STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DEPARTMENT OF HEALTH,
BOARD OF NURSING,

Petitioner,

vs. Case No. 18-2269PL

CYNTHIA L. DENBOW, A.R.N.P.,

Respondent.
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RECOMMENDED ORDER

On August 27 and 28, 2018, a final hearing was held via video teleconference with locations in Pensacola and Tallahassee, Florida, before E. Gary Early, an Administrative Law Judge assigned by the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Kristin M. Summers, Esquire
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For Respondent: Suzanne Suarez Hurley, Esquire
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STATEMENT OF THE ISSUES

The issues to be determined are whether Respondent fell below the minimum standard of acceptable nursing practice in

violation of section 464.018(1)(n), Florida Statutes; engaged in unprofessional conduct by inaccurately recording in violation of section 464.018(1)(h), Florida Statutes, and Florida Administrative Code Rule 64B9-8.005(1); or made deceptive, fraudulent, or untrue statements in or related to the practice of her profession in violation of section 456.072(1)(m), Florida Statutes; and, if so, the appropriate penalty.

PRELIMINARY STATEMENT

As a preamble to the more common and mundane matters that typically comprise a preliminary statement, the undersigned must take the opportunity to recognize the tragedy of the events described herein. There can be no greater loss than the death of a child at the very moment of birth. The emotion present during this hearing was palpable, affecting participants and observers alike. However, it is not within the jurisdiction of the undersigned to mete out "justice" or offer equity. There is nothing that can be done through this proceeding to ease the unfathomable pain experienced by the parents, or the second guessing and regret that must surely weigh on each of the healthcare providers involved, including Respondent. No one can be made whole. The only duty of the undersigned is to dispassionately review the evidence and determine whether the Department has proven, with the requisite standard of proof, the

specific allegations set forth in the Administrative Complaint. The undersigned commits to the performance of that duty.

On March 9, 2018, Department of Health (Petitioner or Department), filed an Administrative Complaint against Respondent, Cynthia L. Denbow, an Advanced Registered Nurse Practitioner (ARNP) certified to practice as a nurse-midwife (CNM). The complaint charged Respondent with violating sections 464.018(1)(n), 464.018(1)(h), and 456.072(1)(m), Florida Statutes, and Florida Administrative Code Rule 64B9-8.005(1).

On March 20, 2018, Respondent filed an Election of Rights in which she disputed the allegations contained in the Administrative Complaint and requested a formal administrative hearing.

On May 7, 2018, the Election of Rights was referred to the Division of Administrative Hearings. The final hearing was scheduled for July 12, 2018. Pursuant to an Unopposed Motion for Continuance, the final hearing was rescheduled for August 28, 2018. An additional day for the hearing was subsequently added and the hearing was scheduled for August 27 and 28, 2018.

On August 21, 2018, the parties filed their Joint Prehearing Stipulation (JPS), which contained 45 stipulated facts. Those facts have been incorporated in this Proposed Recommended Order. The JPS also contained 10 stipulations

regarding issues of law on which there was agreement. Those stipulations, which are determined to accurately set forth applicable issues of law, are incorporated in this Proposed Recommended Order.

The final hearing was convened on August 27, 2018. At hearing, Joint Exhibits 1 through 20 were admitted into evidence. Petitioner offered the testimony of F.R., the father of the deceased child; Jenny Hernandez; A.R., the mother of the deceased child; Joanna Mitrega, who was accepted as an expert in labor and delivery; and Lisa Plano, M.D. Petitioner also offered the testimony of Jennifer Seaton, M.D., via deposition in lieu of live testimony. The use of Dr. Seaton's deposition was stipulated by the parties, and the deposition will be considered and given weight as though Dr. Seaton testified in person at the final hearing. Petitioner's Exhibits 1, 3a, and 3b were received in evidence. Respondent testified on her own behalf and offered the testimony of Penny Lane, D.N.P., who was accepted as an expert in midwifery; Jessica Williamson; Kathryn Williams; Christy Shields; and Kaleen Richards, ARNP, who was accepted as an expert in standards of care for nurse midwives in Florida. Respondent's Exhibits 1, 4, 6, 23, and 24 were received in evidence. Petitioner also offered the testimony of Janet Fuller, R.N., via deposition in lieu of live testimony. The use of Ms. Fuller's deposition was received in

evidence over an objection of relevance. The deposition will be considered as though Ms. Fuller testified in person at the final hearing and, as with all evidence, will be given the weight that it warrants.

The four-volume final hearing Transcript was filed on September 25, 2018. Dr. Seaton's deposition testimony was separately filed on September 27, 2018. The record was closed on September 28, 2018, and the parties were instructed to file their Proposed Recommended Orders by October 17, 2018. Both parties timely filed Proposed Recommended Orders.

This proceeding is governed by the law in effect at the time of the commission of the acts alleged to warrant discipline. See McCloskey v. Dep't of Fin. Servs., 115 So. 3d 441 (Fla. 5th DCA 2013). Thus, references to statutes are to Florida Statutes (2017), unless otherwise noted.

FINDINGS OF FACT

1. The Department of Health, through its Board of Nursing, is the state agency charged with regulating the practice of nursing in the state of Florida, pursuant to section 20.43 and chapters 456 and 464, Florida Statutes.

2. At all times material to this proceeding, Cynthia L. Denbow was a licensed ARNP in the state of Florida, holding license number ARNP 9283016. Prior to the instant case,

Respondent has never had a complaint or discipline against her Florida Registered Nurse or ARNP licenses.

3. Respondent has been certified by the American College of Nurse Midwives (ACNM) to practice as a CNM since 2006. Section 464.012(1)(a) provides that to be licensed as an ARNP, a nurse must be licensed to practice professional nursing and hold certification from an appropriate specialty board. Florida Administrative Code Rule 64B9-4.002(1)(b) provides that the ACNM is one of the specialty boards recognized by the Board of Nursing.

4. Respondent, as a nurse-midwife, is not regulated under chapter 467, Florida Statutes, which governs "licensed midwives" in Florida.

5. Respondent was the owner/operator of Gentle Birth Options (GBO), a birth center located at 296 Bayshore Drive, Niceville, Florida 32578.

6. At GBO, Respondent offered midwifery services, which included prenatal care, child birth education classes, and labor and delivery medical support.

