Georgia Midwifery Association

Standards & Guidelines

2019

I. Preface

Women should have the freedom to choose the care provider and setting for their births. Midwives are uniquely poised to provide access to prenatal care and delivery services in a cost-effective way with excellent outcomes. Midwifery care is the autonomous practice of giving care to women during pregnancy, labor, birth, and the postpartum period, as well as care to the newborn infant. Midwifery care is provided in accordance with established standards, which promote safe and competent care. The Midwife implements these standards through adherence to **MANA's Core Competencies and the Midwives Model of Care**.

Evaluation of the childbearing woman is an ongoing process, including risk screening to assess and identify conditions which may indicate a deviation from normalcy. The identification of those conditions may require physician involvement. In making this assessment, a midwife relies on her/his training, skill, and clinical judgment.

The midwife or designated backup midwife must be able to be reached at all times during the pregnancy, birth, and postpartum period.

This document is representative and not an exhaustive list of the conditions that a midwife may encounter. This document is not meant to replace the clinical judgment or experience of the midwife. There may be variations based on agreements between individual midwives and their consulting physicians.

II. Standards of Care

Prenatal Care

During prenatal care, the client may be seen by the midwife or other appropriate health care provider monthly until 32 weeks, every 2-3 weeks from 32 weeks to 37 weeks, and weekly after 37 weeks gestation , or as appropriate.

1. The midwife will provide an initial assessment of the general health and health history of the woman.
2. For screening purposes, the midwife may order routine prenatal and postpartum laboratory analysis to be performed by a licensed laboratory. Abnormal findings may require a referral.
3. Ongoing prenatal care provides an opportunity for routine assessment of:
    a. blood pressure
    b. pulse (optional)
    c. Weight
    d. abdomen, to include fundal height, fetal heart tones, fetal lie, and presentation
    e. estimation of gestational age by physical findings
    f. assessment of varicosities, edema and reflexes
    g. Diagnosis and treatment for any common discomfort of pregnancy

Intrapartum Care

During active labor, the midwife shall monitor and support the natural process of labor and birth, assessing mother and baby throughout the birthing process

1. Each midwife must maintain current certification in BLS CPR.
2. The midwife shall determine the progress of labor and, when birth is imminent, shall be available until delivery is accomplished.
3. While in attendance, the midwife will assess:
    a. FHT: every 30 minutes in active labor and at least every 15 minutes during the 2nd stage of labor.
    b. Maternal well-being: vital signs assessed every four hours or as indicated
    c. The progress of labor: assessment of cervical dilation, effacement,station and position as needed.
    d. Membrane status for rupture, odor and color of amniotic fluid
4. The midwife will assist in the birth of the baby and delivery of the placenta.

5. The midwife will manage any problems in accordance with MANA Core Competencies and the Midwives Model of Care.

Postpartum Care

The midwife shall remain with the postpartum mother during the postpartum period until the conditions of the mother and newborn are stabilized.

1. Immediate Postpartum Care
    a. Overall maternal well-being: bleeding, vital signs, abdomen (including fundal height and firmness), bowel/bladder function, perineal exam and assessment;
    b. As indicated: Suture 1st or 2nd degree laceration(s)/episiotomy, or refer for repair;
    c. Facilitation of maternal-infant bonding and family adjustment;
2. On going Postpartum Care
    a. Overall maternal well-being, as stated above
    b. Breastfeeding counseling and support
    c. Postpartum Depression and Anxiety screening using a tool such as the Edinburgh Postnatal Depression Scale.
    d. Assessment of pelvic floor function

Newborn Care

After the birth of the baby, the Midwife shall assess, monitor, and support the baby during the immediate postpartum period until the baby is in stable condition and during the ongoing postpartum period.

1. Midwives must hold current certification in Newborn Resuscitation through the American Academy of Pediatrics or approved program/Neonatal Resuscitation Program.
2. Immediate Newborn Care: overall newborn well-being and initial assessment; respond to the need for newborn resuscitation; APGAR scores at 1 and 5 minutes
3. Newborn Physical Exam: standard newborn exam including
    a. Weight and measurements, temperature, feeding, bowel/bladder function, reflexes, physical deviations from normal, clamping and cutting of umbilical cord,

eye prophylaxis as requested by parents, administration or referral for vitamin K as requested by parents, addressing concerns of the family

4. Ongoing Newborn Care

    a. Assessment of: vital signs as appropriate, tone/reflexes, feeding, color, weight gain

    b. CCHD screening with pulse oximetry

    c. Referral or performance of newborn metabolic screening and hearing screening.

III. Midwifery Practice Documents

Practice Guidelines

GMA recognizes that each midwife is an individual with specific practice protocols that reflect her own style and philosophy, level of experience, and legal status, and that practice guidelines may vary with each midwife. GMA does not set protocols for all midwives to follow, but requires that they develop their own practice guidelines in written form.

Practice guidelines are the specific protocols of practice followed by a midwife, and they should reflect the Midwifery Model of Care. Standards, values, and ethics are more general than practice guidelines, and they reflect the philosophy of the midwife. Practice guidelines are based upon the standards, values and ethics held by the midwife. (NARM, 2018) (http://narm.org/faq/cpm-practice-guidelines/)

In the event of a complaint against the midwife, the midwife is required to submit practice guidelines to the GMA Standards Committee for review.

