

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

In the Disciplinary Matter of:

Meagan Alpha, APRN, MSN, CNM
Respondent

DECISION

On 3/19/2019, the American Midwifery Certification Board (AMCB) received a written complaint from a former patient (Complainant) of Meagan Alpha, APRN, MSN, CNM (Respondent) alleging negligence in the birth of her infant (deceased). The patient also provided documentation of sanction on Respondent's midwifery license by the Texas Board of Nursing. These allegations constituted possible violations by Respondent of AMCB's Disciplinary Policy. The alleged violations concerned allegations that Respondent breached standard of care by failing to make appropriate assessments and take appropriate actions related to signs of fetal distress, failing to transfer from the birth center in a timely fashion and failing to document care completely and accurately.

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 2/2/2020, AMCB notified Respondent that it had initiated a disciplinary proceeding to determine whether good grounds existed for discipline under Section I.A. of the Disciplinary Policy. Specifically considered were the following provisions of Section I.A:

- 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 of receipt of our notice. Respondent replied on 3/18/2020 with a description of events from her perspective.

A Review Committee comprised of a Chair and two qualified members was duly

convened. Members of the Review Committee are:

Carol Howe, CNM, DNSc, FACNM, DPNP, FAAN
Rebecca Burpo, CNM, DNP, FACNM
AlexAnn Westlake, CNM, MN

On 4/14/2020, the Review Committee requested additional information from the Respondent and the answer to specific questions about the incident in question.

On 4/23/2020, Respondent provided the requested material.

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.7. and 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 the ACNM Certification Council or 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 April 2018.

3. Respondent was certified by AMCB on May 10, 2014.

4. There is no evidence of sanction on Respondent's license or certification prior to the incident in question.

5. Respondent was sanctioned by the Texas Board of Nursing as a result of the incident that engendered this complaint. Respondent's license was suspended, but STAYED, and she is currently on probation for a minimum of two years. Respondent was further required to notify the Board of employment, have her practice monitored by another APRN or MD who must provide written evaluations to the Board every three months. Respondent was also required to complete additional coursework in Texas nursing jurisprudence and ethics, documentation and the NCSBN's course entitled "Sharpening Critical Thinking Skills". Further, review by the Commission for the Accreditation of Birth Centers (February 4, 2020) identified "areas needing improvement and is requiring the Fort Worth Birthing & Wellness Center revise several clinical guidelines and procedure for medical record documentation."

6. On or about 9/26/18, Respondent attended the birth of patient CC at the Fort Worth Birthing and Wellness Center. In the course of the labor, the fetus demonstrated signs of distress, the patient was transferred to a local hospital where an emergent cesarean section was performed with evidence of severe hypoxic ischemic encephalitis (HIE). The infant subsequently died on 10/22/18.

7. The Complainant was a low-risk nullipara at 41 weeks and 1 day at the onset of spontaneous labor. She was GBS+. Respondent reports that antenatal testing was done, and results were within parameters that allowed for birth in the Birth Center. Complainant was admitted to the birth center on 9/26/18 at 1:27 pm at 5 cm dilation, subsequently progressed to complete dilation at 8:26 pm, pushed for approximately 30 minutes and was then encouraged to “labor down”. Artificial rupture of membranes was performed at 7:34 pm with meconium stained fluid noted.

8. Two periods of tachycardia (≥ 160 bpm) were noted in the medical record. From 6:01 pm until 8:10 pm all FHR ranges included readings of 160 or greater; at 8:35 the FHR was recorded as 166-169; from 9:30 until 9:45 all FHR ranges included readings of 160 or greater. The Complainant was reported to be in the shower from 6:00 – 7:00 pm. FHR was recorded consistent with generally accepted Intermittent Auscultation (IA) protocols (although Complainant disputes accuracy of recordings). FHR was auscultated every 5 minutes in early second stage while pushing and through the first 30 minutes of laboring down. At that point, the FHR was recorded every 10-15 minutes until it was noted to be in the 70s at 10:34. Respondent indicates that the spacing out of the times on which the FHR was recorded was because the patient was not actively pushing. This is consistent with ACNM recommendations (*ACNM Clinical Bulletin, 2015: Intermittent Auscultation for Intrapartum Fetal Heart Rate Surveillance*).

9. After laboring down for approximately 1.5 hours (exact times disputed), the fetal heart rate was noted to be in the 70s at 10:34 per medical record. Per the patient, initial low FHR was noted at 10:25; family text message notes “oxygen mask is going on...heart rate a little low at 10:30. Intrauterine resuscitative efforts were attempted (exact times disputed) and arrangements were made for transfer.

