ATTACHMENT D

SUMMARY OF PUBLIC COMMENTS AND DEPARTMENT RESPONSES
PROPOSED REVISION TO REGULATION 61-24, LICENSED MIDWIVES
State Register Document No. 4210
December 21, 2011

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
Section 103.A South Carolina affiliate of the American College of Nurse Midwives (ACNM)(10) Comment #1	"There is an additional category of midwives who do not practice as such in South Carolina: Certified Midwives (CMs) – this is a non-nurse who enters directly into an ACNM accredited midwifery program and is certified by the American Midwifery Certification Board (the same national examination required for CNMs). Some states have begun to regulate these midwives either the same as CNMs or the same as CPMs. Per the ACNM, the CM is educated and certified to perform all tasks currently afforded a CNM. We respectfully ask that DHEC consider researching and adding this type of midwife to our laws."	**Not Adopted**. Refer to Labor Licensing and Regulation that licenses Certified Nurse Midwives, who practice at an equivalent level of care. Certified Midwives receive the same training as Certified Nurse Midwives and may practice with the same privileges in other states, including prescriptive authority. South Carolina does not license CMs as such. CMs may be licensed as	**Section 103.A** **Text as published in the State Register:** No person may provide midwifery services or represent that s/he is a midwife without first possessing a license issued by the Department in accordance with the provisions of these regulations. Licensure as a midwife shall be by certification by NARM or other Department approved organization(s). ~~is examination only; there is no reciprocity with other jurisdiction~~ Midwives requesting initial licensure will receive a license, provided they have evidence of certification by NARM or other Department approved organization(s) and have also met other requirements as established by the Department. **No Change.**

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		CPMs and practice within the scope of practice as defined in R. 61-24.	
Section 103.A.2 Susan Smart(17) Comment #2	"Current Licensed Midwives should have ability to do skills after attending training workshops, not just those who are CPM's. CPM's Code of Ethics includes items that make it difficult for me to sign as a Christian midwife and I don't know if I am comfortable becoming a CPM."	**Not Adopted** NARM established standards for didactic and practical training to perform the skills listed on the skills verification checklist. The CPM certification assures that the individual has met the standards. In addition, state law prohibits discrimination because of race, religion, color, sex, age, national origin, or disability.	**Section 103.A.2** **Text as published in the State Register:** Individuals that choose not to obtain the CPM certification will not be considered CPMs and are not authorized to perform the skills nor administer medications designated for administration by CPMs. **No Change.**
Section 103.A.2 Susan Smart(17) Comment #3	"For the same reason, if the CPM process begins to not accept trainings from Christian organizations because of this code of ethics, we need an avenue to accept midwives with this training."	**Not Adopted** Correspondence between the Department and	**Section 103.A.2** **Text as published in the State Register:** Individuals that choose not to obtain the CPM certification will not be considered

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		NARM confirms that there is no intent to abandon the Portfolio Evaluation Process. In the unlikely event the PEP is no longer available as an avenue to certification, the Department will provide an alternative process for licensure.	CPMs and are not authorized to perform the skills nor administer medications designated for administration by CPMs. **No Change.**
Section 103.C.3 South Carolina affiliate of the ACNM(10) Comment #4	"As a state affiliate of the ACNM, we can only support regulations that would require newly licensed midwives or midwives renewing their license in our state who have completed an accredited education program as approved by the Department of Education and become certified by NARM exam. We cannot support regulation of licensed midwives whose pathway to CPM was via the PEP or portfolio process."	**Not adopted.** This would cause an undue burden on prospective midwife candidates to attend schools out of state that are approved by the Midwifery Education Accreditation Council.	**Section 103.C.3** **Text as published in the State Register:** Evidence of completion of an educational program to be evaluated by NARM or other Department approved organization ~~(includes self-study) as described in Section E~~; **No Change.**
Section 103.C.5 and Section 103.E.4.b	"*Evidence of valid Healthcare Provider cardiopulmonary resuscitation (CPR) certificate and Neonatal Resuscitation Program in accordance with current NARM/CPM standards.*"	**Adopted**	**Section 103.C.5** **Text as published in the State Register:** Evidence of valid Healthcare Provider

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South Carolina Licensed Midwives Association(15) Comment #5	We find this language to be forward-thinking in light of reports from various parts of the country indicating that CPMs have been unable to obtain NRP from the American Heart Association and American Academy of Pediatrics. If the trend continues, we are confident that NARM will maintain vision and foresight, creating an avenue for CPMs to stay current with these lifesaving skills.		cardiopulmonary resuscitation (CPR) certificate~~ certification~~ by the American Red Cross or American Heart Association ~~in cardiopulmonary resuscitation of the adult~~ and Neonatal Resuscitation Program (NRP) certificate from the American Heart Association and American Academy of Pediatrics"; ~~newborn within the previous year;~~ **Text changed as a result of public comment:** Evidence of valid Healthcare Provider cardiopulmonary resuscitation (CPR) certificate~~ certification~~ by the American Red Cross or American Heart Association ~~in cardiopulmonary resuscitation of the adult~~ and Neonatal Resuscitation Program (NRP) certificate in accordance with current NARM or other Department approved organization standards"; ~~newborn within the previous year;~~ **Section 103.E.4.b** **Text as published in the State Register:** b. Evidence of valid Healthcare Provider cardio-pulmonary resuscitation (CPR) certificate by the American Red Cross or American Heart Association and Neonatal Resuscitation Program (NRP) certificate

