BEFORE THE REVIEW COMMITTEE
OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD

In the Disciplinary Matter of:

Angela Michelle Kreider, CNM
Respondent

DECISION

On December 9, 2021, the American Midwifery Certification Board (AMCB) received written notice from the State of California, California Board of Registered Nursing, of possible violations by Respondent Angela Michelle Kreider of AMCB's Disciplinary Policy. The violations concerned allegations that Respondent "engaged in multiple acts of gross negligence and demonstrated incompetence and unprofessional conduct" resulting in the death of the infant. The violations resulted in the revocation of Respondent's RN license, California Midwifery Certificate and Nurse-Midwife Furnishing Certificate. Further, AMCB received notice from the State of Nevada of revocation of Respondent's RN license based upon actions taken on her California license.

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 dated June 13, 2023, AMCB 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. in the Disciplinary Policy. The AMCB President referred the incident to a Review Committee for consideration of the following provisions.

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. The Respondent failed to reply. Three additional attempts (7/28/23, 8/16/23, and 9/12/23)

were made by Fed-Ex and email to contact Respondent, including a final notification that a meeting of the Review Committee had been scheduled and absent a response, they would have no choice but to proceed without her input.

A Review Committee comprised of a Chair (Carol Howe, CNM, DNSc, FACNM) and two qualified members (P. Fadwah Halaby, CNM, and Ruth Mielke, CNM, PhD, 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 good grounds for discipline against Respondent exist under sections A.7and 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 in April 2018.

3. Respondent was certified by AMCB on 1/16/2004.

4. Respondent has no known previous history of sanction on her license or certificate.

5. At the time of the incident in question, Respondent was licensed, with furnishing privileges in the state of California, practicing under the business name "Women's Circle Nurse-Midwife Services" and offering prenatal care and home birth. Respondent had Practice Guidelines and Policies signed jointly by the Respondent and her collaborating physician. Said Guidelines and Policies detailed transfer procedures in the event of complications, including the statement "All decisions regarding care will be discussed with you."

6. No trained birth assistant was present during labor or birth. An independent doula with no medical training was present for labor support.

7. On or about March 22, 2016, Respondent attended the birth of patient KH in the patient's home. At the time of birth, the infant emerged severely depressed with Apgars 4 (1 minute) and 2 (5 minutes). The infant subsequently died at 1 hour 14 minutes of age.

8. Prenatal care of KH began in the first trimester and was provided consistently

throughout gestation until 38 weeks 2 days when she experienced spontaneous rupture of the membranes (SROM) prior to the onset of labor. No significant pregnancy risk factors were identified.

9. At the time of rupture of membranes, a culture for GBS was "pending," although the culture had been performed 4 days earlier and results are typically available after 48 hours.

10. The timeline of labor events follows.

3/20/16:

-1600: Spontaneous rupture of membranes. KH told to monitor temperature.
-2347: Doula arrived at the home of KH

3/21/16:

-0230: Spontaneous onset of contractions, 3-5 minute apart
-0810: Respondent arrives at the home of KH. Performs examination. FHTs "140s." Patient was advised to do an antiseptic "peri-wash" every 4 hours. This examination occurred less than 24 hours after SROM in the absence of active labor.
-1810: Respondent returned and performed a second examination, again in the absence of active labor. FHTs "130s." Respondent recommended castor oil and herbs for the stimulation of labor.
-2130: FHTs 140s. Respondent left.

3/22/16

-0300: Respondent returned to home of KH. At this time she was in active labor. FHTs 140s
-0400: FHTs 150s
-0430: KH entered birthing tub. Video camera positioned to document birth.
-0600: 9 cm dilated
-0630: Pushing. Birth photographer and doula present.
-0706: FHTs were taken one additional time while pushing. 140s. Infant was born at 0706.

10. The timeline of events after birth follows (all documented on video camera)

-0706: Birth. Infant was limp, pale and gasping.
-0 to 1 minutes after birth: Respondent dried infant and suctioned airway. Apgar 4, HR 40).
-1to 2 minutes after birth: Respondent obtained ventilation bag and mask, administered 9 puffs of air.
-2 to 3 minutes after birth: Cord clamped and cut. Infant moved to table and given more puffs of air. Per patient report, table was not heated nor was a warm blanket available. (Respondent asserts that there was a warm table and blanket.) Doula retrieved oxygen tank which had been left in Respondent's car.
- 3 to 4 minutes after birth: Respondent used bulb syringe to clear airway. Checked heart rate (first time with stethoscope.) There was inconsistent use of the ventilation bag. Respondent picked up infant attempting to stimulate breathing by bouncing

him.
4 to 5 minutes (4 min 45 seconds after birth): Listened to heart rate, suctioned. Respondent asked someone to obtain a homeopathic preparation found in the birth kit.
5 minutes after birth: Respondent suggested calling 911. Birth photographer made call.
5 minutes 22 seconds after birth: Respondent administered homeopathic preparation, then placed infant over her shoulder, bouncing him again.
-5.5 to 9 minutes after birth: Respondent then placed the infant on the table and began to administer CPR briefly then picked the infant up and began to pat his back.
9 minutes after birth: EMS arrived
11 minutes after birth: EMS began resuscitative efforts. Respondent reported to EMS that the infant was unresponsive with a one-minute Apgar of 4. Per EMS, infant was blue and not breathing. EMS reported that Respondent continued to try to stimulate the baby and administer oxygen, interfering with EMS resuscitative efforts.
12 minutes and 30 seconds after birth: Infant was moved to the ambulance where he was intubated, and CPR was continued.
16 minutes 30 seconds after birth: Infant at hospital.
1 hour 14 minutes after birth (0820): Infant was pronounced dead.

