Extraordinary Emergencies: Reproducing the Sacred Child in Institutional Interaction

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Introduction

This study explores interactions that occur in the institutional space of the emergency call centre. The analysis focuses on the practices that are routinely employed by service-providers and callers in the production of "ordinary" emergencies, and subsequently analyses the methods by which certain emergencies are reproduced as "extraordinary". To this end, the analysis makes use of both verbal and written data, in the form of telephone calls that contain a report of the emergency and the written record produced by the call-taker as a function of this report. Finally, the study aims to explore possible accounts for the production of the "extraordinary emergency". Considering the fact that a key insight in my findings highlights the consistent production of emergencies involving child sexual abuse as extraordinary, the literature review will explore various theories of child sacredness and child sexuality.

Emergency medical call centres occupy a central space in the provision of medical services to the public. Their actors consist of call-takers, dispatchers and paramedics, among various other administrative staff. Call-takers serve as the interface between the reported incident and the dispatch of an ambulance, so that in a larger sense they may be viewed as the interface between the personal and the institutional spheres. As Zimmerman (1992, pp. 418-419) suggests, "the term 'call' does not simply refer to instances of telephone contact, but to what is accomplished by parties to those contacts as they interact in the pursuit of their respective concerns". In other words, the noun "call" in this context refers to a set of very particular actions that are being done by two parties, and the call itself can be studied as a social artefact, for what it accomplishes and produces.

Concurrent with each phone call is its written documentation by the call-taker, what Zimmerman (1992, p. 420) terms a "dispatch package" that must be transmitted to a dispatcher, understood by him or her, and utilized in the efficient dispatch of relevant ambulance and paramedic services to the location of the emergency incident. This document is both "product and project" (Drew & Heritage, 1992, p. 19) of the interaction; project insofar as its structure and categories impose an institutional presence that constrains what and how information can be given; product insofar as its completion depends upon an intermediary who may deviate from its script in certain instances.

Unlike the assertion that "the machinery of the state is remorseless and impersonal" (Herzfeld, 1992, p. 46), my analysis provides evidence that institutions do not function in a simplistic and one-dimensional manner, and that in fact the institution is being constantly reproduced through the delicate negotiation of multiple roles that the call-taker faces in his or her capacity as an intermediary of the personal and institutional. This, rather more encompassing, view of the human agent in the institutional role offers the possibility that institutions are shaped by their instantiations in time and space at the same time as they provide the setting for these very occasions, a position taken up by various authors about the constitutive nature of language in the social construction of institutions, and articulated precisely by

Heritage in his description of institutions as "talked into being" (Heritage, 1984, p. 290). Although this position does counter many prevailing (perhaps conservative) sociological theories about the role of the institution in social life, there is both academic and empirical support for its possibility and it is to this growing body of knowledge that I would like to contribute with my forthcoming analysis.

In the following section, I provide a review of a diverse range of literature. I begin with a review of Drew and Heritage's (1992) features of institutional talk, which describe the mechanisms by which institutional (or competing) agendas are made visible. I then review previous conversation analytic research that has been done in the field of emergency services, offering ways in which it is relevant to my own research. Finally, I provide a review of the literature that describes ways that children and sexuality are constituted in society, and explain the way that this supports my own analysis. After the literature review, I provide a description of my methods, which include conversation analysis and textual analysis and their appropriateness for this particular research. I then provide an analysis of the data that I have researched, and conclude by offering some insights that tie the literature and analysis together.

Literature Review

The Emergency Medical Centre as an institution

The view of a government organization such as EMS (Emergency Medical Services) as a bureaucratic system situates this research study within a particular context, that of the state-regulated institution as a social phenomenon that is worthy of critical evaluation in terms of its interactional practices and its record-keeping activities. The relevance of understanding this research in this context stems from two key ideas. The first, offered by Weber, describes institutions as the "arena in which freedom, creativity and responsibility could become manifest" (Weber, 1968, p. xvi), a position that is confirmed and supported by my own analysis, which seeks to highlight the ways in which orientations to social responsibilities are lived and reproduced through institutional interaction. The second key theme that locates my research in the institutional context belongs to Manning, who suggests that organizations are "formally constituted systems for the processing of communicational units utilizing set technology, a structure of roles and tasks systems of encoding and decoding meaning and interpretative practices" (Manning, 1986, p. 288). Another important aspect of my research, especially with regard to empirically displaying the mechanisms used to deviate from institutional agendas in EMS interactions, involves the analysis of written records that are reproduced together with the telephone calls. The codification and institutionalization of information is one of the key features of institutional work, concerned with converting a real life (and death) experience into a crystallized language piece that is

able to effect organizationally actionable work. The evidence for different ways of reproducing emergencies (routine vs remarkable) is often found in these written records, which are thus a crucial part of my analysis and research. The use of these documents as sites of deviation or adherence to the institutional script offers insight into the functions performed by them.

