'Any lumps or bumps up top?' The discourse of midwifery

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Abstract

Traditionally, studies of interaction in medical settings have tended to focus almost exclusively on doctor-patient interaction with the activities and perspective of the medical professionals receiving the lion's share of attention. As a result, the conversational activity of the patient or service-user has been obscured, and their role in the interaction left, with a few exceptions, largely undefined (Davis 1988, Metrustry 1993).

This paper examines the interaction that takes place at a midwives' antenatal clinic in a busy, urban Irish maternity hospital from the perspective of both participants The visits of 22 women to this clinic were recorded over a five-month period. The women ranged in age from 18 to 39 years and from 16 weeks pregnant to 40 weeks and 10 days pregnant. Five midwives were involved in the study. Seventy-one visits to the clinic were recorded.

Using an adaptation of Mishler's (1984) approach to the analysis of medical discourse, the content of participants' models for pregnancy and birth as revealed in the discourse are described. Key elements of the women's model of pregnancy and birth include: their view of these events as integrated into their life as a whole, their subjective experience of these events, their orientation to the midwifery frame of reference, and their ability to challenge dominant cultural assumptions about birth in contemporary Irish society. Midwives were found to use a template of pregnancy and to compare the women they encounter at the clinic to this template. They have sets of expectations for women at different stages of gestation, for women who are pregnant for the first time, for women with experience of pregnancy, and for developments known as minor disorders of pregnancy. The attempts to make women conform to the expectations set out by the model are visible in the discourse and frequently made explicit by the midwives.

Both midwives and women are successful at introducing their model for pregnancy and birth. Ultimately, however, it is the midwifery model that prevails as the midwives, by virtue of their role

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as professionals in the interaction and the location of the interaction in an institutional context, can steer the conversation back into the world of midwifery. This results in the silencing of women's perspective on pregnancy and birth and also results in preventing of a plurality of voices from emerging in the discourse.

Context

Fisher (1986) locates interaction in medical settings at the centre of a contextual web, influenced by the organization in which it takes place and the wider societal context. The interaction at the midwives' clinic is similarly located, and therefore the historical and social contexts of the culture of childbirth require a brief description by which the micro-level of interaction can be understood.

Women, pregnancy, and childbirth

The changes that have taken place in childbirth over time, particularly since the 18th century with the opening of lying-in hospitals in Ireland, have resulted in the emergence of differing models for childbirth. On the one hand is the medical model, characterized by a scientific, technical orientation and a focus on elimination of risk by intervention (Murphy-Lawless 1987). The medical model 'must emphasise the disease-like nature of pregnancy, its riskiness, in order to justify medical management' (Katz-Rothman 1991: 156). In the context of a medical model of pregnancy and birth, 'management' of what is seen as a potentially pathological event that can only be regarded as 'normal' in retrospect is paramount. It has been argued that the ever-present potential for difficulties to arise necessitates monitoring and controlling of women giving birth. Murphy-Lawless (1987: 215) argues that an

> insistence on the dangers of childbirth has also emphasised women's biological unreliability as reproducers, which in turn has led to the necessity, as obstetricians see it, of keeping women in labour under the closest scrutiny. It has established the hospitalised childbirth as the norm for every woman.

The rise of expert knowledge in the area of obstetrics and society's acceptance of the ultimate validity of expert, professional

knowledge in general has nurtured 'an ideology of women's unfitness even to be commentators on what was being done to them in the name of their own or their foetus' health' (Oakley 1986: 3).

Having gradually secured what was portrayed as an indispensable role in the management of women's bodies in labour, a further reconceptualization took place: pregnancy and childbirth were now reconceptualized as a set of infinitely divisible processes that required medical surveillance. 'Monitoring and surveillance of every aspect of both pregnancy and birth replaced classic, dramatic interventions at birth' (Arney 1982: 95). This reconceptualization, along with developments in science such as the discovery of X-rays by a German physicist in the 19th century, facilitated the development of antenatal care as a medical entity in its own right (Oakley 1984). As new technologies emerged in the mid to late 20th century it became possible for medical experts to claim that they knew more about events taking place within the woman's body than she did herself. The new technologies such as X-ray and ultrasound scanning (developed in Glasgow in the mid-1950s; see Oakley 1984), which gave access to the mysteries of the womb enhanced obstetricians' status as medical professionals and boosted their scientific credibility. It then became possible for obstetricians to lay claim to a new patient, the foetus, who had been previously untouchable prior to the onset of labour (Doyal 1995). That which was private and invisible was made public and visible (Symonds and Hunt 1996). This disempowered women in that procedures could now be justified on the basis of their importance to the welfare of the baby and gave further control of birth to the professionals involved.

