IN THE MATTER OF	*	**BEFORE THE MARYLAND**
	*	
KAREN CARR,	*	**STATE BOARD OF**
	*	
Respondent.	*	**PHYSICIANS**
	*	
UNLICENSED	*	**Case No. 2010-0895**
	*	

* *

FINAL DECISION AND ORDER

On October 6, 2011, the Board charged Ms. Karen Carr with violating Section 14-601 of the Medical Practice Act, Md. Health Occ. Code Ann. ("Health. Occ.") § 14-601, by practicing medicine in Maryland without a license. A full evidentiary hearing was held before an Administrative Law Judge ("ALJ") of the Office of Hearings and Appeals on March 19, 20 and 21, 2012. Ms. Carr was present and was represented by counsel. Following that hearing, the ALJ issued a Proposed Decision on May 31, 2012, finding that Ms. Carr had practiced medicine without a license in violation of § 14-601 and recommending that she be fined in the amount of $30,000.

Ms. Carr, through counsel, filed exceptions with the Board, and the Administrative Prosecutor filed a response to Ms. Carr's exceptions. This is the Board's Final Decision and Order after consideration of these arguments and of the entire record in this case. This decision sets out the law as it applies to the facts of this particular case, but it is not intended to be a commentary on the practice of midwifery in general.

Findings of Fact

The Board adopts the Findings of Fact proposed by the Administrative Law Judge. The Proposed Decision of the Administrative Law Judge is incorporated into this final decision and is attached as Attachment A.

Ms. Carr holds no medical license or any other license that would authorize her to practice a health occupation in Maryland. Ms. Carr saw Twin B's mother for prenatal visits on eight occasions. Twin B's mother was pregnant with twins. Ms. Carr obtained a medical history of Twin B's mother and requested and interpreted a sonogram. The sonogram showed that the twins were in a breech-transverse presentation. This meant that one baby was presenting posterior first and the other lay across the mother's abdomen. This presentation constituted a high-risk pregnancy.

Ms. Carr used a Doppler to obtain fetal heart tones, used a blood pressure cuff to measure Twin B's mother's blood pressure, measured the fundal height to determine the size of the babies, determined the babies' positions in part by interpreting the sonogram, conducted pelvic examinations and measured the dilation and effacement of the cervix. Ms. Carr artificially ruptured the amniotic membranes for both twins, stimulated more intense contractions, clamped the umbilical cords after birth, and observed and documented the appearance of the placentas. She calculated the babies' Apgar scores and evaluated their color, peeling, vernix, palate, eyes, feet hands, vessels in the umbilical

cord, and head, and whether there were Mongolian spots or birth marks. She checked twins for respiration, color, tone, heart rate and grimace.

Soon after birth, Twin B stopped breathing. Ms. Carr performed cardiopulmonary resuscitation. She also administered oxygen to Twin B. A paramedic from the Charles County Emergency Services was called. The paramedic examined the baby and found that the heart rate was very low and there were fluid, gurgling sounds from the baby's lungs. The paramedic advised Ms. Carr and the mother that the baby should go to the hospital. Ms. Carr, however, stated that the baby was fine and advised the mother that the baby need not go to the hospital. An Emergency Medical Technician ("EMT") from the Mechanicsville Volunteer Fire Squad observed Ms. Carr attempting to use an oxygen tank to blow oxygen into the baby's face. The EMT asked to examine the baby, but Ms. Carr refused. The father took Twin B to the hospital the following day, but he died shortly thereafter.[1]

Ms. Carr evaluated Patient D during ten prenatal visits, took a medical history, observed her for complications of pregnancy, took Patient D's blood pressure and obtained urine, determined if the mother was spilling glucose or protein to determine if the mother was suffering from preeclampsia or diabetes, reviewed the laboratory data, and used a diagnostic technique to identify group beta streptococcus from a swab of the mother's vaginal opening. Ms. Carr stretched Patient D's cervix from three to five

[1] *See* the ALJ's factual findings on pages 13-14 of the Proposed Decision.

centimeters to promote labor, artificially ruptured Patient D's amniotic membranes by using her fingers, took and documented the fetal heart rate, and made a treatment decision based on the fetal heart rate and her evaluation of the cervical opening that the birth was not progressing adequately and that the mother should be transported to the hospital, based on these observations and evaluations.

To the extent that the issue of whether Ms. Carr was practicing medicine is a factual issue, the Board agrees with the testimony of Dr. Block, the only qualified expert who testified in this case, that Ms. Carr was practicing medicine. Evaluating these patients, recommending diagnostic tests, interpreting the diagnostic tests and performing treatment based upon these tests (or advising parents to refuse treatment in the case of Twin B) constituted the practice of medicine. In the opinion of the Board, this was not a close case, and the testimony of an expert may not even have been needed. Ms. Carr was without a doubt performing obstetrics on these two patients when she (1) diagnosed their conditions and the conditions of their children by using both clinical observations and laboratory and other tests; (2) treated them, sometimes invasively, based on her clinical observations and on her evaluations of the results of these tests; and (3) variously, recommended hospitalization or the refusal of hospitalization based on her clinical observations and interpretations of these tests.

Conclusions of Law

The Medical Practice Act provides that "a person may not practice, attempt to practice, or offer to practice medicine in this State unless licensed by the Board." Health Occ. §14-601. A person who practices without a license is "subject to a civil fine of not more than $50,000 to be levied by the Board." Health Occ. §14-606(a)(4)(ii). *See also* COMAR 10.32.02.06B (4) (setting out the range of fines that may be imposed for practicing medicine without a license).

