State of New Hampshire
Midwifery Council
Concord, New Hampshire 03301

In the Matter of:
Adrian Feldhusen, CPM, NHCM
License No.: 1026
(Misconduct Allegations)

Docket No.: 20-MID-0001

SETTLEMENT AGREEMENT

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of midwifery, the New Hampshire Midwifery Council ("Council") and Adrian Feldhusen, CPM, NHCM ("Respondent"), a midwife certified by the Council, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Council according to the following terms and conditions:

1. Pursuant to RSA 326-D; 326-D:4; RSA 326-D:8; RSA 541-A: 30, RSA 541-A: 31; and Midwifery Administrative Rule ("Mid") 203.01 and 404, the Council has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by midwives. Pursuant to 326-D; RSA 541-A:38; RSA 541-A:31, V(a); and Mid 213.01, the Council may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.

2. The Council first granted Respondent a certificate to practice as a certified midwife in the State of New Hampshire on May 6, 2002. Respondent holds certificate number 1026. Respondent practices midwifery at The Birth Cottage of Milford ("Birth Cottage") located in Milford, New Hampshire. Respondent is the registered owner of Birth Cottage.

3. On or about February 6, 2018, a baby was born at the Birth Cottage with no vital signs. The baby was transported to Southern New Hampshire Medical Center ("SNHMC") where he was pronounced dead soon after his arrival. Respondent subsequently filed a report of Significant Morbidity and Mortality with the Council, which resulted in this complaint.

4. In response to this, the Council conducted an investigation and obtained information from various sources pertaining to Respondent's practice of midwifery and the standard of care followed in her prenatal, labor and birth, and postpartum care for the mother and baby whose care initiated this complaint.

5. Respondent neither admits nor denies the allegations herein, but stipulates that if a disciplinary hearing were to take place, Hearing counsel would seek to present evidence upon which the Council could conclude that Respondent engaged in professional misconduct by the following facts:

   A. On or about June 7, 2017, a 34-year-old pregnant patient ("Mother") began receiving prenatal care at Manchester OB/GYN Associates when she was 8.2 weeks pregnant. Mother was treated at Manchester OB/GYN Associates for approximately three (3) months, during which the prenatal visits were routine and unremarkable, and the Mother's blood pressure was within normal limits at each prenatal visit.

   B. On or about September 26, 2017, Mother transferred her care to the Birth Cottage where she was initially seen by a Certified Nurse Midwife and a

Student Midwife.[1] During Mother's initial visit, the practitioners documented that Mother had a history of increased blood pressure. According to the documentation, Mother told the practitioners that her cardiologist informed her that she did not need to take medication to control her blood pressure.

C. Mother received consistent prenatal care, provided by a variety of practitioners, on a typical prenatal schedule. Mother was seen for in-person visits and also participated in a number of phone consultations.

D. Mother's blood pressure remained within normal limits until January 23, 2018, when it was noted to be elevated at 130/90, during a prenatal visit conducted by the Certified Nurse Midwife.

E. On or about January 29, 2018, Mother was seen for a prenatal visit, conducted by a different Certified Midwife and the Student Midwife. Mother's blood pressure was not taken at that visit.

F. On or about February 5, 2018, the Student Midwife and Respondent conducted a prenatal visit with Mother, whose blood pressure was again elevated at 146/96. Respondent failed to provide proper supervision and care to Mother regarding her increasing blood pressure at the end of her pregnancy.

G. At that visit, Mother showed the Student Midwife a panty liner containing "scant brownish discharge." Mother questioned whether the discharge was meconium. The Student Midwife consulted Respondent, who concluded that it was capillary blood from Mother's cervix and not meconium. At

[1] Only one Student Midwife was involved in the care of Mother and baby.

Respondent's direction, the Student Midwife provided this explanation to Mother.

H. Respondent failed to have the discharge on the panty liner tested. Respondent also failed to offer Mother a sterile speculum examination to rule out leaking fluid or meconium as the cause of the discharge. Respondent failed to direct the Student Midwife to offer these two interventions to Mother.