There is an alternative model, one which challenges the assumptions of the medical model of childbirth and voices the belief that birth is a natural event, part of the life cycle for many women, and necessitating minimal intervention. The alternative model questions both the need for every birth to take place in hosptal and the routine use of interventions such as induction and acceleration of labour (Katz-Rothman 1991). Within the alternative model, the variation in time and location inherent in an event such as birth is accepted and not construed as problematic. Birth is seen as an event to be experienced as it unfolds and not to be managed in the sense of imposing arbitrary time frames or measures of progress such as those recommended by O'Driscoll and Meagher (1986).

As childbirth and pregnancy gradually became redefined over time, differing models for pregnancy and birth continued to evolve for the participants in the experience. Elements of the models, such as the desire for a healthy woman and baby, overlap but because women's experience of birth is individual and unique, it is not surprising that the medicalization of childbirth has problematic elements for many women.

Midwives, pregnancy, and childbirth

For midwives in Ireland and England from the early 20th century, the establishment of an identity as a profession separate from nursing was paramount (Hunt and Symonds 1995). According to Hunt and Symonds (1995: 21) 'there is a circumscribed sphere within which midwifery may practise and this sphere has been constructed by another dominant profession'. The power and autonomy of midwives in contemporary practice has been constrained historically and persists as an everyday experience in maternity hospitals. 'Independence and autonomy may have a strong ideological influence on midwifery, but in everyday practice they have to be constantly redefined' (Hunt and Symonds 1995: 37). The frustration for midwives, resulting from the constraints imposed on the limits of their practice, has received much attention in recent years. Midwives see themselves as qualified to provide care on their own responsibility throughout pregnancy, labour, and the period after birth, to recognize signs of abnormality that necessitate onward referral and to provide advice, information, and support from early pregnancy to the end of the postnatal period (Robinson and Thomson 1989). However, increasing medical involvement in 'normal' maternity care and the fragmentation of this care among a number of health professionals has led to much concern and dissatisfaction among midwives (Robinson and Thomson 1989). The frustration resulting from underutilization of midwives' skills in antenatal care has also been the focus of attention (Robinson 1989). Midwives represent themselves as devoted to deploying their skills so as to meet women's needs as expressed in studies of consumer satisfaction (Robinson and Thomson 1989). As a result, initiatives such as midwifery-led care in which small teams of midwives provide continuity of care for women from early pregnancy onwards have been developed (Curran 1986, Robinson 1989).

Midwifery's attempts to construct its own sphere of power, however, has not always been beneficial to the women it serves. According to Hunt and Symonds (1995), the relationship between the midwives' personal identity as women and their official 'face' is problematic. An essential part of the identity of a professional is dedication to one sphere of activity coupled with an acquired knowledge and expertise but the identity does not necessarily include personal experience or empathy. Hospital-based midwifery is constrained by the medical profession. Therefore, the desire to create a separate professional identity, the projection of an image of independence and autonomy, and the need to claim a status of professionally-based knowledge and practice mitigate against a conflict-free relationship between women and midwives (Hunt and Symonds 1995). Hunt and Symonds's (1995) ethnographic study of hospital labour wards in England in the late 1980s and early 1990s showed how midwives strove to achieve a degree of power and dominance over women by their use of language. They describe 'verbal asepsis' by which midwives frequently blocked conversations from developing or gave answers that sterilized the conversation. Furthermore, they claim that midwives systematically disempowered women at all stages in the childbirth experience. Women's opinions, previous knowledge, and experience were devalued by the 'experts' as the acquired knowledge of the professional woman was seen to dominate the natural knowledge of women (Symonds and Hunt 1996). They felt this situation arose from the practice of a medical model of care. 'Whilst the midwives were supportive, kind and technically proficient, the site of the birth process had reduced this crucial life event to a production-line system' (Hunt and Symonds 1995: 147).

Discourse at the midwives' clinic

Traditionally, studies of interaction in medical settings have tended to focus almost exclusively on doctor-patient interaction and on the conversational activities of the medical professional in question. Examination of interaction in other medical setttings has been relatively limited and discourse analysis has not often been used as an analytic tool in this context (Danziger-Klein 1978, Kirkham 1993). Of the studies carried out, the perspective and conversational skills of the service-user continue to receive less attention with the result that 'the patients' activity becomes, almost

automatically ... less visible and well defined. Her contribution is obscured' (Davis 1988:55). Therefore the focus of this study was interaction at a midwives' ante-natal clinic, with equal emphasis being placed on the conversational activity of both participants.