Practicing medicine is defined as follows:

> (n) (1) "Practice medicine" means to engage, with or without compensation, in medical:
> (i) Diagnosis;
> (ii) Healing;
> (iii) Treatment; or
> (iv) Surgery.
> (2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:
> (i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual:
> 1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or
> 2. By appliance, test, drug, operation, or treatment;
> (ii) Ending of a human pregnancy; and
> (iii) Performing acupuncture as provided under § 14–504 of this title.
> (3) "Practice medicine" does not include:
> (i) Selling any nonprescription drug or medicine;
> (ii) Practicing as an optician; or

(iii) Performing a massage or other manipulation by hand, but by no other means.

Health Occ. §14-101.

To the extent that this is a legal issue, the Board agrees with the conclusion of the ALJ that Ms. Carr's activities constitute the practice of medicine. *See* the ALJ's discussion at pages 7-12 of the Proposed Decision. The Board agrees with the ALJ that Ms. Carr's activities constituted both diagnosis and treatment within the meaning of Health Occ. § 14-401(n)(1), as well as attempting to diagnose and treat and prevent any ailment, within the meaning of Health Occ. § 14-101(n)(2).

The Court of Special Appeals stated in *Rock v. State*, 6 Md. App. 618, 631 (1969) that "[t]he conclusion is inescapable that pregnancy is an 'ailment' within the meaning of the Medical Practice Act." Ms. Carr argues that the court's statement was wrong and should be disregarded. The Board will not disregard this statement by the court. The Board, in fact, would reach the same conclusion even in the absence of court guidance. One has only to look at the results in this case, where Twin B died, and where Patient B had to be sent to the hospital to have the baby delivered by Caesarean section, to understand that pregnancy is an "ailment" within the meaning of the Medical Practice Act.

The Board, however, does not adopt the ALJ's discussion concerning the provisions of the Nurse Practice Act, as is explained below. The Nurse Practice Act is

not relevant to this case. The definition of "practice medicine" in the Medical Practice Act set out above is extremely broad and by its terms would prohibit the practice of nursing, dentistry, chiropractic, and all or almost all other health professions, were it not for an additional provision of the law. That additional provision reads as follows:

> (a) This title does not limit the right of:
> (1) An individual to practice a health occupation that the individual is authorized to practice under this article; ...

Md. Health Occ. Code Ann. §14-102. This provision permits licensed nurses, dentists, chiropractors and other licensed health professionals to practice their professions within the scope of their statutory authority, despite the fact that their activities might otherwise fall within the definition of "practice medicine" in Health Occ. § 14-101(n). Thus, if the Nurse Practice Act and its implementing regulations permit a licensed nurse to perform a certain act, the performance of that act would not subject the nurse to a penalty for "practicing medicine" without a license. This issue has no relevance whatsoever to this case, however, because Ms. Carr does not have a nursing license or any other kind of health occupation license.[2]

[2] Hypothetically, if Ms. Carr had been licensed as a nurse midwife, and performing duties within the scope of practice of a nurse midwife, her activities would have been lawful. The Board does not have to reach the issue of whether Ms. Carr was practicing within the scope of practice of a nurse midwife, however, because Ms. Carr is not licensed as a nurse midwife. The ALJ's comment, that Ms. Carr was performing duties even beyond those authorized for a nurse midwife, was thus not relevant to the case and was not adopted by the Board. Had Ms. Carr been a licensed nurse midwife, it would have become relevant whether she was practicing within (or beyond) the scope of practice of a nurse midwife. Because she is not a licensed nurse midwife, however, this issue is irrelevant.

Consideration of Exceptions

Ms. Carr argues that she was denied due process of law because the ALJ discussed in the Proposed Decision the Nurse Practice Act, a statute that Ms. Carr was not charged with violating. As the Board explained above, however, the ALJ's discussions of the Nurse Practice Act are not relevant to this decision. Ms. Carr could have used the Nurse Practice Act *as a defense* to the charges *if* she was a licensed nurse and *if* she was operating within the scope of duties of a licensed nurse. Because Ms. Carr is not a licensed nurse, however, and because she did not raise that defense, the Nurse Practice Act is completely irrelevant to this case. The Board does not adopt any of the ALJ's discussion concerning the Nurse Practice Act. Ms. Carr was charged solely under the Medical Practice Act, she violated the Medical Practice Act, and the sanction to be imposed is that set by the Medical Practice Act. No due process violation occurred, as Ms. Carr was charged with (and will be sanctioned for) her violation of the Medical Practice Act alone.

Ms. Carr argues that the Medical Practice Act is unconstitutionally vague because the words "diagnosis" and "treatment" in the statute are undefined. A statute is not void for vagueness, however, if "it uses plain language that is understandable to a person of ordinary intelligence," *Finucan v. Maryland Board of Physician Quality Assurance*, 380 Md. 577, 592 (2004), and if it provides "legally fixed standards and adequate guidelines

for ... triers of fact and others whose obligation it is to enforce, apply and administer the penal laws." *Id.*, citing *Bowers v. State*, 283 Md. 115, 121 (1992). In *Finucan*, the Court of Appeals determined that the term "immoral or unprofessional conduct" was sufficiently specific to give notice to physicians that consensual sexual relations with patients was prohibited. *Finucan*, 380 Md. at 591-94. In *Unnamed Physician v. Commission on Medical Discipline*, 285 Md. 1, 15 (1979), the Court of Appeals determined that the term "professional incompetency" was not unconstitutionally vague.

There is nothing vague about the statute as applied in this case. Any person of ordinary intelligence would recognize that examining pregnant patients, including measuring fundal height and conducting internal examinations of the cervix, requesting and evaluating laboratory tests and interpreting the results for preeclampsia, diabetes and other complications, using a Doppler to measure fetal heart rate and making treatment recommendations based on those results, artificially piercing the amniotic membrane, stretching the cervical opening to promote labor, and determining based on clinical findings whether hospitalization is needed or not, constitutes prohibited "treatment" and "diagnosis" in the cases of pregnant women. Because any reasonable person of ordinary intelligence would recognize that these measures constitute medical diagnosis and treatment, the statute is not unconstitutionally vague.

