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Informing Evidence: Claimsmaking in Midwives' and Clients' Talk About Interventions

Pamela J. McKenzie[1] and Tami Oliphant[1]

Abstract

Communication for informed choice is particularly challenging in clinical settings such as direct-entry midwifery, where the care model embraces diverse therapies and forms of knowledge. We identified three discursive moves (explanation, invocation, and evaluation) that Ontario midwives and clients used in making claims about proposed interventions. The analysis was informed by an understanding of communication as an interactionally situated and socially constructed interpretive practice. Both midwives and women called on the authority of biomedical discourse, but they also turned to sources such as women's wisdom to support their cases. The flexible use of these moves afforded participants considerable latitude in accepting or rejecting forms of evidence as authoritative. However, strategies designed to empower clients in making choices could unintentionally serve to enhance the authority of the care provider. Talk about interventions brings into view both the knowledge systems and the broader relations within which regulated midwifery practice operates.

Keywords

communication; discourse analysis; medical/health care discourse; midwifery

Communicating for informed choice is particularly challenging in health care settings that seek to provide access to both mainstream and alternative therapies and, consequently, draw on the diverse forms of knowledge supporting those options. Regulated direct-entry midwifery (Bourgeault & Fynes, 1997) in the Canadian province of Ontario is such a setting. The midwifery profession recognizes pregnancy as a state of health and acknowledges the childbearing woman as the primary decision maker about her care (College of Midwives of Ontario, 1994). The midwifery model therefore values both the free exchange of diverse forms of knowledge and a holistic approach to health that includes a broad range of therapies (Adams, 2006; MacDonald, 2006; Williams & Mitchell, 2007). At the same time, midwifery is licensed and government funded in Ontario, and midwives practice within a complex network of professional responsibilities and regulations (Bourgeault, 2006; Spoel, 2006, 2007). For these reasons, Ontario midwifery is an ideal setting in which to explore the ways that health professionals and their clients draw on different forms of knowledge and sources of information as evidence in clinical communication.

In this article, we identify and describe three discursive strategies, or "moves," that midwives and childbearing women use as they discuss options that are not obstetrically

standard. We consider the ways they use these moves to construct, defend, and challenge claims about specific interventions. We attend to the ways that participants use these moves singly and together, the forms of knowledge and sources of evidence they call on to lend authority to arguments, the ways they call on evidence to make and challenge claims, and the consequences of these constructions (Potter, 1996). This analysis will provide further insight both into the ways in which practitioners and clients communicate about options that are not medically mainstream and into the complex discursive ground midwives and women must cover in negotiating care in a regulated health profession.

Discursive Tensions in Midwifery

Tensions between "natural" and biomedical forms of knowledge have long been part of the professional relationship between midwifery and medicine (Böhme, 2005; Lay,

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2000, pp. 43-76; Mitchinson, 2002; Turner, 2004). In Canada, the history of midwifery is often told as a story of loss and rebirth that reflects these tensions (MacDonald 2006, pp. 236-237): the rising medical profession essentially stamped out traditional home-based midwifery in the 20th Century. Grassroots social movements in the 1970s nurtured a "new" alternative and woman-centered midwifery which achieved full legal and professional recognition in some provinces, beginning with the 1994 implementation of the Ontario Midwifery Act (1991; for a more nuanced reading, see Bourgeault, 2006, and Mitchinson, 2002). Ontario midwives now provide fully funded primary care for low-risk women and their babies during pregnancy, hospital or home birth, and for 6 weeks postpartum. With the exception of aboriginal midwives practicing in their own communities, practice is regulated by the College of Midwives of Ontario. Midwives qualify for registration either by completing a 4-year Bachelor of Health Sciences in Midwifery degree or by demonstrating sufficient prior learning and experience (Ontario Ministry of Health and Long-Term Care, 2003).

Spoel (2006, 2007) argued that midwifery's diverse origins and ties have given rise to ideological tensions between the woman-centered, holistic ideology of pre-regulation midwifery and the dominant biomedical and consumerist discourses that shape mainstream Canadian health care. For example, MacDonald (2006) showed that the traditional midwife and the ideal of the natural birth she attends have become iconic parts of narratives of midwifery in Canada. The ideal posits women as inherently capable of giving birth without high-tech hospital surveillance (p. 236). Emotional, intuitive, spiritual, narrative, and other ways of knowing (James, 1997, p. 184) are therefore both legitimate and welcome (Cheyney, 2008; Davis-Floyd & Davis, 1996). Brigitte Jordan (1997) contended, however, that biomedical knowledge has become the authoritative knowledge in North American pregnancy care. Jordan and others (see Davis-Floyd & Davis, 1996; Davis-Floyd & Sargent, 1997; Lay, 2000; Spoel, 2004; Stewart, 2001) suggested that biomedical authoritative knowledge underlies a representation of pregnancy as risky, which serves to enhance the authority of physicians over women and over midwives. Annandale (1988) argued that women's expectations of birth are "never fully independent of obstetrical notions of risk" (p. 99). In trying to counter medical dominance, midwives have therefore "had to 'engage' the professional medical model, using its very definitions to maintain the independence and alternatives they sought" (Annandale, 1988, p.108; see also Foley & Faircloth, 2003; Lay, 2000; Rushing, 1993). Childbearing women likewise engage in discourses of risk and routine when explaining their decision to accept or refuse diagnostic testing (Markens, Browner, & Press,

1999, p. 364; Press & Browner, 1997). Spoel (2004) and James (2004) cautioned that the incorporation of midwifery into the larger Ontario health care system poses similar cultural pressure to adopt a "more reductive, uni-directional, and 'evidence-based' model of communication" (Spoel, 2004, p. E5) that relies more on biomedical evidence than on other forms of knowledge.

