



## Informing choice: The organization of institutional interaction in clinical midwifery care

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### ABSTRACT

Researchers in LIS have called for the study of the social practices out of which *informing* is achieved. This article analyzes the informed choice discussion (ICD) between midwives and childbearing women as a form of institutional interaction that accomplishes informing. The ICD institutionally presumes a woman to have information needs that must be met before she can make a decision. Conversation analysis, a method commonly used to study practitioner–client interaction but little used in LIS, is employed to identify the unique “fingerprint” of the ICD. Analysis shows how participants develop a joint sense of the interactional tasks of informing and deciding. As an ideal, informed choice divides the cognitive labor: informing is midwife-led and deciding is client-led. In practice, however, informing and deciding are intertwined to such an extent that their resolution is neither automatic nor straightforward but must be negotiated. To be accepted as adequate, a decision must also be deemed adequately informed. Difficulties in negotiating transitions can result in one speaker treating a decision as resolved while another treats it as still open. Analyzing the fingerprints of institutional informing interactions can provide a starting point for analyzing the interactional accomplishment of informing in other settings.

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### 1. Introduction

Conceptualizing information has long been a project of scholars in library and information science (LIS) (e.g., Buckland, 1991). In institutional settings, the collection, provision, or exchange of information is often a mandated part of interactions between service providers and their patrons, clients, or patients. The study of institutional talk-in-interaction (Heritage, 2004) makes visible the ways that both information and institutional contexts are accomplished out of the social practices of participants in particular settings (Talja & McKenzie, 2007). Provider–client interactions therefore offer a site for studying ways that information is constituted out of social and documentary practices (Davenport & Cronin, 1998; Frohmann, 2004).

### 2. Problem statement

The rise of client-centered models in both LIS (Talja & Hartel, 2007) and health care (Lupton, 1997) has prompted reconsideration of two fundamental issues. First, user-centered perspectives critique a mechanistic and paternalistic model of communication that characterizes information as an objective entity that can be transferred from one speaker to another and whose value can be measured in

“amounts” (Frohmann, 1992; Tuominen, 1997). A second consequence has been increased attention to the role of the interaction itself in shaping outcomes (Heritage & Maynard, 2006a, 2006b). In a number of disciplines, this attention has resulted in calls for a shift in focus from cognitive processes to material social practices (Frohmann, 2004; Savolainen, 2007). For example, Frohmann (2004, p.22) advocates “translating talk about ideas, concepts and information into talk about occasioned utterances and inscriptions.”

Discourse-based approaches (see Budd, 2006; Talja & McKenzie, 2007; Wetherell, Taylor, & Yates, 2001; Wooffitt, 2005) are well suited to studying the occasioned utterances that make up *informing* and have provided new insights on professional–client communication in LIS and beyond. One such approach, conversation analysis (CA), has largely been overlooked by LIS researchers. CA provides a means of analyzing how professionals and clients collaboratively accomplish informing as an interactional goal, and how that accomplishment orients to interactional and institutional contexts.

This article has three purposes. First, it reviews cognitive, interactional, and discursive approaches to the study of institutional interaction and introduces Maynard’s (2003) CA framework for analyzing the “fingerprint” of institutional interaction. Second, it presents perspectives on informed choice in health care and introduces the profession of midwifery in Ontario, Canada, as a setting particularly suited to studying the accomplishment of informing. Finally, it presents research findings addressing the general question of how midwives and childbearing women orient to the

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institutional mandate of informed choice in the *informed choice discussion* (ICD). Specifically:

1. What is the overall structural organization (the fingerprint, Maynard, 2003) of the ICD?
2. What identifiable subsections make up the ICD and what interactional patterns do these consist of?
3. What is the institutional and interactional relevance of each component (Arminen, 2005, pp.75–77)?

In other words, what are the practices whereby midwives and childbearing women reassure themselves, one another, and others that an informed choice discussion is taking place and has been successfully resolved?

This article thereby seeks to bring an LIS perspective to clinical communication and to provide insight into the nature of informing as an interactional accomplishment with relevance for other institutional settings.

### 3. Literature review

For more than 100 years librarians have considered the fundamental goal of the reference interaction to be discerning the user's true need (Rothstein, 1977; Taylor, 1968). Studies of reference transactions have therefore focused largely on the cognitive tasks of eliciting users' needs. While these studies may analyze recordings or transcripts of librarian–user interactions, talk is taken as a more or less transparent representation of the cognitive (e.g., Kim, 2005; Wu, 2005; Wu & Liu, 2003) and affective (Nahl, 2007) processes undergone by the user. In health care, the cognitive problem is the converse: determining whether a patient is adequately informed about a health risk, diagnosis, or intervention. Researchers working from a cognitive perspective test patients' knowledge of the issues at hand or solicit their self-reports of feeling adequately informed (Freda, DeVore, Valentine-Adams, Bombard, & Merkatz, 1998; Gourounti & Sandall, 2008; Kohut, Dewey, & Love, 2002; O' Cathain, Thomas, Walters, Nicholl, & Kirkham, 2002; Rowe, Fisher, & Quinlivan, 2006; Shorten, Shorten, Keogh, West, & Morris, 2005; van den Berg, Timmermans, Ten Kate, van Vugt, & van der Wal, 2006). Patients may also evaluate the quality and quantity of information provided (Churchill & Benbow, 2000; Guillemin & Gillam, 2006).

As the popularity of user-centered models has increased (Talja & Hartel, 2007), evaluations of librarian–user transactions based on the correctness of the answer have largely given way to evaluations of the interpersonal interaction in relation to behavioral guidelines (e.g., Curry, 2005; Kwon & Gregory, 2007; Walter & Mediavilla, 2005) or user satisfaction (e.g., Durrance, 1989; though see Arnold & Kaske, 2005). Such evaluations generally analyze interviews and surveys (e.g., Bunge, 1999), possibly combined with unobtrusive observation (e.g., Curry, 2005; Radford, 1998).