Informed Consent Documents

GMA requires the midwife to have a written statement of Informed Disclosure for Midwifery Care on file for each client. An informed disclosure form should be written in language understandable to the client and there must be a place on the form for the client to attest that she understands the content by signing her full name. The form should be entitled “Informed Disclosure for Midwifery Care,” and must include, at a minimum, the following:

1. A description of the midwife’s education, training, and experience in midwifery, including primary care experiences; (***GMA may ask for accountability of numbers from any member)

2. The midwife’s philosophy of practice;

3. Antepartum, intrapartum and postpartum conditions requiring consultation, transfer of care and transport to a hospital (this would reflect the midwife's written practice guidelines) or availability of the midwife's written guidelines as a separate document, if desired and requested by the client;
4. A medical consultation, transfer and transport plan;
5. The services provided to the client by the midwife;
6. The midwife's current credentials and legal status;
7. NARM Accountability Process (including Community Peer Review, Complaint Review, Grievance Mechanism and how to file a complaint with NARM); and
8. HIPAA Privacy and Security Disclosures

(Narm, 2018)

IV. Indications for Discussion or Referral

Definitions

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

1. It is the midwife's responsibility to initiate a discussion with and provide accurate and complete clinical information to another midwife, a nurse practitioner, or a physician in order to plan care appropriately. This discussion can take place between midwives in the same practice.
2. Discussion should occur in a timely manner soon after the clinical situation is discovered.
3. Discussion may occur in person, by phone, fax, e-mail.
4. Discussion may include review of relevant patient records.
5. Discussion may include request for prescriptive medication based on signs or symptoms and/or laboratory results.
6. Discussion should be documented by the midwife in the medical record. Documentation of discussion should refer only to practitioner type without specifying the name of the practitioner contacted. Documentation should also include the midwife's management plan.
7. Discussion need not occur if the midwife has previously encountered a particular situation, discussed it with a colleague, developed a management plan, and is

currently managing the same clinical presentation. In this case, documentation of the management plan and discussion with the client of the management plan is sufficient.

Referral: A referral is a situation in which the midwife, using professional knowledge of the client and in accordance with this document, or by client request, seeks the opinion of a care provider competent to give advice in the relevant field. A GMA member who has additional credentials (i.e.: CNM, ND) that allow for a broader scope of practice need not discuss conditions that are within their scope of practice. The practitioner will either conduct an in-person assessment of the client or will evaluate the client's records in order to address the problem that led to the referral. During such collaborative care the care provider referred to may be involved in, and responsible for, a discrete area of the client's care, with the midwife maintaining overall responsibility within their scope of practice. Any verbal dialogue regarding client care and plan of care should be documented in the client's chart.

1. A referral can involve the practitioner providing advice and information, and/or providing care to the client/newborn, and/or prescribing treatment for the client or newborn.
2. It is the midwife's responsibility to provide all relevant medical records to the practitioner, when possible, including a written summary of the client's history and presenting problem, as appropriate.
3. Referral should be fully documented by the midwife in the medical record, including the practitioner's name and date of referral.
4. After referral with a physician, care of the client and responsibility for decision making, with the informed consent of the client, either continues with the midwife or transfers completely to the referred practitioner.

Transfer of Care: When care is transferred permanently or temporarily from the midwife to a qualified hospital based provider, the receiving practitioner assumes full responsibility for subsequent decision making, together with the client.

Pre-existing Conditions and Initial History

Discussion:

1. Family history of significant genetic disorders, hereditary disease, or congenital anomalies

2. History of preterm birth (< 36 weeks)

3. History of IUGR
4. History of severe postpartum hemorrhage
5. History of severe pre-eclampsia or HELLP[i]
6. History of gestational diabetes requiring oral hypoglycemic or insulin[ii]
7. No prenatal care prior to third trimester[iii]
8. History of lap band, gastroplasty or other bariatric (weight loss) surgery
9. Previous unexplained neonatal mortality or stillbirth
10. Previous delivery resulting in shoulder dystocia

Referral:

1. Absent prenatal care at term[iv]
2. History of seizure disorder in adulthood
3. History of HELLP[v]
4. History of uterine surgery, including myomectomy
5. Prior cesarean birth with low transverse incision
6. Significant history of or current cardiovascular, renal, hepatic, neurological disorder or disease[vi]
7. Significant history of or current endocrine disorder (excluding controlled mild hypothyroidism)
8. Pulmonary disease/active tuberculosis/severe asthma[vii]
9. Any pathological condition currently under the care of a physician
10. Significant hematological disorders
11. Current or recent diagnosis of cancer requiring chemotherapy
12. History of cervical cerclage
13. History of 3 consecutive spontaneous abortions (excluding clients who present to care with viable pregnancy at gestation >14wks and beyond previous miscarriage)

14. Significant uterine anomalies
15. Essential hypertension[viii]
16. History of eclampsia
17. History of postpartum hemorrhage requiring transfusion
18. Current severe psychiatric illness
19. Current seizure disorder

Antepartum Conditions

Discussion:

1. Urinary tract infection unresponsive to treatment
2. Significant abnormal ultrasound finding
3. Significant abnormal laboratory finding
4. Unresolved size/dates discrepancies
5. 42.0 weeks with reassuring fetal surveillance including AFI and BPP with NST

Referral:

1. Reportable sexually transmitted infection
2. Significant abnormal Pap
3. Significant abnormal breast lump
4. Pyelonephritis
5. Thrombosis
6. Fetal demise after 14 weeks gestation
7. Anemia unresponsive to treatment
8. Primary herpes infection
9. Significant vaginal bleeding

10. Hemoglobinopathies
11. Platelets ≤ 105,000/µL
12. Persistent abnormal fetal heart rate or rhythm
13. Non-reassuring fetal surveillance
14. Significant placental abnormalities
15. Significant or unresolved polyhydramnios or oligohydramnios[xi]
16. Presentation other than cephalic at 37 weeks
17. Multiple gestation
18. Significant infection the treatment of which is beyond the midwife's scope of practice

Transfer:

