

2 **BEFORE THE**
4 **BOARD OF DIRECT ENTRY MIDWIFERY**
6 **HEALTH LICENSING OFFICE**

8 *In the Matter of:*) **AMENDED Notice of Intent to Suspend**
9 *Jesica Dolin*) **and Impose Additional Discipline**
10) **Right to Request a Hearing**
11 *License No.*)
12 *DEM-LD-1004154*) **OAH Case No. 1504321**
13 *Respondent,*) **Agency File No. 11-6546**

14 Under ORS 687.420, 687.445, and 687.485, the Board of Direct Entry Midwifery (“Board”), with
15 the assistance of and in consultation with the Health Licensing Office¹ is the State board charged with
16 licensing and disciplining licensed direct entry midwives. Pursuant to ORS 687.445, 676.612(1), and
17 676.992(2), the Board, hereby proposes to:

- 20 1) Suspend Jesica Dolin’s license to practice direct entry midwifery, license DEM-LD- 1004154 for a
21 minimum period of two years with reinstatement contingent on the following:
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23 1.1. Satisfying any general requirements for reinstatement under the applicable statutes and rules and
24 the following specific requirements.
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26 1.2. Respondent violates no laws or Oregon Administrative Rules during suspension period.
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28 2) Upon reinstatement, place the Respondent’s license on probation for a period of one year with the
29 following specific requirements:
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31 2.1. Respondent to have 12 months of supervised practice.¹ Respondent is responsible for identifying
32 a supervisor and submitting information, as required by the Board, for approval by the Board.
33 Respondent is responsible for any fees or costs associated with such supervision.
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35 3) Assess the cost of any disciplinary proceeding against the Respondent, up to a maximum of \$5,000.
36

37 **FINDINGS OF FACT**

- 38 1) At all relevant times, Jesica Dolin (“Respondent”) held Direct Entry Midwifery license DEM-LD-
39 1004154, issued by the OHLA.
40
41 2) At all relevant times, Respondent was a direct entry midwife at the Andaluz Waterbirth Center in
42 Portland, Oregon.

¹ As of July 1, 2014, the “Oregon Health Licensing Agency” (OHLA or Agency) became the “Health Licensing Office” (HLO or Office).

- 2 3) On or about September 19, 2009, at 13 weeks 4 days into her pregnancy Client began her care at
4 Andalus Waterbirth Center.
- 6 4) On or about April 3, 2010, 41 weeks 1 day into her pregnancy and 3 days following a prenatal visit,
8 early that morning Client experienced spontaneous onset of contractions, began leaking amniotic
fluid, and was vomiting. Client later that day went to Andalus Birth Center at approximately 2:30
pm. Another midwife, (DEM1) was Client's primary midwife.
- 10 5) Prior to Respondent's arrival, the Client's labor records documented fetal tachycardia.
12 Additionally on or about April 4, 2010, according to the Client's Labor Record: at 8:43 a.m., the
Client's cervix was dilated to "9 cm head at '0' station, asynclitic, swelling." At 9:01 a.m., Client's
14 contractions had spaced out to 7 to 10 minutes apart. At 10:10 a.m., "have spaced out
significantly." At 12:20 p.m., uterine contractions are "mild;" and at 1:40 p.m., the Client wanted
16 more rest.
- 18 6) On or about April 4, 2010, at 11:00 a.m., the Respondent arrived and became involved in the co-
care of the Client for the duration of the labor, birth and transport.
- 20 7) Throughout the Client's Labor Record, the beat to beat variability of the fetal heart tones is
22 described. The heart tones were monitored using a hand held Doppler. Beat to beat variability
cannot be accurately monitored via a hand held Doppler.
- 24 8) On or about April 4, 2010, at 1:35 p.m. Respondent conducted a vaginal exam. She recorded in a
26 late entry (added sometime around 3:45 p.m. that same day) that she was unable to assess the
Client's cervix, caput at +1 station, "no sutures felt." The typed "Labor Summary" states that the
28 Client was fully dilated at this exam.
- 30 9) At 2:15 p.m., 24 hours after her initial evaluation, the Client's temperature and pulse were checked
and recorded as 98.2 and 100 bpm respectively, blood pressure not recorded. No voidings were
32 recorded since 4:26 a.m. and the Client was catheterized for 2000 cc urine. Chart states: "Discuss
Hosp option [with] concern about maternal condition [Client] declines request, IV fluids refused."
34 Client told investigator IV fluids were not refused.
- 36 10) On or about April 4, 2010, according to the Client's Labor Record, at 8:15 p.m., a chiropractor
arrived to work on Client. DEM1 indicated to the Client that the chiropractor was there because
38 the baby was in the occiput posterior position and the chiropractor may be able to help get the baby
in a better position. It is not noted anywhere in the Client's Labor Record the baby was in an
occiput posterior position. It was not recorded in the Client's Labor Record the chiropractor's
40 actions at the birth center or the purpose for the chiropractor's involvement. The only notation
regarding the chiropractor's recommendation is an entry at 9:45 p.m. stating the chiropractor
42 recommended the client try the pubic pivot technique.
- 44 11) On or about April 4, 2010, according to the Client's Labor Record, at 9:30 p.m., a student
administered an IV of lactated ringers. As noted in the chart, over 90 minutes later, it was found the
46 IV was not inserted into a vein and was infusing into Client's skin.
- 48 12) Respondent did not tell the Client that the labor was abnormal, but that they would continue to
provide labor support as long as mother and baby were doing well. The client was instead told by

2 the attending midwives that transport was one possible option amongst other recommended
4 options, including continuing the labor at Andaluz. Respondent did not recognize or fully inform
6 the clients about the risks of continuing labor outside the hospital and the need for the Client to
transport to the hospital.