11. At no time in the course of labor, and not until 5 minutes after the infant's birth, did Respondent initiate discussion of hospital transfer.

12. Respondent was sanctioned by the Board of Registered Nursing in California (revocation of license) and the Board of Nursing in Nevada (revocation of license). California sanctions were based upon the incident in question. Nevada sanctions were based upon action on Respondent's California license.

13. After being duly informed of the proceeding, neither the Respondent nor any legal representative appeared at the California hearing at which her allegations were considered. The hearing ensued "as a default against Respondent."

14. Respondent was interviewed prior to the hearing. As a result, the California report contained some responses by the Respondent to the allegations of substandard care. Respondent admitted that she had no birth attendant present and that the oxygen tank was in the car. She disputed allegations that she did not have a warm area for resuscitation. Respondent produced documentation indicating that fetal heart rate (FHR) checks were done every half hour in active labor, every 15 minutes while pushing, and twice between 0655 and 0700. Notes taken by the doula. Respondent's description of resuscitative efforts was somewhat in alignment with NPR standards (with the exception of bouncing the baby) but does not comport with the data found on the video.

15. Respondent did not respond to multiple communications from AMCB, including a letter informing her of the date and time of the Review Committee meeting constituted to address her clinical care in the case of KH.

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 available documents, including the Decisions rendered by the California Board of Registered Nursing and the Decision of the Nevada Board of Nursing. No documents or responses were submitted by the Respondent. Review of these documents lead the committee to conclude that Respondent did not meet the expected standard of care in the following instances:

a. Management of spontaneous rupture of membranes prior to the onset of labor
    a. Not having GBS status documented 4 days after the culture was taken.
    b. Performing 2 vaginal examinations prior to the onset of active labor, the first of which was less than 24 hours after PROM.
    c. Failing to discuss options for induction/augmentation of labor including transfer to hospital.
    d. Failing to discuss/recommend the option of antibiotic prophylaxis given 1) no available GBS results and 2) greater than 24 hours of ruptured membranes
b. Neonatal Resuscitation (documented on video).
    a. Not having resuscitation equipment available in the presence of a severely depressed infant. The availability of warm table and blankets are in dispute; the oxygen tank was in Respondent's car.
    b. Not having an NRP certified birth attendant to assist with resuscitation.
    c. Performing resuscitative efforts inconsistently – puffs of air, bouncing the infant over shoulder, intermittent CPR.
    d. Using homeopathic remedies that are not a part of the NRP protocol and have no evidence to support efficacy in an emergent situation.
    e. Summoning EMS only after 5 minutes following birth.
    f. Interfering with EMS attempts at resuscitation.

With regard to spontaneous rupture of membranes prior to onset of labor with unknown GBS status, Respondent should have deferred vaginal examination until the onset of active labor. If vaginal examination was indicated, Respondent should have appreciated the increased risk of infection that would then require recommendation of stimulation or augmentation of labor and prophylactic antibiotics.

With regard to neonatal resuscitation, oxygen should have been immediately available. An NRP certified birth assistant should have been in attendance. American College of Nurse-Midwives Clinical Bulletin "Midwifery Provision of Home Birth" (December 2015) stipulates that "a minimum of 2 health care professionals who have current NRP training and CPR certification" should be present. Further, Guidelines for Perinatal Care (ACOG and AAP) require that one person with neonatal resuscitation skills *whose sole responsibility is the infant* be present at birth. This person, by definition, cannot be the attending midwife as their responsibility includes both mother and infant. If the Respondent was unable to secure an adequately trained birth attendant, she should

have informed the patient that she could not safely attend a home birth.

The resuscitative efforts as described from the professional video clearly do not describe the sequences described by NRP – warmth under radiant heat, infant's head in a "sniffing" position, clearing airway, drying infant and stimulating breathing. After 30 seconds with no improvement, moving to positive pressure ventilation (PPV) followed by reassessment every 30 seconds is recommended. If no improvement in the infant's condition, chest compressions and PPV is instituted after 1 minute. By 1.5 minutes, epinephrine and/or volume expanders should be considered (Neonatal Resuscitation Guidelines, Circulation, 2005), although in a home birth situation it would be reasonable to consider consistent effective CPR until additional help is available. With no clear improvement, and indeed some deterioration, in this infant's condition (Apgar 2 at 5 minutes, heart rate 40), emergency assistance should have been requested significantly sooner than 5 minutes.

The Committee is persuaded that the Respondent breached the standards expected of Certified Nurse-Midwives in a home birth 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 licensing boards in California and Nevada. 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 recommends revocation of Respondent's AMCB certification.

Effective: 12-13-23

REVIEW COMMITTEE

Carol Howe, CNM, DNSc, FACNM, FAAN, Chair
Ruth Mielke, CNM, PhD, FACNM
P. Fadwah Halaby, CNM