A very large literature analyzes professional–client interactions themselves rather than retrospective accounts. In LIS, Pettigrew (1999) analyzed contextual factors and found that “information flow” might occur in unexpected directions (e.g., from patient to nurse, among patients). Linguistic and sociolinguistic analyses of interactions (e.g., Radford, 1999) have become more common with the availability of chat reference transcripts (e.g., Kwon & Gregory, 2007; Maness, 2008; Marsteller & Mizzy, 2003; Pomerantz, Luo, & McClure, 2006; Radford, 2006; Westbrook, 2008). Approaches based on the work of Erving Goffman are common (Chelton, 1997; Linell & Bredmar, 1996; Mokros, Mullins, & Saracevic, 1995; Olsson & Jansson, 2001; Radford, 2006; Westbrook, 2008). In health communication, several studies analyze contextual and interpersonal factors that might influence a patient to accept or refuse a diagnostic or treatment procedure. (For reviews, see Skirton & Barr, 2007; Edwards et al., 2006).

Discursive approaches understand practitioner–client interaction to be socially constructed. A discursive approach focuses on “the study of language in use” (Wetherell et al., 2001, p.2): the understanding of language as constitutive and constructive and of meaning as emerging from complex social processes. As Budd (2006) and Wetherell et al. (2001) cautioned, there are several distinct forms of discourse analysis that share some vocabulary and analytic procedures but differ in theoretical underpinnings. Wetherell et al. (2001, p.5) provide a helpful classification:

1. The study of culture and social relations. This macro-level approach is concerned with the historical and institutional features of discourse. Researchers are especially interested in power relations and how power affects the construction of the discursive space. For example, Frohmann (1992) and Tuominen (1997) critiqued the cognitive paradigm and the interests involved in representing library users as autonomous subjects. Hayter (2007) found that nurses' use of medico-statistical facts downgraded potential side effects. Cowley, Mitcheson, and Houston (2004) showed how the talk and work of home visiting nurses achieved the requirements of institutional agendas.
2. The study of minds, selves, and sense-making. This meso-level approach is concerned with the ways that accounts are constructed as credible and factual and the discursive functions accounts perform within their broader interactional contexts. This approach is particularly useful for analyzing the ways that concepts (e.g., information needs, McKenzie, 2004; evidence, McKenzie & Oliphant, 2006; Adelswärd & Sachs, 1996) and categories (e.g., information providers: Ross & Dewdney, 1998), information seekers and library users (Chelton, 1997; Given, 2003; Hedemark, Hedman, & Sundin, 2005; Dixon-Woods, 2001), are worked up and justified. Tuominen (2004) and Bishop and Yardley (2004) found, for example, that patients constructed discursive positions for themselves that were consistent both with moral values of autonomy and with a sense of accountability for one's own health, which might require sacrificing autonomy to comply with medical recommendations.
3. The study of social interaction, or conversation analysis (CA), the approach employed for this analysis. CA differs in from other analytic approaches in a number of fundamental theoretical assumptions (Heritage, 2004; Wooffitt, 2005). First, CA draws on Erving Goffman's (1983) finding that social interaction itself embodies an institutional order. This “interaction order” comprises a complex set of interactional rights and obligations that exist independently of individual characteristics of participants, and it in fact both underlies and mediates the operation of all other social institutions (Heritage, 2004, p.222).

Second, CA differs from other discursive forms in its focus on the sequential organization of talk. CA assumes that participants manage interaction by displaying their understanding on a turn-by-turn basis within a larger sequence of talk. Epperson and Zemel (2008) observed, for example, that Radford's (2006) turn-by-turn analysis coded the presence of “rapport building” in an utterance regardless of how that utterance was taken up by the next speaker. Since CA focuses on intersubjective understandings, it is “premised on the belief that it is not possible to understand an utterance in isolation” (Epperson & Zemel, 2008, p.2280). A single turn is therefore both *context-shaped*, in that it responds to talk immediately preceding it, and *context-renewing*, as it creates the context for the next person's talk (Heritage, 2004, p.223). CA thus contains a built-in validity mechanism: the meaning of any turn becomes evident by analyzing the ways that recipients construct their understanding of it in subsequent turns (Heritage, 2004, pp. 223–4).

Third, conversation analysts argue that turns of talk perform actions (Heritage & Maynard, 2006a, pp.9–10). Although CA has been “little used” in LIS (Budd, 2006, p.70. See Epperson & Zemel, 2008;

Forrester, Ramsden, & Reason, 1997; Solomon, 1997; Ulvik & Salvesen, 2007; Yakel, 1997), conversation analysts have considered how speakers' talk performs a number of actions of potential interest to LIS scholars. These include "troubles telling" (Jefferson & Lee, 1992), raising new topics (Button & Casey, 1984), informing (Heritage, 1984; Schiffrin 1999), news giving (Maynard, 2003), advice giving (Heritage & Sefi, 1992; Pilnick, 2001), agreeing or disagreeing with prior talk (Kuo, 1994), claiming and challenging authority (Garcia & Parmer, 1999), managing discrepant perspectives (Lehtinen & Kääriäinen, 2005), counselling (Kettunen, Poskiparta, & Karhila, 2003; Silverman, 1997; He, 1995), negotiating (Karhila, Kettunen, Poskiparta, & Liimatainen, 2003), disclosing and responding to fears (Beach, Easter, Good, & Pigeron, 2005), presenting and discussing problems (Gill & Maynard, 2006; Robinson, 2006; Shaw & Kitzinger, 2007), repairing miscommunications (Ridley, Radford, & Mahon, 2002), making indirect requests (Gill, Halkowski, & Roberts, 2001; Weijts, Widder-shoven, Kok, & Tomlow, 1993), discussing difficult or sensitive issues (Epperson & Zemel, 2008; Kinnell, 2001; Parry, 2004; Pilnick & Coleman, 2006), accounting for behavior (Fisher & Groce, 1990), making assessments (McHoul & Rapley, 2002; Jones, 2001), instructing (Epperson & Zemel, 2008), explaining (Collins, 2005), diagnosing (Brookes-Howell, 2006; Peräkylä, 2006), verifying understanding (Lehtinen, 2005), proposing and negotiating diagnostic (Pilnick, 2008; Lehtinen, 2005) and treatment options (Gwyn & Elwyn, 1999; Stivers, 2006), and closing conversations (Rostila, 1995; West, 2006).