- 8 13) On September 21, 2009, Client signed an "Informed Choice/Consent Agreement" where client was
informed that Andaluz would not provide vacuum extractors during labor. The Respondent
10 suggested to the Client that a Naturopathic Doctor could attempt a vacuum extraction at the birth
center. The Respondent called a ND to come to the birth center to attempt a vacuum extraction of
12 the Client's baby. In an addendum to the Client's Labor Record, it is stated that a Naturopathic
Doctor who was called to the birth explained the risks and benefits of vacuum extraction and the
14 Client opted to continue laboring. This entry was initialed by ND. A note that was separate from
the Client's Labor Record, stated that the risks of vacuum extraction were reviewed with Client.
16 There is no signature or informed consent document from the Client in any of the records. On or
about April 5, 2010, a total of 6-9 vacuum extractions were attempted between 1:28 a.m. and 1:50
18 a.m. After each vacuum attempt, the chart showed that there was fetal heart distress. The vacuum
cup popped off the fetus on the last pull at 1:50 a.m. The Client's Labor Records showed fetal heart
20 rate was between 96 and 108 beats per minute. The ND recommended to Respondent that the
Client be transferred to a hospital.
- 22 14) Respondent failed to fully inform the Client of the risks of continuing her labor at the birth center
after the failed vacuum extraction attempts. The client was, instead, reassured by the attending
24 midwives that she had made the correct decision not to transfer to the hospital, that she was in the
right place, a safe place, and that the baby was going to come out at any moment.
- 26 15) On or about April 5, 2010, according to the Client's Labor Record, at 2:34 a.m., Client remained in
28 labor with contractions that were spaced out to once every 8-12 minutes. The ND left the birth
center at 4:00 a.m.
- 30 16) At 4:20 a.m., Respondent failed to appropriately assess Client and clients baby's wellbeing when
32 Client's contractions were spaced out to once every 12-15 minutes: Client was exhausted; severely
dehydrated; her uterus was not contracting effectively, was a high risk for infection; the baby was a
34 "tight fit"; and there had been 6-9 failed vacuum extractor attempts without taking action to correct
the situation.
- 36 17) On or about April 5, 2010, according to the Client's Labor Record, at 6:15 a.m., the fetal heart rate
38 was lowering until it became undetectable at 6:30 a.m. and baby was delivered by 6:47 a.m. with
no signs of life. Resuscitation of the baby was attempted between 6:47 and 6:58 a.m. but was
40 unsuccessful.
- 42 18) Neither Respondent nor anyone else from the birth team called 911 during this time. The Client's
friend called 911 at approximately 6:53 a.m. At 6:47 a.m., according to the Client's Labor Record,
44 Client had lost approximately 1000cc of blood. In front of paramedics, Client is told by DEM1
that transport to hospital is not necessary and then Client and Client's husband declined transport to
46 paramedics.
- 48 19) On or about April 5, 2010, according to the Client's Labor Record, between 7:05 a.m. and 8:04
a.m., Respondent attempted to assist Client to deliver her placenta. During this time, Client was

2 actively hemorrhaging with a retained placenta. At 8:07 a.m., the DEM1 discussed transporting to
4 the hospital with the client. Client's pulse was 120; Blood pressure was 85/60. The Client agreed
and was transported to a hospital.

6 20) On arrival at the hospital, the Client required a manual removal of the retained placenta under
anesthesia, and a transfusion of 4 units of blood. They also repaired a 3rd degree perineal
8 laceration. The placental path report also showed chorioamnionitis and funisitis (an inflammation
or infection in the placenta and cord).

10 21) The Labor and other records do not document discussions of potential adverse/fatal outcomes with
12 the client or recommendations that the out of hospital care was no longer appropriate at the times
that during the labor that absolute risks were present.

14 22) The Labor and other records do not include any signatures of Client verifying that Client refused
16 transport to a hospital during the Client's labor.

APPLICABLE LAW

18 **ORS 676.612(2)(j):** A person subject to the authority of a board, council or program listed in ORS
676.606 commits a prohibited act if the person engages in unprofessional conduct, negligence,
20 incompetence, repeated violations or any departure from or failure to conform to standards of practice in
performing services or practicing in a regulated occupation or profession subject to the authority of the
22 boards, councils and programs listed under ORS 676.606.

24 **(n)** Violation of any rule regulating an occupation or profession subject to the authority of the boards
and councils listed in ORS 676.583.

26 **Former OAR 332-015-0000** (*cert. ef. 7-1-04*) Definitions: The following definitions apply as used in
OAR 332-015-0000 through OAR 332-030-0030.

28 (5) "Client records" means written documentation, including licensee signatures or initials, or midwifery
30 care provided to a client, including but not limited to demographic information, medical history, prenatal
care, diagnostic studies and laboratory findings, labor, birth, and immediate postnatal care, maternal and
32 infant care through postnatal weeks six to eight, emergency transport plan, informed consent
documentation, Health Insurance Portability and Accountability Act (HIPAA) releases.

34 (10) "Emergency transport" means the mechanism by which a mother or newborn would be moved to a
36 location where appropriate care could be provided. Such means may include ambulance or private
vehicle.

38 (15) "Fetal distress" is a condition in which the fetus demonstrates progressive and irresolvable clinical
signs of compromise, such signs to include: abnormal fetal movement; loss of heart tone variability;

2 non-reassuring fetal heart rate deceleration patterns such as late decelerations; non-reassuring changes in fetal heart baseline rate.

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(19) "Intrapartum" means the period of time from the onset of labor through the birth of the baby.

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8 (22) "Maternal exhaustion" means a condition in which the mother demonstrates a combination of clinical signs of compromise, such signs would include: elevated pulse over 100, extreme fatigue, dehydration, hypoglycemia, concentrated urine, ketonuria of 3 or greater, temperature over 101 degree Fahrenheit.

