BEFORE THE REVIEW COMMITTEE
OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD

In the Disciplinary Matter of:

Eileen Stewart, CNM

Decision

The State of New York took action against Eileen Stewart, CNM (a/k/a Eileen S. Ort) in 2019. Ms. Stewart was licensed to practice and was recognized as a Registered Nurse and Certified Nurse Midwife with prescriptive privileges in the State of New York. The New York State Education Department (NYSED) Midwifery Board of Regents granted a Consent Order on May 8, 2019. The Consent Order (Cal. No. 29734) was enacted secondary to charges of delegating duties to an unqualified person, failing to appropriately administer antibiotics to a patient, permitting a pregnant patient to vaginally deliver a baby in breech position at registrant's home, failing to document a patient's vitals and failing to appropriately monitor the fetal heart rate of a patient's baby and providing a false statement to the New York State Education Department. Ms. Stewart did not contest the charges and agreed upon the penalty. The penalty was one (1) year probation, $2,500 fine, 30 months actual suspension, and upon successful completion of specified course of retraining, 3 years of stayed suspension, and 2 years probation to commence upon return to practice.

The allegations were based on the complaint of a patient under Ms. Stewart's care which was submitted to AMCB on January 13, 2020. The patient reported that her full-term son was catastrophically injured and died in August of 2016. Ms. Stewart was subsequently charged by the NYSED with multiple counts of negligence for her deviation from accepted standards of medical practice. The complainant also referenced the 2014 death of another infant under the Respondent's care which was settled in 2019 (NYS Supreme Court case index number: 813232/2016). This case was not reported to, nor reviewed by, AMCB and was not considered as part of the Discipline Committee deliberations when convened here.

The NYSED Office of Professional Discipline, State Board of Midwifery, specifications of professional conduct were cited as:

1. The Respondent (Eileen Stewart) in May and June 2013 allowed an employee of her practice to independently care for and/or treat and/or deliver the baby of a patient. The employee was an LPN.
2. The Respondent was charged with practicing the profession of midwifery with gross negligence between March 14 and November 28, 2014. The Respondent provided care to a nulligravid patient infected with Group B streptococcus. The baby was in frank breech from 30.4 weeks until birth. Gross negligence related to a) failure to perform a full and/or adequate assessment of the patient's ability to vaginally birth a frank breech infant, b) failed to provide intrapartum antibiotic prophylaxis within 18 hours of membranes rupturing, and c) allowed the patient to labor and attempt birth at the Respondent's home – which served as her office and practice.
3. Practicing the profession of midwifery with negligence on more than one occasion. Specifically, the patient was at 41.5 weeks gestation, experiencing labor, and had rupture of membranes. The Respondent failed to document vital signs and failed to monitor the fetal heart rate.

4. Unprofessional conduct and engaging in conduct in the practice of the profession which evidences moral unfitness to practice the profession. Specifically, the Respondent signed and submitted to the NYS Office of Professional Discipline false information. The Respondent knew the statement contained false information.

In accordance with AMCB procedures, Dr. Linda Hunter, President, reviewed the documents from the patient complainant and the Application for Consent Order from the NYSED Office of the Professional Discipline of State Board for Midwifery. In a certified letter dated May 27, 2021, the AMCB notified Ms. Stewart that a Discipline Review Committee had been appointed. The formation of this committee was in response to the consumer complaint and the Consent Order which suggested a possible violation of the AMCB's Discipline Policy:

A.7 Limitation or sanction by federal, state or private licensing board, administrative agency, association or health care organization related 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 AMCB notice requested that the Respondent submit a written answer to these charges within 30 days of receipt of the letter. AMCB received an email of response to the notice of disciplinary proceeding from Ms. Stewart on June 23, 2021. Ms. Stewart provided a limited response, stating she would provide an "abbreviated version of the situation and remain available if you require more information." On August 17, 2021, the committee requested additional information. Specifically, the Discipline Committee requested:

1. The entire medical record of the complainant
2. The Respondent's and/or Buffalo Midwifery Services' Clinical Practice Guidelines or Policies in effect at the time of the incident
3. The findings of the root cause analysis performed by the hospital and NYS Department of Health, as referenced in the email response dated June 23, 2021

