

# Healthcare Professionals' Assertions and Women's Responses during Labour: A Conversation Analytic Study of Data from *One Born Every Minute*

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## **Abstract**

*Objective:* Communication during labour is consequential for women's experience yet analyses of situated labour-ward interaction are rare. This study demonstrates the value of explicating the interactional practices used to initiate 'decisions' during labour.

*Methods:* Interactions between 26 labouring women, their birth partners and HCPs were transcribed from the British television programme, *One Born Every Minute*. Conversation analysis was used to examine how decisions were initiated and accomplished in interaction.

*Findings:* HCPs initiate decision-making using interactional practices that vary the 'optionality' afforded labouring women in the responsive turn. Our focus here is on the minimisation of optionality through 'assertions'. An 'assertive' turn-design (e.g. 'we need to...') conveys strong expectation of agreement. HCPs assert decisions in contexts of risk but also in contexts of routine activities. Labouring women tend to acquiesce to assertions.

*Conclusion:* The expectation of agreement set up by an assertive initiating turn can reduce women's opportunities to participate in shared decision-making (SDM).

*Practice Implications:* When decisions are asserted by HCPs there is a possible dissonance between the tenets of SDM in British health policy and what occurs in

situ. This highlights an educational need for HCPs in how best to afford labouring women more optionality, particularly in low-risk contexts.

**Keywords:** Conversation analysis, medical interaction, shared decision-making, childbirth

## **1. Introduction**

The importance of informed consent and shared-decision making (SDM) in maternity care has been recognised in many national contexts for decades [1-4] and particularly endorsed in the last ten years [5-12]. In the UK, a review of maternity services [12] recommends that care should be, 'centred on the woman, her baby and her family, based around their needs and their decisions, where they have genuine choice, informed by unbiased information.' (p. 8). Substantial evidence supports policies that women should be included in decisions about what happens to them (and their babies) during birth. Whilst women do not always desire complete autonomy [13-15], a sense of choice (and control is associated with greater satisfaction and emotional wellbeing, and decreased anxiety [16-21] as well as better perinatal outcomes [21-23]. A number of studies suggest that interactions between a labouring woman and her caregivers are a key determinant of women's experience [24-28].

Despite evidence of the benefits of engagement in decision-making, women's own accounts suggest considerable variation in the extent they feel included in decision-making during birth [29-33]. However, a knowledge gap exists as to

what *exactly* healthcare practitioners (HCPs) do *in practice* that leads to these appraisals. There is a lack of research on the interactions that occur in real-time between HCPs, labouring women and their birth partners. Most studies rely on women's retrospective reports of birth, which are subject to a range of biases. Ethnographic observations provide insight into more situated practice [34-39] but tend to gloss the specific details of interaction. Moreover, a recent scoping study on maternity care found that few studies have researched the experiences of *both* women/parents and HCPs [40].

A consequence of this limited evidence-base is that only general recommendations for effective practice are afforded. For example, the British National Institute for Health and Care Excellence guidelines on intrapartum care [8] suggest that HCPs should, '*establish a rapport with the labouring woman, asking her about her wants and expectations for labour, being aware of the importance of tone and demeanour, and of the actual words they use*' (1.3.1). Guidance of this kind, however, does not elaborate on *how* to accomplish these fundamentally interactional activities in practice and, crucially, are not underpinned by analysis of real interaction. As Drew et al ([41]: 59) argue, '*to begin to understand the processes which may underlie the quality and effectiveness of medical interaction ... we have first to identify what happens during medical encounters, and how it happens*'.

Conversation Analysis (CA) is a qualitative method for studying real-life interaction and is a leading methodology for investigating *how* communication operates in clinical practice [42]. It uses recordings of authentic interactions to

enable direct observation and fine-grained analysis, focusing not only on *what* is said but *how* it is said. This includes an analysis of the exact words used, silences, use of laughter and non-verbal aspects such as gaze alignment or use of touch. CA begins with the understanding that talk is used to perform social actions (like offering choice of pain relief). We know that the same action may be accomplished in different ways, so a woman can be offered choice about pain relief in a way that invites her active participation in the decision, or in a way that more or less constrains the options available. A key question is not necessarily *whether* shared decision-making (SDM) occurs but *how* it is accomplished [41, 43].

