

Research Article

Borrowed Voices: Conversational Storytelling in Midwifery Healthcare Visits

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Abstract

Midwifery in Ontario, Canada exists at the intersection of mainstream healthcare ideology and an alternative, woman-centred ideology of care. As a result, midwifery interaction is characterized by discursive hybridity. We trace this hybridity in the conversational stories co-narrated by midwives and clients during clinic visits. We show how conversational storytelling performs a complex shifting and blending of rhetorical forms and functions integral to the clinical interaction. Conversational stories conform to the structural requirements of the clinic visit and unfold in different ways and perform different functions at different times. Stories may be told, evaluated, and received as institutionally relevant for both clinical and social purposes. Clinical stories perform relational functions, and stories that appear to be fully social orient to the clinical agenda. Hybridity is accomplished through two forms of linguistic borrowing: the blending of professional-institutional and more casual-conversational modes, and interactional features such as shared narration and recontextualization.

Keywords: Informed choice; midwifery; discursive hybridity; storytelling; recontextualization; social interactional approach

Introduction

Midwifery in Ontario, Canada began as an unregulated practice that emphasized holistic, alternative, woman-centred care. Since 1994, midwifery has been licensed and government funded, and the profession now operates within a complex network of professional responsibilities and regulations (Bourgeault, 2006). Because the midwifery model incorporates both biomedical and feminist healthcare principles, midwifery exists at the intersection of mainstream healthcare ideology and an alternative, woman-centred ideology of care. In addition to clinical health goals, midwifery has a strong interest in relational issues, particularly in how the midwife-client relationship may support childbearing women as the primary decision-makers about their care (College of Midwives

of Ontario, 1994; Bourgeault, 2006). Philippa Spoel (2006; 2007; 2010) and Spoel, Pamela McKenzie, Susan James, and Jessica Hobberlin (2013) have analyzed Ontario midwifery policy documents and healthcare conversations to show how midwifery's social-relational and clinical mandates are intertwined in its professional communication processes. They argue that a defining feature of midwifery interaction is *discursive hybridity*: "shifting modalities" that characterize the "complex and multi-layered nature" of healthcare communication practices and situations (Sarangi & Roberts, 1999, p. 62).

In this article, we develop a more textured and nuanced analysis of how this discursive hybridity occurs within and through the diverse types of stories co-narrated by midwives and their women clients during clinic visits. In contrast to earlier work that explored the interplay of informal storytelling with a more didactic, professional-expert mode of healthcare discourse (McCourt, 2006; Spoel, 2010; Spoel et al., 2013), in this paper we focus solely on *conversational stories* as a complex, varied form of midwife-client talk that exemplifies, within its own contours rather than in relation to other modes of communication, the hybrid discourse and rhetorical functions of midwifery clinical interaction. We demonstrate that conversational stories may be narrated, evaluated, and received as institutionally relevant, potentially for both clinical and social purposes. In their interchangeable roles as storytellers and story recipients, midwives and clients artfully adapt the conversational story to address and shape the situational exigencies and rhetorical possibilities of midwifery healthcare visits. By tracing how these interactions move fluidly between formal elicited institutional narratives and the more "social" stories that emerge in the interstices of clinical work (Ragan, 2000), we show how even stories that appear to be fully social attend to institutional requirements and may have clinical implications, and how storytelling that overtly orients to the clinical agenda has social functions such as relationship building.

The important interactional accomplishment of this mixed function for midwifery storytelling occurs, we propose, through two interrelated forms of "linguistic borrowing":

- i) *blending of discursive modes*, in particular a more formal, structured expert-professional mode (resonant of Elliot Mishler's "voice of medicine") with a more informal, everyday "lifeworld" mode (Mishler, 1985; Fisher, 1995); and
- ii) *interactional features of story(re)telling*, in particular *shared narration features* (such as co-narration, interruption, overlapping, and repetition) and *recontextualization features* (such as reported speech, re-told events, and reformulations).

Through these interrelated forms of linguistic borrowing, among other means, midwives and women enact the hybrid discourse and intertwined social-clinical goals of midwifery healthcare.

Conversational Storytelling

We take a social interactional approach to studying conversational narratives (De Fina & Georgakopoulou, 2008; 2012; Sools, 2013). This approach arises from recent critiques of Labov's structural model of conversational narrative (Labov, 1972; Labov & Waletzky, 1967), namely that the model is inadequate for studying the characteristics of messy, emergent conversation (e.g., Holmes & Marra, 2005, p. 196; Ochs & Capps, 2001, p. 57); that it neglects the interactional context within which narratives unfold (De Fina, 2009, p. 235); and that it is excessively focused on "big stories"—that is, solo-narrated conversational stories recounted in formal social science, life history, or clinical interviews (Freeman, 2006). Current narrative research (e.g., Bamberg & Georgakopoulou, 2008; De Fina & Georgakopoulou, 2012; Fasulo & Zucchermaglio, 2008; Georgakopoulou, 2006a; 2006b) calls for a broader definition of conversational narrative to encompass "small stories," an umbrella term that includes a wide range of brief, incomplete, contextually-embedded stories. In keeping with this approach, our analysis attends to "small story" activities such as giving "breaking news," retelling known stories, co-narrating stories of shared events, and telling a series of stories related by topic or theme.