1. Ectopic pregnancy
2. Molar pregnancy
3. Premature prelabor rupture of membranes (PPROM)
4. Documented persistent/unresolved intrauterine growth restriction (IUGR)
5. Eclampsia, HELLP, pre-eclampsia, or persistent hypertension[xii]
6. Placenta previa at term[xiii]
7. Isoimmunization with an antibody known to cause hemolytic disease of the newborn[xiv]
8. Clinically significant placental abruption[xv]
9. Deep vein thrombosis
10. Cardiac or renal disease with failure
11. Gestational diabetes requiring management with medication; consultation in lieu of transfer if co-managing metformin with physician[xvi]
12. Known fetal anomaly or condition that requires physician management during or immediately after delivery
13. 43.0 weeks gestation

Intrapartum Conditions

Discussion:

1. >8 hours of active labor pattern without significant change in cervix and/or station and/or position
2. >3 hours of active pushing without significant change
3. Hypertension (>140 systolic or 90 diastolic twice 4 hours apart)[xx]
4. ROM > 18 hours with GBS status unknown and no prophylactic antibiotics, or GBS+ and no prophylactic antibiotics

Transfer:

1. Active labor before 37.0 weeks
2. Undiagnosed non-cephalic presentation including breech, transverse lie, oblique lie, or compound presentation at onset of labor
3. Undiagnosed multiple gestation
4. Fever (≥100.4 F) that persists >1 hour
5. Findings indicative of chorioamnionitis including, but not limited to tachycardia, fetal tachycardia, temperature >100.4 F, uterine tenderness, purulent or malodorous amniotic fluid.
6. Persistent non-reassuring fetal heart rate pattern
7. Exhaustion unresponsive to rest/hydration
8. Abnormal bleeding during labor
9. Suspected placental abruption
10. Suspected uterine rupture
11. Suspected pre-eclampsia (hypertension and proteinuria)[xxi]
12. Seizure
13. ROM > 72 hours[4] [xxii]
14. Prolapsed cord or cord presentation

15. Significant allergic response
16. Client's stated desire for transfer to hospital-based care

4\. While best available evidence supports this time frame; the midwife is expected to take into account their community standard of care as well as the relationships with and expectations of the receiving hospital-based providers.

Postpartum Conditions

Referral:

1. Urinary tract infection unresponsive to treatment
2. Mastitis (including breast abscess) unresponsive to treatment
3. Reportable sexually transmitted infections
4. Retained products/unresolved subinvolution/prolonged or excessive lochia
5. Persistent hypertension in the first 72 hours postpartum (> 140 systolic or 90 diastolic twice 1 hour apart)
6. Hypertension presenting beyond 72 hours postpartum
7. Significant postpartum depression

Transfer:

1. Significant postpartum hemorrhage unresponsive to treatment, with or without sustained vital sign instability or shock
2. Retained placenta (>2 hour or active bleeding and manual removal unsuccessful)
3. Lacerations beyond midwife's ability to repair
4. Unusual or unexplained significant pain or dyspnea
5. Significant, enlarging hematoma
6. Endometritis
7. Tonic clonic seizure
8. Anaphylaxis
9. Persistent grade III uterine prolapse or inversion

10. Fever (≥ 100.4 F) that persists > 1 hour within the first 72 hours postpartum
11. Postpartum psychosis

Newborn Conditions

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

Referral:

1. Low birth weight newborn (< 2500 gm = 5 lbs 8 oz)
2. Loss of greater than 10% of birth weight
3. Prolonged asymptomatic jaundice
4. Persistent cardiac arrhythmias or murmurs
5. Significant clinical evidence of prematurity
6. Failure to thrive
7. Hypoglycemia
8. Significant or symptomatic jaundice beyond the first 24 hours
9. Positive critical congenital heart disease screening (CCHD)

Transfer:

1. Seizure
2. Jaundice in the first 24 hours
3. Persistent respiratory distress
4. Persistent central cyanosis or pallor
5. Persistent temperature instability
6. Persistent documented hypoglycemia
7. Abnormal bruising, petechiae or purpura

8. Apgar score 6 or less at ten minutes of age
9. Major congenital anomalies affecting well-being
10. Birth injury requiring medical attention

V. Contraindications for out of hospital birth with a midwife

1. Any serious medical condition associated with increased risk status for parent or baby.
2. Rubella during the first trimester
3. Primary outbreak of genital herpes
4. Serious mental illness or severe psychological problems unresponsive to therapy
5. Persistent hypertension which is defined as:
    a. Sustained blood pressure (BP) 160/100 or a single diastolic reading greater than or equal to 110 mmHg diastolic. (https://www.acog.org/~/media/Task%20Force%20and%20Work%20Group%20Reports/public/HypertensioninPregnancy.pdf)
6. Central placenta previa
7. Placental abruption or signs indicative of placental abruption
8. Suspected or diagnosed congenital fetal anomaly that may require immediate medical care after birth
9. Persistent transverse presentation
10. Intrapartum indications that the baby has died in utero
11. Premature labor (less than 36 weeks)
12. Known active syphilis, gonorrhea, AIDS, or other sexually transmitted disease at term
13. Serious viral/bacterial infection in labor (pneumonia, staph)
14. Previous birth of an infant sick with Group B Strep (https://www.cdc.gov/groupbstrep/guidelines/new-differences.html)
15. Hemoglobin less than 9 at term
16. A baby that is small for gestational age (SGA)

17. Diagnosed intrauterine growth restriction (IUGR)

18. Failure to document adequate prenatal care

    a. Prenatal lab work: Rh antibody screen, rubella titer, VDRL, blood group, blood type and RH factor, hemoglobin, hepatitis screen

19. Isoimmunization with an antibody known to cause hemolytic disease of the newborn[i]

20. Prior cesarean with incision other than low transverse (e.g. classical)[x]

21. Primary VBAC after >1 prior cesareans with low transverse incision

22. Any other condition or situation which may preclude the possibility of a healthy birth, and the midwife's discretion, including:

    a. Documented unwillingness regarding home birth or midwifery care, or otherwise desires transfer of care

VI. Upheld Existing State and Federal Guidelines

Existing state and federal guidelines are listed below. Midwives are expected to follow current state and federal guidelines.