At the same time, midwifery's incorporation into the health care system owes much to the efforts of consumer groups who lobbied for women's right to choose midwifery care, adding liberal feminist rhetoric of choice to the discourses of nature and tradition (Bourgeault, 2006; MacDonald, 2006; Spoel, 2007). Although consumerist discourses have the potential to contribute to empowering care for women (Spoel, 2007), health care consumerism has been widely criticized for its representation of patients/clients as rational and autonomous actors (James, 2004, p. E13; Spoel, 2007, p. 18), thereby ignoring both the embodied and emotional nature of practitioner–client encounters (Bishop & Yardley, 2004, p. 467) and the health care seeker's own goals (Lupton, 1997); for shifting responsibility for the management of health from provider to patient (Salmon & Hall, 2003); and for ignoring the social, cultural, economic, and political contexts within which women live and must make decisions (Spoel, 2007, p. 24).

As the first Canadian province to enact legislation, Ontario is the test case for regulated midwifery in Canada. Spoel (2007) documented the coexistence of competing discourses in the Ontario midwifery regulatory framework and cautioned that their presence might compromise midwives' ability to attain the ideal of feminist rhetorical practice in their communication with childbearing women. Whereas Spoel analyzed the discursive "whats" (Holstein & Gubrium, 2005) of midwifery regulation, we focus on the "hows": the ways that these discursive tensions are taken up in practitioner–client interactions, specifically the ways that midwives and women use these diverse forms and sources of knowledge as discursive resources for making and contesting claims about proposed interventions.

Theoretical Framework

Central to our analysis is an understanding of practitioner–client interaction as interactionally situated and socially constructed interpretive practice (Holstein & Gubrium, 2005). Our approach is consonant with the perspective of authors from health communication, sociology, rhetoric, and information science who caution that an information transfer model brings with it several problematic assumptions (e.g., Dixon-Woods, 2001; Frohmann, 2004; Lee & Garvin, 2003; Spoel, 2007, pp. 12-13; Talja, 1999). This

model characterizes information as "an objective entity that can be measured in discrete units and whose value can be measured in 'amounts'" (Dixon-Woods, 2001, p. 1423). We seek rather to capture the socially and culturally shaped practices through which information is created, used, sought, and shared. We therefore reject the assumption that the communication process is "owned" by the health professional, who initiates the sequence and produces information to deliver to the client (Dixon-Woods, 2001, p. 1423). We begin instead from the presumption that both practitioner and client (and, indeed, any other people present) jointly construct the clinical encounter as an ongoing interaction (Heritage & Maynard, 2006a, 2006b) out of which information is produced (Frohmann, 2004). This orientation means that we take a discursive approach, which focuses on "the study of language in use" (Wetherell, Taylor, & Yates, 2001, p. 2). Whereas phenomenology focuses on how people make meaning of their lived experience and grounded theory seeks to explain social processes in context, discourse analysis examines how language is used to accomplish personal, social, and political projects (Starks & Trinidad, 2007).

Discourse analytic approaches share an understanding that language is not a transparent medium for conveying meaning, but is itself constitutive and constructive. Meaning therefore emerges out of complex social processes (Wetherell et al., 2001, p. 2). As Cheek (2004) and Wetherell et al. (2001) cautioned, however, there are several distinct forms of discourse analysis which share some vocabulary and analytic procedures but differ in theoretical underpinnings. We use Jonathan Potter's (1996; Potter & Wetherell, 1987) approach to discourse analysis. Potter draws from several theoretical traditions that include social studies of science, ethnomethodology, conversation analysis, semiology, poststructuralism, and postmodernism. This is a middle-range form of discourse analysis, concerned with

> *talk and texts as parts of social practices*. This is somewhat broader than the conversation-analytic concern with talk-in-interaction, but rather more focused on the specifics of people's practices than the Foucauldian notion of a discourse as a set of statements that formulate objects and subjects. (Potter, 1996, p. 105, emphasis in original)

This approach provides strategies for analyzing the ways that accounts are structured to appear factual (the epistemological orientation of discourse) and the rhetorical purposes to which accounts are put (the action orientation of discourse). Two studies of women's approaches to coping with menopausal symptoms illustrate the differences between discourse analysis and other forms of qualitative research. Whereas Kafanelis, Kostanski, Komesaroff, and Stojanovska (2009) sought to identify coherent coping patterns within individual women, Stephens, Budge, and Carryer (2002) recognized that a single woman might express apparently contradictory beliefs. By analyzing the ways that women constructed these contradictory explanations, they identified patterns in the interpretative repertoires (Potter & Wetherell, 1987) or discursive building blocks women used in putting together their accounts. Stephens, Budge, and Carryer (2002) were able to identify coherent patterns that existed across women, and to show how potentially contradictory repertoires might be used by a single woman to serve different purposes.