7. In 2017, Respondent provided midwifery services to A.R., a 36-year-old female patient who was pregnant with her first child. Prior to becoming a client at GBO, A.R. and her husband, F.R., attended an open house at GBO designed to introduce prospective clients to the concepts of informed

consent, and how the birthing center differs from the medical model of care. They then selected Respondent as the medical provider to guide them during their pregnancy, to provide one-on-one care to them during labor and delivery, and to make decisions to facilitate the birthing process.

8. As a client of GBO, A.R. signed an informed consent form entitled: "Consent to Deliver in a Birth Center" documenting the date at June 16, 2017. The informed consent documents provided that no matter the quality of care, there remained a possibility of unforeseen events resulting in a poor labor outcome. The forms also informed A.R and F.R. that the midwife would transfer the laboring mother to the hospital if the course of labor was outside her scope of care.

9. The informed consent forms also provided that, whenever possible, decisions regarding transfers would be made jointly by the laboring mother, the father, and the midwife. However, it warned that situations may arise where the midwife's decisions and judgements must be trusted.

10. During the course of the pregnancy, A.R. and F.R. attended prenatal appointments and child birth education classes at GBO. A.R. attended all the provided classes at GBO, while F.R. attended four to six classes.

11. The classes provided at GBO were taught by either Respondent or her assistant, Christy Shields. The classes

covered topics including: shared decision-making, reasons for transfer from GBO to the hospital, what to do when the client begins labor, and the role of the father during and after pregnancy.

12. Breech presentation was discussed in the prenatal classes. However, transfer during labor due to breech presentation was not discussed, as GBO deals only with unplanned breech deliveries.

13. GBO clients were taught not to count contractions, as they are an unreliable indicator of labor progression.

14. GBO clients were provided materials indicating that the Fort Walton Beach Medical Center (FWB) performed an unreasonably high number of cesarean sections per year. That information influenced A.R. and F.R.'s negative feelings toward giving birth at FWB.

15. Two months prior to the delivery date, A.R. and F.R. chose a birth plan that expressed a preference for limited vaginal exams, and a vaginal birth as opposed to a cesarean section. The birth plan preferences did not mean A.R and F.R. were opposed to vaginal exams prior to delivery, or delivery via cesarean section, if medically necessary. Both A.R. and F.R. assumed Respondent would conduct all medically necessary vaginal exams and arrange for a cesarean section, if medically necessary.

16. Jenny Hernandez was hired as A.R.'s doula. A doula is a professional who attends a birth to provide physical and emotional support to the mother and father before, during, and after the birth. The delivery of A.R. and F.R.'s child was the first midwife birth attended by Ms. Hernandez, all others in her experience having been in a hospital with continuous fetal monitoring.

17. On the morning of December 7, 2017, A.R., who was 40 weeks and 4 days pregnant, and 4 days past her due date, presented at GBO for a routine prenatal appointment.

18. Respondent preformed a vaginal exam on A.R., and determined the position of the fetus by placing her hands on A.R.'s abdomen. When the exam was completed, Respondent told A.R. that the fetus was head down (vertex position), and that A.R. was 50 percent effaced and one centimeter dilated. Respondent did not perform an ultrasound on A.R. at this appointment, but did perform Leopold maneuvers which confirmed the vertex position of the baby. Respondent also informed A.R. that the baby was resting on her pelvis. Respondent gave A.R. a sash and some exercises designed to fix the fetus's position before sending her to the chiropractor.

19. The position of a fetus can change from vertex to breech at any time, including up to the very time of delivery.

20. After the appointment A.R. and F.R. retuned home. Before 4:00 p.m., A.R. began feeling pains and felt she was experiencing the signs of early labor. At 3:56 p.m., A.R. called Respondent's number, which was given out specifically for clients going into labor. Respondent did not answer. A.R. then called GBO's front desk and was informed by Ms. Williamson that Respondent was unavailable. A.R. informed Ms. Williamson that she believed she was going into labor and was feeling crampy.

21. Respondent was unable to take A.R.'s call because she was in the birthing suite assisting in another birth. When informed about the A.R.'s call, she believed it to be a "heads up call," a common occurrence at GBO where expecting mothers call in to allow GBO to prepare for the impending birth. She also believed that the cramping could be related to the vaginal examination performed that morning.

22. At 4:00 p.m. on December 7, 2017, A.R. texted her doula, Ms. Hernandez, and said "Hey Jenny, I think I might be in early labor, just FYI. I'll contact you in a little bit if I go into active labor, thanks"

23. At 6:49 p.m., Respondent inquired into A.R.'s condition, texting "How are you." A.R. replied "Doing well. Pressure waves getting a bit more intense, so took a hot shower. Making groaning cake with mom now." A groaning cake is an

intricate cake with lots of ingredients designed to take one's mind off of the pains of early labor.

24. Around 9:00 p.m., A.R. began feeling stronger contractions. F.R. called Respondent at 9:07 p.m. to give a labor update and report the rupture of A.R.'s membranes. Respondent assured F.R. that the labor was progressing normally and did not provide any other guidance. F.R. informed Respondent that he would call back when the labor progressed further. At roughly that time, A.R.'s birth doula, Ms. Hernandez, was called to come to their home.

25. F.R. called Respondent at 9:39 p.m. to give a labor update and to inquire as to whether it was the appropriate time to come to GBO. Respondent replied that this was a normal labor progression and to wait for the doula to arrive before coming in.

26. By the time Ms. Hernandez arrived at A.R.'s home, A.R. had begun to vomit and release a pink discharge. A.R.'s contractions were two to three minutes apart, and very intense.

27. Based on the symptoms displayed by A.R., and the estimated time between contractions, Ms. Hernandez believed that A.R. was in transition between latent and active labor. The transitional period is the shortest stage of labor.

28. The doula and F.R. jointly made the decision that it was time to take A.R. to the birthing center. F.R. called and

informed Respondent that the birth party would be arriving at GBO in around 15 minutes.

29. At no point before reaching the birthing center did A.R. or F.R. count contractions.

30. There is conflicting evidence as to whether A.R. was screaming in pain before heading to GBO. Ms. Hernandez testified that A.R. was not screaming in pain while at her house, but rather was working hard, groaning, and exerting energy, stating that "I wouldn't say that she was out of control. She was working hard and I'd say, in my experience, she was coping well." She further testified that A.R. was screaming only at the end while at GBO, immediately before her transfer to the hospital as described herein. Ms. Hernandez's testimony is accepted.

