

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

In the Disciplinary Matter of:

Jenny Olson, CNM

Respondent

DECISION

On September 3, 2019 the American Midwifery Certification Board (AMCB) received a written complaint from a patient (Complainant) of Jenny Olson, CNM (Respondent), of possible violations of AMCB's Disciplinary Policy. The alleged violations concerned allegations that Respondent breached standard of care by inadequate assessment and inappropriate treatment for Complainant's Polycystic Ovary Syndrome (PCOS) that resulted in the prescription of a potentially teratogenic drug, Spironolactone, in a patient who was subsequently found to be pregnant.

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 September 1, 2020, 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 I.A.9. of the AMCB 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 allegations within 30 days of receipt of the September 1, 2020 letter. On October 1, 2020, Respondent submitted her written answer to the charges, which consisted of a letter describing her care of the Complainant.

A Review Committee comprised of a Chair and two qualified members was duly convened.
Chair: Carol Howe, CNM, DNSc, FACNM, DPNAP, FAAN
Member: Kathleen Bailey, CNM, MA, MS, FACNM
Member: Michele Megregian, CNM, MSN

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 section 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 AMCB in June, 2016.
4. Respondent provided midwifery care for Complainant on three (3) separate occasions:
 - a. First visit: annual exam, last menstrual period 21 days prior to this visit.
 - b. Second visit 3 days later: lab review and prescriptions for oral contraceptive, metformin and spironolactone.
 - c. Third visit approximately 6 weeks later: New OB (following evaluation in Emergency Room for cholecystitis. Pregnancy was diagnosed at that time.)
5. At the first visit, Patient X presented with previous history of PCOS and hypertension. ROS was noted to be negative. Menstrual cycles were notable for “normal frequency.” There was no mention of birth control use or unprotected intercourse. Breast symptoms were significant for “enlargement.” (Patient X reported an increase of 2-3 cups sizes.) Physical examination was within normal limits. Uterus was noted not be enlarged.
6. At the second visit, both LH and FSH hormones were noted to be significantly low, while Testosterone and Prolactin were significantly elevated. DHEA sulfate was within normal limits. An oral contraceptive, metformin and spironolactone were prescribed. Patient X was told that with these lab values it would be “very hard for me to get pregnant.”
7. At the third visit, the patient reported being seen in the ER for symptoms of cholecystitis where an incidental diagnosis of pregnancy was made. An ultrasound was consistent with 14w5d gestation. A new OB workup was done. Patient X expressed concern regarding the prescription of spironolactone which has been reported to feminize the genitalia of a male fetus.

Physician consultation was obtained and “discussed her concerns with her and FOB.” Patient X thereafter transferred her care to another provider.

8. The reported LMP and Respondent’s examination at the first visit were not consistent with the gestational age ultimately determined by ultrasound. Based upon the ultrasound, the pregnancy would have been 8 weeks gestation, with the uterus slightly enlarged, softened and more globular than pear shaped.

9. Complainant’s allegations include:
- a. She presented with symptoms consistent with pregnancy (weight gain, increase in breast size) that were overlooked by Respondent. She was told to see a nutritionist and begin an exercise program.
 - b. Respondent failed to order a pregnancy test prior to starting a medication, spironolactone, that is contraindicated in pregnancy and in the presence of breast enlargement.
 - c. Respondent was dismissive and defensive when confronted with Complainant’s concerns.

DISCUSSION

In this matter we are called upon to decide whether and what discipline is warranted against a CNM who has had a complaint submitted to AMCB regarding her patient care.

Our decision is guided by review of the Complaint, the medical records from the three (3) visits in question, and the reply from the Respondent. The Committee requested copies of the Respondents practice guidelines (as required by the Standards for the Practice of Midwifery: Standard V) but did not receive those guidelines. Instead, Respondent sent copies of an ACOG Committee Opinion (Access to Contraception, 2015) and a CDC publication (U.S. Selected Practice Recommendations for Contraceptive Use, 2016).