The clinic setting was set up specifically in response to the concerns expressed by women about the nature and quality of antenatal care they were receiving (Thomson 1991). It aimed to provide continuity of care to women throughout pregnancy and to provide a forum in which they could feel free to voice their concerns and seek information (Department of Health 1997). Twenty-two women were involved in the study, ranging from 18 to 39 years of age and from 16 weeks pregnant to 40 weeks and 10 days pregnant. Seventy-one visits were recorded in total and ranged in time from three minutes, 17 seconds to 30 minutes, 14 seconds. There were five midwives involved in the study. Transcription conventions were adapted from Mishler (1984). The year of birth, whether the woman has given birth already or is pregnant for the first time (multiparous and primiparous respectively), the number of the recording, and the stage of gestation are given for each extract, for example, **A.B. (1968) P. 1. 40. M.3.**

Models for pregnancy and birth

Mishler (1984), in a study of the discourse of medicine, used the concept of voices to distinguish between two normative orders. The 'Voice of Medicine' and the 'Voice of the Life World' were used to represent differing perspsectives. The 'Voice of the Life World' refers to the patient's contextually-grounded experience of events and problems in his or her life (the Life World). It includes reports and descriptions from everyday life with the timing and significance of events depending on the person's biographical situation and position in their social world. The 'Voice of Medicine', then, reflects a technical interest and expresses a scientific attitude. For the purpose of this research a similar approach was adopted, with the 'Life World' referring to the women within their social context and the 'World of Midwifery' referring to the perspective of the midwives. Both participants were seen as capable of moving between worlds of meaning. Analysis of the discourse from the midwives' clinic revealed the frame of reference through which women and midwives view pregnancy and birth.

The Life World

The key elements of women's perspective on pregnancy and birth as revealed in the discourse at the midwives' clinic are outlined below:

(i) Pregnancy and birth as events that are integrated with other aspects of their lives

Women situate their pregnancies in the context of their life as a whole (the Life World) and work to expand the focus of conversation to reflect their perspective. Women's model of pregnancy places the event firmly in the context of their life world and reflects the reality that for women, pregnancy is inextricably linked to their life as a whole and is not a discrete, isolated medical event. This element of women's model of pregnancy can be seen in the extract below:

(1) **N.M. 1962. M. 2. 21. M.3.**

060 W: I'm tired. I'm actually off this week because I was absolutely
061 exhausted when ah.
062 M: Really? [measuring]
063 W: My other baby has been up at four o clock in the morning
064 sort of thing. My husband's been busy. He's been away a
065 lot. [4] So //
066 M: Right.
067 W: // my G.P. just said to me to take a week. Try and nip it in
068 the bud.
069 M: Yeah.
070 W: B,b,but I'm not that bad now. I feel brilliant today like I mean
071 M: Mmm.
072 W: I had been feeling fine.
073 M: Yeah.
074 W: But it's just that I find it hard going now.
075 [[
076 M: Just. Yeah.
077 W: Particularly in the evening and then he doesn't go to bed until
078 half eight and then he's back up at three or four in the
079 morning.

The woman in (1) takes the floor in line 60 to begin a spontaneous account from her life world. She reports feeling tired and suggests that the reason for this tiredness is rooted in her life context. She portrays herself as situated in a social world: a world in which she is defined by many characteristics, of which pregnancy is one. This perspective differs from that of the world of

midwifery in which the fact of being pregnant is the defining feature for women.

(ii) subjective experience of pregnancy and birth

(2) **D.C. 1964. M. 3. 34. M.1.**

031 M: Very healthy. Plenty o' movement?
032 W: Oh, yes.
033 M: Yeah it's real hard there and that's the baby's head.
034 [
035 W: Yes, that's the head, yeah.
036 M: You can feel it easy. And how're your breasts?
037 W: Fine. [2.24] It's much lower this time in this pregnancy. So
038 when I go
039 M: [
040 M: Lower.
041 W: in my, in my knees, I really feel the baby on my, on my leg.
042 [
043 M: On your
044 legs.
045 W: It's very strange.
046 M: And then your muscle tone this time is a bit more relaxed//
047 W: Mmm.
048 M: // so that's why you feel pressure down there as well.
049 W: Mmm.
050 M: There's nothing wrong with that.
051 W: No (?).
052 M: Now. [2.86 putting B.P. cuff on] I'm just going to do your
053 blood pressure now.

This extract begins shortly after the midwife has started the physical examination. She asks the woman a question in line 36: 'And how're your breasts?'. The woman responds to the question and then holds the floor to introduce an appended account concerning a sensation she has experienced in this pregnancy — a sensation worthy of report as it differs from her previous experience and a serves as a reflection of the subjectivity of the experience which is an intrinsic element of women's model for pregnancy. The midwife provides an explanation from the world of midwifery for this sensation, which the woman accepts. The midwife's account reflects her model of pregnancy. This development is not of concern as it fits in with expectations for a woman who has experience of pregnancy (cf. line 50 'There's nothing wrong with that'). The topic is closed and the transition to the next

midwifery task accomplished, marked by the midwife's comment in line 52, 'Now. I'm just going to do your blood pressure now'.

