

**OREGON HEALTH LICENSING OFFICE
BOARD OF DIRECT ENTRY MIDWIFERY**

IN THE MATTER OF:) **FINAL ORDER**
)
PAMELA ECHEVERIO) OAH Case No. 1303485
) Agency Case No. 12-7029

HISTORY OF THE CASE

On November 1, 2013, the Oregon Health Licensing Office (HLO),¹ Board of Direct Entry Midwifery (Board) issued a Notice of Intent to Revoke a License, Right to Request a Hearing, and Final Order upon Default (Initial Notice) to Pamela Echeverio. On or about November 29, 2013, Ms. Echeverio filed an Answer and Request for Hearing.

On December 4, 2013, the HLO referred the hearing request to the Office of Administrative Hearings (OAH). The HLO indicated that Senior Assistant Attorney General Katharine Lozano would be representing the Board at hearing. The OAH assigned Senior Administrative Law Judge (ALJ) Alison Green Webster to preside over the hearing, scheduled for June 23 through 25, 2014.

On February 28, 2014, the Board issued an Amended Notice of Intent to Suspend License and Impose Additional Discipline, Right to Request a Hearing, and Final Order upon Default (Amended Notice).²

By letter dated March 25, 2014, attorney Hermine Hayes-Klein informed the Board that she was representing Ms. Echeverio in the matter. Also on March 25, 2014, Ms. Echeverio, through her attorney, filed an Answer and Request for Hearing.

On May 23, 2014, Ms. Echeverio filed an unopposed request for postponement of the June 23 through 25, 2014 hearing. ALJ Webster granted the request, and the hearing was rescheduled for October 27 through 29, 2014. Because ALJ Webster was unavailable on those dates, the OAH reassigned the matter to ALJ Jennifer H. Rackstraw.

On September 3, 2014, Senior Assistant Attorney General Joanna Tucker Davis was designated as the Board's representative in the matter. On October 14, 2014, Ms. Echeverio filed another unopposed request for postponement of the hearing. ALJ Rackstraw granted the request, and the hearing was rescheduled for February 9 through 11, 2015.

¹ Because the HLO was formerly called the Health Licensing Agency (HLA), some documents in this case record reference the HLA. There is no practical distinction for purposes of this matter.

² As of January 2014, HLO employees investigate matters such as the one at issue, and the Board has Final Order authority.

On January 14, 2015, the Board issued a Second Amended Notice of Intent to Suspend License and Impose Additional Discipline, Right to Request a Hearing, and Final Order upon Default (Second Amended Notice). On January 27, 2015, Ms. Echeverio, through her attorney, filed an Amended Answer and Request for Hearing.

On February 5, 2015, ALJ Rackstraw convened a telephone prehearing conference. Ms. Tucker Davis represented the Board. Ms. Hayes-Klein represented Ms. Echeverio. The Board moved to exclude Susan Moray as an expert witness for Ms. Echeverio at the upcoming hearing. ALJ Rackstraw heard arguments with respect to the motion, and subsequently granted the motion.

On February 9, 10, and 11, 2015, ALJ Rackstraw presided over the contested case hearing in Tualatin, Oregon. Ms. Tucker Davis represented the Board. Ms. Hayes-Klein represented Ms. Echeverio. The following persons testified: Ms. Echeverio; Elise Erickson, CNM; Wendy Smith, MD; CF, midwifery client; LF, the husband of CF; SF, the father of LF; Anne Frye, CPM; Katherine Greer, CPM, LDM; and Paul Bircher, MD. Nathan Goldberg, HLO Investigator, was present at the hearing, but he did not testify. Kate Donahue, assistant to Ms. Hayes-Klein, was also present at the hearing.

The record closed at the conclusion of the hearing on February 11, 2015. On April 6, 2015, ALJ Rackstraw issued a Proposed Order in this matter. Respondent filed exceptions to the Proposed Order. On June 11, 2015, the Board deliberated on the record and Respondent's exceptions. On June 30, 2015, the Board met to further deliberate on this matter and on that date, the Board voted to issue an Amended Proposed Order and Bill of Costs in this matter. On July 14, 2015, the Board issued the Amended Proposed Order and Bill of Costs. On August 10, 2015, Respondent filed exceptions to the Amended Proposed Order and Bill of Costs. On December 2, 2015, the Board considered and rejected the exceptions filed by Respondent to the Amended Proposed Order. On December 2, 2015, the Board voted to issue this Final Order.

ISSUES³

1. Whether Ms. Echeverio violated OAR 332-025-0021(1)(b)⁴ and 332-025-0130(2) by failing to transfer or terminate care of the client at 11:15 a.m. or earlier, when presented with an intrapartum absolute risk as per OAR 332-025-0021(2)(b)(L), with labor at less than 35 weeks.

2. Whether Ms. Echeverio violated ORS 676.612(2)(j) and OAR 332-025-0022(3)(b)(C) by failing to recognize and communicate the emergent need for the client to receive immediate in-hospital care at 11:15 a.m. or earlier, when the client was in labor at 27 and 5/7 weeks.

3. Whether Ms. Echeverio violated OAR 332-025-0110(1), (4) and (5) by failing to maintain complete and accurate records because she did not date and sign addendums to the client's Prenatal Flow chart.

³ In the Amended Notice, the following violation was included:

3. Whether Ms. Echeverio violated ORS 676.612(2)(j) and OAR 332-025-0022(3)(b)(C) by treating the client with False Unicorn Root, when the client was in labor at 27 and 5/7 weeks, instead of terminating or transferring care of the client.

The ALJ, in the Proposed Order, made the following conclusion as to this violation:

As discussed previously, once Ms. Echeverio was presented with the absolute risk of CF's preterm labor, her obligation was to arrange transportation to the hospital and transfer care of CF. However, Ms. Echeverio continued to provide care to CF for the next 2.5 hours, and that care included the administration of the False Unicorn Root. While that conduct constitutes a violation of OAR 332-025-0021(1)(b), the Board has not established how it also violates ORS 676.612(2)(j) and OAR 332-025-0022(3)(b)(C).

The Board concurs, and now dismisses this violation.

In the Amended Notice, the following violation was also included:

4. Whether Ms. Echeverio violated ORS 676.612(2)(j), as defined in OAR 331-020-0070(2)(e), by altering the client's Prenatal Flow chart after learning of the Board's investigation, in an attempt to deceive the Board.

The ALJ, in the Proposed Order, made the following conclusion as to this violation:

Although Ms. Echeverio's conduct in adding the additional chart notes, and failing to document them as addendums, may very well have been an attempt to deceive the Board, it is equally as likely that Ms. Echeverio was simply trying to provide the Board with more information, and that her knowledge of typical charting practices is, in fact, substandard. In conclusion, the Board has not met its burden of establishing, more likely than not, that Ms. Echeverio violated ORS 676.612(2)(j), as defined in OAR 331-020-0070(2)(e), by deceptively altering CF's Prenatal Flow sheets.

As a result of the ALJ's failure to find that the Board did not meet its burden, the Board now dismisses this violation.

⁴ All citations to statutes and administrative rules in this Proposed Order are to the versions that were in effect when the alleged violations occurred. Such versions frequently refer to the HLA, and not the HLO.

4. Whether Ms. Echeverio violated OAR 332-025-0110(1) and (2)(d) by failing to maintain complete and accurate records of laboratory findings because the client's blood work test results were not with the client's records of care.

5. What is the appropriate proposed sanction, including the assessment of the costs of the proceeding, up to a maximum of \$5,000, that is appropriate for the proven violations.

EVIDENTIARY RULINGS

The Board's Exhibits A1 through A18 and Ms. Echeverio's Exhibits R1 through R22 were admitted into the record without objection.

Pleadings P1 through P16 and Demonstrative Exhibits A19 and R23 are also included in the record.

CREDIBILITY DETERMINATION

The Board adopts the credibility determinations found by ALJ Rackstraw in the Proposed Order. While a witness is presumed to speak the truth, the presumption may be overcome "by the manner in which the witness testifies, by the character of the testimony of the witness, or by evidence affecting the character or motives of the witness, or by contradictory evidence." ORS 44.370. A determination of witness credibility may also be based on the inherent probability of the evidence, whether the evidence is corroborated, whether the evidence is contradicted by other testimony or evidence, whether there are internal inconsistencies, and "whether human experience demonstrates that the evidence is logically incredible." *Tew v. DMV*, 179 Or App 443, 449 (2002), citing *Lewis and Clark College v. Bureau of Labor*, 43 Or App 245, 256 (1979) *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part, dissenting in part).

Here, it is necessary to determine whether and when certain events occurred on October 31, 2012, to assess whether Ms. Echeverio committed one or more of the alleged violations. Of particular importance is a determination of what symptoms the client, CF, reported to Ms. Echeverio during their first phone conversation on October 31, what time Ms. Echeverio arrived at CF's residence, what time a vaginal exam occurred, when CF reported to Ms. Echeverio that she was experiencing uterine contractions, and when Ms. Echeverio called the hospital. The record varies significantly with respect to those matters, and a summary of the conflicting evidence appears below.

Answers and Requests for Hearing – November 29, 2013, March 25, 2014, and January 27, 2015

In her first written Answer, Ms. Echeverio stated that during the first phone conversation on October 31, 2012, CF reported spotting and "some light cramping." November 29, 2013 Answer at 2. Ms. Echeverio further stated in the first Answer that during the second phone conversation, CF "reported that she still had some cramping despite the [intake of] fluids." *Id.*

Similarly, in her second written Answer, Ms. Echeverio admitted to the following Board allegation: "Client called Respondent back at approximately 10:30 a.m., still complaining of cramping." March 25, 2014 Answer at 1.

However, in her third written Answer, Ms. Echeverio denied the Board's allegation that "[c]lient called Respondent back at approximately 10:30 a.m., still complaining of cramping." January 27, 2015 Amended Answer at 1. Instead, she asserted that CF would be testifying that she did not experience or report cramping until after the first phone conversation.

CF's Statements to Goldberg and Erickson on May 18, 2013

On May 18, 2013, CF participated in a telephone interview with HLO Investigator Nathan Goldberg and Elise Erickson, a certified nurse midwife and a subject-matter expert who contracts with the HLO/Board.

During the interview, CF stated that she called Ms. Echeverio at approximately 8:00 a.m. on October 31, 2012, that she did not notice any cramping until after that first phone call, that she called Ms. Echeverio a second time at approximately 10:30 a.m., that Ms. Echeverio arrived at her home at approximately 11:15 or 11:30, and that the vaginal exam occurred approximately 30 minutes later.

With regard to the timing of events on October 31, 2012, CF stated during the interview that "things happened like so fast that day and * * * it's hard for me to remember exactly what time." Exhibit A15 at 7. She subsequently stated, in part:

I think the exam was later than noon. I can't remember exactly what time she came over. Maybe she came over at eleven-forty-five and maybe it was twelve-fifteen or so. But I think I vaguely remember that I didn't really start feeling contractions until about one p.m.

Id. at 17.

CF's Handwritten Letter received by Board on June 26, 2013

On or about June 24, 2013, Ms. Echeverio and CF met to discuss CF's medical records. At hearing, Ms. Echeverio and CF both testified that during that meeting they did not discuss the details of October 31, and they did not go through a detailed timeline of the events of that day. According to Ms. Echeverio's testimony, she and CF did not discuss a specific timeline of the October 31 events until the fall of 2014.

Nevertheless, on or about June 26, 2013, the Board received a handwritten letter from CF that stated, in relevant part, "I have read & reviewed the timeline of the events that transpired on 10-31-12 and find them to be accurate as documented." Exhibit A16 at 5.

CF's Prenatal Flow sheets received by Board on June 26, 2013

While still at CF's home on October 31, 2012, Ms. Echeverio made the following notes on CF's Prenatal Flow sheet:

10/31/12

[CF] called this a.m. @ 8:00 a.m. to report red bleeding – [approximately] 1 tb. Also report brownish spotting for the last 4-5 days but today “red” bleeding. Also reports so[me] diarrhea this a.m. * * *. Will rest & drink lots of H₂O, as she feels some cramping[.]

[CF] called again @ 10:30 – diarrhea stopped, still feeling some cramping & small amt of spotting[.]

10/31/12

Arrived at 10:30 a.m. Discussed options, VE = 3-4 cm cx[,] 80% effaced, 0 station! Explained that cramping & low head & opening cx = early labor. Started dosing 30 gtts False Unicorn Rt[.]

10/31/12

11:30 a.m.

[CF] feeling for the 1st time some possible u/c's[.]

Discussed possible early delivery @ length[.]

12:30 p.m. - ↑ dosing of [False Unicorn Root] to 30 gtts / 15 min, some cramping reported [with] u/c's[.]

1:30 p.m. FHT's 140's-150's u/c's ↑ q 2-3 min[,] lasting 30-40 sec.

