

**BEFORE THE REVIEW COMMITTEE
OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD**

In the Disciplinary Matter of:

Anne Margolis, CNM: Respondent

DECISION

The American Midwifery Certification Board received written notice from the State of Connecticut, Public Health (“Department”), of possible violations by Respondent Anne Margolis, of AMCB’s Disciplinary Policy. The violations concerned allegations that Respondent breached standard of care by failing “to seek timely intervention of emergency medical services in response to complications in the delivery” of an infant; and/or failing “to maintain adequate and/or accurate records related to the care and treatment” of the infant and its mother. Further, the Department alleged that Respondent failed “to maintain an appropriate collaboration with a qualified obstetrician-gynecologist as required” pursuant to named statutes. Investigation resulted in sanctions being imposed against Respondent for the allegations regarding response to intrapartum complications. The allegations regarding medical records and medical collaboration were not sustained. Sanctions included reprimand, a fine, required continuing education and probation.

In accordance with AMCB procedures, the complaint was reviewed by AMCB’s President, who determined that the matters alleged in the notice of possible violation, if true, could constitute grounds for disciplinary action.

Accordingly, by letter August 21, 2018, notified Respondent that it had initiated a disciplinary proceeding to determine whether good grounds existed for discipline under the any or all of four provisions of Section VI.A. of the Disciplinary Policy.

- A.7. Limitation or sanction by a federal, state or private licensing board, administrative agency, association or health care organization relating to public health, or safety, or midwifery practice.
- A.9. Engaging in conduct which is inconsistent with professional standards, including but not limited to (i) any practice that creates unnecessary danger to a patient’s life, health or safety; and (ii) any practice that is contrary to the ethical conduct appropriate to the profession that results in termination or suspension from practice. Actual injury to a patient or the public need not be shown under this provision.

The notice requested that Respondent submit a written answer to these charges within 30 days. Respondent replied with her statement regarding the allegations on September 3, 2018 and was subsequently contacted by AMCB on October 10, 2018 with a request for additional information, specifically her curriculum vita, Clinical Practice Guidelines in effect at the time of the incident and de-identified medical records relevant to the allegations if available. Respondent provided the additional materials on October 10, 2018.

A Review Committee comprised of a Chair (Carol Howe, CNM, DNSc, FACNM) and two qualified members (Ira Kantrowitz, CNM, PhD, FACNM and Andrea Christianson, CNM, MS, FACNM) was duly convened.

The Review Committee has now considered the charges against Respondent and the above-described matters of record. On the basis of the factual findings and reasons set forth below, the Committee unanimously concludes that grounds for discipline against Respondent exist under sections A.7 and A.9. of the Disciplinary Policy; and that the imposition of sanctions is warranted.

FINDINGS

The Review Committee finds the following facts:

1. AMCB, formerly known as the ACNM Certification Council (ACC), was formed in 1991 by the American College of Nurse Midwives (ACNM) as an independent entity to carry on the pre-existing program of ACNM and ACC for certifying the competency of individuals as entry-level nurse-midwives.
2. AMCB has assumed responsibility for discipline of ACNM/ACC/AMCB certificants through the Disciplinary Policy, the most recent version of which AMCB adopted April 2018.
3. Respondent was certified by ACC, now AMCB on 9/8/1995.
4. Respondent has practiced in a home birth environment for greater than 20 years and has no known previous history of sanction on her license or certificate.
5. On or about December 9 and December 10, 2010, Respondent attended the birth of patient JM in the patient's home. In the course of the labor and birth, a severe shoulder dystocia occurred, resulting in damage to the infant. The mother also experienced a retained placenta and episodes of hypotension in the immediate postpartum period.
6. Prenatal care of JM began in the first trimester, and was provided consistently throughout gestation until 37 weeks when the patient went into labor. With the exception

of maternal obesity and stable hypothyroidism (followed by an MD), there were no significant pregnancy risk factors.

7. At 26 weeks gestation, an ultrasound indicated a gestation consistent with 28 weeks, within the range of error at that point in pregnancy. Screening for gestational diabetes was normal. JM continued to have fundal heights consistent with slight LGA (large for gestational age) until 36+ weeks when the fundal height increased significantly. At that time, Respondent ordered an additional ultrasound and laboratory work as well as a physician consult. Prior to the patient's ability to schedule the consult, labor ensued at 37 weeks gestation.

8. Respondent attended the birth doula serving as her birth assistant. Estimated fetal weight by Respondent was 9#. Membranes ruptured just prior to onset of contractions. The length of labor was as follows:

Latent stage: 24 hours

Active stage: 11 hours 45 minutes

Second stage: 5 hours (2 hours 25 minutes pushing effectively per Respondent)

9. Birth was significant for an infant birth weight of 11#5oz, Shoulder dystocia was resolved after several attempts at maneuvers, affecting delivery with cork screw maneuver approximately 5-6 minutes after delivery of head. Respondent began resuscitation. Apgars 3(1 min), 3(5 min), 5(10 min), 5(15 min), 8(20 min). Times are approximate.