(iii) Women as knowledgeable and oriented to the midwifery frame of reference

Women's responses to questions (elicited accounts) posed by the midwives reflect their understanding of specialized midwifery terminology and the concerns of the midwifery model. The conversation reveals the women's attempts to move between the life world and the world of midwifery. They report developments that they consider germane and compare those developments in the present pregnancy to their prior experience of pregnancy or to when they are not pregnant. In doing so, they portray themselves as actively engaged in observing the changes taking place in their bodies and attempt to ensure that the perspective of them in the conversation is not the narrow one of the medical model but rather a life cycle view. This is exemplified in the extract below:

(3) **P.O.1958. M. 2. 29. M.3.**

064 M: That's grand. And you know why you're having the glucose
065 challenge test, don't you?
066 W: Yeah. I had it on the last one as well.
067 M: And it was normal ?
068 W: It was.
069 M: And you're wondering why we're repeating it? [putting B.P.
070 cuff on]
071 W: Well no. My father's diabetic //
072 M: Yeah.
073 W: // and my sister had gestational diabetes //
074 M: Yeah. (?).
075 W: // so I realized (?).
076 M: Yeah. So that's why (?) just because it was normal in the last
077 pregnancy. It may not be normal this time.
078 W: And I was big for dates as well. But I'm not, I don't think I
079 am.
080 M: You don't think you are any more? Right. [measuring B.P.]
081 Everybody carries differently. (?) Sixty. Blood pressure's
082 fine. Weight's up a bit. Urine is clear so that's good.
083 W: Yeah.
084 M: What age are the others?

The midwife's question in line 64 involves a term specific to the world of midwifery — 'glucose challenge test'. The woman's response over lines 71- 79 reflect her familiarity with such a term

and also shows her ability to speak in the voice of midwifery where appropriate (line 73 'my sister had gestational diabetes', line 78 'and I was big for dates as well'). This ability to speak in the voice of midwifery does not preclude her from situating her pregnancy in the context of her life world as shown by her references to her family, nor does it prevent the subjective perceptions of her experiences from appearing in the discourse, as can be seen in her reference to her size in this pregnancy (line 78 'And I was big for dates as well. But I'm not, I don't think I am').

The world of midwifery

The key elements of midwives' perspective on pregnancy and birth as revealed in the discourse of the clinic are outlined below.

After the initial welcoming, greetings, apologies, and so forth, the visits move onto the midwifery tasks. Midwives then orient themselves to their tasks for the visit by finding out the stage of gestation which the woman has reached:

(4) **O.P. 1958. M.1. 24. M.1.**
021 M: So tell me how many weeks you are.
022 W: Twenty four exactly.
023 M: Twenty four. So you're very good, you have the up-to-date
024 information.

Having established a time frame for the woman's pregnancy, the conversation proceeds as the midwives complete their tasks of measuring the women's blood pressure, conducting a physical examination, checking for any signs of potential complications, dealing with topics introduced by women, providing information, and scheduling follow-up visits. Several studies identify a predominance of Question/Response/Comment/Next Question type structures or variations of this structure in interaction in medical settings (Mishler 1984, Fisher 1986, Todd 1989). In such studies doctors are shown to control the introduction of topics using this structure. It is also a consistent feature of the discourse at the midwives' clinic and appears repeatedly. It is used by all midwives in the study, and while there is a degree of individual variation, with some midwives tending to chain questions together tightly without commenting on women's responses during phases of the interaction, such as the physical examination, the use of this type of Question/Response/Comment/Next Question structure is a

pervasive feature of the discourse at the midwives' clinic. It is a significant means by which midwives introduce and maintain topics. It also provides insight into the model of pregnancy that midwives employ as they carry out their work and, as such, reflects aspects of the contemporary culture of childbirth. An example of this type of structure in action can be seen in the extract below:

(5) **R.Q. 1960 M. 1. 39. M.4.**
054 M: Now. Any lumps or bump up top?
055 W: No. Nothing.
056 M: No swelling. Swelling of the hands?
057 W: No. It's grand.
058 M: Nothing doing. Breasts alright?
059 W: Yeah, fine.
060 M: Decided how you're feeding?
061 W: I'll breast-feed.
062 M: D'you breast-feed your last?
063 W: Yeah, three.
064 M: No problems?
065 W: No problems.
066 M: Good. Deep breath in for me.