10. The infant was delivered by emergency cesarean section at 10:49 pm. Apgars were 1 at 1 minute, 2 at 5 minutes and 3 at 10 minutes. The cord pH was 6.80 and the base excess was -25. Cord pathology was consistent with meconium staining and acute chorioamnionitis. The patient was afebrile and maternal WBCs were 24K on admission to the hospital.

11. The following assessments were noted in the course of labor:

Temperature:

98.3 at 1:27

98.4 at 5:30 pm

Pulse: 84 at 1:27 pm

100 at 5:30 pm

B/P: 140/88 at 1:27 pm.

140/92 at 5:30 pm

Urine protein: not performed

Vaginal examinations:

1:27 – 5 cm, 80%, -1station

2:25 – 6 cm

5:30 – 8 cm

7:35 - AROM with meconium (not described), no dilation noted. Cervical edema noted.

8:05 - Anterior lip. No note of station, caput, molding or fetal position

8:26 – 10 cm, -1 station. No note of molding, caput or fetal position

10:34 – caput noted, FHTs in 70s

12. Complainant asserts that the Respondent has misrepresented the frequency and technique (before, during and after a contraction) used in intermittent auscultation of the FHR. In addition, Complainant disputes the timeline recorded in the medical record with regard to the identification of fetal distress and move to transfer to hospital. Complainant submits family text messages and pictures made contemporaneous with the events.

13. Respondent attributes fetal tachycardia to hydrotherapy which, if the maternal temperature is elevated, can elevate the FHR. Respondent further asserts that intrauterine resuscitative efforts were attempted and that transfer to hospital occurred in less than one minute.

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.

Respondent was sanctioned by the Texas Board of Nursing, a fact that she obviously does not contest. Consequently, without more, a basis for discipline exists under section A.7. of the Disciplinary Policy, namely, that Respondent has been sanctioned by a state licensing board.

In consideration of section A.9, the Review Committee reviewed the Complainant's medical record from the birth center and the hospital, the infant's hospital record, the

Respondent's initial reply and answer to additional questions, the timeline and summary of the grievance submitted by the Complainant (including photographs and text messages made at the time of the event), and documents from the Texas Board of Nursing and CABC confirming the results (although not the specifics) of their investigations.

The Committee is persuaded that Respondent's midwifery care in this instance did not meet the standard of care expected of a Certified Nurse-Midwife. Areas of concern are related to a pattern of superficial assessment and inadequate documentation, some of which had direct effect upon the outcome of this case.

Examples of superficial assessment and inadequate documentation include:

- a. No acknowledgement of the results of antepartum testing in record
- b. Failure to follow up two elevated blood pressures (140/88 and 140/92). Respondent does not address these in her assessment, nor is urine protein assessed. In her reply to Review Committee questions, Respondent states she attributed the B/P elevations to pain and walking up two flights of stairs although this thinking is not noted in the medical record. Respondent states that the B/P was retaken in a "timely manner." Documentation in the medical record indicates that it was retaken in 4 hours which would not be considered timely. Testing of urine protein would have been indicated. This was likely not associated with the poor infant outcome.
- c. Inattention to mildly elevated maternal pulse. Over a period of 4 hours, the pulse increased 20 points, from 80-100. While the pulse rate is in the high normal rate for labor, in the context of fetal tachycardia in a GBS+ patient, the pulse should have been monitored more carefully. Maternal fever can be a late sign of infection and its absence does not rule out infection as a cause of tachycardia in mother or fetus. The patient did receive adequate GBS prophylaxis.
- d. Failure to record the type of meconium noted. Birth Center guidelines require transfer with particulate meconium. Respondent's reply to questioning was that it was not particulate; however, particulate meconium was noted at the hospital upon transfer. Family texts indicate that they were told the meconium was "heavy" and that family members reported it was "thick, black and similar to tar." Respondent indicates that no meconium was noted again after AROM. Complainant notes that "Midwife Megan continues to clean up thick black meconium as it comes out" (8:35-8:37 pm); "Meconium dripping on ground." (9:03 – 9:30 pm); and, "Thick meconium continues to drip out." (10:06 – 10:19 pm)
- e. Vaginal examinations, particularly in the later hours of labor should have been more completely recorded (including dilatation, station, fetal position, presence or absence of caput and molding). While these data were likely not directly related to the poor infant outcome, the fact that upon complete dilatation, the fetus was still at a -1 station indicates a need for assessment for further progress in labor. The presence of caput would have indicated adequate labor contractions with no descent since admission, a poor prognosis for labor progress. The presence of molding prior to zero station would indicate a poor prognosis for descent beyond the ischial spines. The knowledge that delivery was not imminent and could not

be effected quickly makes the second episode of tachycardia more worrisome. The high station at complete dilatation likely indirectly affected the fetal outcome by making it impossible to deliver the infant quickly when the FHR fell.

