BEFORE THE REVIEW COMMITTEE
OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD

In the Disciplinary Matter of
Caroline Protter, CNM
Respondent

DECISION

On 10/8/2024, the American Midwifery Certification Board (AMCB) received notice from the New York State Education Department, Office of Professional Discipline, State Board for Midwifery (State Board for Midwifery) that action (suspension) had been taken upon the midwifery license of Caroline Elayne Protter, CNM (Respondent). Professional misconduct was alleged in the care of two patients. In the first instance, the patient experienced a delay in receiving antibiotic prophylaxis for Group Beta Streptococcus (GBS) and in addition was left in the care of a Registered Nurse for 20 minutes without the presence of a midwife during her labor at home. The infant was stillborn as a result of GBS sepsis. In the second instance, the patient received inadequate monitoring for gestational diabetes. (GDM). That infant was also stillborn after an emergent cesarean section. The Respondent did not contest these allegations. In accordance with AMCB procedures, the complaint was reviewed by the President of AMCB, who determined that the matters alleged in the notice of possible violation, if true, could constitute grounds for disciplinary action.

Accordingly, by letter dated 7/9/2025, AMCB notified Respondent that it had initiated a disciplinary proceeding to determine whether good grounds existed for discipline under the provisions of Section A.9 of the Disciplinary Policy:

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 receipt of the July 9th notice. On 8/11/2025, AMCB received a response from the Respondent. Respondent also promptly responded to two requests for additional information.

A Review Committee comprised of the Chair of the Discipline Committee and two additional members was duly convened. Members of the Committee were Carol Howe, CNM, DNSc, FACNM, FAAN (Chair), Nicole Chen, CNM, MSN, and Lauren Olvera, CNM, DNP.

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 formal discipline against Respondent exist under section A.9.

FINDINGS OF FACT

The Review Committee finds the following facts:

1. AMCB (formerly known as ACC) 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 in April, 2018.

3. Respondent was certified by ACNM in May, 2019.

4. AMCB received notice from the New York State Board for Midwifery that Respondent's midwifery license had been sanctioned for complaints alleging that Respondent:

> a. Failed to provide GBS antibiotic prophylaxis in a timely manner and left a home birth patient in active labor with no midwife in attendance (but in the care of an RN) for a period of approximately 20 minutes. The infant was stillborn due to GBS sepsis.
> b. Failed to monitor properly for GDM in a second patient. That infant was also stillborn.

5. The State Board for Midwifery suspended Respondent's midwifery license for a period of three (3) years with the option of reapplying for licensure on completion of the period of suspension. Respondent did not contest the suspension.

6. AMCB received a response from the Respondent admitting the substance of these complaints but noting that a variety of factors influenced her clinical care. These included that the Respondent was a new graduate who was hired in to what she later viewed as a toxic work environment in which transfer to hospital from home or birth center was often reprimanded and in which practice guidelines frequently did not reflect current standards. Respondent notes a consistent lack of support from the employer, citing for example, Respondent's decision to leave a patient in active labor for 20 minutes. While attending to a patient in active labor another call came indicating another patient was laboring with delivery imminent at home. The employer was the back-up midwife but was unprepared to assume care of the second patient. Respondent called for help from another midwife in the practice and left the first patient to attend second one while the third midwife rushed to attend the first patient. Further, Respondent notes in the second case, although the screening for GDM was inadequate and did not meet nationally accepted standards, it did reflect the practice guidelines developed by the employer that the midwives were expected to follow.

DISCUSSION

In this matter we are called upon to decide whether and what discipline is warranted against a CNM who has had her midwifery license suspended as a result of finding that patient care did not meet widely accepted standards of practice.

Our decision is informed by the documents submitted by the New York State Board for Midwifery and by the Respondent. In addition, the Committee had access to statements from a co-worker that corroborated issues related to the work environment and the timeline of the Respondent's responsibilities for care of the second patient (inadequate GDM screening allegation). It should be noted that the discussion was hampered by the lack of clinical evidence submitted by the State Board for Midwifery. Lacking access to patient records, the committee was forced to rely primarily on responses provided by the Respondent. Of note, the Respondent was very prompt in response to several requests for additional details.

The review will be framed by discussion of the two patient cases separately. The first case presented two allegations, the first that antibiotic prophylaxis was delayed resulting in GBS sepsis causing the death of the infant and the second that the patient was left unattended by a midwife for 20 minutes in active labor.

The patient in the first case was a multipara who had tested positive antenatally for GBS and initially agreed to the administration of intravenous (IV) antibiotics per national recommendations. However, when the first attempt at the placement of an IV failed, the patient declined a second attempt. Respondent (per her report) reviewed the risks of foregoing IV prophylaxis in detail and obtained the patient's signature on a form used for informed refusal provided by the practice. She also revisited the subject with the patient periodically throughout labor. Subsequently, the patient agreed to antibiotics but only when labor was far advanced after the second midwife assumed care. The decision of the committee is that Respondent's actions were consistent with midwifery standards, including providing relevant information and recommendations, respecting patient autonomy and documenting the counseling and recommendations given.