Ms. Stewart was also asked to clarify if she had enrolled and completed a midwifery re-education program at the Midwifery Institute at Jefferson (or any other program approved by the NYS Board of Midwifery) as outlined in the NYS Consent Order. The information above was requested within 30 days. Ms. Stewart responded by email on August 30, 2021 that "It's clear by the request that I'm in some kind of process that I don't understand." And "I am not interested in practicing as a license[d] midwife again." In an email from AMCB dated September 2, 2021, the process was clarified and Ms. Stewart was encouraged to provide the requested information. Ms. Stewart responded on September 17, 2021 that she was "….no longer in active clinical midwifery practice" and that she was sending "…what I have access to." Documents received included:

- Medical records for patient/complainant from Buffalo Midwifery Services from October 2015 through August 2017. No medical records were submitted related to transfer and subsequent care of the patient/complainant at the transfer facility.

- Findings of the Root Cause Analysis performed by the hospital and NYS DOH *as summarized by the Respondent* and dated January 31, 2017. The submitted report was not the official report by the NYS DOH.
- Practice Agreement between Eileen Stewart, CNM and Katharine Morrison, MD which was dated May 25, 2011.

Upon review of materials, additional concerns were noted by members of the Discipline Review Committee to include a possible additional violation of AMCB's Discipline Policy:

A.6 Gross or repeated negligence or malpractice in professional work.

This additional violation was based on review of the NYSED Office of Professional Discipline, State Board for Midwifery Application for Consent Order.

Findings

The Review Committee finds the following facts:

1. AMCB (previously known as ACC) was formed in 1991 by the American College of Nurse-Midwives 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 in November 2012.
3. Respondent Eileen Stewart was initially certified by AMCB (formerly ACC) in June of 2000 and is currently certified through 12/31/2021 (certification #7069).
4. It is unclear when the initial complaint was received by the NYSED Office of Professional Discipline State Board for Midwifery.
5. The NYSED State Board for Midwifery, following review of the complaint, charged Ms. Stewart with violation of the NYSED State Board of Midwifery standards and brought a Disciplinary Proceeding against the Respondent (dated December 10, 2019). The four (4) specifications in the Application for Consent Order regarding professional conduct were as follows:
    - The Respondent (Eileen Stewart) in May and June 2013 allowed an employee of her practice to independently care for and/or treat and/or deliver the baby of a patient. The employee was an LPN.
    - The Respondent was charged with practicing the profession of midwifery with gross negligence between March 14 and November 28, 2014. The Respondent provided care to a nulligravid patient infected with Group B streptococcus. The baby was in frank breech from 30.4 weeks until birth. Gross negligence related to a) failure to perform a full and/or adequate assessment of the patient's ability to vaginally birth a frank breech infant, b) failed to provide intrapartum antibiotic prophylaxis within 18 hours of membranes rupturing, and c) allowed the patient to labor and attempt birth at the Respondent's home – which served as her office and practice.
    - Practicing the profession of midwifery with negligence on more than one occasion. Specifically, the patient was at 41.5 weeks gestation, experiencing labor, and had rupture of membranes. The Respondent failed to document vital signs and failed to monitor the fetal heart rate.

- Unprofessional conduct and engaging in conduct in the practice of the profession which evidences moral unfitness to practice the profession. Specifically, the Respondent signed and submitted to the NYS Office of Professional Discipline false information. The Respondent knew the statement contained false information.

The Respondent did not contest the Application for Consent Order and signed the document on December 3, 2019.

The Application for Consent Order established the terms of probation which stated the following (summarized):

- Respondent submit written notification to the NYSED any change in residence or contact information
- Respondent will not participate in any way in labor and delivery in a home setting
- Respondent agreed to the penalty on her license to practice as a midwife in NYS be suspended for three (3) years with leave to apply for a stay of execution of any unserved portion of said suspension upon completion of 30 months of said suspension and upon written proof of the successful completion of a course of re-education in the practice of midwifery at the Midwifery Institute at Jefferson, Philadelphia PA (or other NYS Midwifery Board approved program). Upon successful program completion, the Respondent would be notified of a stay of execution of any unserved portion of said suspension.
- Respondent to be placed on probation for a period of two (2) years to begin if and when the Respondent return to practice as a midwife in NYS.