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			from the American Heart Association and American Academy of Pediatrics"; **Text changed as a result of public comment:** Evidence of valid Healthcare Provider cardio-pulmonary resuscitation (CPR) certificate by the American Red Cross or American Heart Association and Neonatal Resuscitation Program (NRP) certificate in accordance with current NARM or other Department approved organization standards";
Section 103.C.8 South Carolina Medical Association(16) Comment #6	"The South Carolina Medical Association urges caution with respect to the allowance of reciprocity, particularly if the intention is to place more responsibility on a third party assessment while reducing DHEC involvement in the process. An interview of any potential reciprocity candidate would be important, which would include reviewing the physician backup, DHEC perinatal regions, requirements including referral for metabolic screening, hearing screening, shaken baby literature, and other pertinent information."	**Partially Adopted** A personal interview will be conducted with each midwife candidate in which Department policies, procedures and other pertinent information will be reviewed. Each candidate will be required to sign an attestation stating the candidate agrees	**Added Section 103.C.8** **Text to read:** A personal interview will be conducted with each midwife candidate in which Department policies, procedures and other pertinent information will be reviewed. Each candidate will be required to sign an attestation stating the candidate agrees to operate within the scope of practice outlined in the regulation.

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		to operate within the scope of practice outlined in the regulation.	
Section 103.C.8 Dr. Amy Picklesimer(12) Comment #7	"I am OPPOSED to the changes allowing reciprocity with other States, particularly since the proposed changes place more responsibility on a third party assessment while reducing DHEC involvement in the process. I strongly advocate some sort of interview processes at a minimum. Ideally a there would be a committee review of practice, letters of recommendation from other midwives, a requirement to appear before the committee with their back-up physician, and a written examination regarding scope of practice, indications for referral, and prohibitions in the practice of midwifery."	**Partially Adopted** A personal interview will be conducted with each midwife candidate in which Department policies, procedures and other pertinent information will be reviewed. Each candidate will be required to sign an attestation stating the candidate agrees to operate within the scope of practice outlined in the regulation.	**Same response as comment #6**
Section 103.F South Carolina affiliate of the ACNM(10)	"We support all regulation changes regarding testing for Tuberculosis."	**Accepted.** Amendments regarding tuberculin skin testing reflects	**Section 103.F** **Text as published in the State Register:** Tuberculin Skin Testing. (I) 1. A Tuberculin skin test (TST) is a diagnostic tool for detecting *M.*

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Comment #7		current Department policy established by the Bureau of Infection Control. **No Change.**	*tuberculosis* infection. A small dose (0.1 milliliter) of purified protein derivative (PPD) tuberculin is injected just beneath the surface of the skin (by the intradermal Mantoux method), and the area is examined for induration (hard, dense, raised area at the site of the TST administration) forty-eight to seventy-two (48 to 72) hours after the injection (but positive reactions can still be measurable up to a week after administering the TST). The size of the indurated area is measured with a millimeter ruler and the reading is recorded in millimeters, including zero (0) mm to represent no induration. Redness/erythema is insignificant and is not measured or recorded. Two-Step Testing is a procedure used for the baseline skin testing of persons who may periodically receive TST to reduce the likelihood of mistaking a boosted reaction for a new infection. If the initial TST result is interpreted as negative, a second test is repeated 1-3 weeks after the initial test. If the initial (TST) result is interpreted as positive, then the reaction shall be documented and followed up as positive; this reaction will serve as the baseline and no further skin testing is indicated. If the second test is given and its result is interpreted as positive, then the reaction shall be documented and followed up as positive; this reaction will serve as the baseline reading and no further skin testing

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			is indicated. In general, the result of the second TST of the two-step procedure shall be used as the baseline reading. 2. Risk Assessment For Settings In Which Patients With Suspected Or Confirmed TB Disease Are Not Expected To Be Encountered. a. The initial and ongoing risk assessment for midwives and apprentices in these settings shall consist of the following steps and use the applicable elements of the Tuberculosis (TB) risk assessment worksheet found in Appendix B of CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings, 2005. MMWR Vol 54, No. RR-17, December 30, 2005. (1) Review the community profile of TB disease in collaboration with the local or state health department; (2) Consult the local or state TB control program to obtain epidemiologic surveillance data necessary to conduct a TB risk assessment for the healthcare setting (available on the DHEC website at http://www.scdhec.gov/health/disease/tb); (3) Determine if persons with unrecognized TB disease were encountered in the setting during the previous 5 years; (4) Determine if any midwives and apprentices need to be included in the TB screening program; (5) Determine the types of environmental controls that are currently in place, and

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			determine if any are needed in the setting; (6) Document procedures that ensure the prompt recognition and evaluation of suspected episodes of healthcare-associated transmission of *M. tuberculosis*; (7) Conduct periodic reassessments at least annually to ensure 1) proper implementation of the TB infection control plan; 2) prompt detection and evaluation of suspected TB cases; 3) prompt initiation of airborne precautions of suspected infectious TB cases before transfer; 4) prompt transfer of suspected infectious TB cases; 5) proper functioning of environmental controls, as applicable; and 6) ongoing TB training and education for midwives and apprentices; (8) Recognize and correct lapses in infection control. b. The risk classification shall be used as part of the risk assessment to determine the appropriateness and frequency of tuberculosis screening and other tuberculosis related measures to be taken. The risk classification shall be conducted in accordance with Appendix C of the CDC Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Health-Care Settings. A risk classification shall be determined for the entire setting. However, in settings that encompass multiple sites, specific areas defined by geography or patient population locations within the setting might have separate risk classifications.

