## MIDWIVES

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MIDWIFERY
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MIDWIFERY
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FISCAL YEAR 2019

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Midwives Program Update

- Staff conducted two standard of care workgroup meetings.
- Staff has assisted Customer Service with Regulatory Program Management-related emails.
- Program webpage update and streamlining should happen within the next few months.
- The Austin American Statesman published an article on November 25, 2018 concerning the practice of midwifery and the differences in regulation throughout the United States. The article focuses on a Texas midwifery client that died after childbirth, provides statistical data concerning in hospital versus out-of-hospital births, and how TDLR has recently made changes within the profession based upon recommendations from the client’s family.

Public Outreach

- Staff conducted the Midwives Summit on January 7, 2019.

Personnel Updates

- Heather Muehr has replaced Stephen Mills as Section Manager of the Medical and Health Professions Section.
- Katie Brice, Program Specialist, has been assigned to the MHP lead for the Midwifery Program.
- Mary Hoffman, Program Specialist, has been assigned to be the back-up staff member for this program.

Medical & Health Professions Section Update

- The Medical & Health Professions Section remains focused on maintaining the successful operation of the eleven programs assigned to the section.
- MHP has distributed two issues of The Health Monitor newsletter for the medical and health professions programs, since your last meeting. The fourth issue was emailed to subscribers on August 30 and the fifth issue was delivered on December 14, 2018. The latest issue can be found on the program web pages. Links to previous issues can be found under Agency Newsletters on the main TDLR page.
Out-of-hospital births twice as deadly, GateHouse investigation finds

By Eric Dexheimer
@DexInvestigates
Posted Nov 25, 2018 at 1:01 AM

In the spring of 2013, Amanda Garbacz was on top of the world. A standout student, she had recently graduated from the University of Arkansas with a civil engineering degree and became engaged to another engineer. Now she was about to become a new mother.

The previous fall, Amanda, then 23, learned she was pregnant. Her early prenatal checkups showed her to be in generally sound health, but raised several concerns. She had seen a cardiologist for a rapid heartbeat and arm numbness. In October, an obstetrician also had noted her asthma and labeled her pregnancy “high-risk.”

Looking to save money and be closer to family, in early 2013 the young couple moved from Arkansas to the East Texas town of Wake Village, just west of Texarkana. Unable to find a local obstetrician she could afford, in February 2013, she signed a contract with Alternative Birth Choices, a local midwifery practice.

Licensed briefly in Arkansas, Lindsey Cooper had moved to Texas several years earlier. After starting formal midwife training, records show she interrupted her studies when she was recalled to active duty for the U.S. Army National Guard. Cooper over the next several years self-studied and apprenticed with other midwives.

Amanda’s contractions began on May 10. That evening, she summoned Cooper to her house. After some time in a home birth pool, Amanda’s water broke at about 7:30 a.m. Her daughter was born an hour later.

Amanda was too fatigued to nurse her. Soon after, there was a large gush of blood. Amanda’s efforts to push out her placenta stalled.
Two hours later, she collapsed in the arms of her mother, Suzanne. Paramedics were summoned to transfer Amanda to a hospital. As they raced to the emergency room, they started performing CPR.

“May 11, 2013, started out as one of the greatest days of my life; our beautiful granddaughter was born,” Amanda’s father, Matt Garbacz, said. “But it quickly turned into the worst day of our lives.”

**Out of hospital, in danger**

Despite the widespread perception, promoted by midwives, of home births being safer than those that occur in a hospital, an investigation by GateHouse Media, the American-Statesman’s parent company, has found the opposite to be true. U.S. babies are twice as likely to die during delivery — or within a month after — when born at home or in a freestanding birth center as babies born at a hospital, according to a GateHouse analysis of federal data covering 35 million live births from 2006 to 2015.

Babies delivered at home by midwives are three times more likely to die than those delivered by hospital midwives, who typically are more highly trained specialty nurses. The odds get even worse for first-time mothers.

The risks for mothers in Texas are comparable to those nationally. Between 2007 and 2016, Texas babies attended by a hospital midwife died at a rate of 4.3 per 10,000. During the same period, Texas babies died in out-of-hospital births overseen by a midwife at a rate of 7 per 10,000.

The GateHouse findings echo those of several academic studies, whose results have remained consistent even when counting only women who planned to give birth at home, thus excluding unexpected and emergency out-of-hospital births.