1:45 p.m. – Discussed options, called Emanuel Hospital

1:50 p.m. – Transported

See Exhibit A6 at 2-3.

After arriving at the hospital on the afternoon of October 31, 2012, Ms. Echeverio changed the notation regarding her time of arrival at CF's home from 10:30 a.m. to 10:50 a.m. She also added the following notes to CF's Prenatal Flow sheet:

10/31/12

Reviewing notes & time to now sit to write – adding more details to chart notes:

Arrived @ 10:50 a.m. * * * After collecting info regarding her night, still unclear about “cramping” vs u/c. VE was done after interview[,] probably closer to 11:15 a.m. Then lots of explaining needed to help [CF] and [LF]

understand that [they needed to go to the hospital]. We agreed to give false unicorn [root] a chance after discussing transport[.]

12:15 After an hour of resting, the s/s “cramping” ↑ to what she described as more contraction-like. During this time I explained how her transport would go – [t]hat my role would change but I would stay with them. [LF] started packing & calling his parents. I called Legacy Emanuel.

1:30 * * * I was insistent that the time was now & expressed my opinion that the only safe option was getting to the hospital. They agreed & transport[] proceeds to Emanuel.

See id. at 2-4.

Ms. Echeverio’s Statements to Goldberg and Erickson on July 10, 2013

On July 10, 2013, Ms. Echeverio participated in an in-person interview with Ms. Erickson and Mr. Goldberg.

During the interview, when asked to relay the events of October 31, 2012, Ms. Echeverio stated that CF called her at approximately 8:30 a.m. and reported that “she had had some brown spotting and * * * when she woke that morning it was more red.” Exhibit A14 at 2-3. She told the interviewers that CF “was very unclear about whether she was having contractions or not. She said she felt like she was having some cramping.” *Id.* at 3. Ms. Echeverio stated that CF called her again at approximately 10:30 a.m., and that although the bright red bleeding had stopped by that time, “the cramping continued.” *Id.* at 29.

Ms. Echeverio told the interviewers that she arrived at CF’s home at approximately 10:50 a.m., discussed matters with CF and her husband for a while, administered a dose of False Unicorn Root to CF shortly before 11:15 a.m., performed the vaginal exam at approximately 11:15 a.m., and administered a second dose of False Unicorn Root at 11:30 a.m. She reported that they all left for the hospital sometime after 1:30 p.m.

When asked during the interview to clarify certain times that events occurred on October 31, Ms. Echeverio stated, in part:

[I] didn’t do the assessment at ten-thirty. I sat down to write the notes when I had a moment and I put ten-thirty as the time that I arrived. And then I just started writing, you know[.]

* * * * *

[W]hen I got to the hospital * * * I made some notes[.]

* * * * *

[I] had time to sit down and review my notes [at the hospital]. And so then I go through the history a little bit more clearly and said I arrived at ten-fifty.

Id. at 10-14.

During the interview, Ms. Echeverio represented her statements regarding the timeline and events of October 31, 2012 in a definitive and concrete manner. She did not tell the interviewers, or in any way indicate, that the times and events noted on the Prenatal Flow sheets were inaccurate, or that she had estimated times without the benefit of a time-keeping device. See generally Exhibit A14.

Ms. Echeverio's Hearing Testimony on February 9, 2015

At hearing, Ms. Echeverio testified that she erred in her estimation of the timing and existence of certain events on October 31, 2012. She denied that CF reported having brownish spotting for the previous four or five days or any cramping during their first phone conversation on October 31. She testified that she should have indicated that the brownish spotting was merely an "historical" symptom from earlier in the pregnancy.

She further testified that her original notation of arriving at CF's home at 10:30 a.m. was incorrect, and that her amended notation of arriving at 10:50 a.m. was also incorrect. She estimated at hearing that she probably arrived at CF's home closer to 11:15 a.m., that she performed the vaginal exam at approximately noon, that just before 1:00 p.m. she left CF and her husband alone and charted, and that CF felt her first contraction at approximately 1:00 p.m. She testified that she had not been wearing a watch on October 31.

CF's Hearing Testimony on February 10, 2015

At hearing, CF denied experiencing any brownish spotting in the days before October 31, 2012. She further denied that she was experiencing, or that she reported having experienced, any cramping when she called Ms. Echeverio at approximately 8:00 a.m. on October 31.

CF testified that, to the best of her recollection, Ms. Echeverio arrived at her home at approximately 11:15 a.m. She testified that between 30-45 minutes passed between that arrival and the vaginal exam, that she felt her first contractions between 12:30 and 1:00 p.m., and that approximately 45 minutes passed between the time she felt her first contractions and they left for the hospital.

CF admitted more than once during her hearing testimony that she was not certain about the precise timing of the events that occurred on October 31, 2012, and that she was not taking notes or watching a clock as events unfolded that day.

Conclusion

In weighing the conflicting evidence, The ALJ concluded, and the Board concurs, that Ms. Echeverio's contemporaneous (or near-contemporaneous) chart notes from October 31, 2012 and the statements she provided to Mr. Goldberg and Ms. Erickson on July 10, 2013 are more reliable, and therefore more likely to be accurate, than the hearing testimony that Ms. Echeverio and CF provided in February 2015.

When Ms. Echeverio initially made chart note entries on CF's Prenatal Flow sheet on October 31, 2012, there is no reason to doubt that her primary intention was to capture the events and timing of those events as accurately as possible. When she reviewed her notes and had time to further reflect on the day's events a few hours later on October 31, she clarified some of the timing and added additional details. Again, there is no reason to doubt that she intended to document things as accurately as possible at that time. CF, in her June 26, 2013 letter, informed the Board that she concurred with the timeline set forth in those chart notes. At hearing, however, Ms. Echeverio testified that in the fall of 2014, she and CF discussed the timing of the events of October 31, and that her chart notes were incorrect in numerous respects.

More likely than not, a person's attempt to recollect events and reconstruct a timeline of those events more than two years after the events occurred, even if well-intentioned, is not as reliable as contemporaneously prepared chart notes made for the primary purpose of recording the events as they happened. When you add to this the fact that Ms. Echeverio's and CF's more recent attempts at recollecting events and reconstructing the timing of such events was spurred by the HLO's investigation of Ms. Echeverio, it further diminishes their reliability. Although CF presented as an honest, forthright person at hearing, she was visibly upset regarding the pending action against Ms. Echeverio. It is therefore possible that her perception that Ms. Echeverio—a midwife who she trusts and credits with saving her baby's life—is being unfairly treated may alter her recollection of what occurred on October 31, 2012. Also, given that CF was in the midst of a highly emotional and distressful situation, and that she was not taking notes or watching a clock, her perceptions—two years later—of the passage of time and the spacing of events are of questionable reliability.

The Findings of Fact that follow are made in accordance with these considerations and conclusions.

FINDINGS OF FACT⁵

Ms. Echeverio's Background

1. At all times pertinent to this matter, Ms. Echeverio held a Direct Entry Midwifery license.⁶ (See Ex. A3 at 1.) She has not been previously disciplined by the Board. (Ex. A3 at 9.)

⁵ The Board has made no changes to the Findings of Fact in the Proposed Order.

⁶ Under ORS 687.405, "direct entry midwifery" includes the following:

- (1) Supervision of the conduct of labor and childbirth;
- (2) Providing advice to a parent as to the progress of childbirth; [and]
- (3) Rendering prenatal, intrapartum and postpartum care[.]

2. As early as 1979, Ms. Echeverio attended births as a doula and birth attendant. Those births mostly occurred in hospitals. (Test. of Echeverio.)

3. In 2000, Ms. Echeverio began midwifery training at Birthingway College of Midwifery (Birthingway). During the second-year curriculum, she received training in preterm labor. Her training has included the use of medicinal herbs and botanicals for pregnancy and childbirth. She now holds a Bachelor's of Science degree in Midwifery. (Test. of Echeverio.)

4. In 2006, Ms. Echeverio began working as a licensed midwife. Since approximately 2009, she has worked as an independent midwife. She also teaches various courses at Birthingway, including pharmacology for midwives, gynecology skills, suturing, and legends/drugs/devices. (Test. of Echeverio.)

5. Over the years, Ms. Echeverio has had many clients report cramping, and several clients who have reported bleeding. Prior to October 31, 2012, she never had a client who reported having both of those symptoms simultaneously. (Test. of Echeverio.)

6. Prior to October 31, 2012, Ms. Echeverio had experience caring for two women who experienced preterm labor. With both of those clients, their preterm labors started with rupturing membranes as the presenting symptom. (Test. of Echeverio; *see* Ex. A10 at 2.)

7. Ms. Echeverio maintains "Prenatal Flow" sheets to chart the care she provides to her midwifery clients. (*See* Ex. A6; test. of Echeverio.) At the top of each page is a space for the client's name, date of birth, and estimated due date. Each page contains three columns: one for the date; one for the provider's initials; and one for the notes. (*See* Ex. A6.)

Midwifery

8. Midwives Alliance of North America (MANA) is the trade organization for midwives. MANA's "Statement of Values and Ethics" (revised and approved August 2010) provides, in part: "We value a woman as autonomous and competent to make decisions regarding all aspects of her life." (Ex. R4 at 1.)

9. Anne Frye was a midwife from September 1978 to October 1992. She was a Board member from June 1993 to June 1998. Since leaving clinical practice, she has focused on writing textbooks, including *Holistic Midwifery: A Comprehensive Textbook for Midwives in Homebirth Practice*, Volumes 1 and 2 (*Holistic Midwifery*); *Understanding Diagnostic Tests in the Childbearing Year: A Holistic Approach (Understanding Diagnostic Tests)*; and *Healing Passage: A midwife's guide to the care and repair of the tissues involved in birth*. These textbooks are part of the core curriculum at Birthingway. (Test. of Frye.) Midwives commonly refer to *Holistic Midwifery* as "The Bible." (Test. of Echeverio.)

10. False Unicorn Root (*Chamaelirium luteum*) is an herbal remedy with a variety of uses. Midwives have used the herb for centuries to relax the uterus and decrease preterm, non-productive uterine cramping. The herb may lower the intensity of such cramping and the related

feelings of pressure and discomfort. Midwives have also used the herb to prevent preterm cramping from developing into preterm labor. The herb will not, however, stop preterm labor once it is underway. (Test. of Frye, Greer; Ex. R8 at 2.) False unicorn root is not used when a woman has reached full-term labor. In Ms. Frye's opinion, the herb can be used for miscarriage or preterm cramping before approximately 36 weeks of pregnancy. (Test. of Frye.)

Medical Documentation and Recordkeeping

11. In a revised edition of *Holistic Midwifery*, Volume 1,⁷ titled "Care During Pregnancy," the following appears under the heading "Charting and Record Keeping":

Record keeping, although tedious and distracting at times, is an important component of competent care. Records serve as a memory bank, as it is impossible to remember all the physical, medical, emotional and psychological details of each client's history. * * * * *. This is particularly true during labor, when time can become very distorted for both you and the family. Accurate charting helps immensely when you must, for whatever reason, transfer care to another provider[.]

Legal issues: Your charts are a legal record of your interaction with your clients. Your chart is your best and sometimes your only resource to back up your claims should questions regarding your recommendations or how you dealt with a problem come up. * * *. All entries should be legibly entered in black ink to facilitate photocopying. Errors can be corrected by drawing a single line through the error so that it remains legible; obliterating the entry with white-out, scratch outs or markers should not be done. Write "error" above the mistake, initial it, then write the correct information beside or below the error. * * *. Each page should contain the woman's name as well as the date, time, and the signature (first initial and last name) of the person charting on that page. In narrative charting, do not leave blank or incomplete lines. Draw a line to the end of the line, then initial it. Do not chart anything until it has been completed[.]

(Ex. A17 at 7.) *Holistic Midwifery* is not Oregon-specific. (Test. of Frye.)

12. The Centers for Medicare and Medicaid Services (CMS) has stated the following with respect to physicians and other healthcare providers who submit claims to CMS or document treatment for Medicare beneficiaries:

[M]edical records should be complete and legible; and

[M]edical records should include the legible identity of the provider and the date of service.

* * * * *

⁷ This edition was last printed in 2013, and it has not been revised in the past three years. (Test. of Frye.)

Documents containing amendments, corrections, or delayed entries must employ the following widely accepted recordkeeping principles:

1. Clearly and permanently identify any amendments, corrections or addenda.
2. Clearly indicate the date and author of any amendments, corrections or addenda.
3. Clearly identify all original content (do not delete).

(Ex. A18 at 26-27.)

13. A document titled "Medicaid Documentation for Medical Professionals" states, in part:

[M]eeting ongoing patient needs such as furnishing and coordinating necessary medical services is impossible without documenting each patient encounter completely, accurately, and in a timely manner. Documentation is often the communication tool used by and between medical professionals. Records not properly documented with all relevant and important facts can prevent the next provider from furnishing the correct or sufficient services. The outcome can result in erratic or even dangerous treatment and cause unintended complications.