A social interactional approach to storytelling rejects a conceptualization of conversational narrative as decontextualized canonical genre and instead recognizes it as interactionally emergent, embedded in local context (both contextualized and contextualizing), and related to the "business at hand." Analysis focuses on the micro-processes through which the teller and hearer co-construct meaning and attends to the characteristics of the storytelling event "such as time, place, relations between interlocutors, events in which the storytelling is inserted, salient topics discussed before and after the narrative," and the narrative interactional dynamics "such as telling roles and telling rights, audience reactions, etc." (De Fina & Georgakopoulou, 2008, p. 381). An analysis of stories in their interactional context makes visible their moral practices, rhetorical functions, and performative aspects (e.g., Radley & Billig, 1996). In a clinical healthcare setting, for example, narratives may perform institutionally relevant functions such as presenting symptoms and explaining the reason for coming to the clinic (e.g., Gill & Maynard, 1995; Heritage & Robinson, 2006; Robinson, 2006; Robinson & Heritage, 2005), providing additional evidence to support or challenge an interpretation (Bercelli, Rossano, & Viaro, 2008), negotiating the concerns of the patient (Mishler, 1985; Clark & Mishler, 1992), accounting for past behaviour (Fisher & Groce, 1990), giving advice (Heritage & Sefi, 1992), making moral claims (Heritage & Lindström, 1998), and recommending treatment options (McKenzie & Oliphant, 2010). Failing to attend to the interactional embeddedness of narratives therefore eliminates an important element of the context.

In this paper, we analyze a small selection of the conversational stories present in

transcripts of 48 clinic visits between Ontario midwives and clients. Pamela McKenzie recorded single visits between 40 southern Ontario women and each woman's midwife. Visits took place in 15 midwifery practices in settings ranging from small towns in rural areas to the city of Toronto. Philippa Spoel recorded eight northern Ontario visits, four each for two women and their midwifery teams. Our research conforms to Canadian ethical guidelines (Canadian Institutes of Health Research, Natural Science and Engineering Research Council of Canada & Social Sciences and Humanities Research Council of Canada, 2003). All participants are identified here by an initial describing their role: midwife (M), Client (C). Transcription standards are described in Appendix 1.

In coding our data, we followed William Labov's (1972) minimal criteria for identifying stories: two or more temporally and/or causally sequential elements recounted by the teller in their sequential order. "I slipped and I fell" is a story; "I fell because I slipped" is not.¹ We identified more than 150 individual narratives that met these criteria. Stories were a common feature of the midwifery interaction, appearing in 43 of our 48 transcripts. Most stories stood alone, but there were also several pairings and groupings of multiple stories on related topics or themes.

In what follows, we explore some of the multiple forms and functions of storytelling during the midwifery visit. Some stories engage mainly in overt institutional talk (Holmes, 2000) clearly addressed to clinical healthcare objectives such as presenting a health history or describing a health problem (e.g., Clark & Mishler, 1992; Stivers & Heritage, 2001). Other stories have more in common with the small stories told in social settings among longstanding friends (Coates, 1996; De Fina, 2009; Georgakopoulou, 2008; Norrick, 2000). Storytelling may also take different forms and perform different functions depending on where it occurs in the structure of the visit (Bercelli, Rossano, & Viaro, 2008). Our analysis shows how this complex combination of storytelling forms and functions is enacted through the blending of discursive models and the interactional features of story(re)telling.

The Midwifery Interaction

The hybrid discourse of midwifery interaction borrows and blends generic forms from friendly casual conversation and professionalized institutional communication. Jennifer Coates (1996) identifies several characteristics of sociable talk among women friends, including laughter, fluid shifts from topic to topic, alternations between individual and collaborative conversational floors, supportive mirroring, and the mingling of personal experience or story with topical chat. Talk in an institutional context is structured in a

¹ Although Labov's structural analytic approach has come under substantial critique, we acknowledge the utility of his minimal criteria as a place to start for identifying conversational stories in clinical interaction.

more regular way than everyday conversation, with components characteristically emerging in a particular order (Heritage & Maynard, 2006, p. 14). Institutional interaction further involves participants in specific goals that are tied to their institution-relevant identities, and that may constrain what will be treated as allowable contributions (Heritage, 2004, p. 225).

