

2 2) On September 10, 2010, OHLA received a complaint against Respondent, opened
an investigation of Respondent's conduct and found the following:

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6 3) At all relevant times, Respondent was a direct entry midwife at the Motherwise
Community Birth Center, LLC (Motherwise) in Bend, Oregon.

8 4) Client entered care with a Motherwise midwife on or about September 21, 2009.

10 5) Respondent did not begin assisting with Client's care until approximately the 27th
week of Client's pregnancy. Respondent continued to assist with client care, including through
12 the postpartum period, until approximately June 3, 2010 when Client's relationship with
Motherwise staff had deteriorated and Client discontinued use of their client services.

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16 6) At all relevant times, Respondent was not the Motherwise midwife responsible for
explaining the general practices of the birth center, including which staff might be present for the
18 birth and who would supervise them, nor was Respondent responsible for billing matters or
responses to client records requests.

20 7) At no time did Respondent provide disclosure to Client regarding whether
Respondent carried malpractice insurance.

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24 8) There was no emergency transport plan in Client's file, and Respondent was the only
non-apprentice midwife present for approximately 15 hours of Client's labor. Yet, at no time
26 throughout her care of Client did Respondent provide Client with a written emergency transport
plan.

28 9) On or about April 19, 2010, at approximately 7:30 p.m. Client arrived at
Motherwise for labor and birth. Respondent was the only midwife providing Client's care for the
30 first approximately 15 hours of labor, was assisted by two apprentices, and was the only licensed
midwife on-site during those approximately 15 hours to supervise the apprentices.

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34 10) Respondent's seven-month old baby was also on-site and was brought into the birth
room during Client's labor, distressing Client.

36 11) Throughout labor, Client had persistent difficulty voiding, but Respondent and
apprentices continued providing her fluids orally and intravenously. Client made frequent trips to
38 the restroom to attempt to urinate and was unsuccessful, but Respondent "assumed" Client was
voiding. On or about April 20, at approximately 6:30 a.m., Client complained of being unable to
40 void and Respondent catheterized Client for approximately 30 minutes. At approximately
9:55 a.m., Client again complained of being unable to void. A persistently full bladder may
42 prevent the fetus's head from descending and interfere with the progress of labor and birth.

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2 12) On or about April 20, 2010, at approximately 10:00 a.m., Respondent was joined by
another Motherwise midwife and at 10:10 a.m., fetal heart tones dropped with uterine
4 contractions into the range of 94 to 118 beats per minute, Client was provided oxygen, but fetal
heart tones then declined to 90 beats per minute.

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8 13) Respondent and another Motherwise midwife then determined that transport of
Client to hospital was appropriate because of late decelerations and fetal distress, and telephoned
10 St. Charles Medical Center at approximately 10:15 a.m. Client was transported in a private
vehicle to the nearest hospital, St. Charles Medical Center – Bend, in Bend, Oregon.

12 14) On or about April 20, 2010, at approximately 1:00 p.m. and after an unsuccessful
hospital attempt to deliver Client's infant vaginally, Client's infant was delivered by cesarean
14 section at St. Charles Medical Center – Bend. During the procedure, an unspecified defect in the
serosal layer of the bladder was present, such that it was required to be supported by sutures.

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18 15) No detailed labor flow charts were created or provided on April 19, 2010 or April
20, 2010. No detailed labor flow charts were provided to Client at the time she requested them.
Respondent was assisted in Client's labor by two apprentices who could have taken labor flow
20 notes. However, detailed labor flow charts, written by Respondent and with date April 21, 2010
written on them, were not available until four months after Client requested them.

22 APPLICABLE LAW

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26 1) **ORS 687.480:** The State Board of Direct Entry Midwifery shall develop practice
standards that shall include but not be limited to:

28 (1) Maintenance of records of care, including client charts;
* * *

30 (3) Development of a written plan for emergency transport;
* * *

32 (5) Maintenance of patient disclosure forms, which includes information regarding whether
the midwife has malpractice insurance.

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36 3) **Former OAR 332-025-0020(11)(h) (2004):** Licensees shall maintain a midwife
disclosure statement providing current and accurate information to prospective clients and must
provide clients with this information. This statement must include but not be limited to * * *
38 malpractice coverage.

40 4) **Former OAR 332-025-0020(12) (2004):** Licensees shall maintain a plan for
emergency transport and must discuss the plan with client. The plan must include but not be
42 limited to:

44 a) Place of transport;

b) Mode of transport;

46 c) Provisions for physician support and hospital including location and telephone
numbers; and

2 d) Availability of private vehicle or ambulance including emergency delivery
4 equipment carried in the vehicle.

6 5) *Former OAR 332-025-0020(13) (2004)*: Licensees shall maintain accurate
8 written client records documenting the course of midwifery care.

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

16 CONCLUSIONS OF LAW

18 1) By failing to provide Client with disclosure regarding whether Respondent carried
20 malpractice insurance, Respondent violated *former OAR 332-025-0020(11)(h) (2004)*.

22 2) By failing to provide Client with a written emergency transport plan, Respondent violated
24 *former OAR 332-025-0020(12)*.