Features of institutional talk

According to Drew and Heritage (1992), who cite Levinson (1992), there are three features of institutional talk that distinguish it from more mundane conversation. I will discuss each of these features briefly.

Goal-oriented talk

In institutional interactions, the exchange is dominated by a mutually recognized goal which both parties work towards accomplishing. In the case of emergency services and the telephonic interactions and dispatch forms which I am analysing, the end goal is the provision of an ambulance to the scene of the emergency with the aim of preserving a life, and the conversation is organized around the information gathering that is relevant to the dispatch of the service. This point is crucial to my analysis, since, when efficiency, as an overarching institutional goal, is forsaken or replaced in the exchange, it suggests that the institutional agenda has been put on hold, and a different goal is being prioritised.

Constrained interaction

Another feature of institutional talk is the way that the exchange is constrained by its overarching structural requirements. In the case of EMS, the call-taker is oriented to the need for efficient service provision, which is enacted through rapid information gathering and simultaneous transposition onto institutionally relevant documents which are then sent through to an ambulance dispatcher. The information that is gathered during the exchange is directly related to the form's requirements; it could thus be suggested that the institutional form that is filled in has a direct bearing on the structure and sequential organization of the interaction. Since this format determines the types of things that should, or should not, be said during the exchange, deviations from this format indicate the pursuit of a competing agenda. Another, related, point in the institutional constraint of interactions is the use of medicalized language during these interactions, a function of the formal nature of the interaction as well as an efficiency practice that contributes to its goal-oriented focus.

Special aspects of inference and reasoning

This last defining feature of institutional talk describes the orientation to a professionalism that precludes expressions of "surprise, sympathy, agreement, or affiliation" (Drew & Heritage, 1992, p. 24). In the case of emergency services, there is a distinct orientation to a professional constraint against these kinds of displays, one that might be counterintuitive in an ordinary or informal conversational context but that is appropriate to the institutional context being reproduced by the participants. In my

analysis, then, displays of this kind suggest the abandonment of the institutional agenda; i.e. during this type of deviation, a different context is being co-constructed by the participants.

These three features of institutional talk differentiate it from interactions of a more ordinary or personal nature. Therefore when any or all of these defining features of the institutional context are abandoned, it suggests that a different agenda is being pursued and a different context being produced by the participants. This context might be seen as the orientation towards the co-construction and joint reproduction of important social and moral norms, what I refer to in my analysis as "personal" work. The aim of my analysis is to identify the ways that this competing agenda is pursued by participants, the ways in which parties align or disalign with this newly introduced agenda, and the methods by which the institutional agenda is taken up again by the parties. The examination of the constant renegotiation of roles in the interaction, and the accompanying constant renewal of their competing contexts, is one of the key objectives of this analysis.

Deviations from the institutional agenda (and their place in the normative order)

As Heritage (1984, p. 210) suggests, there are two interrelated practices that contribute to the maintenance of institutional realities:

1. the routine production of actions which can be viewed in terms of their appropriate interpretative framework, and
2. the maintenance of the interpretative framework itself in the face of "wear and tear" arising from deviant or discrepant courses of action.

In other words, there is a general adherence to required institutional practices in a given context, since deviation from such practices requires a special accountability, a feature which encourages conformity to normative procedures. In addition, there is the maintenance of this context even in the face of deviations from its normative requirements. How can the institutional frame be maintained despite obvious breaches to its structure? Heritage (1984, p. 210) provides an explanation for this by suggesting that people create "special circumstances" in which deviations are made acceptable and thus incorporated into the "routine production of actions" that maintain the institution. Thus, built into normative procedure is a range of deviations with their own "special accountabilities" that exhausts the range of possible contingencies for a particular event. Speakers may refer to one of these when deviations are enacted and thus maintain the institutional context which they "inhabit". In this sense, deviations are systematic things and can be analysed as such. The presence of a deviation could be said to account for itself by its very presence (a circularity which mirrors the reflexive and self-referential

