rules for CPM's. I am a certified birth doula and breastfeeding counselor In Aberdeen and I am so excited for the time when families in South Dakota will have access to a skilled CPM. I have read and like most of the wonderful work you have already done on the rules. I greatly appreciate all the work the Board has done so far and respectfully ask for their consideration to some small changes to the rules:

1. Proposed 20:85:03:01 (3) I believe the addition of testing for syphilis, HIV and Hepatitis B adds a considerable expense to the testing for families who know they are not at risk for these illnesses. Women should be able to opt out of these tests If they know they are not at risk for STD's. Women are able to opt out of these test under the care of an OB (I have multiple times) they should be able to do the same under the care of a midwife. I suggest the following changes:
    a. Remove syphilis, HIV, and Hepatitis B from 20:85:03:01 (3) "required tests" and allow for a signed refusal of these tests from client.

2. Proposed 20:85:03:02 (1) requires a doctor's visit for every client that has had a previous cesarean section. Since the doctor is not providing any services what is the benefit of this visit? I believe the CPM is quite qualified to know if the mom is a vbac candidate according to the proposed rules (18mo from the c-section, has a low horizontal cut ect) . I see two problems with "requiring" this Dr. consult. 1) It may be hard to find a physician who is willing to see a women planning a home vbac. I personally have had one doctor refuse altogether to see me when I was planning my own home birth and when I did get into a visit with another OB, that OB told me "why are you here if you are having your baby at home? Why don't you just go to your midwife? This visit is silly." My sister also had an OB walk out of her appointment and refuse to document it once she found out she was planning a home birth. 2) If the woman does find a willing provider for the visit, this visit may add considerable expense to the family. I personally was charges $250 for my 15 min visit with an OB during my home birth pregnancy. Some women may not desire to have this extra expense. I would recommend you,

    a. Move 20:85:03:02 (1) from the "Conditions where consultation is required." Over to 20:85:03:03. "Conditions where consultation shall be recommended". This way a family can choose to opt out if they do not desire or are unable to find a physician for a consult.

B. If you are not willing to move this requirement then I ask you Change 20:85:03:02 (1) to read "Previous cesarean section without a subsequent vaginal Delivery:"

3. In Proposed **20:85:03:04 (4)** it requires a transport for any baby not in a head down position. I would be disappointed to see that the CPM's who are skilled and experienced in Vaginal Breech Birth would not be allowed to attend the vaginal breech births of women who desire it. As you know, hospitals and OB's trained and willing to attend a vaginal breech birth have all but disappeared. Even though ACOG supports the options of a vaginal breech birth with a skilled provider (ACOG committee opinion #340 "Planned vaginal delivery of a term singleton breech fetus may be reasonable under hospital-specific protocol guidelines for both eligibility and labor management."). Since women will likely have no hospital option for a vaginal breech birth when desired, I suggest that if the CPM is experienced and skilled with breech birth that the CPM should be allowed to continue care for women who do not desire a transport and the resulting "required" c-section at the hospital. Since CPM's are often the only providers that still have the skills/training required to safely attend a vaginal breech birth, I feel it would be a shame to not let them use and pass on their skill when the birthing woman desires it. I would request :

A. Proposed 20:85:03:04 (4) be removed from the rules.

B. If you are unwilling to remove it, I suggest you change Proposed 20:85:03:04 (4) to add "Noncephalic presentation at the onset of labor or rupture of membranes, whichever occurs first, unless mom has had a previous vaginal birth or birth is imminent; If a mother who has had a previous vaginal birth desires a vaginal breech birth with her midwife, the midwife should inform the mother of the risks and benefits of a breech birth and her experience and level of skill attending breech birth." Since we know that a vaginal breech birth is considerably safer with a mother who has had a previous vaginal birth.

Thank you for your consideration of these recommendations. I am very pleased with the majority of the rules so far and am so thankful for all your hard work.

Sincerely,

Abbie Paulson/ Birth Doula

Exhibit E

SOUTH DAKOTA STATE MEDICAL ASSOCIATION

Values. Ethics. Advocacy.

2600 W. 49th Street, Suite 200
Sioux Falls, SD 57105-6569
605-336-1965
Fax 605-274-3274
www.sdsma.org

July 10, 2018

Board of Certified Professional Midwives
Attn: Ashley Tanner, JD
Division of Administration
South Dakota Department of Health
500 E. Capital Ave
Pierre, SD 57501

RE: Board of Certified Professional Midwives Draft Administrative Rules

Dear Ms. Tanner:

In follow-up to our letter sent May 3, 2018, in regard to the proposed administrative rules governing the practice of certified professional midwives. We thank you for your consideration and the actions taken to address a number of the concerns we shared with you in our May 3 letter.