HIPAA

According to HIPAA law, midwives must inform all persons of their rights to privacy as medical information is collected either directly or indirectly (such as by filling a prescription). The statement must tell your clients what you do with their information and it either must be signed by the patient, or the patient must sign a HIPAA consent form that they have received a copy of your privacy practices prior to signing a HIPAA consent form.

Newborn Screening

Critical Congenital Heart Defect (CCHD) Screening

Midwives screen the newborn for heart defects using pulse oximetry, applied to the right hand and either foot, 24 hours or more after birth. Pulse oximetry results will be entered on the Newborn Screening Card, upon filing the birth certificate, or reported with the Delayed Screening Report. Newborns that fail CCHD screening should be referred to appropriate resources as listed.

https://dph.georgia.gov/sites/dph.georgia.gov/files/MCH/NBS/CCHD_Training_PPT_3_2015.pdf

Metabolic Screening

Georgia state rules and regulations require that a sample of the infant's blood is taken after 24 hours of age, or prior to the infant's discharge from the hospital; whichever comes first. In addition, the hospital administrator or a designated representative must provide written notice to the parents, guardians, or legally responsible person if the infant must be tested again. Retest must be completed as soon as possible.

Hearing Screening

Newborns “referring” (failing) the initial or follow-up hearing screening, due to suspected hearing impairment: Newborns that “refer” a newborn hearing screening are to be reported one of three ways:

1. To the child’s pediatrician
2. Listed on the birth certificate at filing, at which point C1st will automatically be notified.
3. To the Children 1st (C1st) Coordinator in the health district where the child resides, using the Children 1st Screening and Referral Form immediately following screening or at least within 7 calendar days. All information on the form that is known to the screener/evaluator/audiologist should be filled out and submitted.

(https://dph.georgia.gov/children1st)

Midwives not performing hearing screenings should notify parents of where to get this mandatory screening done.

Birth Certificate Filing

A certificate of birth for each live birth which occurs in this state shall be filed with the State Office of Vital Records within five days after such birth and filed in accordance with this Code section and regulations of the department.

O.C.G.A. 31-10-9 (2010) 31-10-9. Registration of births

Syphilis and HIV Testing

Georgia law (§31-17-4.2.) mandates that all pregnant women be tested for syphilis and HIV in the first and third trimesters of their pregnancy unless the patient declines.

- All congenital syphilis cases must be reported within 24 hours to your local district health office or entered in SendSS. This includes babies without congenital syphilis symptoms, but who were born to mothers with untreated syphilis at time of delivery.

- All babies born to HIV positive mothers and women diagnosed with HIV or AIDS must be reported within seven days to the Georgia Department of Public Health.

Universal Precautions

The Centers for Disease Control (CDC) defines Standard Precautions as a set of minimum infection prevention practices that apply to all patient care regardless of suspected or confirmed infection status. These precautions are designed to protect patients and healthcare workers from the spread of infectious disease. Standard Precautions apply to all blood, bodily fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes as they may contain infectious agents that can be passed to others. In an out-of-hospital midwifery setting these practices extend from care of the mother to care of the newborn. These standards include :

1. Hand hygiene
2. The use of personal protective equipment such as gloves
3. Disposal of sharps- Disposable syringes and needles, scalpel blades, and other sharp items should be placed in puncture-resistant biohazard containers for disposal after use; the puncture-resistant containers should be located as close as practical to the use area. Replace containers when they are 2/3 full.
4. Environmental control and cleaning
5. Respiratory hygiene/ cough etiquette

CDC: Guide to Infection Prevention for Outpatient Settings: Minimum Expectations for Safe Care. (April 2015) Retrieved from: http://www.cdc.gov/HAI/settings/outpatient/outpatient-care-gl-standardprecautions.html#hh

King, T. L., Brucker, M. C., Kriebs, J. M., Fahey, J. O. Gregor, C. L. & Varney, H. (2014). Varney's Midwifery (Fifth). Burlington: Jones and Bartlett Learning

Rose Midwifery. (December 2015). Standard Precautions. Retrieved from: http://rosemidwives.com/hl/?/2010812166/Standard-Precautions

Occupational Safety and Health Administration. (January 2011). Bloodborne Pathogens. Retrieved from: https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051

References

CPM Practice Guidelines | NARM. (2018). *Narm.org*. Retrieved 30 April 2018, from http://narm.org/faq/cpm-practice-guidelines/

Shared Decision Making and Informed Consent | NARM. (2018). *Narm.org*. Retrieved 30 April 2018, from http://narm.org/accountability/informed-consent/

The Midwives' Association of Washington State. (2016). Indications for Discussion, COnsultation and Transfer of Care in a Home or Birth Center Midwifery Practice. Retrieved 14 May 2018, from: http://www.washingtonmidwives.org/for-midwives/indications-consultation.html

Tennessee Midwives Association. (2010). Tennessee Midwives Association Practice Guidelines. Retrieved 14 May 2018, from: https://www.tennesseemidwives.com/documents.html

[i] Platis, P. (1994). Risk factors for severe preeclampsia. Stone JL, Lockwood CJ, Berkowitz GS, Alvarez M, Lapinski R, Berkowttz RL. Obstet Gynecol 1994; 83:357–361. Journal of Nurse-Midwifery, 39(5), 336-337.

