

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

In the Disciplinary Matter of:

Melanie R. Miller, CNM
Respondent

DECISION

On April 23, 2020, the American Midwifery Certification Board (AMCB) received written notice from legal counsel for Melanie R. Miller (Respondent) that the Ohio Board of Nursing had entered into a Consent Agreement with Respondent regarding an incident that resulted in the death of an infant. The alleged violations concerned Respondent's decision to leave the hospital to obtain dinner while her patient [Patient] was in labor in the presence of 1) a potentially concerning heart rate tracing, 2) meconium-stained amniotic fluid and 3) oxytocin induction. While Respondent was absent the hospital for an approximately two (2) hour period, the monitor tracing deteriorated resulting in emergency delivery and subsequent demise of the infant. The attorney's letter included a detailed description of events from the perspective of the Respondent as well as a copy of the Notice for Opportunity for Hearing and Consent Agreement.

In accordance with AMCB procedures, the complaint was reviewed by the AMCB President, who determined that the matters alleged in the Consent Agreement, if true, could constitute grounds for disciplinary action.

Accordingly, by letter dated January 24, 2022, AMCB notified Respondent that it had initiated a disciplinary proceeding to determine whether good grounds existed for discipline under the provisions of Sections VI.A.7. and VI.A.9. of the AMCB 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 of the January 24th notice. On February 25, 2022, Respondent provided a written response to AMCB providing her narrative of the events related to the incident. On April 22, 2022,

Respondent was contacted asking her to provide de-identified medical records related to the incident as well as responses to specific questions requested by the Review Committee. AMCB received her response on May 20, 2022.

A Review Committee comprised of a Chair (Carol Howe, CNM, DNSc, FACNM) and two qualified members (Laura Valle, CNM, DNP, and Jessica Newgard, CNM, MN) was duly convened.

The Review Committee has now considered the charges against Respondent and the above-described matters of record. Based on 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 AMCB Disciplinary Policy and that the imposition of sanctions is warranted.

FINDINGS

The Review Committee finds the following facts:

1. AMCB (formerly the ACNM Certification Council) was formed in 1991 by the American College of Nurse Midwives (ACNM) as an independent entity to carry on the existing program of ACNM 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 AMCB on July 27, 2012.
4. Incident in question. The following sequence of events appears to be uncontested.
 - a. A physician admitted the patient in labor. Labor progress was slow. Respondent assumed responsibility for the Patient about 1800 on the day in question.
 - b. After assumption of care by Respondent, artificial rupture of the membranes (AROM) was performed and meconium-stained amniotic fluid was noted. Oxytocin augmentation was begun.
 - c. Respondent left the hospital for dinner, noted blood on her leg from a previous delivery, and decided to shower before returning to the hospital. Respondent was out of the hospital for approximately 2 hours.
 - d. Prior to leaving the hospital, Respondent was consulted by a Registered Nurse (RN) regarding a possible late deceleration on the fetal monitor tracing.
 - e. A call from the RN reporting minimal variability and variable decelerations is documented one hour prior to the birth of the infant.
 - f. While returning to the hospital, Respondent received a call from the RN indicating a decrease in the fetal heart rate and informing her that the physician hospitalist was being summoned.
 - g. The patient was taken to the operating room emergently where a severely depressed infant was delivered. The baby was removed from life support after 24 hours and subsequently expired.

5. Consent Agreement. A Consent agreement was entered into between the Respondent and the Ohio Board of Nursing (BON) on February 6, 2020.

a. Allegations from the BON focused upon Respondent's decision to leave the hospital with a laboring patient on oxytocin augmentation with meconium-stained fluid (MSF). Further, issues of documentation (or lack thereof) were cited, including failure to document AROM with MSF, fetal status and rationale for ordering oxytocin as well as failure to document physician consultation.

b. Terms of the Consent Agreement included a 1-year suspension of license (stayed) with the following continuing education requirements:

1. Documentation: 5 hours
2. Professional accountability and legal liability: 4 hours
3. Effective communication: 3 hours
4. Ohio Law and Rules: 2 hours

Further, Respondent was required to submit quarterly performance reports to the BON by the employing institution and the collaborating physician.

c. Respondent has satisfactorily completed these requirements and currently holds an unencumbered license to practice midwifery. Respondent has also completed certification in Electronic Fetal Monitoring (EFM).