As previously stated, the practice of midwifery is not without risk of serious injury – up to and including death of the mother and/or newborn. Upon review of the proposed rules released June 26, 2018, the following concerns remain. Therefore, we respectively ask for reconsideration of the following for the final rules:

1. The statute authorizes a Certified Professional Midwife ("CPM") to "manage and care for the low-risk mother-baby unit ...." SDCL 36-9C-1(3). "Low risk" is then defined as "a pregnancy that is anticipated to be problem free ...." SDCL 36-9C-1(6). There is no definition of "problem free," so that term must be construed and interpreted based on its usual and ordinary meaning. The provisions of the draft rules that allow for a CPM to continue to care for a mother-baby unit with a history of "problems" relating to pregnancy (e.g., 20:85:03:03) is not consistent with the statute, and we respectfully assert, is prohibited by the statute. If there is a history of problems relevant to the pregnancy that warrant a referral to a physician, the pregnancy is clearly not "problem free" and the CPM should not continue to provide care for the mother-baby unit. We believe that documentation of a referral to a physician does not go far enough to protect mother and baby.

2. 20:85:03:01(1)(a) Placental abnormality – We ask that this section be amended to prohibit care for a patient with placental abnormality, including 1) Placenta previa or low-lying placenta at term, defined as the placental edge lying within 2 cm of the cervical os; 2) Signs indicative of placental abruption; 3) Placenta located over previous uterine scar; and 4) Ultrasound or MRI evidence of morbidly adherent placenta, including placenta accreta, increta, or percreta.

3. 20:85:03:01(1)(u) – We question how a CPM will detect a suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth without a prior ultrasound. We ask that the rules specify how screening for such an anomaly will be conducted and by whom.

4. 20:85:03:01(1)(x) – We would respectively ask that this read, "any infection at time of delivery."

5. 20:85:03:01(1)(y) – Diagnosed intrauterine growth restriction. We believe the word, "diagnosed" should be removed and replaced with "suspected." In doing so, we also ask that growth restriction be defined at an estimated fetal weight less than the 10th percentile for gestational age and add and define macrosomia (an estimated fetal weight greater than the 90th percentile for gestational age or greater than 4500g). An ultrasound is required to detect/diagnose an intrauterine growth restriction. The rules should specify how screening for such an anomaly will be conducted and by whom.

6. 20:85:03:02(1) – While the CPM may be able to provide care during delivery, it is critical that any woman who has a prior cesarean section deliver in a facility with the capability to perform a cesarean section within ten (10) minutes. We do not believe the proposed rules as written adequately protect mother and baby as physician monitoring, treatment and management is required at the bedside or in close proximity at time of delivery.

7. 20:85:03:06 – The required transport information should include the reason for transfer.

8. 20:85:03:07 – In accordance with the applicable statutes of limitations, the record keeping requirement should be 20 years.

9. 20:85:03:08 – We ask that the rules contain specific language indicating that CMPs be certified in neonatal resuscitation.

10. 20:85:03:10(6) – The requirement to report services and outcomes should be extended to the standard postpartum period, which is defined as 42 days after birth.

Once again we thank you for your consideration of our concerns. Please let us know if you would like to see medical literature to support the substantive medical proposals, or if you have any questions.

Sincerely,

Christopher Dietrich, MD, President
South Dakota State Medical Association

cc: Barbara Smith, CEO, SDSMA
Tom Martinec, Deputy Secretary, SD Department of Health

Dr. McKay's written comments provided to Board:

Required Prenatal Lab Testing

We should keep with ACOG, SMFM, AAFP recommendations for routine prenatal lab work. Agree that informed refusal could be an option as long as we have a standard form from the board that gives risks and benefits. As you may be aware, the above rates to not reflect that South Dakota rates are "low" in absolute volume, but not in a per capita comparison. We are actually higher.