- f. FHR assessment was also inadequate. Two distinct episodes of fetal tachycardia are noted. The earlier one was associated with a period of time spent in the shower and may have been related to temporary elevation of maternal temperature as asserted by the Respondent. However, according to the medical record, the second episode (in second stage) was not associated with hydrotherapy. Tachycardia in the presence of meconium and the baby remote from delivery should have prompted consideration of transfer prior to deceleration of the FHR.
- g. There is incomplete documentation of the circumstances surrounding the transfer to hospital. While, by nature of a crisis situation, the practitioner cannot be expected to sit at a computer to chart contemporaneously, it is critical that a comprehensive note be added to the chart when time permits and identified as a late entry. According to the medical record, the FHR was noted to be in the 70s at 10:34 pm. Complainant asserts that first low FHR was noted at 10:25 pm. Family texts indicate “Oxygen mask on...heart rate is a little low” at 10:30 pm and “She’s on oxygen his hr [heart rate] is low they’re freaking out a little” at 10:32pm. And additional text message at 10:33 indicates “They just brought in some kind of machine for him.” Attempted use of an electronic fetal monitor is not mentioned in the medical record. It would appear from texts that the fall in FHR occurred at least 4 minutes prior to notation on the medical record. Transfer to the hospital occurred at 10:35 pm, which is consistent with the medical record. Of note, also related to FHR assessment, Respondent demonstrated incorrect understanding of IA terminology, referring to “good variability” (which cannot be assessed by IA) and “Baseline was not assessed at FWBC due to being a member of the CABC. CABC states continuous monitoring is not appropriate for normal labor, which in turn, would establish a baseline FHR.” While it is true that the CABC does not believe continuous fetal monitoring to be necessary or appropriate for normal labor in a birth center, that does not preclude obtaining a baseline heart rate by IA. “To determine the baseline FHR, the FHR is auscultated between contractions and when the fetus is not moving. At the same time, the mother’s radial pulse is palpated to ensure that the fetal heart rate is auscultated, not the mothers. After establishing the baseline rate, the FHR is auscultated for 15 to 60 seconds at recommended intervals between contractions and when the fetus is not moving to assess the baseline rate.” (*ACNM Clinical Bulletin, 2015: Intermittent Auscultation for Intrapartum Fetal Heart Rate Surveillance*)

There are aspects of this complaint that cannot be addressed by the Review Committee. For example, the complaint that the Respondent falsified entries related to the FHR into the medical record cannot be verified as the Review Committee was unable to contact any third party for corroboration. Similarly, photographs submitted by Complainant purporting to show her receiving oxygen earlier than documented in the medical record were not time stamped and could not be used as evidence.

In summary, the labor record indicates a failure to assess findings completely, not providing follow up on objective findings related to blood pressure, labor progress and FHR abnormalities. Earlier consideration should have been given for transfer to hospital in the presence of fetal tachycardia and meconium in a patient remote from delivery. Accordingly, we conclude that a basis exists for discipline under section A.9., namely, that the Respondent engaged 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. A letter of Censure shall be issued.
2. A fine of \$500 will be assessed.
3. Submission of Additional Information. Respondent shall inform the CEO of AMCB in writing of any change in her status regarding her nurse-midwifery license including investigation or sanction by any federal, state or private licensing boards, administrative agency, association or health care organization relating to public health, or safety or midwifery practice, within thirty days of such change.
4. Respondent, in addition to coursework required by the Texas Board of Nursing will complete an Annotated Bibliography on Intermittent Auscultation. Bibliography will include the following documents: ACNM Clinical Bulletin on Intermittent Auscultation, ACNM Reducing Primary Cesareans Bundle on Intermittent Auscultation, recommendations from AWOHNN and NICHD plus 3 primary research, peer reviewed articles on IA. The Annotated Bibliography must be completed within 3 months of issuance of the letter of Censure.

Effective: 9-1-2020

REVIEW COMMITTEE

Carol Howe, CNM, DNSC, FACNM, FAAN, Chair
Rebecca Burpo, CNM, DNP, FACNM
AlexAnn Westlake, CNM, MN

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