From: John\_Krauser@baud.matra.com.au (John Krauser)

Subject: Global Witch Hunt

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Reprinted from 'The Lancet' - vol 346 -- article on the world-wide opposistion to Independent Midwives and Domiciliary Birth Services (home-based materntiy care).

**A Global Witch-Hunt**

**Marsden Wagner, MD**

Five years ago a midwife working in the University hospital in Uppsala, Sweden, told the chief of obstetrics that she was going to assist occasionally at home births. Although he was angry, he could not stop her since home births attended by a midwife are not unlawful. Nevertheless, the pressure from the hospital doctors became so unpleasant that, after a while, she felt she had no option other than to resign from her hospital post. Her independent practice flourished, although she was unable to get any local doctor to back her up or even give her occasional advice. She was denied hospital privileges and was unable to follow labouring women to hospital if the planned home birth needed transfer. She had no perinatal deaths and encountered no problems with the families she served. Yet in 1994 the chief of obstetrics asked the local government authority to investigate her practice.

There is a global witch-hunt in progress - the investigation of health professionals in many countries to accuse them of dangerous maternity practices. This witch-hunt is part of a global struggle for control of maternity services, the key underlying issues being money, power, sex, and choice. The investigation often leads to a public court, a medical review board, or a health insurance review board. Over the past 10 years I have been asked to consult, and in some instances testify, in twenty cases in ten countries - a very small proportion of the actual cases. In the USA alone: "Though no one knows how many out-of-hospital midwives have actually been charged, we have reports of legal altercations involving more than 145 out-of-hospital midwives in 36 states"

Whilst the profession of the accused in my twenty cases includes obstetrics

(Austria, Italy, UK), general practice (Australia, New Zealand), and

midwifery (Canada, France, Germany, Italy, Sweden, UK, USA), the striking

thing is that, of the accused, 70% were midwives and 85% were women.

Bringing a health professional before a court of review board is the last and

most extreme sanction for professional deviances. In the cases I am familiar

with, other sanctions have included loss of hospital privileges (Australia,

Canada, France, Italy, Sweden, USA), refusal of insurance companies to

provide malpractice insurance (USA), and refusal of insurance companies or

governments to reimburse certain practices such as home births or alternative

birth centres (Australia, New Zealand, Germany, USA).

In the twenty cases, all of the accused have one thing in common; at least

some of their practice is not mainstream. In other words, what they do is not

what the local doctors in authority most commonly do. For example, of the

twenty accused, fifteen practised home births, three practised in alternative

birth centres, and two were doctors in hospital practice. All of the midwives

were in independent practice. Orthodox maternity care providers are seldom

brought to review boards but, in the USA and Britain, over 70% of

obstetricians have been sued one or more times by parents. Unorthodox

providers are rarely sued by parents but are now being brought to review

boards or public courts by the medical establishment.

Irrespective of the country, certain methods are commonly used by the

obstetric establishment to accrue evidence against the accused. For example,

in most cases, the doctors notify the legal authorities only after a

perinatal death. One death, even if not preventable and not the result of any

mistake, suddenly negates years of impeccable statistics. This is in stark

contrast to what happens when an orthodox doctor is involved in a perinatal

death in the hospital - there may be a hospital review committee meeting

behind closed doors but it will not come to the attention of the public or

legal authorities. After 25 years of successful practice, an obstetrician in

Rome who favours the Laboyer approach had a perinatal death. She was

immediately sued after other doctors told the family that the death was due

to the "soft" methods used at birth. 10 years ago midwifery was illegal in

Canada but the obstetricians knew there were a few midwives managing home

births. The medical establishment waited until there was a death during a

home birth in Toronto, and then immediately went to the provincial prosecutor

claiming it was a preventable death.The midwife who assisted at the home

birth was taken to court.

Another ploy is to scrutinise obstetric patients records connected with the

accused looking for possible mistakes. This method was used against doctors

in London, Vienna, and Melbourne. With midwives, a common method is to accuse them of practising medicine without a license. Sometimes local

law-enforcement officers (police) will arrest the accused individuals, search

their records, cause them to spend money on legal assistance, and then just

before the court date, drop the charges. Such a strategy creates fear in all

those in that community who might deviate from orthodox practice.