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			3. TB Testing Requirements For Settings In Which Patients With Suspected or Confirmed TB Disease Are Not Expected To Be Encountered. a. Low Risk. (1) Baseline two-step TST or a single Blood Assay for *Mycobacterium tuberculosis* (BAMT): All midwives and apprentices must have a baseline two-step TST or a single BAMT performed within 3 months prior to contact with patients unless the midwife or apprentice has a documented TST or a BAMT completed within the previous 12 months. If a new midwife or apprentice has had a documented negative TST or a BAMT result within the previous 12 months, a single TST (or the single BAMT) can be administered in the new setting to serve as the baseline there. (2) Serial (periodic) TST or a single BAMT: Not indicated (not required). (3) Post-exposure TST or a BAMT for midwives and apprentices upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one TST or a BAMT as soon as possible to all midwives and apprentices who have had unprotected exposure to an infectious TB case/suspect. If the TST or the BAMT result is negative, administer another TST or a BAMT 8-10 weeks after the initial date of exposure to *M. tuberculosis.*

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			b. Medium Risk. (1) Baseline two-step TST or a single BAMT: All midwives and apprentices must have a baseline two-step TST or a single BAMT within 3 months prior to contact with patients unless there is a documented TST or a BAMT result during the previous 12 months. If a new midwife or apprentice has had a documented negative TST or a BAMT result within the previous 12 months, a single TST (or the single BAMT) can be administered in the new setting to serve as the baseline. (2) Serial (periodic) testing (with TST or BAMT): All midwives and apprentices who have risk of TB exposure and who have previous documented negative results must have a TST or BAMT performed annually. Instead of participating in serial (periodic) testing, midwives and apprentices with documented TB infection (positive TST or BAMT) shall receive a symptom screen annually. This screen shall be accomplished by educating the midwifes and apprentices about symptoms of TB disease, documenting the questioning of the midwives and apprentices about the presence of symptoms of TB disease, and documenting the responses and instructions provided to midwife or apprentice on reporting any such symptoms immediately to a physician. Treatment for latent TB infection (LTBI) shall be considered in accordance with CDC/DHEC guidelines

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			and, if recommended, treatment completion shall be encouraged. (3) Post-exposure TST or a BAMT for midwives and apprentices upon unprotected exposure to *M. tuberculosis*: Perform a contact investigation when unprotected exposure is identified. Administer one TST or a BAMT as soon as possible to midwives and apprentices who have had unprotected exposure to an infectious TB case/suspect. If the TST or the BAMT result is negative, administer another TST or a BAMT 8-10 weeks after the date of initial exposure to *M. tuberculosis*. c. Baseline Positive or Newly Positive Test Result. (1) Midwives and apprentices with a baseline positive or newly positive test result for *M. tuberculosis* infection (*i.e.*, TST or BAMT) or documentation of treatment for LTBI or TB disease or signs or symptoms of tuberculosis (*e.g.*, cough, weight loss, night sweats, fever, *etc.*) shall have a chest radiograph performed immediately to exclude TB disease (or evaluate an interpretable copy within the previous 3 months). These midwives and apprentices will be evaluated for the need for treatment of TB disease or LTBI and will be encouraged to follow the recommendations made by a physician with TB expertise. (2) Midwives and apprentices who are known or suspected to have TB disease

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			shall be excluded from work and required to undergo evaluation by a physician. Midwives and apprentices who are known or suspected to have TB may only return to work with approval by the DHEC TB Control program. Repeat chest radiographs are not needed unless symptoms or signs of TB disease develop or unless recommended by a physician or DHEC TB Control Program. **No Change.**
Section 201 South Carolina Medical Association(16) Comment #8	"Finally, the South Carolina Medical Association does not support any increased scope of practice through regulation. While it is unclear from the proposal whether the revised regulation would include any increased scope of practice, particularly in the section regarding the provision of intrapartum care, the regulatory process is not the proper place for this to occur."	**Clarification** The Department is not seeking to increase the scope of practice of licensed midwives beyond the practice of midwifery. **No Change.**	**Section 201** **Text as published in the State Register:** Scope of Practice. (I) A. The licensed midwife may provide care to low-risk women and neonates determined by medical evaluation by a healthcare provider to be prospectively normal for pregnancy and childbirth (see Sections ~~K, L and M~~ 302). ~~and a~~ A licensed midwife may deliver only women who have completed between 37 to 42 weeks of gestation, except under emergency circumstances. Care includes: ~~(I)~~ 1. Prenatal supervision and counseling; 2. Preparation for childbirth; 3. Supervision and care during labor and delivery and care of the mother and newborn in the immediate postpartum, so long as progress meets criteria generally accepted as normal.

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			No Change.
Section 202.B and Section 302.E.1.d South Carolina Licensed Midwives Association(15) Comment #9	"These language changes will allow CPMs to care for our clients in a much more appropriate, safe manner than the current Regulation 61-24. We are excited to have this skill included in the draft. Permitting basic suturing will increase safety for mothers by decreasing delays in repairing lacerations, which in turn will decrease blood loss and risk of infection. Mothers with minor lacerations which require repair will no longer need to endure an uncomfortable transport to an emergency room, incurring additional expense, and involving additional health care providers unnecessarily. Nineteen other states have regulatory language for midwives that authorize these specific skills, and it is considered the standard of care by NARM for CPMs. SCLMA agrees wholeheartedly that women suffering extensive lacerations must be referred to a specialist, and we will continue to do so. "	**Accepted** **No Change.**	**Section 202.B.** **Text as published in the State Register:** Surgical Procedures. The midwife shall not perform any operative procedures other than artificial rupture of membranes at the introitus, clamping and cutting of the umbilical cord. CPMs may perform those procedures as well as basic suturing of 1st degree, 2nd degree and labial tears. **Section 302.E.1.d** **Text as published in the State Register:** Infiltration of 1% lidocaine hydrochloride (without epinephrine) to provide local anesthesia for basic suturing of 1st degree, 2nd degree and labial tears (to be performed by a CPM only); (II) **No Change.**
202.E Dr. Sarah Gareau, DrPH, MEd, MCHES(1) Comment #10	"I am submitting comments regarding the below policy which seemingly would further limit the ability for LMs and CPMs to provide VBAC care in the state of SC. There is a growing body of literature supporting VBAC as the standard of care. The National Institute of Health convened a meeting to discuss this issue last year and determined the following: *We are concerned about the barriers that women face in gaining access to clinicians and facilities that are able and willing to offer trial of labor.*	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after	**Section 202.E** **Text as published in the State Register:** Vaginal Birth After Cesarean Section (VBAC). The midwife shall not provide care for or assist in delivery of any patient who has had a previous Cesarean section. VBAC patients must be referred to a physician for medical care and delivery. **No Change.**