Potter's approach provides insight into the ways that important concepts and categories, such as *safe*, *normal*, *natural*, *holistic*, *appropriate*, and *authoritative* are collaboratively negotiated, and can identify the consequences of such negotiations (Potter, 1996; Potter & Wetherell, 1987). It has been widely used in studies of health care. For example, Adelswärd and Sachs (1996) showed how numbers are deployed and accepted as evidence in clinical communication. McKenzie (2003) found that childbearing women pitted the biomedical knowledge of their obstetricians against the experiential knowledge of other mothers to justify one as better suited than the other as authoritative evidence for the problem at hand. Wilkinson and Kitzinger (2000) and Lumme-Sandt, Hervonen, and Jylhä (2000) demonstrated the ways that patients described their self-care practices to accommodate understandings of responsible individualism and of appropriate compliance. Aguinaldo and Myers (2008) showed how gay men managed their explanations of their sexual activity to normalize unsafe practices. Ho (2007) analyzed the complexities of representations of "holistic" health care. Viisainen (2001) and Bishop and Yardley (2004) showed how discourses of "natural" and "alternative" are conflated with representations of "choice," "control," and "agency." Because it focuses on the ways that speakers and writers assemble their versions of the world and on the social functions those versions perform (Potter, 1996), Potter's approach is particularly well-suited for analyzing the ways that evidence and its underlying forms of knowledge are presented, worked up, defended as authoritative, and challenged in conversation.

Methods

We analyzed audio recordings of clinic visits of 40 childbearing Ontario women and their midwives. Data were collected by the first author. With a goal of recruiting 35 to 45 midwife–client pairs, she purposively sampled geographic regions to maximize variation of community size

and hospital access. Within each region, she recruited a convenience sample of 15 willing practices, then willing midwives within each practice, and finally willing clients of those midwives. Data collection ended when she had collected data from 40 pairs from a variety of communities and recruiting a 41st pair would have entailed contacting a new community. She recorded one visit between each woman–midwife pair and conducted and audiotaped follow-up interviews with each participant. Trustworthiness was ensured through triangulation of sites and methods (Lincoln & Guba, 1985). For this article we analyzed transcripts of the midwife–client visits. The 40 participating clients ranged from 14 weeks pregnant to 2 weeks postpartum, and the 31 midwives—all women—ranged from first-year registrants to senior practitioners with more than 20 years of experience. Participants largely, but not completely, represented the mainly White, middle-class, well-educated population of women drawn to Ontario midwifery both as clients and practitioners (MacDonald, 2006; Nestel, 2006). Data collection and analysis conformed to the Tri-Council ethical guidelines on research on human subjects (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2003), and the study was approved by the Non-Medical Research Ethics Board at The University of Western Ontario. All participants are identified by pseudonym.

From these transcripts, we identified discussions of interventions, which we consider to be any action, outside of the routine physical examination in the visit itself, that is taken up by one or more participants as a potentially legitimate strategy for diagnosing or solving a problem (e.g., relieving a symptom, treating illness), or maintaining wellness. Although low-risk pregnancy is a state of health, pregnant women present complaints and concerns (Robinson, 2006) to their midwives as they would to a physician, and seek diagnoses (Peräkylä, 2006) and treatment options (Stivers, 2006). We took an interactional approach to determining whether something counted as an intervention: We considered the nature of the action to be less significant than the manner in which it was presented and responded to by participants (Heritage & Maynard, 2006a, pp. 11-12; see Heritage & Sefi, 1992, on identifying "advice"). For example, we do not consider the following to have been an intervention[1]:

Adele (midwife): Baby moving lots?
Angela (client): Yes
Adele: Oh yeah?
Angela: [laughs]
Adele: It's beating you up?
Angela: Yeah. It's fun.

Adele: Yeah. Do you ever put a glass of water on it? [laughs]
Angela: We have a video with one of my pregnancies with the baby having hiccups. Yeah.
Adele: Is it a tidal wave?
Angela: Yeah, so fun, yeah.

The action of placing a glass of water on the abdomen is introduced without an attendant formulation of a clinical problem, so it is therefore not proposed as a potential diagnostic or treatment option. The light-hearted nature of the discussion additionally marks this as something "fun" to do and not as a diagnostic tool. However, we would consider this same action to be an intervention if Angela had expressed concern about fetal well-being and Adele had suggested assessing movement by watching the ripples in a glass of water placed on her abdomen.

The discussion of clinically standard interventions has been well researched, both in primary medical care (e.g., Elwyn, Gwyn, Edwards, & Grol, 1999; Gwyn & Elwyn, 1999) and in maternity care. Several researchers have studied the ways that health care providers and clients discuss obstetrically routine interventions, such as maternal serum screening, diagnostic ultrasound, and glucose tolerance testing (e.g., Markens et al., 1999; Pilnick, 2008; Press & Browner, 1997; Stivers, 2005; 2006). Elsewhere, the first author has analyzed discussions of the clinically routine interventions in this data set (Burkell & McKenzie, 2005; McKenzie, 2004, 2009). Our purpose with the present article is therefore different. We specifically focus on those options that are not listed in Canadian childbirth guides (Hawkins & Knox, 2003; Lalonde & Schuurmans, 2006) or on standard forms such as the Antenatal Record (Ontario Ministry of Health and Long-Term Care, 2005), as routine or legally required. The Antenatal Record is widely used in the province of Ontario (Ontario Medical Association Subcommittee on the Antenatal Record, 2000), and Sharpe (2004, p. 160) considered it to be "required" for midwives.