Once the case is brought before a court or review board, other methods are

commonly adopted. Threats may be used to pressure local doctors who are

perceived to be sympathetic to the accused so they will be too afraid to

testify. A local doctor in the Toronto case mentioned above informed me that

he was told he would lose his hospital privileges if he testified on behalf

of the accused midwife. Because the defence lawyer in this case could not

find a local doctor to testify, the lawyer turned to me because I am a

physician and perinatal scientist with many years experience as a specialist

in maternity services in the World Health Organisation.

The local professor of obstetrics usually testifies for the prosecution, and

the testimony is based on what the professor believes to be acceptable

practice rather than on the scientific evidence. Attempts are made by the

prosecution to prevent outside experts from testifying. For example, a judge

in a court in Vienna would not allow me to testify because I was a

"foreigner", and in Sicily a judge would not allow me in the courtroom except

when I gave testimony for the defence, although a local professor of

obstetrics, who testified for the prosecution was allowed in the courtroom at

all times. Moreover, tribunals, especially if they are medical or insurance

review boards, usually try to forbid the public or media from being present.

In London in the 1980s. Mrs Wendy Savage, an obstetrician, caused an enormous

upheaval when she demanded - ultimately successfully - a public hearing.

The results of these cases have been mixed. The circumstances of the trial

affect the chances that the accused will win the case. The accused who comes

before a public court with a jury has the greatest chance of winning. The

chances are progressively less with a public court with a judge, then a

medical review board open to the public and the media, and finally a closed

medical review board. If the accused is allowed to bring in experts to

testify, including those from other countries, the chances of winning are

higher. If the case has media coverage and the accused has visible media

support, again there is a better chance of winning, as was the case with Mrs

Savage and the California and Toronto midwives.

If the accused loses, that often means losing the possibility, at least

temporarily, of continuing to practise. Apart from the great personal losses

entailed there is an impact on the health professionals. Midwives in that

country feel threatened in their independent practise rightly fearing loss of

medical backup and/or hospital privileges. Doctors are afraid to support

midwives or to go along with the wishes of their patients when the requests

are outside mainstream policy - eg, water births. Women in that community

therefore lose the freedom to choose among a broader set of options for

giving birth.

Conversely, investigation of independent midwives and unorthodox doctors,

with a possible board hearing or court case, can sometimes have the opposite

effect, leading to solidarity among midwives and between midwives and

unorthodox doctors, and women, irrespective of whether the accused wins or

loses. The trial of the midwife in Toronto began with a process which

resulted in the eventual legislation of midwifery in the province of Ontario.

Similarly, the case of Mrs Savage in London brought about a re-examination of

the medical review board system. In a case I was involved with in California,

the state board of medical quality assurance recruited the local police to

assist them in organising an entrapment operation, arrested a breastfeeding

midwife, took her infant away, and threw her in jail because a local

obstetrician accused her of practising medicine without a license. In another

case, as reported by Korte,' "In 1994, the 13-year-old daughter of a

California midwife was kept on the floor at gunpoint while law enforcement

personnel searched for evidence of a midwifery practise." Such harassment and

many trials of midwives in California eventually led to new state legislation

strengthening midwifery.

Nevertheless, there is no apparent slowing of the global witch-hunt. In the

1980s, the German society of Obstetrics and Gynaecology demanded that their

government abolish the law requiring the presence of midwives at all births,

and in 1990 the same society wrote to their national government demanding

that home births be outlawed. This plea failed and the society has now turned

to Lander (state) governments with the same demands. In 1994, there were

attempts in France to forbid independent midwives from entering the hospital

when a home birth patient had to be transferred. Last year also saw the first

attempt in Sweden to bring an independant midwife to tribunal.

The witch-hunt is part of a global struggle for control of maternity systems

and there are several key issues, one of which is economic. An obstetrician

in private practise in Des Moines, USA, told me that he and the other

obstetricians in that city were determined to close down the only alternative

birth centre, staffed by midwives, because "it is stealing our patients"

(Shortly after this remark, the only doctor in the city willing to back up

the alternative birth centre retired and, since no other doctor would provide

such support, the centre had to close.) As birthrates fall, the competition

for pregnant patients increases, especially in countries largely reliant on

private medical care; and as more and more countries move towards pluralistic

health care systems with private practice, maternity care becomes more

competitive.

However, in the face of increasingly limited economic resources, governments

and insurance companies are becoming more and more concerned with the waste

associated with high-technology, high-intervention obstetrics. It is much

more difficult for obstetricians to defend this expensive type of practice

when midwives and a few doctors are meanwhile showing that a much less

expensive type of maternity care is equally safe. The witch-hunt is an

attempt to display lack of safety among the competitors.