nature of context itself); while at the same time it constructs its catalyst (or the thing it deviates towards) as extraordinary. Regarding this analysis, it emerges that deviations from institutional procedure are enacted to create "extraordinary emergencies". A key finding in my research indicates that these deviations occur systematically and recurrently with reference to a specific type of incident: one involving the sexual exploitation of the child. This explanation offered by Heritage can help us to understand how the institutional agenda is maintained and delivery of services does take place despite what can be seen as the orientation to a competing agenda. It may be that the reason the institutional context persists in the face of competing possibilities and enactments is that these deviations occur over something collectively recognizable as a "special case", and are accountably produced as such, thus contributing to the institutional context remaining intact in the mass of other emergencies that do not reach the type of threshold required for them to be extraordinary.

A review of emergency call literature

This section of the literature review begins with a collection of the common practices and methods used in the reporting of an emergency to Emergency Medical Service centres. Whalen and Zimmerman (1987, p. 181) suggest that "talk and its setting or occasion are reflexively tied" and that therefore institutional talk has a nature distinctive from other, more mundane forms of talk, that, together with the sequential nature of the exchange, serves to constantly reproduce the context in which the talk is being held. The institutional nature of the interaction and its corresponding aims serve to reproduce a set of practices that deviate from those commonly found in more mundane exchanges, and suggest that institutions are "accountably talked into being" (Heritage, 1984, p. 290), such that the nature of an emergency medical centre is constantly being renewed through talk by interactants' practices that orient to it as such. These practices serve the institutional aims of the interaction as well as providing its defining characteristics, and thus serve as the baseline for the most regular instantiation of the procedure. The analysis that I will do focuses specifically on interactions between institutional professionals: call-takers at EMS, and callers from 107, a general emergency call centre that often acts as a router or operator and directs emergency calls to various specific departments.

Whalen, Zimmerman and Whalen (1988, p. 342) offer "a distinctive organization of sequences" in which "informing is done" in emergency calls: (1) opening/identification, (2) request, (2a) interrogative series, (3) response, and (4) closing. The opening sequence generally consists of a self-identification ("Emergency medical services, how can I help you?") by the answerer and a greeting response ("Hi") by the caller. This opening sequence has as its defining feature a "specialization" or "reduction" (Whalen & Zimmerman, 1987, p. 172), referred to by Drew and Heritage (1992) as the "institutional fingerprint" of the exchange, such that it expedites the efficiency of the interaction while still situating the interactants in their respective roles for the exchange. As Whalen and Zimmerman suggest, the extended greeting sequence typically found in ordinary exchanges is "absent but not missing" (1987, p.

37); absent in its distinction from mundane talk but not missing due to the regularity of its absence in specialised interactions. The next portion of the exchange involves a request by the caller for the provision of a service, in this case the dispatch of an ambulance. In emergency calls, this request is often done as the second part of the caller's first turn, after the acknowledgement token ("Hi, I'm calling from 107, I've got a medical for you" / "I have a patient here"). This sequence, and its immediacy to the previous, provides evidence for the appropriateness of the brevity or reduction of the previous, and acts to define the call as institutionally relevant to both parties. However, this request as the first part of a request sequence, is not immediately followed by its second part (the answer). Rather, the presentation of the request elicits an insertion in the form of an interrogative series directed by the call-taker. The function of this insertion is to defer response to the request in order to evaluate its relevance, as well as serving the purpose of gathering information relevant to the request. A deferral of this sort can only be managed unproblematically if both parties are oriented to the crucial function it serves as an information-gathering mechanism. This orientation is most readily available in exchanges between professionals (i.e. the call-taker and a 107 caller) and can be the source of distress in calls from laypeople whose requests are as much a search for reassurance as for service delivery.

In my analysis below, concerning exchanges between professionals, this difficulty rarely arises and the interrogative series is generally undertaken unproblematically. The interrogative sequence also functions to redistribute the roles of the interactants; so that the service provider briefly becomes the interrogator, while the service seeker briefly takes the role of interrogatee. The interrogative sequence is generally broken up into three portions that together form the "contingencies of response" (Whalen & Zimmerman, 1987, p. 175): "location", "caller details", and "incident description" (in no particular order) which details are the condition for provision of an affirmative response to the request. The analysis in this research report will focus specifically and exclusively upon one portion of the interrogative sequence: the incident description and its related occurrences in exchanges between professionals. This sequence typically unfolds with the call-taker responding to the second part of the caller's first turn ("I've got a medical for you") with a token phrase indicating the opening of the insertion sequence ("What's your medical?") which acts to elicit all relevant information about the incident description from the caller. The caller typically orients to this phrase as a general request for incident information and may provide patient details including age and gender, as well as a detailed description of the incident. In many instances, the description requires further follow-up questions by the call-taker in order to gather all the relevant details. Upon successful completion of this insertion sequence, the call-taker reverts back to his or her role as service provider by either granting or denying the service requested, and the caller once again becomes the service seeker as he or she acknowledges the provision or lack of provision of said service. This normative structure may be deviated from over a range of circumstances: from an expansion of the opening sequence that accommodates a relationship between professionals that goes beyond its institutional bounds, to expressions of sympathy or dismay