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	Given the low level of evidence for the requirement for "immediately available" surgical and anesthesia personnel in current guidelines, we recommend that the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists reassess this requirement with specific reference to other obstetric complications of comparable risk, risk stratification, and in light of limited physician and nursing resources. Health care organizations, physicians, and other clinicians should consider making public their trial of labor policies and VBAC rates, as well as their plans for responding to obstetric emergencies. We recommend that hospitals, maternity care providers, health care and professional liability insurers, consumers, and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor. http://consensus.nih.gov/2010/vbacstatement.htm As a women's health specialist, I am concerned that policies are being considered which would further limit a woman's access to VBAC, especially now that the standard of care is VBAC (for most cases). It often takes a long time for practice to catch up with research and advocacy measures. It is my hope that this will not be the case for SC where VBAC access has already been limited -- to the level that some women will drive to NC to give birth. The American Public Health Association's Committee on Women's Rights and Women's	Cesarean and licensed midwifery practice. This section does not change the Department's policy. However, in the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	

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	Caucus have hosted several scientific sessions in the past few years identifying the evidence in support of VBAC. I hope that the state of SC will do everything it can to support the availability of birth options for women and respect a woman's choice to have a VBAC."		
Section 202.E South Carolina Licensed Midwives Association(15) Comment #11	"*The midwife shall only provide care for or assist in delivery of any patient who has had a previous Cesarean section in accordance to the community standards of care*. In the current political/birth climate, LMs would be unable to provide care for women seeking VBAC. It is SCLMA's belief that the research will continue to prove the safety of VBAC, especially secondary VBAC. ACOG's current Practice Bulletin reflects this, as does a recent meta-analysis, which we have included today. This looser verbiage will allow growth without a need for revision of Regulation 61-24 entirely."	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. However, in the event that future research proves the safety of vaginal birth after	**Same response as comment #10.**

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		Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Christy Kollath(19) Comment #12	"I agree with the SCLMA statement that language regarding VBACs should be less prohibitive to leave room for future changes in national VBAC standards. South Carolina has a higher c-section rate in general and 91% of women with c-sections in SC have repeat c-sections (Mike Smith's analysis of PRAMS data presented @ Womens Health Research Forum 2011). This goes against WHO and Healthy People recommendations. Information about health care providers providing VBACs in hospital settings should be made accessible to women. I personally know or have spoken to many women (at least 10) who have felt they have had no other options and bypassed the medical community entirely to have an unassisted VBAC. New information regarding the safety of VBACs should constantly be taken into account and made available to all maternity care providers in order to increase the safety of women in the state.	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in	**Same response as comment #10.**

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		the out of hospital setting, the Department may consider modifying its policy.	
202.E Amber E. Canaan(6) Comment #13	"I understand that you are seeking to ban licensed midwives from being able to care for women who wish to have a vaginal birth after cesarean (VBAC). Why would you consider such a restrictive ban that limits a woman's right to choose where and how she delivers her babies? As a former labor and delivery RN, I have taken care of many women who have successfully given birth vaginally after a c-section, without complications or medical interventions on the part of the doctor. As a mother myself, I fully support the right for women to choose where and how their babies are brought into the world. Midwives provide a wonderful and safe alternative to hospital births, whether babies are born in a birth center, such as the wonderful facility in Fort Mill where my daughter was born last year. The business side of healthcare that is responsible for bringing a profit to hospitals and doctors is also responsible for causing the United States to have a higher maternal and neonatal mortality rate than many other parts of the world. We have such wonderful technology here, but when it comes to childbirth, it is being used adversely to turn a profit and the ones suffering from all this are the mothers	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in	**Same response as comment #10.**

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	and babies. We need to take a step back and realize that pregnancy is generally a normal and healthy part of life and it doesn't need to be medicalized all in the name of making a profit. I urge you to please look at the real statistics on this, not just what ACOG wants everyone to believe. Women deserve the right to choose how their babies will be born and not forced into another dangerous surgical birth just because a group of doctors and health professionals deem it appropriate. Forcing mothers into surgical births by banning VBAC's is a dangerous move for everyone as women will search for a natural and peaceful way to birth their babies without being subjected to an operating room. I am a resident of North Carolina, was born here and have lived here my whole life. My family and I are moving to South Carolina in the spring, largely because from the research we've done, it is a better place to raise our family. Home birth is legal there and having greater options for childbirth was a huge draw for me. I urge you to dismiss this ban on VBAC's for licensed midwives and keep your state the wonderful and natural childbirth supportive place that I know it is and can continue to be."	the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Interested Citizen(9) Comment #14	***"...'The Licensed Midwife is trained and equipped to carry out life-saving measures.'...*** A 'VBAC' woman can actually be in a more dangerous situation in the hospital with these health professionals, as opposed to at home or in a birth center with LM's... If a VBAC woman wants	**Not Adopted** The Department is adding this section to incorporate a	**Same response as comment #10.**