6. Respondent's reply to allegations. The Respondent's written reply to the Review Committee confirmed the basic sequence of events. Respondent states the following regarding the incident in question.

a. Respondent's reply to the RN who consulted regarding a potential late deceleration prior to Respondent leaving hospital includes that it was an "isolated event" occurring during a "triple contraction" in the presence of an otherwise reassuring fetal hear race tracing. This assertion was made in response to a note in the medical record by an RN indicating that Respondent spoke disparagingly to RNs regarding their concern about the deceleration. The medical record note asserts that two RNs believed the deceleration was a late deceleration while Respondent allegedly replied, "You can't have lates with moderate variability." Of note, the RN medical record entry was made 4 days after the event when the infant outcome was known. Respondent further states that "the conversation she [the RN] references never took place and the statements that I was alleged to have made are completely fictional."

b. Respondent reports that while she was at home, she received a call from the triage RN regarding another patient. At that time, she asked to speak to the RN caring for the patient in question and was told that she was "doing fine." While returning to the hospital, Respondent reports receiving two additional phone calls from the RN caring for the Patient. The first reported a deceleration of the fetal heart rate to 60 beats per minute which had returned to baseline and was now "fine." The second call, 10 minutes later, indicated that the heart rate and once again dropped and that the hospitalist physician was being summoned. There is only one call noted by the RN in the medical record during the time period Respondent was in route to the hospital.

c. Respondent indicates that she notified her collaborating physician after both of the calls and requested his presence in the hospital after the second call.

d. Respondent indicates that after review of the fetal heart rate tracing "it was apparent that [the Patient] was having late decelerations which became repetitive and significant

soon after I left the hospital. I was never called regarding her tracing until they called to tell me the heart tones were down.” An RN note reporting a call with Respondent documents minimal heart rate variability and variable decelerations of the fetal heart rate 25 minutes prior to the call placed while Respondent was driving to the hospital. A call from the RN reporting minimal heart rate variability and variable decelerations is documented 25 minutes prior to the call in route.

7. Medical Record. The de-identified medical records received for review included only Progress Notes. Despite several attempts to obtain additional documentation for the Review Committee to evaluate, the Committee was unable to obtain copies of the Electronic Fetal Monitor (EFM) Strip, Provider Orders, Delivery Report, Flow Sheets or the Operative Report from the delivery. Relevant Progress Notes are cited below. Entries are date and time stamped. All notes cited are from the same day.

a. Time: 2255 - RN note

“[Respondent] updated on pt. SVE 5/90/0. Minimal variability with variables. Order received for amnioinfusion. See orders.”

b. Time: 2255 – 2352 – RN note

This note is a late entry summary note, apparently composed at 0501 and filed at 0648 the following day. The times listed within the note begin at 2255 when the RN is reported to be “in room to start amnioinfusion, searching for FHTs”, and continuing through 2352 when the NICU team returns a call. Interim notations detail Patient position changes, attempts to place a fetal scalp electrode (FSE), discontinuation of oxytocin, call to physician, call to Respondent at 2322 and Patient transfer to OR at 2342.

c. Time: 2320 - RN note

“Called [Respondent], updated on FHT tracing and interventions tried, she states she is on her way in at this time.” (Entry filed at 2328.)

d. Time: 2325:

“Called and spoke with [physician], our in-house MD just to update on FHTs with decels and possibility of being needed for backup, he is aware and states to call him if he ends up being needed.” (Filed 2327)

e. Time: 2335: DO note

Summary – In my office and was called to come down and evaluate patient and tracing...Because fetal heart tones had been down for a long period of time and the decision to do an emergency C-section was made.” (Filed at 0137 approximately 2 hours after call received.)

f. Time: 2350 – Respiratory Therapist (RT)

Time of birth is inferred to be approximately 2350 as RT called a “Code Pink” at this time.

g. This record indicates that Respondent was notified of EFM tracing with minimal variability and variable decelerations approximately 25 minutes prior to the call Respondent received while returning to the hospital.

h. Only one note from Respondent is found in the medical record – a History and Physical (H&P) timed 1818 and filed prior to leaving the hospital. No subsequent note was found.

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.