Ms. Carr also disputes much of the testimony of the State's expert, Dr. Block. The ALJ correctly noted, however, that Ms. Carr did not present any expert testimony to the contrary. The Board accepts the testimony of Dr. Block that the actions taken by Ms. Carr in these cases constitute the practice of medicine.

The Board finds no merit in any of Ms. Carr's other exceptions.

Sanction

For practicing medicine without a license, the Board may impose a civil fine of up to $50,000. Health Occ. § 14-606(4) (ii). The ALJ recommended a fine of $30,000 – without, however, explicitly considering the factors set out in COMAR 10.32.02.06B (3) & (4), which are to be considered in deciding the amount of the fine. Those regulations set the amount of fine for a first offense as between $1,000 and $30,000. COMAR 10.32.02.06B (4)(a). It could be argued that the cases of patients B and D constitute two separate offenses and that the $40,000 maximum penalty of COMAR 10.32.02.06B(4)(b) is in play. The Board, however, will give Ms. Carr the benefit of the doubt on this legal issue and will consider these two patients' cases as constituting a "first offense." Thus, the maximum penalty for this first offense is $30,000.

Considering the factors set out in COMAR 10.32.02.06B (3), the Board finds that Ms. Carr did derive a financial benefit from her improper conduct. She charged fees for her services and in fact formerly made her living from practicing medicine without a

license. Her conduct was clearly willful. Most importantly, there was "actual or potential public harm caused by the improper conduct." COMAR 10.32.02.06B (3)(c). Twin B died after Ms. Carr not only attempted to treat a mother going through a very complicated pregnancy but also advised the mother to refuse the help of the emergency rescue technicians who were on the scene and recommending that they take the baby to the hospital. Ms. Carr's actions thus created the potential for public harm in the form of the death of Twin B. Likewise, Ms. Carr's unlicensed diagnosis and treatment of Patient D through ten visits, culminating in the patient being transported to the hospital for a Caesarean section, created the potential for public harm in the form of serious health risks to the mother and the baby. Considering these factors, the Board will impose a fine of $30,000, the maximum fine that may be imposed for a first offense.

Order

It is hereby **ORDERED** that the Respondent Karen Carr is **FINED** in the amount of $30,000; and it is further

ORDERED that this order is a public document under Md. State Gov't Code Ann. §10-617(h) (2)(vi).

SO ORDERED this 9th day of November, 2012.

Carole Catalfo, ExecutiveDirector
Maryland State Board of Physicians

NOTICE OF RIGHT TO APPEAL

Pursuant to section 14-408(a) of the Health Occupations Article of the Maryland Annotated Code and the applicable regulations, Ms. Carr has the right to appeal this decision to the Board of Review of the Department of Health and Mental Hygiene within thirty days of the date this order is mailed. The cover letter of this order indicates the date the decision is mailed. Any appeal shall be directed to:

Maryland State Department of Health and Mental Hygiene
Board of Review
c/o Carlean Rhames-Jowers, Liaison
201 West Preston Street, 5th floor
Baltimore, MD 21201

If an appeal is filed, Ms. Carr should send a copy to the Board's counsel, Thomas W. Keech, Esq. at the Office of the Attorney General, 300 West Preston Street, Suite 302, Baltimore, Maryland 21201. The Administrative Prosecutor is not involved in the appeal process and need not be served or copied on pleadings filed in the appeal.

IN THE MATTER OF	*	BEFORE MARY SHOCK,
KAREN CARR,	*	AN ADMINISTRATIVE LAW JUDGE
RESPONDENT	*	OF THE MARYLAND OFFICE
v.	*	OF ADMINISTRATIVE HEARINGS
MARYLAND STATE BOARD OF	*	OAH CASE No: DHMH-SBP-79-12-00326
PHYSICIANS	*	

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PROPOSED DECISION

STATEMENT OF THE CASE
ISSUES
SUMMARY OF THE EVIDENCE
STIPULATIONS OF FACT
FINDINGS OF FACT
DISCUSSION
CONCLUSIONS OF LAW
PROPOSED DISPOSITION

STATEMENT OF THE CASE

On October 6, 2011, the State of Maryland's Board of Physicians (Board) filed charges against Karen Carr (Respondent), under the Maryland Medical Practice Act. Md. Code Ann., Health Occ. §§ 14-101 through 14-702 (2009 & Supp. 2011). The Board forwarded the charges to the Office of the Attorney General (State) for prosecution.

I held a hearing on March 19, 20 and 21, 2012, at the Office of Administrative Hearings in Hunt Valley, Maryland. Md. Code Ann., Health Occ. § 14-405(a) (2009). Tracee Orlove Fruman, Assistant Attorney General, Administrative Prosecutor, represented the State. Micah Salb, Esquire, Lippman, Semsker & Salb, LLC, represented the Respondent.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, the Rules of Procedure for the Board, and the Rules of Procedure of the Office of

Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (2009 & Supp. 2011); Code of Maryland Regulations (COMAR) 10.32.02; COMAR 28.02.01.

ISSUES

A. Did the Respondent practice, attempt to practice, or offer to practice medicine without a license in violation of the Health Occupations Article, Annotated Code of Maryland, sections 14-301 and 14-601 (2009), in her prenatal, delivery, and/or postnatal care of:

1. Patient A, hospitalization on or about May 30, 2010
2. Twin B, hospitalization on or about November 15, 2010
3. Patient D, hospitalization on or about April 2, 2010.[1]

B. If so, is the Respondent subject to a civil penalty under the Health Occupations Article, Annotated Code of Maryland, section 14-606 (2009)?