Solomon noted in 1997 (p.219) that CA had largely been applied to everyday rather than institutional talk. In recent years, however, a growing body of research has looked specifically at institutional interaction (Arminen, 2005; Drew and Heritage, 1992; Heritage & Maynard, 2006a, 2006b; Heritage, 2004). Rather than assuming that an institutional context encloses and constrains interaction, CA considers that the social worlds of institutions are evoked and made actionable in and through talk: "talked into being" (Heritage 2004, pp.222–223).

CA has been used to identify interactional characteristics that affect the outcomes of reference interviews (Ulvik & Salvesen, 2007). Epperson and Zemel (2008) analyzed two chat reference transcripts in depth, identifying "the interactional technologies used by librarians and users to manage chat reference encounters" (p.2276). They demonstrated how librarians and users oriented to the institutional imperatives of library instruction to manage the introduction of delicate matters such as initiating requests for help and making refusals. Negotiating a reference interview (Epperson & Zemel, 2008, p.2279) and communicating risk in a health-care setting (Pilnick, 2008) are interactionally complex and subtle processes. CA recognizes and acknowledges the interactional work required in accomplishing even the most mundane institutional settings.

Everyday conversations have structural features, including preferred "slots" for particular kinds of talk which may be noticeable and accountable when absent (e.g., an acknowledgement is expected to follow a statement of thanks). Apart from these, however, everyday talk may be quite fluid. Everyday practices for interaction (e.g., telling news) and for the joint management of self-other relations (e.g., conventions for interruption) are largely carried forward into institutional settings (Heritage & Maynard, 2006a, p.13). However, institutional interaction differs from everyday interaction in important ways.

Institutional interaction may be structured in a more regular way, with components characteristically emerging in a particular order (Heritage & Maynard, 2006a, p. 14). Institutional talk often involves reductions or respecifications of the conventions of everyday talk that constrain what will be treated as allowable contributions. Institutional interaction further involves participants in specific goals that are tied to their institution-relevant identities (e.g., librarian and user, midwife and client). Interaction between service providers and their clients operates at the interface of workplace and everyday systems: the very reductions and respecifications that ensure smooth and routine

institutional functioning for the professional may be experienced by the client as constraining or irksome (Heritage, 2004, p. 225).

Together, the specific "tasks, identities, constraints on conduct, and relevant inferential procedures that the participants deploy and are oriented to in their interactions with one another" create a unique "fingerprint" (Heritage, 2004, p.225) for each kind of institutional interaction. Pilnick (2001) and Heritage (2004) have identified the institutional fingerprint of pharmacist-client advising and school calls home to check up on absent students; this article does the same with the midwifery informed choice discussion. By identifying this fingerprint, CA can respond to LIS calls for the study of social and documentary practices (Frohmann, 2004; Davenport & Cronin, 1998).

## 4. Methods

### 4.1. The institutional setting

The ideals of informed choice are foundational to the decision-making model espoused by direct-entry midwifery in Canada (Spoel, 2007; Thachuk, 2007). Health decision models abound, but terminology and specific details are often inconsistent (Moumjid, Gafni, Brémond, & Carrière, 2007; Young et al., 2006). In a paternalistic model, the provider's knowledge is taken as superior to the client's, and simply providing information is seen as sufficient to improve outcomes (Dixon-Woods, 2001; Frohmann, 1992; Lee & Garvin, 2003; Tuominen, 1997). The provider sets the goals and makes decisions, assuming that the client's interests will be congruent with his or her own. In a consumerist model, the client or patient sets the goals and agenda and uses the practitioner as a technical consultant in making his or her own informed choices. A shared decision-making model lies between (Heritage & Maynard, 2006a,b, p.354; Elwyn, Gwyn, Edwards, & Grol, 1999).

In the province of Ontario, informed choice, continuity of care, and "respect for pregnancy as a state of health and childbirth as a normal physiologic process and a profound event in a woman's life" (College of Midwives of Ontario, 1994) are inextricably intertwined in the midwifery model of care. The principle of informed choice is prominent both in official midwifery documentation (College of Midwives of Ontario, 2005; Association of Ontario Midwives, n.d.; Ontario Ministry of Health and Long-term Care, 2003) and in popular works for childbearing women (Hawkins & Knox, 2003). The *Philosophy of Midwifery Care in Ontario* sets forth informed choice is a guiding principle for an egalitarian, relational, empowering, woman-centered communication model. The term informed choice is a conscious echo of the liberal feminist rhetoric of reproductive choice, on the basis of which Canadian consumer groups lobbied for women's right to choose midwifery care (Bourgeault, 2006; MacDonald, 2006; Spoel, 2007; Thachuk, 2007). It is also a reaction against a medical model of informed consent seen as based on a narrow ideology of autonomy (Thachuk, 2007) and as providing legal protection for physicians (Spoel, 2007, p.6). In the midwifery model, women's experience and knowledge ideally determines midwifery knowledge and practice (Bourgeault, 2006; MacDonald, 2006), and decisions are made by women in the context of an ongoing caring relationship with their midwives.