A forthcoming systematic review [44] of CA studies that have explicitly addressed SDM in healthcare interactions includes one that demonstrates a spectrum of HCP approaches, ranging from more 'unilateral' (clinician-determined) to more 'bilateral' (shared) [45]. Several studies demonstrate interactional strategies clinicians use to persuade patients to accept recommended treatment [46, 47], and others illustrate strategies patients use to resist recommendations [48-50]. These findings highlight the ways in which treatment decisions are negotiated in talk, **mediated by reference to the local and distal contexts in which they are enacted [51, 52]**, as well as the subtle ways in which authority and agency may be enacted or inhibited in interaction.

Decision-making during labour is neglected in interactional studies, which tend to focus on medical consultations in non-acute contexts, where discussion refers

to possible future courses of action. Decisions in labour are contingent upon what is happening currently, and involve time-sensitive interactions with women who might be in pain, at clinical risk, or whose focus is turned inward to manage the exigencies of birth [53]. Research is needed to analyse situated clinically relevant talk during labour to demonstrate how SDM may occur [29] when there are special contingencies.

In preparation for funded research of this kind, we conducted a pilot study using data from the British television programme *One Born Every Minute* (Dragonfly Productions for Channel 4). Here, we report our findings from a subset of the range of interactional strategies identified in this research. The focal practice is use of 'assertions' by HCPs to treat a proposed course of action as necessary or as going to happen.

## **2. Methods**

This CA study [42, 54] is based on transcribed video interactions between 26 labouring women their birth partners (n=40), and HCPs (midwives and obstetricians; n=137), selected on the basis of evident continuous interaction from the first three series of the British reality television programme *One Born Every Minute* (2010-2012; henceforth, OBEM). This show is based on recordings of births in large consultant-led maternity units in England and was filmed using four ceiling mounted cameras in each labour room, allowing multiple perspectives to be recorded simultaneously [55]. The cameras were operated remotely, removing presence of a TV crew in the vicinity. Consequently, the recordings capture naturalistic birth experiences in high quality video and audio.

For CA purposes having access only to the broadcast materials is a limitation. Clearly, Channel 4 made editorial decisions to reduce hours of material to approximately fifteen minutes per birth for each episode. Nevertheless, we are confident that the analyses presented here are based on continuous interactions and therefore suitable for CA.

The data were examined by the three authors working inductively and independently, searching for instances of decision-making in interaction. In keeping with a conversation analytic mentality [56], we did not predefine decision-making. On comparing our findings, however, it was clear that we had each adopted a pragmatic understanding of decision-making, as occurring in moments when a clinically relevant activity was discussed or acted on for the labouring woman or her baby. Using this definition, we identified decisions enacted around a range of clinical activities including: fetal monitoring, vaginal examinations, pain relief, and position and type of birth.<sup>1</sup>

Our analysis of decisions focused on features of both turn-design (*what* was said and *how* it was said) and on the sequence of turns that precede and follow a first mention or reference to a decision-to-be-made [45]. For each case we noted: the context of the first mention of a proposed activity (e.g. whether there were concerns of risk); *who* made the first mention of a proposed activity (HCP, woman or birth partner); how the first mention was phrased (e.g. a declarative,

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<sup>1</sup> We acknowledge this pragmatic view might not accord with other models of decision-making (cf. 55).

request or open-question); and what happened next (e.g. whether and what type of response was made).

### **3. Findings**

We identified a variety of interactional strategies women and HCPs use to instigate decision-making (birth partners tend not to instigate decisions but do participate in discussions and shape decisional outcomes). We focus here on HCPs' practices. These varied in the 'optionality' afforded to women in the responding turn [41, 58] ranging from omissions (e.g. when a decision was implemented without discussion), directive assertions (e.g. 'You need to...'; 'We are going to...') through more propositional constructions (e.g. 'Do you want to do...'; 'Why don't you...'), to open questions (e.g. 'What is your plan for pain relief...'). Given the edited nature of the dataset, we are cautious about offering statistical descriptions of the occurrence of these practices. However, uses of two phrases were prominent: 'we need to...' and 'we're going to...'.<sup>2</sup> These assertive formulations are the focus of our analysis.

