

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

In the Disciplinary Matter of:

Shelie Ross, CNM

DECISION

In September 2011, the American Midwifery Certification Board (AMCB) was contacted by a patient of Shelie Ross, CNM (Respondent), with regard to care rendered in the birth of her son. The patient alleged that Respondent had practiced negligently in the vaginal breech delivery of the patient's infant conducted at the Greenhouse Birth Center. Specifically, the parents alleged that the midwives practicing at the Birth Center (including Respondent) had failed to provide adequate informed consent and had conducted the birth without any previous experience in vaginal breech delivery. At the time of delivery, the baby's head was entrapped for 7 minutes. The infant subsequently died of birth asphyxia.

Further research by the AMCB Discipline Director revealed action taken upon Respondent's midwifery license in Michigan. At the initial contact with the Michigan Department of Licensing and Regulatory Affairs Respondent's case was still open. The original Administrative Complaint was filed in January, 2013 and was amended in June, 2014. Subsequently, a consent order was signed on 7/10/2014. Michigan Department of Licensing and Regulatory Affairs actions upon Respondent's license were as follows:

- January 2013: An Administrative Complaint was filed alleging 1) negligence or failure to exercise due care, 2) incompetence and 3) lack of good moral character. This Administrative Complaint was based upon an accusation that Respondent had participated actively in management of labor and conduct of the birth.
- June, 2014: An amended Administrative Complaint was filed dismissing allegations of incompetence and lack of good moral character. The amended complaint alleged negligence or failure to exercise due care based upon failure to obtain adequate prenatal ultrasound testing. The amended Administrative Complaint acknowledged that Respondent did not actively participate in the patient's labor and birth.
- July 2014 : A Consent Order was issued limiting Respondent's license. Respondent was placed on Probation and Respondent's care required supervision for a period of one year. Quarterly reports to the Board of Nursing were required. A fine of \$250 was levied.

In accordance with AMCB procedures, the matter was reviewed by the President of AMCB. It was determined that Respondent's behavior constituted grounds for disciplinary review. Accordingly, by a letter dated August 28, 2013, AMCB notified Respondent that it had initiated a disciplinary proceeding to determine whether good cause existed for imposing discipline under the following provisions of the Disciplinary Policy:

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 and/or;

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.

A Disciplinary Review Committee comprised of three individuals with no prior involvement with the matter was constituted. As the case against Respondent by the Michigan Department of Licensing and Regulatory Affairs was ongoing, Respondent requested an extension until the Complaint had been resolved. The extension was granted. AMCB requested that Respondent submit a written response to the charge within thirty days of receipt of the letter. AMCB received a response from Respondent dated 10/23/13. Subsequently, the Disciplinary Review Committee met and requested additional information from Respondent. A response dated 3/28/15 was received.

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 discipline against Respondent exist under sections A.7. and A.9 of the Discipline Policy.

FINDINGS

The Review Committee finds the following facts:

1. AMCB (previously 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 assumed responsibility for discipline of ACNM/AMCB certificants through the Discipline Policy, the most recent version of which AMCB adopted in November, 2012.
3. Respondent was initially certified as a CNM by AMCB (formerly ACC) on 10/28/2005.
4. In the amended Administrative Complaint, Respondent stipulated to the following facts:
 - a. Respondent practiced midwifery at the Greenhouse Birth Center at the time in question.
 - b. Respondent saw the patient prenatally at her 37 week visit and suspected breech presentation.
 - c. Respondent ordered an ultrasound for fetal position and measurement of amniotic fluid.

- d. Respondent did not request estimated fetal weight, attitude, or position of umbilical cord.
- e. Respondent saw patient for one additional prenatal visit at which the baby was noted to continue to be in a breech presentation.
- f. Respondent did not participate in the labor management or birth of the infant.
- g. Respondent did participate actively in the infant's attempted resuscitation
- h. Respondent reported to EMTs that there was no meconium after viewing the vocal cords during an attempted intubation.