Spoel (2007) cautions, however, that the ideals of midwifery informed choice are challenged by the very consumerist discourse from which the model emerged. Consumerism has been widely critiqued for representing clients as rational and monologic subjects (Tuominen, 1997), simultaneously enlightened and ignorant (Frohmann, 1992). These representations are criticized as ignoring both the embodied and emotional nature of practitioner-client encounters (Bishop & Yardley, 2004, p.467) and the social, cultural, economic, and political contexts within which individuals live and must make decisions (Spoel, 2007, p.24; Lupton, 1997; Henwood, Wyatt, Hart, & Smith, 2003); and for shifting responsibility for the

management of health from provider to patient (Salmon & Hall, 2003). Midwifery's adoption of the informed choice model therefore makes it an ideal site for understanding ways that the impression of "information" is "constituted out of certain practices" (Nunberg, 1996, p.115), institutionally mandated and discursively located.

#### 4.2. Data collection

Data for this article come from transcripts of audio recordings of a clinic visit between each of 40 childbearing women and her midwife. Ontario communities were purposively sampled to maximize variation of population and hospital access. The researcher approached all midwifery practices within the selected communities. From willing practices all willing midwife–client pairs were accepted. The sample of practices is therefore purposive, and the midwives and clients constitute a convenience sample.

Participants came from 15 practices. Women ranged from 14 weeks pregnant to two weeks postpartum, and midwives ranged from first-year practitioners to senior midwives with more than 20 years' experience. Between two and five people were present for each visit, including midwifery students and clients' children, partners, and other support people. The study conforms to the ethical guidelines of the Social Science and Humanities Research Council of Canada (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada & Social Sciences and Humanities Research Council of Canada, 2003), and all participants are identified by institutional role.

From the corpus of 40 transcripts, the researcher identified the discussions of medically routine "tests, medications, and considerations of a management plan for care in the antenatal, intrapartum and postpartum period" that are mandated as necessary in order for a client to be informed (College of Midwives of Ontario, 2005). Their medically routine status is demonstrated by their identification on standard forms (e.g., Ontario Ministry of Health and Long-term Care, 2005) or in Canadian childbirth guides (Hawkins & Knox, 2003; Lalonde & Schuurmans, 2006) as routine or legally required. This is certainly not the only kind of midwife–client talk that orients to informing as an interactional goal. Pregnant women do present acute complaints and concerns for which they seek diagnoses and treatment options (McKenzie, 2004). It is argued, however, that this *informed choice discussion* (ICD) constitutes a particular form of interaction because of its official mandate: the Ontario midwifery *Informed Choice Standard* (College of Midwives of Ontario, 2005) institutionally understands childbearing women to possess information needs on certain topics, and mandates that those needs be met through the act of informing in order for women to make decisions.

Midwives and childbearing women likewise identified the ICD as a particular kind of talk:

##### Extract 1<sup>1</sup>:

M: Has [other midwife] actually had a full-blown informed choice discussion about home birth versus hospital birth with you?

P: No.

W: No I don't think so.

M: We probably should have it at some point. Not that obviously we're not completely in support of your choice. And I don't, like I think you're, you're a fine candidate for home birth but. And, it seems odd that we have to have that informed choice discussion.

But we do because [home birth]'s not the norm. And because it is still a choice.

W: Mhmm.

M: even though you are pretty //sure// of that choice you have already made it.

//W: Yeah.//

W: Mhmm.

M: So I just want to make sure that you are aware of all the risks and benefits of either side.

W: Mhmm.

M: So I won't get into that now cause it's a little more lengthy but we should make sure that between now and the next month or so.

W: Okay.

M: That we or you and [other midwife] or like, myself and you discuss it.

W: Okay.

M: Okay?

In this example, all participants treat the ICD as having distinctive characteristics. It is mandated, will be lengthy, and should happen at a particular time. It will address strengths and weakness of more than one option. The ideal of informed choice divides the interactional and cognitive labor: The responsibility for informing falls to the midwife, while deciding is the client's job. Finally, even though this woman and her partner have made a provisional decision to have their baby at home, the decision cannot be accepted as informed until the ICD has taken place. "The midwife's job is to provide the information, and *then* let you select your option" (Hawkins & Knox, 2003, p.6, emphasis mine).

The data set contains 61 ICDs from 27 of the 40 visits. The shortest consisted of a single pair of conversational turns, while the longest occupied 17 transcript pages and 20 min of interaction. Topics discussed were: testing (for sexually-transmitted diseases, hemoglobin levels, and the Group B Streptococcus bacterium), screening (first trimester prenatal screening, screening for gestational diabetes), routine ultrasound, administration of immune globulin to Rh negative women, choice of birthplace, internal exam, fetal monitoring and pain management in labor, circumcision, administration of vitamin K and prophylactic eye drops to newborns, and postpartum Pap test.

#### 4.3. Data analysis

Data analysis followed Heritage's (2004) strategy for probing the institutionality of interaction: creating a map of the overall structural organization of the interaction to identify its typical phases or sections. The analytic procedure starts with the identification of relevant sequences and a careful turn-by-turn analysis of what action each turn accomplishes and how it relates to previous turns. This allows the analyst to break the general structure into smaller identifiable sections which themselves consist of particular interactional patterns. Once this preliminary enumeration is complete, instances and subsections are compared for consistencies and deviations to identify patterns and to begin to specify the potential relevance of each component (Arminen, 2005, pp.75–77). In this way the analytic method is similar to constant comparison (Strauss & Corbin, 1990) but with the goal of identifying the characteristics of the interaction rather than of developing grounded theory.

The purpose of identifying these sections is not to describe each exhaustively, to find statistical regularity, or to claim that each section will always occur in the same order in every ICD (Heritage, 2004, p.229). As will be shown, midwives and women "break out of and return to particular activities, reopen them and reinstate task orientations they had previously treated as complete" (Heritage & Maynard, 2006a, p.14). The purpose is rather to identify the goal-related sections that participants themselves orient to as relevant to the completion of their business together.

<sup>1</sup> Transcription standards. M: Conversational turns are prefaced by an initial identifying the speaker (Midwife, Woman, Partner, Student), and a colon. // Marks overlapping talk. (( )) Inaudible. [] Nonverbal elements such as laughter, physical gestures, changes in tone, or to indicate the removal or identifying details or the editing of the excerpt for this article. ... Indicates the approximate length of a pause in seconds. ? ! Punctuation indicates both grammatical sentence-ends and emphatic or interrogative intonation, syntax, or intent.