We focus on nonstandard interventions for several reasons. First, although practitioners might consider these interventions to be marginal, midwives and women themselves did not treat these discussions as peripheral to clinical care. Second, interventions for which there is no established biomedical consensus are the likeliest sites for the negotiation of competing forms of knowledge. The discussion of nonmainstream interventions therefore constitutes an ideal site for analyzing the ways that more diverse forms of knowledge are brought to bear in making and justifying claims. We can therefore analyze whether and how the discursive tensions identified by Spoel (2007) in regulatory documents are taken up in practice. Finally, this decision allows us to respect the holistic ideals of midwifery by framing problems and interventions in the

widest possible sense. An intervention might therefore include such activities as reading a book, joining a mothers' group to meet people in a new community, or engaging a babysitter to provide childcare relief.

Our sample consisted of 157 instances of talk about interventions. Between 1 and 11 instances occurred in 38 of the 40 transcripts, for an average of 3.9 per visit, well exceeding the 15 to 20 instances commonly recommended for reaching saturation (Strauss & Corbin, 1990, p. 177). Both midwives and women proposed interventions in response to routine physical concerns (e.g., indigestion, swelling, fatigue, or physical discomfort in pregnancy or postpartum; pain management in labor; infant colic; breastfeeding), psychosocial issues (loneliness, relationship concerns, physical and emotional support for infant care), and more serious clinical issues (for example, the management of a fetus presenting in a nonstandard position). The range of interventions discussed was very broad and included many of the practices identified by Mansfield (2008).

We analyzed the data consistent with Potter's (1996; Potter & Wetherell, 1987) discourse analytic approach, which requires

- close attention to the details of language use by examining transcripts or written texts rather than summaries or notes;
- focus on the talk or text as the primary object of research rather than as a transparent representation of an individual's beliefs or the true nature of events; and
- close study of variations in the construction of talk, both within and across accounts, to identify both the discursive building blocks speakers use when producing an account and the discursive functions that account might be serving.

Our analysis focused on the ways midwives and women presented, challenged, and justified interventions, how they used different kinds of evidence for making claims, and what kinds of counterarguments were made and on what authority. Our goal is not to produce a definitive or generalizable analysis, but to explain how certain things come to be said or done (Cheek, 2004, p. 1147). Identifying discursive building blocks makes them visible and can show the consequences of their use (Ho, 2007).

Results

The Discursive Construction of Interventions

We identified three different kinds of rhetorical moves that midwives and women used for making, supporting, and contesting claims for interventions. They invoked authoritative sources to support their cases, they provided explanations, and they reported evaluations. These moves accomplished several purposes, including building a consensual case, negotiating conflict, and putting a menu of options on the table for discussion. Our use of the term *moves* keeps in view speakers' active and ongoing production of the interaction (Heritage & Maynard, 2006b). In this section we describe the characteristics of the three rhetorical moves when used on their own, and in the following section we identify some of the ways midwives and women used them in combination.

Invocation. The first move speakers used for making claims was direct invocation of some source. Speakers invoked a source by drawing directly or indirectly on its "category entitlement,"

the idea that certain categories of people, in certain contexts, are treated as knowledgeable. In practice, category entitlement obviates the need to ask how the person knows; instead, simply being a member of some category—doctor, hockey player, hospital worker—is treated as sufficient to account for, and warrant, their knowledge of a specific domain. (Potter, 1996, p. 133)

First, speakers invoked their own entitlement to biomedical authority or to childbearing knowledge acquired through experience. Although the kind of authority they claimed was commonly linked to their institutional role (e.g., midwife or childbearing woman), this was not always the case. All speakers (women, partners, and other lay support people; midwives; and students) potentially had access to different types of authority and could make claims of various kinds. For example, midwives who had themselves given birth were able to claim experiential expertise:

Maia: I remember with my second [pregnancy I had contractions at night] [. . .] And I got into the tub and stayed there. And relaxed, until I was ready to get everyone else up.

Childbearing women could likewise make legitimate claims to clinical knowledge. Brandi, a pregnant woman, used her own professional education to warrant her decision not to attend prenatal classes:

Brandi: I'm not doing prenatal classes, and I feel good about that choice having reviewed a lot of, kind of the information about the programs, and having, um, a little bit of my background in nursing training and having my base maternal–newborn, you know, textbook at home, and having access to all of that.

Second, a speaker could invoke an outside source, which allowed her to present herself as merely the animator of a position held by someone else (Potter, 1996, p. 143). Such a footing shift (Goffman, 1981) minimizes the speaker's stake, as the claim then becomes a report from others and cannot be dismissed as merely the speaker's own opinion. Again, although sources and forms of knowledge invoked largely corresponded to the speaker's institutional role, women could and did claim biomedical knowledge, and midwives invoked childbearing women to claim experiential knowledge. Sybilla, a pregnant woman, used a nonspecific reference ("the reading I did") to suggest a consensus of biomedical opinion:

> Sybilla (client): Now, some of the reading that I did said that [turning a breech baby in utero] **can** cause the heart rate to plummet temporarily and in some cases the heart rate goes down and **stays** down.
> Rhea (midwife): Well.
> Sybilla: And they need to do a C-section.
> Rhea: Yeah.
> Sybilla: It was like 22% or something like that.

