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Pentadic Cartography:

Mapping Obstetric Medicine and Traditional Midwifery *

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Abstract

Is midwifery the practice of medicine? Cartographic mapping of the trial transcript of a midwife convicted of practicing medicine without a license and child endangerment demonstrates that while the professions of obstetric medicine and traditional midwifery both assist women during childbirth, the differences in what each health care system defines as appropriate are predicated upon different mental processes and reflected in different patterns of discourse. Pentadic cartography provides a means for analyzing marginalized paradigms such as midwifery on their own terms and for translating with equanimity between seemingly incommensurate systems of thought, discourse, and behavior.

In a recent QJS article entitled "Pentadic Cartography: Mapping the Universe of Discourse," Floyd D. Anderson and Lawrence J. Prelli note that a wide range of twentieth century social critics agree that "advanced industrial society is so pervaded with a technological rationality that it fosters a closed universe of thought and discourse that stifles and silences all other points of view" (73). Anderson and Prelli recommend Kenneth Burke's critical method for its utility in opening up that closed universe by directing "attention to particular terministic features of texts and, from those features, [the] implicit associations or underlying systems of terms that those features imply" (77). Anderson and Prelli call their Burkean approach "pentadic cartography." The job of the pentadic cartographer is to locate the "pivotal sites of ambiguity" that allow the critic to transform one ideological system's vocabulary into the terms of another, with the goal of legitimizing marginalized discourse otherwise excluded from expression when constrained to the dominant discourse of technological rationality (80, 82).

Although my doctoral dissertation was all but complete by the time Anderson and Prelli's article appeared, pentadic cartography was precisely the method employed in my study, and I can personally attest to the efficacy of this approach. My dissertation, entitled "The Rhetoric of Childbirth: A Burkean Analysis of Medical Demarcation in the Trial of a California Midwife," examined the discourse of physicians and midwives who testified at the 1997 criminal trial of midwife Abigail Odam. Odam was charged with seven felony counts and one misdemeanor arising from her attendance at five births in 1993 and 1994; the most serious charges against her were practicing medicine without a license and child endangerment. The object of my study, the transcript of the trial of *The People of the State of California, Plaintiff, v. Abigail Odam, Defendant*, brings the tension between obstetric medicine and traditional midwifery into sharp, adversarial focus, with the obstetric approach clearly aligned with technological rationality and, not coincidentally, the state's prosecution of the case.

Kenneth Burke tells us that the particular choice of terms used to describe an act reveals the speaker's personal view of the symbolic nature of the act. As he states in *Language As Symbolic Action*: "much that we take as observations about 'reality' may be but the spinning out of possibilities implicit in our particular choice of terms" (46). The trial of *People v. Odam* presents the voices of competing health care professionals describing the same observable phenomena while using different vocabularies arising from different underlying assumptions, employing different theoretical hypotheses, and arriving at different conclusions and treatment protocols. These variant testimonies provide the "pivotal sites of ambiguity" called for in pentadic cartography.

For obstetricians, birth is a medical event, fraught with hazards held at bay through well-timed and necessary technological intervention. Midwives, on the other hand, view birth as a natural, normal event imbued with profound personal meaning, and their professional vocabulary is rich with emotional, social, and spiritual references. The midwives, who came to the trial as a marginalized group, were further hampered by the structural imposition of rules of discourse that tended to undermine their rhetorical style and non-scientific worldview while simultaneously privileging the conventional medical worldview. Odam never disputed attending the births in question, but whether or not these were medical events and whether or not she functioned as an obstetrician or a midwife at those births entirely hinged on the experts' characterization of those births. Therefore, rhetoric pertaining to professional demarcation provided the sole evidentiary foundation for Odam's guilt or innocence. The jury would ultimately judge the case based upon their assessment of these conflicting rhetorical representations of "fact."