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	to labor and birth at home, and is attended by a LM, I suggest the following protocol: 1. Documentation and signature of uterine scar location (LTS) 2. Informed consent 3. 2 Midwives, and one assistant 4. 2 or less Low Transverse Uterine Incisions 5. "Back-Up" Physician that has been following the care of pregnancy 6. Emergency Plan (Hospital, Route, signed consent for emergency transfer) 7. 1st Trimester U/S, with mandatory 3rd trimester U/S for placental location 8. Cephalic Presentation (no breech, transverse babies) 9. Electronic Fetal Monitoring (at home and birth center), Telemetry okay, EFM is recommended to be continuous in active labor. 10. Heplock (IV Access) 11. No Augmentation (no, castor oil, herbs or Pitocin) Some of the factors that expel the home birth and birth center option would be the following: Classical and "T" uterine incision, previous uterine rupture, Multiple Pregnancy, non-cephalic presentation, and obviously any "high-risk" perinatal issues such as PIH, history of abruption, in which that case the pregnant woman would be referred to a physician... I will tell you right now, that it is EXTREMELY hard for a woman to want to have a VBAC at a hospital in this state... Our women need better options than what they currently have access to."	Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	

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Section 202.E Amy Gruenwald Mattison(2) Comment #15	"I'm writing to express my concern over the possibility of a ban on allowing women to have a trial of labor after previously delivering a child surgically. The option to have a VBAC is critical to improving health outcomes for women and children. Of course, reducing the number of primary surgical births should be the focus of our attention when talking about improving health outcomes. However, for the majority of women who have their first child or children (in the case of twins), having a subsequent child delivered vaginally is safe -- whether they are attended by Licensed Midwives (with ability to transfer if the need arises) or physicians. Please consider removing the restrictions that limit a woman's choice to birth her children in the way that she and her care provider decide is best for them."	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	**Same response as comment #10.**

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Section 202.E Melissa Aldrich(5) Comment #16	"Please do not allow DHEC to ban midwifes from attending vaginal births after cesearan section (VBAC). I very much wanted to attempt a homebirth VBAC with my son, but I could not do so because midwifes were too scared to lose their licences over my 'high risk' vaginal birth. My c-section was required due to a footling breech positioning of my twin A. I had no choice in that matter. I was determined to have a vaginal birth with my second pregnancy and I was the 'perfect' candidate. I had to switch OB practices to a VBAC friendly one, as well as find a hospital that allowed and supported VBACs. My son was born October 19 as a successful unmedicated VBAC, but not without a scare caused by a monitor moving (hospital VBACs are required to be on a monitor at all times) and picking up my heartbeat instead of my son's. Luckily the doctor was a little more liberal and did not rush me for an emergency c-section. I feel like women should be able to make educated choices about who their care provider should be: midwife, nurse/midwife, family doctor, or OB/GYN. I think midwives should be given their right to make educated decisions on who they feel is too high risk for their standard of care. This ban on Midwife assisted VBACs robs both parties of their right to choose. Please reconsider your position on this matter."	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	**Same response as comment #10.**
Section 202.E	"I recently found out that DHEC is considering a ban on VBAC. I feel this is a terrible idea. ACOG	**Not Adopted**	**Same response as comment #10.**