I. On or about February 6, 2018, at approximately 12:16 am, Mother arrived at the Birth Cottage in active labor. Respondent conducted an admission examination and documented that Mother's blood pressure was elevated at 150/96. Respondent failed to consult with a Certified Nurse Midwife or a physician with experience in obstetrics to determine if Mother needed to be transported to a hospital for labor and delivery.

J. Respondent and the Student Midwife assisted Mother during labor and delivery at the Birth Cottage. Respondent primarily monitored the baby's fetal heart rate, which remained stable until decelerations were noted at approximately 1:41 am. Respondent was unable to locate the baby's fetal heart rate from approximately 2:48 am until the baby was born at approximately 2:56 am with no respiratory and cardiac effort. Respondent and the Student Midwife initiated and followed full neonatal resuscitation and protocols and called 911. The baby was transferred to SNHMC by ambulance at approximately 3:12 am, and was pronounced dead soon after his arrival at the hospital.

K. Respondent failed to monitor Mother's blood pressure during the entire labor and delivery process. Respondent did not take Mother's blood pressure until after the delivery at approximately 3:22 am, when it was noted to be 138/86.

L. Between the baby's birth and Mother's subsequent transfer to the hospital at approximately 4:23 am, Mother was unable to expel the placenta. During that time, Respondent made several unsuccessful attempts to remove the placenta using different techniques and/or methods.

M. Mother was transported to the hospital at approximately 4:23 am for pain relief and removal of the placenta. Mother lost a total of approximately 1,000 ml of blood between the baby's birth and her transport to the hospital.

N. Respondent failed to consult with a physician or Certified Nurse Midwife once one hour had passed after the baby's birth and the placenta had not been delivered. Respondent also failed to consult a physician or Certified Nurse Midwife when Mother lost a large volume of blood during the unsuccessful attempts to expel and/or remove the placenta.

6. The Council finds that Respondent committed the acts as described above and concludes that, by engaging in such conduct, Respondent violated RSA 326-D:2, V; and/or RSA 326-D:S, II (f); and/or Mid 502.01 (c); and/or Mid 502.01 (d); and/or Mid 502.01 (e); and/or Mid 502.03 (e)(4); and/or Mid 502.03 (e)(5); and/or Mid 502.04(a)(l); and/or Mid 502.05 (e)(3); and/or Mid 502.05 (g)(2); and/or Mid 502.05 (g)(3); and/or Mid 502.09 (c).

7. Respondent acknowledges that this conduct constitutes grounds for the Council to impose disciplinary sanctions against Respondent's license to practice as a certified midwife in the State of New Hampshire.

8. Respondent consents to the Council imposing the following discipline, pursuant to RSA 326-D:S, II:

A. Respondent is REPRIMANDED.

B. Respondent's certification to practice as a midwife is LIMITED for a period of one (1) year from the effective date of this *Settlement Agreement.* During the period of limitation, Respondent must consult with a physician or a Certified Nurse Midwife when providing or assisting in providing any prenatal, labor, birth or postpartum care to any client. Respondent may not supervise a new or existing Student Midwife while the limitation on her certification to practice as a midwife is in effect.

C. Every three (3) months from the effective date of this *Settlement Agreement,* Respondent is required to provide the Council with written proof that she has consulted with a physician or Certified Nurse Midwife when providing, or assisting in providing, any prenatal, labor, birth, or postpartum care to any client. The written proof must be filed under seal and include the name of the client, or clients, the date the services were provided, the name of the physician or Certified Nurse Midwife that Respondent consulted, and the signature of the physician or Certified Nurse Midwife verifying that he/she provided consultation to Respondent.

D. On or after six (6) months from the date the Council approves this *Settlement* Agreement, Respondent may petition the Council to end the limitation on her certification when she has complied with all of the terms of this *Settlement Agreement*, and provides proof of compliance to the Council.