during the incident description sequence. Although deviations from the institutional script are more typical between two professionals than between a professional and civilian, the quality or type of the deviation warrants inspection for the function it performs and the light this can shed on larger social structures, which is ultimately what this research aims to do.

Further to the information gathering work described above, Zimmerman (1992, pp. 422-423) also describes the work of the call-taker as "codifying and entering particular items of information… that constitute the dispatch package into the computer". Thus, while callers are concerned with producing an accountable report of an incident as something requiring medical assistance, call-takers are dually concerned with talking with and listening to the caller as well as transposing or converting the information they are receiving into a dispatch package that displays this incident as something medically recognizable (and requiring medical assistance). Zimmerman's term, "dispatch package", is useful for the analysis that follows here, since the analysis of both sets of data (verbal and written) makes up my research, and various institutional practices can be identified in each of these that empirically support my analysis and findings.

Emergency centres: the routinization of unpredictability

Emergency services are architectures of life and death: the routinization and efficient management of disaster is often key to the preservation of a life. Unlike institutional settings that pursue a variety of bureaucratic or social aims: justice in the courtroom, rehabilitation in the prison or mental asylum and socialization or education in the school, the institution of medicine is directed towards the preservation of life – as such, its decisions and behaviours are often bequeathed an additional gravity. Emergency medical services, as part of this structure that is the medical institution in society, is geared towards this overarching aim, and its workings are reflective of this. As Whalen (1990, p. 9, quoted in Zimmerman, 1992, p. 458) suggests:

> For practitioners (call-takers and dispatchers), the intended effect of the standard ordering of work tasks… is to make the handling of calls as routine as possible, and in this way process "emergencies" as routine, expected, and even predictable events in practitioners' work lives. For nonpractitioners like citizen callers, however, "emergencies" are visibly experienced – that is to say, their "experiencing" of their circumstances is displayed in their talk – as anything but routine events. For them, it is overwhelmingly the case… that the event is not expected, is hardly a "nothing special about it, just another one of those" occasions.

This quote provides part of the rationale for my decision to work with calls only between institutional professionals. While a civilian may attend to an emergency as "uncommon", "devastating" or "unexpected", the mutual work of institutional professionals is that of producing these as ordinary

events; in this context, the construction in a hyper-professional setting of an event as "extraordinary" or "remarkable" is deserving of close examination.

One of the instances where the institutional aim of "efficiency in the pursuit of preservation of life" is most evident is in the information gathering sequence during telephonic reports of emergency. Garcia and Palmer (1999) identify a problem that can arise in this space. Their article begins with the assertion made by Garfinkel (1967, p. 50) that interaction is made possible only through the mutual assumption by interactants that they can trust each other to comply with "the expectancies of the attitude of daily life as a morality". This means that, in daily life, "certain things can and must be taken for granted in order for interactants to successfully coordinate their actions and achieve intersubjectivity" (Schutz, 1970, as cited in Garcia & Parmer, 1999, p. 2 ; also see Heritage, 1984). Not only do social actors take for granted certain aspects of interaction, but they also hold one another morally accountable for taking these things for granted, so that breaches of this mutual taking-for-grantedness by interactants can result in severe sanctions. Obviously the extent to which this trust can be assumed depends on the level or quality of consequence that would occur were this assumption to be false.