Aydin, S., Ersan, F., Ark, C., & Ayd?n, Ç A. (2014). Partial HELLP syndrome: Maternal, perinatal, subsequent pregnancy and long-term maternal outcomes. J Obstet Gynaecol Res Journal of Obstetrics and Gynaecology Research, 40(4), 932-940.

Delahaije, D. H., Kuijk, S. M., Dirksen, C. D., Sep, S. J., Peeters, L. L., Spaanderman, M. E., . . . Smits, L. J. (2010). Cost-effectiveness of recurrence risk guided care versus care as usual in women who suffered from early-onset preeclampsia including HELLP syndrome in their previous pregnancy (the PreCare study). BMC Pregnancy Childbirth BMC Pregnancy and Childbirth, 10(1), 60.

Pampus, M. G., Wolf, H., Mayruhu, G., Treffers, P. E., & Bleker, O. P. (2001). Long-Term Follow-up in Patients with a History of (H)Ellp Syndrome. Hypertens Pregnancy Hypertension in Pregnancy, 20(1), 15-23.

[ii] Glazer, Nicole L., Audrey F. Hendrickson, Gina D. Schellenbaum, and Beth A. Mueller. "Weight Change and the Risk of Gestational Diabetes in Obese Women." Epidemiology 15.6 (2004): 733-37. Web.

Avalos, G. E., L. A. Owens, and F. Dunne. "Applying Current Screening Tools for Gestational Diabetes Mellitus to a European Population: Is It Time for Change?" Diabetes Care 36.10 (2013): 3040-044. Web.

Schwartz, Naama, Zohar Nachum, and Manfred S. Green. "The Prevalence of Gestational Diabetes Mellitus Recurrence—effect of Ethnicity and Parity: A Metaanalysis." American Journal of Obstetrics and Gynecology 213.3 (2015): 310-17. Web.

[iii] Brown, S. S. (n.d.). Prenatal care: Reaching mothers, reaching infants.

Hanson, L., Vandevusse, L., Roberts, J., & Forristal, A. (2009). A Critical Appraisal of Guidelines for Antenatal Care: Components of Care and Priorities in Prenatal Education. Journal of Midwifery & Women's Health, 54(6), 458-468.

Maupin, J. R., Lyman, R., Fatsis, J., Prystowiski, E., Nguyen, A., Wright, C., . . . Miller, J. J. (2004). Characteristics of women who deliver with no prenatal care. J Matern Fetal Neonatal Med Journal of Maternal-Fetal and Neonatal Medicine, 16(1), 45-50.

[iv] Brown, S. S. (n.d.). Prenatal care: Reaching mothers, reaching infants.

Hanson, L., Vandevusse, L., Roberts, J., & Forristal, A. (2009). A Critical Appraisal of Guidelines for Antenatal Care: Components of Care and Priorities in Prenatal Education. Journal of Midwifery & Women's Health, 54(6), 458-468.

Maupin, J. R., Lyman, R., Fatsis, J., Prystowiski, E., Nguyen, A., Wright, C., . . . Miller, J. J. (2004). Characteristics of women who deliver with no prenatal care. J Matern Fetal Neonatal Med Journal of Maternal-Fetal and Neonatal Medicine, 16(1), 45-50.

[v] Platis, P. (1994). Risk factors for severe preeclampsia. Stone JL, Lockwood CJ, Berkowitz GS, Alvarez M, Lapinski R, Berkowttz RL. Obstet Gynecol 1994; 83:357–361. Journal of Nurse-Midwifery, 39(5), 336-337.

Aydin, S., Ersan, F., Ark, C., & Ayd?n, Ç A. (2014). Partial HELLP syndrome: Maternal, perinatal, subsequent pregnancy and long-term maternal outcomes. J Obstet Gynaecol Res Journal of Obstetrics and Gynaecology Research, 40(4), 932-940.

Delahaije, D. H., Kuijk, S. M., Dirksen, C. D., Sep, S. J., Peeters, L. L., Spaanderman, M. E., . . . Smits, L. J. (2010). Cost-effectiveness of recurrence risk guided care versus care as usual in women who suffered from early-onset preeclampsia including HELLP syndrome in their previous pregnancy (the PreCare study). BMC Pregnancy Childbirth BMC Pregnancy and Childbirth, 10(1), 60.

Pampus, M. G., Wolf, H., Mayruhu, G., Treffers, P. E., & Bleker, O. P. (2001). Long-Term Follow-up in Patients with a History of (H)Ellp Syndrome. Hypertens Pregnancy Hypertension in Pregnancy, 20(1), 15-23.

[vi] Siu, S., Sermer, M., & Colman, J. (2002). Prospective multicenter study of pregnancy outcomes in women with heart disease. ACC Current Journal Review, 11(1), 87.

Brooks, R. (2011). Pregnancy and heart disease: An introduction. Br J Midwifery British Journal of Midwifery, 19(12), 763-772.

Hou, S. (1999). Pregnancy in chronic renal insufficiency and end-stage renal disease. American Journal of Kidney Diseases, 33(2), 235-252.

Guntupalli, S. R., & Steingrub, J. (2005). Hepatic disease and pregnancy: An overview of diagnosis and management. Critical Care Medicine, 33(Supplement).

Front-matter. (2011). Neurological Disorders and Pregnancy, I-Iii.

Keller, J., Frederking, D., & Layer, P. (2008). The spectrum and treatment of gastrointestinal disorders during pregnancy. Nature Clinical Practice Gastroenterology & Hepatology Nat Clin Pract Gastroenterol Hepatol, 5(8), 430-443.

[vii] Goldrick, B. (1996). Tuberculosis: Old nemesis, new problems. American Journal of Infection Control, 24(4), 223-225.

Rey, E., & Boulet, L. (2007). Asthma in pregnancy. Bmj, 334(7593), 582-585.

Bhatia, P. (2000). Pregnancy and the lungs. Postgraduate Medical Journal, 76(901), 683-689.