31. At 10:35 p.m., A.R., F.R., Ms. Hernandez, and A.R.'s mother arrived at the birthing center and were greeted by the medical assistant, Katherine Williams. A.R walked into GBO on her own. Ms. Williams accompanied A.R. to the birthing suite, and A.R. sat down on the bed.

32. Ms. Williams' job as medical assistant at GBO was to support the midwife during labor. Her duties included checking a client's vitals upon admission into the birthing suite, documenting intrapartum and postpartum records, and comforting the mother and father during the birthing process.

33. While it is disputed if Ms. Williams ever performed a check of vital signs on A.R. upon admission to the birthing suite, Ms. Williams testified that she did so, and the intrapartum records state that Ms. Williams documented A.R.'s blood pressure, respiration, temperature, and fetal heart tones. The report indicates A.R. was coping with contractions at this time. Ms. Williams's testimony and contemporaneous records are accepted.

34. Shortly after the birthing party arrived in the suite, Respondent and Ms. Shields entered the room. Respondent greeted the party, and observed A.R. in labor, but did not perform any physical examination. Ms. Shields saw the records of Ms. Williams's vitals check when she entered the birthing suite.

35. Respondent and her assistants watched and assessed A.R. in the birthing suite in an attempt to determine what stage of labor A.R. was in. Ms. Hernandez was massaging A.R.'s back, applying counterpressure, and generally offering encouragement.

36. At 11:15 p.m., A.R. got up to go to the bathroom. She returned from the bathroom and sat at the foot of the bed. Ms. Shields then checked the baby's vitals.

37. A.R. alternated positions from the bed to the birthing stool and back. Respondent and her assistants continued to monitor A.R. to determine the stage of labor. At some point,

Respondent left the room to review materials on stem cell extraction from the umbilical cord.

38. F.R. called Respondent back into the birthing suite. Respondent indicated that A.R. did not seem to be handling the contractions well, and had begun to vocally express pain and breathe heavily. A.R. expressed the desire to get into the birthing tub, at which time Respondent asked A.R. if she would like her to perform a vaginal exam. A.R. responded in the affirmative. Respondent conducted the vaginal exam and informed A.R. she was 100 percent dilated and completely effaced, but that the baby was in breech position. Meconium was observed after the vaginal exam. The parties stipulated that the examination was performed one hour and seven minutes after A.R. arrived at GBO, making the time 11:42 p.m.

39. Respondent informed A.R that it was her decision as to how to proceed with the breech delivery. Respondent told A.R. that she had performed unplanned breech deliveries and was comfortable with undertaking the delivery. Respondent gave A.R. two choices: give birth at the birthing suite; or give birth at the hospital where they would likely perform a cesarean section.

40. There was conflicting evidence as to whether Respondent provided information to A.R. about the options for safe delivery based on the nature of the delivery and its imminence. Respondent testified that she informed A.R. that

because the birth may be imminent, it could occur in the ambulance which can be dangerous due to a lack of available trained personnel and equipment, a conversation described in the intrapartum records. Respondent did testify that "I did not quote exactly what I said. I may not have used the word precipitous, but I told her, your labor is progressing fast, and that means the same thing." Ms. Shields went to check the emergency cart because, to her, "it seemed like we were about to have a baby any second now." F.R. and Ms. Hernandez testified that Respondent did not tell them that the birth was imminent or precipitous. However, they knew at a minimum that A.R. was 10 centimeters dilated and completely effaced, which would reasonably suggest that delivery could come quickly -- within 30 minutes according to Ms. Mitrega. F.R., Ms. Hernandez, or A.R. could not recall Respondent advising that an ambulance delivery could be dangerous, but recalled Respondent reiterating the downside of a FWB delivery. A complete review of the testimony of each of the witnesses, including GBO staff, indicates that the differences in the recollection of the witnesses were not so dissimilar as to suggest that any witness was intentionally fabricating their testimony. Rather, given the impact of the situation -- as stated by F.R., "all the air went out of the room" -- the differences in time, tone, and

substance were, more likely than not, an artifact of the stress and tumult of the moment.

41. The greater weight of the evidence indicates that Respondent gave A.R. the option of continuing with the delivery at GBO or going to FWB. A.R. initially agreed to continue with the delivery in the birthing suite. As stated by F.R., "I agreed, let's do this," a statement reiterated by several witnesses. To be sure, the decision was influenced by information provided during birthing classes as to the cesarean delivery rate at FWB, and by Respondent's assurance that she could manage the unplanned breech delivery. Such does not constitute "encouragement" as pled in the Administrative Complaint. Thus, the evidence is not clear and convincing that Respondent failed to meet the minimal standards of acceptable and prevailing nursing practice by encouraging A.R. to continue delivery at GBO after learning that A.R.'s fetus was in breech position, that Respondent engaged in unprofessional conduct as a result of the circumstances surrounding A.R.'s consent to continue the delivery at GBO after learning that A.R.'s fetus was in breech position, or that Respondent made deceptive and/or untrue representations in A.R.'s patient records regarding the decision to continue the delivery at GBO after learning that A.R.'s fetus was in breech position.

42. After A.R. agreed to continue the birth at GBO, Respondent had to assess whether the birth was imminent in case there had to be a decision to transfer to the hospital. Respondent then allowed A.R. to push, stating that:

> I had to determine if the baby was imminent or not. It was an assessment. She had to push a few times before I could even decide if I had a minute to go use the phone and call -- call 911. The baby could have been born when I walked out the room. Her labor was progressing quickly. I had to establish if birth was imminent.

43. There is conflicting evidence on the number of contractions A.R. went through at the birthing center before a transfer to FWB was initiated by Respondent. A discussion of the discrepancy and the charting thereof is set forth below. Regardless of the number of contractions, Ms. Hernandez indicated that after contractions on the birthing stool, Respondent got the fetal Doppler to measure heart tones. Respondent instructed A.R. to get on the bed on “all-fours” to get a better read on the baby’s heart rate because, as stated by Ms. Shields, “[a] lot of times if it's just the positioning thing, that will help the baby's heart rate just fine if the baby didn't like the position.”

44. Respondent determined that the baby’s heart tones were decelerating during contractions, though they recovered to normal levels thereafter. The second incident of decelerating

heart tones prompted the Respondent’s decision that this was a precipitous labor, and that it was time for transfer.[1/]

45. After the contractions described above, Respondent noted the baby was not descending normally, and noticed abnormal decelerations of the baby’s heart tones. Respondent told A.R. to stop pushing at this point. Respondent determined that the situation was emergent and left the room to call emergency services for hospital transport. Ms. Shields stayed with A.R. “encouraging her to breathe, [and] trying to discourage her from pushing if she had another contraction.” Ms. Williams retrieved the emergency cart and began to administer oxygen to A.R.