In (5) the discourse is tightly controlled by the midwife's questions throughout the physical examination. There is a sense of compartmentalization of the woman as the midwife proceeds through a checklist of possible complications. The midwife's lexical choices (line 54 'Any lumps or bumps up top?', line 56 'Swelling of the hands?', line 58 'Breasts alright?') reinforce this sense of depersonalization. Consequently, the opportunities for the woman to expand the focus of the conversation are limited.

The discourse at the midwives' clinic also reflects that the midwives employ a particular model of pregnancy and that they compare the women they encounter at the clinic to this model. The model includes a template or sets of expectations for (i) women at different stages of gestation, (ii) women who are pregnant for the first time, (iii) women with experience of pregnancy, and (iv) expected developments (known as minor disorders of pregnancy), which are considered part and parcel of pregnancy and not indicative of pathology. When women report symptoms that do not conform to the expectations of the midwives, either (a) a doctor is summoned, if the report is considered potentially medically relevant, or (b) the topic does not fully enter the discourse, if it is not considered germane. The attempts to make women conform to the

expectations set out by the model are visible in the discourse and frequently made explicit by the midwives. They work to ensure that the midwifery model for pregnancy is the model that prevails in the discourse both through conversation and through silence, as evidenced in the extracts below.

Midwives' expectations for stage of gestation

That midwives have expectations for different stages of gestation is made explicit in the discourse in the way in which they orient themselves to the number of weeks' gestation at the beginning of each woman's visit. It also becomes apparent in the questions they ask women and in their responses to women's reports and questions.

Early pregnancy

(6) **N.M. 1962. M. 1. 16. M.3.**

(i)

059 M: [3.02] Right. I've to do these. (?) So you're just sixteen weeks
060 really //
061 W: Yeah.
062 M: // and a little bit. So did you feel any movement yet?
063 W: Slightly.
064 M: Slightly. Did you?
065 W: You know, there' s a little flutter.
066 M: A little, is there?
067 W: Yeah. Yeah.

(ii)

095 M: Great. O.K. We'll just see can we feel anything. I mightn't
096 W: Yeah.
097 M: be able to feel anything as yet //
098 [
099 W: O.K.
100 M: // ahm Niamh but.
101 W: (?)

This is an extract taken from the early stages of a woman's pregnancy. The midwife's comments in lines 59-62 ('So you're just sixteen weeks really and a little bit. So did you feel any movement yet?') show her to be orienting herself to the stage of gestation. When she has established the stage of gestation, this opens a set of expected findings for that stage of pregnancy which is made explicit in lines 95-100 ('I mightn't be able to feel anything as yet ahm Niamh but').

Late pregnancy

(7) **S.T. 1978. P. 4. 39+5. M.4.**

051 M: Yeah. Now there's no doubt Laura at this stage the nature of
052 the movements change so that instead of getting arms and
053 legs out like you more get stretchy //
054 W: Yeah.
055 M: // sort of movements. Yeah. O.K. Let's feel this baby.
056 [looking at chart] Your weight's up. Your urine's clear. Your
057 blood pressure's fine. And this baby's doin' somersaults//
058 W: Yeah.
059 M: // for you. Yes. Ah, sure he's as happy as Larry in there. And
060 you're forty weeks exactly?
061 W: Yeah. On Saturday
062 [
063 M: Exactly.

This extract again reflects the midwives' model of pregnancy. This woman is in the late stages of pregnancy and the expectation that the baby's movements will change are made explicit by the midwife's comments in lines 51-53 ('at this stage the nature of the movements change').

A template for women pregnant for the first time

That midwives have particular expectations regarding length of gestation and labour for women pregnant for the first time also surfaces in the discourse and supports the findings of Danziger-Klein (1978, 1980) in a similar setting. As the midwives proceed through their tasks, the perspective of the world of midwifery is revealed. Their comparison of the women to the template and their attempts to ensure the women fit the expectations is illustrated in extract (8) where the midwife describes a standard scenario for 'first time babies' (line 311). This presentation of the standard scenario makes it difficult to acknowledge the unique nature of each woman's experience and individual difference in pregnancy and birth.

(8) **E.F. 1968. P. 5. 37+. M.3.**

311 First time babies tend to go over in the majority of cases
312 but definitely it does help if the head is, is well down, well
313 engaged //
314 W: Mhmm.
315 M: // as you can imagine because there's several factors
316 involved, you know? If the head is high up and you're getting
317 pain, nothing is going to open as quickly as if something is

318 pressing //
319 W: Yeah.
320 M: // on something you know?
321 W: Yeah.