If anything, the statistics likely understate the risk. Even when a fatal condition develops during birth at home and a mother or child dies later in an emergency room, the death often is recorded as occurring at the hospital.
Birth fatalities overall remain rare, and the vast majority of U.S. mothers still give birth in hospitals, which carry their own risks. Maternal mortality rates in hospitals have soared in recent years, with tens of thousands of other new mothers only narrowly avoiding medical disaster.

“We have a very complex situation for maternity care in the U.S., where people are not being well served,” said Mary Lawlor, executive director of the National Association of Certified Professional Midwives.

Yet the heightened dangers of out-of-hospital births attended by midwives present a risk for a growing number of women and infants. From 2005 to 2016, U.S. out-of-hospital birth rates nearly doubled, from 0.8 percent to 1.5 percent.

In Texas, 1.38 percent of Texas births occur outside of a hospital, placing it in the middle ranges of rates across states. Still, more Texas mothers gave birth at home last year than mothers in any other state except California and Pennsylvania.

**FAILURE TO DELIVER: How the rise of out-of-hospital births puts mothers and babies at risk**

‘I want to go to the hospital’

While friends and family attending Amanda’s home delivery thought her post-birth blood loss was alarming, according to written accounts of their recollections of that morning, Cooper reassured them it was no reason for concern. Ten minutes later, when Amanda lost more blood, Cooper administered medicine to control the bleeding.

Cooper was assisted by Morgen Rozenboom, a physician. While Cooper’s clinic promoted their partnership, Rozenboom wasn’t an obstetrician and hadn’t worked full-time as a doctor for several years. She said she helped Cooper for no pay as “a labor of love.” After the birth, the doctor tended to the baby girl, Matt Garbacz recalled.

Amanda, meanwhile, said she was starting to feel peculiar. “I can’t see,” she told Suzanne Garbacz. “I want to go to the hospital.” But Cooper calmed her, Suzanne recalled, and they decided to stay and wait for the placenta to appear.

Mothers typically deliver their placenta about 10 minutes after childbirth, although it can take
longer. After 30 minutes, Amanda’s still hadn’t delivered.

Cooper declined to discuss what happened that day. “It was a traumatic year for me,” she said in a brief interview. But she later explained in a licensing hearing that she considered it acceptable to wait up to two hours for the placenta.

Experts said such a delay can signal a potential complication. Sylyna Kennedy, a certified nurse midwife for 30 years, said the standard of care for midwives is to transfer the mother to a hospital if she hasn’t delivered her placenta within a half-hour, according to court records. Each minute beyond that increases the risk of postpartum bleeding, she said.

As they waited, Suzanne Garbacz tried to get Amanda to nibble on a peanut butter sandwich and sip Gatorade. The midwife and physician “both agreed a prayer wouldn’t hurt, so they prayed,” Suzanne recounted.

Court and medical records show that Amanda’s skin felt cool and clammy — a potential early sign of shock. When Amanda again said she wanted to go to the hospital, Cooper reassured her once more that everything was fine, Suzanne said.

Her placenta finally delivered around 10 a.m. — about an hour and 30 minutes after her daughter’s birth, records show. When her mother tried to help her daughter go to the bathroom, Amanda “collapsed in my arms,” Suzanne recalled.

“I yelled for someone to call 911.”

**Avoidable risks**

The GateHouse investigation found that higher mortality rates for midwife-attended home births are caused by several, often preventable factors.

Some tragedies occur when midwives inappropriately accept pregnant mothers with medical conditions that place them at elevated risk for birth complications. A study published in the American Journal of Obstetrics and Gynecology found that nearly a third of home births from 2010 to 2012 did not meet the medical definition of low risk.
One problem is the definition of acceptable risk varies by state. A previous cesarean section always indicates a mother is a poor candidate for a home birth, said Lisa Hollier, president of the American College of Obstetricians and Gynecologists and a Baylor College of Medicine professor.

But several states permit it. Texas law allows midwives to accept patients with a previous cesarean section for home birth in some situations. New rules being considered by state regulators would further restrict the practice.

Home deliveries also can go downhill quickly if midwives delay transferring patients who are showing signs of medical distress to an emergency room. Although many work closely with local obstetricians and gynecologists, lingering distrust between the professions has meant that midwives can be reluctant to call 911.

Some states have urged midwives to adhere to a just-in-case planning program to protect their patients. In Washington state, Smooth Transitions helps home-birth attendants coordinate each out-of-hospital birth with a local emergency room in case something goes wrong. Texas has no such program.