46. Respondent called 911 and asked Ms. Shields to gather and print A.R.’s records for delivery to FWB. A.R. and the rest of her party were led to Respondent’s office where A.R. laid down on the couch to await the arrival of the ambulance.

47. Respondent approximated the call with 911 took about five minutes to provide all the information the emergency operators were asking for. As the call progressed, Respondent transferred the phone to Ms. Williams so Respondent could complete the transfer records for the hospital and check on A.R. Respondent used the fetal Doppler to check fetal heart tones and performed an ultrasound to confirm the baby was in breech position.

48. When the first responders arrived at GBO and were able to assume the care of A.R. and prepare her for transport, approximately 12 minutes after the 911 call was placed, Respondent called in a report to the Labor & Delivery unit at FWB. Deborah Wahlman, R.N., was the charge nurse that answered the call. Respondent gave a full report to Ms. Wahlman that included: A.R. was 40+5 weeks pregnant, complete, breech, and pushing.

49. A.R. was transported from GBO to FWB, a distance of 11 miles, via ambulance. Respondent sat in the back of the ambulance with A.R., while F.R. sat in the front with the driver. Upon arrival at FWB, Respondent transferred full responsibility for the care of A.R. and her fetus to the hospital in accord with her physician protocols.

50. It was not disputed, nor was it an issue, that Respondent correctly performed the steps related to A.R.'s transfer to FWB, ensured that pushing efforts were ceased, encouraged A.R. to breathe, administered oxygen, repositioned A.R., performed a bedside sonogram, and went with A.R. in the ambulance.

51. Respondent provided FWB with handwritten and incomplete intrapartum notes, along with lab reports from A.R.'s 28th and 36th weeks. These lab reports included CBC's, a glucose tolerance test, and a group beta test strip. She did

not provide the OB labs to the hospital because the birthing staff lacked the time to obtain them.

52. A.R. was taken in on a stretcher and admitted to the operating room after being asked preliminary health questions by the hospital staff. Respondent and F.R. were not permitted in the operating room.

53. While waiting in the operating room, Respondent and her staff were completing the notes and forms detailing what occurred at GBO. Respondent and F.R. disagreed as to the number of times A.R. pushed at GBO. At the hearing, A.R., F.R., and the doula testified A.R. went through two to four contractions on the birthing stool. A.R. testified that she had perhaps three to four contractions on the bed before Respondent made the decision to go to the hospital. Respondent indicated that she documents contractions, rather than individual pushes that may occur during a contraction. She testified that a patient may push multiple times during a single contraction. Respondent testified as to her recollection that A.R. had two contractions during which she pushed several times before the decision to transfer her to the hospital was made.

54. When she was charting, Respondent had to estimate how many pushes A.R. might have had in the 15 frenetic minutes or so between the discovery that the baby was breech and the call to 911. She asked Ms. Shields how many pushes she counted, and

she indicated two or three. F.R. disagreed, indicating that A.R. pushed at least six times. Respondent construed the statements as meaning there were multiple pushes over two contractions, and charted it as such, logging "attempted to push x2 contractions."[2/] The evidence that Respondent was being untruthful both at the time she prepared the charts and at the hearing was not clear and convincing. Thus, the allegation that Respondent engaged in unprofessional conduct by inaccurately recording the number of times A.R. pushed after Respondent learned that the baby was in breech position is not supported by the applicable quantum of proof.

55. The fetal heart rate with beats per minute (BPM) in the 80s was heard by Ms. Wahlman at FWB when A.R. arrived via ambulance, before A.R. was taken to the operating room. The fetal heart rate with BPM in the 60s was heard when A.R. was in the operating room.

56. A.R. underwent an emergency cesarean section surgery performed by Jennifer Seaton, M.D. Dr. Plano, neonatologist, was called by the hospital staff to report for neonatal resuscitation. She arrived approximately eight minutes after delivery, and testified that "the baby had had normal heart rate in the ambulance ride over, but had had a decrease in the heart rate just prior to delivery and so -- so I proceeded to try to

resuscitate a child that -- that according to the history, might have had had a heart rate ten minutes before."

57. After some time had passed, Dr. Seaton came in to the waiting room and informed F.R. and Respondent that the outcome had not been positive, and that A.R. and F.R.'s child had died. The child died minutes before birth as estimated by the pathologist who performed the autopsy. The autopsy report also documented that the child was diagnosed with cardiomegaly and myocarditis.

58. The Department alleged that Respondent misrepresented to Dr. Seaton whether A.R. pushed while at GBO. Dr. Seaton testified that Respondent "stated that she did not ask the patient A.R. to push." Respondent testified that the exchange with Dr. Seaton started when she asked "Did you make this patient push when you knew she was breech? And I said, no, I did not make her push. She chose to push. She was pushing spontaneously." F.R.'s recollection of the initial exchange between Respondent and Dr. Seaton differed from both of theirs. The allegation that Respondent was falsifying information is undercut further by the fact that Respondent advised Ms. Wahlman that A.R. was breech and pushing when she called in the report to FWB. Without something further, the evidence is not clear and convincing that Respondent made deceptive and/or untrue representations to Dr. Seaton regarding her interactions with

A.R. while at GBO as alleged in Count III of the Administrative Complaint.

59. Respondent's notes go up to 2:00 a.m. on December 8, 2017. Respondent testified that all of the notes were completed during the period at GBO, in the FWB waiting room, or shortly thereafter on December 8, 2017, when she was able to sit down at her computer and recollect the events as they happened. The electronic signature of December 19, 2017, was a result of Respondent leaving the record open to confirm her recollection of the time she called for the EMS was consistent with their records. The evidence is not clear and convincing that Respondent, or anyone on the GBO staff, modified her records on December 19, 2017, or that she made deceptive and/or untrue representations in A.R.'s patient records as alleged in Counts II and III of the Administrative Complaint.

Standards of Care

60. It is not the individual opinion of a qualified witness that establishes the standards of acceptable and prevailing nursing practice. Rather, it is "community standards" that define the appropriate standard of care.