A template for women with experience of pregnancy

Just as there is a set of midwifery expectations for women pregnant for the first time, so is there a set of expectations for women with experience of pregnancy. Midwives interpret their findings and women's reports by referring to this template. Women do not have similar access to this template as their model for pregnancy emphasises its uniqueness for each woman. In (9) the midwife's template for women with experience of pregnancy is illustrated in lines 68-77. It took place following a question by the woman regarding a possible complication.

(9) **U.V. 1963. M. 2. 34. M.4.**
068 M: With, with so. And really the thing is you haven't had
069 toxemia before //
070 W: No.
071 M: // and it is more common in first pregnancies.
072 W: Right.
073 M: Much more common.
074 W: I haven't.
075 M: Now if you had it the first time you'd be more likely to get
076 it in subsequent pregnancies. But if you didn't have it in the
077 first time and ahm.
078 W: Now, this morning I was, I ahm, did an awful lot of retching.
079 I dunno. [laughs] I had an extremely bad pain here.

The way in which women consider developments reportable does not always match what midwives consider to be significant. So while the women are adept at introducing their perspective, the midwives, by virtue of their role as professionals and members of the hospital staff can determine the topics that enter the discourse fully. Extract (10) highlights this phenomenon.

(10) **D.C. 1964. M. 2. 32. M.5.**
099 W: But, I also, I feel very now //
100 M: Mmm?
101 W: // it's really heavy.
102 M: Mhmm. Well you feel heavy anyway, ahm, you know in
103 subsequent pregnancies when your muscle tone is much
104 looser //
105 W: Mmm.

106 M: // you feel a, a lot heavier. And some women get the
107 sensation that the baby's falling out.
108 W: Mmm.
109 M: They think everything's falling out. Babies don't fall out.
110 [
111 W: No.
112 M: [laughing] Certainly not in my ex //
113 W: (?)
114 M: // not in my experience, they don't fall. [laughing]
115 [
116 W: Sometimes, no, it's only (?) that I feel
117 like a sack of potatoes or something.
118 M: Yeah, I know. That's just muscle tone. [4 .27–listening to
119 baby's heart-funnel] Bumpety bumpety bumpety bumpety
120 bumpety bumpety bump.That's quite nice. [2.13-laughing]

The woman reports a feeling she has experienced during her pregnancy (lines 99-101 'But, I also, I feel very now it's really heavy'). The midwife explains her experience by referring to the world of midwifery expectations for women who have experience of pregnancy (lines 102-104: 'Well you feel heavy anyway, ahm, you know in subsequent pregnancies when your muscle tone is much looser'). The woman has mentioned this sensation as she considers it reportable. In her model of pregnancy, this is unusual. However, it is not unusual to the midwife for a woman who has experience of pregnancy to report this sensation and so she explains it by reference to her model. The woman repeats her subjective experience of this feeling (lines 116-117: 'Sometimes, no, it's only (?) that I feel like a sack of potatoes or something') and again the midwife counters with the midwifery model explanation (line 118: 'Yeah I know. That's just muscle tone'). This is the final word on the matter as the midwife proceeds to listen to the baby's heartbeat.

Expected developments in pregnancy

As women proceed through their pregnancy, midwives expect certain physical adjustments to take place that are considered typical, for example, a degree of swelling of the woman's hands or feet and a sensation of pressure as the baby's head descends into the woman's pelvis. These expectations are known in the world of midwifery as 'minor disorders of pregnancy' and are made explicit in the discourse, as in

(11) **C.D. 1969. P. 2. 36. M2.**

047 M: Ahm [1.21] a lot of women when they're pregnant get
048 various aches and pains and the main thing we do is to sort of
049 out-rule the serious //
050 W: Mmm.
051 M: // causes. Ahm, that's not to say that is it's not a serious
052 cause it's not a severe //
053 W: Mmm
054 M: // pain. But ahm, [1.66] it's when you're pregnant there are
055 so many changes going on //
056 W: Mmm.
057 M: // in your whole body

This extract takes place during the physical examination where the woman introduces a spontaneous account in line 95 ('I just go to the toilet millions of times'). The midwife's response indicates that this is an expected development and also reflects where women's experiences and the expectations of the world of midwifery diverge (lines 98-99: 'Millions of times is fine for me. It's you have the problem with that').

(12) **T.S. 1964. M. 2. 38. M.5.**

092 M: Swelling of your feet?
093 W: No.
094 M: No.
095 W: I just go to the toilet millions of times.
096 M: Ah, that's great. [laughing] [listening to heart beat] Bumpety
097 bumpety. That's nice and loud and clear. I love to hear that.
098 That's great. Millions of time is fine for me. [laughing] It's
099 you have the problem with that. [3.12-writing in chart]

Deviations from the expected course of events

Occasionally women report or midwives notice developments that do not fit in with the midwifery expectations for stage of gestation or with the definition of 'minor disorders' of pregnancy. When this occurs, a doctor may be requested to see the woman or she may be referred to another department. This orientation to deviations from an expected course are reflected in the extract below.