The mechanics of the trial itself displayed the government's official cultural sanction of the highly rational, technological discourse of physicians over the narrative, non-technological discourse of midwives. During the trial, Judge Zvetina's rulings sought to limit testimony regarding the midwifery model to scientific quantification, thus establishing conditions that largely precluded midwifery's modes of thought and discourse, forcing the defense witnesses to employ the dominant paradigm's philosophical and discursive style. While it undoubtedly appeared perfectly reasonable to Judge Zvetina to insist that any information regarding the midwifery model of care first pass through the sieve of scientific objectivity, this belief itself reflects the Court's consubstantial relationship with the medical and scientific hegemony. Throughout the trial, the Court's dismissal of midwifery's alternate knowledge system and narrative discursive style would serve as a political endorsement of the medical model of birth.

The defense's battle was entirely uphill and ultimately unsuccessful, for they were forced to express their position in terms of the dominant style of discourse. Anderson and Prelli put it this way: "Whenever we are induced to see things or interpret experiences 'in terms of' some particular vocabulary, we are constrained by its circumference of motives" (80). As my cartographic mapping of obstetrics and midwifery discovered, it is literally impossible to defend the ancient art of traditional midwifery in terms of the modern medical model; the defense's attempts to do so simply upheld the dominant paradigm, causing the midwives to appear the ignorant, bumbling, incompetent and illogical women medical men have historically taken them to be.

Pentadic Cartography and the Demarcation of Obstetrics and Midwifery

In *A Grammar of Motives*, Burke presents an analytical framework combining rhetoric and the poetic as a means for sorting out human relations and motivations which he calls the dramatic pentad. Burke identifies five dramatic elements common to human relations: scene, agent, agency, act, and purpose. Any human endeavor may be identified by where it occurs [scene], who does it [agent], the means by which it gets done [agency], what it is that happens [act], and why it occurs [purpose]. These five elements are related to one another as "principles of consistency" that bind pentads together in certain "ratios" (Motives, 9). Burke's principle of consistency states that any particular description of "scene" carries within it the implications of how the other elements will be defined; a hospital scene, for example, implicates the physician as agent, consistent with the scene:agent ratio, whereas the homebirth scene implicates the birthparents as agents. The pentad also asks for a definition of the "God term" that serves as the ultimate motivational ground for human action under any particular schema.

The Analytical Process

Most of the analysis performed on the trial transcript centered on one of the five births involved in the case--the birth of Nicholas Annerino. The scope of the analysis was further constrained to testimony offered only by physicians, midwives, and birthmothers. The testimonies of other witnesses, such as state investigators and firemen, were read and set aside. I then identified and labeled recurring topics and themes that were common to both sides' renditions of the Annerino birth, though expressed in different terms. Some of these topics arose from the particular physical exigencies of the Annerino birth itself, such as the midwife's subcutaneous administration of pre-partum Pitocin and the baby's shoulder dystocia complication. Other topics emerged as general themes that ran throughout the trial, such as issues involving standards of care, the proper role of technology, and the nature of authoritative knowledge.

Once the emerging topics and themes were identified, I reviewed the transcript again, searching for more instances of these identified categories. In this manner, I was able to compare each witness's take on the same topics and themes. Doing so confirmed my suspicion that the testimony of each witness reflected their personal identification with either the culture of obstetrics or midwifery. As I had suspected, there was a clear distinction between the foundational beliefs and practices of the obstetric and midwifery models of care. These distinctions held true for practically every identified topic and theme and constituted the manner by which members of each profession demarcate themselves. As a final methodological step, I sorted these recurrent topics and themes according to Burke's pentad and discovered the pentad's elegant utility as a means of distinguishing between the obstetric and midwifery models of care. In this manner, I was able to locate and identify in the trial transcript 35 unambiguous examples of purely

medical dramatic elements plus 31 examples of necessary medical ratios, and 57 examples of midwifery elements plus 25 examples of necessary midwifery ratios.

Burke's Dramatistic Pentad Applied

The testimonies offered by physicians and midwives at the trial of Abigail Odam clearly demonstrate that obstetricians and midwives attend different symbolic events and these disparate symbolisms elicit disparate observations about the "reality" of the birth event-- what Burke referred to as a "terministic screen." These differing symbolic representations of birth also require different physical actions on the part of birth attendants and different material preparations for the event, as the following pentadic mapping makes clear.