61. In order to establish the standard of care applicable to nurse midwives, Petitioner relied on the testimony of Joanne Mitrega, who was accepted as an expert in labor and delivery. Ms. Mitrega has been a CNM in Florida since 2001. Although she

“came to Florida to join a birth center, a freestanding birth center,” her primary practice since then has been in a hospital setting or a private practice setting with two OB/GYNs. The last time Ms. Mitrega worked at a birth center was in 2002, and even that center was owned and operated by a hospital.

62. Ms. Mitrega indicated that, when asked to develop an opinion regarding standards of care for CNMs:

> I had reviewed my own practice guidelines from my birth center, at which I used to practice and current practice guidelines, yes.
>
> Q And the guidelines from your birth center, are those the same guidelines that Ms. Denbow would be required to follow?
>
> A No. Every place has their own set of practice guidelines.

63. Ms. Mitrega further testified that the standard of care is established through a practice’s operating guidelines and protocols, stating that:

> Every place I've practiced I had Standards of Care, I had guidelines, practice guidelines, which is the Standards of Care, and they were always provided to me by my group.

64. Confirming Ms. Mitrega’s testimony as to the basis for an applicable standard of care, Ms. Richards stated that “in the State of Florida, a nurse midwife has protocols that are signed off by a physician and that's really kind of her governing body, like what she needs to follow.”

65. When asked the basis for her opinion as to "the Standards of Care that are within the community," particularly as it relates to a vaginal examination upon presentment at a birth center, Ms. Mitrega responded that they were derived from "within the community and establishments I have been a part of." As indicated previously, the community and establishments with which Ms. Mitrega has recent experience include only hospital or hospital affiliated facilities. They do not include home birth or birthing centers similar to GBO.

66. Ms. Mitrega testified that "everywhere I practiced there was a set of practice guidelines under which I had to practice and be compliant with." Nonetheless, Ms. Mitrega did not review the protocols in place at GBO. Despite her testimony that every facility has their own set of practice guidelines and their own approved relationship with a physician in the form of signed protocols, her testimony as to standard of care was based on protocols established at <u>her</u> places of employment. As will be discussed herein, in light of Ms. Mitrega's credible testimony as to the basis for a practioner's standard of care, her failure to review Respondent and GBO's operating practices and protocols diminishes the credibility and weight of her testimony that Respondent violated her applicable standard of care. Furthermore, Ms. Mitrega did not, with any degree of

specificity, rely on sources she identified and acknowledged as authoritative as support for her opinions.

67. Dr. Lane was accepted as an expert in midwifery. She is a certified nurse midwife, and specializes in home birth, outcomes in home birth and birth center deliveries, and vaginal breech deliveries. She has never practiced midwifery in Florida, but is familiar with community standards of midwifery in Florida, having taught midwifery classes in Destin, worked with community representatives in Florida, and reviewed the Nurse Practice Act. She was a co-author for the Home Birth Standards published by the ACNM, of which she is a member of the Home Birth Section and the committee for Full Practice Standards for Nurse Midwives. Ms. Mitrega recognized ACNM clinical bulletins and physician statements as being authoritative in the field of midwifery. Ms. Mitrega further recognized the ACNM, as the governing body for midwives, as "very influential in establishing the guidelines for us."

68. Dr. Lane reviewed the intrapartum records, birth plan, prenatal records, lab reports, and all other documents at issue in this case, along with the written complaint. Of critical importance is the fact that she reviewed Respondent's collaboration agreement with her associated physician, and, thus, had a familiarity with the standard of care that would apply to Respondent.

69. Dr. Lane knew Respondent prior to being asked to offer opinion testimony in this case. They were in school together, and Dr. Lane considered themselves to be friends. That, in itself, is not sufficient to demonstrate bias, and is not a reason to discount Dr. Lane's sworn testimony.

70. Ms. Richards was accepted as an expert in the Florida Standards for Nurse Midwifery. Ms. Richards is a nurse midwife who has been practicing in Central Florida since 2006. She owns a company providing midwifery care including prenatal, delivery, and postpartum care. Ms. Richards has practiced midwifery in a variety of settings, including both birth centers and hospitals.

Vaginal Examination

71. Ms. Mitrega identified four stages of labor, with the "second stage" being from complete dilation to delivery. The second stage for a first-time mother can be from three hours to as few as 30 minutes, with a mean of 50 minutes. By watching and listening to a patient, a midwife can "get an idea about what stage of labor she's in, . . . but if I don't do my pelvic exam, I am only guessing." Therefore, in the hospital setting at which Ms. Mitrega practices, she performs an initial vaginal exam upon the patient arriving to establish a baseline.

72. When asked when nurse midwives should perform their initial assessment and vaginal exam upon patient admittance, Ms. Mitrega testified:

> Again, if I'm admitting a patient, I've got to have all my information so I know what diagnosis to put and I know my plan for the patient.
>
> Q. Was that the standard when you were at the birth center?
>
> A. Yes.
>
> Q. That's the standard at the hospital?
>
> A. Yes. An initial assessment of a patient, including vaginal exam, was a part of any practice I have been part of. (emphasis added).

As previously indicated, Ms. Mitrega's practice for the 17 years she has been in Florida has been limited to hospital or hospital-affiliated facilities. She has no recent experience in home birth or birthing centers similar to GBO.

73. Ms. Mitrega acknowledged the increased risk of infection and chorioamnionitis resulting from vaginal exams after the patient's water breaks. Thus, "when the patient is ruptured, the membranes are ruptured, we tend to be mindful of how many vaginal exams we perform." Dr. Lane corroborated that when a patient's water has broken, vaginal examinations increase the possibility of infection, and opined that they should only

be administered when there may need to be a change in management.

74. Respondent's operating protocols, and her agreement with A.R., establish that vaginal examinations were to be done minimally. Respondent indicated that A.R.'s delivery appeared to be progressing normally. Given that a vaginal exam had been performed the morning of December 7, 2017, Respondent did not believe another to be necessary, or within the general "non-invasive" practice regimen of a midwife. It was not until A.R. appeared to be having difficulty handling the contractions, combined with her desire to get into the birthing tub, that a vaginal examination was determined to be warranted.

75. Dr. Lane and Ms. Richards, appearing on behalf of Respondent, opined that Respondent did not fall short of the minimum standard of care in performing a vaginal exam after one hour of observation.

76. Dr. Lane testified that the practice of midwifery relies in large measure on non-invasive means of assessing the progress of labor. Thus, discussion and observation are within the standard of care in the absence of some sign of distress or complication.