(13) **D.C. 1964. M. 5. 37. M.2.**

020 M: The key thing with, with swollen ankles when you're
021 pregnant is whether your blood pressure is normal or not.
022 W: Mmm.
023 M: If your blood pressure is normal, and there isn't protein in
024 your urine //

025 W: Mmm.
026 M: // then it's just a normal part of pregnancy.
027 [
028 W: Mmm. Mmm.
029 M: And it's your body saying 'Rest a bit.'
030 W: Yeah.
031 M: Ahm but if it goes along with high blood pressure, //
032 W: Yeah.
033 M: // then we'd get the doctor to see you 'cos that would, we'd
034 be a bit more concerned about.
035 W: Mmm.

The midwife noticed that the woman's ankles were swollen when she entered the room. She asked the woman when she had first noticed this and after the woman responds, the midwife proceeds to provide information from the midwifery model of pregnancy (lines 20-21: 'The key thing with, with swollen ankles when you're pregnant is whether your blood pressure is normal or not'). What is considered an expected development (lines 20-22) and what is considered a deviation from the expected course (lines 32-35) is made explicit in the discourse.

Diverging and converging worlds

The previous sections describe the perspectives of women and midwives as revealed in the discourse at the midwives' antenatal clinic. Women and midwives can move out of their primary world of meaning and enter the world of the other i.e. the life world in the case of midwives and the world of midwifery in the case of women. This sub-section describes that movement which throws the diverging perspectives into relief.

Women move towards the world of midwifery

This woman, pregnant for the first time and at 39 weeks gestation, had brought a birth plan to the clinic in which she made her wishes for the birth explicit. Her orientation to the world of midwifery is reflected in her lexical choices as revealed by what the midwife reads from the plan (e.g. line 157 ' suction routinely', line 159 'episiotomy') and also in the topics, such as acceleration of labour, that she has included.

(14) **Q.R. 1974. P. 2. 39+. M.3.**
157 M: Ahm, [1.94] they don't suction routinely. There'll be no

158 problem with that. The other thing, ah, about the episiotomy,
159 which I said they wouldn't do, if the baby was in distress, and
160 they wanted the baby out quicker, //
161 W: Yeah.
162 M: // it might be an indication of having to be done but it's not a
163 policy that we would do it unless it's actually absolutely
164 necessary. O.K.?
165 W: That's fine.
166 M: Ah, she's just a little bit saying about, [laughs] ah, the
167 labour being speeded up because the hospital is busy.
168 W: [laughs]
169 M: That's not true. (?) It's because of people wanting the, the
170 labour within twelve hours.
171 W: But I don't. [laughs]
172 M: But then you don't, which is fair enough, so definitely things
173 will be, if everything is normal, as you want, you know?

The midwife's reference to the acceleartion of labour in lines 169-170 reflects an assumption of the hospital system of care that procedures have been developed only as a result of women's demands, an assumption that is arguable. The woman's subsequent comment in line 171 ('But I don't.') stresses her individuality and challenges the assumption of the hospital system by which women tend to be seen in relation to standardized expectations. The midwife's description of hospital birth reflects its technical aspects and describes the experience from the perspective of the staff, as opposed to from the perspective of the woman who is in labour.

Midwives move towards the life world

Midwives introduce topics other than pregnancy or birth into the discourse, showing themselves to be oriented to the life context of the women who attend the clinic. These sequences tend to be brief and the 'voice of the life world' is not the primary voice in which midwives speak. Midwives usually move to life world topics such as holidays and the woman's family or job either at the very beginning of the visit, before the tasks of midwifery have begun, or at the end of the visit when the midwife's work has been completed. This switch to life world matters by the midwives is usually accomplished by the use of a closed question/response/comment/ next question structure. While midwives move towards the life world of women and can, by virtue of their role as professionals, explore such topics, they rarely offer information from their own life world and women do not seek such information spontaneously.

The extracts below reflect these features of the discourse at the midwives' clinic.

(15) **P.O. 1958. M. 5. 35. M.4.**
332 M: Have you Santy organised?
333 W: Sort of.
334 M: Sort of. Well you'd want to get Santy organised.

(16) **A.B. 1968. P. 1. 40. M.3.**
006 M: You're lookin' well. Were you out in the sun? Yes!
007 W: Yesterday and today.
008 M: Look at you!
009 W: Yeah, gave it a real blast. [laughing]
010 M: You look great.
011 W: Dying to get back out there again. [laughing]
012 M: I'd say so.
013 W: [laughing]
014 M: It's lovely really isn't it?
015 W: Oh, it's magnificent.