[A]nother reason for documenting medical services includes complying with Federal * * * and State laws[.]

* * * * *

[T]here are some general rules that apply to all State Medicaid programs. These rules include:

* * * * *

Accurate, clear and concise medical records are maintained and available for review and audit;

* * * * *

All medical records are legible, signed, and dated;

Medical records are never altered[.]

(Ex. A18 at 21-22.)

Preterm Labor

14. Preterm labor is generally defined as labor occurring before 37 weeks of pregnancy. (Ex. R14 at 1.)

15. Possible signs and symptoms of preterm labor include the following: changes in the type and amount of vaginal discharge; bleeding, cramping; diarrhea; and a sense of pressure or fullness in the pelvis or lower abdomen. (Test. of Smith, Erickson; Ex. R15 at 2.) Preterm labor may also occur with no discernable warning signs. (Test. of Smith.)

16. Cramps are typically low pressure, achy sensations in the back, groin, and/or pelvic floor area. By contrast, contractions are more of a "full uterus experience," they are typically palpable from the outside, and they can be rhythmic. (Test. of Greer, Echeverio.)

17. Preterm bleeding is not always indicative of preterm labor. Such bleeding could be idiopathic, or caused by coitus or other trauma, cervical polyps, or placenta previa. An expectant mother complaining of preterm bleeding could also have a rectal hemorrhoid and simply be mistaken as to the source of the bleeding. (Test. of Echeverio, Greer, Frye, Erickson; Ex. R8 at 3.)

18. There is a risk of harm to an unborn baby if the mother is Rh Negative, the baby is Rh Positive, and their blood mixes.⁸ If a woman who is Rh Negative has bleeding before 28 weeks of pregnancy, she has a 72-hour window of time in which to receive a Rhogam shot to protect her baby from potential negative effects of blood mixing. (Test. of Frye; see Ex. R9 at 1-5.) Rhogam is a derived blood product. (Test. of Erickson.)

19. Preterm cramping is not always indicative of preterm labor. Such cramping could be caused by a mother's excessive activity and/or time on her feet, sexual intercourse, the sensitivity of a mother to cervical changes, or a change in the baby's position. (Test. of Greer, Frye.)

20. Katherine Greer has been an LDM since 2009.⁹ She has diagnosed one mother (less than 30 weeks in pregnancy) with preterm labor, and the mother was subsequently transported to the hospital.¹⁰ If a client between 27 and 28 weeks in pregnancy called her complaining of red

⁸ In *Understanding Diagnostic Tests*, Ms. Frye states, in part:

If mother's blood type differs from that of her baby and if their blood mixes, the mother's body will eventually begin to produce immunoglobulin G (IgG antibodies) against the foreign blood factor. These IgG antibodies can cross the placenta, which, depending upon the factor involved, can result in fetal RBC destruction (hemolysis), referred to as hemolytic disease of the fetus and newborn (HDFN). Hemolysis can lead to life-threatening fetal anemia.

(Ex. R9 at 1.)

⁹ Ms. Greer received a nursing degree from Oregon Health & Science University (OHSU). She subsequently worked as an ICU nurse from 2006 to 2009. She currently has a small home midwifery practice. She also teaches at Birthingway. (Test. of Greer.)

¹⁰ In that situation, the mother was leaking fluid and experiencing contractions. Ms. Greer communicated with the mother via phone and directed her to go to the hospital. After that phone call, Ms. Greer called the hospital to alert

spotting and mild cramping, she would be unable to diagnose preterm labor without conducting further assessment. Ms. Greer would ask the mother various questions and go to the mother's home to assess the situation in-person. (Test. of Greer.)

21. Paul Burcher is a bioethicist and Board-certified obstetrician-gynecologist.¹¹ If a mother at 28 weeks called him complaining of spotting, cramping, or both, he would ask the mother various questions, and most likely advise her to rest, hydrate, and call him back in an hour. If after that hour, the symptoms persisted, he would ask her to come in for an assessment. (Test. of Burcher.)

22. Elise Erickson is a certified nurse midwife (CNM).¹² She does not attend home births. If a mother at 28 weeks called her and complained of cramping, red spotting, and brown spotting for the previous four to five days, she would ask the mother questions regarding the following: the amount and type of blood; the quality of the cramping; whether the mother recently had intercourse; whether the mother had any nausea, vomiting, or fever; whether the mother had experienced any trauma; whether the mother felt fetal movement; and whether her belly felt hard to the touch. She would advise the mother to come in for an assessment fairly quickly. (Test. of Erickson.)

23. In Ms. Frye's opinion, if a woman between 27 and 28 weeks complained of spotting and cramping, and the woman had otherwise had been experiencing a normal pregnancy, it is appropriate for a midwife to recommend that she rest and take fluids for an hour. In Ms. Frye's opinion, if the woman reports continuing symptoms after an hour, it is appropriate for the midwife to go to the client's home and assess her. (Test. of Frye.)

24. A diagnosis of preterm labor requires both cervical change and uterine contractions. (Test. of Greer, Burcher; *see* Exs. R12 at 1, R14 at 1.) Cramping does not cause cervical change, but it can be a symptom of it. (Test. of Greer.)

25. Preterm labor may be assessed and diagnosed with one or more of the following: fetal monitoring; tocodynamic monitoring (to measure contractions), a fetal fibronectin test; palpation of the uterus; a check of vitals and urine; ultrasound; a sterile speculum examination; and vaginal examination with gloved fingers. (Test. of Smith; Ex. R14 at 2.)

26. To assess for preterm labor with a vaginal examination, an LDM would check the mother's cervix and look for dilation and effacement, and whether it is possible feel the baby's head on the cervix. (Test. of Greer.)

staff of the mother's impending arrival. Ms. Greer subsequently met up with the mother at the hospital. (Test. of Greer.)

¹¹ Dr. Burcher has practiced obstetrics and gynecology for approximately 20 years, and for the past four years, he has done so at Albany Medical College, a tertiary care hospital. (Test. of Burcher.)

¹² Ms. Erickson has a Bachelor's degree in Nursing and a Master's degree in Women's Health and Midwifery. She has practiced as a CNM for 10 years, and she is currently a doctoral student at OHSU. (Test. of Erickson.)

27. If Ms. Greer identified an absolute risk factor, while in a client's home, and determined that transfer to a hospital was appropriate, Ms. Greer would not tell the mother that she could no longer provide any care to the mother. Ms. Greer would, however, make it clear to the mother that she could not deliver the baby and that she could not remain the mother's primary care provider. Once she discussed transfer with the mother/family, she would call the hospital to inform staff of the situation. In the intervening period between discovery of the absolute risk and the completed hospital transfer, Ms. Greer would still observe the condition of the mother and baby, and she might monitor vital signs and fetal heart tones. She considers it her responsibility to prepare the mother for transport by explaining why transfer of care is necessary and what the mother might expect after transfer is complete. She would answer any questions the mother might have on these topics. She considers this stabilizing care, and not treatment. (Test. of Greer.)

28. In Ms. Frye's opinion, after a midwife identifies an absolute risk and the need for the client to go to the hospital (for a transfer of care), the midwife should still do whatever is necessary to support and stabilize the client until the transfer of care occurs. (Test. of Frye.)

29. At Legacy Emanuel Hospital (Emanuel), if preterm labor is detected early enough a mother may receive betamethasone, a corticosteroid that can be administered twice during a 48-hour period to improve a baby's cerebrovascular outcome. (Test. of Smith; *see* Exs. R12 at 6, 8, R13 at 7-8; *see also* Exs. R14 at 2, R22 at 2-3.) A mother may also receive magnesium sulfate, which is a neuroprotectant that may decrease a baby's risk for cerebral palsy. (Test. of Smith, Burcher, Erickson; *see* Exs. R14 at 2, R22 at 3, 6.) Magnesium sulfate may also act as a tocolytic,¹³ and could potentially decrease contractions and prolong labor. (Test. of Smith; Ex. R14 at 2.)

30. For preterm labor at 28 weeks, the hope would be to delay labor for at least 48 hours for the administration of betamethasone. (Test. of Smith, Erickson; *see* Exs. R12 at 6, 8, R13 at 7-8, R22 at 6.) The earlier a tocolytic agent is administered, the better the expected outcome of prolonging labor. (Test. of Smith, Erickson.) After a mother in preterm labor has dilated to four to six centimeters, tocolytics are generally ineffective. (Test. of Erickson.) Not all hospitals use tocolytics. In Dr. Burcher's opinion, tocolytics do not lead to improved neonatal outcomes and they carry significant risks. (Test. of Burcher.)

31. In a June 2012 article titled "Management of Preterm Labor," the American College of Obstetricians and Gynecologists (ACOG) stated, in part:

The most beneficial intervention for improvement of neonatal outcomes among patients who give birth preterm is the administration of antenatal corticosteroids.

* * * * *

Neonates whose mothers receive antenatal corticosteroids have significantly lower severity, frequency, or both of respiratory distress

¹³ Tocolytics are medications used to stop or slow preterm labor. (Ex. R14 at 2-3.)

syndrome * * *, intracranial hemorrhage * * *, necrotizing enterocolitis * * *, and death * * *, compared with mothers who did not receive antenatal corticosteroids.

* * * * *

Overall, the evidence supports the use of first-line tocolytic treatment * * * for short-term prolongation of pregnancy (up to 48 hours) to allow for the administration of antenatal steroids.

(Ex. R22 at 1-4.)

32. Preterm labor is significantly more unpredictable than full-term labor with regard to how it presents and the course it takes. (Test. of Smith, Burcher, Erickson.) Preterm labor often happens much more quickly than normal labor because of other processes that may be occurring concurrently. (Test. of Erickson.) If a mother is 3 cm dilated at around 28 weeks, it's "unclear" how quickly her preterm labor might progress. (Test. of Smith.)

33. If a mother at 28 weeks of pregnancy, who was 3 cm dilated, 80 percent effaced, and at zero station, arrived at a community hospital that had no neonatal intensive care unit (NICU), the hospital would likely consider it an emergent situation, get betamethasone medications going, and transfer the mother via ambulance to a tertiary care center, such as Emanuel. (Test. of Smith.)

34. In Dr. Wendy Smith's opinion,¹⁴ a period of two hours "can absolutely matter" for a mother who is 3 cm dilated at around 28 weeks. At Emanuel, it can take 15-30 minutes to call for a medication, and another 15-30 minutes to get the medication going. (Test. of Smith.)

35. At Emanuel, the survival rate for a baby born around 28 weeks is greater than 80 percent. The survival rate for a baby born around 28 weeks in a home setting is close to zero if there is no transport to a hospital. (Test. of Smith.)

36. The following are possible consequences for a baby born around 28 weeks: pulmonary/respiratory problems; cerebrovascular and intestinal events; cerebral palsy; blindness, deafness; and motor/developmental concerns. (Test. of Smith; *see also* Ex. R14 at 1.)

The Client, CF

37. CF became pregnant on or about May 5, 2012. It was her first pregnancy. At the time, she was under the care of naturopathic physician Karina Jarvela, ND. (Test. of CF, Echeverio; *see* Ex. A16 at 37-51.)

¹⁴ Dr. Smith is an obstetric hospitalist at Legacy Emanuel Hospital, which has the highest level of care for obstetrics and neonatal care. She is also a Board member. (Test. of Smith.) As per ORS 687.470(1), of the seven Board members appointed by the Governor, four must be direct entry midwives, one must be a certified nurse midwife, one must be a physician involved in obstetrical care or education, and one must be a member of the public.

38. On June 8, 2012, by order of Dr. Jarvela, CF had the following blood work performed: CBC with Differential/Platelet; Lipid Panel with LDL/HDL Ratio; hCG, Beta Subunit, Qnt, Serum; Vitamin D, 25-Hydroxy; Vitamin B12; and Venipuncture. (Exs. A9 at 1-2; A16 at 37-39.)

39. During her first trimester of pregnancy, while still under the care of Dr. Jarvela, CF experienced intermittent spotting. The spotting ultimately resolved.¹⁵ (Test. of CF; *see* Ex. A16 at 49, 51.)

40. CF and LF are Jehovah's Witnesses. Their faith is extremely important to them. Jehovah's witnesses believe strongly in the principles of free will, self-determination, and informed consent with regard to healthcare and medical treatment. They are not adverse to emergent hospital care if necessary, but they prefer to exhaust natural modalities before turning to conventional medical treatment. They also believe in educating themselves with regard to medical conditions, healthcare issues, and treatments so that they can make informed choices regarding care. They do not generally accept blood products, and forgo procedures such as blood transfusions. (Test. of CF, LF, SF; Exs. R5 at 2, 4-5, 10-11, R7 at 1-2.)