Douglas Maynard and Pamela Hudak (2008) suggest that boundaries between institutional and social talk are fluid, and that participants “organize these boundaries through their concrete practices of embodiment, talk, and social interaction” (p. 672). In interactions between healthcare professionals and their clients, social talk may be enmeshed with more instrumental talk, and relational and instrumental goals may be interdependently achieved (Ragan, 2000; Sharpe, 2004).

Social forms of talk have been shown to perform both relational and institutional functions in healthcare settings. Sandra Ragan (2000), for example, found positive outcomes of humour and verbal play and of healthcare providers’ extra-medical self-disclosure. Both Ragan (2000) and Jennifer Fenwick, Lesley Barclay, and Virginia Schmied (2001) found that when female healthcare providers attended to relational aspects of their interaction with women clients, they were able to reduce power imbalances, mitigate patient stress and improve confidence, and facilitate the reciprocal self-disclosure that promotes both relational and medical goals. Moreover, there is recognition that social talk in clinical settings can support and promote instrumental goals (Ragan, 2000) and can minimize potentially uncomfortable or negative effects (Maynard & Hudak, 2008). Ragan (2000) argues that including small talk such as social storytelling in clinical interactions enacts a patient-centred model of healthcare that may disrupt inequalities between provider and client by taking a broader definition of health, one that encompasses both the biomedical *world of medicine* and the everyday *lifeworld* of the patient or client (Mishler, 1985).

According to Spoel (2010) and Spoel et al. (forthcoming), the shifting and blending of professional-expert healthcare discourse with informal lay-lifeworld discourse characterizes Ontario midwifery communication. Similarly, Christine McCourt (2006) identifies two main interacting communicative styles in British midwifery care: the “professional expert guidance” style (p. 1315) that enacts an essentially didactic, information-transfer educational model, and a more collaborative narrative style of communication characterized, as Kerstin Martin (2002) puts it, by midwives and women “sitting together in relaxed, enjoyable, mutually-engaged discussion, exchanging experiences and information and getting to know one another” (p. 32). Here, we extend the analysis of midwifery’s hybrid discourse by tracing how informal storytelling itself performs a complex shifting and blending of rhetorical forms and functions, accomplished in significant ways through practices of linguistic borrowing and occurring in different ways at different stages of the visit.

Storytelling and the Structure of Midwifery Visits

Fabrizio Bercelli, Federico Rossano, and Maurizio Viaro (2008) have shown how institutionally relevant stages in the psychiatric encounter encourage particular kinds of storytelling and how the same kind of story performs different functions at different stages. We likewise have identified general patterns and functions of storytelling in different stages of the midwifery visit.

The main institutional tasks of the midwifery visit relate to assessing the well-being of the woman and baby, and the structure of the typical visit supports this work. The midwife and client establish their relationship by opening their encounter. The midwife then asks a general question that invites the client to discuss any symptoms or concerns that have arisen since the previous visit. Next, the midwife addresses topics mandated for discussion at particular points during the pregnancy, including issues about which the client will need to make decisions (e.g., place of birth and whether to participate in various forms of prenatal testing). The midwife then conducts a physical examination and performs any required clinical procedures (e.g., a blood draw). The client and midwife close their visit by making plans for their next meeting (Hawkins & Knox, 2003, pp. 91-92; McKenzie, 2010).