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12 (31) "Postpartum" means the period of time after the birth of the baby.

14 (36) "Risk Assessment" means the analysis of health compromising conditions relevant to pregnancy, birth and the postpartum period based on information gathered through interview, clinical examination and historical data. Risk categories are identified as follows:

16 (a) "Absolute Risk" means the conditions or clinical situation which places a client at increased obstetric or neonatal risk which would preclude being an acceptable candidate for an out of hospital birth.

18 **Former OAR 332-015-0040(1)** (*cert. ef. 7-1-04*) All applicants must have completed the following minimum core competencies adapted from the 1997 Edition of the Midwife Alliance of North America (MANA and approved by the Board:

20 (c) Care During Labor, Birth and Immediately Thereafter (Intrapartum): The midwife provides health care, support and information to women throughout labor, birth and the hours immediately thereafter. The midwife determines the need for consultation or referral as appropriate. The midwife uses a foundation of knowledge and/or skill which includes the following:

22 (A) The normal processes of labor and birth.

24 (B) Parameters and methods for evaluating maternal and fetal well-being during labor, birth and immediately thereafter, including relevant historical data.

26 ***

28 (J) Causes of, evaluation of and appropriate treatment for variations which occur during the course of labor, birth and immediately thereafter.

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2 (f) Professional, Legal and Other Aspects: The entry-level midwife assumes responsibility for practicing
in accord with these core competencies.

4 **Former OAR 332-025-0020** (*cert. ef. 7-1-04*) Practice Standards Pursuant to ORS 687.480, licensed
6 direct entry midwives shall comply with the following practice standards when supervising the conduct
of labor and childbirth; , advising the parent ; and, in rendering prenatal, intrapartum and postpartum
care.

8 (13) Licensees shall maintain accurate written client records documenting the course of midwifery care.

Former OAR 332-025-0021(*cert. ef. 7-1-04*) Risk Assessment Criteria

10 Licensed direct entry midwives shall assess the appropriateness of an out-of-hospital birth for each
12 client, taking into account the health and condition of the mother and fetus or baby according to the
following two categories of risk assessment criteria in determining appropriate care:

14 (1) “Absolute risk” as defined in OAR 332-015-0000(36)(a). Clients who present one or more of the
following absolute risk factors are not appropriate candidates for out-of-hospital birth:

16 (a) When absolute risk factors are present during the antepartum period, the midwife and the client must
plan for an in-hospital birth;

18 (b) When absolute risk factors appear during the intrapartum period, the midwife must arrange to have
the client transported to the hospital unless the birth is imminent;

20 (c) When absolute risk factors appear when the birth is imminent the midwife must take the health and
condition of the mother and baby into consideration in determining whether to proceed with out-of-
hospital birth or arranging for transportation to a hospital;

22 (d) When absolute risk factors appear postpartum, the midwife must immediately arrange for
transportation to a hospital;

24 (e) When absolute risk factors appear in the infant, the midwife must immediately arrange for
transportation to a hospital.

26 (2) The following constitute absolute risk factors:

28 (b) INTRAPARTUM ABSOLUTE RISK CRITERIA: * * * evidence of fetal distress or abnormal
fetal heart rate pattern unresponsive to treatment or inability to auscultate fetal heart tones; excessive
vomiting, dehydration, * * * or exhaustion unresponsive to treatment; * * * maternal exhaustion; fetal
30 distress; * * * .

32 (c) MATERNAL POSTPARTUM ABSOLUTE RISK CRITERIA: * * * retained placenta with
abnormal or significant bleeding; * * * uncontrolled postpartum bleeding; * * * signs or symptoms of
shock unresponsive to treatment.

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2 (5) In the event that the client refuses transport for herself or her infant upon the midwife's
4 recommendation for absolute, non-absolute, or other risk factors, the midwife must:

6 (a) Document the midwife's discussion including potential adverse/fatal outcomes with the client that
8 the out of hospital care is no longer appropriate, and document the client's refusal to transport, with
10 client's signature in the chart; and

(b) If the situation is immediately life-threatening for the mother or infant or if, in the midwife's
judgment it is warranted, activate the 911 emergency response system

Former OAR 332-0025-0022 (cert. ef. 7-1-04) Standards of care for the determination of initial visits,
laboratory tests, prenatal visits, education/counseling/anticipatory guidance, emergency access,
intrapartum care, postpartum care, and newborn care include:

14 (7) Intrapartum Care:

16 (a) Assessment during labor: The following parameters shall be included as part of the initial assessment
18 of a laboring woman and her baby as indicated: maternal temperature, blood pressure, pulse, frequency,
20 duration and intensity of uterine contractions, and the physical and emotional environment. Fetal well-
being shall also be assessed which includes fetal lie, position, and presentation, fetal movement, heart
rate before, during and after uterine contractions, fetal scalp color as appropriate, and if relevant, the
color, odor and clarity of amniotic fluid. Appropriate assessment of mother and fetus should be ongoing
during labor including regular assessment of fetal heart tones.

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24 (d) Physiologic care during labor: The primary care giver must make certain that the mother is receiving
nourishing, easily digestible foods and adequate fluid throughout labor. The woman must be encouraged
to urinate every one to two hours.

26 **CONCLUSIONS OF LAW**

28 1. By failing to recognize the significance and appropriately arrange transport for Client with a
severely protracted labor pattern, 24 hours of active labor followed by 17 hours of pushing,
30 which was unresponsive to treatment the Respondent violated former OAR 332-015-0040
(1)(c)(A), (1)(c)(J), (1)(f), and OAR 332-025-0021(5), OAR 332-025-0022(7)(a) (cert. ef. 7-1-
04) and ORS 676.612(2)(n).