41. CF has an Advanced Directive that appoints LF as her health care representative. The Advanced Directive states that CF is one of Jehovah's Witnesses and that she refuses transfusions of whole blood, red cells, white cells, platelets, or plasma (including fresh frozen plasma). The Directive further states that she may be willing to accept some minor blood fractions and certain medical procedures involving her own blood, but that the details must first be discussed with her, or her representative (in the event of her incapacitation). (Ex. R6 at 1, 3-4.)

42. On or about June 10, 2012, CF and LF hired Ms. Echeverio to provide midwifery care and attend them in an out-of-hospital birth. Ms. Echeverio found CF to be an educated and medically informed client. CF wished to give birth at a birthing center, and she expected Ms. Echeverio to support and respect her preferences and informed decisions. (Test. of CF, Echeverio.)

43. CF informed Ms. Echeverio that she had just recently had a "prenatal panel" done by Dr. Jarvela.¹⁶ (Test. of Echeverio.) On July 16, 2012, CF signed a form titled "Authorization for Use and Disclosure of Protected Health Information" so that Ms. Echeverio could obtain CF's medical records from Dr. Jarvela. (Ex. A4 at 1; test. of Echeverio.) Also on July 16, 2012, CF signed a form titled "Midwife Disclosure and Consent." (Ex. A4 at 8-10.) The form states the following under a section titled "Transport of Care":

[D]uring labor if complications arise requiring hospital transport, what your midwives do will depend on the nature of the complication. Your midwife will either call a doctor or midwife with hospital privileges to

¹⁵ According to ACOG, "[m]any women have vaginal spotting or bleeding in the first 12 weeks of pregnancy" and "slight bleeding often stops on its own." (Ex. R15 at 1.)

¹⁶ Once Ms. Echeverio finally obtained CF's blood lab results from Dr. Jarvela's office, she learned that the blood work was not, in fact, a prenatal blood panel. (Test. of Echeverio.)

transfer care or we will go directly to the hospital and transfer care to the midwife or obstetrician on call. If the transport is not an emergency we call ahead to the midwife or obstetrician on [call] and usually transport by car. If there is an emergency your midwives will call 911 for an ambulance and then call the hospital labor and delivery unit to advise them of the problem and that we are on our way. The ambulance EMT's and/or hospital staff will take over responsibility for your medical care immediately on contact. Your midwives will come with you to interact with the hospital staff, help with a smooth transfer of care, and work as a support person and advocate for you during your labor and birth.

(*Id.* at 9-10.)

44. CF also filled out a "Health History" form for Ms. Echeverio. (Ex. A4 at 2-5.) On the form, when asked why she was choosing an out of hospital birth, CF wrote, "Want a positive experience, afraid of hospitals, want freedom of movement, etc." (*Id.* at 5.) When asked on the form how she felt about going to a hospital if complications arose, CF wrote, "Will hate it, but if necessary, will do it." (*Id.*)

45. On June 22, 2012, CF had an ultrasound, which confirmed the approximate date of conception and showed a small fluid collection at the cervical edge of the placenta consistent with a subchorionic hematoma. (Ex. A11 at 255.) Dr. Ed Hoffman Smith informed CF that the issue was not likely to be problematic. (Test. of CF.)

46. In July 2012, Ms. Echeverio requested that Dr. Jarvela's office provide her with all of CF's medical records, including blood labs. (See Ex. A4 at 7; test. of Echeverio.) In August 2012, Ms. Echeverio again requested that Dr. Jarvela's office send CF's blood lab results. (See Ex. A4 at 7.) Ms. Echeverio subsequently received SOAP notes for CF, but none of CF's blood lab results. (Test. of Echeverio.)

47. By early September 2012, Ms. Echeverio had still not received any blood lab results for CF. CF informed Ms. Echeverio that she would follow up and get a copy for Ms. Echeverio. By October 31, 2012, CF had not obtained the lab records for Ms. Echeverio, and Dr. Jarvela's office had still not sent a copy of them to Ms. Echeverio. (Test. of Echeverio.)

48. On September 11, 2012, CF had a second ultrasound. The findings appeared normal. (Exs. A11 at 256, R16 at 1; test. of Echeverio.)

49. On a Phone Log for CF, an October 2, 2012 entry states that Ms. Echeverio left a message for Dr. Jarvela that day, requesting CF's blood labs. Another entry on October 2, 2012 states that Ms. Echeverio called CF to ask whether CF was able to get more information from Dr. Jarvela. According to that entry, CF agreed to bring more information to her next appointment with Ms. Echeverio. An October 3, 2012 entry states that Ms. Echeverio received a message from Dr. Jarvela explaining that the labs would be faxed or CF could pick them up at Dr. Jarvela's office. The entry states that the message "[a]nswered the question re * * * blood type" and "will discuss Rh [at] next prenatal visit." (Exs. A8 at 1, A16 at 27.)

50. Ms. Echeverio's customary practice is to perform a CBC and other blood work on a midwifery client at 28 weeks of pregnancy. She discussed this with CF, and they agreed that the blood work would be performed after CF obtained secondary health care coverage through the Oregon Health Plan (OHP)¹⁷ at 28 weeks. (Test. of CF, Echeverio; see Exs. A4 at 7, A16 at 18.)

51. Ms. Echeverio saw CF for approximately four prenatal appointments prior to October 31, 2012. (Ex. A14 at 2.)

Events of October 31, 2012

52. On October 31, 2012, CF was 27 and 5/7 weeks into her pregnancy. (Ex. A10 at 1.)

53. At approximately 8:00 a.m. on that date, CF called Ms. Echeverio complaining of red spotting, cramping, and diarrhea. (Exs. A6 at 2, A14 at 3; test. of CF.) When Ms. Echeverio asked CF to describe the spotting, CF reported that it consisted of perhaps a teaspoon or tablespoon's worth of red blood that morning. (Exs. A6 at 2, A14 at 3; test. of CF, Echeverio.) She then asked CF whether she had taken her temperature, whether she had any signs of an infection (such as a urinary tract infection), whether she had been hydrating well, whether she had recently had sexual intercourse, whether she was experiencing any back pain, and whether the baby was moving. (Test. of Echeverio; Ex. A14 at 3.) Ms. Echeverio informed CF that her symptoms could be benign, or they could be as serious as preterm labor. She suggested that CF meet her for an ultrasound to assess what was occurring. CF declined the suggestion and stated that she preferred to stay home, rest, and hydrate. She agreed to call Ms. Echeverio back in an hour with a progress report. (Test. of Echeverio, CF.) CF tried unsuccessfully to rest. (Test. of CF.)

54. At approximately 10:30 a.m., CF called Ms. Echeverio and reported that the diarrhea had stopped, but she was still feeling some cramping, and she still had a small amount of spotting.¹⁸ Ms. Echeverio told CF she was coming to CF's home to check on her and the baby. (Ex. A6 at 2; test. of CF, Echeverio.) If Ms. Echeverio had said during this second phone call, "let's go to the hospital and get this checked out," CF would have complied. (Test. of CF.) CF was "conscious that something was wrong" at this point. (*Id.*)

55. At approximately 10:50 a.m., Ms. Echeverio arrived at CF's home. Ms. Echeverio asked CF various questions about her symptoms, and CF asked questions of Ms. Echeverio. Ms. Echeverio told CF that she could possibly be in preterm labor. At that time, CF was in denial that preterm labor was occurring. (Test. of CF, Echeverio; Ex. A14 at 4-5.)

56. Shortly before 11:15 a.m., Ms. Echeverio administered a dose of False Unicorn Root, to CF.¹⁹ Ms. Echeverio and CF hoped that the herb would calm CF's uterus and possibly prevent

¹⁷ The OHP is the state's Medicaid program. (Ex. A18 at 24.)

¹⁸ In Ms. Erickson's opinion, Ms. Echeverio should have directed CF to go to a hospital at this point for assessment. (Test. of Erickson.)

¹⁹ At hearing, Ms. Echeverio testified that she had discussed the herb with CF during one or both of the phone calls on the morning of October 31, and that CF requested it once she arrived at CF's home. She reported the same things

her symptoms from progressing into preterm labor. (Test. of CF, Echeverio; Exs. A6 at 2, A14 at 5, 15.)

57. At approximately 11:15 a.m., Ms. Echeverio performed a vaginal examination and determined that CF was dilated to between three and four centimeters (cm), she was 80 percent effaced, and she was at zero station. Ms. Echeverio also felt a presenting part of the baby. (Exs. A6 at 2; A14 at 5; test. of Echeverio.) Ms. Echeverio determined that CF was in preterm labor and that she needed to go to the hospital. She knew the situation constituted an "absolute risk." (Test. of Echeverio; *see* OAR 332-025-0021(2)(b)(L).) She told CF, "Your baby is coming" and "We're going to have to go to the hospital." (Test. of CF.) Upon hearing that, CF knew that her baby had a chance to live, and she tried to focus on that possibility. (*Id.*)

58. CF and LF live approximately 10 minutes away from Legacy Emanuel Medical Center (Emanuel). (Test. of CF.) Ms. Echeverio told them that the time frame for the labor was unclear, and that the baby could come within a few hours or a few weeks. CF and LF were in a state of shock and disbelief and they had many questions for Ms. Echeverio. Ms. Echeverio discussed with them what it would mean to go to the hospital. Ms. Echeverio told them that the hospital had drugs that could possibly slow down the labor. She also told them that the baby's chance of survival was approximately 80 percent, and that his greatest chance for survival was to be born in a hospital. She also told them that the baby would likely be in the NICU for an extended period of time. CF asked whether she would be able to deliver her baby naturally, and Ms. Echeverio said she most likely would be able to do so. (Test. of CF, LF, Echeverio; Ex. A6 at 3.)

59. CF was lying down at that time, and Ms. Echeverio told her not to get up. CF elected to wear her "belly band," in the hope that it would slow down labor and "keep things a little bit calm." (Test. of CF, Echeverio.) She requested another dose of False Unicorn Root, in the hope that it too might slow down her preterm labor. She did not believe that the herb would actually stop the labor. (Test. of CF.) Although Ms. Echeverio believed that the False Unicorn Root would have minimal effect on CF's uterus at that point, and would not reverse the preterm labor, she nonetheless administered another dose at approximately 11:30 a.m. In so doing, she hoped to maintain her relationship with CF and allow CF the opportunity to realize for herself that hospitalization was the only option at that point.²⁰ (Exs. A6 at 3, A14 at 15-16; test. of Echeverio; *see also* Ex. A14 at 8.) She did not administer the herb at that time to "treat" CF's preterm labor. (Test. of Echeverio.)

during her interview with Mr. Goldberg and Ms. Erickson. (*See* Ex. A14 at 4-5, 14-15.) CF, on the other hand, testified at hearing that she and Ms. Echeverio did not discuss the herb during their phone conversations that morning, and that Ms. Echeverio offered her the herb once she arrived at her home. She reported the same to Mr. Goldberg and Ms. Erickson. (*See* Ex. A15 at 18.)

²⁰ Dr. Burcher testified at hearing that he would not give a patient a medication that he believed would have no beneficial effect for the patient simply so the patient could determine for herself that it would not work. (Test. of Burcher.)

60. Sometime before 12:30 p.m., Ms. Echeverio went into the other room and charted some of the day's events on CF's Prenatal Flow sheet.²¹ Prior to that time, she had not charted anything that occurred on October 31, 2012. (See Exs. A3 at 11-12, A7 at 2-3; test. of Echeverio, CF.) She charted the following:

10/31/12

[CF] called this a.m. @ 8:00 a.m. to report red bleeding – [approximately] 1 tb. Also report brownish spotting for the last 4-5 days but today “red” bleeding. Also reports so[me] diarrhea this a.m. Asked her if movement felt – lots of movement. Will rest & drink lots of H2O, as she feels some cramping. Explained that her baby could be coming & she needs to call back if these s/s do not resolve.

[CF] called again @ 10:30 – diarrhea stopped, still feeling some cramping & small amt of spotting. Movement felt & curious about what's going on. Explained that options are limited & would be over to check on her & baby.

10/31/12

Arrived at 10:30 a.m. Discussed options, VE = 3-4 cm cx[,] 80% effaced, 0 station! Explained that cramping & low head & opening cx = early labor. Started dosing 30 gtts False Unicorn [Root] tincture to help ↓ cramping. Lots of H2O – drank 12-16 oz [with] 1st dose. FHTs – 120-140s.

10/31/12

11:30 a.m.

FHTs – 120's-140's. [CF] in bed on [left] side, feeling for the 1st time some possible u/c's [uterine contractions] (vs the cramping she's been feeling since [approximately] 8:00 a.m.) 2 dose False Unicorn Rt – 30 gtts [with] H2O.

Discussed possible early delivery @ length as strong possibility baby could be born sooner rather than later. Discussed transport to Leg Emanuel [with] NICU. Discussed prematurity & how that [a]ffects lung maturation – discussed Panda team and possible birth in OR or if baby HR ↓ possible c/s [cesarean section].