Sybilla made a claim to biomedical authority by presenting herself as a consumer of research and reporting research findings in quantitative form (Adelswärd & Sachs, 1996). Her midwife accepted her right to make this claim.

Speakers used two strategies to warrant the lived knowledge of childbearing women. First, they used nonspecific terms like *usually*, *most women*, or *most of the time* to normalize a problem and implicitly invoke women's collective experience or wisdom. Second, they told specific and detailed stories about individual women's experiences. As Potter (1996, pp. 165-166) noted, detail can be used to build up the veracity of an account, particularly when the speaker can make a compelling claim for having been a witness, which entitles her or him to provide an authoritative account of the event, as midwife Shelagh does in the following excerpt:

> Shelagh (midwife): I had one baby, a mother paged me at four months [laughs] I think.
> Rachel (client): Mhmm.
> Shelagh: She's like, "She won't stop screaming! She's been screaming for hours!"
> Rachel: Mhmm.
> Shelagh: [laughs] And she didn't have a fever, she didn't have anything else, there was no sign of any problem, and then I said, "Try the bath," and the minute she stuck her in the bath, silence.
> Rachel: Mmm! Oh that's interesting.

Midwives and women invoked both biomedical knowledge and their own and other women's experiential knowledge when they made claims for or against interventions. Invoking childbearing women certainly acknowledges them as possessors of valid forms of knowledge. However, this strategy is somewhat double-edged. Although a midwife's, student's, or support person's invocation of individual or collective women's experience allows women's voices to be heard as evidence, it also enhances the speaker's own category entitlement and can place her or him in the position of knowing what is best for a woman, perhaps better than the woman herself.

Explanation. The second move midwives and women used was explaining the mechanisms behind an intervention. Whereas invocation minimizes the speaker's stake or bias in an account by attributing the account to an authoritative and difficult-to-counter source, explanation draws attention away from the speaker's own stake by constructing a description as something factual, existing "out there," independent of the person producing it, and often of anyone else (Potter, 1996, p. 150). In particular, scientific or empiricist representations can be used for "*divesting* agency from fact constructors and *investing* it in facts" (Potter, 1996, p. 158, emphasis in original). Midwives and women provided impersonal explanations that were not attached to any individual source but drew from biomedical and other knowledge systems:

> Shelagh (midwife): If the baby acts like a parasite with anything it's calcium and iron. So. The baby will suck calcium out of your bones and it'll suck iron out of your blood whether you need it or not. They store up enough for six months postpartum actually. So they give themselves a nice little supply.
> Jane (client): Oh wow! [laughs] Maybe I should start taking iron pills.

Shelagh presents her account of the baby's calcium and iron needs as fact and Jane responds to this presentation as sufficiently credible to warrant her own suggestion that an intervention (iron pills) might be necessary.

Sometimes it is not possible for a speaker to present herself as neutral on an issue. In such cases, speakers can counter actual or potential claims of bias by minimizing or confessing their own stake in a matter (Potter, 1996):

> Sam (midwife): If you are ever awoken with something that feels like [labor] and you're not quite sure, one of the other things is just to have a glass of wine. Seriously! Wine is a muscle
> Julia (client): [cuts off Sam's turn] You guys have been sneaking that in.

Sam: Yeah

Julia: I'm getting the picture. [laughs]

Sam: Yeah. No, but really. You know.

Julia: Just to relax you.

Sam: It'll let you know. And sometimes, and I really think that when it comes to labor, slip in that one and if that quiets things down enough that you get, some sleep. If you have the baby that day you're, you know?

Julia: Yeah.

Sam: And obviously if it's labor, a glass of wine is not going to do anything [to ease the contractions].

Julia's initial response to the suggestion of a glass of wine was skepticism. Sam countered with reassurances ("Seriously!" "No, but really."), strengthened by an explanation of the means by which wine operates as a muscle relaxant. Her explanation provides evidence, which Julia does not challenge, that drinking wine is a legitimate strategy and not just something that "you guys" are proposing.

In addition to creating difficult-to-counter claims for or against an intervention, explanations served to establish the speaker as an authority who possessed specific knowledge of processes and mechanisms and was fluent in technical (usually biomedical) vocabulary. Not surprisingly, then, midwives rather than clients were the primary users of explanation in discussing interventions.

Evaluation. The third move was evaluation, the provision of an explicit or implicit assessment of an intervention. Evaluation was most commonly supported with invocation and/or explanation, as discussed below. However, it is worth considering the specific cases in which it was used alone. An unsupported evaluation was both rare and quite striking: its acceptance by a listener without further explanation or justification indicated a situation in which a common understanding was strong enough that it need not be articulated. It simply went without saying.