#### **3.1 Assertions**

We label as assertions instances where a course of action is formulated by HCPs as something that is either going to or needs to happen.<sup>3</sup> These formulations are 'assertive' in two ways. First, they are grammatically and pragmatically built to prefer agreement from recipients [60] and, second, as declarative statements they do not provide a space for discussion in next turn [61]. It is possible for a

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<sup>2</sup> And their variants, e.g. 'I need to', 'we will need to', 'I'm gonna'.

<sup>3</sup> The definition and characteristics of assertion is debated (e.g. see 57)



recipient not to go along with the built-in preference structure but, in line with other dispreferred responses [62], doing so necessitates further interactional work.

We found assertive formulations used in a range of contexts from managing mundane administrative issues (e.g. room allocation) through routine monitoring activities (e.g. vaginal examinations), to managing clinical risk to a woman and/or baby.

### **3.1.1 Assertions in moments of clinical risk**

Consultant-led maternity units are a contested space where (mostly) healthy women can become subject to medical authority [63-66]. Debates about the complexities of the competing and conflicting agendas and authority of obstetricians, midwives, women and their families [67-70] are associated with an increased concern in the Global North with falling rates of normal births (i.e. without intervention [71]) [72-74]. Underpinning these debates is the 'risk-choice' paradox [75], in which an evident surge in risk-aversion contends with concurrent demands for more choice in maternity care [39]. Numerous studies suggest that when clinical risk is detected, HCPs tend to assert their medical authority in ways that can reduce women's opportunities to engage in SDM [76-78]. Whilst the appropriateness of foregrounding risk over choice has been variously debated [79-81], designedly asserted decisions commonly occur where there are signs of identified risk to mother and/or baby. It is often doctors, rather than midwives, who make the assertions. This is not surprising, given the institutional role doctors embody, in which they are specifically called

upon (generally by midwives) to make decisions in the context of reported risk. Calling for a doctor heralds the possibility of interventions, a fact that is not lost on labouring women and their partners. For instance, in response to a midwife requesting a doctor, a woman's partner says, 'It'd be most frustrating having got this far y'know to end up with a caesarean'.

In the context of risk and embodying their medical authority [82], doctors often strongly propose that a next course of action is necessary. The lack of optionality built into these turns contributes to conveying urgency and, faced with these assertively formulated turns, women generally (although not always) accept the proposed course of action. **Recurrent instances of clinical risk include** moments of detected risk to the baby, doubts about the possibility of an unassisted birth, and 'failure to progress'. There is not space to consider instances of each of these in detail. **We will instead focus here on Extract 1, a single case in which the health of the baby is at risk (Table 1).**

In this extract, the labouring woman is being continuously monitored following an induction of labour and a long first stage. Just before this extract begins (data not shown), the labouring woman has announced that she wants to push but the midwife expresses concern on two counts: i) because she would be, 'incredibly surprised if that cervix has gone and we're ready to go', and; ii) the baby's heart rate is not responding well to contractions. It is in this context of perceived risk that the doctor is called. He performs a vaginal examination (VE) and encourages the woman to push but on observing the baby's heart rate he

announces his decision to perform an unspecified surgical/assisted delivery first, implicitly, to the midwife (line 1) and then explicitly to the woman (lines 5-7).

