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## Intuition and the Emergence of Midwifery as Authoritative Knowledge

One of my first teachers in midwifery was a wonderful family doctor who told me that it was vital to pay attention to what mothers had to say about their babies. My doctor friend had not learned in medical school to place such value on mothers' intuitions; he had learned this from his mentor, an older physician whose practice he took over after a period of apprenticeship. "If a mother thinks there is anything wrong with the baby," he said, "believe her and check it out, even if you can't find anything wrong. She's almost always going to be right." A few months later I made a routine postpartum visit with a mother and her day-old son. Although the baby had been in good condition at birth and was nursing well, the mother told me something about him just wasn't right. We took the baby to a pediatrician for a more thorough examination, which revealed that he had an abnormal kidney condition requiring surgery. The mother's rational mind in this case had told her the baby was doing well, but she had not been able to shake the feeling that something was wrong.

I had already learned from my own first birth a few years earlier that my intuition was sometimes more trustworthy than the accepted obstetrical knowledge about pregnancy and birth of the United States in the mid-1960s. I had gone through that pregnancy assuming that I would have no trouble giving birth because my body had never failed me before. There was almost no reading material available about birth at that time, so I had no idea that approximately one-third of American women, including most first-time mothers, had forceps deliveries, and that large episiotomies were mandatory. My obstetrician told me I was to gain no more than 12 to 15 pounds during the entire pregnancy, so I dieted the whole time to avoid his scoldings. I was shocked when, two days before I went into labor, he told me that I must have spinal anesthesia and forceps for this birth because the baby, being my first, risked being brain-damaged if she was to be born without these interventions. It was the first time I had experienced a clash between my intuition about my own abilities and the prevailing knowledge of medical authorities, and I had no idea how to deal with the difference. Despite my arguments the doctor did the episiotomy, forceps delivery, and spinal anesthesia, and I was left believing that my baby and I had been subjected to unnecessarily harsh treatment. I knew that forceps sometimes caused brain damage in babies, so the fact that my daughter and I both survived the experience without prolonged physical trauma did not convince me that the doctor had been right.

My sense of rebellion against authoritative knowledge in obstetrics was strengthened when I later met several couples who decided to give birth at home because of experiences similar to mine. Hearing their stories and seeing their healthy babies gave me the affirmation I needed to reject the conventional view

that home birth was dangerous and irresponsible and that doctors always knew more about women's bodies than women did. For the first time in my life I began to hear the word *midwife*. It wasn't long before I began to attend home births. I later had my three youngest children at home attended by midwives. Even though each of these children was significantly bigger than my first baby, I gave birth without anesthesia, episiotomy, perineal laceration, or forceps. Because of these experiences and countless stories I was told by the women I cared for during pregnancy or birth, I read medical literature with a mixture of open-mindedness and skepticism. Some of the information I got from medical texts was valuable and lifesaving. Some of it was superstition; I began to label such stuff "old doctors' tales."

I have intensely clear memories of certain labors I attended at our birth center or at mothers' homes during my early years of practice when intuition led me or one of my partners to suggest a new technique, practice, or posture that was not mentioned in the obstetrics books of the time. Our techniques were well enough developed early on that our cesarean section rate has remained below 2 percent and our forceps and vacuum extraction rates below 0.5 percent for over 2,000 births. I learned from watching a few couples do what came naturally to them that smooching sometimes helped alleviate pain and pressure during labor. Almost invariably, these were the mothers who seemed to have the least pain in labor. Quite often a hunch occurred during a long labor and helped a woman give birth when she had previously been "stuck." Such a birth typically involved a first-time mother who was scared or exhausted, and the solution presented itself as an idea that at first seemed wild but compelling. I remember the labor of a petite woman who became exhausted during the pushing phase of labor. Although the baby's head was visible, she no longer had the strength to push it down farther. I voiced the wish that she were standing up and pulling on something above her head. Her husband then tied a thick nylon rope to the beam above their bed, which she pulled as she pushed the next few times. Her son was soon born with no problems. Another time I was attending a first-time mother who was having trouble relaxing as her labor intensified. I had a sudden impulse to convince her to stand up and swing her hips around in time to music. The suggestion worked dramatically, and the technique soon became part of the knowledge shared by the women of my community. Several years later I read of midwives in other times or places who similarly invited women to dance when they were having a long and difficult labor, and saw drawings in a 100-year-old medical book of the rope-pulling technique for difficult births (Engelmann 1883).