The Obstetric Model Pentad. God-term: Science

Medical Scene: The scene for a medicalized birth is the hospital delivery room, or, in extreme circumstances, the hospital emergency room or obstetric operating theater. The props that adorn this scene are technological; the lighting is bright; the atmosphere is noisy and hectic. In this scene, the birthmother is the central prop, for she is the object upon which the physician operates. The mother may be further objectified through the use of drugs that render her unable to physically participate in the birth. The unborn baby is the desired object the agents in this drama strive to acquire. The larger ideological ground of the scene is the mechanistic, rationalistic, scientific worldview.

Medical Agent: According to Burke's scene: agent ratio, by virtue of the fact that the scene is the hospital, the physician is the primary agent of the scene, because the hospital is the stage upon which he or she acts. The obstetrician is the star of this show; all of the ritualistic events surrounding hospital labor lead up to the physician's arrival on the scene and in the physician's absence the birth cannot proceed. The obstetric nurses function as co-agents supporting the needs of the physician. The agent status of physicians is largely based upon the deference accorded doctors as exclusive sources of authoritative knowledge in issues considered to be medical.

Medical Agency: Rationalism, as a key constituent of the medical god-term science, is the critical-thinking engine that drives medical agency (god-term: agency ratio). The means by which the birth is achieved is through technological intervention. This intervention is directed by the attending medical personnel (agency: agent ratio). The technology may be mechanical (scalpels, forceps, vacuum extractors, syringes, mechanized infusion pumps, IV drips), electronic (EFMs, ultrasound, blood gas readouts), or medicinal (Pitocin, anesthetics, narcotics). When the birthfather is present, his job is that of a tool for managing the birthmother, in order to encourage her cooperation with the medical

management of the birth.

Medical Act: The act is the delivery of the child from the mother by the obstetrician. The mother, in this scene, does not actively birth the baby; the child is taken from her by the primary agent, the physician, who immediately severs the umbilical cord. The physician then hands the newborn directly to the co-agent, the nurse, who dries and wraps the baby at a separate work station.

Medical Purpose: The purpose of the hospital birthing scene is the safe delivery of the child and the comfort and safety of the mother (scene: purpose ratio). Successful accomplishment of these two primary goals serves an important secondary purpose of avoiding hospital lawsuits; hence, a "perfect birth" is the ultimate goal. The obstetric model on the whole is based on the presumption that any risk to a mother or baby is too great. The goal of the obstetric model is to reduce risk to as close to zero as possible--hence, the high frequency of interventions designed to prevent "what-if" scenarios. Efficiency is also a primary goal for, at any given time, laboring women may greatly outnumber care providers.

Even in their absence, the above classifications apply, and any deviation from this schema constitutes a grave emergency in and of itself. For example, giving birth outside the confines of the hospital is considered an emergency condition fraught with peril. If a physician were to encounter a woman laboring at the "wrong" scene--at home, for example--emergency transport to the nearest hospital is top priority (scene: purpose ratio). In the absence of an attending physician, those present are considered helpless in the face of the impending birth (agent: agency ratio). Even if a doctor is present, if the proper means of technological agency is missing--e.g., a power outage that idles the machines--the physician's ability to assure a safe delivery for mother and child is considered severely impaired (agent: agency ratio).

The Midwifery Model Pentad. God-term: Nature

Midwifery Scene: The birthmother's home, surrounded by family, friends, neighbors. The birth may occur anywhere in the home, but most typically in the bedroom or living room. The larger ideological ground is nature and natural womanly processes.

Midwifery Agent: Because the scene is the birthmother's home, Burke's scene: agent ratio indicates the birth parents will be the primary agents of the scene. The midwife or visiting physician is only a "guest" in the home, there to bring about whatever it is those parents wish to bring about. The birthmother is the star of the show; it is through her actions that the birth will take place. The fetus is also considered a primary agent in this model, and

his or her movement through and beyond the birth canal is sometimes referred to as the "hero's journey." The birthfather's presence reinforces the "natural" ideological ground of the bonded family unit. The midwife functions as the birthmother's co-agent and is motivated by the mother's and baby's needs rather than imposing her own agenda upon them (agent: agency ratio). Difficult decisions, such as whether or not to transfer to the hospital during the course of a long labor, are arrived at through conversation with the birthmother.

