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Authority and Authoritative Knowledge in American Birth

The questions “What is authoritative knowledge in the obstetric setting?”; “Who possesses the information on which action is based?”; and, more importantly, “Who should make the decisions in the birth place?” are the topic of this remarkable series of articles. It is commonly accepted that, as a practicing obstetrician in the United States, I am an authority in the realm of birth. I have training in science and technology that allows me to manipulate the tools of modern medicine. This ability has come to be the accepted standard for bringing new human life into the world here in the United States and increasingly in the rest of the world. I, along with my colleagues, create the “standards of care” that become the basis of legal actions that control physicians and midwives, profoundly affect women in birth, and have trapped us in a model of childbirth that is unhealthy and destructive.

An undercurrent of distrust for biomedical authority, whose hegemony is spreading worldwide, runs through all these articles. I share this distrust. I also know that I am often asked to apply biomedical technology when less invasive techniques would produce a better outcome. The key question to be considered here is, “If science and technology are not the best sources of authoritative knowledge, who then should be in control and what knowledge should be considered authoritative in decisions made in the birthplace?”

Trevathan proposes that physiological changes in the birth canal, brought about by bipedalism, caused rotation of the infant’s body to face away from the mother’s reach, a change that necessitated the presence of a birth attendant. The introduction of a need for a birth attendant, I believe, also created the basis for the current power of the technomedical model in childbirth. When it became necessary to have an attendant, it also became necessary to have some way to signal the mother that birth was near and that she should seek out safety and help. The signal had to be something no woman could ignore. That signal is *pain*. No other normal body function is accompanied by pain. Only when there is pathology does the body signal us with pain: “Stop walking on your foot! There is a piece of glass in it.” “Stop running! You are about to have a heart attack.” Pain in labor is different. It exists primarily to signal the mother that she needs to find shelter and get someone to help her, and it is very effective. Even women who are in denial about the very presence of their pregnancy will arrive at the emergency room complaining of belly pain. (It is interesting to wonder whether the pain would be so intense in modern childbearing if the signal did not have to be so strong to get women to listen to their bodies.) Pain has also been the major hold doctors have had on women in childbirth. Early in the course of physician management of birth, techniques such as forceps, operative delivery, blood transfusions, and antibiotics were developed to save the

mother or baby. As the general health and nutrition of women improved, the risks necessitating these interventions became less frequent. Indeed, I wonder if they would have been frequent enough to keep the physician's place in the birth room if it hadn't been for the introduction of anesthesia. Even the brief resurgence of the natural childbirth movement in the 1960s and 1970s ultimately failed due to the development of forms of anesthesia that allowed the mother to be awake and to participate without feeling pain.

But these advances have not been without a price. The incidence of cesarean delivery has reached levels that are alarming to almost everyone. The need for more technological intrusion when anesthesia is given (IVs, monitoring of the mother and infant, more frequent intrusions by the nursing and medical staff, and a higher chance of forceps and cesarean delivery) continues to reinforce the belief that hospitals and doctors are a necessary part of safe modern obstetrics, and robs birth of its social, sexual, and spiritual significance. Women have gradually given over their own authority in birth to the authority of technomedicine, leaving themselves powerless to affect their circumstances in ways that, I have come to believe, are key to safe and normal birth. For example, a woman who gives up her authority becomes powerless to make decisions about where to give birth, what positions to adopt, how best to nourish herself during labor, when to push and when to rest, and so on. Such decisions will affect her physical ability to birth her child. In other words, to give up one's authority in birth is to decrease its safety.

As documented by several of the preceding articles, women of other cultures are coming to see the technomedical model as superior to the innate wisdom of their own bodies. This appears to occur even when the health care system cannot finance these technologies, as in Jamaica (Sargent and Bascope), when the technologies do not really improve the outcome of birth, as with the overuse of ultrasound in Greece (Georges), or when the technology is rudimentary and poorly understood, as in the Mayan villages where midwives use pitocin to speed labor (Sargent and Bascope). In all of these cases Western medicine is believed to be superior to the traditional birthing knowledge of the local culture; more and more, traditional methods are forfeited along with the mother's ability to know her own body. As Georges notes, "[T]hese women's comments further suggest that doctor- and machine-mediated 'seeing' demotes bodily experience to a secondary order of significance." It appears that relinquishing one's own personal power is a prerequisite for obtaining the gifts of modern medicine.

The significance of women's relinquishment of power is documented in Robbie Davis-Floyd's book *Birth as an American Rite of Passage* (1992). She describes birth as a series of rituals that, by enacting our scientific, mechanistic, reductionistic worldview, support the core values of the culture. Davis-Floyd and Davis address the emergence of this worldview in their article on midwives' use of intuition as a source of authoritative knowledge. They discuss "ratiocinative" versus "intuitive" knowledge, noting that rational thinking and deductive reasoning are believed to be the basis of scientific knowledge, a notion that helped to create the mind/body split frequently attributed to Descartes. The cultural power of this way of knowing is evidenced in Heriot's article when she suggests that legislators rely on scientific definitions of personhood as "objective and nonjudgmental. In some ways, this appeal to science offers them one obviously needed legitimating

rhetorical strategy since they cannot appeal to their religious justifications in this particular context.” In the same way, ratiocinative thought has replaced intuition as the preferred source of authoritative knowledge. I believe this is so partly because intuitive knowledge is personal and difficult to communicate; and acting upon it requires a leap of faith. Rational thought, however, is easily communicated, duplicated, and retraced. It therefore lends itself to decision making, especially in the medical realm, where the threat of lawsuit is ever present.