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Angel Finley(7) Comment #17	has issued a statement saying that is a safe option for women. I feel that taking this option for women will be devastating to many. So many women have been forced in to c-section or not informed of other options. It is not fair to say that a woman cannot make this choice. Many women have gone on to have healing experiences from having VBACs. I feel that many women will not seek out medical care if their only option is a repeat c-section. I have friends in other states where VBAC is banned that chose to give birth at home without a midwife or a dr. Because they were deprived of the option. Telling a woman she cannot do what she would like is controlling and irresponsible. By taking this choice away women will be forced to make some really hard decisions. Repeat c-sections in mothers can cause much more damage and risks than a VBAC. There is so much information out there, please educate yourself before you put this into action. Please don't cause other mothers and families harm by taking this away. “	The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department’s policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department’s policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Brooke Erickson(3)	“I wanted to write to say that I disapprove of what I've been hearing about the new ideas about vaginal birth after cesarean.	**Not Adopted** The Department is adding this	**Same response as comment #10.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
Comment #18	SC DHEC is pushing to limit women's choices on vaginal birth after cesarean by legally restricting Licensed Midwives from serving this growing segment of women! For the last several years we have had our hands tied by a cease and desist letter; now, DHEC is on the cusp of putting the VBAC ban into the regulations for the first time. I think this is ludicrous. Women should have the rights to make their own informed decisions. Thank you for your time."	section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Kim Manning(4) Comment #19	"I have just heard that DHEC is planning to ban Licensed Midwives from performing VBACs in their facilities. While this decision does not impact me directly (as I have had three vaginal births), I do have several friends who have had VBACs with no problems at all. One of my friends even had a	**Not Adopted** The Department is adding this section to incorporate a	**Same response as comment #10.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
	home birth VBAC, and another had **five** VBACs with no problems. I think it is absurd to take choices away from women who are willing to try this. I believe that these Midwives are professional and knowledgeable enough to know that if there is a risk to the health of the baby or mother, they will refer them to a hospital. But to take choices away from women who want to try this type of birth without even giving them a chance, this is just not right. I ask you to please reconsider your stance on this and let these women decide what type of birth they would like for their experience. Thank you for your service,"	Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Jill Cody(8) Comment #20	"I am writing to you today to plead with you on behalf of all women in the Carolinas. I say "all women", because almost every woman is impacted by taking away any woman's option of VBAC. How does this effect almost every woman? Natural childbirth is a rite of passage - an empowering, confidence-boosting, psychological mountain that, once climbed, gives mental,	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27,	**Same response as comment #10.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
	emotional, and spiritual stamina to its conqueror. And attitudes like this are contagious. I have not experienced a VBAC, but I have several friends who did successful VBACs. In fact, I don't know anyone who has tried to do a VBAC who wasn't successful with it. These women all felt that something was stolen from them in their previous birth experiences when they ended up with C-sections...but they all felt an amazing victory when they were finally able to experience birth in the way they had hoped through a VBAC."	2006 that stated the Department's policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Susan Siegler(11) Comment #21	"I was recently informed that SC DHEC is trying to make it illegal for licensed Midwives to attend vaginal births after cesarean (VBAC). I would like to voice my concern that this is moving SC in the opposite direction that maternity care should go and that by doing so, it will take away from the right's of women to give birth in the manner that they would like. would like to show that VBACs are not inherently dangerous and that the majority of women who have had a cesarean section would	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's	**Same response as comment #10.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
	be able to give birth vaginally should they choose to... In conclusion, I believe that preventing licensed Midwives from attending VBACs will further raise the already high cesarean rate of the United States and would be a step in the wrong direction for women and their rights involving childbirth. I feel that I have shown that VBACs are of no greater risk of harm to either the child or the mother than a repeat cesarean. The only thing standing in the way of allowing more women to VBAC is rules and legislation that either prevent or scare away caregivers from allowing prior cesarean moms to have a trial of labor and attempt a VBAC."	policy on vaginal birth after Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E Ifetayo White(13) Comment #22	"I am appalled to hear that Licensed Midwives might be restricted from servicing women who are seeking a vaginal birth after a ceasarean section. I am a Certified Doula/Birth Assistant in Beaufort and have supported VBACs at hospitals and in homes. My certification and training happened in Vermont where I have attended many births, and have a certain level of shame regarding the birthing attitude with authorities in SC. Please consider the right of each woman to have choice in planning a personal and safe birth experience. Thank you,"	**Not Adopted** The Department is adding this section to incorporate a Memorandum issued March 27, 2006 that stated the Department's policy on vaginal birth after	**Same response as comment #10.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		Cesarean and licensed midwifery practice. This section does not change the Department's policy. In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	
Section 202.E South Carolina Medical Association(16) Comment #23	"The South Carolina Medical Association supports adding previous caesarean section to prohibitions in the practice of midwifery."	**Accepted** In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy.	**Section 202.E** **Text as published in the State Register:** Vaginal Birth After Cesarean Section (VBAC). The midwife shall not provide care for or assist in delivery of any patient who has had a previous Cesarean section. VBAC patients must be referred to a physician for medical care and delivery. **No Change.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		No Change.	
Section 202.E South Carolina affiliate of the ACNM(10) Comment #24	We approve the proposed regulation that vaginal birth after cesarean (VBAC) clients be referred to a physician for medical care and delivery.	**Accepted** In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy. **No Change.**	**Same response as comment #23.**
Section 202.E Dr. Amy Picklesimer(12) Comment #25	"I would like to very STRONGLY SUPPORT the addition of previous caesarean section to prohibitions in the practice of midwifery."	**Accepted** In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy. **No Change.**	**Same response as comment #23.**
Section 202.E	"Very concerned about giving lay midwives privledges to do VBAC deliveries. This would add	**Accepted**	**Same response as comment #23.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
Christine Case(14) Comment #26	to S.C.'s mortality rates. Please don't allow this change."	In the event that future research proves the safety of vaginal birth after Cesarean in the out of hospital setting, the Department may consider modifying its policy. **No Change.**	
Section 301.A South Carolina Licensed Midwives Association(15) Comment #27	"It is unacceptable to require the Licensed Midwife to obtain a written "low risk" assessment from the physician or CNM visit, as the proposed revision indicates. The Licensed Midwife is an independent practitioner who is educated and skilled in performing a medical history and identifying potential risks at the initial prenatal visit. Nine states permit the LM to perform a risk assessment; only two require an MD or CNM to do so. The regulation already requires consultation and / or transfer for risk conditions. This added requirement creates more burden without adding any safety for the pregnant mother."	**Partially Adopted** The Department recognizes the difficulty midwives face when attempting to obtain a risk assessment that contains the term, "low risk". Therefore, the midwives must retain documentation from the visits to a healthcare provider that demonstrate the pregnancy is low	**Section 301.A** **Text as published in the State Register:** The midwife shall, upon acceptance of a woman for care, require her to have two visits with a physician, community health center or health department. One of these visits must be conducted in the final six weeks of pregnancy. ~~The midwife shall make entries in the patient's record of the physician, health center, or health department visits.~~ The midwife shall place in the patient's record, copies of documentation from the two (2) visits with a physician, community health center, or health department, which includes a risk assessment from a health care provider determining the mother's pregnancy to be a low risk pregnancy. **Text changed as a result of public**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		risk for review by Department personnel	**comment:** The midwife shall, upon acceptance of a woman for care, require her to have two visits with a physician, community health center or health department. One of these visits must be conducted in the final six weeks of pregnancy. ~~The midwife shall make entries in the patient's record of the physician, health center, or health department visits.~~ The midwife shall place in the patient's record, copies of documentation from the two (2) visits with a physician, community health center, or health department, which shall include a risk assessment from a health care provider.
Section 301.A Susan Smart(17) Comment #28	"A written risk assessment has been added to these regulations. It has been very difficult at times in past years to find physicians to do the two visits. This will make it even harder to get support. The midwife can do the risk assessment supported by copies of the mother's physician / Cnm records."	**Partially Adopted** The Department recognizes the difficulty midwives face when attempting to obtain a risk assessment that contains the term, "low risk". Therefore, the midwives must retain documentation from the visits to a healthcare	**Same response as comment #27.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		provider that demonstrate the pregnancy is low risk for review by Department personnel	
Section 301.E South Carolina Licensed Midwives Association(15) Comment #29	"we request that this be moved, in its entirety, to Section 401. Record Keeping and Reporting Requirements. The current draft could possibly be interpreted that a full Informed Consent document must be submitted to the Department for each client, instead of simply maintained within the client's midwifery chart."	**Partially Adopted** The Department will not require an Informed Consent document to be sent to the Department for each client. Text will remain at Section 301.E and be added to the regulation at Section 401.A.1.p as well.	**Section 301.E** **Text as published in the State Register:** Informed Consent. The midwife shall assure that all women under his/her care understand that s/he is a midwife licensed by this Department to perform only midwifery services and that he/she ~~by virtue of approved education, clinical experience, and examination, but~~ is not a nurse or physician. The midwife must provide the Department with evidence that the patient has been advised and understands the ~~and are advised of the risks,~~ responsibilities of the midwife, risks of receiving midwifery services, and alternative~~s~~ options for care. In consultation with the expectant parents, s/he shall, prior to the expected date of confinement, plan a strategy for backup medical care for mother and infant, and for transportation to medical facilities in case of emergency, and shall coordinate such arrangements with the backup health care providers. The midwife shall obtain a signed informed consent form to keep in his/her permanent records.