In addition to the issue of GBS prophylaxis in this patient, the New York State Board for Midwifery alleged unsafe clinical decision-making in a situation regarding the need to cover care for two separate patients in active labor at home with delivery potentially imminent. Respondent chose to leave the first patient to attend to the second while arranging for coverage for the first patient, leaving a gap of approximately 20 minutes in which the first patient had no midwifery coverage at all. Additional information indicated that the first patient (a multipara) was almost completely dilated (only an anterior lip of cervix remained) and had recently had a blood pressure of 160/100 (in the context of previous normal blood pressures). Auscultation of the fetal heart rate revealed intermittent variable decelerations, the last of which occurred several hours earlier with no evidence of fetal compromise. A plan to retake the blood pressure in 30 minutes was made. Of note, a multipara at that stage of labor can deliver in 1-2 contractions if the fetal position is favorable. It was at this point that Respondent received a call that another patient was laboring at home and had not notified the midwife-on-call (Respondent) earlier. As noted earlier, having found that the back-up midwife (her employer) was not prepared to assume care of the

second patient, Respondent called a third midwife to care for the first patient and left to care for the second.

The Committee grants that this was an untenable situation. However, it is the consensus of the Committee that Respondent's first priority was the patient already in her care, particularly with the elevated blood pressure. A wait of 30 minutes to retake the blood pressure was too long. The attendance of a midwife would have been mandatory in this situation. The second patient should have been told to call for an ambulance transfer to the hospital, especially since she had not provided adequate notice of her labor status. It is likely that the employer would have been angry that a patient was transferred (thus losing the ability to bill for labor care). Nevertheless, this circumstance was acute with significant implications for fetal health. It is likely that the infant would have succumbed due to the GBS sepsis regardless of the abandonment by the midwife. However, should delivery have occurred without the presence of a midwife there would not have been anyone there licensed to conduct the birth or the subsequent infant resuscitation that would have been required. The Committee is unanimous in its opinion that Respondent response to this situation did not constitute good clinical decision-making.

Allegations were also made regarding the care of a second patient with regard to proper screening for gestational diabetes. This patient was a G2 P1001without a history of GDM but with a history of Polycystic Ovary Syndrome (PCOS) which is associated with GDM. Standard of care would consist of a 1-hour glucose screen followed by a 3-hour glucose tolerance test if the result of the 1-hour test was elevated. GDM would be diagnosed if 2 or more values (out of 4) were elevated (United States Preventative Services Task Force). An additional option offered in the policies of the midwifery practice was glucose monitoring four times daily for four days. If elevated blood glucose recordings were noted, the patient was asked to monitor her glucose four times daily for an additional 1- 2 weeks. In this case, the patient chose the non-standard option and had several elevated levels the first week. The patient was asked to continue monitoring. During the subsequent monitoring, fewer levels were elevated. It is not clear if the patient was asked to change her diet. Nevertheless, this protocol is not evidence based. There are no published clinical trials to support this mechanism of screening nor universally accept cut-off levels that would diagnose GDM. Although information regarding estimated fetal weight is not available to the Committee, the infant birth weight was 8lb 3oz which is within normal limits for a term infant and not necessarily indicative of a missed GDM diagnosis. Further, while the Respondent admitted the patient in labor, she managed only the first 2 hours, while a colleague managed the labor for the remaining 14 hours, after which the patient was transferred for an emergent cesarean section for fetal distress. Although the exact cause of death for the infant is not clear, it does not appear to be related to GDM. The Committee unanimously agrees that Respondent, while not using recognized standards for diagnosis of GDM, did follow her practice guidelines and was not responsible for the death of the infant.

Finally, the Committee notes that while the Respondent was cooperative with the review process. Respondent's initial statement was that she accepted full responsibility for her actions and did not contest the findings of the New York Board for Midwifery. However, her response thereafter focused largely on the toxic work environment and how the expectations of her employer governed her decision-making especially in situations in which transfer of care to the hospital was an issue. In particular, it was apparent that the decision to recommend transfer of

care to the hospital engendered significant negative feedback. In addition, until she was actually employed, she was unaware that the practice had recently lost its hospital privileges and physician consultant. Respondent felt compelled to remain in the practice due to financial considerations. As a result, the Committee asked the Respondent to address what she would have done differently in retrospect, not just in the clinical decision-making but in the decision to accept employment in this practice. The response that was received was complete and well-reasoned, showing significant understanding of the circumstances that led to these disciplinary proceedings and a determination not to place herself in a similar situation again.

The Committee is persuaded that while the Respondent was not responsible for either fetal death, the decision to leave a multiparous patient who was almost completely dilated without a midwife in attendance clearly did not meet adequate standards for midwifery care.

SANCTIONS FOR VIOLATIONS

The Review Committee has determined that the following sanctions will be imposed.

1. Reprimand of Respondent's AMCB Certification. A letter of reprimand will be issued.
2. Respondent is required to develop a short reference or guideline targeted at new midwifery graduates that addresses the issues, red flags and questions that are critical for midwives to consider before applying for their first midwifery job.
3. A fee of $500 to cover the AMCB costs related to the disciplinary process.

Effective: 3-23-2026

REVIEW COMMITTEE

Carol Howe, CNM, DNSc, FACNM, FAAN, Chair
Nicole Chen, CNM, MSN
Lauren Olvera, CNM, DNP