Midwifery Agency: The birthmother labors naturally and by her efforts the baby is pushed down the birth canal. In this model, in addition to being the birthmother's co-agent, the midwife serves as a tool used by the mother as primary agent (agent: agency ratio). Technological instruments are minimal (blood pressure cuff, DeLee suction trap, oxygen bottle and mask, Doppler device), while natural remedies are found in abundance (herbs, homeopathics, medicinal foods, hot baths, massage, body fluids, essential oils) (god-term: agency ratio). A midwife's agency may be difficult to identify because of its alignment with the natural course of events. Patience is a key attribute. Bodily awareness and intuition are abundantly employed as salient sources of knowledge. Prudential reasoning determines when, if, and how the midwife responds to the unfolding exigencies of birth. There are few, if any, fixed protocols.

My study demonstrates there are no hard and fast normative standards under the traditional midwifery model. A midwife intuitively responds to the unique exigencies of the particular case, occasionally deviating from textbook recommendations through a process of non-rational thought. This ability is developed through experience and practice, and often results in unexpected but efficacious responses. The standard of midwifery's prudential reasoning is the ability to successfully respond to exigencies on a case-by-case basis.

Midwifery Act: The baby is not taken from the birthmother as in the hospital model, but is birthed by the mother's active agency. Due to the birthmother's status as primary agent of this pentad, the birth proceeds at her pace and according to her individual physiology rather than predetermined time limits and mandated standards of care (agency: act ratio). After birth, the infant is either placed immediately upon the mother's bare breast, or is allowed to continue its own heroic journey from her crotch up to her breast. In addition to supporting the mother's labor, the father ritualistically cuts the umbilical cord after it stops pulsating.

Midwifery Purpose: The purpose of the homebirth setting is to respond to emerging exigencies in the most natural way possible, with the expectation that a natural birth is a good birth (god-term: purpose ratio). For the mother as well as the child, this natural

birth implies a reduction in extraneous emotional stressors such as unknown agents in the scene and unfamiliar surroundings, in keeping with Burke's scene: purpose ratio. The homebirth is considered by its participants to be a physical demonstration and embodiment of the spiritual quality of familial love.

As was the case with the alternate, obstetric model's pentad, any violation of the schema outlined above constitutes a violation of the midwifery model. Because of the relationship ratio between the scene, agent, and agency, it is considered extremely difficult to have a truly "natural" birth in a hospital setting. For example, certified nurse midwives who practice in a hospital setting necessarily adopt a more medicalized approach to midwife-assisted birth that stands in tension with both the midwifery practiced by traditional, homebirth midwives, and the obstetrics practiced by physicians.

Discussion

This exercise in pentadic cartography has demonstrated that while the professions of obstetric medicine and traditional midwifery may share the common boundary of assisting women during childbirth, the differences in the social institutions and patterns of interpersonal interactions, as well as the protocol of behaviors that constitute what each health care system defines as appropriate, are predicated upon different mental processes and reflected in different patterns of discourse. The mental processes that shape these distinctive cultures of care consist of different sets of values as well as reliance upon different modes of critical thinking.

Burke's dramatisitic pentad has proven to be a useful tool that not only clearly maps the distinctions between the two systems, it is also a useful means of determining which behavioral manifestations are appropriate by employing the necessary ratios among the various pentadic elements. For example, obstetric medicine's god-term "science" not only explains but mandates technological agency, whereas midwifery's god-term "nature" discourages technological agency due to the god-term:agency ratio. Likewise, the scene:agent ratio of the midwifery model places the parturient woman as the primary agent of her homebirth scene, whereas the scene:agent ratio of the obstetric model designates the physician as primary agent of the hospital scene.