32 2. By failing to recognize the significance and appropriately arrange transport for Client with a
34 severely protracted labor pattern, 24 hours of active labor followed by 17 hours of pushing,
which was unresponsive to treatment the Respondent failed to conform to standards of practice
36 in violation of ORS 676.612(2)(j) and (2)(n) and former OAR 332-015-0040 (1)(c)(A), (1)(c)(J),
(1)(f), and OAR 332-025-0021(5), OAR 332-025-0022(7)(a) (cert. ef. 7-1-04).

38 3. By failing to recognize the significance and appropriately arrange transport for Client with a
40 severely protracted labor pattern, 24 hours of active labor followed by 17 hours of pushing,
42 which was unresponsive to treatment the Respondent acted incompetently in violation of ORS
676.612(2)(j).

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6 4. By failing to recognize the significance and appropriately arrange transport for Client with a severely protracted labor pattern, 24 hours of active labor followed by 17 hours of pushing, which was unresponsive to treatment the Respondent acted negligently in violation of ORS 676.612(2)(j).
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10 5. By failing to adequately monitor maternal vital signs with multiple risk factors present, the Respondent violated former OAR 332-015-0040(1)(c)(B), (1)(f), and OAR 332-025-0022(7)(a) (cert. ef. 7-1-04), and ORS 676.612(2)(n).
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14
16 6. By failing to adequately monitor maternal vital signs with multiple risk factors present, the Respondent failed to conform to standards of practice in violation of ORS 676.612(2)(j) and (2)(n) and former OAR 332-015-0040(1)(c)(B), (1)(f), and OAR 332-025-0022(7)(a) (cert. ef. 7-1-04).
- 18 7. By failing to adequately monitor maternal vital signs with multiple risk factors present, the Respondent acted incompetently, violating ORS 676.612(2)(j).
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22 8. By failing to adequately monitor maternal vital signs with multiple risk factors present, the Respondent acted negligently, violating ORS 676.612(2)(j).
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26 9. By failing to assess the appropriateness of an out-of-hospital birth for a Client with maternal dehydration unresponsive to treatment, an intrapartum absolute risk, Respondent violated former OAR 332-025-0021(2)(b) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
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30 10. By failing to arrange transport for a Client with maternal dehydration unresponsive to treatment, an intrapartum absolute risk, Respondent violated former OAR 332-025-0021(1)(b) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
- 32
34 11. By failing to counsel the Client regarding potential adverse outcomes, that out-of-hospital birth was inappropriate, when the Client had maternal dehydration unresponsive to treatment, an intrapartum absolute risk, Respondent violated former OAR 332-025-0021(1)(b) and (5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
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40 12. By failing to document the midwife's discussion of potential adverse outcomes with the Client, that out-of-hospital birth was inappropriate, if the Client refused transport, when the Client had maternal dehydration unresponsive to treatment, an intrapartum absolute risk, Respondent violated former OAR 332-025-0021(5)(a)(cert. ef. 7-1-04) and ORS 676.612(2)(n).
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44
46 13. By not obtaining the Client's signature on the chart refusing transport after the midwife's discussion of potential adverse outcomes and that out-of-hospital birth was inappropriate, when the Client had maternal dehydration unresponsive to treatment, an intrapartum absolute risk, if the Client refused transport, Respondent violated former OAR 332-025-0021(5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
- 48 14. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for a Client with maternal dehydration unresponsive to treatment, an intrapartum absolute risk, failing to counsel the Client regarding the potential adverse outcomes and that out-of-hospital

2 birth was inappropriate, failing to document the midwife's discussion of potential adverse
4 outcomes with the Client and that out-of-hospital birth was inappropriate, if the Client refused
6 transport, or failing to obtain the Client's signature on the chart refusing transport, Respondent
failed to conform to standards of practice, violating ORS 676.612(2)(j) and (n) and former OAR
332-025-0021(1)(b), (2)(b) and (5)(a)(cert. ef. 7-1-04).

8 15. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
10 a Client with maternal dehydration unresponsive to treatment, an intrapartum absolute risk,
12 failing to counsel the Client regarding the potential adverse outcomes and that out-of-hospital
14 birth was inappropriate, failing to document the midwife's discussion of potential adverse
outcomes with the Client and that out-of-hospital birth was inappropriate, if the Client refused
transport, or failing to obtain the Client's signature on the chart refusing transport, Respondent
acted incompetently, violating ORS 676.612(2)(j).

16 16. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
18 a Client with maternal dehydration unresponsive to treatment, an intrapartum absolute risk,
20 failing to counsel the Client regarding the potential adverse outcomes and that out-of-hospital
22 birth was inappropriate, failing to document the midwife's discussion of potential adverse
outcomes with the Client and that out-of-hospital birth was inappropriate, if the Client refused
transport, or failing to obtain the Client's signature on the chart refusing transport, Respondent
acted negligently, violating ORS 676.612(2)(j).

24 17. By failing to assess the appropriateness of an out-of-hospital birth for a Client with maternal
26 exhaustion or exhaustion unresponsive to treatment, an intrapartum absolute risk, Respondent
violated former OAR 332-025-0021(2)(b) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

28 18. By failing to arrange transport for a Client with maternal exhaustion or exhaustion unresponsive
30 to treatment, an intrapartum absolute risk, Respondent violated former OAR 332-025-0021(1)(b)
(cert. ef. 7-1-04) and ORS 676.612(2)(n).

32 19. By failing to counsel a Client regarding potential adverse outcomes, and that out-of-hospital birth
34 was inappropriate, when the Client had maternal exhaustion or exhaustion unresponsive to
treatment, an intrapartum absolute risk, Respondent violated former OAR 332-025-0021(1)(b)
and (5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

36 20. By failing to document the midwife's discussion of potential adverse outcomes with the Client,
38 and that out-of-hospital birth was inappropriate, when the Client had maternal exhaustion or
exhaustion unresponsive to treatment, an intrapartum absolute risk, if the Client refused
40 transport, Respondent violated former OAR 332-025-0021(5)(a)(cert. ef. 7-1-04) and ORS
676.612(2)(n).