Trustworthiness was ensured through triangulation of sites and methods (Lincoln & Guba, 1985); this is one of several analyses of this data set (Burkell & McKenzie, 2005; Davies & McKenzie, 2004; McKenzie & Oliphant, 2006; McKenzie, 2004, 2006). Consistent with the specific tenets of CA, the validity of the analysis can be verified by attending to the ways that the speakers themselves interpret previous conversational turns (Heritage, 2004, pp.223–4).

The initial analysis section will present the basic ICD sequence and describe the business of the overall interaction and the significant stages in the parties' co-construction of tasks and goals (Heritage 2004, p.229). It will then describe how participants develop a joint sense of informing and deciding as interactional tasks and, finally, consider situations where developing a joint sense is problematic.

## 5. Findings

### 5.1. The basic ICD sequence

A single informed choice discussion sequence was typically completed in one section of talk, although there were exceptions. The basic ICD sequence consists of four major sections: initiation (IN), elaboration (EL), disposal (DS), and closing (CL) (Fig. 1).

#### Extract 2:

**IN** M: The other thing, last time when we checked your hemoglobin it was a bit on the low side,

**EL** have you been takinnng, //iron?//  
//W: Yeah, // yeah, I've been taking

that Floradix

M: Great.

W: Yeah.

M: Good. So we'll probably want to check it again next, at your next visit just to make sure it hasn't gotten, too low.

→1 W: Okay.

M: Umm just to, you know usually it'll have been mov, going up, especially after taking the iron?

→2 W: Mmhmm.

M: For two weeks.

**DS** but we'll check it again just to make sure, cause it was, a bit on the low side.

**CL** Um, and the other thing just for you do decide around that is, um, something called active management of the third stage?

The overall sequence deals with managing informed choice as an action. Sectional analysis opens up the incremental steps whereby participants move (or fail to move) toward this goal.

The initiation section raises the topic at hand. Although the midwife in Extract 2 simply nominates a topic for conversation (Button & Casey, 1984), initiation could further institutional goals by tying the topic explicitly to an institutional schedule, or by orienting to the ICD as a particular kind interaction by initiating the topic as something "decisionable," as the midwife does in the final turn. Midwives led the initiation of most, but not all, ICDs.

The elaboration section, which will be analyzed in more detail below, orients most directly to the goals of informing and deciding. Elaboration continues until participants jointly resolve either or both informing and deciding as a) unnecessary or b) sufficiently

completed. In Extract 2, deciding is resolved first. The midwife proposes a treatment and the client produces a receipt token ("Okay," at marked turn 1) that is different from the responses she has used before. Stivers (2006, pp.282–3) showed that an "okay" response treats a statement as a proposal to be accepted rather than as an informing to be acknowledged. The midwife responds to this "Okay" as an acceptance of the procedure, moving on to further explanation. The client treats this next turn as informing, responding with a continuation token ("Mmhmm") at marked turn 2. The midwife does not respond with further informing but closes off the elaboration as complete.

Once informing and deciding have been resolved, parties move to disposal, where they determine what next actions will be taken. An important subgoal in this stage is the making of arrangements, and the disposal stage can be quite long. Further informing talk may occur: as Stivers (2006, p. 283) found, acceptance of a treatment proposal allows a clinician to move from generic discussion of remedies to determining what specific type will be prescribed.

Once arrangements have been resolved, participants move on to closure, which effects an orderly progression to the next topic. The midwife closed this discussion by initiating another topic as decisionable.

Although the entire sequence accomplishes the business of resolving informed choice and making the necessary institutional arrangements for the decision to be acted on, it is the elaboration stage that most directly accomplishes the interrelated subgoals of informing and deciding. In order to close off the elaboration stage, the midwife and woman must resolve both informing and deciding as unnecessary or complete, and the midwife must accept both as sufficient. The remainder of the article will look in more detail at the elaboration section to analyze how participants develop (or fail to develop) a joint sense of informing and deciding as interactional goals and the roles of each participant in achieving these goals.

### 5.2. Informing and deciding as interactional goals

#### 5.2.1. Resolving "informing"

Heritage (1984, p.304) characterized informing as a form of talk that proposes the teller as knowledgeable about a topic on which the recipient is proposed to be ignorant. The ICD institutionally presumes the midwife to be knowledgeable and the pregnant woman to be ignorant on the topics under discussion. In Extract 3 the participants orient to the problematic nature of attempting to inform someone of something to which she may already lay claim knowledge (Maynard, 2003):

#### Extract 3:

M: Fasting blood sugar, and then, one hour and two hour [blood sugar measures].

W: Okay.

M: Which I know you're familiar with, but

W: Yeah, that's okay.

M: I'll just start, and you can't stop me talking!

W: No, no, no. It's that good. It's always a good review. [laughs]

Accepting institutionalized positions with regard to knowledgeability is not sufficient to ensure that "informing" will take place. A midwife can warrant a woman's query as ineligible for informing if it

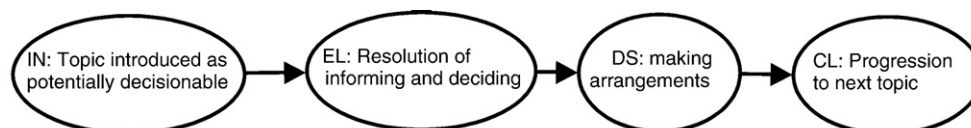


Fig. 1. Simplified model of the ICD.

comes at the wrong time according to the schedule of discussion topics (Davies & McKenzie, 2004):

**Extract 4:**

M: it's too soon to worry about that. [laughs]  
 W: I don't know, it's coming fast!  
 M: We'll burn that bridge when we get to it. Yeah. [laughs]

Participants used several techniques to accept an informing sequence as sufficient. First, they could *display* the woman's informed status. The simple receipt token "Oh" can serve the interactional function of indicating that a hearer has undergone a change in state from uninformed to informed: "With the use of 'oh,' recipients thus confirm the presupposition, relevance, and upshot of the prior act of informing as an action that has involved the transmission of information from an informed to an uninformed party" (Heritage, 1984, p.304). An "oh" can therefore signal that "the informant may lawfully withhold from further talk" (Heritage, 1984, p.333. See also Maynard, 2003, p. 101; Schiffrin, 1999).