In emergency services, the institutional worker treads a fine line: on the one hand, the provision of an ambulance to a person who is not adequately in need of it may well deprive another of life, negating the institutional aim of "preservation of life" in this case. On the other hand, excessively questioning a caller to ascertain this "adequacy of need" may delay efficiency, thus depriving the patient of life. Further, the disbelief of "adequate need" of a patient may also deprive him or her of life. In statistical theory, researchers often come up against the problem of alpha error vs beta error. An alpha error would mean that a significant result was found where none existed, whereas a beta error would mean that a significant result was overlooked where it did in fact exist. Each error has to be constantly weighed against the other, since an increase in the precision of the former would parallel a decrease in the precision of the latter, and vice versa. In research where lives are on the line, typically in the medical or scientific field, researchers tend to opt for the "false negative" rather than the "false positive", meaning that significant occurrences are often overlooked. In the case of EMS the call-taker faces a similar conflict: "actively" sending out an ambulance will most likely deprive another person of this service; while "passively" retaining the ambulance and not dispatching it might cause damage by its omission. Thus medical workers often do not assume the trust that is a feature of most ordinary conversation, since they may feel they have more to lose by dispatching an ambulance than by not dispatching it. Obviously, this may lead to decreased precision in determining a patient's "adequate need" and may occasionally cause fatalities. Such a circumstance is the focus of Garcia and Parmer's article, which highlights an interactional difficulty in the securing of an institutional service bestowed by a bureaucratic authority. Whalen et al. (1988) describe a similar incident, where the information-gathering exercise in emergency calls is mismanaged, leading to delays in service provision and,

ultimately, a fatality. This second example serves to illustrate the difficulties encountered by emergency workers who must constantly balance their need for information with their goal of efficiency. As Raymond and Zimmerman (2007, p. 38) suggest, participants must pursue "no more, but no less talk than necessary" – a daunting task in the face of such immediate and grave consequences.

Raymond and Zimmerman (2007) explore a related feature of interactional troubles in the medical services arena, concerning the distribution of rights and responsibilities within the interaction. EMS is a governmentally sanctioned provider of a service, and thus interactants display an orientation to the different roles that they inhabit in the exchange: the caller, either a layperson or corresponding medical/bureaucratic professional (e.g. the 107 caller), and the call-taker, an institutional authority of the provision of the service required. In most instances, these roles are adhered to admirably, where the caller orients to his or her responsibility to provide adequate information, and his or her right to thereafter receive a service; and the call-taker orients to his or her right to acquire such information and his or her responsibility to thereafter provide the service. These practices embody an "alignment of identities" and also suggest a "default directionality" regarding the flow of information (Raymond & Zimmerman, 2007, p. 34). Deviations from this institutional orientation do occur, over a range of circumstances, and require interrogation of their competing function in the exchange.

Raymond and Zimmerman's article analyses the ways that these rights and responsibilities can be threatened, breached or exchanged. They offer as an example the case of a large fire that was reported by multiple civilians, who eventually began requesting information on the incident from the call-taker, who was suddenly in the position of "knowing more about it" due to the multiplicity of reports on the event. This change in the direction of information flow is seen by Raymond and Zimmerman as a deviation from the usual character of these interactions, which results in further deviations in the interaction, such as callers beginning to "request advice" from call-takers, typically not part of the call-taker's role as service provider. Raymond and Zimmerman suggest, however, that although these deviations to the exchange do occur, there is nevertheless an overall orientation to the institutional structure underlying the interaction and a resistance to abandoning it completely. This evidence is confirmed in my data analysis below, where I demonstrate that the institutional agenda is occasionally abandoned temporarily, but is always taken up again, reflecting a mutual alignment with the institutional structure of the exchange. I have elaborated on this point above, in my discussion on the maintenance of institutional realities described by Heritage (1984) and the important function that this plays in social life.

Regarding structural constraints of the phone call as a feature of institutional talk, I have mentioned above that a crucial identifying factor in emergency calls is their typical absence of emotional action. Tracy and Tracy (1998, p. 392) use the phrase "emotional labour" to refer to the enactment of "an emotional performance that is bought and sold as a commodity". One of the (counterintuitive) ways

that emotional labour is performed is as "emotion suppression" (p. 393) particularly seen in vocations that require an absence of emotion in order to function optimally. There are a number of reasons that this particular institutional constraint might be advantageous in the emergency call setting. Tracy and Tracy (1998, p. 393) suggest that one of the most important reasons that bureaucratic workers do emotion suppression is to avoid "burnout", a condition where a person becomes emotionally exhausted, depersonalized and even depressed through over-involvement in others' tragedies. Another advantage of emotion suppression is that call-takers are often able to keep a clear head in difficult situations and can reassure the caller as well as gather information more effectively.