(Exs. A3 at 11-12, A7 at 2-3; test. of Echeverio.)

61. While Ms. Echeverio was charting in the other room, CF and LF discussed and prayed about their situation. (Test. of LF.) At the time, neither of them believed that there was any urgency to get to the hospital. (Test. of CF, LF.) CF thought they had “a few hours.” (Test. of CF.) She realized that nothing could prevent her labor from coming, but she thought it would

²¹ Ms. Echeverio told Mr. Goldberg and Ms. Erickson that she charted for approximately 15 minutes. (Ex. A14 at 41.)

be beneficial if she could slow it down with rest, the herbs, and the belly band. (*Id.*) LF did not consider the herbs an actual replacement for going to the hospital. (Test. of LF.)

62. At approximately 12:30 p.m., CF informed Ms. Echeverio that she felt what she believed were uterine contractions (as opposed to cramping). (Ex. A6 at 3; test. of CF.) Ms. Echeverio told CF that it was time to get to the hospital. (Test. of Echeverio.) She administered a third dose of False Unicorn Root to CF in the hope that it might decrease the intensity of CF's contractions.²² (Ex. A6 at 3; test. of Echeverio.)

63. Mentally, CF knew she had to go to the hospital as soon as the vaginal exam showed she was in preterm labor. But emotionally, she did not feel ready to go until she felt her first contractions. (Test. of CF.) After the contractions began, LF realized that there was a need to get to the hospital promptly. (Test. of LF.)

64. By approximately 1:30 p.m., CF's contractions had intensified. Ms. Echeverio "got more urgent about the situation" at that point, and they started making plans to go to the hospital.²³ (Test. of CF, LF.) Around that time, CF sent LF out so he could get some food for himself. She thought they might be headed for a long, drawn-out process, and she did not want him to be hungry and potentially cranky. He was gone for approximately 20 minutes. (Test. of CF, LF.) At Ms. Echeverio's urging, CF got dressed and prepared to leave her home. (Test. of CF, Echeverio.)

65. Sometime between approximately 12:15 p.m. and 1:45 p.m., Ms. Echeverio called Emanuel.²⁴ (Ex. A6 at 3.) After Ms. Echeverio called the hospital, she told CF who the doctor was, that he was a good doctor, and that CF would be offered medication to try to prolong her labor. (Test. of CF; Ex. A14 at 32-36.)

66. When LF returned from eating, at approximately 1:50 p.m., they all left for the hospital. CF and LF rode in one vehicle, and Ms. Echeverio rode in another. Ms. Echeverio met CF at the hospital entrance and brought her to the labor and delivery unit in a wheelchair. (Test. of CF, LF, Echeverio.)

67. Sometime prior to arriving at Emanuel, Ms. Echeverio added the following notes to CF's Prenatal Flow sheet:

²² In Ms. Frye's opinion, it was "very smart" of Ms. Echeverio to administer False Unicorn Root to CF after determining that CF was in preterm labor. (Test. of Frye.) Ms. Frye believes that there was no harm in Ms. Echeverio giving CF the additional doses of False Unicorn Root, and that the third dose could have served to calm down CF's uterus. (*Id.*)

²³ At hearing, CF testified that Ms. Echeverio practically pulled her off the bed and led her out the door at this point.

²⁴ At hearing, Ms. Echeverio testified that it was possible she called Emanuel twice on October 31, 2012. On CF's Prenatal Flow sheet, she noted a call at 1:45 p.m. When she added additional notes at the hospital, she noted a call at 12:15 p.m. (*See* Ex. A6 at 3-4.) It's unclear whether the 12:15 notation is meant to indicate a separate call, or whether Ms. Echeverio was simply modifying the time of the phone call referenced in her earlier note.

12:30 p.m. - ↑ dosing of [False Unicorn Root] to 30 gtts / 15 min, some cramping reported [with] u/c's – emptied bladder, wearing belly bander[,] lying on l[eft] side. FHTs – 140's-150's – movement felt.

1:30 p.m. FHT's 140's-150's u/c's ↑ q 2-3 min[,] lasting 30-40 sec.

1:45 p.m. – Discussed options, called Emanuel Hospital

1:50 p.m. – Transported

(Exs. A3 at 11-12, A6 at 3, A7 at 2-3; test. of Echeverio.)

68. Once at Emanuel, Ms. Echeverio transferred care of CF to a hospital provider and provided a copy of CF's Prenatal Flow sheet to the staff. (Test. of Echeverio.) At that time, the chart notes ended with the notation, "1:50 p.m. – Transported." (Exs. A3 at 12, A7 at 2-3; test. of Echeverio.)

69. CF was admitted to Emanuel at 2:22 p.m. (Ex. A11 at 37.) Ms. Echeverio remained with CF and LF and reassured them that they were receiving the best possible medical care for their situation. (Test. of Echeverio, CF.)

70. Approximately 30 minutes after arriving at the hospital, CF had a vaginal exam. She was 8 cm dilated, completely effaced, at zero station, and had a bulging bag of water. She was evaluated with an ultrasound, and the baby was found to be in a frank breech presentation. The hospital ordered the administration of magnesium sulfate for neuroprotection, but there was insufficient time for administration of betamethasone. CF was prepped for a cesarean section. (Exs. A11 at 39, 76, 123; A12 at 2; test. of Smith, Echeverio.) Bloodless surgery preparations were made, and a "Cell Saver" was brought to the operating room.²⁵ (Test. of Smith; see Ex. A11 at 39.)

71. At 3:00 p.m., CF's blood was collected for lab testing. The results showed that she was Rh Negative. (Ex. A11 at 3, 91.)

72. The baby was born via cesarean section at 3:40 p.m. (Ex. A11 at 76, A12 at 1-5, 23, 29.) He experienced respiratory distress syndrome at birth. He remained in the NICU for 11 weeks. (See Ex. A12 at 23-34; test. of CF.)

73. Sometime at the hospital on October 31, 2012, Ms. Echeverio called Dr. Jarvela's office and left a message requesting that CF's labs be faxed to Emanuel. (Test. of Echeverio; see Exs. A6 at 3, A14 at 13.) Also while at the hospital on October 31, 2012, Ms. Echeverio wrote more chart notes on CF's Prenatal Flow sheet. Those notes were as follows:

10/31/12

Called Dr. Jarvela to get copy of labs faxed to hospital but only [left message]. Hospital staff will draw blood for stat results.

²⁵ It can take anywhere from 30 minutes to two hours to assemble a bloodless surgery team. (Test. of Smith.)

10/31/12

C/S immediate as position of baby transverse.

10/31/12

Reviewing notes & time to now sit to write – adding more details to chart notes:

Arrived @ 10:50 a.m. – with history of headaches & hydration and sleep issues, uncertain until arriving @ [CF]'s home whether just preterm u/c or preterm labor. After collecting info regarding her night, still unclear about “cramping” vs u/c. VE was done after interview[,] probably closer to 11:15 a.m. Then lots of explaining needed to help [CF] and [LF] understand that these s/s when unfortunately heading to hospital [*sic*]. We agreed to give false unicorn [root] a chance after discussing transport for tributaline.²⁶ [CF] also tied her belly bander [on] (cont) to help keep baby's head higher.

12:15 After an hour of resting, the s/s “cramping” ↑ to what she described as more contraction-like. During this time I explained how her transport would go – [t]hat my role would change but I would stay with them. [LF] started packing & calling his parents. I called Legacy Emanuel.

1:30 this process took time as the change in plans for [out of hospital birth] & their religious faith – processing & moving towards hospital was feeling abrupt but I was insistent that the time was now & expressed my opinion that the only safe option was getting to the hospital. They agreed & transport[] proceeds to Emanuel.

(Ex. A6 at 3-4; test. of Echeverio.)

74. On or about November 1, 2012, a nurse informed CF that she was Rh Negative. After researching, talking, and praying, CF and LF decided that CF would accept a Rhogam injection. (Test. of CF; *see* Exs. A11 at 28, A12 at 7.)

HLO/Board Involvement

75. Sometime on or after October 31, 2012, the HLO received a complaint regarding Ms. Echeverio's care of CF. (*See* Ex. A16 at 1.) HLO Investigator Nathan Goldberg was assigned to the matter. (*See* Ex. A3.) Ms. Erickson was retained as a subject-matter expert for the case. (*See* Ex. A10; test. of Erickson.)

76. On February 28, 2013 the Mr. Goldberg requested CF's medical records, via subpoena, from Emanuel. On April 12, 2013, he received the records. (Ex. A3 at 2.)

²⁶ This is likely a reference to Terbutaline. (*See* Exs. A10 at 3, A14 at 32.)

77. On May 18, 2013, CF participated in a telephone interview with Ms. Erickson and Mr. Goldberg. (Exs. A15, A3 at 3-4; test. of Erickson, CF.) During the interview, CF stated, in part, the following regarding the events of October 31, 2012:

I called [Ms. Echeverio] probably around eight in the morning.

* * * * *

[Ms. Echeverio] wanted to schedule an appointment to get an ultrasound right away, but I told her I was going to lay down for a little bit. So she said, well, that would be okay only if I * * * called her within an hour. [I]’m the one who let it go maybe an hour longer than I should have. But, yeah, it was probably about ten-thirty * * * when I called her back and then she made arrangements to come over right away.

* * * * *

[She got to my house maybe] around eleven-fifteen or eleven-thirty.

* * * * *

[W]hen she first walked in the door she says I want you to take this [false unicorn root] right away and let’s – and I said why. She said because you might be in labor and – okay. So we started that. But after, you know, passing of a few minutes then she said let’s just do the exam.

(Ex. A15 at 4-5, 18; *see also id.* at 9.)

78. During the interview, when asked about the cramping she experienced on the morning of October 31, 2012, CF stated, in part:

[I] noticed [the cramping] only after I got off the phone with [Ms. Echeverio] the first time. When I had called her first the only – the only thing I had was a little bit of spotting. I didn’t have any cramps at that point. So after I got off the phone and I tried to go lay down then that’s when I noticed cramping that was – yeah, it was like menstrual cramping.

(Ex. A15 at 15.)

79. During the interview, CF stated that Ms. Echeverio performed the vaginal exam approximately 30 minutes after arriving at CF’s home. (Ex. A15 at 10.) CF further stated that after Ms. Echeverio performed the vaginal exam, she told CF that she was three centimeters dilated and that she was going to have to go to the hospital. (*Id.* at 6-7.)

80. During the interview, when asked about the contractions she experienced on the afternoon of October 31, 2012, CF stated, in part:

[I]t was definitely – like it started feeling like cramping but then it * * * just escalated. * * * * *. It started like that, kind of mild, but it got really intense really fast. And I would say, you know, as soon as [Ms. Echeverio] noticed that it was getting really intense –

* * * * *

It really didn't take long for that to happen, maybe half an hour or something, and I thought we had more time. And I had actually sent my husband to go get some food for himself and I said, yeah, it will be a while. And then she said to him, no, we're going to the hospital now. So she was very determined.

(Ex. A15 at 16-17.)

81. With regard to the timing of events on October 31, 2012, CF stated during the interview that “things happened like so fast that day and * * * it's hard for me to remember exactly what time.” (Ex. A15 at 7.) She subsequently stated, in part:

I think the exam was later than noon. I can't remember exactly what time she came over. Maybe she came over at eleven-forty-five and maybe it was twelve-fifteen or so. But I think I vaguely remember that I didn't really start feeling contractions until about one p.m.

(*Id.* at 17.)

82. On or about May 28, 2013, the HLO requested that Ms. Echeverio provide a copy of CF's medical records. (*See* Ex. A16 at 1-2.)

83. On or about June 24, 2013, Ms. Echeverio went to CF's home to discuss her medical records. In reviewing the Prenatal Flow sheets, CF reminded Ms. Echeverio of several things that were not included on the sheets. For example, CF reminded her that CF had agreed to obtain the blood lab results from Dr. Jarvela's office directly. (Test. of CF, Echeverio; Ex. A14 at 19-20.) Ms. Echeverio added that information to the records. She did not note that it was an additional or late entry. She also added other information to the records, without noting that those additional details were additional or late entries. (*See* Exs. A2, A3 at 4-5, A6, A19.) Ms. Echeverio and CF did not discuss the specific timeline of events from October 31, 2012 until the Fall 2014. (Test. of Echeverio, CF.)

84. On or about June 26, 2013, the Board received a handwritten letter from CF that stated, in relevant part:

[I] have given Pamela Echeverio, my former midwife, my permission to copy my chart for your review. I have read & reviewed the timeline of the events that transpired on 10-31-12 and find them to be accurate as

documented. My husband and I feel strongly that the care given was extremely professional, and whereas my husband and I were somewhat in denial & hesitant about the urgency of the situation, Pamela was very insistent on our need to act quickly & go to the hospital, for which we are extremely grateful.

(Ex. A16 at 5.)