**Extract 5:**

W: So you //would just be concerned// if [the baby's heart rate] was fast when it was resting  
 //M: (( )) we would look be//  
 M: Uh, not if it was fast when it was resting, we would be concerned if it was uh, if it, if the baby was moving around, and there was a deceleration.  
 W: Ohh, right.  
 M: instead of an acceleration?

A display of informed status could in fact completely close off further informing talk. This midwife responded to the woman's extensive display by abandoning this topic and initiating a new one:

**Extract 6:**

M: Now did [the obstetrician] discuss with you risks of caesarean?  
 W: Well, I'm quite clear about the risks of caesarean, I've had one.  
 M: Right. Yes.  
 W: [laughs] It hurt like hell and I don't want to do it again. [laughs]  
 M: Right, well, exactly. So you've had the first-hand experience.  
 W: And it's major surgery.  
 M: Yeah.  
 W: I mean, you know, any, as far as I'm concerned any time you go into a hospital right now you stand a larger chance of septicaemia, you know.  
 M: Mhmm.  
 W: Picking up bugs that you wouldn't necessarily be more immune to as you might be at home.  
 M: Mhmm. [woman's description of her previous labor removed]  
 So I think, you know, certainly my role as your midwife is to support you if you want to birth in the home or birth in the hospital.

Second, an adequately warranted statement of the woman's informed status could close off informing and lead to consideration of deciding:

**Extract 7:**

M: Group B strep.  
 W: Right.  
 M: Oh God, this is like an informed choice marathon!

W: Well no, I was told, [other midwife] talked to me about that last week.  
 M: So you're gonna swab today.  
 W: I'm gonna swab today?  
 M: I'm asking.

Finally, informing could be closed off by resolving "deciding."

5.2.2. Resolving "deciding"

The subgoal of deciding is taken to be resolved when participants propose and accept a decision as

1. unnecessary or inappropriate, for example, when only one option is presented as open or when a proposed intervention does not pertain to this woman.

**Extract 8:**

M: Umm, ... Yeah. And you are Rh positive, correct? Yyyeaaaaah.  
 W: Rh positive?  
 M: Yeah.  
 W: Yeah.  
 M: You're O positive, okay.  
 W: Yeah.  
 M: So we don't have to worry about setting up, immune globulin //or// anything like that for you  
 //W: Yeah//  
 W: Okay.

2. eventually but not immediately necessary.

**Extract 9:**

S: Had yoouu, said yes? at this point //to Vitamin K?//  
 //W: We said we were  
 // gonna wait //and see//  
 //S: Okay //

M: Mhmm.  
 W: what, how the birth goes?  
 S: Mhmm.  
 W: and if it's really traumatic then we'll go for it.  
 S: Okay.  
 W: We were gonna decide.

3. complete: reported by the woman and accepted by the midwife as in [Extract 2](#).

Women sometimes spontaneously reported decisions in the course of a proposed informing. In [Extract 10](#), the midwife raises a previous discussion, which the woman suggests might have been inadequate ("Well, briefly"). The midwife responds with an offer of further informing, but the woman rejects the offer with a decision report, which the midwife accepts:

**Extract 10:**

M: Yeah. So you arrre, now last time we briefly talked about genetic screening, right? And  
 W: Yes, we did. Um well, briefly.  
 M: [paper rustling] So do you want me to talk a bit about, more about the options?  
 W: Well I, I think that I would like to have it done. Like I think I, I, my husband and I have talked about it and I would like to do it.  
 M: Okay. So we'll (( )) [banging]. So you want to have the first trimester screen. //Right?//  
 //W: Yeah. [rustling]//

M: Okay.

If a decision report was not forthcoming, midwives sometimes used strategies to elicit one, such as explicitly presenting an option as

decisionable. In *Extract 11*, the midwife made two such attempts before the woman responded (marked turns 1 and 2):

**Extract 11:**

→1 M: Uh, this is a choice, again. You can choose, not to do that? and just, you know, we can just listen to your heart, the baby's heartbeat every few days, check up with you and uh, see, you know, wait for you to go into labor as well, wait for signs of labor to start.

W: [quietly] Mhmm [several elaboration turns deleted]

→2 M: So those are things we have to think about and uh, you can //(( ))//

//W: I would rather// go into labor naturally.

Finally, a midwife might directly request a decision report:

**Extract 12:**

M: Great... And we were gonna do the GBS, swab. //Today//

//W: Okay.//

M: Had you decided that? That's what //[other midwife] had written//

//W: Yeah//

M: down //that you// wanted do that this time so um.

//W: Yuh!//

Three things are noteworthy here. First, informing is accepted or rejected interactionally and is not necessarily reflective of the woman's state of knowledge. Second, "information" is not simply transmitted by the midwife and received by the woman in a one-sided communication. As in classroom lecturing, the interaction is jointly constructed (Arminen, 2005). Finally, although the above examples

have shown some of the ways in which informing and deciding might be independently resolved, the two are deeply intertwined. The final analytic section will address some of these interconnections.

5.3. The interactional interconnectedness of informing and deciding

There are many ways in which the elaboration section may be closed off to enable a move into disposal: Both informing and deciding might be negotiated and then resolved as sufficient; informing may be resolved, and deciding may be dismissed as unnecessary; informing may be dismissed as previously complete, and the parties may move straight into negotiating and resolving deciding; or both informing and deciding may be identified as previously completed, and the ICD may move directly into disposal (Fig. 2).