Transport Requirements if Client Refuses Transport

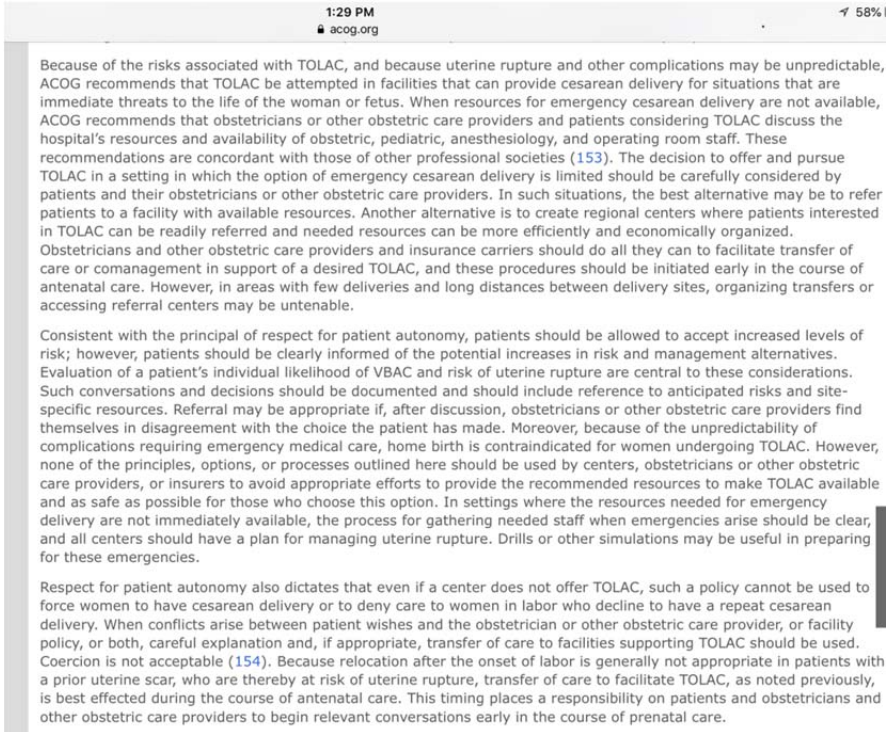
I am not sure how I would vote here. I would need to compare and contrast. I do not want the CPM to be in a position where a transport is offered and refused, but then forces that CPM to practice outside their scope, thereby putting their license at risk even further.

Previous C-Section

I will not compromise on my opinion, based not only on clinical experience, but also on literature review, that VBACs are not a candidate for out of hospital births. Mandatory consultation is, at a minimum, a necessity. I would prefer a set of rules that excludes any prior uterine incision from the CPM practice.

Of course, the real issue is not adherence of the placenta to the previous scar—though a consultation with a board certified OB/GYN would rule this out, but the risk of uterine rupture in the setting of labor. Current risk models show that this risk is 1% in an ideal candidates (one prior Low Transverse incision with 2 layer closure). I will enclose the ACOG Bulletin on VBAC and Out Of Hospital Births for your review. In the event of uterine rupture, catastrophic outcome (for both mom and baby) is mitigated if delivery can occur quickly (10 minutes). This is only possible in a hospital setting.

https://www.acog.org/Clinical-Guidance-and-Publications/Practice-Bulletins/Committee-on-Practice-Bulletins-Obstetrics/Vaginal-Birth-After-Cesarean-Delivery