Because of the strong relationships implicated among pentadic ratios, it is difficult to maintain the integrity of a given system when these ratios are violated. For example, midwife-assisted birth in a hospital setting establishes a tension that threatens to violate a number of pentadic midwifery ratios, including scene:purpose, scene:agency, and scene:agent. Scene, in other words, exerts a powerful influence upon cultural systems, one that can, of itself, override other cultural elements. Agency is another powerful

pentadic influence on a system, especially when agency is taken to include the critical thinking skills employed during decision making. Obstetric medicine's reliance upon rationalism falls under medical agency, which mandates that certain formulaic protocols and standards of care be employed in answer to particular exigencies. Midwifery's reliance upon prudential reasoning under midwifery agency allows for more inventive solutions to birthing exigencies that would be not be considered reasonable under obstetric's rule-based system.

This application of Burke's pentad is directly and immediately applicable to the ongoing national debate over the practice of traditional midwifery for it can be argued that critics of the midwifery model do not recognize the validity of midwifery's alternative pentadic schema. In Odam's trial, the midwifery scene, the home, was criticized because it was not the medical scene, the hospital. Odam was personally chastised by the judge for not exercising authority as the agent in charge, which would have been a violation of the midwifery agent:agency ratio; it is only under the medical model where the agent is the professional on the scene. Odam was excoriated by the prosecution for using non-technological agency in keeping with the midwifery model, as when she used her own body as an instrument to gauge an infant's heart rhythms or garlic to treat an infection. Odam was severely criticized by the medical experts for allowing a birth to proceed at a slower pace than the medical model's act element would allow, yet allowing a birth to proceed at its own pace is fully in keeping with the act under the midwifery model. Finally, the purpose of the midwifery model was criticized because the midwife on trial did not put safety first, risk reduction being a primary motivator of the medical model. These types of criticisms can only be levied against someone of a marginalized culture when the critic is so firmly entrenched in the dominant cultural schema that the critic either does not recognize, because of the terministic screen phenomenon, or recognizes but completely rejects the alternative paradigm and so holds the individual personally accountable for all deviations from the dominant model.

Odam was also greatly criticized for the unauthorized use of medical agency when she administered the drug Pitocin to stimulate uterine contractions. Interestingly enough, this is a valid criticism that does not violate the cultural integrity of either model. Pitocin is a medical intervention; it does not belong under midwifery agency, unless one rationalizes that Pitocin so resembles a woman's own natural hormones that Pitocin can be considered "natural." If a midwife believes it is necessary to administer pre-partum Pitocin, then she appears to be admitting that this birth is not proceeding "naturally" under the midwifery model and should be addressed under the medical model with medical agency. Such an admission would mandate an emergency shift of scene to the hospital where all other elements of the medical model are in place. So, while the pentadic mapping of the midwifery model provides a kind of ideological "shelter" for the practices of traditional

midwifery, it provides an equally strong mandate for the obstetric model when medical conditions rule out the "natural" course.

Pentadic mapping has demonstrated that each healthcare system has its own integrity in keeping with the necessary ratios implied among its pentadic elements. Because these distinctive schemas were not made clear during the case at hand, it was not possible for the jury to tell which of the defendant's actions were fully in keeping with the midwifery model of care and therefore exempt from prosecution, which behaviors were actually medical interventions under the obstetric model of care and therefore a violation of medical licensing, and which behaviors were simply negligent under anyone's model of care and indictable as, for instance, child endangerment.

In Conclusion

This Burkean analysis of the trial of *The People v. Odam* successfully employed pentadic cartography to "open up" the otherwise closed universe mandated by the rational, technological discourse of the Court and the medical model. As evidenced by the "Guilty" verdicts reached at the conclusion of that trial, when one is required to utilize the modalities of the dominant universe of discourse, it is impossible to fully articulate and analyze systems of thought and behavior that fall outside that ideological mainstream. Doing so reduces marginalized discourse to the terms of the dominant paradigm, thereby causing the Other to appear substandard as a by-product of that rendering. Pentadic cartography provides a means for analyzing marginalized paradigms on their own terms and for translating with equanimity between seemingly incommensurate systems of thought, discourse, and behavior.

—Cyd C. Ropp

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