

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: KRISTINA GRACE ZITTLE, C.P.M., L.M.
License No.: 0129-000032

ORDER OF SUMMARY SUSPENSION

Pursuant to § 54.1-110 of the Code of Virginia (1950), as amended ("Code"), a quorum of the Virginia Board of Medicine with a member of the Advisory Board on Midwifery ("Board") met on September 9, 2008, by telephone conference call after a good faith effort to convene a regular meeting of the Board failed.

The purpose of the meeting was to receive and act upon information indicating that Kristina G. Zittle, C.P.M., L.M., may have violated certain laws and regulations relating to the practice of midwifery in the Commonwealth of Virginia, as more fully set forth in the Statement of Particulars, which is attached hereto and incorporated by reference herein.

WHEREUPON, pursuant to its authority under § 54.1-2408.1 of the Code, the Board concludes that a substantial danger to the public health or safety warrants this action and ORDERS that the license of Kristina G. Zittle, C.P.M., L.M., to practice midwifery in the Commonwealth of Virginia be, and hereby is, SUSPENDED. It is further ORDERED that a hearing will be convened forthwith to receive and act upon evidence in this cause, and that the Executive Director of the Board shall be authorized to execute this Order and all other documents, notices, and Orders on behalf of the Board necessary to bring this matter to hearing.

Upon entry of this Order of Summary Suspension, the license of Kristina Grace Zittle, C.P.M., L.M., will be recorded as suspended and no longer current.

Pursuant to § 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD



William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

ENTERED: 9/9/08

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**IN RE: KRISTINA GRACE ZITTLE, C.P.M., L.M.
License No.: 0129-000032**

STATEMENT OF PARTICULARS

The Virginia Board of Medicine ("Board") alleges that:

1. Ms. Zittle may have violated Sections 54.1-2915.A(3), (13), (16), and (18) of the Code, and 18 VAC 85-130-120 of the Board of Medicine Regulations Governing the Practice of Licensed Midwives, in that she provided negligent pre-natal, intra-natal and intra-partum care to Patients A and B, including failure to transfer care of Patients A and B to, or consult with, other appropriate healthcare providers at critical points when the circumstances became unsafe for these patients and their unborn infants and exceeded Ms. Zittle's ability to provide safe care. Specifically:

A. With respect to Patient A, a 25-year-old female in her third trimester of pregnancy who presented to Ms. Zittle for initial evaluation on January 4, 2008, seeking a midwife-assisted home birth subsequent to having received obstetrical care at a medical facility:

i. Ms. Zittle failed to recognize that Patient A was an unsuitable candidate for home birth in light of the multiple high risk factors with which she presented. Specifically, Patient A was morbidly obese, had failed a one-hour glucose tolerance test for gestational diabetes performed earlier in her pregnancy by another practitioner, failed to follow Ms. Zittle's recommendation to obtain a 3-hour glucose

tolerance test or a Group B strep test, and was a known Group B strep carrier in a prior pregnancy.

ii. Ms. Zittle did not obtain a comprehensive medical history of Patient A at her initial visit and did not obtain medical records from her previous treating gynecologist/obstetrician or other healthcare provider. Ms. Zittle treated the patient for approximately three weeks without obtaining the patient's previous medical records despite statements to a Department of Health Professions Investigator that she would never accept a new client without receiving a copy of their previous medical records.

iii. Ms. Zittle changed the estimated March 8, 2008 delivery date determined by Patient A's previous practitioner to February 15, 2008, even though the prior provider confirmed the March 8th estimated delivery date with an ultrasound and Ms. Zittle did not obtain an ultrasound confirming her estimated delivery date. Ms. Zittle's change in the estimated delivery date was based solely on information provided to her by Patient A, fundal height measurements, and external palpation assessing gestational size. Based on the March 8, 2008 estimated delivery date, the January 23, 2008 labor would have required immediate transfer to a hospital for delivery as it was below Ms. Zittle's established cutoff for a planned home delivery.

