

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

In the Disciplinary Matter of:

Julie Stackhouse, CNM: Respondent

**DECISION**

On September 14, 2018, the American Midwifery Certification Board (AMCB) received a complaint from a physician in Indiana who accepted a home birth transfer from Julie Stackhouse, CNM, Respondent. The Complainant alleged that an incident involving a prolapsed umbilical cord was improperly managed, resulting in the death of the infant. These allegations, if true, would be a violation of ACNM Standards for the Practice of Midwifery and would constitute a violation of AMCB's Disciplinary Policy

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 January 14, 2021, AMCB notified Respondent that AMCB had initiated a disciplinary proceeding to determine whether good grounds existed for discipline under the following provision of Section VI.A. 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 statement regarding the incident within 30 days. Of note, Respondent did not comply with the request. The letter was sent by Fed-Ex with a signature required upon receipt. A signature (DD) was obtained by Fed-Ex. It is not clear, however, if the signature belonged to the Respondent. When a reply had not been received within 30 days, an email was sent on 4/14/2021 to the address on record with AMCB from Respondent's recertification in 2020 and which was presumed to be current as no bounce-back was received.

A Review Committee comprised of a Chair (Carol Howe, CNM, DNSc, FACNM) and two qualified members (Jody Perez, CNM, MS and Hillary Kieser, CNM, MS, APRN-FPA) was duly convened.

After discussion, the Chair of the Review Committee and the AMCB Discipline Director determined that it was not possible to conduct a review without some additional information that could corroborate the physician's complaint. A letter was sent to the physician asking if further information could be obtained, either in the form of medical records or a statement from the patient. The physician contacted the patient and received permission for AMCB to communicate with her. The patient subsequently submitted a six (6) page detailed statement to AMCB. The physician had not submitted a complaint to the Indiana licensing board.

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 March 2006.
4. Respondent has no known previous history of sanction on her license or certificate.
5. On or about September 11, 2018, Respondent attended the birth of patient DS in the patient's home. The patient was a Gravida 6 Para 5 with a history of precipitous birth. In the course of the labor and birth, which was described by the patient as "different" from her previous experiences, Respondent ruptured the amniotic membranes at complete dilatation, the umbilical cord prolapsed and the cervix retracted to 8 cm.
6. According to the physician's statement and based upon Respondent's report during the transfer of care, Respondent told the patient to push and when that did not result in delivery, a vacuum extractor was applied. When the vacuum extractor was not successful, the patient was transported in a sitting position to the hospital by the Respondent in her personal vehicle. Upon arrival, fetal heart tones were not heard, and a stillborn infant was subsequently delivered.
7. The statement received by the patient confirms the sequence of events contained in the physician complaint. Further, patient alleges that Respondent told the father to apply fundal pressure while the vacuum extractor was applied. In addition, the statement describes Respondent's demeanor, reporting that Respondent "was almost going out of her head" and making statements such as "Oh, I've had other bad experiences and I'm afraid this outcome is not gonna be good either" and "Gotta go for help, this is NOT gonna be good!" The patient states she was told to get in the car with her legs over the back of the seat, but that proved logistically impossible. She was thus transported "being slumped down a bit leaning on my left side." According to the physician report, Respondent defended transport in her personal vehicle because "the infant was already dead" although the patient reports fetal movement just prior to transport.
8. The sequence of events is reported by the physician and patient was:

- a. Artificial rupture of membranes with prolapse at complete dilatation: 7:30 am (per physician as reported by Respondent)
  - b. Retraction of cervix to 8 cm; patient told to push immediately thereafter.
  - c. Vacuum extractor applied without success. Patient reports father was asked to provide fundal pressure to the uterus while vacuum was applied.
  - d. Transport to hospital (7:25-7:30 per patient)
  - e. Arrival at hospital: 7:53 (per physician)
  - g. After documentation of demise, infant delivered vaginally at 8:20 am)
9. There was no assistant at the birth.
  10. Fundal pressure is contraindicated due to risk of rupture of the uterus.

## DISCUSSION

In this matter we are called upon to decide whether and what discipline is warranted against a CNM who has had a formal complaint submitted to AMCB alleging failure to adhere to the standard of care regarding management of a prolapsed umbilical cord.

Our discussion was informed by review of the complaint submitted by the physician and by a detailed statement from the patient and her husband. We again note that the Respondent failed to reply to our requests for a statement and any other documentation she wished to submit.