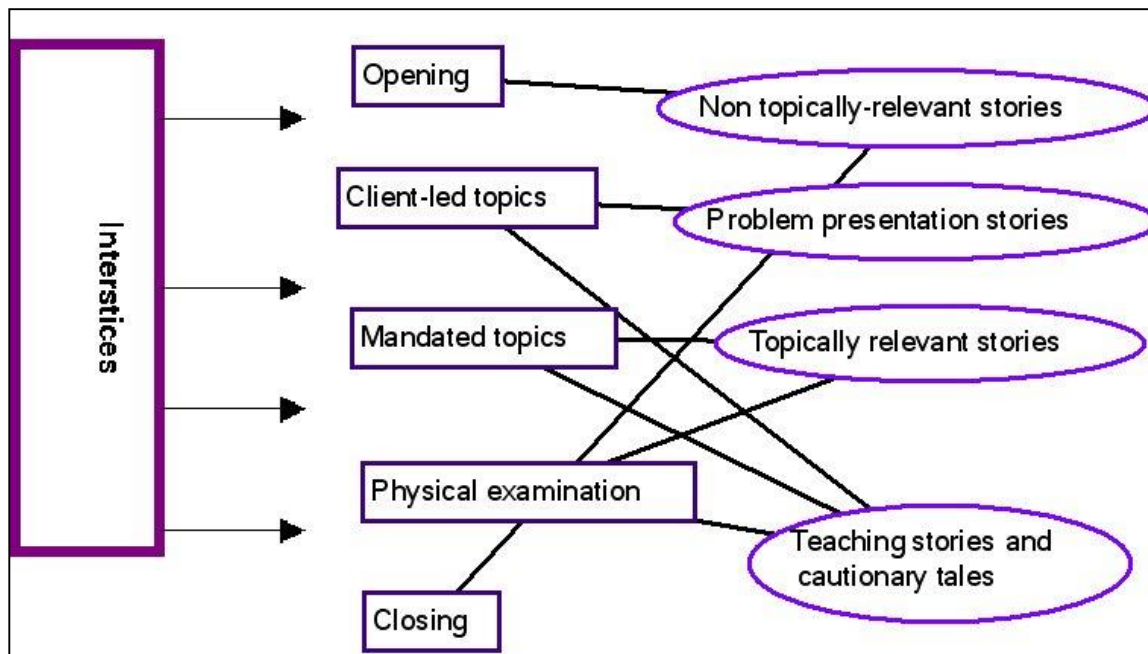


Figure 1. Storytelling in the midwifery visit

Our research shows how storytelling in midwifery care typically took place in particular parts of the visit and performed different functions (figure 1). By contrast with Bercelli et al.'s (2008) finding that in counselling visits only the patient is treated as a

legitimate narrator while the therapist assumes the role of story recipient, in the midwifery setting all participants—midwives, client, student midwives, and the client’s attending partners or family members—took turns as tellers and recipients. Clients responded to invitations to discuss their concerns by telling stories that presented problems or symptoms. During the discussion of mandated topics and physical examinations, participants largely told topically relevant stories (for example, an anecdote about a previous blood draw, or the story of seeing an ultrasound image). Midwives, and sometimes clients and their family members, told cautionary tales that built rapport and also communicated value judgements about particular courses of action. Participants generally saved non-topically relevant stories for the interstitial spaces before, after, and within the formal stages of the clinic visit, for example during openings and closings, in the transitions to or from clinical procedures, or during waiting times within them. This was particularly the case when the “action” of the visit was stopped to accommodate the physical movement of individuals or the preparation of spaces or materials.

Our research shows that the overall structure of the midwifery visit shaped the forms and functions of stories that participants accepted as appropriate to tell and respond to. However, an analysis of selected stories told at different stages of the visit shows how these forms and functions are enacted in complex, hybrid, and dynamic ways through the borrowing and blending of diverse linguistic forms. This includes the blending of professional-healthcare and informal-lifeworld discursive modes along with interactional features of shared narration and recontextualization. The four stories that we analyze here illustrate both the general correspondence between story type and the structure of the visit, and the situated discursive-interactional richness of each storytelling occasion. We begin with a client-led “problem presentation” story told near the beginning of her visit; we then discuss two “topically-relevant” stories told in relation to institutionally-mandated topics, the first of which also functions as a “teaching story” or “cautionary tale” while the second illustrates the co-narration of a shared story; lastly, we analyse a “small,” seemingly “non-topically-relevant” story told during the interstices of clinical work.

Story 1: “I really felt light-headed”

Our first story is a client-led “problem-presentation” story. In our research, women often used stories to present and contextualize problems or symptoms, frequently near the beginning of the visit in response to a general “how are things?” question from the midwife. Jack Clark and Elliot Mishler (1992) argue that a patient’s presentation of her concerns and symptoms in a clinical encounter “is an integral component of the interaction that both reflects and reflexively informs and guides that interaction” (p. 367). Problem presentation is “one of the only (often *the* only) structurally provided-for

locations where patients are licensed to present their concerns in their own way and in accordance with their own agendas” (p. 367). The problem presentation story represents the joint effort of the healthcare recipient and healthcare provider to make coherent sense of a problem within a jointly constructed context of requests, acknowledgements, expansions, and elaborations (Heritage & Robinson, 2006, p. 48).

While the story we have selected illustrates these typical features of problem presentation in healthcare settings, it also indicates the fluid and relaxed interactions of midwifery care, occurring as it did during a leisurely discussion that moved freely between concerns the client presented and topics the midwife initiated. After greeting the client and her children, the midwife opened with a general invitation to discuss her concerns (“Did you come with any questions?”), and the two discussed an issue presented by the client. The midwife then recorded the client’s weight and asked about her eating. After they discussed nutrition, the woman raised the topic of screening for gestational diabetes and reported her decision not to undertake it. The midwife provided nutrition advice, and then offered another opportunity for the client to present her concerns:

M: And did you have any other questions?

C: Well I had one day that I wasn’t feeling, that I was considering phoning in, umm I had done my Aquafit class, and the water was really cold. So it was really cold coming home, and I ate a lot, and had hot bath for quite a while—[the children] were all asleep, which was a big change [laughs]. But then when I went to bed I really felt light-headed and the next morning I still felt very off. Just sort of dizzy, so I don’t know if my blood sugar was low, or what, blood pressure or whatever. [...]

