



## MEDICATION ABORTION

### Editor:

We appreciate the publication of the "Update on Medication Abortion" by Margaret W. Beal (J Midwifery Womens Health 2007;52:23–30) in the January/February 2007 issue of the *Journal*. The article provides a timely and essential update on the clinical aspects of medication abortion and an overview of important research on innovative protocols.

It is important for midwives to also consider laws and regulations which have implications for clinical practice. Forty-four states and the District of Columbia have some kind of law (often called "physician-only laws") restricting the types of medical professionals that can provide abortions. Some states may require that only physicians provide abortions, other states may draw distinctions between medical and surgical abortions, and other states may allow licensed professionals other than physicians to provide abortions under certain circumstances. Clinicians who provide abortion services, medical or surgical, can find state-specific information in the "State Profiles" section of the NARAL publication, *Who Decides?*<sup>1</sup> Laws and regulations that define midwifery practice can be accessed by ACNM members,<sup>2</sup> and ACNM staff are available to respond to questions about interpretation of those laws and regulations.

Lisa Summers, CNM, DrPH, FACNM  
Michelle Sara King, JD  
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### REFERENCES

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2. American College of Nurse-Midwives Web site. Nurse-midwifery today, 2006 edition. Available from: [www.midwife.org/today.cfm](http://www.midwife.org/today.cfm) [Accessed March 1, 2007].

### AUTHOR REPLY

I would like to thank Lisa Summers, CNM, DrPH, and Michelle Sara King, JD, at the national office of the ACNM for their thoughtful comments about the legal aspects of expansion of midwifery practice to include abortion.

The resources they have pointed out are helpful. I would like to add that in some states with "physician-only laws" still on the books, advanced practice nurses,

physician assistants, and CNM/CMs licensed as midwives are able to provide medication abortion services based on a legal opinion written by the state's Attorney General. In the absence of this resource, the issue of whether to request such an opinion is complex, and should be considered only in partnership with national and local groups that are knowledgeable about state politics.

In addition to the sources of information cited by Dr. Summers and Ms. King, clinicians interested in learning more about regulation of abortion in their states can consult with Clinicians for Choice<sup>1</sup> or The Abortion Access Project.<sup>2</sup> Another possible source of information is a state administrative office for Planned Parenthood.

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### REFERENCES

1. National Abortion Federation Web site. Clinicians for choice. Available from: [www.prochoice.org/cfc](http://www.prochoice.org/cfc) [Accessed March 1, 2007].
2. The Abortion Access Project. Available from: <http://abortionaccess.org> [Accessed March 1, 2007].

## MANAGEMENT OF NUCHAL CORD

### Editor:

We read with great interest the article entitled "Midwives and the Fetal Nuchal Cord: A Survey of Practices and Perceptions" in the January/February 2007 issue of the *Journal of Midwifery and Women's Health*.<sup>1</sup> The authors present a thorough and well organized literature review of nuchal cord management for term infants and identified no published randomized or controlled trials on the topic. Their review generated a survey which found that English midwives' management of nuchal cord at term mirrored the findings of a survey of American midwives,<sup>2</sup> save for a lower reported use of the somersault maneuver.

One reference by Schorn and Blanco<sup>3</sup> appears to have been misconstrued. Jackson et al<sup>1</sup> cite in their article that "some authorities maintain that delayed cord clamping and cutting may lead to neonatal asphyxiation by strangulation and/or anoxia." In our review of the same article,<sup>3</sup> we were unable to find any reference to support this statement. We wonder if the authors might have had another reference for this statement? However, we have been unable to find any similar information in a wide review of the literature on nuchal cord.

Schorn and Blanco<sup>3</sup> suggest that nuchal cord may

result in more frequent variable fetal heart rate decelerations, lower Apgar scores, and more frequent need for resuscitation at birth, but they did not suggest that delaying the timing of cord clamping and cutting is associated with perinatal asphyxia. This reference is extremely important because it provides the basis for the authors' conclusion that additional trials on management of nuchal cords are necessary.