42 21. By failing to obtain the Client's signature on the chart refusing transport after the midwife's
44 discussion of potential adverse outcomes with the Client, and that out-of-hospital birth was
inappropriate, when the Client had maternal exhaustion or exhaustion unresponsive to treatment,
46 an intrapartum absolute risk, if the Client refused transport, Respondent violated former OAR
332-025-0021(5)(a)(cert. ef. 7-1-04) and ORS 676.612(2)(n).

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- 2 22. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
4 a Client with maternal exhaustion or exhaustion unresponsive to treatment, an intrapartum
6 absolute risk, failing to counsel the Client regarding potential adverse outcomes and that out-of-
8 hospital birth was inappropriate, failing to document the midwife's discussion of potential
10 adverse outcomes with the Client and that out-of-hospital birth was inappropriate, if the Client
12 refused transport, or failing to obtain the Client's signature on the chart refusing transport,
14 Respondent failed to conform to standards of practice, violating ORS 676.612(2)(j) & (n) and
16 former OAR 332-025-0021(1)(b), (2)(b) and (5)(a)(cert. ef. 7-1-04).
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23. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
20 a Client with maternal exhaustion or exhaustion unresponsive to treatment, an intrapartum
22 absolute risk, failing to counsel the Client regarding potential adverse outcomes and that out-of-
24 hospital birth was inappropriate, failing to document the midwife's discussion of potential
26 adverse outcomes with the Client and that out-of-hospital birth was inappropriate, if the Client
28 refused transport, or failing to obtain the Client's signature on the chart refusing transport,
30 Respondent acted incompetently, violating ORS 676.612(2)(j).
24. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
26 a Client with maternal exhaustion or exhaustion unresponsive to treatment, an intrapartum
28 absolute risk, failing to counsel the Client regarding potential adverse outcomes and that out-of-
30 hospital birth was inappropriate, failing to document the midwife's discussion of potential
32 adverse outcomes with the Client and that out-of-hospital birth was inappropriate, if the Client
34 refused transport, or failing to obtain the Client's signature on the chart refusing transport,
36 Respondent acted negligently, violating ORS 676.612(2)(j).
25. By recommending and facilitating a surgical procedure, a vacuum extraction by a naturopath, at
28 an out-of-hospital birth, contrary to signed informed choice consent agreement, Respondent
30 failed to conform to standards of practice, violating ORS 676.612(2)(j).
26. By recommending and facilitating a surgical procedure, a vacuum extraction by a naturopath, at
32 an out-of-hospital birth, contrary to signed informed choice consent agreement, Respondent
34 acted incompetently, violating ORS 676.612(2)(j).
27. By recommending and facilitating a surgical procedure, a vacuum extraction by a naturopath, at
36 an out-of-hospital birth, contrary to signed informed choice consent agreement, Respondent
38 acted negligently, violating ORS 676.612(2)(j).
28. By failing to assess the appropriateness of an out-of-hospital birth after the vacuum extraction
40 attempts, given the naturopath's recommendation to transport Client to the hospital, Respondent
42 violated former OAR 332-025-0021(1)(b) and (2)(b) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
29. By failing to arrange transport for the Client after the vacuum extraction attempts, against the
44 naturopath's recommendation, Respondent violated former OAR 332-025-0021(1)(b) (cert. ef. 7-
46 1-04) and ORS 676.612(2)(n).
30. By failing to counsel the Client regarding the potential adverse outcomes, that out-of-hospital
48 birth was inappropriate, after the vacuum extraction attempts, given the naturopath's

2 recommendation to transport Client to the hospital, Respondent violated former OAR 332-025-
0021(1)(b) and (5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

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6 31. By failing to document the midwife's discussion of potential adverse outcomes with the Client, if
8 the Client refused transport, that out-of-hospital birth was inappropriate after the vacuum
extraction attempts, given the naturopath's recommendation to transport Client to the hospital,
Respondent violated former OAR 332-025-0021 (5)(a)(cert. ef. 7-1-04) and ORS 676.612(2)(n).

10 32. By failing to obtain the Client's signature on the chart refusing transport, if the Client refused
12 transport, after the midwife's discussion of potential adverse outcomes with the Client, that out-
of-hospital birth was inappropriate after the vacuum extraction attempts, against the naturopath's
14 recommendation to transport Client to the Hospital, Respondent violated former OAR 332-025-
0021 (5)(a)(cert. ef. 7-1-04) and ORS 676.612(2)(n).

16 33. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
18 the Client, failing to counsel the Client regarding the potential adverse outcomes and that out-of-
hospital birth was inappropriate, failing to document that discussion if the Client refused
20 transport, or failing to obtain the Client's signature on the chart refusing transport, after the
vacuum extraction attempts, against the naturopath's recommendation to transport Client to the
22 hospital, the Respondent failed to conform to standards of practice, violating ORS 676.612(2)(j)
and (2)(n) and former OAR 332-025-0021(1)(b), (2)(b) and (5)(a)(cert. ef. 7-1-04).

24 34. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
26 the Client, failing to counsel the Client regarding the potential adverse outcomes and that out-of-
hospital birth was inappropriate, failing to document that discussion if the Client refused
28 transport, or failing to obtain the Client's signature on the chart refusing transport, after the
vacuum extraction attempts, against the naturopath's recommendation to transport Client to the
30 hospital, the Respondent acted incompetently, violating ORS 676.612(2)(j).