The first kind of unsupported evaluation arose when participants had successfully and consensually framed an intervention as safe or natural. Such evaluations suggested that there is neither cost nor commitment to trying (or not trying, or trying and abandoning) an intervention, and that the decision is entirely the client's (e.g., "give it a try," "it's up to you"). Midwife Sabina provided Leah with a requisition for a lab test that could lead to a prescription for antibiotics in case her urinary tract infection symptoms persisted or worsened. In the meantime, she presented cranberry juice as a risk-free option that might or might not solve the problem:

Sabina (midwife): Okay, go ahead with the cranberries, call me if you're getting any burning or anything like that.

Leah (client): Okay.

Sabina: Or even if you say, "Ah forget this, [laughs] it's too much. I can't take this much cranberry."

Leah: Oh! [laughs]

Sabina: Or you know. Um. And then this, [paper rustling] take into the lab Monday.

Cranberry juice is presented here as an option that can be taken up and discarded, not just if worsening symptoms show it to be ineffective, but also in accordance with the woman's preferences ("I can't take this much cranberry"). This kind of evaluation draws on a consumerist discourse that posits a low-risk situation in which several options are equally valid, at least for the moment. The woman is correspondingly posited as free to make an unconstrained choice among options.

The second kind of unsupported evaluation was associated with the other end of the risk spectrum. When speakers collaboratively represented a situation as inherently risky they accepted an intervention as legitimate and, indeed, essential without requiring a justification (e.g., "you need to"). Midwife Ruby contrasted the symptoms of hypertension with those of a virus going through Denise's family, and provided clear directions for what to do if she experienced them. Although there might be leeway in treating a cold, Denise accepted without comment that symptoms of preeclampsia required immediate intervention:

Ruby (midwife): But, you know, yeah [your blood pressure]'s up a bit from what you normally have?

Denise (client): Yeah.

Ruby: I'm not, it's not in any

Denise: No.

Ruby: danger zone. [paper rustling] But you know, ya know if you start kinda having kinda, weird feelings and stuff you need to page somebody?

Denise: Okay.

Ruby: So if you're feeling, you know, well flu, you're unwell but

Denise: Mmm.

Ruby: But, you know, the spots in front of your eyes, the frontal headache, all those kind of things, something just doesn't seem right.

Evaluation that draws on a discourse of risk presents options as differing in appropriateness. When risk is framed as extreme, the woman is posited as having only one option legitimately open to her: in this case, to contact a midwife ("page somebody") if she experiences the symptoms described.

In both kinds of cases, all speakers accepted the construction of an intervention as either completely optional

or absolutely required. No justification was needed, and the representation was received without question or challenge. Speakers used evaluation along with invocation and explanation as discursive building blocks in their constructions of more complex claims. The next section illustrates some of the ways that childbearing women and midwives combined the three moves to make and contest cases together.

Combining Moves

A single speaker could combine two or more discursive moves to build a case for a single option, present a menu of several options as equally valid, or pit one form of warranting against another. Two or more speakers might use these moves together to build collaborative cases for a single intervention, or to manage a conflict between knowledge systems, sources, or speakers.

Building consensual cases. In cases in which a single speaker was the primary claimsmaker, she or he could combine two or more moves to provide different forms of justification for a single intervention. Midwife Ellen used three moves over the course of a lengthy justification of homeopathy. First, she presented herself as an expert ("I've had training in homeopathy. [. . .] I am really comfortable, familiar with homeopathy") to justify her evaluation: "I have a huge faith in homeopathy." Second, she provided an explanation that minimized the intervention's risk:

> Ellen: Homeopathy can do no harm.
> Wendy (client): Mhmm.
> Ellen: It can't hurt you, it can't hurt the baby. Because the original substance that it's derived from? Is no longer there in the homeopathic remedies. Basically if you took the homeopathic remedy and looked at it under a microscope? You would see sugar and water.
> Wendy: Okay.
> Ellen: So the original amount, of uh whatever is used to make the remedy whether it's a plant or a mineral or whatever?
> Wendy: Right
> Ellen: It's so diluted that, they say it's like a drop. In a sea from here to the sun. So it's so, so tiny.
> Wendy: Oh my gosh.

Finally, she reported an evaluation, which she supported with additional explanation and invocation:

> Ellen: It makes sense because what the premise of homeopathy **is**, is to um, stimulate your body to do what it needs to do.
> Wendy: Has to do.

> Ellen: So it doesn't force your body to do anything like medications and, and so forth.
> Wendy: Right. Right.
> Ellen: It just, gives your body a gentle nudge to say, okay, you may want to go into labor now. And it sort of does a system check for you, is the baby ready, is mum ready? If everything's ready, then it works. If it's not ready it doesn't work. Or if you haven't picked the **right** remedy.

Ellen called on multiple knowledge traditions and sources to create and justify a claim of homeopathy as a legitimate option to consider. One technique she used was "inoculating" against a stake to neutralize its potential negative impact on her account (Potter, 1996). First, by highlighting her training and familiarity with homeopathy, Ellen provided a justification for her "huge faith," something that might otherwise be dismissed as bias. Second, she minimized the risk of the intervention ("it can't hurt") to present it as "choose-able" and low cost. Third, she supported her detailed explanation of the mechanisms of homeopathy with an invocation of an unspecified "they" that suggests that her views were supported by an expert community. Fourth, her evaluation ("it makes sense") simultaneously invoked Wendy's own common sense and provided an opportunity for Wendy to indicate agreement or disagreement. Finally, she contrasted homeopathy, a "gentle" remedy with more invasive biomedical interventions (McKenzie & Oliphant, 2006). Contrasts can serve simultaneously to present one version as solid and factual and to undermine the credibility of alternatives (Potter, 1996, p. 107).