The decision to perform a surgical/assisted birth is announced as a need in the context of expressed concern and follows a physical examination as well as orientation to the fetal monitor. Hence, there are contextual grounds to expect that a decision about further treatment will feature in the interaction. The doctor's first announcement, 'I'll tell everybody' (line 1) is designed in shorthand terms for the midwife, and conveys that a decision has already been made. The doctor's actions construct the urgency of the situation, and implicitly direct the HCPs to start making preparations. He prioritizes these activities before addressing the woman. When he does address her, it is to proclaim more explicitly the need to move to theatre (lines 5-7) and to provide the rationale for doing so – 'baby doesn't like this after you've pushed' (lines 7-8). The assertive formulation of his turn 'we will need to', together with the invocation of risk and the visible preparation for the move, narrow the woman's opportunity for discussion.

In this case, the labouring woman is presented with one option, and can see that, for all practical purposes, a decision has been made. As the doctor has spoken to her, she maintains her gaze on him, but **neither** responds verbally **nor** non-verbally. The midwife notices her silence and treats it as indicating some form of uncertainty, and pursues a response using an affectionate address term, reiterating what is *going* to happen (line 10), offering reassurance (lines 13-14)

before re-invoking the grounds of implied risk on which this decision has been taken (line 13-14). When the woman does not respond, the midwife pursues again, asking 'alright' (line 16) and it is here that the woman agrees, sotto voce (line 17). Hence, although a decision was presented interactionally as having already been made and even instigated, the woman's consent is oriented to as relevantly absent and is pursued.

Assertively produced decisions contribute to prioritising risk over optionality but are not wholly unilateral because HCPs seek consent and respond to signs of resistance. **A similar observation to this has been made in oncology [45]. HCPs have, in this context, been observed to produce directives in such moments of risk because of medical exigencies.** Nevertheless, in the context of perceived risk, we have not seen cases where women's resistance result in a change of plan, nor do we have cases where women actively disagree with proposed activities, suggesting that women's active opposition is rare.

### **3.1.2 Assertions and Routine Activities**

Vaginal examinations (VE) are conducted regularly, most commonly as a way of assessing progress through labour [83], but also to augment labour (e.g. breaking waters). In both cases, guidelines state that a woman's consent should be ensured [84]. In our dataset, HCPs regularly seek consent before conducting VEs but do so in a way that invokes their *necessity* **by** using formats that are built

to prefer agreement (**Table 2**). The specifics of what women are agreeing to (or not) are rarely made explicit.

In **Extract 2**, a doctor implicitly proposes to conduct a VE **by invoking** a need to assess **the** progression of labour. **The necessity of this examination is provided for over the doctor's turn (lines 1-4 & 6) by reference to the ambiguous position of the women's current state (i.e. as one that cannot be determined without a VE). This ambiguity is construed here as such through the turn-design of the assertion, proposing to investigate whether 'any of these (0.2) tightenings' (lines 2-3) are 'doing anything' (line 4). Despite establishing the necessity of VE, however, the exact method for achieving this is not specified but nevertheless yields minimal consent (line 7).**

In **Extract 3** the midwife uses a 'need to' format and appears on a trajectory towards presenting a VE as necessary but repairs it such that the examination is implied but not named (lines 1-2). The labouring woman minimally consents in next turn (line 3).

In **Extract 4 (Table 3)** the midwife indexes the need for a VE and there is a similar problem in articulating exactly what is needed (line 1) as indicated by the 0.4 second silence and the euphemistic "down below" (line 2).

In **Extracts 2, 3 and 4**, the 'needs' are produced delicately and are attributed to a requirement of the larger activity of induction. However, in **Extract 4**, the woman treats the requirement as problematic by exhaling, closing her eyes and