Reclaiming earlier ways of knowing, midwives use intuition frequently. So do physicians, as I can attest. But midwives feel free to *talk* about intuition and how it affects their practice, something physicians rarely do. In fact, as Browner and Press discuss, in prenatal care (where pain relief is not an issue and where medical education is sorely lacking and knowledge is minimal) women use three sources of information in making decisions: embodied knowledge (intuition), medical information (ratiocinative knowledge), and experience (their own, a family member’s, or a friend’s). Jambai and MacCormack quote Max Weber, who traces authoritative knowledge (which he refers to as “uncoerced legitimacy”) to three sources: charismatic (intuitive), rational-legal (ratiocinative), and traditional (experience). I believe these authors have identified three key sources of authoritative knowledge and that a balance of the three is what is needed in the birthplace.

In the current medical/legal arena, control is the major issue. Authoritative knowledge is not as much the issue as *authority*—who controls. The question of whether authority is conferred by knowledge or just by possession of the technology is a smoke screen. As demonstrated by Georges, the current technomedical model encourages dependence on technology in order to wrest control from nature and women and “to know what is really going on.” As a culture we are simply not willing to accept that only the mother can take responsibility for the baby prior to the birth. Heriot documents the attempts of the legal system to use arguments from science to gain control over the pregnant body. In medicine, in order to maintain the illusion of control, we learn to treat the *potential* for problems as a problem. As Davis-Floyd and Davis point out, midwifery normalizes uniqueness, but the medical paradigm pathologizes it by seeing uniqueness as an outlier on the bell-shaped curve. Our culturally supported belief in science and technology, which systematically undermines women’s knowledge of their own bodies, has led to unjustifiably high cesarean rates and health care costs, and has failed to improve outcomes in spite of the increasing amounts of high technology we throw at birth. In contrast, the limited use of technology in Japan observed by Fiedler, which stems from a continuing belief in the normalcy of birth, suggests an appropriate relationship of science and technology in the field of obstetrics. An ideal situation would be one in which physicians and midwives cooperate: the midwife would use her experiential and intuitive skills to empower the woman in the birthing process, and use her medical knowledge to communicate the mother’s status and needs to the mother, the family, and the medical staff. She would also serve as the gatekeeper, calling in the physician as a technician to intervene if and only if intervention is truly needed.

I would take this scenario a step further. The midwife must have full knowledge of the sources of her authority. She must have a complete understanding of the science and technology available to her, and of their limitations. She must use

her experience and that of her sister midwives, as well as the experience represented by medical studies, to communicate her authoritative knowledge to her client and to the physicians with whom she works. She must use her intuition to guide her own actions, but, more importantly, she must use it as model for the mother so that the mother can use her own intuitive knowledge to effect safe delivery of her infant.

As an obstetrician I am nudged by the system to take control of birth in a thousand visible and invisible ways. My personal preference is to resist and allow control to rest in the hands of the mother. Because this is not the accepted method of care, I must know that she is in touch with her body and her inner knowing in order to have the confidence I need to subordinate my authority to hers. But women in our culture are not intuitively knowledgeable in this way. We are taught not to trust our bodies, not to listen to our bodies, and often to abuse our bodies. Medicine teaches us to trust doctors and science and to place the locus of control outside of ourselves, surrendering control to technomedical authority. When my patients choose to give themselves over to me in this way, I respond and take charge. But I realize that although they will gain the sense of security they seek, they will at the same time lose the opportunity to generate that sense of security for themselves.

Part of the attraction of midwifery today is midwives' belief that a strong relationship to the caregiver is necessary. Yet there are drawbacks to this belief. It locks many midwives in solo or very small group practices, which puts them under enormous stress. While this type of midwifery provides a high degree of continuity of care, it also fosters overreliance on the caregiver. Such overreliance is inevitable when the caretaker, consciously or unconsciously, takes control from the birthing woman, but does not develop when the caregiver turns control back to the birthing woman herself. We must create an environment in which women's inner knowing is acknowledged and respected by all their potential caregivers. Midwives must ask themselves the difficult question: Is the caregiver important because of her own need, or because of the need of the birthing woman? To ensure that women can access their inner knowing, their connection to their bodies must be reawakened, their ability to trust nature's processes must be cultivated, and their reliance on themselves as the primary source of authoritative knowledge must be reinforced. Midwives are already positioned by tradition, training, and experience to play a key role in this revolution in childbirth, and they should be given authority by the medical profession and by the culture to take on this role.

In my ideal world authoritative knowledge in the birthplace resides in the inner knowing of the birthing mother, provided that she is in touch with herself, is motivated to stay healthy, and will give her best to the process of bringing in new life. When she is unable to do this her caregivers should first try to help her work through her anxieties and fears, which may be impeding her ability to connect with herself, and then, only as a last resort, use their own intuitive knowledge, experience, and technology to assist her to birth her infant. There is ample evidence that this new model of care in the birthplace has the best chance for a successful outcome, the least opportunity to do harm to the mother, the infant, and the new family being created, and fosters intuition, self-reliance, and self-trust in all the participants.

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