SUMMARY OF THE EVIDENCE

Exhibits

The parties presented the following joint exhibits:

1. Complaint, May 30, 2010
2. St. Mary's Hospital Medical Records, Patient C, April 27, 2010
3. EMAIS Patient Care Report: Official, Patient A, May 30, 2010
4. St. Mary's Hospital Medical Records, Patient A, May 30, 2010
5. EMAIS Patient Care Report: Official and related forms (Mechanicsville Volunteer Rescue Squad) Twin B, November 15, 2010
6. EMAIS Patient Care Report: Amended Official (St. Mary's County Advanced Life Support Unit) Twin B, November 15, 2010
7. Twin B Medical Records from Southern Maryland Hospital Center, November 16, 2010
8. Email Correspondence from Harold Lee, M.D., to the Board, November 19, 2010
9. St. Mary's Hospital Variance Reports, April 2, and 27, 2010, April 5, 2008, and January 28, 2004
10. Cease and Desist Order, May 25, 2011
11. Report of Investigation, June 15, 2011
12. Notice of Charges Under the Maryland Medical Practice Act, October 6, 2011
13. Respondent's Records, Patient C
14. Respondent's Records, Twin B
15. Respondent's Records, Patient D

[1]At the beginning of the hearing on March 19, 2012, the State withdrew the charges against the Respondent with respect to Patient C, hospitalization on or about April 27, 2010.

16. Curriculum Vitae, Andrew B. Block, M.D.
17. Statement of Facts, Commonwealth of Virginia v. [Respondent], File #CF1001066
18. Transcript of Board's Interview with Respondent, July 26, 2011
19. Andrew B. Block, M.D., Report, February 28, 2012

The State did not offer any additional exhibits.

The Respondent presented the following exhibits:

RSP #1	North American Registry of Midwives (NARM), Respondent's Certification Records, December 8, 2009
RSP #2	Photograph, Nicole Jolley, undated
RSP #3	Photograph, Nicole Jolley, undated

Testimony

A. The State called the following witnesses:

1. Andrew B. Block, M.D., Obstetrician/Gynecologist (OB/GYN), accepted as an expert in Obstetrics and Gynecology (OB/GYN)
2. Mary Virginia Barnes, Emergency Medical Technician/Paramedic, St. Mary's County, Advanced Life Support Unit
3. Michael Anthony Fox, Emergency Medical Technician, Mechanicsville Volunteer Rescue Squad

B. The Respondent testified on her own behalf and called the following witnesses:

1. Tina Overton
2. Evelyn Muhlhan
3. James, Patient A's husband
4. Joey Pascarella

STIPULATIONS OF FACT

The parties stipulated to the following facts:

1. The Respondent is not licensed to practice medicine in Maryland, and she has never held a license to practice medicine in Maryland.

2. The Respondent is a Certified Professional Midwife (CPM), certified by NARM.

FINDINGS OF FACT

I find the following facts by a preponderance of the evidence:

1. The Respondent did not provide Patient A antepartal, intrapartal, or postpartal care (prenatal, childbirth, postnatal) [2] in 2010. (Trans. pp. 379-380)

2. The Respondent provided Twin B's mother prenatal care beginning on June 10, 2010. The Respondent obtained a medical history of Twin B's mother including previous pregnancies; Twin B's mother had seven previous pregnancies. (JT #14, pp. 817-819) The Respondent cared for the mother for five of the previous pregnancies and births. (Trans. p. 441)

3. From June 10, 2010 to November 14, 2010, the Respondent saw Twin B's mother eight times. (JT #14, p. 817)

4. On September 30, 2010, the Respondent believed that the mother might be having twins. She referred the mother for a sonogram. The sonogram confirmed the twins. (JT #14, p. 817)

5. At the prenatal visits from June 10, 2010 to November 14, 2010, the Respondent took a fetal heart tone for the babies' heart rate using a Doppler, and the mother's blood pressure, using a blood pressure cuff, she measured fundal height to determine the size of the babies, and she determined the position of the babies. The babies were variously breech-transverse, breech-breech, or vertex-breech. (JT #14, p. 817, Trans. p. 97-98)

6. The birth of twins in a vertex-breech presentation is a high risk delivery (Trans. pp. 100-101)

7. The Respondent and Nicole Jolley, another midwife, attended the twins' birth on November 15, 2010, at the parents' home. The Respondent performed pelvic exams and determined that the mother's cervix was dilated at five centimeters, she was twenty percent

[2] *See* www.merriam-webster.com/medlineplus.

effaced and having contractions. The Respondent artificially ruptured the fluid for Twin A. Twin A was delivered at 4:35 p.m., and the Respondent clamped the cord. (JT #14, pp. 820-821)

8. The Respondent then ruptured the membrane of Twin B. Twin B was delivered from a breech presentation at 5:05 p.m. (JT #14, p. 821)

9. The Respondent observed the placenta after the births and found that it was normal. (JT #14, p. 820)

10. Following the birth of the twins, the Respondent conducted an exam of both babies. (JT #14, pp. 812 , 816, 820-821) She took the newborns' Apgars,[3] weight, length, and circumference, documented presentation, the cord, meconium staining,[4] respiratory problems, and heart rate range. She noted that there were no birth injuries or congenital malformation. (JT #14, p. 820)

11. The Respondent evaluated the babies' color, peeling and vernix[5] on the body, palate, eyes, feet, hand, vessels in the umbilical cord, and head, and whether there were Mongolian spots or birth marks. (JT #14 pp. 812 and 816).

12. Twin B suffered respiratory problems and the Respondent gave him full cardiopulmonary resuscitation (CPR) and administered oxygen. (JT #6, p. 724, JT #14, pp. 812 and 820)

13. On November 15, 2010 at 5:29 p.m. someone in the household called Emergency Medical Services (EMS) because Twin B was not breathing and CPR was in progress. An EMS unit responded to the home at 5:40 p.m. (JT #5, pp. 713 and 722)

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[3] Apgar is an index used to evaluate the condition of a newborn infant based on a rating of 0, 1, or 2 for each of the five characteristics of color, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being a perfect score. www.nlm.nih.gov/medlineplusdictionary.html.