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
			Text changed as a result of public comment: Informed Consent. The midwife shall assure that all women under his/her care understand that s/he is a midwife licensed by this Department to perform only midwifery services and that he/she ~~by virtue of approved education, clinical experience, and examination, but~~ is not a nurse or physician. The midwife must document that the patient has been advised and understands the ~~and are advised of the risks,~~ responsibilities of the midwife, risks of receiving midwifery services, and alternative~~s~~ options for care. In consultation with the expectant parents, s/he shall, prior to the expected date of confinement, plan a strategy for backup medical care for mother and infant, and for transportation to medical facilities in case of emergency, and shall coordinate such arrangements with the backup health care providers. The midwife shall obtain a signed informed consent form to keep in his/her permanent records. **Text was also added at Section 401.A.1.p.**
Section 302.D South Carolina affiliate of the ACNM(10)	"We approve the addition of the following skills and medications only if performed by a CPM as the proposed regulations stipulate: 1) urinary catherization for bladder distension 2) Basic suturing of 1st and 2nd degree and labial tears	**Accepted** **No Change.**	**Section 302.D** **Text as published in the State Register:** Skills. These skills shall only be performed by a CPM. (II) 1. Maternal

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
Comment #30			a. Urinary catheterization for bladder distention; b. Perform basic suturing of 1st degree ,2nd degree and labial tears. **No Change.**
Section 302.D.1.a South Carolina Licensed Midwives Association(15) Comment #31	"The inclusion of this basic midwifery skill is another example of Regulation 61-24 changing to reflect current standards of care and safety for mothers. Occasionally, women will be unable to urinate, in labor or after birth, and this is not, by itself a dangerous condition. However, if urinary retention is not resolved in a timely manner, it can cause arrest of descent, retained placenta, or postpartum hemorrhage. A simple skill performed in a timely fashion by a CPM can help prevent these complications resulting from an inability to void. Maternal and fetal safety could be compromised with the delay in care that results from transport."	**Accepted** **No Change.**	**Section 302.D.1.a** **Text as published in the State Register:** Urinary catheterization for bladder distention **No Change.**
Section 302.D.1.b Dr. Amy Picklesimer(12) Comment #32	"Finally, I am opposed to the increased scope of practice which would allow licensed midwives to perform suturing, administer local anesthetic and administer IV fluids. I do not believe that the regulatory process is the proper place for this to occur."	**Not Adopted** Suturing is a skill that may be performed by properly trained personnel. Competency is established by qualified preceptors and documented on the Skills	**Section 302.D.1.b** **Text as published in the State Register:** Perform basic suturing of 1st degree and 2nd degree labial tears. **No Change.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		Verification Form. R. 61-24 is the sole source of regulation for licensed midwives.	
Section 302.D.2.a South Carolina Licensed Midwives Association(15) Comment #33	"Administration of this medication after birth is the standard of care according to the American Academy of Pediatrics, and until now, SC midwives have been unable to meet this standard of care for the babies under our care. This inclusive language will allow us to meet that standard, with a very basic midwifery skill. Eighteen states reference Vitamin K within their regulatory language for midwives."	**Accepted** **No Change.**	**Section 302.D.2.a** **Text as published in the State Register:** <u>Intramuscular injection of vitamin K for prophylaxis of vitamin K deficiency bleeding.</u> **No Change.**
Section 302.E South Carolina affiliate of the ACNM(10) Comment #34	We approve the proposed medications given by the a Midwife: 1) For control of postpartum hemorrhage 2) Rhogam in accordance with accepted standards of professional practice 3) IV fluids for the treatment of shock or postpartum hemorrhage (CPM only) 4) Analgesia for suturing (CPM only) 5) Oral or IM vitamin K (CPM only) 6) Ophthalmic medication in accordance with regulations governing the prevention of infant blindness. 7) Medical Oxygen	**Accepted** **No Change.**	**Section 302.E** **Text as published in the State Register:** Medications. Drugs or medications shall be administered only after consultation with, and prescription by, a physician. The midwife shall not administer any drugs or medications except: ~~a. For control of postpartum hemorrhage;~~ ~~b. When administering medication in accordance with regulations governing the prevention of infant blindness.~~ ~~c. When administering RhoGam in accordance with accepted standards of professional practice.~~