The examples discussed so far have all been resolved straightforwardly, but two kinds of challenges threatened the successful negotiation of the ICD. The first set of challenges relates to an inherent tension in the informed choice model. It is the midwife's responsibility to inform the woman of the risks and benefits of each course of action so that she may make appropriate choices. In informing, the midwife's professional training and experience grant her expert status. At the same time, however, the midwife's role is to support women's choices whether she agrees with them or not. In decision making, the woman is institutionally framed as the expert about what is appropriate for her.

Because a midwife is mandated to support a woman's informed decision, one of the few ways she can legitimately challenge a decision is to declare it insufficiently informed. She may do this by deferring her acceptance of a decision report until the woman actively displays informed status or until she herself engages in more informing. Instead of accepting the woman's initial decision report in *Extract 13* (marked turn #1), the midwife explains the predictive value of the

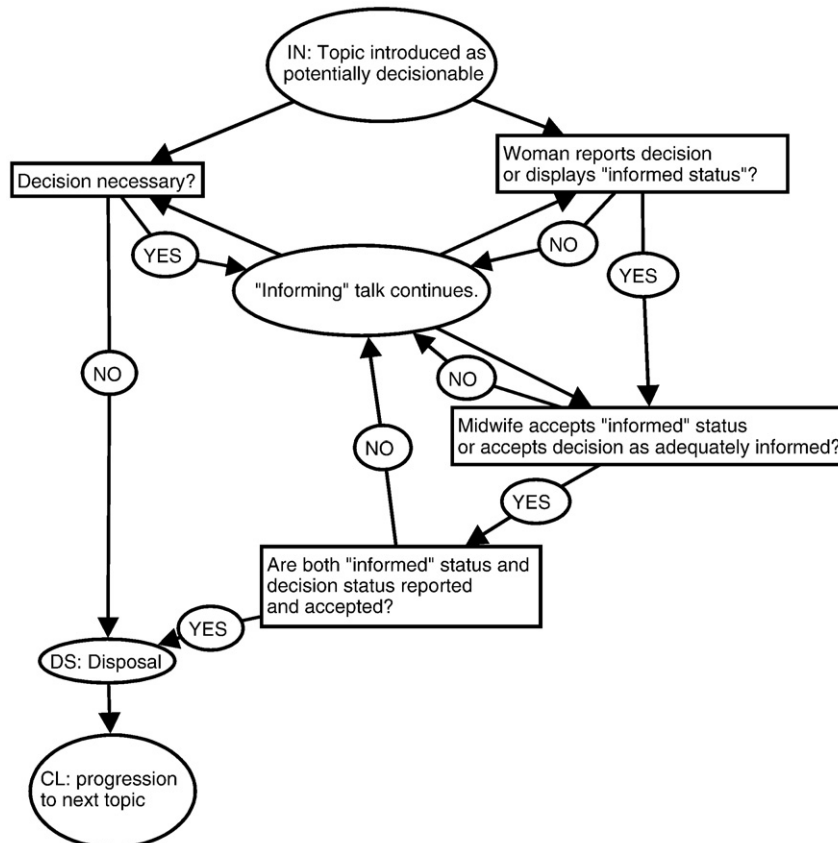


Fig. 2. Expanded model of the ICD.

procedure under discussion. The woman's second decision report specifically references the further elaboration, showing it her decision to be "informed" on that point. The midwife then accepts the second decision report (marked turn #2).

**Extract 13:**

M: I can do a vaginal exam today if you want.

→1 W: Okay.

M: I mean it wouldn't.

W: Will we have the baby soon?

M: [laughs] You know the more I tell you you'll have the baby ((soon)) from the vaginal exam, the less likely that it will do anything. [elaboration turns removed] Regardless of what your cervix is doing, it doesn't tell us when you're gonna go into labor [elaboration turns removed].

→2 W: Okay. Well, still. I mean I wouldn't mind you uh taking a look and seeing if anything, has happened.

The second set of challenges arises in negotiating the transition from elaboration to disposal. Talk that participants took to have "informing" characteristics (Heritage, 1984) could occur in both in discussion of the intervention under consideration and in the making of arrangements once a decision was reported (Stivers, 2006). This could result in a situation in which one speaker treats the talk as being one kind (elaboration, where the decision is still under negotiation), while another treats it as another (disposal, with a decision having been accepted; Jefferson & Lee, 1992).

In Extract 14, a midwifery student introduces a diagnostic test. The woman provides a lengthy anecdote about her experience with this test in a previous pregnancy and then reports a decision. The student accepts the decision and goes on to discuss arrangements (marked turn 1). The two treat the question as resolved, but the midwife reopens elaboration (marked turn 2) by asking the client for a report of her informed status. After some negotiation, the client reports herself to be uninformed and requests a fuller explanation of the procedure.

**Extract 14:**

S: So the other thing we have to talk about is screening for group B strep. I don't know if you remember that with [previous pregnancy] or not?

W: [anecdote removed] So I can do that as well. Um like, so you have to take a, a, a swab?

→ 1 S: Yeah and you can //do it// actually yourself.

//M: Yeah//

W: I can do it myself?

S: Yeah.

W: Okay.

S: The next visit, you can do it. //((That's fine)).//

//W: Okay the next visit.//

→ 2 M: You know about, what it means and all that. Like //you're okay// from last time?

//W: Yeah//

M: We don't //need to explain everything over again?//

//W: Yeah can you, can you// explain it a little bit

though?

M: Yeah.

W: Actually?

M: Yes, we can. [laughs]

W: Just a little more.

S: [laughs]

M: //We can pretend you know nothing about it!//

//W: [laughs at length]//

W: I just know that it was, it was more dangerous once thee. It, it was like the timing of the, thee um, the waters breaking? Like it

gets, doesn't it, it gets a little bit more. I don't know, what is it about again? [laughs]

Even though the woman displayed previous experience with this intervention and reported a decision, the midwife withheld full acceptance until she had reopened informing.