Review of these documents lead the Committee to the following conclusions:

- a. Although the Respondent failed to provide a statement with her account of the incident, the independent statements from the physician and the patient were remarkably congruent, lending credence to the circumstances and timeline that were described. Respondent's reaction to the occurrence of the prolapsed umbilical cord did not meet with recognized standards for the management of this clinical situation. While given the patient's history of precipitous birth, it might have been worthwhile to try to effect rapid delivery with one push, when that failed, the next maneuver would have been to place the patient in knee-chest position while elevating the baby's head with her hand in the vagina to keep the baby's head from compressing the cord against the cervix. This movement should have been followed by a call to 911 for emergency transport to the hospital. Some sources recommend placing a urinary catheter filled with 500ml of normal saline to assist with elevation of the presenting part, especially if not in a position to effect immediate delivery. (Khan, 2017; Ahmed and Hamdy, 2018) While survival would not have been guaranteed, it would certainly have been more likely than having constant maternal pushing followed by application of a vacuum extractor and transporting in a sitting position resulting in continual disruption of fetal circulation. With regard to notifying 911, the patient reports that Respondent did have a mobile phone.
- b. Respondent also failed to meet standard of care for home birth by not having an assistant at the birth. The American College of Nurse-Midwives, in its Clinical Bulletin "Midwifery Provision of Home Birth Services" (2015) states:

*Ensuring that a minimum of 2 health care professionals, who have current Neonatal Resuscitation Program (NRP) training and cardiopulmonary resuscitation (CPR) certification, are present at birth and have the necessary knowledge and skills to independently make assessments and implement needed interventions as indicated;*

- c. Lastly, with regard to the Respondent's alleged unprofessional behavior (appearing panicked, statements regarding probable poor outcome), the patient's report is compelling, although it cannot be verified.

The Committee is persuaded that the Respondent's care of this patient did not meet the recognized standard of care for the management of a prolapsed umbilical cord. Further, the lack of an assistant at the birth violates standards for home birth. Accordingly, the Committee concludes 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."

### **SANCTIONS FOR VIOLATIONS**

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

1. Censure of Respondent's AMCB Certification. A letter of censure will be issued.
2. Continuing Education: Respondent is required to complete a continuing education course in birth emergencies. Committee recommends Birth Emergency Skills Training® focused on out of hospital birth, or equivalent to be approved by AMCB. The course must be completed by 12/31/2021. Failure to complete the course will result in reconsideration of sanctions Respondent's certificate, including possible loss of certification.
3. Fine. A fine of \$250 will be assessed.

#### REVIEW COMMITTEE

Carol Howe, CNM, DNSc, FACNM, FAAN, Chair  
Jody Perez, CNM, MS  
Hillary Kieser, CNM, MS, APRN-FPA

The Executive Committee for Discipline recommended that the AMCB Discipline Director put forth additional efforts to contact Respondent. Multiple attempts were made to contact Respondent via email and voice mail messages. All attempts were unsuccessful in reaching Respondent.

Respondent did provide a brief email response to our initial letter. A request for additional information and documentation was sent to Respondent by email and FedEx (signature of Respondent obtained on 9/10/2021). Respondent was given 30 days to respond to our request. Respondent did not comply with our request.

The Executive Committee for Discipline has amended sanctions as written above as follows:

1. Respondent's certification is hereby suspended for a period of 6 months.
2. Continuing Education: Respondent is required to complete a continuing education course in birth emergencies. Committee recommends Birth Emergency Skills Training® focused on out of hospital birth, or equivalent to be approved by AMCB. The course must be completed by 4/30/2022. Failure to complete the course will result in reconsideration of sanctions Respondent's certificate, including possible loss of certification.
3. Respondent is fined \$500.00.

In addition to the sanctions above, The Executive Committee for Discipline added the following:

Respondent must fulfill all sanctions outlined above within 6 months. Failure to do so will result in immediate revocation of Respondent's certificate.

Effective: October 20, 2021

#### EXECUTIVE COMMITTEE FOR DISCIPLINE REVIEW

Linda Hunter, EdD, CNM, FACNM  
President, AMCB Board of Directors  
Barbara Graves, CNM, MN, MPH, AMCB Treasurer  
Erin McMahan, EdD, CNM, RN, MSN, AMCB Secretary  
LaurenElizabeth Cohen, MPH, AMCB Consumer Member