32 35. By failing to assess the appropriateness of an out-of-hospital birth, failing to arrange transport for
34 the Client, failing to counsel the Client regarding the potential adverse outcomes and that out-of-
hospital birth was inappropriate, failing to document that discussion if the Client refused
36 transport, or failing to obtain the Client's signature on the chart refusing transport, after the
vacuum extraction attempts, against the naturopath's recommendation to transport Client to the
hospital, the Respondent acted negligently, violating ORS 676.612(2)(j).

38 36. By failing to assess the appropriateness of an out-of-hospital birth for a Client with a retained
40 placenta with abnormal or significant bleeding from approximately 6:47 a.m. to 8:07 a.m.,
Respondent violated OAR 332-025-0021(2)(c) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

42 37. By not arranging for transport of a Client with a retained placenta with abnormal or significant
44 bleeding, from approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-025-
0021(1)(d) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

46 38. By failing to counsel the Client with a retained placenta with abnormal or significant bleeding
48 regarding the potential adverse outcomes, that out-of-hospital birth was inappropriate, from
approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-025-0021(1)(d) and (5)(a)
(cert. ef. 7-1-04) and ORS 676.612(2)(n).

- 2
- 4 39. By failing to document the midwife's discussion of potential adverse outcomes with the Client, if
- 6 the Client refused transport, that out-of-hospital birth was inappropriate, from approximately
- 8 6:47 a.m. to 8:07 a.m., when the Client had a retained placenta with abnormal or significant
- 10 bleeding, Respondent violated OAR 332-025-0021(5)(a) (cert. ef. 7-1-04) and ORS
- 12 676.612(2)(n).
- 14
- 16 40. By failing to obtain the Client's signature on the chart refusing transport, if the Client refused
- 18 transport, after the midwife's discussion of potential adverse outcomes with the Client, that out-
- 20 of-hospital birth was inappropriate, from approximately 6:47 a.m. to 8:07 a.m., when the Client
- 22 had a retained placenta with abnormal or significant bleeding Respondent violated OAR 332-
- 24 025-0021(5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
- 26
- 28 41. By failing to assess the appropriateness of an out-of-hospital birth, not arranging for transport of
- 30 a Client with a retained placenta with abnormal or significant bleeding, failing to counsel the
- 32 Client regarding potential adverse outcomes and that out-of-hospital birth was inappropriate,
- 34 failing to document the midwife's discussion of potential adverse outcomes with the Client and
- 36 that out-of-hospital birth was inappropriate, if the Client refused transport, or failing to obtain the
- 38 Client's signature on the chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m.,
- 40 Respondent failed to conform to standards of practice, violating ORS 676.612(2)(j) and (n) and
- 42 OAR 332-025-0021(1)(d), (2)(c) and (5)(a) (cert. ef. 7-1-04).
- 44
- 46 42. By failing to assess the appropriateness of an out-of-hospital birth, not arranging for transport of
- 48 a Client with a retained placenta with abnormal or significant bleeding, failing to counsel the
- Client regarding potential adverse outcomes and that out-of-hospital birth was inappropriate,
- failing to document the midwife's discussion of potential adverse outcomes with the Client and
- that out-of-hospital birth was inappropriate, if the Client refused transport, or failing to obtain the
- Client's signature on the chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m.,
- Respondent acted incompetently, violating ORS 676.612(2)(j).
43. By failing to assess the appropriateness of an out-of-hospital birth, not arranging for transport of
- a Client with a retained placenta with abnormal or significant bleeding, failing to counsel the
- Client regarding potential adverse outcomes and that out-of-hospital birth was inappropriate,
- failing to document the midwife's discussion of potential adverse outcomes with the Client and
- that out-of-hospital birth was inappropriate, if the Client refused transport, or failing to obtain the
- Client's signature on the chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m.,
- Respondent acted negligently, violating ORS 676.612(2)(j).
44. By failing to assess the appropriateness of an out-of-hospital birth of a Client with signs and
- symptoms of shock unresponsive to treatment, from approximately 6:47 a.m. to 8:07 a.m.,
- Respondent violated OAR 332-025-0021(2)(c) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
45. By not arranging transport of a Client with signs and symptoms of shock unresponsive to
- treatment, from approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-025-
- 0021(1)(d) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
- 46
- 48 46. By failing to counsel a Client with signs and symptoms of shock unresponsive to treatment
- regarding potential adverse outcomes, that out-of-hospital birth was inappropriate, from

2 approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-025-0021(1)(d) and (5)(a)
4 (cert. ef. 7-1-04) and ORS 676.612(2)(n).

6 47. By failing to document the midwife's discussion of potential adverse outcomes with the Client,
8 that out-of-hospital birth was inappropriate, if the Client refused transport, from approximately
10 6:47 a.m. to 8:07 a.m., when the Client had signs and symptoms of shock unresponsive to
12 treatment, Respondent violated OAR 332-025-0021(5)(a) (cert. ef. 7-1-04) and ORS
14 676.612(2)(n).

16 48. By failing to obtain the Client's signature on the chart refusing transport, if the Client refused
18 transport, after the midwife's discussion of potential adverse outcomes with the Client, that out-
20 of-hospital birth was inappropriate, from approximately 6:47 a.m. to 8:07 a.m., when the Client
22 had signs and symptoms of shock unresponsive to treatment, Respondent violated OAR 332-
24 025-0021(5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

26 49. By failing to assess the appropriateness of an out-of-hospital birth, not arranging transport of a
28 Client with signs and symptoms of shock unresponsive to treatment, failing to counsel Client
30 regarding potential adverse outcomes and that out-of-hospital birth was inappropriate, failing to
32 document the midwife's discussion of potential adverse outcomes with the Client and that out-
34 of-hospital birth was inappropriate, if the Client refused transport, or failing to obtain the Client's
36 signature on the chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m., Respondent
38 failed to conform to standards of practice, violating ORS 676.612(2)(j) and (n) and OAR 332-
40 025-0021(1)(d), (2)(c) and (5)(a) (cert. ef. 7-1-04).