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
			1. Maternal a. For control of postpartum hemorrhage; (I) b. When administering RhoGam in accordance with accepted standards of professional practice; (II) c. IV fluids for the treatment of shock or postpartum hemorrhage (to be performed by a CPM only). When IV fluids are administered, the Emergency Medical System (EMS) must be activated for transfer of the mother; (I) d. Infiltration of 1% lidocaine hydrochloride (without epinephrine) to provide local anesthesia for basic suturing of 1st degree, 2nd degree and labial tears (to be performed by a CPM only); (II) e. Medical oxygen. (I) 2. Newborn (I) a. Oral or IM administration of Vitamin K (neonatal concentration 1mg) to prevent hemorrhagic disease of the newborn. IM administration is only to be to be done by a CPM; b. When administering ophthalmic medication in accordance with regulations governing the prevention of infant blindness; c. Medical oxygen. **No Change.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
Section 302.E.1.a Dr. Amy Picklesimer(18) Comment #35	"...I noticed that in Section 302. E. 1. a. midwives are granted permission to administer medications for the control of post-partum hemorrhage but no specific medications are listed. I would strongly support adding a list of approved medications in this section. My choice of agents, consistent with the didactic component of the National Association of Registered Midwives Eduactional Process for Certified Professional Midwives, would be Methylergonovine Maleate (Methergine) and Oxytocin (Pitocin) as approved anti-hemorrhagic agents. Misprostol (Cytotec) should not be included."	**Adopted**	**Section 302.E.1.a** **Text as published in the State Register:** a. For control of postpartum hemorrhage; (I) **Text changed as a result of public comment:** For control of postpartum hemorrhage. Medications approved for use are limited to Methylergonovine Maleate (Methergine) and Oxytocin (Pitocin). The Department does not approve the off label use of medications not approved by the U.S. Food and Drug Administration to treat post-partum hemorrhage (e.g. Misprostol (Cytotec)); (I)
Section 302.E.1.c Dr. Amy Picklesimer(12) Comment #36	"Finally, I am opposed to the increased scope of practice which would allow licensed midwives to perform suturing, administer local anesthetic and administer IV fluids. I do not believe that the regulatory process is the proper place for this to occur."	**Not Adopted** Administration of intravenous fluid is a skill that may be performed by properly trained personnel. Competency is established by qualified preceptors and documented on the Skills Verification	**Section 302.E.1.c** **Text as published in the State Register:** IV fluids for the treatment of shock or postpartum hemorrhage (to be performed by a CPM only). When IV fluids are administered, the Emergency Medical System (EMS) must be activated for transfer of the mother; (I) **No Change.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		Form. R. 61-24 is the sole source of regulation for licensed midwives.	
Section 302.E.1.c South Carolina Licensed Midwives Association(15) Comment #37	"*Intravenous fluids as clinically indicated, to be performed by a CPM only.* The inclusion of the current language requiring activation of EMS has no precedence within other states regulatory laws overseeing midwives. However, eleven states do include provision for IV fluid administration with no additional involvement of unnecessary emergency personnel." "*f. Other clinically appropriate medications per community standard of care, to be performed by a CPM only.* Nine states have similar open-ended language, allowing midwives and health care providers with prescriptive authority to collaborate to administer medications on an individualized basis to mothers and babies.	**Not Adopted** The Department maintains its position that it will allow the administration of intravenous fluids only in emergency situations where transport to a hospital will occur. Only the medications the Department has listed in the regulation will be administered. If other medications are accepted for use in the future, the Department will issue appropriate notices to inform the regulated	**Section 302.E.1.c** **Text as published in the State Register:** IV fluids for the treatment of shock or postpartum hemorrhage (to be performed by a CPM only). When IV fluids are administered, the Emergency Medical System (EMS) must be activated for transfer of the mother; (I) **No Change.**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		community.	
Section 302.E.1.d Dr. Amy Picklesimer(12) Comment #38	"Finally, I am opposed to the increased scope of practice which would allow licensed midwives to perform suturing, administer local anesthetic and administer IV fluids. I do not believe that the regulatory process is the proper place for this to occur."	**Not Adopted** Administration of local anesthesia for simple lacerations is a skill that may be performed by properly trained personnel. Competency is established by qualified preceptors and documented on the Skills Verification Form. R. 61-24 is the sole source of regulation for licensed midwives.	**Section 302.E.1.d** **Text as published in the State Register:** Infiltration of 1% lidocaine hydrochloride (without epinephrine) to provide local anesthesia for basic suturing of 1st degree, 2nd degree and labial tears (to be performed by a CPM only); (II) **No Change.**
Old Section F.2 South Carolina affiliate of the ACNM(10) Comment #39	"We approve the deletion of oral and written examination given by the Department."	**Accepted.** The Department adopted the use of the NARM written examination in 2000. The Department will	**Old Section F.2** **Text as published in the State Register:** ~~2. Scope of Oral Exam.~~ ~~a. Course and management of normal antepartum, intrapartum, postpartum and neonatal periods;~~ ~~b. Early recognition and management of potential problems for mother and baby;~~

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		continue to proctor the NARM written examination. The oral examination is a tool that was developed by Division of Health Licensing staff. The Department seeks to discontinue the use of the oral examination. **No Change.**	~~e. Recognition and management of emergency situations for mother and baby.~~ **No Change.**
No Section Susan Smart(17) Comment #40	"Midwives also need to consider client's desires for GBS prophylaxis and have access to IV's for those situations. Rarely, it would be beneficial for the woman with N&V and for those for whom you've managed a PPH but you would feel more comfortable with if she had some extra fluids."	**Not Adopted** The Department maintains its position that it will allow the administration of intravenous fluids only in emergency situations where transport to a hospital will occur. Only the medications the	**No Section**

SECTION/ COMMENTER	PUBLIC COMMENT	STAFF RESPONSE	TEXT
		Department has listed in the regulation will be administered. If other medications are accepted for use in the future, the Department will issue appropriate notices to inform the regulated community.	