leaning back; visibly withdrawing from the interaction (line 4). The midwife orients to this possible resistance by providing an explanation that produces the proposed action as one that is a constituent element of the activity of 'induction' – to which the woman has already agreed - and reinforces this by mentioning the 'plan' (line 12) as a reminder of a previous discussion. Here, the woman's prior consent for the larger activity of induction of labour appears to be used as a basis for managing her resistance in the here-and-now. **The midwife's subsequent turns (lines 06-07, 10 & 12-15) pursue a response from the woman, indexing an orientation to her** lack of responses and work to seek consent; she does not simply perform the examination. However, she does not, in the first instance, **solicit an account for** why the woman has disengaged. Instead, the woman's partner conducts this more emotional labour when he asks 'Oi, what's up' (line 16). The midwife and partner **then** cooperate to **diagnose the problem, offer reassurance, and to** secure the woman's agreement. Her partner characterizes her withholding of responses as 'being silly' (line 19) and later reminds her that she is a 'big girl' and can 'handle it' (line 47). These chastisements are uttered more sympathetically than they appear on the page and it is noteworthy that he also voices the woman's concerns, explaining that she does not 'like all these examination sort of things' (lines 21-22). On hearing this, the midwife **proposes to** proceed with the induction but offers to take the VE 'very very slowly' (line 26). The availability of staff already known to the woman is also discussed **(lines 40-42)** and, **through negotiation between the three parties, rejected** (pointing to difficulties with practising continuity of care). Finally, after withdrawing from the interaction for some time, or having engaged only minimally, the woman tearfully requests: 'can I- have I got the

option to wait' (lines 50-51). This request begins using the modal 'can I', conveying both a right to ask and an expectation that her request will be straightforwardly grantable [85]. However, this is reformulated as a question about whether there is an option for her to wait. This **self-repair** may be dealing with the plan for induction, to which she has already agreed. On this occasion the midwife agrees to delay for twenty-four hours (lines 56-57 & 59).

In this case, the woman's declination of an already agreed plan takes significant interactional work; withdrawing from the interaction was not in itself enough to modulate the institutional 'need' to continue with it. Instead, after several attempts to explore options that were based on the assumption that the induction would continue, the woman is pushed to make explicit her desire to delay the process through asking a question about a single option.

Women might know little about why VEs are used during labour and may not know that they can decline these examinations [86]. The UK General Medical Council is clear that practitioners should be satisfied that consent has been given prior to "undertaking any examination or investigation" ([87]: 4). However, patients "may imply consent by complying with the proposed examination or treatment, for example, by rolling up their sleeve to have their blood pressure taken." ([88]: 20). This creates a grey area in which some of these procedures could be taken as having implied consent by assenting to a larger activity such as induction of labour or, more generally, to the package of a hospital birth. **This lack of clarity, concerning patients' choice of routine procedures, is not**

**unique to labour-ward interactions, and has been observed previously in antenatal screening [89].**

This issue of ongoing consent is also evident in relation to fetal monitoring (**Table 4**). In **Extract 5**, the midwife puts forward monitoring as something that needs to be done as an upshot of using a pessary to 'ripen and soften' the cervix (line 5) (and something the woman appears to have consented to without fully understanding (see line 1)). An explicit reference made to this being a subsequent episode of monitoring ('another', line 7) might contribute towards invoking ongoing consent implicitly. Coupled with the formulation of monitoring as something minimal ('pop' line 6), that needs to be done (line 6), the procedure is compellingly produced as routine.

In **Extract 6**, a midwife invokes the need for continuous monitoring. This time, the need is not minimized, nor is there mention of a previous episode of monitoring. The woman's membranes have spontaneously ruptured and the amniotic fluid is stained. The midwife explains why this is the case (lines 1 & 3) and what this might mean for the baby (lines 5-8). The need for monitoring (lines 9-11) comes immediately next, thereby producing this preceding explanation as an account for this need.

Although the clinical context for continuous monitoring is made clear, the interactionally produced 'need' in Extract 11, is in direct opposition to professional advice on continuous monitoring [90, 91]: "All decisions to use continuous electronic fetal monitoring should be discussed with the patient and



the reasons for offering it should be outlined. It is important to note that these criteria are only for the *offering* of continuous electronic fetal monitoring, not its mandatory use, and the pregnant mother is entitled to have the last word on whether or not she wishes to use it" [90]. **Extract 6** highlights the tension for HCPs between duty-of-care and offering women choice.

## **4. Discussion and conclusions**

### **4.1 Discussion**

This CA study of data taken from a documentary series has shown the utility of such analysis for studying decision-making in situated practice in the maternity ward. In focusing on one sub-set of HCPs' interactional practices for initiating decisions, we have shown how HCPs' authority, as indexed through assertive turn-designs, can act to reduce women's agency to participate in discussions of their options in contexts of both perceived risk and more routine activities during their labours.