In its discussion, the Review Committee considered two separate aspects of this case. The first focused on documentation of practice decisions and communication with the health care team. According to the Standards for Midwifery Practice (ACNM, 2011), records should “provide prompt and complete documentation of evaluation, course of management, and outcome of care.” It is clear that documentation in this case was wholly inadequate given that the only documentation found was an H&P filed prior to the events in question. Ideally, notes should be contemporaneous, but sometimes situations dictate the need for late entries. Respondent notes in her written response to the Committee, “Admittedly, I did not chart well that evening. I was unable to chart from home and was planning on catching up on my charting when I returned to the hospital. Given the devastating outcome, I did not go in and add late entries.” On the contrary, when adverse outcomes occur, documentation becomes even more important. As a result of the lack of charting, there is no documentation of the rationale for Respondent’s clinical decision making nor of her communication with the nursing or medical staff. If the notes are clearly marked “Late Entry” they are both legal and critical to the understanding of the events that led up to the outcome. Thus, in this aspect of the discussion, Respondent’s standard of care was clearly deficient.

The second aspect of the Committee’s discussion focuses upon Respondent’s clinical decision making. The absence of charting and the absence of critical aspects of the medical record (in particular the fetal monitor tracing) make a clear understanding of Respondent’s thinking and actions most difficult. Although some would criticize Respondent’s decision to leave the hospital under the noted circumstances, apparently the presence of the practitioner in the hospital during oxytocin infusion was not required by policy. In addition, there was an in-house physician that the RNs could have consulted if they had concerns regarding the fetal monitor strip. The lack of a fetal monitor strip precludes the ability of the Committee to evaluate the significance of the deceleration noted prior to Respondent leaving the hospital or the onset and significance of subsequent decelerations associated with the infant outcome.

There seems to be a discrepancy between Respondent’s report that while at home she spoke to the RN and was told the Patient was “fine” and the RN report of minimal variability and variable decelerations. That call occurred 25 minutes prior to the call when Respondent indicated that she was on the way back to the hospital. Presumably, this call was the call that was taken at home as Respondent stated to the patient prior to leaving the hospital that she was “only 15 minutes away if they needed anything.” Per the RN note, in addition to the report of a less than reassuring fetal monitoring strip, an order was given for amnioinfusion, indicating some concern on the part of the Respondent. Lack of documentation on the part of the Respondent makes it difficult to ascertain if the RN did call to report concerns about the fetal heart rate tracing earlier. If that did occur, there is concern that the Respondent should have returned to the hospital sooner due to the minimal variability and recurrent decelerations. There is also concern that the oxytocin should have been discontinued at that time as well.

No conclusion can be reached regarding the discrepancy between Respondent and the RN with regard to the deceleration noted prior to leaving the hospital as there is no documentation to support Respondent's position.

Nonetheless, sufficient concern exists for the Review Committee to defer to the decision of the Ohio Board of Nursing. Our decision is guided by the general principle that a private certification organization like AMCB, in the absence of clear evidence to the contrary, will normally give full faith and credit to the disciplinary decisions of an expert public body such as a state licensing board. As a matter of policy, therefore, the Review Committee will presume that acts of a state licensing board taken pursuant to statutory authority are valid and worthy of respect. That is, absent some factual and compelling reason to believe that the licensing board's decision-making process violated the licensee's right to due process, we will not attempt to decide *de novo* whether the state licensing board acted properly. It is the burden of a certificant charged with violation of the Disciplinary Policy to show such a reason. Although we acknowledge that the presumption of validity may be difficult to overcome in any particular case, we believe that it is appropriate to AMCB's mission and circumstances.

The Committee is persuaded that no evidence exists that would cast doubt on the observance of due process in this case. The Committee is satisfied that the Ohio Board of Nursing acted under lawful authority and valid procedures.

Respondent was sanctioned by the Ohio Board of Nursing, a fact that she does not contest. Consequently, without more, a basis for discipline exists under section A.7. of the AMCB Disciplinary Policy. With regard to section 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), the Review Committee accepts the decision of the Ohio BON in its allegations regarding clinical decision-making. Thus the Committee recommends sanction under Section A.9 as well. The Committee accepts the requirements of the BON as appropriate and sufficient for this case.

SANCTIONS FOR VIOLATIONS

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

1. A Letter of Reprimand shall be issued.
2. A fine of \$500 will be assessed.

REVIEW COMMITTEE

Chair: Carol Howe, CNM, DNSc, FACNM

Member: Laura Valle, CNM, DNP, FACNM

Jessica Newgard, CNM, MN

Linda Hunter, CNM, EdD, FACNM
President, AMCB Board of Directors
Effective date: 11-11-2022