Worlds diverging

Women report developments that they consider to be significant according to their model. They compare these developments either to when they were not pregnant or to their previous experience of pregnancy. This is the model by which they consider developments to be reportable. The midwifery model is a different and, at times, incompatible one. The midwives have a set of expectations for the different stages of gestation, for women who are pregnant for the first time, for women with prior experience of pregnancy, for minor disorders of pregnancy, and for deviations from the expected course of events. When these two models meet in the discourse, there is a subtle negotiation for a model to prevail. By and large it is the midwifery model that prevails in the discourse. The women's perspective of pregnancy is thus silenced and the established midwifery perspective endures. This mismatch of models can result in a discourse that may appear dismissive or insensitive to women, as shown in the extract below.

(17) **U.V. 1963. M. 2. 34. M.3.**
(i)
330 W: No, it's just that I felt the last time, you see I think they
331 didn't think I was in labour at all because they put me in a
332 side room. Of course my husband went in and said 'Look my
333 wife is in labour' so they brought me straight into the labour

334 ward she says to me 'You're still four' and I thought to myself
335 'Jesus if I'm feeling this rock at four //
336 M: Mmmm.
337 W: // I'll never make it //
338 M: Mmm.
339 W: // you know, to the ten'. So I said (?) in a very short space of
340 time I was pushing.
341 M: It might be though that too Ursula you'll often find that
342 people when they get the epidural that everything relaxes and
343 it
344 does open up very quickly.
345 W: Mmm.
346 M: I mean you may not actually be fully dilated //
347 W: Mmm.
348 M: // that you know when you get the epidural everything goes
349 (?).
350 W: I reckon though I was more than four.
351 M: But you reckon you were more than four yourself. Yeah.
352 W: You see I had the epidural at four with Robert.
353 M: Yeah.
354 W: And sure I was going off for a cigarette you know?
355 M: Mm. Different baby. First babies are very different.
356 W: And I said I'd have a cigarette at four centimetres.
(ii)
364 M: Second labours are very different though. They're fast and
365 furious in comparison to, first are slow, real drudgery.
366 Second and other subsequent babies are fast and furious. And
367 you can feel them worse. Even though it's a shorter duration
368 It sometimes can take more out of you because you just don't
369 have time to stop and get your self together at all
371 W: Maybe that was it then.

The woman's account which begins in line 330 reveals the conflict that can occur between women's experience of labour and the hospital's definition of progress in labour. The midwife's response to her account is minimal and she remains discursively silent in the early stages of the woman's account. Where the midwife does respond, she attempts to clarify the woman's account of her experience of hospital birth in accordance with the midwifery model (lines 341- 348: 'It might be though that too Ursula you'll often find that people when they get the epidural that everything relaxes and it does open up very quickly... I mean you may not actually be fully dilated ... that you know when you get the epidural everything goes (?)'). The woman resists this attempt to interpret her subjective experience of the event through the lens of midwifery with her reiteration of her perspective in line 347: 'I

reckon I was more than four'. However, the midwife continues to interpret events from the world of midwifery, with the result that eventually the woman is left with little choice but to concur (line 371: 'Maybe that was it then'), and her perspective is silenced.

Conclusion

Adapting the framework developed by Mishler (1984) provides a means of examining interaction in medical settings in a balanced way, allowing the researcher to analyse the discourse from the perspective of both participants. Both participants are seen as operating in different worlds (the life world and the world of midwifery) that meet in their interaction. When differing worlds meet, there is negotiation so that one will prevail. In the context of the midwives' antenatal clinic, women and midwives were shown to have differing models for pregnancy and birth, models which were made explicit in the discourse. Both women and midwives were construed as being capable of conversing in the voice of either world, although for the most part, midwives remained in the world of midwifery while women were more likely to attempt to move between worlds of meaning. Women were shown to be adept at introducing their model for pregnancy and birth into the conversation; a model in which the individuality of experience and social context is emphasized. They were also shown to resist the imposition of a standardized view of pregnancy and birth on their individual experience. The world of midwifery, then, was shown to consist of templates for women who possessed experience of pregnancy or were pregnant for the first time and for women at different stages of pregnancy. Ultimately, however, it is the midwifery perspective that prevails and is facilitated by the authority conveyed upon this model by virtue of the fact that the midwives are in the role of professionals and that the discourse is located in an institutional setting. As a result, midwives can respond minimally to reports not considered germane, can clarify the women's accounts, and can close topics as they see fit. Therefore it is difficult for the women to sustain their perspective in the discourse; the validity of their perspective is diminished and the life world excluded.

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