The 'risk-choice' paradox [75] plays out in situated practice. In this corpus, particularly in moments of risk to women and/or babies, a professional duty-of-care is prioritised over women's participation in discussion of options. This can be achieved through the particulars of turn-design that contextually produce a course of action as urgent/medically exigent. However, consent remains an important goal of even assertively produced decisions, and when women resist asserted actions, HCPs notice and pursue agreement.

There is, however, a grey area between routine and risk so that a birth that is progressing 'normally' can be treated as if at any time it might become high risk [92]. HCPs are navigating this in a risk-adverse culture that may inadvertently curtail women's agency in decision-making in relation to more routine monitoring activities. In the UK, midwives have relative autonomy as healthcare professionals [7] and there are policy developments that recognise that women experience more choice (**however so perceived [93]**) when they are cared for by midwives [12]. Although research suggests that midwives working in consultant-led units strongly endorse the notion of informed consent with reference to labour and fetal monitoring, the reality of working under competing agendas of managing consent, risk, and choice can mean that, 'the women often got the choice the midwives wanted them to have' ([94]: 306). In our dataset, we see how this can happen when midwives use interactionally assertive formulations. Women can and do resist, but declining to go along with the proposed course of action is an interactionally dispreferred activity and can take significant work.

## **4.2 Conclusions**

Assertive turns may be attendant to risk or to taken-for-granted procedures and strongly indicate what is going to be done to a woman. Some activities that are referred to are – as far as professional guidelines are concerned – optional, but are produced as something that has already been decided and/or required. Assertions are designed for, and are regularly responded to, with agreement; other responses can and do occur but they take interactional work.

### **4.3 Practice implications**

This research suggests that when HCPs use assertively designed formulations they reduce the interactional space for labouring women to participate in discussion of their options and, hence decisions about what happens to them. There are moments when reduced options are clinically indicated. However, we suggest that where procedures are optional for women, their optionality is made clear in interaction.

### **Conflict of interest**

The authors report no conflicts of interest.

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**Table 1: Clinical risk: Extract 1**

**Extract 1:** [OBEM 2:1 J&R]

1 Doc: ((To Mid)) I'll tell everybody  
2 ((walks away from the bed to discard  
3 gloves))  
4 Mid: Okey dokey. Right.  
5 Doc: ((walking back to bed)) **Uhm we will need to**  
6 **take you (round) to theatre to deliver the**  
7 **baby. Baby doesn't like this after you've**  
8 **pushed;**  
9 (2.0)  
10 Mid: Okay sweetie (0.2) **we're going to be going**  
11 **round.** ((removes blood pressure cuff))  
12 (0.5)  
13 Mid: It's alright I'll be with you. (It's/he's)  
14 just not a happy bunny.  
15 (.)  
16 Mid: Alright?  
17 Wom: ((nods)) °Yeah°

**Table 2: Vaginal Examinations: Extracts 2 & 3**

**Extract 2:** [OBEM 2:5 J&D]

1 Doc: **What we need to do:** (0.2) is to see  
2 if **any** of these (0.2) ((he nods  
3 towards Woman)) tightenings that  
4 you're having [(.) are doing **anything=**  
5 Wom: [Mm.  
6 Doc: =to the cervix.  
7 Wom: Mmhm.

**Extract 3:** [OBEM 2:1J&R]

1 Mid: **Now what I need to do uhm** (2.5) **find**  
2 **out how dilated you are.**  
3 Wom: **Mmhm.**  
4 Mid: And the[n hope]fully (0.2) =  
5 Wom: [( )]  
6 Mid: =and hopefully (.) break your waters  
7 with this (1.0)  
8 Mum: Crotchet hook.  
9 Mid: Ye[s:. Now then.