85. On June 26, 2013, Mr. Goldberg received CF's medical records from Ms. Echeverio. He noticed that the Prenatal Flow sheet he received contained several notes that were not on the Prenatal Flow sheet Ms. Echeverio had provided to hospital staff on October 31, 2012. The differences between the two Prenatal Flow sheets are as follows:

On the original 8/7/12 entry, the following notes were added in what had originally been blank spaces on the notes:

- “[CF] will follow up [with] Dr. Jarvel[]a for records/labs.”
- “Testing for C/6 will be revisited during GBS testing”

On the original 9/11/12 entry, the following note was added in what had originally been a blank space on the notes:

- “Asked [CF] to follow up [with] Dr. Jarvel[]a re: labs, etc.”

On the original 10/31/12 entry, the following notes were added in what had originally been blank spaces on the notes:

- “but may only be preterm cramping”²⁷
- “Will do follow-up CBC & panel at 28 wks.”

Also on the original 10/31/12 entry, Ms. Echeverio changed the note, “Arrived [at CF's home] @ 10:30 a.m.” to “Arrived [at CF's home] @ 10:50 a.m.” by changing the “3” to a “5.”

(See Exs. A2, A3 at 4-5, A6, A19; test. of Echeverio.) Ms. Echeverio did not mark or otherwise identify the additional/changed notes as addendums to the original notes. She did not date or initial the additional notes. (See Exs. A2, A6, A19; test. of Echeverio.)

²⁷ The original notes stated, in part “Explained that her baby could be coming and she needs to call back if these [signs/symptoms] do not resolve.” (Ex. A3 at 11.) In the notes Ms. Echeverio provided to the Board, the period at the end of that sentence had become a comma and the sentence read, “Explained that her baby could be coming and she needs to call back if these s/s do not resolve, but may only be preterm cramping.” (*Id.* at 14.)

86. On July 10, 2013, Ms. Echeverio participated in an in-person interview with Ms. Erickson and Mr. Goldberg. (Exs. A14, A3 at 5-7; test. of Erickson, Echeverio.) At times, she referred to her written notes to answer questions. (See, e.g., Ex. A14 at 2.)

87. During the interview, when asked to relay the events of October 31, 2012, Ms. Echeverio stated, in part:

[CF] called in the morning about eight-thirty to let me know that she had had some brown spotting and it – when she woke that morning it was more red. * * * she indicated that it was about a tablespoon or, you know, just – she wasn't sure[.]

She was very unclear about whether she was having contractions or not. She said she felt like she was having some cramping. And so I asked her about the basics. Is the baby moving? Yes, lots of movement. Are you hydrated? Have you slept well? Have you eaten? You know, the kinds of things that sometimes cause pre-term contractions, not pre-term labor but pre-term contractions.

* * * * *

She also had some leg cramps, I believe, earlier in the pregnancy, so I reminded her to take some cal-mag or that we would discuss that later. And I also said if this could be something other than just pre-term contractions then these could be serious signs and symptoms and you'll need to call me back and let me know. So we made a plan and the plan was that she would call me in two hours and then give me a report. Whether or not they stopped I still wanted to hear from her in two hours.

And so she did call back about two hours later, about ten-thirty,²⁸ and we had a conversation on the phone in which I indicated to her that I was going to come right over and see her and the baby. Again, I just asked her some basic questions, * * * trying to get, you know, a more complete picture * * *. [I] think I arrived there about ten-fifty.

And so we chatted for a while when I got there[.]

And so we talked about options. I had talked to her on the phone about false unicorn root * * *. And so I brought some with me, and so we discussed that. And I took her * * * vitals and spoke with her husband, and then we made a plan. And I was going to do a vaginal exam. We were going to dose with false unicorn root. I was going to have her lie down on her left side. She had a belly bander so we decided that, you

²⁸ Later in the interview, Ms. Echeverio informed Mr. Goldberg and Ms. Erickson that although the bright red bleeding had stopped by 10:30, "the cramping continued." (Ex. A14 at 29.)

know, was part of the plan, too, that she would wear her belly bander and take some more cal-mag and to see if things would calm down.

And I did the vaginal exam and she was three centimeters * * * stretchy – so I gave her that information and at that time I explained to her that this was in my opinion more than * * * pre-term contractions; that I actually thought it was moving towards pre-term labor because of the changes in her cervix. [A]nd that was the first point where I was really direct with her about the necessity to change her plans about what her birth was going to be like.

[I]t wasn't that she was uncooperative. * * *. It was difficult for both her and [LF]. I think they were actually kind of in that state of just disbelief. So I took that time to talk to them as gently as I could about prematurity; about PANDA care; about hospital care; about what it would look like when we got to the hospital. And this whole time, * * * she's lying down and * * * breathing and she's trying to relax and to see if this * * * could actually stop.

And I told her that I needed to take some time to chart, which I hadn't, you know, been able to do up to * * * that point, and that I needed to call the hospital and let them get a head's up[.]

[I]t was clear that they lived so close to Emanuel [so] that's where we would transport to. So that wasn't a difficult conversation. Everyone knew we were going to Emmanuel. So I needed to take time to call Emmanuel * * *. So I did that while she was resting. And she continued to drink. And then [LF] came out and spoke with me.

* * * * *

So I spoke with [LF] who really needed to be reassured, actually even more than [CF], * * * he just needed to wrap his mind around this. But also he just needed some reassurance. So I asked him to call his parents[.]

And so after I spent some time charting, and I gave her some time to recognize that this was not necessarily going to be the answer, you know, the lying down, the false unicorn root * * * when I went back and checked on her she reported to me that they were feeling less crampy and * * * more like contractions. And so that is when I said to her, I, as your health care provider, have to insist that we move to the hospital now. You know, I've tried to ease this passage for you, but we have to get there.

And so that is when she said, okay, well, all right. And so that's when she was willing to get dressed. You know, prior to that time she was undressed completely. So she got dressed. [LF] made some phone calls.

We got the bags packed. We talked about what we needed, you know, the baby car seat and that kind of stuff, and we got in the car and we left.

(Ex. A14 at 2-8.)

88. During the interview, Ms. Echeverio stated that she administered doses of False Unicorn Root to CF just prior to the approximately 11:15 a.m. vaginal exam, and again at 11:30 a.m. (Ex. A14 at 10, 15.) Ms. Echeverio stated that once the cramping had continued after 10:30 a.m., despite CF resting, eating, drinking, and taking cal-mag, Ms. Echeverio "felt pretty convinced that the picture wasn't going to change too much." (*Id.* at 29.) Nevertheless, Ms. Echeverio told Mr. Goldberg and Ms. Erickson the following:

But [CF and I] had already talked about false unicorn root. [CF] had looked it up on the Internet so she was comfortable. I brought my text with information about false unicorn root [to CF's home]. * * *. And so that was something that they were hoping was going to work. * * *. They really did not want to go to the hospital.

(*Id.*)

89. When asked during the interview to clarify certain times that events occurred on October 31, 2012, Ms. Echeverio stated, in part:

[I] arrived at ten-fifty [at CF's home]. I did the vaginal exam around eleven-fifteen. And then we left for the hospital somewhere * * * after one-thirty.

* * * * *

[I] didn't do the assessment at ten-thirty. I sat down to write the notes when I had a moment and I put ten-thirty as the time that I arrived. And then I just started writing, you know[.]

* * * * *

[W]hen I got to the hospital * * * I made some notes[.]

* * * * *

[I] had time to sit down and review my notes [at the hospital]. And so then I go through the history a little bit more clearly and said I arrived at ten-fifty.

* * * * *

The vaginal exam was done after, you know, an interview, probably closer to * * * eleven-fifteen.

* * * * *

[A]fter the [vaginal] exam it was clear to me that * * * we needed to transport her care, and that's when we made a plan. We would continue to give the false unicorn root some time because that's what she had in her mind that she needed to do, and that we would transport if the cramping didn't stop, which it certainly did not.

(*Id.* at 10-14.)

90. During the interview, Mr. Goldberg asked Ms. Echeverio if she believed that CF was in preterm labor once she did the vaginal exam at approximately 11:15 a.m. Ms. Echeverio responded, in part:

I felt that there was a very small possibility that the cramping would stop. Now, I have worked with moms who've had their cervixes opened, you know, I've had several moms who've been five centimeters before their babies were born, but those are usually moms who've had children, not first-time moms. So in my opinion this was unlikely that it was going to stop.

Unfortunately, we had already talked about the false unicorn root and so in her mind she felt like she needed to give this a try. So we gave a second dose after * * * the exam, * * * and that was my opportunity to move her * * * away from that plan and towards the understanding that she was going to have to get to the hospital.

(Ex. A14 at 15-16.)

91. During the interview, Ms. Echeverio stated the following with regard to what she told CF and LF they could expect after transport to the hospital:

[I] talked about terbutaline * * * and that it's good for * * * forty-eight hours, but it would give enough time for the baby's lungs to mature a little bit.

* * * * *

And at twenty-six weeks that could be helpful. We did have that conversation.

* * * * *

[I] went over * * * [that] we would go straight to the floor, they would have a room available for her; that I've transported there [to Emanuel] many times; * * * and that my role would change and that most likely when they got there they would want to put in an IV right away.

* * * * *

[A]nd then we talked about the terbutaline and what it does. And she had a lot of questions[.]

* * * * *

I discussed [that] * * * they would probably put the baby on a fetal monitor. And since the baby's so low it's possible they might do an internal monitor * * *. [I] did talk about c-section.

* * * * *

I am almost positive that that when we talked about * * * the terbutaline I explained that it's good for forty-eight hours. I couldn't remember if they redosed after forty-eight hours. But I knew that it was effective for forty-eight hours and that that forty-eight hours was imperative in order to get * * * the steroids.

* * * * *

I discussed medication to mature the baby's lungs and I explained why surfactin was so important and that the biggest concern for her baby if her baby was born today was going to be the breathing.

(Ex. A14 at 32-36.)

92. During the interview, Mr. Goldberg asked Ms. Echeverio why the chart notes she provided to the Board contained certain information that was not on the chart notes she provided to hospital staff on October 31, 2012. (Ex. A14 at 17-19.) She responded, in part:

[W]hat I'm remembering now, I think that when those notes were added is when [CF] and I went over her chart [on June 23 or 24, 2013.]

* * * * *

When I took the chart over to her home and I went over the chart to make sure that she agreed with everything that I had written. * * *. I didn't want there to be any disparity in her memory and my memory. So we went over the chart together and there may have been something that she said to me that jogged my memory[.]

* * * * *

This was not an easy situation. As home birth midwives we don't have a lot of pre-term labor so it's not something that we deal with. * * * * *

So in her situation a lot of these notes were written under a certain amount of duress so I wanted to make sure that she could read them, have a chance to read them and look at them and say did I forget anything; was there something that we talked about that I didn't write down.

(*Id.* at 18-21.)

93. Ms. Erickson subsequently prepared a report for the Board, dated August 12, 2013, regarding the care Ms. Echeverio provided to CF. (Ex. A10; test. of Erickson.) Under the "Conclusion" section of the report, Ms. Erickson wrote, in part:

1. Delay in thorough assessment of a preterm client exhibiting symptoms commonly associated with preterm labor

In my opinion, a client with a gestational age of less than 34 weeks * * * should be assessed immediately if she is reporting symptoms of cramping, bleeding, and diarrhea. This is particularly true given that there were no other precipitating factors, like recent intercourse or current treatment of infection. It would have been reasonable for Echeverio to go to [CF]'s home at 0800 after she called the first time or to recommend assessment in a hospital setting.

2. Delay in transport once assessment of preterm labor was made

After assessing the client, Echeverio was correct in her diagnosis of preterm labor[.] This diagnosis was made at 1115 at which point the absolute risk criteria regarding premature labor would apply and the client needed to be transported to the hospital. While counseling a client and respecting the family's need for processing is important and respected, the imminent need to transport should have been relayed and insisted upon much earlier.

3. Lack of knowledge regarding current evidence-based treatment options for preterm labor and the need for expedited assessment and transport to hospital

In my opinion, Echeverio failed to perform an early assessment and expedite transport. In the case of a 27[-] week nulliparous woman at 3-4 centimeters with bleeding and cramping and a low presenting part, the window of time for stopping labor in order to administer betamethasone is

small as labor is advancing. While nulliparous labor at term may take many hours to progress, premature labor is often much quicker and needs to be dealt with as expeditiously as possible. An argument could be made that if Echeverio had better working knowledge about the process of stopping preterm delivery, she may have sent [CF] to the hospital at 0800, at which point she may have been able to receive adequate treatment and possibly delay birth 48 hours. Note: Terbutaline is not a medication used for preterm labor anymore, and it is not “good for 48 hours” as Echeverio stated.²⁹

Finally, Echeverio’s stated inexperience with preterm labor should have played a role in her decision making process. While many preterm labors do start with spontaneous rupture of membranes, it can also be an insidious process that has few overt symptoms (mild cramping and spotting). Echeverio failed to seek advice or help in assessment from others. In this situation, it would be reasonable to recommend that the client go to be assessed for preterm labor in a hospital setting or with another practitioner who has immediate access to tools that may help diagnose this condition more quickly.