“They keep hoping that if they stay home longer, the baby will just be born, and everything will be fine,” said Amy Tuteur, an obstetrician-gynecologist and former clinical instructor at Harvard Medical School who has been an outspoken critic of home births.

But the difference between life and death often can be measured in minutes, and delays can be catastrophic.

'Please stay with us'

Cooper called for a transfer to the hospital at 10:30 a.m. About 15 minutes later, a Wake Village fire and EMT crew arrived on the scene.

“No one gave me nor my partner a patient report,” the first responders' incident report stated. “Anyone with any type of medical training should have easily been able to recognize that the patient was in bad shape and the situation was serious.”
"I got on the radio and told (the ambulance crew) that they needed to hurry up because our patient was rapidly fading. (The) midwife looked at my partner and I as if we were stupid and didn't know what we were talking about."

Due to confusion over the address, the ambulance crew arrived about 10 minutes later, their run sheet shows. Suzanne Garbacz was "stroking (Amanda's) hair saying 'please stay with us,'" according to the paramedic's written notes. "The midwife was standing to the side of the bed and seemed a little surprised by me wanting to hurry."

By then, the notes indicated the medics couldn't find Amanda's wrist pulse. Because her blood volume was so low, paramedics struggled to insert an IV. During the ride to Texarkana, Amanda's nail beds began turning blue, their report stated.

They started CPR soon after. According to her death certificate, 24-year-old Amanda Garbacz died at St. Michael Hospital at 19 minutes past noon.

"Complications following vaginal delivery of an intrauterine pregnancy," the Dallas medical examiner concluded, mostly from uterine atony, a dangerous condition in which the uterus stops contracting after birth and can lead to bleeding.

"Manner of death: natural."

'52 little countries'

Some midwives are registered nurses with advanced training — certified nurse midwives — who typically are affiliated with a hospital or medical practice. Most, however, are so-called direct-entry midwives. Also known as professional or licensed midwives, they usually enter the field after a shorter and less formal course of study, either at a school or on their own, and an apprenticeship.

"So it all comes down to the preceptor and how well they're trained," said Vicki Wells, a licensed midwife in Tyler. Home births attended by direct-entry midwives are more common than those overseen by certified nurse midwives, according to the federal Centers for Disease Control and Prevention.

All states regulate nursing. Texas is one of 32 states that also oversee the practice of non-nurse midwifery. Five ban it outright. The profession is unregulated in the remainder.
Even in states that do regulate non-nurse midwives, standards and rules vary. Illinois allows only nurse midwives to oversee out-of-hospital births; Iowa lets anyone do it. Tennessee allows midwives to perform vaginal births after previous cesarean sections outside of a hospital; Alabama does not.

“You basically have 52 little countries, if you count Washington, D.C., and Puerto Rico,” said Kate McHugh, director of global outreach for American College of Nurse-Midwives.

The Garbaczes filed complaints with both the Texas Medical Board and the Department of State Health Services. In November 2014, medical regulators ordered Rozenboom to stop participating in obstetric care until she received additional medical training.

The state’s investigation into Cooper dragged on, during which time she continued to work as a midwife. It took nearly a year for regulators to file a notice of violation against her.

“The evidence proves overwhelmingly that (Cooper)’s conduct resulted in (Amanda)’s death,” the health department’s attorney wrote in requesting a two-year suspension of her license. “It is clear she simply does not have a good grasp of the most elementary of midwifery procedures.”

Cooper contended Amanda’s deterioration was sudden, and that her care was appropriate. She disputed the pathologist’s determination of Amanda’s cause of death and blamed it instead on a rare and unforeseen birth complication.

After one hearing, the Garbaczes said they were approached by another midwife who said she had information about Cooper. At her suggestion, they asked the Arkansas Department of Health for records of when Cooper worked in that state.

The documents showed that in 2010 Arkansas had suspended Cooper’s license after an investigation into a home birth the previous year. Cooper, whose last name then was Foster, had “endangered (her) client’s safety and welfare due to (her) gross negligence and non-compliance with the Lay Midwife Regulations,” a December 2010 memo stated. Cooper also had let her license lapse and did not try to reinstate it, a department spokeswoman said.