The Committee is persuaded that Respondent used poor judgement in the prescription of both oral contraception, and in particular spironolactone, without confirming that the Complainant was not currently pregnant. Although the signs of pregnancy or potential pregnancy were subtle, they were nevertheless appreciable – reported regular menstrual cycles, weight gain, and breast enlargement. The patient was, in retrospect, eight (8) weeks pregnant. Although not detected by the Respondent, it is likely that uterine changes were there at that time, although perhaps difficult to ascertain due to body habitus. Simply requesting the patient to start her contraception and other prescriptions after the next menstrual cycle would have prevented the prescription of drugs inappropriate for use in pregnancy. Further, the laboratory results were likely more compatible with pregnancy than with PCOS. In particular, levels of LH (which are elevated in PCOS) were exceptionally low, consistent with pregnancy. Other laboratory findings (FSH, DHEAS, Prolactin and Testosterone) were not sufficiently irregular to be diagnostic of either PCOS or pregnancy.

Other concerns include the prescription of oral contraceptives in a patient with a history of hypertension and the prescription of 3 new drugs at once (regardless of the potential for pregnancy). A safer approach is to prescribe one new drug and determine the response. If the response is not

satisfactory, a second drug may be prescribed, and the process repeated. It does not appear that spironolactone, although a drug that is used for some androgenic symptoms, was indicated at this time. It is more appropriate as a second or third drug in the sequence of treating this syndrome. Follow-up for determining the response to the medication is more appropriately a 3-month interval rather than 6 months.

Respondent's reply to the Review Committee included:

- A. "She also reported having regular cycles so there was no reason to believe at the time that she was pregnant." "When she returned for her results on...she still had not missed a cycle so I still would not have had a reason to do a pregnancy test." In fact, regular cycles would indicate that she was or could be fertile and there was no report of current use of contraception. In addition, Complainant reported signs and symptoms consistent with early pregnancy.
- B. "When I saw [Complainant]..., I had only been practicing for 10 months despite having graduated almost three years prior, as such there has been a re-learning curve." Lack of experience does not justify poor judgement.
- C. "...I made changes to my practice by ordering a pregnancy test prior to initiating both birth control and Spironolactone." While this is a positive change, it does not address the fact that there was evidence of a potential for pregnancy that was not appreciated. While verification of pregnancy prior to the prescription of birth control and Spironolactone is a good personal protocol, there are other medications that are also contraindicated and safe practice requires not only protocol, but sound clinical judgement. It is of concern that the proposed change in practice is protocol driven rather than including a commitment to understand the interface between clinical knowledge (e.g. laboratory values) and clinical judgement (appreciation of subtle clinical findings, laboratory findings and potential differential diagnoses). Of note, had the Complainant been given a pregnancy test at the first appointment, it might not have been positive as she was only 7 days post (presumed) conception. Most commonly used pregnancy tests are positive at 6-8 days post conception. In retrospect, the last reported menstrual cycle likely represented pre-implantation bleeding, a situation that was also not considered in clinical decision making.

With regard to the complaint that Respondent was dismissive and defensive in her interaction with the Complainant, this Committee can make no judgement. Interactions are colored by perceptions on both sides and the Committee was not party to the conversation.

SANCTIONS FOR VIOLATIONS

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

1. Letter of Reprimand. Letter of reprimand shall be issued to Respondent.
2. Fine: A fine of \$500 shall be assessed.
3. Practice Guidelines: Respondent shall submit a copy of her practice guidelines within 8 weeks of receipt of Letter of Reprimand.
4. Annotated Bibliography and Case Report: Respondent shall complete an annotated bibliography of at least 5 sources including the following topics: diagnosis and management of PCOS, lab interpretation in PCOS and early pregnancy, and medication use in PCOS. A brief case report summarizing the findings of this case in the context of the material found in the bibliography and discussion of what Respondent would do differently now must accompany the annotated bibliography. These are to be returned to AMCB within 3 months of receipt of the Letter of Reprimand.

Effective: 1-28-2021

REVIEW COMMITTEE

Carol Howe, CNM, DNSc, FACNM, DPN,
FAAN, Chair

Kathleen Bailey, CNM, MA, MS, FACNM
Michele Megregian, CNM, MS

Linda Hunter CNM, EdD, FACNM
AMCB President, Board of Directors