M: Yeah, yeah, because the cold cuts your blood sugar, going down, it’s ((inaudible)) to your blood sugar levels anyways, so if it did go down, your blood sugars had gone down, if you hadn’t eaten, that can definitely make you feel dizzy, so. If it happens again, you should probably let us know, just ‘cause, we can make sure whether it’s because of blood sugar or low blood pressure.

This story served the clinical purpose of presenting a problem and was treated by both client and midwife as an appropriate response to the midwife’s professionally-standard initiating question. In telling the story, the client asks for, and receives, a tentative diagnosis and recommendation from the midwife. However, the client herself initially enacts an informal clinical role by articulating her own potential diagnosis of the problem (“I don’t know if my blood sugar was low, or what, blood pressure or whatever”), which is subsequently affirmed by the midwife (“yeah, yeah”). This concurs with Tanya Stivers’ (2002) finding that doctors treat symptoms-only problem presentations as requests for medical evaluation, and problem presentations including candidate diagnosis as a request

for diagnosis confirmation and treatment recommendation.

Even as the client and the midwife enact the standard healthcare mode of problem-presentation, the client's telling of her "problem" illustrates a lively, possibly digressive mode of "lifeworld" discourse, vividly narrating details that exceed a strict symptom presentation ("I had done my Aquafit class, and the water was *really* cold. So it was really cold coming home, and I ate a lot, and had hot bath for quite a while—they were all asleep, which was a big change"). Importantly, the midwife does not interrupt and allows the client rhetorical space to recount these lifeworld particulars, suggesting the participants' mutual acceptance of and comfort with this kind of storytelling within the healthcare visit. However, the fact that the midwife replies to the client's story with a generalized response to her symptoms rather than taking up any of the contextual details she has recounted mitigates somewhat the degree of affiliation and engagement rhetorically constructed through this exchange.

This response recontextualizes the client's problem presentation and candidate diagnosis through a technique of reformulation that both resembles and diverges from standard expert-patient interaction. After listening to the client's story, the midwife confirms the likely accuracy of the client's diagnosis by reformulating, in her own talk, the client's symptoms and probable causes for them. As Patty Kelly (2012) explains, in the psychotherapeutic context, therapists may jointly produce client speech by reformulating it "to summarize for gist, draw out relevant implications, and seek ratification from clients" (p. 115). Reformulation typically involves therapists deleting client terms and selecting and substituting specialized terms in their stead. By contrast, in the midwifery setting, the midwife's reformulation of the client's account largely repeats or borrows rather than deletes or substitutes her everyday terminology ("cold," "dizzy," "blood sugars") and maintains the client's sequence of diagnosis ("blood sugar or low blood pressure"). This shared narrative style can be seen as indexing and strengthening a collaborative healthcare relationship between midwife and client. At the same time, though, the contrast between the contextual details of the client's narrative and the midwife's generalized evaluation of her problem-presentation indicates a rhetorical distance in their conversational roles and positions and suggests the limits—as well as the possibilities—of this storytelling episode for building affiliation between the participants.

Story 2: "My husband called me 'a cyclops'."

The following example of storytelling occurred during a "booking visit," in which a woman early in pregnancy is introduced to the midwife, the midwifery practice, and often the midwifery model of care, and gives her complete medical and reproductive history. This is typically the first substantive visit a woman has with her midwife, although it may be preceded by an orientation meeting.

At the beginning of the booking visit, the midwife invited questions from the client and introduced the history taking, structured according to the provincially mandated Antenatal Record 1 form (Ontario Ministry of Health and Long-Term Care, 2005). She began by asking for background information about the client and her partner (date of birth, marital status, education level, occupation, first language, contact information, ethnic background), then discussed the client's personal and family health history (e.g., cigarette and recreational drug use, exposure to occupational hazards, diet, medications, family medical history) and reproductive history (date of her last menstrual period, characteristics of previous pregnancies and births). She then moved on to discuss breastfeeding:

M: And, [previous child] had no problem breastfeeding?

C: No. No. My, uh, well [...] my big thing was my left breast was full of milk and by the, after a few months was huge and my right breast was

M: Yeah

C: really small. I have to overcome that for this one [laughs] I can't do this!

M: Well you know what happens is // you get more comfortable //

// C: I feel so comfortable! //

M: I know

C: I know that's what it was it was more comfortable and it was just a vicious circle.

M: I know.

C: It's awful.

M: I had the same thing with both my kids.

C: Did you?

M: And then the last one just breastfed on the left side.