26 3) By failing to provide Client with an emergency transport plan when there was none in
28 Client's file and Respondent was the only non-apprentice midwife present for all but the last
30 30 minutes of Client's pre-transport labor, Respondent engaged in unprofessional conduct,
32 violating ORS 676.612(2)(j) on one occasion.

34 4) By failing to competently monitor Client's voiding during labor, only making invalid
36 "assumptions" about Client's ability to void and allowing Client's bladder to become
38 distended, Respondent engaged in incompetent practice, violating ORS 676.612(2)(j) on a
40 third occasion.

42 5) By failing to properly chart labor flow, Respondent violated OAR 332-025-0020(13).

36 ORDER

38 Pursuant to ORS 676.992(1), the Agency may impose a maximum civil penalty of \$5,000
40 per violation. Pursuant to ORS 676.612(1) and ORS 676.992(2), the Agency may take any
42 disciplinary action it finds proper, including revocation of Respondent's license, for any
44 violation.

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Pursuant to ORS 676.992(1)(d) and (m) and OAR 332-030-0000, the Oregon Health Licensing Agency, in consultation with the Board of Direct Entry Midwives, finds and hereby ORDERS:

1) Respondent violated *former* OAR 332-025-0020(11)(h) (2004) and in accordance with ORS 676.992(1)(d) and (4) is assessed a civil penalty of \$1,000.

2) Respondent violated *former* OAR 332-025-0020(12) and in accordance with ORS 676.992(1)(d) and (4) is assessed a civil penalty of \$500.

3) Respondent violated ORS 676.612(2)(j) on a first occasion, by engaging in unprofessional conduct, and in accordance with ORS 676.992(1)(m) and (4) is assessed a civil penalty of \$250.

Total Civil Penalties are \$1750.00

5) Respondent violated ORS 676.612(2)(j) on a third occasion, by engaging in incompetent practice, and in accordance with ORS 676.992(2) is required to successfully complete 6 (six) continuing education credits approved by the Board and at Respondent's own expense, pertaining to intrapartum monitoring of and communication with clients. These continuing education credits are to be completed, and documentation of their completion submitted to the Agency, within six months of the date a final order is issued in this case or this notice becomes final by default.

6) Respondent violated *former* OAR 332-025-0020(13) and in accordance with ORS 676.992(2) is required within one calendar year from the date a final order is issued in this case or this notice becomes final by default to submit complete client charts for 5 pregnancies and corresponding labors and births to a licensed direct entry midwife selected by Respondent and approved by the Board of Direct Entry Midwifery (Board), for that licensed direct entry midwife's review, and such reviews to be provided to the Board within 18 months from the date a final order is issued in this case, or this notice becomes a final order by default. Respondent is responsible for any fees or costs associated with such chart review.

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2 7) Additionally and in accordance with ORS 676.992(2), for these violations the Respondent is
4 also assessed the costs of any disciplinary proceeding up to a maximum of \$5,000.00.

6 DATED 6/21/2012

8 R. Bothwell
10 Robert Bothwell, Manager
12 OHLA Regulatory Operations Division
For Randall Everitt, Director

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16 **NOTICE OF RIGHT TO HEARING**

18 *Licensee is entitled to a hearing as provided by the Administrative Procedures Act, Oregon*
20 *Revised Statutes, and Chapter 183. If Licensee wishes to receive a hearing Licensee must file a*
22 *written request for a hearing with the Board no later than 30 days from the date of service of this*
24 *notice. If a request for hearing is not received within the 30 day period Licensee's right to a*
26 *hearing shall be considered waived unless the failure to request a hearing was beyond*
28 *Licensee's reasonable control. If Licensee requests a hearing, Licensee must also provide with*
30 *the request an answer to each factual matter alleged in the notice and a short, plain statement of*
32 *any affirmative defense Licensee will raise at the hearing pursuant to OAR 331-020-0010 and*
34 *331-020-0020. Except for good cause: factual matters alleged in the notice and not denied in the*
36 *answer shall be deemed admitted; failure to raise a particular defense in the answer will be*
considered a waiver of such defense; new matters alleged in the answer (affirmative defenses)
shall be presumed to be denied by the agency; and, evidence shall not be taken on any issue not
raised in the notice and the answer. Hearing requests shall be mailed to Oregon Health
Licensing Agency, 700 Summer St. NE, Suite 320, Salem, Oregon 97301-1287. Licensee has the
right to be represented by legal counsel. ORS 183.457 provides a corporation may be
represented by an authorized representative at the hearing. If Licensee requests a hearing the
Licensee will be notified of the time and place of the hearing. Information on the procedures,
right of representation and other rights of parties relating to the conduct of the hearing is
attached to this citation.

38 **NOTICE OF FINAL ORDER**

40 *If Licensee does not request a hearing within 30 days, this citation will become a final order,*
42 *effective 31 days after it was served on Licensee. If Licensee does not request a hearing or fails*
to appear at a scheduled hearing, the Agency's file on the matter becomes record for the purpose

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2 *of establishing a prima facie case. Licensee is entitled to judicial review of this order. Judicial*
4 *review may be obtained by filing a petition for review with the Oregon Court of Appeals within*
6 *30 days from the date this order becomes final, pursuant to the provisions of ORS 183.482.*

8 SENT VIA CERTIFIED MAIL #: 70110470000300568361