Murphy, V. E. (2006). Asthma exacerbations during pregnancy: Incidence and association with adverse pregnancy outcomes. Thorax, 61(2), 169-176.

Frye, D., Clark, S. L., Piacenza, D., & Shay-Zapien, G. (2011). Pulmonary Complications in Pregnancy. The Journal of Perinatal & Neonatal Nursing, 25(3), 235-244.

[viii] Sullivan, J. M. (1979). The management of essential hypertension during pregnancy. Clin Cardiol Clinical Cardiology, 2(5), 368-374.

[ix] Moise, Kenneth J. "Management of Rhesus Alloimmunization in Pregnancy." Obstetrics & Gynecology 112.1 (2008): 164-76. Web.

Pirelli, Kevin J., Bradley C. Pietz, Susan T. Johnson, Holly L. Pinder, and Daniel B. Bellissimo. "Molecular Determination of RHD Zygosity:predicting Risk of Hemolytic Disease of the Fetus and Newborn Related to Anti-D." Prenatal Diagnosis Prenat. Diagn. 30.12-13 (2010): 1207-212. Web.

Hirose, Masaya, Keiko Nakanishi, Shouji Kaku, Hiroko Moro, Keiko Hodohara, Hirofumi Aotani, Koichi Takebayashi, and Yoichi Noda. "Fetal Hemolytic Disease Due to Anti-Rh17 Alloimmunization." Fetal Diagn Ther Fetal Diagnosis and Therapy 19.2 (2004): 182-86. Web.

[x] Shipp, T. (1999). Intrapartum uterine rupture and dehiscence in patients with prior lower uterine segment vertical and transverse incisions1. Obstetrics & Gynecology, 94(5), 735-740.

Chauhan, S. (2002). Pregnancy after classic cesarean delivery. Obstetrics & Gynecology, 100(5), 946-950.

[xi] Odibo, Imelda N., Trista M. Newville, Songthip T. Ounpraseuth, Mandi Dixon, Monica A. Lutgendorf, Lisa M. Foglia, and Everett F. Magann. "Idiopathic Polyhydramnios: Persistence across Gestation and Impact on Pregnancy Outcomes." European Journal of Obstetrics & Gynecology and Reproductive Biology 199 (2016): 175-78. Web.

Lallar, Meenakshi, Anam Ul Haq, and Rajesh Nandal. "Perinatal Outcome in Idiopathic Polyhydramnios." J Obstet Gynecol India The Journal of Obstetrics and Gynecology of India 65.5 (2014): 310-14. Web.

Dilbaz, Berna, Esmen Ozturkoglu, Serdar Dilbaz, Nilgun Ozturk, A. Akin Sivaslioglu, and Ali Haberal. "Risk Factors and Perinatal Outcomes Associated with Umbilical Cord Prolapse." Arch Gynecol Obstet Archives of Gynecology and Obstetrics 274.2 (2006): 104-07. Web.

Karahanoglu, Ertugrul, Funda Akpinar, Erhan Demirdag, Neslihan Yerebasmaz, Tugba Ensari, Aysegul Akyol, Dilek Ulubas Isik, and Serdar Yalvac. "Obstetric Outcomes of Isolated Oligohydramnios during Earlyterm, Full-term and Late-term Periods and Determination of Optimal Timing of Delivery." J. Obstet. Gynaecol. Res. Journal of Obstetrics and Gynaecology Research (2016): n. pag. Web.

Naveiro-Fuentes, Mariña, Alberto Puertas Prieto, Rocío Sánchez Ruíz, María Paz Carrillo Badillo, Francisco Montoya Ventoso, and José Luis Gallo Vallejo. "Perinatal Outcomes with Isolated Oligohydramnios at Term Pregnancy." Journal of Perinatal Medicine 0.0 (2015): n. pag. Web.

Shrem, Guy, Sima S. Nagawkar, Mordechai Hallak, and Asnat Walfisch. "Isolated Oligohydramnios at Term as an Indication for Labor Induction: A Systematic Review and Meta-Analysis." Fetal Diagn Ther Fetal Diagnosis and Therapy (2016): n. pag. Web.

[xii] Abalos, E., Duley, L., & Steyn, D. W. (2014). Antihypertensive drug therapy for mild to moderate hypertension during pregnancy. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002252. DOI: 10.1002/14651858.CD002252.pub3.

[xiii] Taga, Atsuko, Yukiyasu Sato, Chieko Sakae, Yumiko Satake, Ikuko Emoto, Shunsuke Maruyama, Hiroko Mise, and Tomoko Kim. "Planned Vaginal Delivery versus Planned Cesarean Delivery in Cases of Low-lying Placenta." The Journal of Maternal-Fetal & Neonatal Medicine (2016): 1-5. Web.

Nojiri, Takeshi, Toshiyuki Yoshizato, Ayako Sanui, Ryota Araki, Hirotsugu Obama, Kyoko Shirota, and Shingo Miyamoto. "Proposal of a New Parameter for Diagnosing a Low-lying Placenta in the Third Trimester: The Distance between the External Os and Placental Edge." Taiwanese Journal of Obstetrics and Gynecology 54.4 (2015): 390-93. Web.

Kollmann, Martina, Jakob Gaulhofer, Uwe Lang, and Philipp Klaritsch. "Placenta Praevia: Incidence, Risk Factors and Outcome." The Journal of Maternal-Fetal & Neonatal Medicine 29.9 (2015): 1395-398. Web.

Wortman, Alison C., Diane M. Twickler, Donald D. Mcintire, and Jodi S. Dashe. "Bleeding Complications in Pregnancies with Low-lying Placenta." The Journal of Maternal-Fetal & Neonatal Medicine 29.9 (2015): 1367-371. Web.