It seems that the kind of intuitive flashes I have described develop from being with many women continuously during labor. I believe that the subconscious mind is able to pick up signals too subtle to be perceived by the conscious mind, and that the mind can apprehend the gestalt, which may then surface in the form of an intuition, a hunch, or a dream. It should not be surprising that a deep level of insight about the subtleties of the labor process can come to the practitioner whose presence during labor is uninterrupted—particularly when the practitioner is a woman who has herself experienced birth. The doctor, nurse, or midwife who has been with laboring mothers only intermittently is likely to have very different ideas (more mechanistic, usually) about how labor works.

U.S. obstetrics has changed a great deal since 1970, when the cesarean section rate was only 5.5 percent. No longer do a third of American women have forceps deliveries; now, one-fourth have cesarean sections, and many more have their babies by vacuum extraction. The two hospitals close to our birth center in central Tennessee have cesarean section rates over 39 percent. So few U.S. obstetricians have the training to safely attend vaginal breech or twin births that the resulting loss of manual skills has been frequently mentioned in their own journals. Routine use of ultrasonography has replaced touch in diagnosis, to the point that many obstetricians can no longer reliably assess the size or position of a baby, the size of a woman's pelvis, or the strength of contractions without the use of machines. Having babies by virtual reality presents the same problem as having sex by virtual reality; in the end, you are not really there.

Addiction to machine knowledge endangers social behavior that has enabled our species to survive for millions of years. Knowledge of the benefits of breastfeeding and bonding is lost, as is the understanding that good nutrition can prevent problems in pregnancy, labor, and birth. It is encouraging that social scientists are beginning to take notice of how quickly machine worship is replacing older hands-on knowledge on a global scale. We must ask if the pleasure experienced by pregnant women, doctors, and the ultrasonography industry is worth the knowledge and social skills lost when a large percentage of women have their babies surgically removed from their bodies. Nations must be educated about the personal, social, and medical costs of overly high cesarean rates (Wagner 1994). Billions of dollars are involved when cesarean rates are doubled in developed countries. Eugenia Georges's article illustrates well how a system of socialized medical care may be just as susceptible to commercial interests as a profit-based system like the one in the United States.

Carolyn Sargent and Grace Bascope's discussion of birth at Victoria Jubilee Hospital in Kingston, Jamaica, vividly demonstrates how dangerous it is for a society to put all of its eggs in the cultural basket of progress, under the mistaken impression that the artifacts of the technological birthing system of the hospitals will always be there. When, in hard economic times, hospitals in cities become dangerous places in which to give births, it might take quite some time before people catch on that they could be safer at home. I visited Moscow in 1989 and saw a situation similar to that described by Sargent and Bascope: mothers sometimes labored in filthy beds in crowded wards where, even in the age of HIV, needles and gloves were recycled. Despite the danger, almost no one chose to give birth at home, because any useful knowledge about pregnancy and childbirth that once existed among the members of the society had long since been destroyed. During the 21st century it is likely that urban societies will have to relearn means of survival from rural societies, where hospitals are few and far between and people depend on their own resources. Those who find themselves helpless because of machine addiction will have to return to their senses, and midwives will be some of the most important leaders in rediscovering forgotten survival skills.

Amara Jambai and Carol MacCormack's article about maternal health, war, authoritative knowledge, and the role of religion in the Pujehun district of Sierra Leone is noteworthy for several reasons. The Western-trained medical officers (who respected the knowledge and insights of traditional midwives but also noticed

an area—prevention of neonatal tetanus—where they needed improvement) have demonstrated how to achieve synthesis when there is a clash between the authoritative knowledge of distinctly different systems. This culture's ingenious way of transmitting women's secret knowledge through song is instructive, and it is heartening to read how quickly training programs can be organized, and culture transmitted, even in the harsh conditions of refugee camps close to war zones.

All over the world traditional cultural wisdom about pregnancy and childbirth is threatened as childbirth is moved into hospitals and midwives are made responsible to institutions rather than to their communities. I believe that the growth of a strong and independent midwifery profession that works to limit the use of technology to those cases where it is appropriate will be an essential ingredient of sustainable lifestyles of the future.

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