**Table 3: Resistance: Extract 4**

**Extract 4:** [OBEM 2:10 O&D]  
01 Mid: Okay. mcht .hh **What we need to do is to**  
02 **examine you (0.4) down below (0.2) and**  
03 **see if we can break the waters.**  
04 Wom: hh ((closes eyes))  
05 (1.2)  
06 Mid: Okay. 'Cause that's like the next step on  
07 from (0.2) inducing [(0.2) you.  
08 Par: [.hhh  
09 (0.5)  
10 Mid: Okay.  
11 (0.2)  
12 Mid: .hhh So the plan is uh-uh us to examine  
13 you see'f we can break that waters .hhh  
14 and then uhm uh g-go from there. An'  
15 then [ (.) we are in fact-  
16 Par: [(Oi:¿ ) What's up?  
17 (0.4)  
18 Mid: Are you alright?  
19 Par: ( ) being silly:.  
20 Mid: I know it's a bit scary.  
21 Par: She don't like all these  
22 examina[tion sort things.  
23 Mid: [No.  
24 Par: ( ) for 'er.  
25 Mid: If you're worried about the examination  
26 [.hhh we can take it very very slowly.  
27 Wom: [((nods))  
28 Mid: D'you want ((Midwife 1)) to come an' do it¿  
29 Wom: ((nods))  
30 Par: I thought it might be that.  
31 (0.4)  
32 Par: Mm.  
33 (0.2)  
34 Par: 'Cause she's used to ((Midwife1)) you see.  
35 That's what it is basically an'  
36 (0.8)  
37 Par: ( )?  
38 (0.2)  
39 Par: An' ((Mid2)) not 'ere¿  
40 Mid: An' ((cuts off Mid2))- No unfortunately  
41 it's jus:t .hhh there's not enough people  
42 y'[know.  
43 Par: [(Alright)  
44 (1.0)  
45 Par: Come on.  
46 (1.5)  
47 Par: You're a big girl. You can handle it.  
48 ( )?  
49 (3.5)  
50 Wom: ((tearful)) Can I - 'Ave I got the option  
51 to wait.  
52 Mid: If you want to wait [(1.2) you can wait.  
53 Wom: [((nods))  
54 (1.0)  
55 Mid: We just rest you for twenty four hours  
56 [an' then just bring you back (.) down =  
57 Wom: [((nods))  
58 Mid: = here again tomorrow. An' then try again.

**Table 4: Foetal monitoring: Extracts 5 & 6**

**Extract 5:** [OBEM 2:10 O&D]

01 Wom: So what was the tablet thing (for)?  
02 Mid: .hh That's the prostin.  
03 (0.4)  
04 Mid: Remember the prostaglandin that's gonna  
05 s- ripen and soften your cervix. .hhh **So**  
06 **what we need to do is pop you on the**  
07 **monitor for another half an' hour or**  
08 **so. Just to make sure baby hasn't**  
09 **objected to us doing that**  
10 (2.0)  
11 Mid: An' then we'll get you up an' walking  
12 about.  
13 (4.0) ((Oakley stands up))  
14 Par: Sexy ( )

**Extract 6:** [OBEM 1:8 S&M]

01 Mid: It's bec↑ause .h your baby's pooed.  
02 Wom: Ha[ww  
03 Mid: [Is why it's that c[olour.  
04 Wom: [Aww  
05 Mid: Loads'v babies do it. .hh It can (.) be a  
06 sign that baby's getting' a bit ((midwife  
07 closes the door of the ensuite toilet) fed up¿  
08 Okay. Most of the time it isn't. >.hh<  
09 But because it can be .h **what we need**  
10 **to do is listen >to the< baby's heartbeat**  
11 **continuously.**  
12 (0.2)  
13 Mid: Okay. Which means we need to go down stairs  
14 to labour ward.  
15 (.)  
16 Mid: If I go out of the room do you  
17 promise not to have a baby down the  
18 lo(h)o [( (h) (h) )  
19 Mum: [Huh huh huh  
20 Mid: Yeah? Okay. I'll be back in a sec I just  
21 need tuh .hh sort'v phone labour ward  
22 let them know we're coming et cetera.  
23 Al:right¿