C: Yeah, me too! And my husband called me "a cyclops." [laughs]

M: Ohh. So yeah, you have to really discipline yourself in the beginning to try and then you just go "uhh." And your last pap, do you know when that was?

This story demonstrates how the mixing of the client's *and* the midwife's lifeworld voices

with professional healthcare discourse may occur in even the most prescribed of clinical structures, the booking visit. The inclusion of breastfeeding history on the Antenatal Record 1 form makes this a mandated discussion topic during this formal and structured history-taking (Stivers & Heritage, 2001). Both midwife and client orient to the history-taking as the appropriate structure for their conversation, with the client's story functioning as a topically-relevant response to a history-taking query.

However, the pair of stories in the above excerpt illustrates some important differences between midwifery history-taking and medical history-taking (Stivers & Heritage, 2001). Even the very structured history-taking was open to lifeworld storytelling by both the client and the midwife. Their friendly exchange of amusing, self-deprecating stories about shared experiences from their everyday lives can be seen as having important social-relational functions. The midwife's story does relational work by presenting the midwife herself as a fallible mother. The story shows empathy and shares in the client's framing of lopsided breasts as a source for self-deprecating humour.

At the same time, these stories are topically relevant, address institutional structures, and enact healthcare goals: the midwife's story functions as a "cautionary tale" which she follows up with professional advice ("you really have to discipline yourself in the beginning"). An apparently irrelevant or insignificant feature of the client's lifeworld (uneven breasts) thus comes to have clinical relevance. This mixing of lifeworld and clinical meanings is consistent with Canadian midwifery's commitment to pursuing a holistic understanding of women's health and well-being which recognizes the significance of the client's lifeworld to professional healthcare (e.g., College of Midwives of Ontario, 1994; James, 1997). A wider range of story topics is treated as relevantly tellable and hearable in the midwifery clinic than might be expected in a doctor's office (Mishler, 1985; Fisher, 1995; Martin, 2002).

The blending of discursive modes in this story exchange is achieved largely through interactional means common to women's friendly conversation (Coates, 1996). The client's laughter marks her disclosure as humorous and self-deprecating. The midwife chimes in with a simultaneous evaluation of the situation, using exactly the same word that the client used ("comfortable"). The "I know," repeated three times, emphasizes the participants' shared experiences as mothers and enables the midwife to tell a story from her own lifeworld about breastfeeding misadventures. The client further indicates affiliation with the midwife's experiences ("Me too!") and her recontextualization, through reported speech, of her husband's description ("My husband called me 'a cyclops'") serves to evaluate both stories as rueful tales of misadventure, which Coates (1996) found to permeate women's social talk. The midwife indicates her appreciation of the client's "punch-line" ("Ohh") and then closes the shared narration sequence by re-adopting a more professional, authoritative role: she formulates clinical advice for the client ("you")—albeit still using an informal narrative style and everyday language (e.g. her reported

speech expression “you just go ‘uhh’”)—and re-embeds the discussion within the history-taking structure by moving on to the next topic on her list.

Story 3: “We let you labour down for a while”

Like Story 2, this next story is a topically-relevant narrative related to the “official” business of the visit at that moment, in accordance with Ontario’s standardized timeline for prenatal care (Hawkins & Knox, 2003, pp. 91-92). Certain topics, such as typical symptoms, choices to be made, and test results to report, are mandated for discussion at particular points in the pregnancy. This predictable, regulated structure affords the telling of stories relevant to clinically-mandated discussion topics (McKenzie & Oliphant, 2010; Spoel et al., forthcoming). Here, the reporting of blood test results led into a discussion of having blood taken. The client recalled her discomfort with having an IV inserted to induce her previous labour and shared her wish to avoid both induction and epidural pain relief for her next labour. The midwife responded by justifying the client’s need for pain relief (“it is very difficult to go through an induction without pain medication, just because you’re so restricted, and you can’t do a lot of the things that you would normally do to help cope with your labour”), and began recounting the story of the client’s previous labour:

M: Well, it’s nice to, it’s nice to avoid an induction if at all possible. You know the other thing is that last time umm you know, [...] you were fully dilated at about eleven o’clock at night and [child] was born at one which is also pretty average for a first baby cause we let you labour down for a while? ’Cause I don’t recall that you actually pushed for two hours I think we let you labour down

C: No, no no no because because you said “Okay we’re just gonna lay loose,” and then [other midwife] called my mother and then we went and woke [partner] up because of course he was asleep on the couch and

M: Yeah yeah so we did all that umm, we did all of that before we actually umm got you pushing and so. You know, the my guess is that umm in all likelihood you’re not gonna be, having, nearly the length, that you did the last time.