5. Respondent reports that:

- a. The discussion regarding the plan of care among the birth center midwives occurred after the 37 week visit at which the breech presentation was documented.
- b. Respondent "made it clear to my partner midwives" that she disagreed with the planned vaginal breech birth at the birth center
- c. Respondent did not discuss her concerns about the planned vaginal breech birth with the patient at a subsequent prenatal visit.
- d. Respondent replied "no" to parents' question regarding whether any of the midwives at the Greenhouse Birth Center had experience with vaginal breech birth.
- e. Respondent gave the parents the names of other midwives in the area who attended vaginal breech births.
- f. Respondent agreed to be available at the time of birth for infant resuscitation.

DISCUSSION

In this matter we are called upon to decide whether and what discipline is warranted against a CNM whose license to practice nurse-midwifery has been limited for failure to meet the standards of practice for nurse-midwifery.

The Committee is persuaded that there is evidence that Respondent's practice was inconsistent with professional standards, reflecting practice that created unnecessary danger to a patient's life, health or safety.

The Disciplinary Review Committee finds that, although Respondent did not actively participate in the vaginal breech birth, Respondent's duty to the patient in her care was breached by failure to convey Respondent's legitimate concerns regarding the plan of care. A CNM's primary responsibility is to the patient and for the patient's safety. The Committee does not find that Respondent was negligent in failing to order additional measurements at the 37 week ultrasound as the plan for a vaginal breech birth had not yet been discussed with the patient or among the midwives. However, once vaginal breech birth was considered an option, those tests were critical. Respondent had the opportunity to order those tests, to discuss the rationale for those tests and to convey her professional assessment regarding birth options at the subsequent prenatal visit. Further, the Greenhouse Birth Center Informed Choice Contract Document specifically stated that "...babies who are breech at labor...are best served in a setting that provides medical, surgical and pediatric services." Respondent was obligated to review that

recommendation with the patient. The Disciplinary Review Committee recognizes the professional conflict inherent in providing a different recommendation than her colleagues; however, Respondent's principal duty was to the patient.

Evidence is presented that Respondent understood the obstetrical implications of the planned out of hospital vaginal breech birth in the hands of inexperienced providers and Respondent appropriately declined to participate. No evidence exists of lack of knowledge or incompetence. However, failure to exercise the midwife's primary obligation to safeguard patient well-being by providing appropriate information and guidance according to her expertise represents a lapse of professional judgment and is not consistent with the professional standards of nurse-midwifery. Respondent's silence implies agreement. Respondent is obliged to document dissent and her recommendation for attempted version and for hospital care in spite of the patient's resistance. The Disciplinary Review Committee notes that Respondent provides no evidence that she believes any aspect of her involvement in this case to be inappropriate.

SANCTIONS FOR VIOLATIONS

The Review Committee agrees with the sanctions imposed by the Michigan Department of Licensing and Regulatory Affairs and recommends that Respondent receive a letter of Reprimand that includes the above findings (or Discussion).

Respondent is also required to:

1. Notify AMCB at such time as her Michigan license becomes unrestricted.
2. Pay a \$250 fine to AMCB
3. Must complete the following professional educational courses and submit certificates of completion to AMCB within the next 3 months:
 - a. National Council of State Boards of Nursing (NCSBN) online course "Documentation: A Critical Aspect of Client Care", available at: <http://learningext.com/nurses/p/documentation.aspx> and
 - b. NCSBN online course "Righting A Wrong" Ethics & Professionalism in Nursing", available at: http://learningext.com/nurses/p/ethics_professionalism.aspx

Effective: 12/8/2015

REVIEW COMMITTEE

Cara Krulewitch, CNM, PhD, FACNM
AMCB President, Board of Directors

Carol Howe, CNM, DNSc, FACNM, Chair
Lisa Chickadonz, MS, CNM
Susan Wente, MSN, CNM