iv. Ms. Zittle continued to provide care to this patient despite the patient's refusal of the 3-hour glucose tolerance test and despite the patient reporting to her that her 1-hour result was a 169, necessitating follow up care and treatment. Although Ms. Zittle produced a log of sugar levels that included results of up to 110, the patient reported to staff at the

hospital that her blood sugars were variable during the pregnancy and that some levels were over 120 when monitored. Further, Ms. Zittle misled the treating physician during the emergency hospital visit in that she reported obtaining a 3-hour glucose tolerance test to include identifying the lab that supposedly processed the test results. Ms. Zittle reports that the patient's minimal weight gain was calculated in the decision to assist in a home birth despite concerns related to gestational diabetes; however, the patient reported weight gain of up to 50 pounds during the pregnancy when providing medical information at the hospital.

v. Ms. Zittle failed to take appropriate and timely action when Patient A informed her via telephone at approximately 9:30 p.m. on January 23, 2008, that she had experienced spontaneous rupture of membranes. Specifically:

a. Ms. Zittle failed to recognize the need to transfer Patient A's care to another appropriate healthcare provider due to possible prematurity. According to Ms. Zittle's recalculated delivery due date, Patient A was only 36 weeks and six (6) days and, according to her original due date of March 8, 2008, she was over six weeks early.

b. Ms. Zittle waited over 12 hours from the report of spontaneously ruptured membranes, until approximately 10:00 a.m. on January 24, 2008, to check Patient A in her office. At that visit, Ms. Zittle determined that Patient A's membranes had ruptured and that she was not in labor, but failed to perform a vaginal examination. Instead of transferring Patient A's care to another appropriate healthcare provider to induce labor or take other

appropriate action, Ms. Zittle provided Patient A with two homeopathic substances to be taken every 15 minutes to soften the cervix and start contractions, and instructed Patient A to go home. Patient A did not begin contractions until 6:45 p.m. that evening (January 24, 2008) and did not deliver until 6:42 a.m. on January 25, 2008. Consequently, approximately 33 hours elapsed between Patient A's spontaneous rupture of membranes and delivery, a significant time interval during which the risk of infection was increased and not addressed with antibiotic treatment or other appropriate intervention.

vi. In lieu of transferring Patient A's care to a healthcare provider who could administer antibiotics during labor and delivery to address the patient's potential status as a Group B strep carrier, Ms. Zittle instructed Patient A's husband, an unlicensed individual, to administer a chlorhexidine vaginal flush in conjunction with a vaginal examination prior to her arrival at the patient's home around 9:40 p.m. on January 24, 2008, to attend the labor and delivery. Further, Ms. Zittle did not perform a vaginal examination of Patient A until 12:30 a.m. on January 25, 2008, approximately six hours after contractions began and approximately 27 hours after the spontaneous rupture of membranes, at which time Ms. Zittle incorrectly identified the presence of a nuchal hand.

vii. Although a vaginal examination at 5:02 a.m. on January 25, 2008 revealed Patient A to be 8 centimeters dilated with the foot, thigh, and shin of the left foot presenting, Ms. Zittle failed to recognize the emergent and potentially dangerous nature of this footling breech presentation and did not transfer Patient A to the

hospital. Even though Ms. Zittle had never before performed a breech delivery, she opted to continue with a home delivery after obtaining the parent's informed consent to do so. However, the informed consent to a home vaginal breech delivery signed by Patient A and her husband did not specify stillbirth or death of the baby as a risk of such a delivery.

viii. Delivery of Patient A's infant began at approximately 6:06 a.m., when the left foot delivered. Notwithstanding the fact that Ms. Zittle was attending a breech delivery, she did not physically intervene to assist the delivery of the infant until approximately 6:35 a.m., when the pulsating umbilicus emerged and Ms. Zittle used her right hand to prevent cord compression. The infant's buttocks emerged at 6:22 a.m. and by 6:38 a.m. the chest, only to the nipple line, had cleared the cervix. Although Ms. Zittle subsequently noted that the umbilical pulse was getting weaker and, at 6:40 a.m., documented the absence of a fetal heart rate, she did not initiate a 911 call until after the infant was born at 6:42 a.m. in a lifeless condition. At delivery, Ms. Zittle noted the infant to have a gray body with purple/blue extremities, and no grimace, response, movement, or respiratory effort. Apgars were 0 at both 1 and 5 minutes. Ms. Zittle immediately began performing DeLee suction of the mouth, then nose, and began performing CPR, which she had never performed before on an infant.

ix. An autopsy on Patient A's infant revealed that the liver had ruptured, spilling 55 cc's of blood into the abdomen, and also that the infant was positive for Group B strep infection. The Medical Examiner who performed the autopsy stated that the condition of the liver indicated that the infant had been breech for some time; that the

rupture had developed over time, most likely from being pressed against Patient A's hard pelvic floor; and that "a c-section would have been life saving in this case."