42 50. By failing to assess the appropriateness of an out-of-hospital birth, not arranging transport of a
44 Client with signs and symptoms of shock unresponsive to treatment, failing to counsel the Client
46 regarding potential adverse outcomes and that out-of-hospital birth was inappropriate, failing to
48 document the midwife's discussion of potential adverse outcomes with the Client and that out-
of-hospital birth was inappropriate, if the Client refused transport, or failing to obtain the Client's
signature on the chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m., Respondent
acted incompetently, violating ORS 676.612(2)(j).

51. By failing to assess the appropriateness of an out-of-hospital birth, not arranging transport of a
Client with signs and symptoms of shock unresponsive to treatment, failing to counsel the Client
regarding potential adverse outcomes and that out-of-hospital birth was inappropriate, failing to
document the midwife's discussion of potential adverse outcomes with the Client and that out-
of-hospital birth was inappropriate, if the Client refused transport, or failing to obtain the Client's
signature on the chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m., Respondent
acted negligently, violating ORS 676.612(2)(j).

52. By failing to assess the appropriateness of an out-of-hospital birth of a Client with uncontrolled
postpartum bleeding from approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-
025-0021(2)(c) (cert. ef. 7-1-04) and ORS 676.612(2)(n).

53. By not arranging transport of a Client with uncontrolled postpartum bleeding from
approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-025-0021(1)(d) (cert. ef. 7-
1-04) and ORS 676.612(2)(n).

- 2 54. By failing to counsel a Client with uncontrolled postpartum bleeding regarding the potential
4 adverse outcomes with the Client, that out-of-hospital birth was inappropriate, from
6 approximately 6:47 a.m. to 8:07 a.m., Respondent violated OAR 332-025-0021(1)(d) and (5)(a)
8 (cert. ef. 7-1-04) and ORS 676.612(2)(n).
- 10 55. By failing to document the midwife's discussion of potential adverse outcomes with the Client,
12 that out-of-hospital birth was inappropriate, if the Client refused transport, from approximately
14 6:47 a.m. to 8:07 a.m., when the Client had uncontrolled postpartum bleeding, Respondent
16 violated OAR 332-025-0021(5)(a) (cert. ef. 7-1-04) and ORS 676.612(2)(n).
- 18 56. By failing to obtain the Client's signature on the chart refusing transport, if the Client refused
20 transport, after the midwife's discussion of potential adverse outcomes with the Client, that out-
22 of-hospital birth was inappropriate, from approximately 6:47 a.m. to 8:07 a.m., when the Client
24 had uncontrolled postpartum bleeding, Respondent violated OAR 332-025-0021(5)(a) (cert. ef.
26 7-1-04) and ORS 676.612(2)(n).
- 28 57. By failing to assess the appropriateness of an out-of-hospital birth, not arranging transport of a
30 Client with uncontrolled postpartum bleeding, failing to counsel the Client regarding potential
32 adverse outcomes and that out-of-hospital birth was inappropriate, failing to document the
34 midwife's discussion of potential adverse outcomes with the Client and that out-of-hospital birth
36 was inappropriate, if the Client refused transport, or failing to obtain the Client's signature on the
38 chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m., Respondent failed to
40 conform to standards of practice, violating ORS 676.612(2)(j) and (n) and OAR 332-025-
42 0021(1)(d), (2)(c) and (5)(a) (cert. ef. 7-1-04).
- 44 58. By failing to assess the appropriateness of an out-of-hospital birth, not arranging transport of a
46 Client with uncontrolled postpartum bleeding, failing to counsel the Client regarding potential
48 adverse outcomes and that out-of-hospital birth was inappropriate, failing to document the
midwife's discussion of potential adverse outcomes with the Client and that out-of-hospital birth
was inappropriate, if the Client refused transport, or failing to obtain the Client's signature on the
chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m., Respondent acted
incompetently, violating ORS 676.612(2)(j).
59. By failing to assess the appropriateness of an out-of-hospital birth, not arranging transport of a
Client with uncontrolled postpartum bleeding, failing to counsel the Client regarding potential
adverse outcomes and that out-of-hospital birth was inappropriate, failing to document the
midwife's discussion of potential adverse outcomes with the Client and that out-of-hospital birth
was inappropriate, if the Client refused transport, or failing to obtain the Client's signature on the
chart refusing transport, from approximately 6:47 a.m. to 8:07 a.m., Respondent acted
negligently, violating ORS 676.612(2)(j).

PROPOSED ORDER

Pursuant to ORS 687.445, 676.612(1) 676.992(2), the Board of Direct Entry Midwifery may take any disciplinary action it finds proper and hereby proposes to ORDER:

2 1) Suspend Jessica Dolin's license to practice direct entry midwifery, license DEM-LD- 1004154 for a
4 minimum period of two years with reinstatement contingent on the following:

6 1.1. Satisfying any general requirements for reinstatement under the applicable statutes and rules and
the following specific requirements.

8 1.1.1. Respondent violates no laws or Oregon Administrative Rules during suspension period.

10 2) Upon reinstatement, place the Respondent's license on probation for a period of one year with the
following specific requirements:

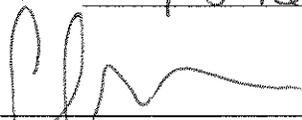
12 2.1. Respondent to have 12 months of supervised practice by a Board approved supervisor.

14 Respondent is responsible for identifying a supervisor and submitting information, as required
by the Board, for approval by the Board. Respondent is responsible for any fees or costs
16 associated with such supervision.

18 3) Assess the cost of any disciplinary proceeding against the Respondent, up to a maximum of \$5,000.