C: But I–

M: And hopefully

C: But

M: you won’t have an induction [...] [in breath] Alrighty now we’re [moves on to discuss procedure for taking the client’s blood pressure]

This sequence illustrates how conversation about one mandated pregnancy topic (blood test results) may slip easily into storytelling about another standard topic (plans for labour). As in the previous excerpts, this topically-relevant story blends professional-healthcare and informal-lifeworld discourses. Together, the midwife and the client recollect the experience, reconstructing who, what, when, and where. The client in particular narrates engaging home-life details about the characters, dialogue, and setting. The shared development of the narrative builds rapport by borrowing from and incorporating the experiences and memories of each. The co-narrated story indexes the historicity and ongoing trajectory of the client-midwife relationship, enacted for example through the client's use of reported speech ("you said 'Okay we're just gonna lay loose'") in recounting her memory of what the midwife had said.

However, despite these strong features of co-narration, the rapport that the client and midwife enact and index is countered by the midwife's obvious efforts to control both the telling of the story and the evaluation of its significance in ways that appear to ignore or dismiss the client's seemingly different concerns. Although the midwife's "Yeah yeah so we did all that" response to the client's main contribution could be interpreted as confirming her shared memory of the event, it also interrupts the client's recounting somewhat impatiently, allowing the midwife to reassert control of the story with an encapsulating, concluding statement that segues into her professional evaluation of the story's significance ("we did all of that . . . and so").

While the client and the midwife share in the telling of this story and seem to agree about what happened, their evaluations of its meaning for the current healthcare context appear less congruent. The midwife uses the retelling of this jointly familiar story as the basis for professionally evaluating and advising the client about plans for her upcoming labour. Even though the story is about the client's birthing experience, the midwife clearly initiates and frames its telling for clinical purposes: she uses it to advise the client that, based on her previous labour, there's a good chance she won't need an induction this time. The client's repeated response of "but" signals her unease with the midwife's professional assessment, suggesting that she has current healthcare concerns that she feels have not been sufficiently addressed by the midwife's summary interpretation of the previous birth story. The midwife's ignoring of these "but" responses combined with her prior rather dismissive interruption of the client's recollection shows how—similarly to story 1—storytelling in midwifery healthcare may simultaneously perform significant rapport-building work between midwives and women *and* function as a rhetorical site of professional dominance and social-clinical tensions between care-provider and care-receiver.

Story 4: “Sister’s twins”

Our fourth excerpt illustrates the kind of story, both topically relevant and not, that midwives, women, students, and family members often tell at the opening or closing of a visit or during transitions to, from, or within clinical work such as physical examinations. Because clinical procedures may cause a patient to experience discomfort, pain, embarrassment, or a violation of privacy (Ragan, 1990, pp. 68-69), small talk such as conversational storytelling during these procedures enables the healthcare provider and recipient to “manage their activities so as to conduct the exam with a requisite amount of detachment and decorum” (Maynard & Hudak, 2008, p. 668). Small talk therefore often arises in clinical settings as a parallel endeavour that allows the clinician and patient to manage their interaction while disattending to “instrumentally oriented and especially embodied practices that are necessary to the work of the setting” (Maynard & Hudak, 2008, pp. 685-686).

Lulls before or after clinical procedures such as the taking of blood pressure and of blood, measuring the client’s abdomen, and auscultation of the fetal heart, provide common opportunities for this type of storytelling. Because a midwife focuses, or appears to focus, her attention and sometimes specifically her listening on the woman’s body during these procedures, clients and midwives often remain silent while they are taking place. Talk only resumes when the sound of the ultrasound subsides or an audible hiss of pressure escapes from the blood pressure cuff and the midwife reports a number.

The final story comes from a woman’s first meeting with her back-up midwife. In the waiting area, the midwife and client participated in a larger discussion in which the woman reported that her sister had recently given birth to twins. The woman and midwife then entered the examining room and introduced themselves. They discussed an underlying health condition and some mandated issues, such as the role of the back-up midwife.² The woman asked a question, which the midwife answered at length. The midwife then asked the woman for the results of her urine test. The woman reported a slightly elevated protein level, which the midwife flagged: “Your blood pressure’s been very nice, so only thing we’d worry about is if your blood pressure was higher today than normal.” After a brief discussion of vaccines, the midwife took the woman’s blood pressure:

M: Um, I’m gonna, do your blood pressure [sounds of clattering, movement]. Did your sister’s twins go to term?

C: They were induced at 37. [...] And the first one, she was fine, like they didn’t have

² The roles of back-up midwives varied across the practices that we studied. In this case, the midwife explained that she would assist the primary midwife at the birth.

to cut her or anything, but then with the second one, the cord was wrapped around the baby's neck, so they did a teeny bit of an episiotomy

M: Awwww!

C: It was just such a shame.

M: That's such a shame! [laughter]

C: 'Cause the first baby measured first and he was 7'7. And the second one was smaller, he was only 6'13.