Although Wendy did not contribute directly to the framing of a case by providing evidence herself, her responses were not inconsequential to the interaction. As Stivers (2006) found, for example, a hearer's response might resist the clinician's presentation of treatment recommendations. Wendy did not do this, but used response tokens that acknowledged that she had learned something new, accepted what Ellen said, and invited Ellen to continue (McKenzie, 2009). In this way, the turns of both participants in fact contributed to the presentation of homeopathy as a reasonable option.

In other instances, two or more speakers contributed directly to the formulation of a case for or against an intervention. In these more complex cases, individual speakers used complementary strategies to create a unified case:

> Margaret (client): Even if I limit myself I'm still voiding [during the night].
> Jean (midwife): Oh don't limit yourself! You can't cause it doesn't work.
> Margaret: I know.

Jean: That's right.
Margaret: It doesn't. I tried. Like after 6 o'clock I won't drink anything, well it doesn't make any difference.

Instead of answering with response tokens as Wendy did, Margaret contributed her own claim based on her experience. Margaret's claim supported the advice Jean had already provided.

"Informing" about interventions is therefore not a one-way communication from midwife to woman (McKenzie, 2009). Multiple speakers contribute both directly and indirectly to the framing of options in a particular way, collaboratively presenting a single case for or against an intervention or working together to manage conflicts.

Overcoming conflict. Conflicts arose when evidence was inconclusive and no single option was clearly preferable, when different forms of evidence suggested different evaluations of a single intervention, or when there was a conflict in the perspectives of speakers themselves. Sometimes a conflict arose between sources representing the same knowledge system, whereas at other times biomedical authority conflicted with other ways of knowing. Although biomedical evidence was generally associated with conventional clinical interventions, the relationships between the origins of interventions and the forms of knowledge used to justify them could be linked in very complex ways. For example, midwife Rhea both called on and then dismissed clinical evidence that supported an alternative remedy for turning a breech baby:

Rhea (midwife): In terms of research-based there's one, truly alternative therapy that has been shown to be very effective? I have no idea where I would get the equipment for it. It's called moxibustion. Does that word mean anything to you?
Sybilla (client): No.
Rhea: It means **burn**. There's a Chinese therapy, called moxibustion, where they put a little bit of petroleum jelly on your baby toe, you put a little bit of, mugwort, which is a plant, that is compressed, it's like a powder
Sybilla: Yeah.
Rhea: and they put it on your baby toe
Sybilla: and they light it
Rhea: And they light it on fire. Isn't that hysterical?
Sybilla: And that makes the baby move?
Rhea: It is 70, 70% more effective than doing nothing.
Sybilla: Mmm. Goodness.
Rhea: But I have no idea where I'd get it [in this community], to be totally honest.
Sybilla: Yes, and I don't know whether I'd

Rhea: But, No. Burning on your baby toe. That might just be. Yeah. [laughs]
Sybilla: I'd do that the day before a C-section just [both laugh] as a last resort.
Rhea: I'm, I'm just throwing it out there so you can't come back and say, "And my midwife knew nothing about it." I wasn't quite sure how to get it here, but I knew about it. [Sybilla continues to laugh]
Sybilla: Ohhh.
Rhea: It's, I mean it's it's certainly not standard care.
Sybilla: No. [laughs through words] No exactly.
Rhea: It's stepping outside of **most** people's care. And if you tell your OB [obstetrician] that your midwife offered it to you, he'll, he or she will just laugh at you. Either that or, call me up to the committees.

While Rhea invokes the consensus of biomedical research that in fact supports this alternative therapy, she simultaneously emphasizes the therapy's alternative, even laughable status ("truly alternative," "Isn't that hysterical?"). Sybilla's response aligns with the skeptical view. Although neither speaker contests that moxibustion has been demonstrated to be clinically effective, they go on collaboratively to represent it as being outside of boundaries of standard care as defined by the local obstetrical community, and possibly outside the boundaries of common sense. At the same time, Rhea uses her discussion of a marginal option as evidence that she is a good information provider who presents all options to the client for consideration.

Far from simply pitting biomedical and holistic forms of knowledge against one another, midwives and women create complex justifications through their talk that show how both forms of knowledge are tied into the structures of local clinical standards and regulated health care. Midwives and women do not therefore negotiate competing knowledge systems in a vacuum, but must do so within a broader context (Burkell & McKenzie, 2005; Levy, 1999).

In some cases, the context for the negotiation included a conflict among the speakers themselves rather than among the sources they called on. Renée was visiting her midwife, Iona, after having consulted an obstetrician:

Iona: There's something called evening primrose oil, which again, hasn't been studied at all, but anecdotally, works to soften and ripen the cervix. It's kind of like a prostaglandin that way. And so that's something you can start taking as early as 37 weeks. [. . .]
Renée: I'm taking it now.
Iona: Oh, you are taking it now?

Renée: [The obstetrician] told me that it doesn't hurt to take them, take it now. [. . .]