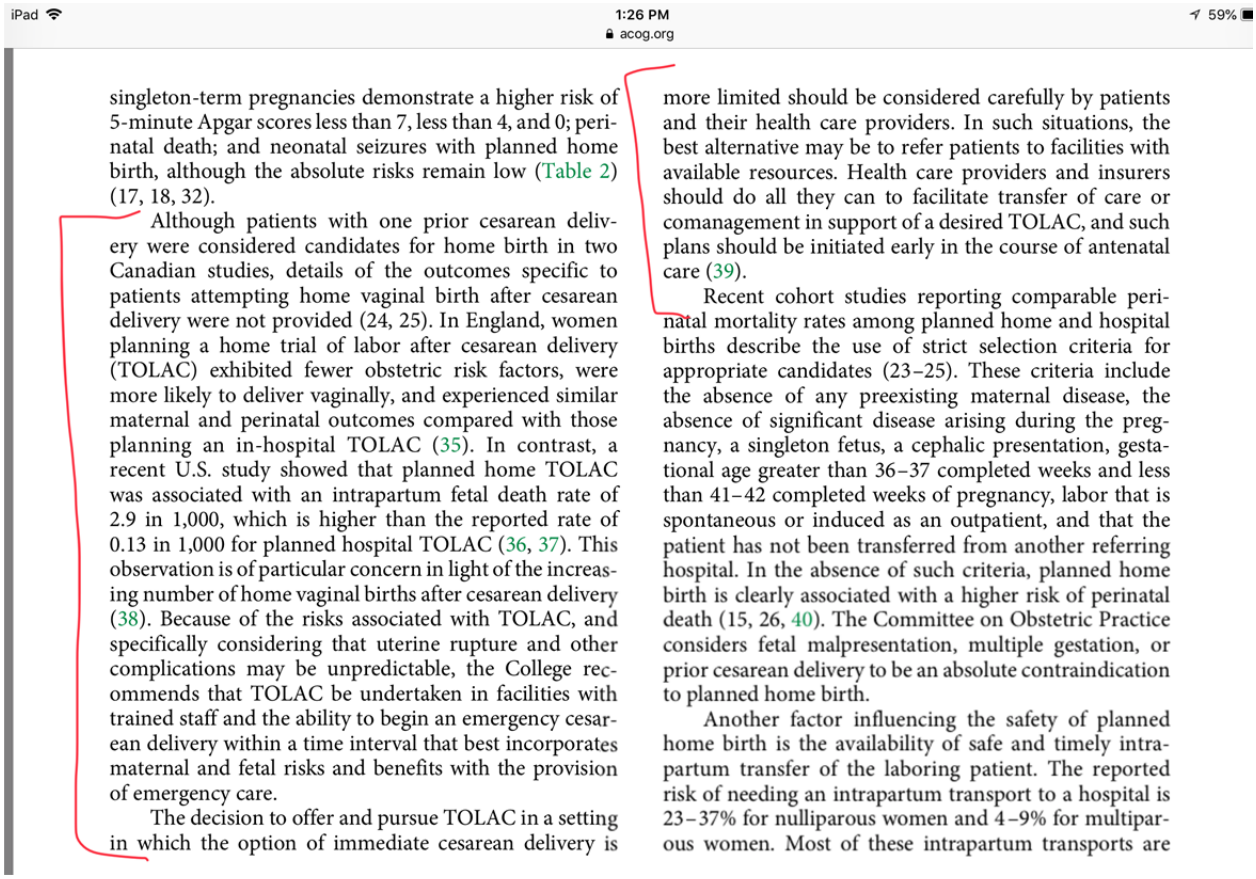


Because of the risks associated with TOLAC, and because uterine rupture and other complications may be unpredictable, ACOG recommends that TOLAC be attempted in facilities that can provide cesarean delivery for situations that are immediate threats to the life of the woman or fetus. When resources for emergency cesarean delivery are not available, ACOG recommends that obstetricians or other obstetric care providers and patients considering TOLAC discuss the hospital's resources and availability of obstetric, pediatric, anesthesiology, and operating room staff. These recommendations are concordant with those of other professional societies (153). The decision to offer and pursue TOLAC in a setting in which the option of emergency cesarean delivery is limited should be carefully considered by patients and their obstetricians or other obstetric care providers. In such situations, the best alternative may be to refer patients to a facility with available resources. Another alternative is to create regional centers where patients interested in TOLAC can be readily referred and needed resources can be more efficiently and economically organized. Obstetricians and other obstetric care providers and insurance carriers should do all they can to facilitate transfer of care or comanagement in support of a desired TOLAC, and these procedures should be initiated early in the course of antenatal care. However, in areas with few deliveries and long distances between delivery sites, organizing transfers or accessing referral centers may be untenable.

Consistent with the principal of respect for patient autonomy, patients should be allowed to accept increased levels of risk; however, patients should be clearly informed of the potential increases in risk and management alternatives. Evaluation of a patient's individual likelihood of VBAC and risk of uterine rupture are central to these considerations. Such conversations and decisions should be documented and should include reference to anticipated risks and site-specific resources. Referral may be appropriate if, after discussion, obstetricians or other obstetric care providers find themselves in disagreement with the choice the patient has made. Moreover, because of the unpredictability of complications requiring emergency medical care, home birth is contraindicated for women undergoing TOLAC. However, none of the principles, options, or processes outlined here should be used by centers, obstetricians or other obstetric care providers, or insurers to avoid appropriate efforts to provide the recommended resources to make TOLAC available and as safe as possible for those who choose this option. In settings where the resources needed for emergency delivery are not immediately available, the process for gathering needed staff when emergencies arise should be clear, and all centers should have a plan for managing uterine rupture. Drills or other simulations may be useful in preparing for these emergencies.

Respect for patient autonomy also dictates that even if a center does not offer TOLAC, such a policy cannot be used to force women to have cesarean delivery or to deny care to women in labor who decline to have a repeat cesarean delivery. When conflicts arise between patient wishes and the obstetrician or other obstetric care provider, or facility policy, or both, careful explanation and, if appropriate, transfer of care to facilities supporting TOLAC should be used. Coercion is not acceptable (154). Because relocation after the onset of labor is generally not appropriate in patients with a prior uterine scar, who are thereby at risk of uterine rupture, transfer of care to facilitate TOLAC, as noted previously, is best effected during the course of antenatal care. This timing places a responsibility on patients and obstetricians and other obstetric care providers to begin relevant conversations early in the course of prenatal care.

https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Planned-Home-Birth



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