4. Lack of complete medical records during course of care & lack of documented counseling regarding Rhogam during pregnancy prior to date in question

Echeverio had been taking care of [CF] since July of 2012. In my opinion, this was more than adequate time to have a complete prenatal record including a blood type. In the event of bleeding during pregnancy, Rhogam is indicated if Rh Negative. Without this information documented, Echeverio cannot counsel her client adequately. At 0800 when the client was bleeding, this should have been part of the counseling.

5. Altering medical records following events without specification of addendum and after complaint had been filed

Medio-legally this is an unacceptable practice that leaves the practitioner open to more scrutiny and liability. Addendums should be clearly marked and signed with a date of addendum. In my opinion, it is also questionable if charting months after the fact while conferring with the client is a recommended practice. While it may be [a] useful exercise to “debrief” a client’s experience together, recording new or editing prior medical record entries during the process gives the appearance of impropriety.

(Ex. A10 at 3-4; bold emphasis in original.)

²⁹ See Exhibit A14 at 36.

CONCLUSIONS OF LAW³⁰

1. Ms. Echeverio violated OAR 332-025-0021(1)(b) by failing to transfer or terminate care of the client at 11:15 a.m. or earlier, when presented with an intrapartum absolute risk as per OAR 332-025-0021(2)(b)(L), with labor at less than 35 weeks.

2. Ms. Echeverio violated ORS 676.612(2)(j) and OAR 332-025-0022(3)(b)(C) by failing to recognize and communicate the emergent need for the client to receive immediate in-hospital care at 11:15 a.m. or earlier, when the client was in labor at 27 and 5/7 weeks.

3. Ms. Echeverio violated OAR 332-025-0110(1) and (4) by failing to maintain complete and accurate records because she did not date and sign addendums to the client's Prenatal Flow chart.

4. Ms. Echeverio violated OAR 332-025-0110(1) and (2)(d) by failing to maintain complete and accurate records of laboratory findings because the client's blood work test results were not with the client's records of care.

5. A proposed sanction imposing specified conditions on Ms. Echeverio's license if and when she returns to practice including direct supervision of five births and courses on charting, pre-term labor and risk assessment as well as an assessment of the costs of the proceeding of \$2,500, is appropriate for the violations proven herein.

OPINION

The Board, with the assistance of and in consultation with the HLO, is charged with promulgating administrative rules and establishing practice standards for direct entry midwifery and licensing and disciplining licensed direct entry midwives. ORS 687.420, ORS 687.480, ORS 687.485, ORS 687.445.³¹

³⁰ The Board has not made any changes to the reasoning of the Proposed Order that are adverse to the Respondent. The Board has made changes to clarify its reasoning and position, to correct grammar and textual placement. The Board has also modified the sanction to be imposed against Ms. Echeverio.

³¹ ORS 687.420(1) directs the Board to "establish standards for qualifications for the licensure of direct entry midwives." ORS 687.480 directs the Board to develop practice standards that include the following:

- (1) Maintenance of records of care, including patient charts;
- (2) Participation in peer review;
- (3) Development of a written plan for emergency transport;
- (4) Guidelines for equipment; and
- (5) Maintenance of patient disclosure forms[.]

ORS 687.485 authorizes the Board and the HLO to do the following:

- (1) Determine whether applicants meet the qualifications under ORS 687.405 to 687.495, conduct examinations and grant licenses to qualified applicants upon compliance with the rules of the board and the agency;

The Board must prove its allegations by a preponderance of the evidence, and it must establish that the proposed sanctions are appropriate. See ORS 183.450(2) ("The burden of presenting evidence to support a fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Metcalf v. AFSD*, 65 Or App 761, 765 (1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

1. Failure to transfer or terminate care at 11:15 a.m. when presented with intrapartum absolute risk

Ms. Echeverio violated OAR 332-025-0021(1)(b) and 332-025-0130(2) by failing to transfer or terminate care of CF at 11:15 a.m. or earlier.

OAR 332-025-0021(1) provides, in part:

Licensees must assess the appropriateness of an out-of-hospital birth taking into account the health and condition of the mother and baby according to the following absolute and non-absolute risk criteria:

(1) "Absolute risk" as used in this rule means conditions or clinical situations of obstetrical or neonatal risk that cannot be resolved and that preclude out-of-hospital care.³² If the mother or baby presents with any absolute risk factors, the LDM must:

* * * * *

(b) During the intrapartum period,³³ arrange transportation to the hospital and transfer of care unless the birth is imminent[.]

(2) Do any act necessary or proper to effect and carry out the duties required of the agency by ORS 687.405 to 687.495;

(3) Adopt rules for the administration of ORS 687.405 to 687.495[.]

ORS 687.445 allows the Board and the HLO to "impose a form of discipline specified in ORS 676.612 against any person practicing direct entry midwifery for any of the grounds listed in ORS 676.612 and for any violation of the provisions of ORS 687.405 to 687.495, or the rules adopted thereunder."

³² In contrast, OAR 332-025-0021(3) defines a non-absolute risk as "a condition or clinical situation that places a mother or baby at increased obstetric or neonatal risk, but does not automatically exclude a mother and baby from an out-of-hospital birth."

³³ OAR 332-015-0000(8) defines "intrapartum" as "the period of time from the onset of labor through the birth of the placenta."

Pursuant to OAR 332-025-0021(2)(b)(L) “[l]abor or premature rupture of membrane less than 35 weeks according to estimated due date” constitutes an intrapartum absolute risk.³⁴

The record establishes that CF and her baby presented with an absolute risk when Ms. Echeverio conducted the vaginal exam and determined that CF was dilated between 3 and 4 cm, was 80 percent effaced, and was at zero station. There was “zero question” that CF was in preterm labor at this point. For the reasons previously explained, the record establishes, more likely than not, that this occurred at approximately 11:15 a.m.

Given that the situation presented an intrapartum absolute risk, the remaining issue is whether Ms. Echeverio complied with OAR 332-025-0021(1)(b) by arranging “transportation to the hospital and transfer of care.”³⁵ OAR 332-025-0021(6) defines “transfer of care” as follows:

For the purpose of this rule “transfer of care” means the process whereby any LDM who has been providing care relinquishes this responsibility to a hospital or to licensees under ORS chapter 682.

(a) The LDM must provide the following at the time of transfer, to the hospital or licensees under ORS chapter 682: medical history, prenatal flow sheet, diagnostic studies, laboratory findings, and maternal and baby care notes through time of transfer;

(b) In cases of emergency, at the time of transfer, the LDM must provide the records required in subsection (a) to the hospital or licensees under ORS chapter 682, including notes for care provided during the emergency, if available. If notes are not available, an oral summary of care during the emergency must be made available to the hospital or licensees under ORS chapter 682; and

(c) Under no circumstances shall the midwife leave the mother or baby until such a time that transport is arranged and another Oregon licensed health care provider or a licensee under ORS chapter 682 assumes care.

OAR 332-025-0130 is titled “Practice Standards for Terminating Midwifery Care” and states, in relevant part:

(2) To terminate midwifery care in an emergency, the LDM must activate the 911 emergency system and transfer care to a licensee under ORS chapter 682.

³⁴ Under OAR 332-025-0021(5)(b), examples of intrapartum non-absolute risks include the following: history of substance abuse during current pregnancy; labor or premature rupture of membrane from 35 to 36 weeks gestation; frank and complete breech presentation; and lack of adequate progress in second stage.

³⁵ There is no evidence that birth was “imminent” at 11:15 a.m., such that OAR 332-025-0021(1)(c) applied.

(3) An LDM in the home setting may leave after transferring care to a licensee under ORS Chapter 682.

(4) If the mother refuses assistance from licensees under ORS chapter 682 the LDM must continually urge the mother to transfer care to a licensee under ORS Chapter 682 and may:

(a) Continue care to save a life; and

(b) Only perform actions within the technical ability of the LDM.

When presented with an absolute risk during the intrapartum period, a midwife must transfer or terminate care. Ms. Echeverio contended at hearing, and in her exceptions to the Proposed Order, that the conversation with the Client began the process of transferring care to the Hospital or to an EMT as she was simply engaging in an informed consent dialogue with CF and LF to facilitate the transport to the hospital and subsequent transfer of care.

Ms. Echeverio insists that she complied with OAR 332-025-0021(1)(b) by arranging hospital transportation and transferring care of CF when they left CF's home at approximately 1:50 p.m. She argues that there is no requirement in the relevant administrative rules that the transfer of care be immediate, and that the fact that the transfer took up to 2.5 hours to occur does not mean that it did not occur. Under Ms. Echeverio's theory, where transfer begins with the dialogue with the mother, the transfer of care could involve an unlimited amount of time, hours or even days.

The record establishes that between the time Ms. Echeverio was presented with an absolute risk (around 11:15 a.m.) and the time that CF left for the hospital (around 1:50 p.m.), approximately 2.5 hours passed. During that period, Ms. Echeverio discussed with CF and LF what they could expect once arriving at the hospital, she answered their questions and attempted to assuage their concerns about the change in their birth plans, she continued to monitor fetal heart tones and CF's signs and symptoms, and she administered at least two doses of False Unicorn Root to CF. She intended for at least one of those doses to lessen the intensity of CF's uterine contractions.

Ms. Echeverio is correct that the relevant rules do not specify a precise time limit for transferring a client with an intrapartum absolute risk. However, as noted above, the transfer must occur upon discovery of the absolute as risk. The rules do make clear that an absolute risk is one that, by definition, precludes out-of-hospital care and that once such a risk presents itself, transfer of care must occur (absent imminent birth). Transfer of care is defined, in part, as the process whereby a midwife relinquishes the responsibility of providing care to the client to the hospital or to licensees under ORS chapter 682.³⁶

Ms. Echeverio discovered the absolute risk at 11:15. The discovery of the absolute risk shifted the responsibility of CF's care from Ms. Echeverio to the hospital or an EMT. Therefore, at 11:15, Ms. Echeverio needed to affirmatively shift her care of CF out of her hands

³⁶ OAR 332-025-0021(6).

and into those of a hospital or EMT. Transfer, on discovery of the absolute risk, would have included seeing that the Client was physically on route to the hospital or by calling 911. In contrast, at 11:15, Ms. Echeverio did not ensure that CF was physically on route to the hospital nor did she call 911. Instead, she continued to maintain full responsibility for CF's care for another 2.5 hours. Although it is certainly reasonable for an LDM to explain to a Client why the LDM has a duty to transfer care upon discovery of an absolute risk, the Client cannot waive the responsibility of the LDM to transfer the care, by consent or otherwise.³⁷

The failure to transfer or terminate care upon discovery of the absolute risk was in contravention of OAR 332-025-0021(1)(b).

2. Failure to recognize and communicate emergent need for CF to receive immediate in-hospital care at 11:15 a.m.

Next, the Board contends that Ms. Echeverio violated ORS 676.612(2)(j) and OAR 332-025-0022(3)(b)(C) by failing to recognize and communicate the emergent need for CF to receive immediate in-hospital care at 11:15 a.m. or earlier.

ORS 676.612(2)(j) states:

(2) 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:

* * * * *

(j) Unprofessional conduct, negligence, 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 boards, councils and programs listed under ORS 676.606.

OAR 331-020-0070 provides, in relevant part:

(4) As used in ORS 676.612(2)(j) incompetence means engaging in conduct which evidences a lack of ability or fitness to perform the holder's professional functions.

(5) As used in ORS 676.612(2)(j) negligence means engaging in conduct detrimental to the client.

OAR 332-025-0022 is titled "Mother and Baby Care Practice Standards" and states, in relevant part:

³⁷When there is an absolute risk, if a Client refuses to go to the hospital, the LDM can transfer care to an EMT by calling 911. If the Client refuses assistance from an EMT after the LDM has transferred the care, the LDM may continue care only to save a life that is within their technical ability. OAR 332-025-0130.

(3) [A]n LDM must adhere to the following mother and baby care practice standards:

* * * * *

(b) Care During Labor, Birth and Immediately Thereafter (Intrapartum) – the LDM must:

* * * * *

(C) Make appropriate and ongoing risk assessment and document maternal and fetal status and response throughout labor.

After determining that there was an absolute risk, Ms. Echeverio should have immediately arranged transportation to the hospital and transferred care of CF to hospital providers. The record establishes that preterm labor does not typically follow a predictable course, and that at just under 28 weeks of pregnancy, the best chance for the survival of CF's baby was to be born in a hospital. The record also establishes that the sooner CF was transported to the hospital, the sooner she would have had the opportunity to receive a tocolytic agent, which might have been successful in delaying her labor for up to 24 to 48 hours, potentially affording the baby the opportunity to receive corticosteroids for lung maturation and magnesium sulfate for neuroprotection.