E. Respondent is required to meaningfully participate in a total of fifteen (15) hours of CONTINUING EDUCATION to be divided between the following topics: (I) Gestational Hypertension and Preeclampsia; (2) Importance of consulting a physician or a Certified Nurse Midwife in cases involving a patient with high blood pressure; (3) Assessing vaginal discharge and meconium present in amniotic fluids; (4) Placenta delivery techniques and early contact with EMS in relation to transport for retained placenta and postpartum hemorrhage; and (5) Importance of early consultation, transfer and activation of EMS when complications are identified. These hours shall be in addition to the hours required by the Council for renewal of certification and shall be completed within one (1) year from the effective date of this *Settlement Agreement.* Within fifteen (15) days of completing these hours, Respondent shall notify the Council and provide written proof of completion.

F. Respondent is required to submit a three (3) to five (5) page reflection paper covering each of the five (5) identified areas of concern as listed under the aforementioned Continuing Education topics in Section E. The reflection paper shall be submitted to the Council for review and approval.

G. Respondent is assessed an ADMINISTRATIVE FINE in the amount of one thousand dollars ($1,000.00). Respondent shall pay this fine in full within thirty (30) days of the effective date of this *Settlement Agreement*, as defined further below, by delivering a money order or bank check, made payable to "Treasurer, State of New Hampshire," to the Council's office at 121 South Fruit Street, Concord, New Hampshire, 03301.

H. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the *Settlement Agreement* to any current employer for whom Respondent performs services as a midwife or work which requires a midwifery degree and/or certificate as a midwife, or directly or indirectly involves patient care, and to any agency or authority which licenses, certifies or credentials midwives, with which Respondent is presently affiliated.

I. For a continuing period of one (1) year from the effective date of this agreement, Respondent shall furnish a copy of this *Settlement Agreement* to any employer or party to whom Respondent may apply for work as a midwife or for whom she shall work in any capacity which requires a midwife degree or training and/or midwife certificate, or directly or indirectly involves patient care, and to any agency or authority that licenses, certifies or credentials midwives, to which Respondent may apply for any such professional privileges or recognition.

9. Respondent's breach of any terms or conditions of this *Settlement Agreement* shall constitute unprofessional conduct pursuant to RSA 326-D:8, II, and a separate and sufficient basis for further disciplinary action by the Council.

10. Except as provided herein, this *Settlement Agreement* shall bar the commencement of further disciplinary action by the Council based upon the misconduct described above. However, the Council may consider this misconduct as evidence in the event that similar misconduct is proven against Respondent in the future. Additionally, the Council may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.

11. This *Settlement Agreement* shall become a permanent part of Respondent's file, which is maintained by the Council as a public document.

12. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to her other than those terms and conditions expressly stated herein.

13. The Council agrees that in return for Respondent executing this *Settlement Agreement,* the Council will not proceed with the formal adjudicatory process based upon the facts described herein.

14. Respondent understands that her action in entering into this *Settlement Agreement* is a final act and not subject to reconsideration or judicial review or appeal.

15. Respondent has had the opportunity to seek and obtain the advice of an attorney of her choosing in connection with their decision to enter into this agreement.

16. Respondent understands that the Council must review and accept the terms of this

Settlement Agreement. If the Council rejects any portion, the entire *Settlement Agreement* shall be null and void. Respondent specifically waives any claims that any disclosures made to the Council during its review of this *Settlement Agreement* have prejudiced her right to a fair and impartial hearing in the future if this *Settlement Agreement* is not accepted by the Council.

17. Respondent is not under the influence of any drugs or alcohol at the time she signs this *Settlement Agreement.*

18. Respondent certifies that she has read this document titled *Settlement Agreement.* Respondent understands that she has the right to a formal adjudicatory hearing concerning this matter and that at said hearing she would possess the rights to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on her own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Settlement Agreement,* she waives these rights as they pertain to the misconduct described herein.

19. This *Settlement Agreement* shall take effect as an Order of the Council on the date it is signed by an authorized representative of the Council.

FOR RESPONDENT

Date: July 6, 2020

Adrian Feldhusen, CPM, NHCM
Respondent

FOR THE COUNCIL/*

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: July 28, 2020

(Signature)

Lindsey B. Courtney

(Print or Type Name)
Authorized Representative of the
New Hampshire Midwifery Council

/* Council members, recused:

K. Hartwell