77. Dr. Lane testified that A.R.'s need to push so soon into her active labor could be taken as a sign of precipitous labor that could change management and, therefore, warrant a

vaginal exam. Thus, Respondent's administration of the vaginal exam after one hour of observation and assessment, and after A.R. began to vocally express pain and breath heavily, was appropriate based on the signs displayed by A.R.

78. Given the totality of the evidence in this case, including the testimony of Dr. Lane and Ms. Richards, Petitioner did not prove, by clear and convincing evidence, that Respondent fell below the minimum standards of care applicable to nurse midwives when she waited to perform a vaginal examination, or that Respondent acted inconsistently with GBO's policies and physician-approved protocols when she did so, as alleged in Count I of the Administrative Complaint.[3/]

Breech Birth/Attempt at Delivery

79. Ms. Mitrega testified a breech baby can be delivered vaginally by "a skilled, trained provider who is trained in doing breech vaginal deliveries or in emergency -- in emergencies, or under an emergency situation."

80. When asked her opinion as to the standard of care for nurse midwives upon discovery of a breech birth, Ms. Mitrega testified:

> Under my practice guidelines and the birth center, as soon as I diagnose by my guidelines, as soon as I diagnose breech, I had to transfer the patients to physicians to the hospital under physician's care. (emphasis added).

81. As indicated previously, Ms. Mitrega’s guidelines as a midwife member of a hospital staff, is not the standard of care for nurse midwives practicing in a free-standing birthing center, unaffiliated with a hospital.

82. In addition to the foregoing, which indicates a lack of knowledge as to the standard of care for midwives other than those operating under her practice guidelines, the force of Ms. Mitrega’s testimony as to whether the standard of care was violated by Respondent in this case was effectively extinguished by the following:

> Q. . . . Couldn't a skilled nurse midwife who trained in breech deliveries be able to deliver a breech if it was imminent?
>
> A. If she's trained in doing so and her protocols allowing her to do so, yes.
>
> Q. Well, that was the situation here, wasn't it?
>
> A. I don't know.
>
> Q. Why don't you know?
>
> A. I don't know the protocols. I don't know if the midwife was trained in breech vaginal deliveries and her protocols were corresponding with that.
>
> Q. Well, that was a missing component that was important, wasn't it?
>
> A. Yes.

83. Ms. Mitrega admitted, on several occasions, that she did not review GBO’s protocols and practice guidelines. Such an

astonishing omission of such a critical element serves, in large measure, to decrease the weight to be afforded the witness' testimony to near zero.

84. Ms. Mitrega was unable to identify a guideline or standard providing that a skilled and trained midwife should not attempt to deliver a breeched baby vaginally if birth was imminent. She had no knowledge of the standard of care required to determine if a breech birth was imminent, or how many pushes are necessary to conduct an assessment on the imminence of a breech birth.

85. In the course of her testimony, Ms. Mitrega admitted that if Respondent was trained in breech vaginal delivery, then it would be her opinion that A.R. would not have to be transferred immediately.

86. Respondent testified that she has experience and training in delivering breech babies, though she has only delivered one breech baby at GBO, in 2017. There was no evidence to contradict her testimony.

87. GBO's policies and procedures provide that a patient presenting with a breech presentation is to be transferred to a hospital "if there is time for transport before birth." However, Respondent and GBO staff will manage the breech birth in the event the patient presents too late for transport.

88. Dr. Lane and Ms. Richards, appearing on behalf of Respondent, opined that Respondent did not fall short of the minimum standards of care in asking A.R. to push once breech delivery was discovered, or failing to immediately transfer A.R. once breech delivery was discovered.

89. Dr. Lane testified that the goal of a midwife is to determine a safe environment for birth, and noted that certified nurse midwives are trained in how to manage surprise breech delivery. The GBO informed consent forms authorized Respondent to manage complications.

90. Ms. Richards testified that certified nurse midwives are required to have their protocols signed off on by a physician. Respondent had done so. Respondent's protocols authorized Respondent to deliver a baby if birth was imminent in a surprise breech birth, and she acted in accord with the required protocols.

91. Dr. Lane testified that, based on the potential danger to the mother and child from giving birth in an ambulance, the most prudent course of action in this case was for Respondent to determine how quickly A.R. was expected to give birth.

92. As to whether Respondent asking A.R. to push after the breech was identified violated the standard of care, Dr. Lane concluded that allowing A.R. to push over the course of roughly 15 minutes informed Respondent as to how fast the birth would

likely occur, allowing her to make an informed choice as to the safest birthing environment. Dr. Lane further concluded that Respondent's assessment to determine that birth was not imminent prior to transfer, including the observations of contractions and measurement of fetal heart tones, was reasonable and necessary. Based thereon, Dr. Lane opined that Respondent did not breach the standard of care by failing to immediately refer A.R. to a higher level of care when breech was diagnosed.

93. Based on the totality of the evidence in this case, Petitioner did not prove, by clear and convincing evidence, that Respondent fell below the minimum standards of care applicable to nurse midwives when she failed to immediately refer A.R. to a higher level of care, or when she allowed A.R. to push through several contractions to assess the imminence of birth before effecting a transfer, as alleged in Count I of the Administrative Complaint.

Recordkeeping

94. As to the recordkeeping required of a nurse/midwife, Ms. Mitrega testified that late entry notes on intrapartum records are an acceptable practice, unless the charting is done at a much later date.

95. Respondent testified that her birth assistant incorrectly charted the pre-transfer heart rate decelerations on the intrapartum record because she was not properly trained to

diagnose or document the decelerations. Respondent testified she later charted the correct documentation in her Subjective Objective Assessment Plan.

96. Ms. Mitrega testified that, in general, Respondent's records were legible and accurate. Her testimony to that effect, and her belief that the entry bearing a signed date of December 19, 2017, was not, is as follows:

> Q. . . . You said that her records were done appropriately and legibly; correct?
>
> A. Right.
>
> Q. Prenatal records show the patient's care was documented properly, subject followed standard charts and way of charting to maintain records; correct?
>
> A. As far as the flow charts go, and as far as what I can see, yes, I have to agree that they were filled according to the rubrics.
>
> Q. Okay. And she had appropriate blood work and cultures down at the appropriate time for the standard of care?
>
> A. Yes. Yes.
>
> Q. Intrapartum records and intrapartum flow chart were filled out completely, timely and according to rubric?
>
> A. Yes.
>
> Q. And second stage documentation calls for entry every 5 minutes?
>
> A. Uh-huh.
>
> Q. And you see that was documented, as well?