A second issue is the control of maternity services. Until recently,

government regulations in most countries have given medical doctors a

monopoly in providing health services. Medical licensure represents "a social

tolerance for a monopoly in return for a promise of social benefit in the

form of competent and dedicated medial care".' But this monopoly can easily

be abused, especially behind closed doors. The issue becomes one of peer

control versus accountability to the public. In medical board reviews of

professional behaviour, if the medical profession can make secret judgments

on the accused, the doctors have absolute control of their monopoly, and

there is the possibility of abusing the system for professional gain.

On the other hand, in a public court in which a judge makes the final

decision, there is a danger that the judge, as part of power elite in the

community, will be more influenced by another member of the same elite-the

local professor- than by a midwife or even by outside scientific opinion.

From my experience in the courtrooms in Sicily and Vancouver, where the judge

made all decisions, the judge and the local professor of obstetrics

testifying for the prosecution in both places made no attempt to hide that

they knew each other well and that they shared their annoyance that the

defence had brought in a foreign expert. But if the public court uses a jury

to make the final decision, there is a greater possibility that the midwife

or outside will be listened to. There is a great difference between

unorthodox doctors and midwives being judged by orthodox doctors and judges

or being judged by the public - and that is why it is so important to have a

medical review board open to the public.

Fortunately the pendulum is swinging, at least in some places, with the

coming of quality assurance systems that include public accountability of

health care and health care professionals. Maternity services are in the

forefront of the controversy over peer control and public accountability

because birth, like death, is a deeply personal social and family event and

does not fit the doctors disease model. So today the medical monopoly of

maternity services is coming into question and the witch-hunt is one means of

reasserting the orthodox doctor's control.

Choice and freedom for health care consumers are at issue here. In the USA

and UK, consumers of health care have been asserting themselves for some

time. The health consumer movement is slowly coming to continental Europe but

it is still almost non-existent in central and eastern Europe. This lack of

freedom of consumer choice is illustrated by a statement in an article about

home birth, published in 1994 in a German journal of obstetrics and

gynaecology: "It remains to be tested in law whether the infant has legal

claims, independent of the mother, to the best possible standard of safety in

obstetrics." 'The claim is made that the obstetrician must protect the best

interest of the fetus by overriding any woman's choice not approved by

orthodox obstetricians. As pluralistic health care systems increase in

Europe, so will consumer choice; the witch-hunt is one way of limiting that

freedom of choice.

Choice and freedom for healthcare providers are also at stake here. There is

considerable peer pressure to conform because deviations may threaten the

legitimacy of supremacy of a standard of practice based on opinion rather

than evidence. It is no coincidence that 90% of the accused in my sample were

involved in homebirth or alternative birth centres. It is important to

distinguish between the quality assurance function and the witch-hunt

function so that the courts are not inappropriately used for professional

gain. When making that distinction in a particular case, think about who

might gain from a successful prosecution; is the evidence brought against the

accused scientifically based ?

Whilst tribunals may have a declared function to weed out true incompetence

and protect the public in the cases I describe the real function was to

punish deviant professional behaviour that could threaten the income,

practise style, prestige, and power of mainstream doctors.

For example, the time and effort spent recently by the California state board

of medical quality assurance trying to prosecute independent midwives might

have been better spent pursuing incompetent doctors. A recent review of state

medical boards in the USA showed that most states have a long way to go

before "they are even beginning to seriously protect their residents from

doctors who are incompetent, sexually abuse patients, or otherwise have

serious problems that interfere with delivering high-quality medical care in

a compassionate way"

Another issue is the two-hundred-year-old struggle of doctors to control

midwifery. It is no coincidence that 70% of the accused in my sample are

midwives, all in independant practice where they are not under the immediate

control of doctors. Fear of being investigated by authorities is a strong

deterrent to independent midwives.

Solutions begin with increasing the public's awareness of the witch-hunt and

its basis in political not medical issues. As quality assurance systems

develop in health care, public accountability must be built in. There should

be no closed doors in health policy making, in health service delivery, or

when the behaviour of health professionals is being judged. The evaluation of

professional behaviour must be based on deviations from practice based on

scientific evidence rather than on deviations from peer-controlled opinions

of what constitutes good practice.

Marsden Wagner, MD

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|  | Please write to me  Faith Gibson at  [goodnews@best.com](mailto:goodnews@best.com) |
| home page [GoodNewsNetWork](http://docs.google.com/index.htm) | |