In the most striking example of reinstating task orientations previously treated as complete (Heritage & Maynard, 2006a, p.14), a midwife and woman discussed options for diabetes screening: no test, a one-hour screen, and a two-hour diagnostic test. The woman reported a decision, which the midwife accepted.

**Extract 15**

W: I would probably feel better if I did it.

M: Yeah. Okay.

W: Yeah.

M: So we'll do the one hour. I'm happy to do that. And I'm not suggesting you do the two hour unless it's a bit, [in breath] high and, and if it's blatantly high then we'll, we'll just go then for the two hour one. [turns removed] So we do that as I say at 28 weeks. Okay, is that okay? So that will be next visit, we'll just have you come in a little bit earlier.

W: Yeah, and drink that drink.

At the very end of the visit, as they were going over arrangements in preparation for closing (West, 2006), the woman reopened the previously resolved issue:

**Extract 16**

W: It will ease my mind. Probably the two step would ease my mind. [laughs]

M: What?

W: You know?

M: Doing the two hour thing? You want to go for straight for that?

W: Well what do you th-? I mean, like what's the, why not just do it?... I don't know.

M: It, well, yes some people do //slip// through the net with the one hour test, you're right.

//W: Mhmm//

M: //I'm happy if//

//W: That's what I'm thinking//

M: I just don't want to subject you to that unless we really really feel we have to. But if you are going to be more confident with that, then that's fine.

Significantly, even though the midwife voiced her reservations about the more invasive test ("I just don't want to subject you to that..."), she accepted the decisions both against and for it as informed and therefore sufficient.

**6. Discussion**

Informed choice is a central ideal in woman-centered Ontario midwifery. In practice, clinical disciplines have struggled with implementing client-centered models of decision making. Providers must reconcile potential conflicts among clinical evidence, local practice, and client-centered care (Burkell & McKenzie, 2005; Levy, 1999), especially in situations where a client's choice conflicts with the clinician's own preferences (Delany, 2007; Lehtinen & Kääriäinen, 2005), or with population benefits (Raffle, 2001; Seavilleklein, 2009; Hargreaves, Stewart, & Oliver, 2005) or acceptable clinical practice (e.g., Gwyn & Elwyn, 1999; Stivers, 2005; Whitney et al., 2008). Midwives may need to negotiate several competing interests (Burkell & McKenzie, 2005), and Levy (1999) found that they controlled the release of information in order to protect women and themselves.



As an ideal, the informed choice discussion divides the cognitive labor: informing is midwife-led, but decision making is client-led. In practice, although informing and deciding may be distinct goals, they are intertwined to such an extent that their resolution may be problematic. As new mothers may prevent the resolution of a conversation with nurses by withholding their acceptance of advice (Heritage & Sefi, 1992), so may childbearing women withhold a display of informed status or a decision report, and so may midwives withhold acknowledgment of either. It is important to note that withholding acceptance of a woman's informed status is not the same as refusing to accept her decision: In Extracts 14 and 15, the midwife initially withheld acceptance but provided it once informing had been renegotiated. Likewise, in Extract 15 the midwife accepted two different decisions as adequately informed and therefore legitimate.

In order for a woman's decision to be institutionally accepted as an informed choice, the midwife must first warrant her as adequately informed. In theory, as soon as this happens, control of the action switches from midwife to client. In practice, this switch is neither automatic nor straightforward but must be negotiated among participants. Midwives are therefore faced with a dilemma: how to maximize both support and latitude for the decision-making woman? Although the woman may control when, how, or even whether to display informed status or report a decision, it is the midwife who has the final authority and responsibility to evaluate both as adequate. It is the midwife's evaluation that warrants the closing off of the elaboration section and the move to making arrangements.

Analyzing the fingerprint of the informed choice discussion therefore sheds light on the complex interactional work required in accomplishing informing in this institutional setting. The concrete practices through which the informed choice discussion is “talked into being” offer a starting point for LIS researchers interested in any setting where informing is institutionally mandated.

## 7. Conclusion

This analysis represents one possible response to LIS calls for a shift in attention from an abstract understanding of “information” to “the intertwined, institutionally disciplined, documentary and non-documentary practices from which ‘information’ emerges as an effect” (Frohmann, 2004, p.198; Davenport & Cronin, 1998). A study of institutional interaction takes the focus away from the individual and her or his characteristics and allows for a study of the concrete institutional and social practices through which “informing” is jointly accomplished in interaction. This shift in focus is potentially valuable for LIS practitioners, educators, and researchers alike.

Heritage and Maynard (2006a, p.20) argue that ordinary norms and practices of language use and social interaction “profoundly shape social dynamics in the clinic in ways that practitioners of technical medicine have not been trained to handle.” Without an understanding of how interaction works, providers and clients “may jointly produce the appearance of shared understanding rather than the reality.” Understanding the complex interactional work that underlies the accomplishment of institutionally mandated informing could alert LIS educators and practitioners to the dilemmas inherent in practice, and could provide strategies for recognizing and navigating these dilemmas.

For LIS researchers, the midwifery informed choice discussion represents a very rich kind of talk. Studying it can provide insight into the practices underlying institutionally mandated and -supported informing in a variety of settings, including libraries and information centers. Such practices include the negotiation of conflicts among competing sources and knowledge systems (McKenzie & Oliphant, 2006), the translation of the ideals of governing documents (Spoel, 2007) into practice (Burkell & McKenzie, 2005), and the navigation of mandated client-centeredness (Salmon & Hall, 2003) and neutral

informing (Williams, Alderson, & Farsides, 2002; Alcock, n.d.) when these may be neither possible nor desirable.

Analyzing the contingent and flexible ways that practitioners and clients jointly produce “informing” through their interaction opens up new questions for which new (to LIS, at least; Frohmann, 2004; Davenport & Cronin, 1998) forms of analysis are required. Interactional analysis holds much promise for transforming the age-old LIS question of “what is information?” into a more fruitful “how?”

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