A. Yes. I do say, again, according to what they use at the center, it is filled out correctly, yes.

Q. And that late entry note is an acceptable practice; is that right?

A. Right. And I was referring to the note that was done at the hospital, when the patient arrived to the hospital, and I do say late entry note is acceptable. We do take care of patients and patients do come first and then we chart, when we find the next available moment. But when I was reviewing the case again, I did see that there was a really late entry note, the events were happening on December 7th, and there was a note from the December 19th.

Q. Where are those?

A. If I recall, again, reviewing the case, it was page 153.

Q. Could that have been the page -- could that have been the date that it was signed?

A. It was electronically signed but how do you sign a record if you don't enter the record?

Q. It could be left unsigned; right?

A. <u>Right</u>. But, to me, the record was redone, rewritten. (emphasis added).

97. Respondent testified, credibly, that the electronic signature of December 19, 2017, was a result of her leaving the record open to confirm her recollection of the time she called for the EMS. She testified, without any evidence to the contrary, that she did not alter A.R.'s records after she initially prepared them on December 8, 2017. Ms. Mitrega's

testimony that the record was "redone, rewritten" was pure speculation, unsupported by competent, substantial evidence.

98. For the reasons set forth herein, the evidence is not clear and convincing that Respondent, or anyone on the GBO staff, modified A.R.'s records on December 19, 2017, that the records kept and produced were materially inaccurate, or that Respondent made deceptive and/or untrue representations either to Dr. Seaton or in A.R.'s patient records.

CONCLUSIONS OF LAW

A. Jurisdiction

99. The Division of Administrative Hearings has jurisdiction over the parties and the subject matter of this proceeding. §§ 456.073(5), 120.569, and 120.57(1), Fla. Stat. (2018).

100. The Department has authority to investigate and file administrative complaints charging violations of the laws governing the practice of nursing. § 456.073, Fla. Stat.

B. Standards

101. Section 467.003, Florida Statutes, defines "certified nurse midwife" as "a person who is licensed as an advanced registered nurse practitioner under part I of chapter 464 and who is certified to practice midwifery by the American College of Nurse Midwives." Respondent is a certified nurse midwife.

102. Section 464.018, Florida Statutes, provided, in pertinent part, that:

> (1) The following acts constitute grounds for . . . disciplinary action, as specified in s. 456.072(2):
>
> * * *
>
> (h) Unprofessional conduct, as defined by board rule.
>
> * * *
>
> (n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience.

103. Section 456.072 provided, in pertinent part, that:

> (1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
>
> * * *
>
> (m) Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession.

104. Rule 64B9-8.005 provides that "Unprofessional conduct shall include: (1) Inaccurate recording."

105. The standards of acceptable and prevailing nursing practice are not established by statute or rule.

106. Section 464.012(3) provides that:

> An advanced registered nurse practitioner shall perform those functions authorized in

> this section within the framework of an established protocol which must be maintained on site at the location or locations at which an advanced registered nurse practitioner practices. In the case of multiple supervising physicians in the same group, an advanced registered nurse practitioner must enter into a supervisory protocol with at least one physician within the physician group practice.

107. While the protocols establish the framework in which an ARNP is permitted to practice, community standards define the standards of acceptable and prevailing nursing practice.

C. Burden and Standard of Proof

108. The Department bears the burden of proving the specific allegations that support the charges alleged in the Administrative Complaint by clear and convincing evidence. Dep’t of Banking & Fin., Div. of Sec. & Inv. Prot. v. Osborne Stern & Co., 670 So. 2d 932 (Fla. 1996); Ferris v. Turlington, 510 So. 2d 292 (Fla. 1987); Fox v. Dep't of Health, 994 So. 2d 416 (Fla. 1st DCA 2008); Pou v. Dep’t of Ins. & Treasurer, 707 So. 2d 941 (Fla. 3d DCA 1998).

109. Clear and convincing evidence “requires more proof than a ‘preponderance of the evidence’ but less than ‘beyond and to the exclusion of a reasonable doubt.’” In re Graziano, 696 So. 2d 744, 753 (Fla. 1997). The clear and convincing evidence level of proof:

> [E]ntails both a qualitative and quantitative standard. The evidence must be

> credible; the memories of the witnesses must be clear and without confusion; and the sum total of the evidence must be of sufficient weight to convince the trier of fact without hesitancy.
>
> > Clear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

In re Davey, 645 So. 2d 398, 404 (Fla. 1994) (quoting, with approval, Slomowitz v. Walker, 429 So. 2d 797, 800 (Fla. 4th DCA 1983)); see also In re Henson, 913 So. 2d 579, 590 (Fla. 2005). "Although this standard of proof may be met where the evidence is in conflict, it seems to preclude evidence that is ambiguous." Westinghouse Elec. Corp. v. Shuler Bros., 590 So. 2d 986, 989 (Fla. 1st DCA 1991).

110. A proceeding to suspend, revoke, or impose other discipline upon a license is penal in nature. State ex rel. Vining v. Fla. Real Estate Comm'n, 281 So. 2d 487, 491 (Fla. 1973). Penal statutes must be construed in terms of their literal meaning, and words used by the Legislature may not be expanded to broaden the application of such statutes. Thus, the

provisions of law upon which this disciplinary action has been brought must be strictly construed, with any ambiguity construed against Petitioner. Elmariah v. Dep't of Bus. & Prof'l Reg., 574 So. 2d 164, 165 (Fla. 1st DCA 1990); see also Griffis v. Fish & Wildlife Conserv. Comm'n, 57 So. 3d 929, 931 (Fla. 1st DCA 2011); Beckett v. Dep't of Fin. Servs., 982 So. 2d 94, 100 (Fla. 1st DCA 2008); Whitaker v. Dep't of Ins., 680 So. 2d 528, 531 (Fla. 1st DCA 1996); Dyer v. Dep't of Ins. & Treasurer, 585 So. 2d 1009, 1013 (Fla. 1st DCA 1991).

111. The allegations of fact set forth in the Administrative Complaint are the grounds upon which this proceeding is predicated. Trevisani v. Dep't of Health, 908 So. 2d 1108, 1109 (Fla. 1st DCA 2005); see also Cottrill v. Dep't of Ins., 685 So. 2d 1371, 1372 (Fla. 1st DCA 1996). Thus, the scope of this proceeding is properly restricted to those matters. M.H. v. Dep't of Child. & Fam. Servs., 977 So. 2d 755, 763 (Fla. 2d DCA 2008).