The Discipline Committee reviewed the documents requested from the Respondent to include:

- Medical Records for the complainant (October 2015 through August 2017) from the Buffalo Midwifery Services practice.
- Signed statement of the practice agreement between the Respondent and Katherine Morrison, MD that was in place from May 25, 2011.
- Respondent summary of the Root Cause Analysis conducted by the NYS DOH.

Discussion

In this matter, we were called upon to decide whether and what discipline is warranted against the CNM, Eileen Stewart, regarding the patient complaint and the NYSED Board of Midwifery Application for Consent Order.

There is evidence, by the Respondent's own admission in the signed Consent Order, that she was responsible for a) delegating duties to an unqualified person, failing to appropriately administer antibiotics to a patient, permitting a pregnant patient to vaginally deliver a baby in breech position at registrant's home, failing to document a patient's vitals and failing to appropriately monitor the fetal heart rate of a patient's baby and providing a false statement to the New York State Education Department. Ms. Stewart did not contest the charges and agreed upon the penalty. The penalty was one (1) year probation, $2,500 fine, 30 months actual suspension, and upon successful completion of specified course of retraining, 3 years of stayed suspension, and 2 years probation to commence upon return to practice.

In addition to review of the Application for Consent Order, the Discipline Committee also reviewed documents provided by the Respondent. The Committee found:

- The complainant medical records were substandard. The patient entered care with the Respondent at 35.3 weeks gestation following transfer of care from Katherine Morrison, MD (Respondent consulting physician). Once entering midwifery care, documentation was noted to be substandard. During active labor, the records lacked documentation of timely fetal surveillance (e.g., no documentation of FHTs from 9:30 a.m. until 9:15 p.m. while in active labor), evaluation of estimated fetal weight or fetal presentation when in active labor, lack of documentation regarding frequency/length of hydrotherapy, and maternal vital signs (e.g., maternal temperature never documented). There were no records regarding the transfer process nor for care following transfer; records only state "asking for pain control, anxiety rising not coping deciding for transfer". If the Respondent had privileges at the transfer facility, it would have been prudent to submit the patient's medical records related to such. In addition, the Root Cause Analysis (RCA) by the NYS DOH was summarized by the Respondent and was not the official report. The summary did identify data regarding care that were not in evidence in the medical records that were submitted from Buffalo Midwifery Services. However, other evidence refutes the RCA summary. Specifically, the RCA notes that the patient was told "not to use a jacuzzi hot tub during labor" yet on August 2, 2016, the midwifery antepartum note at 404 weeks states "Checked logistics of water birth/vs laboring in hot tub and swimming pool outside in yard." A home birth was planned (per midwifery note on July 22, 2016 at 39.0 weeks) and it is unclear if the patient was counseled regarding need to refrain from hot tub use during labor. The labor record notes that the patient was "Out of hot tub" at 9:45 p.m. on August 10, 2016 – which was approximately 3 hours and 15 minutes prior to transfer and 16 hours prior to her cesarean birth.
- The Respondent's Collaborative Practice Agreement was close to a decade old though was in place. Policies, protocols, and procedures to be followed were based on four (4) midwifery/women's health documents. No edition is identified and given that the agreement was signed in 2011, the sources would likely be outdated.

In summary, it was the Discipline Committee's unanimous decision that the Respondent violated AMCB's Discipline Policy (2018). Specifically, there was evidence of gross or repeated negligence or malpractice in professional work (A6), limitation or sanction by federal, state, or private licensing board, administrative agency, association or health care organization related to public health or safety of midwifery practice (A7), and 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 (A9). There were documented adverse patient outcomes as noted in the patient complaint and NYSED Board of Midwifery Consent Order. The Respondent concurred with these accusations. Materials that were available indicate substandard care and do not provide evidence that would otherwise refute the Consent Order.

Therefore, the Disciplinary Review Committee recommends AMCB sanction the certificant by ***revoking the certification*** of Eileen Stewart.

REVIEW COMMITTEE

Marie Hastings-Tolsma, PhD, CNM, FACNM, Chair
Julia Lange Kessler, CM, DNP, FACNM
Lauren Olvera, CNM, DNP

Linda A. Hunter, CNM, EdD, FACNM
President, AMCB Board of Directors
Effective date: 1-10-2022