In a previous work,<sup>4</sup> we have provided a strong physiologic basis for not clamping the nuchal cord. The literature has clearly shown an association between clamping the nuchal cord before delivery and cerebral palsy, especially if it has in conjunction with a shoulder dystocia. As outlined in our article, the effects of prebirth cutting of the nuchal cord on infants include hypotension and shock, anemia, reduced birth weight, cerebral palsy, and death.<sup>4</sup>

Jackson et al<sup>1</sup> "propose this area of practice should now be subject to a *controlled trial*" (p. 53). Although we agree that management of nuchal cord at term needs further study, we believe that a word of caution is indicated. Controlled trials, considered the gold standard of evidence-based practice, can in certain situations be less than ideal and create an ethical dilemma.<sup>5</sup> Evidence is mounting that an adequate blood volume is necessary for a successful neonatal transition. Randomizing an infant with nuchal cord to immediate clamping and cutting of the cord could be considered unethical. As we focus our research efforts on this important topic, we must first be guided by the motto, "Do No Harm." We quote Enkin,<sup>5</sup> who so eloquently addresses this issue:

*"Randomized trials currently at the top of the evidence-based hierarchy are perfectly suited to evaluate the (average) relative effects of alternative forms of care, for both simple and complicated problems, where the form of care used is the principal cause of the outcome found. They are less suitable, and often seriously misleading, for more complex problems where the outcomes depend more on the web of interactions between the care, the individuals concerned, and the context in which they occur"* (p. 267).

Judith S. Mercer, CNM, DNSc, FACNM

Debra Erickson-Owens, CNM, PhD(c)

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1. Jackson H, Melvin C, Downe S. Midwives and the fetal nuchal cord: A survey of practices and perceptions. *J Midwifery Womens Health* 2007;52:49–55.

2. Mercer JS, Nelson CC, Skovgaard RL. Umbilical cord clamping: Beliefs and practices of American nurse-midwives. *J Midwifery Womens Health* 2000;45:58–66.

3. Schorn MN, Blanco JD. Management of the nuchal cord. *J Nurse Midwifery* 1991;36:131–2.

4. Mercer JS, Skovgaard RL, Peareara-Eaves J, Bowman T. Nuchal cord management and nurse-midwifery practice. *J Midwifery Womens Health* 2005;50:373–9.

5. Enkin MW, Glouberman S, Groff P, Jadad AR, Stern A, for the Clinamen Collaboration. Beyond evidence: The complexity of maternity care. *Birth* 2006;33:265–9.

## Author Reply:

We were very pleased that our study<sup>1</sup> has been of interest to readers of the journal, and we appreciate the close attention paid to it by Mercer and Erickson-Owens, and, indeed, their important contribution to the topic of umbilical cord management over the years. We accept their correction of our interpretation of the Schorn and Blanco<sup>2</sup> reference: since these authors only note the risk of coil compression, reduced fetal blood flow and subsequent hypoxia associated with intrapartum nuchal cord, and of a very tight cord at delivery making expulsion of the fetus difficult or tearing of the cord a possibility. Any added risk of not clamping and cutting the cord at the time of birth is therefore implied rather than stated. However, we do depart from the statement of Mercer and Erickson-Owens that this reference was the sole basis for our conclusion. More than 50% of the respondents to our survey, and to the survey conducted previously by Mercer et al,<sup>3</sup> indicated that they would clamp and cut a tight nuchal cord. As the sample of qualitative data we presented suggested, this appears to be based, at least in part, on precertification (i.e., prequalification) teaching that immediate clamping and cutting the cord can protect the infant from oxygen deprivation. Indeed, case studies of retinopathy secondary to tight cord at birth<sup>4</sup> and of traumatic birth linked to nuchal cord at delivery<sup>5</sup> do exist in the literature, although we agree that they are rare. Our parallel work in this area, and, specifically, our systematic review of nonrandomized controlled trial evidence, which we are just completing, indicates that evidence on longer term impact of nuchal cord in utero and at the time of birth is very mixed. The design of studies in this area is generally weak, with inadequate follow-up, and management of the cord at the time of birth is rarely taken into account in the research design or analyses. As both surveys indicated,<sup>1,3</sup> and based on the number of papers on the topic of nuchal cord that are still appearing regularly in the medical press, there is a lack of agreement in practice about the best approach to this situation at various stages of birth. This means that tens of thousands of women and babies may be being exposed to interventions (or noninterventions) that are harmful to them. We are currently planning a prospective observational study of outcomes of nuchal cord that takes into account both the nature and degree of cord entanglement, and how the cord is managed. We intend to use both short- and longer-term measures of infant neurologic development and of anaemia. We have chosen the latter