[xiv] Moise, Kenneth J. "Management of Rhesus Alloimmunization in Pregnancy." Obstetrics & Gynecology 112.1 (2008): 164-76. Web.

Pirelli, Kevin J., Bradley C. Pietz, Susan T. Johnson, Holly L. Pinder, and Daniel B. Bellissimo. "Molecular Determination of RHD Zygosity:predicting Risk of Hemolytic Disease of the Fetus and Newborn Related to Anti-D." Prenatal Diagnosis Prenat. Diagn. 30.12-13 (2010): 1207-212. Web.

Hirose, Masaya, Keiko Nakanishi, Shouji Kaku, Hiroko Moro, Keiko Hodohara, Hirofumi Aotani, Koichi Takebayashi, and Yoichi Noda. "Fetal Hemolytic Disease Due to Anti-Rh17 Alloimmunization." Fetal Diagn Ther Fetal Diagnosis and Therapy 19.2 (2004): 182-86. Web.

[xv] Ananth, Cande V., Jessica A. Lavery, Anthony M. Vintzileos, Daniel W. Skupski, Michael Varner, George Saade, Joseph Biggio, Michelle A. Williams, Ronald J. Wapner, and Jason D. Wright. "Severe Placental Abruption: Clinical Definition and Associations with Maternal Complications." American Journal of Obstetrics and Gynecology 214.2 (2016): n. pag. Web.

[xvi] "Practice Bulletin No. 137." Obstetrics & Gynecology 122.2, PART 1 (2013): 406-16. Web.

Coustan, D. R. "Gestational Diabetes Mellitus." Clinical Chemistry 59.9 (2013): 1310-321. Web.

Imam, Ahmad A. "Can We Prescribe Oral Hypoglycemic Agents Safely for Treatment of Gestational Diabetes Mellitus (GDM)? Evidence-Based Medicine Review Article." Canadian Journal of Diabetes 36.5 (2012): n. pag. Web.

Dhulkotia, Jaya Saxena, Bolarinde Ola, Robert Fraser, and Tom Farrell. "Oral Hypoglycemic Agents vs Insulin in Management of Gestational Diabetes: A Systematic Review and Metaanalysis." American Journal of Obstetrics and Gynecology 203.5 (2010): n. pag. Web.

Su, D.f., and X.y. Wang. "Metformin vs Insulin in the Management of Gestational Diabetes: A Systematic Review and Meta-analysis." Diabetes Research and Clinical Practice 104.3 (2014): 353-57. Web.

Kitwitee, Pimprapa, Supon Limwattananon, Chulaporn Limwattananon, Ornanong Waleekachonlert, Tananan Ratanachotpanich, Mattabhorn Phimphilai, Tuan V. Nguyen, and Chatlert Pongchaiyakul. "Metformin for the Treatment of Gestational Diabetes: An Updated Meta-analysis." Diabetes Research and Clinical Practice 109.3 (2015): 521-32. Web.

Mcgrath, Rachel T., Sarah J. Glastras, Samantha Hocking, and Gregory R. Fulcher. "Use of Metformin Earlier in Pregnancy Predicts Supplemental Insulin Therapy in Women with Gestational Diabetes." Diabetes Research and Clinical Practice 116 (2016): 96-99. Web.

[xvii] Dare MR, Middleton P, Crowther CA, et al. Planned early birth versus expectant management (waiting) for prelabour rupture of membranes at term (37 weeks or more). Cochrane Database Syst Rev 2006; :CD005302.

Hannah ME, Ohlsson A, Farine D, et al. Induction of labor compared with expectant management for prelabor rupture of the membranes at term. TERMPROM Study Group. N Engl J Med 1996; 334:1005.

Tran SH, Cheng YW, Kaimal AJ, Caughey AB. Length of rupture of membranes in the setting of premature rupture of membranes at term and infectious maternal morbidity. Am J Obstet Gynecol 2008; 198:700.e1.

Herbst A, Källén K. Time between membrane rupture and delivery and septicemia in term neonates. Obstet Gynecol 2007; 110:612.

Keirse MJ, Ottervanger HP, Smit W. Controversies: prelabor rupture of the membranes at term: the case for expectant management. J Perinat Med 1996; 24:563.

Seaward PG, Hannah ME, Myhr TL, et al. International Multicentre Term Prelabor Rupture of Membranes Study: evaluation of predictors of clinical chorioamnionitis and postpartum fever in patients with prelabor rupture of membranes at term. Am J Obstet Gynecol 1997; 177:1024.

[xviii] Shapiro-Mendoza, C. K., K. M. Tomashek, M. Kotelchuck, W. Barfield, A. Nannini, J. Weiss, and E. Declercq. "Effect of Late-Preterm Birth and Maternal Medical Conditions on Newborn Morbidity Risk." Pediatrics 121.2 (2008): n. pag. Web.

Engle, W. A., K. M. Tomashek, and C. Wallman. ""Late-Preterm" Infants: A Population at Risk." Pediatrics 120.6 (2007): 1390-401. Web.

[xix] Bhutani VK. Developing a systems approach to prevent meconium aspiration syndrome: lessons learned from multinational studies. Journal of Perinatology. 2008;28(3, supplement):S30–S35

Dargaville, P. A. (2006). The Epidemiology of Meconium Aspiration Syndrome: Incidence, Risk Factors, Therapies, and Outcome. Pediatrics, 117(5), 1712-1721. doi:10.1542/peds.2005-2215

Davis, R. O., Philips, J. B., Harris, B. A., Wilson, E. R., Huddleston, J. F., & Ramamurthy, R. S. (1985). Fatal Meconium Aspiration Syndrome Occurring Despite Airway Management Considered Appropriate. Obstetric Anesthesia Digest, 5(3), 108-109. doi:10.1097/00132582-198505030-00015

Fleischer A, Anyaegbunam A, Guidetti D, Randolph G, Merkatz IR Obstet Gynecol. 1992 Feb; 79(2):185-90.)