Records showed Cooper was first licensed in Texas in April 2009. Midwife licenses must be renewed every two years, meaning she would have submitted three more applications. It’s unclear if Texas regulators ever knew about or considered her Arkansas suspension.
Administrative oversight of the profession was moved from the Department of State Health Services to the Department of Licensing and Regulation in 2016; both agencies said they did not retain any of Cooper’s application or renewal records.

'It didn’t have to happen’

The Garbaczes set up a scholarship in Amanda’s name at the University of Arkansas. They also began contacting attorneys who might take on a malpractice case. Yet like many other states, Texas does not require midwives to carry insurance because the practice of assisting births is not considered medical care.

“I'm a contractor,” Matt Garbacz said. “I just build decks, and I've got to carry $500,000 in liability insurance. And here you are dealing with human lives, and you don't have to have any insurance? That's crazy.”

Without the promise of any meaningful recovery, the attorneys who promised to look into Amanda’s death dropped off one by one. Eventually, the Garbaczes gave up.

In February 2016, nearly three years after Amanda’s death, Administrative Law Judge Pratibha Shenoy concluded Cooper had accepted Amanda as a patient when she shouldn’t have, and she then failed to notice and act on clear signs of her patient’s deteriorating condition. “There were numerous signs of an impending emergency that (she) either missed or ignored,” the judge wrote.

An administrative opinion isn’t final until the regulatory board votes to accept it. Six months later, the Texas Midwifery Board suspended Cooper’s license for two years, adding that she could not reapply until she’d completed an education program that lasted at least that long. Cooper said she no longer is a practicing midwife.

Two weeks after that Matt Garbacz appeared in front of the Texas Department of Licensing and Regulation, which was preparing to take over regulation of midwives from the health department. He propped up a portrait of Amanda next to him and opened a small stenographer’s pad to consult his handwritten notes.

“This is the story of a terrible tragedy,” he said. “It didn’t have to happen.” He asked the board to consider a list of reforms that might spare others his pain.
Department of Licensing and Regulation spokeswoman Tela Mange said the agency has since adopted two of the family's recommendations: requiring midwives to disclose whether they carry malpractice insurance, and to describe in writing their plan in case of an emergency.

"Some changes were inspired by information presented by Mr. Garbach," she said.

"This is not an indictment of all midwives," Matt Garbach concluded. "But no one should have to go through the pain and suffering we've had to endure. I have a granddaughter who shares her birthday with the death of her mother."

*GateHouse Media's Emily Le Coz, Josh Salman and Lucille Sherman contributed material.*
Because Midwives take a Written National Examination, we will not have those statistics. We will have the number of Jurisprudence Examinations taken by month.

### FY 2019

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MIDWIFERY SCHOOL INSPECTION PROCESS

Field inspections is responsible for performing pre-license, provisional, and periodic inspections for 11 of the agency’s 39 programs, including school inspections. We are organized into three regions with inspectors throughout the state. Joe Carrasco, North Region Manager will head up the inspection process for this program. Field Inspections staff is working with Exams and Education, Regulatory Program Management, General Counsel and Enforcement to document an inspection reference guide for provisional licenses.

PERSONNEL UPDATES

Separations
Quang Hoang, Field Inspector for the East Region, resigned, effective November 30. We wish Quang the very best in his future endeavors. A posting for Field Inspector in the North Houston area closed on December 12, 2018. A new hire is expected to begin after January 10.

New Hires
We are happy to announce that the North Region has a new field inspector. Don Morefield has accepted our offer for Field Inspector in the DFW area. His first day was January 3 and is currently in training.
Case Highlights
Morgan E. Crowson, MID20180011302 – On August 22, a Default Order was entered against the Respondent, assessing an administrative penalty of $2,000 for acting as a midwife without a license, in violation of TEX. OCC. CODE 203.002(6) which states “Midwife” means a person who practices midwifery and has met the licensing requirements established by this chapter and commission rules.

Current Projects
On November 14, met with the Enforcement Workgroup of the Midwives Advisory Board to discuss the division’s procedures for investigating and resolving midwifery cases, and how we incorporate health-related expertise into the process. Staff discussed how we utilize the penalty matrix to identify potential standard of care violations, the role of the expert witness in these types of cases and provided an overview of the expert witness training. The advisory board members appointed to this workgroup are Meredith Rentz, Brenda Buffington, and Janet Dirmeyer.

Key Statistics
Shown below are key statistics for the Midwives program and for all TDLR programs combined through November of Fiscal Year 2019.

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