[4] Meconium is a baby's first bowel movement. www.nlm.nih.gov/medlineplusdictionary.html.

[5] Vernix is a thick waxy substance covering the baby's skin. www.nlm.nih.gov/medlineplusdictionary.html.

14. When EMS personnel arrived on the scene, the Respondent, Ms. Jolley, and the parents told the personnel that Twin B was breathing and did not have to be transported to the hospital. Twin B's father signed a form refusing treatment. (JT #5, p. 715)

15. On November 16, 2010, at approximately 7:00 a.m., Twin B's father took the baby to Southern Maryland Hospital Center. Twin B was experiencing respiratory distress. Southern Maryland Hospital transferred the baby to Children's Hospital. (JT #7, p. 767)

16. Twin B. died at Children's Hospital. (JT #14, p. 812)

17. The Respondent provided prenatal care for Patient D beginning on September 23, 2009. She saw Patient D ten times between September 23, 2009 and March 30, 2010. (JT #15, p. 824)

18. At the prenatal visits, the Respondent took a fetal heart tone for the baby's heart rate using a Doppler, and the mother's blood pressure, using a blood pressure cuff. She measured the fundal height to determine the size of the baby, and she tested the mother's urine samples. (JT #15, p. 824, Trans. p. 137)

19. Patient D underwent laboratory tests including blood tests, tests for gonorrhea, herpes, and a test for group beta streptococcus (GBS). (JT #15, p. 136)

20. The Respondent attended at the birth of Patient D's baby on April 2, 2010. (JT #15 pp. 825-826)

21. In order to promote labor, the Respondent placed her fingers in Patient D's cervix to stretch the cervix from three to five centimeters. She ruptured the membrane artificially. (Trans. p. 144, JT #15, p. 825)

22. Patient D's labor failed to progress (FTP), the baby's head was not descending into the pelvis properly and dilation was not proceeding normally. The Respondent made the diagnosis of FTP by vaginal exam and monitoring. The Respondent also listened to the baby's

heart tones during the labor process to determine if the baby was having deceleration or dips in heart rate. (Trans. p. 141)

23. The Respondent recommended that Patient D go to the hospital to deliver the baby because of the FTP. Patient D resisted, but the Respondent insisted. (Trans. pp. 419-420, 478-479)

24. Patient D delivered her baby by Cesarean section at the hospital. (JT #15, p. 826)

DISCUSSION

I. Charges and Law.

The State has charged the Respondent with practicing medicine without a license based on her care of three women prenatally and in childbirth. The Board seeks to fine the Respondent $50,000.00 for the unlicensed practice of medicine. Md. Code Ann., Health Occ. §§ 14-301, 14-601, 14-606(a)(4)(ii).

Maryland law defines the practice of medicine as follows:

(n) Practice medicine.

(1) "Practice medicine" means to engage, with or without compensation, in medical:

(i) Diagnosis;
(ii) Healing;
(iii) Treatment; or
(iv) Surgery.

(2) "Practice medicine" includes doing, undertaking, professing to do, and attempting any of the following:

(i) Diagnosing, healing, treating, preventing, prescribing for, or removing any physical, mental, or emotional ailment or supposed ailment of an individual:

1. By physical, mental, emotional, or other process that is exercised or invoked by the practitioner, the patient, or both; or
2. By appliance, test, drug, operation, or treatment;

(ii) Ending of a human pregnancy; and
(iii) Performing acupuncture as provided under § 14-504 of this title.

(3) "Practice medicine" does not include:

(i) Selling any nonprescription drug or medicine;

(ii) Practicing as an optician; or

(iii) Performing a massage or other manipulation by hand, but by no other means.

Md. Code Ann., Health Occ. § 14-101(n) (Supp. 2011).

The Respondent presents several arguments. First, she maintains that her care fails to meet the legal definition of the practice of medicine because she does not diagnose pregnancy and because pregnancy is not an ailment for which she renders healing or treatment. Instead, she assists mothers in pregnancy and childbirth. Moreover, the State's expert witness, Andrew B. Block, M.D., failed to define diagnosis and treatment, but instead, reviewed medical reports and, unsupported by facts and analysis, concluded that the Respondent practiced medicine without a license. Dr. Block failed to explain, for example, why a parent diagnosing a child's fever cannot be said to be practicing medicine. Thus, he failed to differentiate between the parent's and the Respondent's situations to prove that the Respondent's actions constitute the practice of medicine.

Second, the Respondent argues that the statute is unconstitutionally vague because it fails to provide reasonable notice to the Respondent, a person of ordinary intelligence, that her conduct is illegal. If the State seeks to regulate an activity, here professional midwifery, it must tell the public it is regulating that conduct. Instead, the State only regulates the practice of medicine and nurse-midwifery, not professional midwifery. The Respondent has only held herself out to the public as a professional midwife, not a nurse and not a doctor. The families she attended chose her over a doctor. The State is arrogant in its assertion that the reason for the prohibition against the unlicensed practice of medicine is public protection; the public here does not want the State's protection. The Respondent argued that deeply embedded in American law

is a person's fundamental right to decide whether to receive medical care from a doctor or to seek the assistance of a lay practitioner or a midwife.

Addressing the last argument first, regardless of any right a family may hold to seek the assistance of a lay practitioner or a midwife, that issue is not before me in these proceedings. Instead, the issue is whether the Respondent has the legal right to care for pregnant women and assist in childbirth when she is neither a licensed physician nor a licensed nurse-midwife. I find that the Respondent's actions constitute the practice of medicine, specifically obstetrics, that she practiced medicine without a license, and that she is subject to a civil penalty.