Iona: Well, so that, that is something we usually recommend at 37 weeks just because, I mean, what I've read it is safe throughout pregnancy too but it's one of those things like liability, whoops! If we recommend something that's meant to ripen the cervix and then you go into preterm labor, how are we ever going to convince you it wasn't

Renée: Mhmm.

Iona: that agent that caused the labor?

Iona opened with an acknowledgement of the legitimacy of biomedicine as a potential source of authoritative evaluation. The absence of such evaluation, however ("it hasn't been studied at all"), did not preclude making authoritative claims based on other forms of knowledge such as the midwifery community's professional knowledge and the experiential knowledge of childbearing women ("anecdotally"). Iona then provided a treatment recommendation, which Renée challenged by referring to another biomedical source: the obstetrician's framing of evening primrose oil as low risk and therefore safe to take earlier in pregnancy. Iona drew on two sources to counter the doctor's assessment: the community of midwives ("we"), and her own professional reading. She made the case that it was in fact the remedy's potential effectiveness that rendered it risky for Renée, who was less than 37 weeks pregnant, and she subtly challenged the doctor's commitment to responsible care. This example contains traces of complex relations: in rejecting the obstetrician's recommendation, Iona simultaneously challenges obstetrical authority and references a professional concern with liability that midwives and obstetricians hold in common. By contrasting her concern for safety with the obstetrician's lack of concern, she also challenges the obstetrician's dismissal of an alternative therapy as harmless. Talk about interventions for which evidence is contested therefore brings into view both the knowledge systems and the broader relations within which regulated midwifery practice operates.

Discussion

Childbearing women and their midwives made flexible use of the three discursive moves to call on multiple sources and knowledge traditions as they framed, challenged, and defended potential interventions. Speakers did invoke the authority of the controlled research preferred by conventional medicine. They likewise turned to sources such as women's experiential knowledge that reflect midwifery's feminist orientation. They did so in complex ways that provided them considerable latitude

in accepting or rejecting forms of evidence as authoritative and in combining potentially conflicting evidence to make a case.

A close analysis of the presentation of evidence confirms that Ontario midwives and their clients do in fact "challenge the powerful discourses of science and medicine and the institutions of maternity care that have shaped women's embodied subjectivity" (MacDonald, 2006, p. 251). At the same time, however, biomedical authoritative knowledge was rarely absent even when it was being discounted. Our findings therefore concur with Spoel's (2007, p. 3), that biomedical and consumerist discourses "inevitably though ambiguously affect midwifery discourse and values," and talk about nonstandard interventions references and brings to light some of the contextual constraints within which regulated midwifery operates.

Our data provide insight into warranting in a clinical setting where the model of care embraces diverse forms of knowledge and diverse therapies. A discourse analytic approach allows us to see informing as an ongoing and ever-changing two- or multiway process enacted by multiple speakers in interaction. Attending to the epistemological orientation (Potter, 1996, p. 9) of talk about potential interventions shows how speakers draw on different forms of evidence and different knowledge systems in ways that counter alternatives and that focus attention away from the speaker. Attending to the action orientation of claimsmaking (Potter, 1996, p. 9) further enables a consideration of the social functions authority claims perform. This brief analysis has identified several functions, including building up the category entitlement of the midwife and childbearing woman, challenging the entitlement of other kinds of care providers, and collaborative construction of acceptable and appropriate forms of evidence.

Conclusion

A recognition of clinical communication as interactionally situated and socially constructed allows both practitioners and researchers to be alert to the complex discursive environment within which practitioners and clients negotiate informed choice (McKenzie, 2009), and to the roles of both practitioner and client in making claims for or against an intervention.

Our analysis draws attention to a dilemma for practitioners who seek to empower clients or patients to make informed choices. Foregrounding clients' individual or collective experiences might have particularly complex and unintended consequences. In our data set, invoking women's experiential knowledge could indeed validate that knowledge and could provide childbearing women with resources with which to contest dominant discourses

and challenge other forms of knowledge, including that presented by the midwives themselves. On the other hand, invocations of that same expertise could enhance the category entitlement of the speaker him- or herself. If the midwife or another support person is the speaker, her or his views might prevail over those of the childbearing woman.

Analyzing the "hows" of interpretive practice (Holstein & Gubrium, 2005) shows us what forms of knowledge are turned to and the rhetorical purposes for which they are used. It can also provide insight into the "whats" (Holstein & Gubrium, 2005): the ways that the hegemonic discourses identified in the regulatory documents (Spoel, 2007) permeate practice and are taken up and/or resisted in clinical talk. It is only by analyzing the interpretive practices of real midwives and women that we can hope to achieve Spoel's (2007) goal of midwifery as feminist rhetorical practice. An awareness of the discursive building blocks practitioners and clients use and a sensitivity to the embeddedness of these building blocks within the complex discursive ground of regulated health care can therefore deepen reflective practice.

Acknowledgments

Declaration of Conflicting Interests

Funding

Note

1. We have chosen transcription conventions consistent with our analytic procedures. We therefore include response tokens and false starts but provide less detail (e.g., latching, length of pauses) than a full conversation analytic transcript. Bolded text indicates louder speaker volume. Ellipses in square brackets indicate the removal of text. Square brackets indicate paralinguistic features like laughter and indicate that text has been anonymized.

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