Ms. Echeverio points to ORS 127.507, which states that “[c]apable adults may make their own health care decisions.”³⁸ She asserts that throughout the events of October 31, she attempted to respect CF's right to make informed choices about her health care, and she allowed CF the time she believed CF needed to accomplish that. No one expected Ms. Echeverio to “bully” CF into promptly going to the hospital after determining that there was an absolute risk. Here, Ms. Echeverio failed to competently recognize and convey the sense of urgency that existed in the situation.

The record establishes that while Ms. Echeverio worked on her charting sometime prior 12:30 p.m., neither CF nor LF believed that there was an urgent need to get to the hospital. CF testified at hearing that she did not believe her labor would progress as fast as it did, and that she thought she had “a few hours.” Even after CF began feeling what she identified as uterine contractions and reported them to Ms. Echeverio at approximately 12:30 p.m., the record establishes that Ms. Echeverio did not become increasingly urgent about getting CF to the hospital until the contractions intensified over the next hour. Even as the contractions apparently

³⁸ A “health care decision” is defined as “consent, refusal of consent or withholding or withdrawal of consent to health care, and includes decisions relating to admission to or discharge from a health care facility.” ORS 127.505(9).

“Health care” is defined, in relevant part, as the “diagnosis, treatment or care of disease, injury and congenital or degenerative conditions[.]”

intensified and plans were made to go to the hospital, CF and LF still believed there was sufficient time for LF to leave the home for about 20 minutes to go and eat.³⁹

Ms. Echeverio testified at hearing that CF finally mobilized to depart for the hospital because CF “finally felt in her own body” that her baby was coming after experiencing uterine contractions. However, CF testified that it was Ms. Echeverio’s *sense of urgency* after her contractions intensified that persuaded her that it was time to get up and go to the hospital. CF testified that she had not at any time “refused” to go to the hospital and that after Ms. Echeverio performed the vaginal exam that morning, all three of them knew they were going to end up at the hospital. While CF undoubtedly appreciated having time to process the fact that she was in preterm labor, ask Ms. Echeverio questions about what was happening and what to expect at the hospital, and discuss and pray about the situation with her husband, there is no evidence to establish that CF would have refused to go to the hospital promptly after the vaginal exam at 11:15 a.m. if Ms. Echeverio had *strongly* and *urgently* communicated a *dire* need for that to occur.

The Board has proven that Ms. Echeverio failed to recognize and communicate the emergent need for CF to receive immediate in-hospital care at after determining that an absolute risk was present at 11:15 a.m. In so doing, Ms. Echeverio failed to make appropriate and ongoing risk assessment, in violation of OAR 332-025-0022(3)(b)(C) and ORS 676.612(2)(j).

3. Failure to sign and date addendums to CF’s chart

The Board asserts that Ms. Echeverio violated OAR 332-025-0110(1), (4) and (5) by failing to maintain complete and accurate records because she did not date and sign addendums to CF’s Prenatal Flow chart.

OAR 332-025-0020 is titled “General Practice Standards” and states, in part:

Pursuant to ORS 687.480, licensees must comply with the following practice standards when, advising the mother and in rendering antepartum, intrapartum and postpartum care.

(11) A licensee must maintain complete and accurate written records documenting the course of midwifery care as listed under OAR 332-025-0110.

³⁹ During her interview with Mr. Goldberg and Ms. Erickson, CF stated that her contractions “got really intense really fast.” Exhibit A15 at 16. She further stated:

It really didn’t take long for that to happen, maybe half an hour or something, and I thought we had more time. And I had actually sent my husband to go get some food for himself and I said, yeah, it will be a while. And then she said to him, no, we’re going to the hospital now. So she was very determined.

Id. at 17.

OAR 332-025-0110 provides, in relevant part:

(1) The LDM must maintain complete and accurate records of each mother and baby.

* * * * *

(4) All records must be legibly written or typed, dated and signed.

(5) All records must include a signature or initial of the LDM.

The record establishes that more than one year after providing and charting care for CF, Ms. Echeverio made five addendums to CF's Prenatal Flow sheets, and she did not date the addendums. This conduct violates OAR 332-025-0110(1) and (4).

4. Failure to maintain complete and accurate records of laboratory findings

The Board alleges that Ms. Echeverio violated OAR 332-025-0110(2)(d) by failing to maintain complete and accurate records of laboratory findings because CF's blood work results were not included in CF's midwifery care records.

As discussed above, OAR 332-025-0110(1) requires an LDM to maintain complete records. Section (2) of the rule describes in detail what type of documentation is required to constitute complete records and states, in pertinent part:

(2) Records mean written documentation, including but not limited to:

(a) Midwifery care provided to mother and baby;

* * * * *

(c) Medical history;

(d) Diagnostic studies and laboratory findings;

It is undisputed that Ms. Echeverio did not have a copy of CF's blood work results, which had been ordered by CF's previous care provider, in CF's medical records. And while Ms. Echeverio made multiple requests for the provider, Dr. Jarvela, to send her those records, Ms. Echeverio had not obtained them nearly 28 weeks into CF's pregnancy.

OAR 332-025-0110 contains no exception to the requirement that a midwifery client's medical records must contain her laboratory findings to be considered complete. And, although the evidence shows that Ms. Echeverio was having a difficult time obtaining the lab results, Dr. Jarvela left a message for Ms. Echeverio on October 3, 2012, stating that she would fax the results to Ms. Echeverio or that CF could come pick them up. Even so, by October 31, 2012, Ms. Echeverio still had not procured a copy.

The Board has established a violation of OAR 332-025-0110(2)(d).

5. Sanctions

A. Conditional License with Stayed Suspension

In its Amended Notice, the Board proposed a two-year suspension of Ms. Echeverio's midwifery license, with reinstatement contingent upon satisfying all general requirements for reinstatement under the statutes and rules applicable at the time of reinstatement, as well as the following conditions:

1. Ms. Echeverio must successfully complete a Board-approved pre-term labor course within 12 months of the issuance of the Final Order in this matter. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.
2. Ms. Echeverio must complete a Board-approved ethics course within 12 months of the issuance of the Final Order in this matter. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.

See Second Amended Notice at 1.

ORS 676.612(1) provides, in part:

[T]he Oregon Health Licensing Agency may refuse to issue or renew, may suspend or revoke or may otherwise condition or limit a certificate, license, permit, or registration to practice issued by the agency or may discipline or place on probation a holder of a certificate, license, permit or registration for commission of the prohibited acts listed in subsection (2) of this section.

ORS 676.992 is titled "Civil penalties" and provides, in part:

(1) [I]n addition to any other penalty or remedy provided by law, the Health Licensing Agency may impose a civil penalty not to exceed \$5,000 for each violation of the following statutes and any rule adopted thereunder:

* * * * *

(d) ORS 687.405 to 687.495 (direct entry midwifery);

* * * * *

(m) ORS 676.612 (prohibited acts)[.]

* * * * *

OAR 331-020-0070 states, in part:

(1) The Oregon Health Licensing Agency may discipline authorization holders for violations of laws and rules, in accordance with ORS 676.612 and 676.992.

* * * * *

(3) The agency, at its discretion, may require supplemental training in an appropriate area of study as determined by the agency, board or council, as a disciplinary sanction. Supplemental training may be in addition to assessment of a monetary penalty or the agency, board or council may waive or reduce a penalty, in cases requiring supplemental training.

After fully reviewing the record, and taking into account the withdrawal of two of the violations proposed in the Amended Notice, the Board proposed in its Amended Proposed Order to reduce the sanction of a two year suspension to a stayed two year suspension, so long as the following conditions on her license are met.

Ms. Echeverio, if and when she reactivates her license,⁴⁰ must, within the first 12 months that she returns to practice:

1. Submit 10 of her cases during the 12 months to a Board-approved reviewer for supervised practice.¹
2. Of the 10 cases, 5 must have the births directly supervised by a Board-approved reviewer who is fully familiar with the records in the cases and is physically present for the births.
3. Ms. Echeverio must successfully complete a Board-approved pre-term labor course. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.
4. Ms. Echeverio must complete a Board-approved course on charting. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.

⁴⁰ At the time of the issuance of this Amended Proposed Order, Ms. Echeverio had not renewed her license since July 2014. The current status of her license is inactive.

5. Ms. Echeverio must complete a Board-approved course on risk assessment. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.

6. Ms. Echeverio is fully responsible for all costs incurred to comply with the conditions described above in (1)-(5).

The Board will stay the two year suspension so long as these requirements are met. If these requirements are not met at the end of the first 12 months after Ms. Echeverio reactivates her license, the two year suspension will be immediately imposed.

The Board now adopts the proposed sanction in its Amended Proposed Order.

B. Costs

ORS 676.992(2) authorizes the Board to impose costs of a disciplinary proceeding, up to \$5,000:

(2) The agency may take any other disciplinary action that it finds proper, including but not limited to assessment of costs of disciplinary proceedings, not to exceed \$5,000, for violation of any statute listed in subsection (1) of this section or any rule adopted under any statute listed in subsection (1) of this section.

In addition to and separate from the sanction described above, the Board also proposed to assess Respondent \$2,500 of the costs of the proceeding. Accompanying the Amended Proposed Order was a Bill of Costs for the \$2,500. The Board now assesses Respondent \$2,500 of the costs of this proceeding.

FINAL ORDER

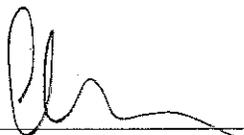
Ms. Echeverio, if and when she reactivates her license,⁴¹ must, within the first 12 months that she returns to practice:

1. Submit 10 of her cases during the 12 months to a Board-approved reviewer for supervised practice.ⁱⁱ
2. Of the 10 cases, 5 must have the births directly supervised by a Board-approved reviewer who is fully familiar with the records in the cases and is physically present for the births.
3. Ms. Echeverio must successfully complete a Board-approved pre-term labor course. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.
4. Ms. Echeverio must complete a Board-approved course on charting. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.
5. Ms. Echeverio must complete a Board-approved course on risk assessment. She is responsible for identifying the course, submitting the course for Board-approval, and paying all costs associated with the course.
6. Ms. Echeverio is fully responsible for all costs incurred to comply with the conditions described above in (1)-(5).

The Board will stay the two year suspension so long as these requirements are met. If these requirements are not met at the end of the first 12 months after Ms. Echeverio reactivates her license, the two year suspension will be immediately imposed.

In addition and separate from this sanction, the Board assesses \$2,500 of the costs of the proceeding.

DATED 12-2-15



Colleen Forbes, LDM
Chair, Board of Direct Entry Midwifery

⁴¹ At the time of the issuance of this Amended Proposed Order, Ms. Echeverio had not renewed her license since July 2014. The current status of her license is inactive.

APPEAL

If you wish to appeal the final order, you must file a petition for review with the Oregon Court of Appeals within 60 days after the final order is served upon you. See ORS 183.480 *et seq.*

¹ The Board's supervision requirements for those 10 cases 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

ⁱⁱ The Board's supervision requirements for those 10 cases 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)

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

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

- 8) Assess, identify, evaluate and support maternal and fetal well-being throughout the process of pregnancy
- 9) Lab work and testing
- 10) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
 - f) Was there an appropriate consultation and with who
 - g) Consult to confirm risk factor
 - h) What was the result of that consultation
 - i) Was there a documented discussion with the client
 - j) What was the result
- 11) Other potential risks identified or preexisting conditions
 - c) Therapeutic actions/interventions instituted in alignment & identified problems
 - d) Consult to rule out a risk factor

Antepartum continued

- 12) Informed choice discussions documented
 - d) Risks/benefits
 - e) Pros/cons
 - f) Midwife's recommendations
- 13) Informed consent documentation
- 14) Records of Care properly documents

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

- 5) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
 - f) Was there an appropriate consultation and with who
 - g) Consult to confirm risk factor
 - h) What was the result of that consultation
 - i) Was there a documented discussion with the client
 - j) What was the result
- 6) Postdates testing
- 7) Informed consent documentation
- 8) Records of Care properly documents

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

- 10) Vital signs at appropriate intervals temperature, blood pressure, pulse, fetal heart tones
- 11) Urine dip done
- 12) If abnormal vital signs – what action taken & is it consistent?
- 13) Labor progress assessed. How?
- 14) Interventions
- 15) Documentation of interventions & effect
- 16) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
 - f) Was there an appropriate consultation and with who
 - g) Consult to confirm risk factor
 - h) What was the result of that consultation
 - i) Was there a documented discussion with the client
 - j) What was the result
- 17) Informed consent documentation
- 18) Records of Care properly documents

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

- 2) Postpartum
 - d) Assessment at appropriate intervals
 - e) ID deviations
 - f) Action taken documented