With regard to the Respondent's position that Dr. Block failed to define diagnosis and treatment, I find that argument meritless. Dr. Block defined diagnosis and treatment as follows: after receiving data including patient history, physical exam, blood work, laboratory data, radiological exams, sonograms, the provider determines what is going on with the patient and determines how to help the patient through the problem. (Trans. pp. 75-76)

Dr. Block describes a process of identifying a physical condition by signs or symptoms and then helping the patient with those symptoms. He acknowledged that an unlicensed person might be able to provide a diagnosis and recommend treatment, but is not legally permitted to do so. (Trans. pp. 76-78) Thus, while a range of a physician's actions might overlap with those of a lay person or other health practitioner, the doctor, unlike the lay person, is professionally and legally responsible to orchestrate the entire process with the patient's collaboration. The physician determines what is occurring in the individual, recommends action to take in response, implements the response, and follows up to determine if the response resolved the targeted condition.

One Maryland case discusses whether reproductive care falls within the definition of the practice of medicine. *Rock v. State*, 6 Md. App. 618 (1969). In 1968, James Francis Rock was

criminally charged and convicted of practicing medicine without a license. Rock gave pills to a woman to induce an abortion. There was no expert testimony at trial stating that pregnancy was an ailment in the medical sense. *Id.* at 628. On appeal, the court found Rock's statements to an investigating police officer inadmissible under *Miranda v. State of Arizona,* 384 U.S. 436 (1966) and overturned the conviction. The court went on, however, to construe the statute. It found that pregnancy is an "ailment" within the meaning of the statute.[6] While assuming that pregnancy is not an ailment in the medical sense, the court found that the word "ailment" as used in the statute, still medically applies to pregnancy because obstetrics is a recognized branch of medical science and the practice of medicine. The Legislature did not intend that a person could engage in the practice of obstetrics without a license to practice medicine. *Id.* at 629.

Similarly, "diagnosis" and "treatment" must be considered in the context of the statute. While the Respondent did not diagnose pregnancy and treat the condition in a global sense, as discussed below in connection with individual patients, she was involved in the process of taking medical histories, performing physical exams, interpreting test data, assisting women and Twin B in the discrete stages of pregnancy and childbirth, which, as discussed in *Rock*, is the practice of obstetrics, a recognized branch of medicine.

Turning to the constitutionality of the Medical Practice Act, I find that the definition of the practice of medicine is written in plain language that a person of ordinary intelligence can understand. Md. Code Ann., Health Occ. § 14-101(n). The law informs the Respondent that if she engages in diagnosis and treatment, no matter what she chooses to call those activities, she is subject to a civil fine. *Finucan v. Board of Physicians*, 380 Md. 577, 591-593 (2004).

[6] The statute in effect at the time, Article 43, Section 139, Maryland Code, defined the practice of medicine in part as "diagnosing or treating any physical or mental ailment."

Additionally, the nurse midwifery law is relevant here. Md. Code Ann., Health Occ. §§ 8-601 through 8-603 (2009).[7] That statute defines the practice of nurse midwifery as "the management and care of essentially normal newborns and of essentially normal women antepartally, intrapartally and postpartally." Md. Code Ann., Health Occ. § 8-601(1). Under the Maryland regulations, authorized by law, (Md. Code Ann., Health Occ. § 8-602), a nurse midwife must collaborate with a physician. COMAR 10.27.05.03A(1).

Reading those statutes together, the Respondent was on notice that only a licensed physician or a licensed nurse midwife may treat or care for a woman in pregnancy and delivery of a child. Additionally, managing a high risk birth of twins in a vertex-breech presentation took the Respondent out of the practice of nurse midwifery and placed her squarely in the practice of medicine.

Further, Maryland case law has clarified that an individual must be a licensed physician or a licensed nurse midwife in order to practice midwifery in Maryland. In *Hunter v. State*, 110 Md.App. 144, (1996), a midwife was convicted of practicing nursing without a license. She argued on appeal that with the amendments to Maryland law defining and regulating "nurse midwives," the Legislature was not regulating "traditional" midwives. The court found that the Legislature intended that only registered nurses be allowed to practice midwifery in Maryland, and the practice of midwifery without a nursing license constitutes the practice of registered nursing without a license. *Id.* at 158. *Hunter* establishes that professional midwives, like the Respondent, are not permitted to practice in Maryland.

The Medical Practice Act, read with the nurse midwifery law and Maryland case law, provides individuals of ordinary intelligence with notice that if they engage in midwifery without

[7]Although the State Board of Nursing holds statutory authority to penalize a person who practices registered nursing, including nurse midwifery, without a license, neither party addressed the issue of the State Board of Nursing's authority or lack of authority over the Respondent's actions. Md. Code Ann., Health Occ. §§ 8-701 and 8-710.

a license to practice medicine or nurse midwifery that they are subject to the sanctions set out in the law. Thus, the statute is not unconstitutionally vague.

II. Patient A.

Patient A's husband testified that he and his wife did not hire the Respondent to serve as their midwife. He named other midwives that attended his wife's births. (Trans. p. 380) Joey Pascarella, one of those midwives, also testified. She stated that the Respondent was not present at any of Patient A's deliveries. (Trans. pp. 385-386) The medical records in evidence support the husband's and Ms. Pascarella's testimony. The hospital reports do not identify the Respondent as Patient A's midwife and the records do not include any notes made by the Respondent. (JT #4) Absent further evidence to demonstrate that the Respondent cared for Patient A, I find that the State failed to prove the charges against Respondent with regard to that individual.