D. Analysis

112. Whether a particular standard of care has been violated is not dependent upon a medical outcome. An outcome can be positive when there has been a violation of a standard of care, just as an outcome can be negative when all standards of care have been met. The undersigned is mindful of the tragedy of this case. It stayed at the forefront as the testimony and

evidence were carefully weighed. Nonetheless, the conclusions drawn here are based solely on the credible and supported record evidence of the policies, protocols, and standards of care applicable to and applied by Respondent.

Count I

113. Count I of the Administrative Complaint alleges that Respondent violated section 464.018(1)(n) as follows:

> Respondent failed to meet the minimal standards of acceptable and prevailing nursing practice in one or more of the following ways:
>
> a. By failing to promptly perform a vaginal examination on Patient A.R. when Patient A.R. presented to GBO in active labor;
>
> b. By failing to immediately refer Patient A.R. to a higher level of care, including a hospital, when Respondent learned F.R was in breech position; and/or
>
> c. By encouraging Patient A.R. to continue the delivery at GBO after learning F.R. was in breech position.

114. As indicated above, the burden on the Department to prove the allegations of the Administrative Complaint is fairly high. In light of the Findings of Fact set forth herein, and the complete record, the evidence adduced in this case was not clear and convincing that Respondent violated an applicable and proven standard of care by: failing to immediately perform a vaginal examination of A.R. upon her presentation at GBO; failing to immediately refer A.R. to a higher level of care when

it was discovered that the child was in breech position; or by having A.R. continue the delivery at GBO, including allowing her to push to determine whether birth was imminent. The testimony of Ms. Mitrega was simply not persuasive due to her inexplicable failure to review Respondent's practice guidelines, policies, and protocols, and was outweighed by that of Dr. Lane and Ms. Richards, who did review Respondent's practice guidelines, policies, and protocols and were able to convincingly correlate them to generally applicable and recognized nursing standards. Thus, Petitioner failed to prove, by clear and convincing evidence, that Respondent violated section 464.018(1)(n), as alleged in Count I of the Administrative Complaint.

Count II

115. Count II of the Administrative Complaint alleges that Respondent violated section 464.018(1)(h) and rule 64B9-8.005(1) as follows:

> Respondent engaged in unprofessional conduct by inaccurately recording the following details related to Patient A.R.'s delivery:
>
> a. The circumstances surrounding Patient A.R.'s consent to continue the delivery of [the child] at GBO; and/or
>
> b. The number of times Patient A.R. pushed after Respondent learned that [the child] was in breech position.

116. In light of the Findings of Fact set forth herein, and the complete record, the evidence adduced in this case was

not clear and convincing that Respondent inaccurately recorded: the circumstances of the decision to continue the delivery of the child at GBO when it was discovered that the child was in breech position; or the number of times A.R. pushed after Respondent learned that the child was in breech position. Thus, Petitioner failed to prove, by clear and convincing evidence, that Respondent violated section 464.018(1)(h) and rule 64B9-8.005(1), as alleged in Count II of the Administrative Complaint.

Count III

117. Count III of the Administrative Complaint alleges that Respondent violated section 456.072(1)(m) as follows:

> Respondent made deceptive, untrue, or fraudulent representations in or related to the practice of her profession in one or more of the following ways:
>
> a. By making the deceptive and/or untrue representation that she did not instruct Patient A.R. to push after learning that F.R. was in breech position; and/or
>
> b. By including deceptive and/or untrue representations in Patient A.R.'s patient records.

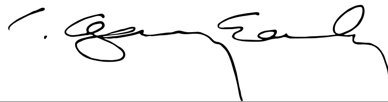
118. In light of the Findings of Fact set forth herein, and the complete record, the evidence adduced in this case was not clear and convincing that Respondent made deceptive, untrue, or fraudulent representations: to Dr. Seaton regarding the number of times A.R. pushed after Respondent learned that the

child was in breech position; or otherwise in A.R.'s patient records. Thus, Petitioner failed to prove, by clear and convincing evidence, that Respondent violated section 456.072(1)(m), as alleged in Count III of the Administrative Complaint.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is RECOMMENDED that the Department of Health, Board of Nursing, enter a final order DISMISSING the Administrative Complaint against Cynthia Denbow, ARNP.

DONE AND ENTERED this 26th day of December, 2018, in Tallahassee, Leon County, Florida.



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Filed with the Clerk of the
Division of Administrative Hearings
this 26th day of December, 2018.

ENDNOTES

[1/] Oddly enough, Ms. Mitrega had no concern with the decelerations noted by Respondent that warranted A.R.'s transfer, testifying as follows:

> All right. So page 3 of 8, what I see is this, at time -- this is the times 2357, fetal heart tones noted to decelerate to 80 with recovery to 120 while pushing with contractions. Assisted to hands and knees position at this time, and continuously on 0002, fetal heart tones were compared to maternal pause. So, if I read that, fetal heart tones noted to decrease to 80 with recovery to 120 while pushing with contractions, that's not an abnormal occurrence, and if we are talking about nonreassuring, to me, that doesn't constitute a nonreassuring fetal heart rate safe, that would be more like an early deceleration. There are various types of decelerations. And this deceleration goes to 80, with recovery to 120 while pushing. So it's telling me that this exactly corresponds with the contractions. And deceleration that corresponds with the contraction is nothing but an early deceleration, which is not a nonreassuring.
>
> Q. In any of the documentation in the intrapartum flow record, were any of the documented heart rates what you would consider nonreassuring?
>
> A. No.

[2/] The Department's Proposed Recommended Order characterized the entry as being that A.R. attempted to push "x2 [with] contractions." The addition of the non-record "with" fundamentally changes the meaning of the entry, changing the meaning from A.R. pushing over two contractions, consistent with Respondent's testimony, to A.R. pushing two times, which is not consistent with Respondent's testimony.

[3/] The Department, in its Proposed Recommended Order, suggested that, even if a vaginal examination was deemed to be

inappropriate, other methods of physical assessment could have been employed, including palpation of the abdomen, Leopold's maneuvers, or ultrasound, making Respondent's physical assessment "still incomplete." However, a vaginal examination was the only assessment method pled in the Administrative Complaint as being required by a standard of care.

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.