M: Well, 'cause it's usually the ((inaudible))

C: I know, it was such a shame, but she's healed fine though, so...

M: But it's a drag.

C: Yeah. It's more of an insult. A little high?

M: [sound of pumping, long delay then a hiss.] Your blood pressure **is** higher.

The occasion for this story is embedded within the standard visit structure: the measurement of blood pressure typically follows the discussion of woman-led and temporally-mandated topics. In performing this standard clinical procedure, however, the midwife solicited details relevant to the woman's lifeworld but not evidently relevant to the clinical task at hand. The midwife's request for the story references the informal discussion she had had with the woman before the beginning of the visit. Asking for information about the woman's lifeworld rhetorically constructs historicity in their new relationship as they build knowledge about one another (McKenzie, 2010). In responding to the woman's story, the midwife borrows her language ("such a shame"), which the woman then repeats again herself. These evaluative phrases, along with "drag" and "insult," do affiliative work by indexing shared values and a common understanding of what constitutes a "good" birth.

But this exchange also shows how both the woman and midwife treat clinical work as the most important aspect of the situation, and structure their talk around it. As soon as the blood pressure reading is complete, they immediately transition back into clinical mode. The woman asks for an assessment of her blood pressure by providing a candidate diagnosis, which the midwife confirms. Following this excerpt, the midwife proceeded with further assessment and advice, and requisitioned follow-up blood work.

On the surface, this was a story set in the lifeworld. By examining it within the overall structure of the healthcare visit, however, we may see how the story performs

important clinical functions. The midwife had previously flagged the protein in the woman's urine as potentially worrisome, depending on the blood pressure results. The blood pressure assessment was therefore potentially quite fraught for the woman, and her immediate response ("A little high?") demonstrates that this possibility was in fact on her mind. The midwife therefore invited a lifeworld story to detract from the potential seriousness of the clinical procedure (Clark & Mishler, 1992), and this story functioned simultaneously to fulfill midwifery's social-relational healthcare goals.

Conclusion

While each episode of midwifery storytelling occurs in unique, situated ways, studying these particular instances as interactional accomplishments foregrounds how clients and midwives are not simply recipients of one another's "professional advice" or "lifeworld experience," but rather both actively participate in constructing narratives that have complex clinical-instrumental and social-relational functions. Compared to counselling visits where the patient is treated as the sole legitimate narrator and the therapist serves as audience (Bercelli, Rossano, & Viaro, 2008), both midwives and women flexibly and fluidly took on and shifted between the interactional roles of storyteller and story recipient. As other analysts of conversational storytelling have found (e.g., Coates, 1996; Norrick, 2000), story recipients contributed to the original telling by borrowing and mirroring individual words and themes from the teller's narrative. They also mirrored or borrowed the teller's entire story to occasion telling a parallel story of their own. This co-narration and borrowing/sharing of stories fulfills the relational mandates of midwifery care by doing affiliative work at the same time as it attends, directly and indirectly, to the mandated topics and structure of Ontario pre-natal care.

However, as the storytelling episodes that we have explored here illustrate, the situated ways and degrees to which each one enacts midwifery's combined relational-clinical mandates vary considerably. Most notably, as evidenced by story 1 and story 3, the "small stories" that women and midwives tell together and to each other do not always clearly—or solely—fulfill midwifery's professional commitment to a non-authoritarian, woman-centred form of healthcare based on egalitarian relationships of trust, mutual respect and understanding, and shared decision-making (College of Midwives, 1994; Spoel, 2007). The significant affiliative work that storytelling can and does perform in the midwifery clinic exists in tension with the enactment of stories that also index participants' asymmetrical positions, diverging concerns and purposes, and professional control within the healthcare encounter. It may be that the combined relational and clinical goals of midwifery healthcare inevitably lend themselves to these sorts of tensions.

The discursive hybridity of midwifery interaction disrupts the separation of clinical and social worlds by mingling—sometimes uneasily—professional-expert discourse (the

“voice of medicine” uttered as clinical, instrumental, task-oriented talk) with informal, everyday discourse (“voice of the lifeworld” enacted as sociable, non-medical forms of talk). As we have aimed to show in this paper, this mixing of forms and functions occurs not simply *between* storytelling and other more clearly expert-professional modes of discourse; it also occurs in important and complex ways *within* storytelling itself. Conversational storytelling in the midwifery setting, we maintain, accomplishes both medical-clinical healthcare work and social-interactive healthcare work through its blending of these discursive modes and interactional features of shared narration and recontextualization. Far from being secondary to or separate from the main business of midwifery healthcare, the small stories that midwives and women tell each other, and tell together, are integrally interwoven with that business.

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Appendix 1. Transcription standards

- M: Conversational turns are prefaced by an initial identifying the speaker (M for midwife, C for client).
- // 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.