III. Twin B.

Dr. Block testified as an expert in OB/GYN on behalf of the State. He noted that the Respondent saw Twin B's mother for prenatal visits eight times from June 10, 2010 through November 14, 2010. When the mother was thirty-one and one-half weeks pregnant, the Respondent suspected that she might be having twins. She sent the mother for a sonogram. The test confirmed twins in a breech-transverse presentation; meaning one baby was coming posterior first, the other lay across the mother's abdomen, as opposed to head down or posterior first. (Trans. p. 97) In each prenatal visit following the sonogram results, the Respondent documented the presentation of the babies, which were variously breech-transverse, breech-breech, or vertex-breech

The Respondent also performed vaginal exams, took fetal heart tones, blood pressure, urine dips, fundal height, and identified the size of the pregnant uterus. (Trans. pp. 98, 109-110)

Dr. Block stated that the delivery of the twins would be a high risk delivery. There is a risk of head entrapment with any type of twin delivery, but especially with a twin pregnancy and a vertex-breech presentation. (Trans. pp. 100-101) Also, the mother had seven previous deliveries. After the fifth delivery, there are increased risks of postpartum hemorrhage and precipitous labor and delivery. (Trans. p. 100)

Dr. Block further testified that the Respondent diagnosed that Twin B's mother was in labor on November 15, 2010, when she determined that the mother's cervix was dilated at five centimeters, she was twenty percent effaced and having contractions. (Trans. pp. 113-114) Also, she ruptured the membranes for both babies, which was a diagnostic act and therapeutic. The Respondent identified the fluid and initiated more intense contractions and a potentially quicker labor for the mother. Delivering twins, a vertex and breech delivery, is treatment, usually performed by a licensed physician or caregiver. (Trans. pp. 115-116)

After the babies were born, the Respondent calculated their Apgar's scores, including looking at each baby's respiration, color, tone, heart rate and grimace. In taking the Apgar's scores, the Respondent was making a diagnosis. On Twin B, she then performed CPR and administered oxygen, treatments aimed at improving the baby's wellbeing. (Trans. pp. 118-119)

The Respondent maintained that she was not the lead midwife at Twin B's delivery. She stated that she did not tell the paramedics when they arrived on the scene that the baby was breathing and they were not needed. Instead, she alleges that Nicole Jolley was with the mother when the paramedics arrived on the scene and that the paramedics misidentified the Respondent as the midwife in charge.

Michael Anthony Fox, Jr., Emergency Medical Technician (EMT), Mechanicville Volunteer Rescue Squad, testified that he responded to a call at 5:30 p.m. for a minutes-old infant not breathing. A fire unit that had arrived on the scene first told Mr. Fox that the infant

was breathing at the time of their arrival. In the home, Mr. Fox observed the Respondent and her assistant with the baby on the bed, with an oxygen tank trying to blow air into the baby's face to help it get more oxygen. (Trans. p. 332-333) The Respondent told Mr. Fox that the baby was fine and that the parent did not want them to take the baby to the hospital. (Trans. pp. 333-334) He asked to examine the baby, but the Respondent refused. (Trans. pp. 334-335) Mr. Fox testified that the Respondent was speaking with the mother, saying that the baby was doing better. (Trans. p. 336)

Mary Virginia Barnes, a paramedic for Charles County Emergency Services, testified that when she arrived at the home the mother was sitting in a chair with a baby and the Respondent had an oxygen tank and was giving blow-by-blow oxygen near the baby's face. She could hear the baby making grunting sounds. (Trans. p. 277) Ms. Barnes listened to the baby's lungs and could hear gurgling and fluid sounds and his heart rate sounded very slow. (Trans p. 278) She stated to the Respondent and the mother that the baby should go to the hospital. The Respondent said the baby was fine and did not need to go to the hospital. (Trans. p. 279) The Respondent was advising the mother. (Trans. p. 283)

For the reasons discussed below, I did not believe the Respondent's testimony that she was not the lead midwife and that she did not tell the paramedics to leave. I also do not believe that Mr. Fox and Ms. Barnes confused the Respondent and Ms. Jolley.

The Respondent has been certified by NARM since 1997. (RESP #1, Trans., p. 393) Ms. Jolley had been a midwife for several years by November 2010. (Trans. pp. 393 and 456) The Respondent decided that Ms. Jolley should be there, and permitted to her take the lead in Twin B's birth, although she assisted when the baby got stuck during delivery. (Trans. p. 456-460). Further, the Respondent saw Twin B's mother prenatally and attended at five of her previous childbirths. (Trans. p. 441) Based on the Respondent's experience compared to Ms. Jolley's

experience and the Respondent's history with Twin B's mother, I believe the Respondent was in charge.

Further, notwithstanding the Respondent's testimony that she assists mothers in birth and does not tell them what to do, she did not strike me as a person who would relinquish control. Because she practiced midwifery when she knew or should have known that it is not legal in Maryland, her conduct demonstrates that she will act as she believes right regardless of the consequences or another person's opposition. For example, as discussed below, the Respondent insisted that Patient D go to the hospital, although the mother did not want to go and remained angry with the Respondent after the birth. (Trans. pp. 419-420, 478-479) Thus, it is more likely than not that if the Respondent believed that Twin B should have been taken to the hospital, she would have said so; she would not have merely told the paramedics that she was "open to the idea." (Trans. p. 470)

Finally, I did not believe the Respondent's testimony based on her demeanor. She resented the proceedings, she was angry because she objects to the medical model of pregnancy and birth, and she made that anger obvious. (JT #18, p. 840) She was stern, as Ms. Barnes described her. (JT #6, pp. 724-725) She downplayed her actions, describing her conduct as merely assisting and attending. I believe she would not admit that she gave Twin B's parents any direct advice. For these reasons, I accept Mr. Fox's and Ms. Barnes' testimony, that the Respondent was in charge and, with the parents' acquiescence, refused medical care for Twin B.