Goldsmith JP. Continuous positive airway pressure and conventional mechanical ventilation in the treatment of meconium aspiration syndrome. Journal of Perinatology. 2008;28(3):S49–S55)

Heijst, M., Roosmalen, G., & Keirse, M. J. (1995). Classifying Meconium-Stained Liquor: Is It Feasible? Birth, 22(4), 191-195. doi:10.1111/j.1523-536x.1995.tb00257.x

Hiersch, L., MD, Krispin, E., MD, Linder, N., MD, Aviram, A., MD, Gabbay-Benziv, R., MD, Yogev, Y., MD, & Ashwal, E., MD. (2016, May 31). Meconium-Stained Amniotic Fluid and Neonatal Morbidity in Low-Risk Pregnancies at Term: The Effect of Gestational Age. American Journal of Perinatology. doi:http://dxdoi.org/10.1055/s-0036-1585056

Hiersch, L., Melamed, N., Rosen, H., Peled, Y., Wiznitzer, A., & Yogev, Y. (2013). New onset of meconium during labor versus primary meconium-stained amniotic fluid – is there a difference in pregnancy outcome? The Journal of Maternal-Fetal & Neonatal Medicine, 27(13), 1361-1367. doi:10.3109/14767058.2013.858320

Ierland, Y. V., Boer, M. D., & Beaufort, A. J. (2009). Meconium-stained amniotic fluid: Discharge vigorous newborns. Archives of Disease in Childhood - Fetal and Neonatal Edition, 95(1). doi:10.1136/adc.2008.150425

Locatelli A, Regalia AL, Patregnani C, Ratti M, Toso L, Ghidini A. Prognostic value of change in amniotic fluid color during labor. Fetal Diagn Ther. 2005;20:5-9

Maymon E, Chaim W, Furman B, Ghezzi F, Shoham Vardi I, Mazor M Eur J Obstet Gynecol Reprod Biol. 1998 Oct; 80(2):169-73.)

Mundhra, R. (2013). Fetal Outcome in Meconium Stained Deliveries. Jcdr Journal Of Clinical And Diagnostic Research. doi:10.7860/jcdr/2013/6509.3781

Priyadharshini.v, D. P. (2013). Meconium Stained Liquor and Its Fetal Outcome - Retrospective Study. IOSR-JDMS IOSR Journal of Dental and Medical Sciences, 6(2), 27-31. doi:10.9790/0853-0622731

Qian L, Liu C, Zhuang W, Guo Y, Yu J, Chen H, et al. Neonatal respiratory failure: a 12-month clinical epidemiologic study from 2004 to 2005 in China. Pediatrics. 2008;121:e1115-24 Review Meconium staining and the meconium aspiration syndrome. Unresolved issues. Wiswell TE, Bent RC Pediatr Clin North Am. 1993 Oct; 40(5):955-81.]

Ross MG. Meconium aspiration syndrome – more than intrapartum meconium. N Engl J Med. 2005;353:946-8

Rossi EM, Philipson EH, Williams TG, Kalhan SC Am J Obstet Gynecol. 1989 Nov; 161(5):1106-10.

UK NICE Guidelines- https://www.nice.org.uk/guidance/cg190/chapter/1- Recommendations#presence-of-meconium

Vain NE, Szyld EG, Prudent LM, Wiswell TE, Aguilar AM, Vivas NI. Oropharyngeal and nasopharyngeal suctioning of meconium- stained neonates before delivery of their shoulders: multicentre, ran- domised controlled trial. Lancet. 2004;364:597–602. doi: 10.1016/ S0140-6736(04)16852-9.) (http://www.ncbi.nlm.nih.gov/pubmed/25661412

[xx] Rigó, János, Bálint Alasztics, Anikó Árokszállási, Noémi Dobó, Mária Prosszer, József Gábor Joó, and Attila Molvarec. "PL59. The Impact of Classification of Hypertensive Disorders of Pregnancy Based on the ACOG 2013 and ISSHP 2014 Criteria." Pregnancy Hypertension: An International Journal of Women's Cardiovascular Health 5.3 (2015): 222-23. Web.

Lowe, S.a., M.a. Brown, G.a. Dekker, S. Gatt, C.k. Mclintock, L.p. Mcmahon, G. Mangos, M.p. Moore, P. Muller, M. Paech, and B. Walters. "Guidelines for the Management of Hypertensive Disorders of Pregnancy, 2008." Obstetric Anesthesia Digest 30.2 (2010): 78-79. Web.

Abalos, E., Duley, L., & Steyn, D. W. (2014). Antihypertensive drug therapy for mild to moderate hypertension during pregnancy. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002252. DOI: 10.1002/14651858.CD002252.pub3.

[xxi] Lowe, S.a., M.a. Brown, G.a. Dekker, S. Gatt, C.k. Mclintock, L.p. Mcmahon, G. Mangos, M.p. Moore, P. Muller, M. Paech, and B. Walters. "Guidelines for the Management of Hypertensive Disorders of Pregnancy, 2008." Obstetric Anesthesia Digest 30.2 (2010): 78-79. Web.

Abalos, E., Duley, L., & Steyn, D. W. (2014). Antihypertensive drug therapy for mild to moderate hypertension during pregnancy. Cochrane Database of Systematic Reviews 2014, Issue 2. Art. No.: CD002252. DOI: 10.1002/14651858.CD002252.pub3.

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http://www.ontariomidwives.ca/images/uploads/guidelines/No13CPG_PROM_final.pdf

https://www.nice.org.uk/guidance/cg70/evidence/full-guideline-241871149