20 DATED

4-5-16



24 Colleen Forbes, LDM

26 Chair, Board of Direct Entry Midwifery

28 Enclosures: Option form, Notice of Contested Case Rights and Procedures

30 CERTIFIED MAIL: 7014 2120 0003 6351 7572

32 NOTICE OF RIGHTS TO REQUEST A HEARING

34 You have the right to a hearing to contest this order. The hearing, if requested, will be conducted
36 according to the Administrative Procedures Act, ORS chapter 183. A **request for hearing** must be in
writing and **must be received** by the Health Licensing Office **within 30 days** from the date this Notice
38 was mailed to you. The written request for a hearing must be sent to the Health Licensing Office, 700
Summer St. NE, Suite 320, Salem, Oregon 97301-1287.

40 If you request a hearing, you **may be required to provide, with your request, an answer** to
each factual matter alleged in the Notice and a short and plain statement of any **affirmative defense** you
42 will raise at the hearing. Please see OAR 331-020-0020. If a specific response is required, factual
44 matters alleged in the notice and not denied in the answer shall be presumed admitted; failure to raise a
particular defense in the answer will be considered a waiver of such defense; new matters alleged in the
46 answer (affirmative defenses) shall be presumed to be denied by the office; and evidence shall not be
taken on any issue not raised in the notice and the answer. You may be represented by an attorney. If
48 you cannot afford an attorney, you may contact Oregon's Legal Aid providers to attempt to obtain free
or low-cost representation.

2 If you are an active duty service member you have the right to request a stay of proceedings under the
4 federal Servicemembers Civil Relief Act and may contact the Oregon State Bar toll-free at (800) 452-
6 8260, or the Oregon Military Department toll-free at (800)452-7500, or the United States Armed Forces
Legal Assistance (AFLA) locator at <http://www.militaryonesource.mil> or
<http://legalassistance.law.af.mil>.

8 You will be notified of the date, time and place of the hearing. If you request a hearing you may
10 be represented by an attorney at hearing and you may subpoena and cross-examine witnesses. If you
12 cannot afford an attorney, you may contact an Oregon legal aid office to apply for assistance. If you
14 request a hearing, you will also be given information on the procedures, right of representation and other
rights relating to the conduct of the hearing before the commencement of the hearing.

¹ The Board's supervision requirements are as follows:

Midwifery Supervision Guidelines

The supervisee must meet with the Board approved supervisor to develop a plan of supervision. The supervisee will notify the supervising midwife upon discovery of any confirmed or suspected Absolute or Non-Absolute Risks listed in OAR 332-025-0021.

The supervisor will meet with the supervisee at the following points throughout the course of care to review and discuss the client's charts for a total of no less than four meetings for each supervised birth. The supervisor will at minimum address the areas listed below with specific attention to areas where violations have occurred as listed in the final order and standards of care pursuant with midwifery laws and rules. The supervisor will address any areas of concern with the supervisee and submit a supervision report to the Board for each supervised birth.

I. Intake and initial risk assessment (meeting to take place shortly after initial visits or initial assessments)

- 1) Medical History
 - a) OB/GYN History
 - b) Surgical History
 - c) Family History
- 2) Dating parameters identified & discrepancies resolved per accepted standards
- 3) Absolute or Non-Absolute Risks identified-did the supervisee appropriately assess and recognize risk factors.
 - a) Was there an appropriate consultation and with who
 - b) Consult to confirm risk factor
 - c) What was the result of that consultation
 - d) Was there a documented discussion with the client
 - e) What was the result
- 4) Other potential risks identified or preexisting conditions
 - a) Therapeutic actions/interventions instituted in alignment with identified problems
 - b) Consult to rule out a risk factor
- 5) Informed choice discussions documented
 - a) Supervisees recommendations
- 6) Records of Care properly documents

II. Care During Pregnancy (Antepartum) (meeting to take place around 36 weeks)

- 1) Assess, identify, evaluate and support maternal and fetal well-being throughout the process of pregnancy
- 2) Lab work and testing
- 3) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
 - a) Was there an appropriate consultation and with who
 - b) Consult to confirm risk factor
 - c) What was the result of that consultation

-
- d) Was there a documented discussion with the client
 - e) What was the result
 - 4) Other potential risks identified or preexisting conditions
 - a) Therapeutic actions/interventions instituted in alignment & identified problems
 - b) Consult to rule out a risk factor

Antepartum continued

- 5) Informed choice discussions documented
 - a) Risks/benefits
 - b) Pros/cons
 - c) Midwife's recommendations
- 6) Informed consent documentation
- 7) Records of Care properly documents

III. Later Pregnancy and Post Dates (meetings to take place as necessary)

- 1) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
 - a) Was there an appropriate consultation and with who
 - b) Consult to confirm risk factor
 - c) What was the result of that consultation
 - d) Was there a documented discussion with the client
 - e) What was the result
- 2) Postdates testing
- 3) Informed consent documentation
- 4) Records of Care properly documents

IV. Labor, Birth and Immediately Thereafter (Intrapartum) (meetings to take place as necessary)

- 1) Vital signs at appropriate intervals temperature, blood pressure, pulse, fetal heart tones
- 2) Urine dip done
- 3) If abnormal vital signs – what action taken & is it consistent?
- 4) Labor progress assessed. How?
- 5) Interventions
- 6) Documentation of interventions & effect
- 7) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
 - a) Was there an appropriate consultation and with who
 - b) Consult to confirm risk factor
 - c) What was the result of that consultation
 - d) Was there a documented discussion with the client
 - e) What was the result
- 8) Informed consent documentation
- 9) Records of Care properly documents

V. Postpartum (meetings to take at the end of Midwifery care or as necessary)

- 1) Postpartum
 - a) Assessment at appropriate intervals
 - b) ID deviations
 - c) Action taken documented