The Respondent acknowledged in her birthing record that twins was a complication of pregnancy. (JT #14, p. 820) That complication means that the Respondent managed and cared for a woman and newborns that were not "normal" within the meaning of the nurse midwifery statute. Md. Code Ann., Health Occ. § 8-601(1). In caring for the mother prenatally, delivering

the babies, performing CPR, administering oxygen, and advising the parent to refuse care for Twin B, the Respondent practiced medicine without a license.

IV. Patient D.

Patient D was a forty-one-year-old woman, with a history of one pregnancy that ended in miscarriage in 1986. She also had a history of cryosurgery, freezing of the cervix for treatment of HPV or abnormal pap smear. (Trans. pp. 136-137)

Dr. Block described the Respondent's care of Patient D and how her care constituted the practice of medicine. The Respondent evaluated Patient D on ten visits, observing her for any complications, and documenting blood pressure, fetal heart rate and Patient D's urine. She took a medical history from Patient D, reviewed laboratory data, and used a diagnostic technique to identify GBS, which required that the Respondent take a sample by swabbing the mother's vaginal opening. An unlicensed person is not permitted to perform that test. (Trans. p. 138-139) Further, testing Patient D's urine was diagnostic. The tests are used to identify if a woman is spilling protein or glucose; protein in the urine is associated with preeclampsia; spilling glucose requires screening for diabetes. (Trans. p. 147)

The Respondent diagnosed and used therapies throughout Patient D's labor, including dilating the cervix and rupturing the membrane artificially. She placed her fingers in Patient D's cervix to stretch the cervix from three to five centimeters in order to promote labor, and that action was a therapeutic technique. (Trans. pp. 144- 145)

Finally, the Respondent transported Patient D to the hospital, which was a treatment decision she made based on decelerations in the baby's heart rate and Patient D's FTP, for which she was required to conduct a vaginal examination. (Trans. pp. 146-147 and p. 167) Dr. Block stated that the Respondent did not attend at the birth, but diagnosed and provided therapy to the

mother through the labor process; she made critical decisions about how to proceed. (Trans. p. 149).

The Respondent did not contest Dr. Block's factual testimony except to state that the mothers do their own swabs for GBS. She sends them a kit and they do it themselves. (Trans. p. 476) With regard to Patient D's labor, she testified that she artificially ruptured the membrane using her fingers. She would pluck the membrane, as she learned in her training. (Trans. pp. 483-484) The Respondent stated that Patient D arrived at a point where she was no longer progressing. (Trans. p. 474) The Respondent made that determination by checking the mother's cervix with her fingers to see how open it was. She also tested the baby's heart tones using a Doppler, which is a portable ultrasound device to determine the heart rate. (Trans. p. 479) When the baby's heart rate was well below the normal range, the Respondent recommended that the mother go to the hospital. (Trans. pp. 472-473) The mother opposed transfer to the hospital, but the Respondent insisted.

The Respondent did not offer any testimony to contradict Dr. Block's opinion that her conduct, particularly during labor, constitutes the practice of medicine, except to generally argue that she does not diagnose or treat pregnancy. Thus, I find that the State has demonstrated that the Respondent practiced medicine without a license in her care of Patient D prenatally and during childbirth. She took Patient D's medical history, performed physical exams, and interpreted test data. She observed the signs of FTP and tried to remedy the condition by artificially rupturing the membrane and dilating the mother's cervix to promote labor. She determined that the baby's heart rate was decelerating to a dangerous level and recommended a solution - treatment at a hospital.

V. Sanction.

The law provides that any person who practices medicine without a license is subject to a civil fine of not more than $50,000.00. Md. Code Ann., Health Occ. 14-606(a)(4). The statute does not set out any factors to consider when determining the appropriate amount of a civil fine. I have considered the following factors. First, the State failed to prove the charges connected to Patient A. Second, the Respondent knew or should have known that Maryland does not permit the practice of certified midwifery, yet she continued her practice anyway. Finally, although Twin B might have died under any circumstance, the Respondent's determination that emergency medical care was not needed for the newborn was a serious lapse in judgment and a medical decision that had dire consequences.

PROPOSED DISPOSITION

I **PROPOSE** that the charges filed by the Board on October 6, 2011 against the Respondent be **UPHELD**.

I **PROPOSE** that the Board fine the Respondent $30,000.00.

May 31, 2012
Date Order Mailed

Mary Shock
Mary Shock
Administrative Law Judge

MKS/kkc
#131139

NOTICE OF RIGHT TO FILE EXCEPTIONS

Any party may file exceptions, in writing, to this Proposed Decision with the Board of Physicians within fifteen days of issuance of the decision. Md. Code Ann., State Gov't § 10-216 (2009) and COMAR 10.32.02.03F. The Office of Administrative Hearings is not a party to any review process.

Copies mailed to:

Karen Carr
2222 Kentucky Avenue
Baltimore, MD 21213

Tracee Orlove Fruman, AAG
Administrative Prosecutor
Health Occupations Prosecution & Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

S. Micah Salb, Esquire
Lippman, Semsker & Salb, LLC
7979 Old Georgetown Road
Suite 1100
Bethesda, MD 20814

Christine Farrelly, Supervisor
Compliance Administration
State Board of Physicians
4201 Patterson Avenue
Baltimore, MD 21215

Carole J. Catalfo, Executive Director
State Board of Physicians
4201 Patterson Avenue, 3rd Floor
Baltimore, MD 21215

Rosalind Spellman, Administrative Officer
Health Occupations Prosecution & Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201

Paul T. Elder, M.D., Chairman
State Board of Physicians
Metro Executive Plaza
4201 Patterson Avenue, Third floor
Baltimore, MD 21215

John Nugent, Principal Counsel
Health Occupations Prosecution & Litigation Division
Office of the Attorney General
300 West Preston Street, Room 201
Baltimore, MD 21201