10. Immediate postpartum period was characterized by:

a. Retained placenta (1 hr 30 min): EBL 450cc. Incident of transient hypotension in the mother, resolved.

b. Continued hypotonia in infant, initial decreased movement in left arm, apneic episodes x2. Respondent called 911 2.5 hours after delivery.

11. Respondent's statement to the Review Committee included the following declarations:

a. Although Respondent planned for birth in the bedroom, patient pushed most effectively on the toilet and ultimately delivered in bathroom where no clock was visible and a wrist watch was masked by sterile gloves, making timing of birth and Apgars estimates rather than exact times.

b. There were no accessible phones in the bathroom.

c. Resuscitation was accomplished in the bathroom.

d. After resuscitation, Respondent allowed patient time for "emotional bonding."

e. Respondent asked the father to call 911 while in the middle of resuscitation but "he was unresponsive to my requests." Respondent again "raised the need to transfer the baby" with parents after initial resuscitation, but parents resisted.

f. Respondent continued to monitor the baby until apneic episodes were noted, then insisted upon transfer of the infant.

g. Respondent's self-admitted critique: "I should have been more forceful in making sure that a call was made to 911 after the wrenching birth and before the mother's

own emergency erupted – despite the family’s resistance.”

12. Respondent was sanctioned by the Connecticut Department of Public Health for failing to transfer the infant in a timely manner. Sanctions included: reprimand, monetary fine, required continuing education and probation.

DISCUSSION

In this matter we are called upon to decide whether and what discipline is warranted against a CNM who has been sanctioned for professional negligence or malpractice by a state licensing board.

Our discussion was informed by review of multiple documents, including the Memorandum of Decision rendered by the Connecticut Department of Public Health, the Respondent’s Post-Hearing Brief, the Respondent’s personal statement, and extensive de-identified copies of the patient records in this case.

Review of these documents lead the committee to the following conclusions:

- a. With regard to prenatal care, intrapartum management and initial resuscitation, the standard of care was met, and in some areas, was exemplary. Efforts to effect the delivery of such a macrosomic infant were appropriate and demonstrated calm assessment of the situation and consideration of all possible options and maneuvers.
- b. With regard to documentation, the medical record was extensive, complete and appropriate. Extensive communication with the patient was also a noted strength.
- c. With regard to the timing of the 911 call, the standard of care was not met. Respondent’s own practice guidelines indicate that Apgars of less than 7 at 5 minutes requires “pediatric consultation and possible transfer” as well as “in the event of any medical or obstetrical emergency occurring at home, the client will be transferred by ambulance...” The shoulder dystocia was clearly an emergent situation, as was the infant’s condition after birth. While recognizing the urgency of providing direct emergency care, it is incumbent upon the midwife to insure that a call for emergency assistance occurs in a timely fashion. If the midwife is unable to make the call, the birth assistant must be prepared to do so, without relying on a potentially traumatized family member. The call ideally should have occurred when the shoulder dystocia had lasted more than 2-3 minutes, and certainly immediately upon delivering a severely depressed infant. This could have occurred by the assistant while the midwife was drying and stimulating the infant in preparation for full resuscitation.
- d. With regard to the lack of ability to time the birth and its sequelae, the standard of care was also not met. This function is typically assigned to a birth assistant, and it is not clear why, given the presence with an assistant who should have had a watch, a smart phone or stop watch, they were not able to time the events accurately.

The Committee is persuaded that the Respondent, while generally providing competent care, allowed the patient's family to dictate management in a clearly emergent situation. Accordingly, we conclude that a basis exists for discipline under section A.9., namely, engaging in conduct which is inconsistent with professional standards, including but not limited to (i) any practice that creates unnecessary danger to a patient's life, health or safety; and (ii) any practice that is contrary to the ethical conduct appropriate to the profession that results in termination or suspension from practice. Actual injury to a patient or the public need not be shown under this provision

Respondent was sanctioned by the Connecticut Department of Public Health, a fact that she obviously does not contest. Consequently, without more evidence, a basis for discipline exists under section A.7. of the Disciplinary Policy, namely, that Respondent has been sanctioned by a state licensing board.

SANCTIONS FOR VIOLATIONS

The Review Committee determines that the following sanctions shall be imposed for the violations found:

1. Reprimand of Respondent's AMCB Certification. A letter of reprimand will be issued.
2. Fine. A fine of \$250 will be assessed.

REVIEW COMMITTEE

Carol Howe, CNM, DNSc, FACNM, FAAN, Chair
Ira Kantrowitz-Gordon, CNM, PhD, FACNM
Andrea Christianson, CNM, MS, FACNM

Linda Hunter, CNM, PhD, FACNM
President, AMCB Board of Directors
Effective: 2/8/2019