B. With respect to Patient B, a 42-year-old female who presented to Ms. Zittle for initial evaluation on December 27, 2007, at approximately 16 weeks gestation, seeking a midwife-assisted home birth:

i. Ms. Zittle failed to recognize that Patient B was an unsuitable candidate for home birth in light of the multiple high risk factors with which she presented. Specifically, Patient B was morbidly obese, had previously delivered two macrosomic infants in the 1980's, was Rh negative, and was 42 years old, an advanced maternal age known to present potentially increased risks and complications. Ms. Zittle further failed to recognize that she was not a suitable healthcare practitioner to provide Patient B with home delivery services in that Ms. Zittle lived over 45 minutes away from Patient B, and consequently could not arrive at Patient B's home in a timely manner in case of an emergency.

ii. Ms. Zittle failed to recommend or request a follow-up ultrasound or to take other appropriate action subsequent to an ultrasound performed at approximately 27 weeks gestation on March 7, 2008, which indicated Patient B's infant was in breech presentation and recommended continued follow-up. Despite this information, Ms. Zittle did not order another ultrasound to determine the infant's position closer to Patient B's estimated delivery date, and instead determined that the infant was in a head-down position based solely on external palpation that she performed on Patient B on or about June 5, 2008.

iii. Ms. Zittle failed to respond in a timely fashion to Patient B's report of the loss of her "plug" at 1 a.m., commencement of contractions at approximately 4:00 p.m. and the intensification thereof around 10:00 p.m. on June 9, 2008, in that she did not leave to go to Patient B's home to attend her labor and delivery until approximately 12:34 a.m. on June 10, 2008, notwithstanding the 45-50 minute drive anticipated to Patient B's home and the fact that Patient B was located approximately 17 miles from the nearest hospital and lacked transportation at that time.

iv. Upon being advised by Patient B via telephone around 11:00 p.m. that she was moving to a birthing tub to continue her labor, Ms. Zittle did not advise Patient B to refrain from such action even though it was against Ms. Zittle's policy to have a patient enter the birthing tub prior to her arrival due to the possible adverse effects water can have on the progress of labor and delivery. Further, Patient B's position in the birthing tub subsequently proved an impediment to her transfer to an ambulance for transport to the hospital.

v. En route to Patient B's home, after Ms. Zittle was aware that Patient B was in the midst of a footling breech delivery, EMT personnel informed Ms. Zittle by telephone that Patient B's infant had been delivered up to the chest but they were unable to further deliver the infant. Notwithstanding this information, Ms. Zittle instructed EMT personnel not to take Patient B to the hospital, but instead to assist Patient B in delivering her infant at home in the birthing tub. Ms. Zittle also instructed EMT personnel to wait for her arrival, estimated to be approximately 30 minutes later, before transporting Patient B to the hospital.

vi. After transport to the emergency room by EMS, at approximately 1:37 a.m., June 10, 2008, Patient B delivered an infant with a distended abdomen and without respiration, color, movement, or a heartbeat, who was pronounced dead. Additionally, the umbilical cord lacked blood and the placenta was meconium stained indicating that the infant was in distress for several days prior to delivery. The cause of death listed on the death certificate was umbilical cord entanglement and compression subsequent to breech delivery.

2. Ms. Zittle may have violated Sections 54.1-2915.A (1) and (16) in that after being licensed in the Commonwealth of Virginia, Ms. Zittle continued to practice in Commonwealth of Pennsylvania and acknowledged that said practice was "illegal" while continuing to advertise that she offered services in that jurisdiction through August of 2008. Specifically, in a February 2008 interview with an investigator for the Department of Health Professions, Ms. Zittle admitted to attending an unlicensed delivery in Pennsylvania in December of 2007 and to having a pregnant client in Pennsylvania that she planned to return to deliver the baby.

Please see Attachment I for the identity of the patients listed above.

FOR THE BOARD



William L. Harp, M.D.
Executive Director
Virginia Board of Medicine

DATE: 9/9/08