With regard to 107 callers and their interactions with EMS call-takers, one of the benefits of emotion suppression for both parties might be that adherence to the institutional script expedites the efficiency of the exchange and is thus a mechanism utilized in fulfilling the institutional aim of "preservation of life". This lack of observable emotion in emergency calls is thus one of their defining features. This is not to suggest that parties in the exchange do not feel emotions – on the contrary, Tracy and Tracy (1998, p. 397) suggest that call-takers do sometimes experience emotions such as "sadness, irritation and anxiety, disgust, amusement, powerlessness and complex mixtures thereof" when confronted with the tragedies of others, but they generally suppress them during the interaction itself. When emotions are not suppressed, it may be a signal that the institutional agenda has been temporarily abandoned in favour of a competing one. As my analysis will indicate, the abandoning of emotion suppression in interactions occurs in a highly systematized and regulated manner and its instantiation allows us to observe the ways that it is done as well as the things that it is done for.

Tracy and Anderson (1999, p. 201) explore "relational positioning strategies" or ways that callers position themselves relative to the person they are "reporting about". They suggest that a significant amount of interactional work must be done by callers when they are reporting an incident relating to someone with whom they are closely connected in order for their report to withstand the scrutiny of the authority to whom they are reporting. It is important to note that my research focuses on calls between professionals, and so typically the person doing the reporting is calling in a professional capacity and not, say, as a relative or friend. For this reason these professionals are exempt from the need to account for the incident they are reporting, in a way that civilian callers are not (Tracy & Anderson, 1999). Something that Tracy & Anderson do not discuss in their article but that offers rich a field for analysis is the way that callers (including professionals) describe the patient that they are reporting on. Theories of membership categorization analysis (Sacks, 1972; Schegloff, 2007b) offer the empirically-based suggestion that different types of categorizations of persons refer to different activities that that category of person would regularly do, and that out of a range of possible descriptions, the one that is used is usually "inference-rich" (Schegloff, 2007b, p. 469) and can lend insight into what type of action the reporter is doing by choosing that particular description. In my analysis I will examine the work or

function that a particular description performs in a way that relates to my broader analytic aim of uncovering the mechanisms by which certain events are produced as extraordinary.

Incident descriptions typically begin with a broad, open-ended question such as "What's your medical?" or "What's happening there?". In my analysis I demonstrate that professional callers orient to this opening as a request for all information relevant to an incident description to be presented here, including the age and gender of the patient as well as medical history and other medically-relevant information. Kidwell (2009) describes the assertion made by Schegloff (2007a) and Sacks (1972) that a question, as a first-pair part of an adjacency pair, makes relevant a second-pair part of a similar type, namely an answer. However, questions and answers can be complex sequences and, as in all sequences, the types of things that can be said or done in the second part depend largely on what is made relevant in the first part, so that a question can "do" different types of things, from making relevant a confirmation/negation to making relevant the provision of a full medical description.

Often, in emergency calls, call-takers make use of "confirmables" that they have reason to believe are correct (even if their co-participants have primary rights to know and thus may confirm or reject their accuracy). Confirmables can be viewed as questions that are offered as statements, and are thus a form of questioning that displays a presupposition towards a particular set of facts, arguably an orientation to the efficiency imperative present in the interaction. These presuppositions, in general, reflect the assumption of a "no problem" state of affairs, in that if they prove to be correct, it would indicate that there are no further medical complications that would make this into a more serious emergency. So presupposing "no problem" responses is a systematic practice that call takers can use for maximising efficiency – they do not have to ask about all the possible complications individually; they just assume "no problem" and display this assumption in their question format, unless they are informed otherwise. Confirmables are one of the ways that emergencies are jointly reproduced as "ordinary" or "business as usual".

An example of this type of confirmable would be, in an obstetric emergency where a caller reports a woman in labour, the call-taker stating "And she's full-term", to describe that the patient's labour is not extraordinary or high-risk, thereby situating the bulk of obstetric emergencies as routine. The reason for the provision of confirmables (that are typically treated as accurate) is that they most often require only a brief confirmation and thus aid in the efficiency of the call. Another reason might be that call-takers and professional callers have a shared knowledge about what constitutes an "ordinary" emergency and the offering of a confirmable which orients to this "ordinariness" aligns both parties as professionals completing an ordinary call. This way of offering confirmables ties in with another interesting phenomenon that occurs in emergency calls: deontic authority, or "the right to announce, propose and decide" (Stefanovic & Perakyla, 2012, p. 297). This type of authority differs from epistemic authority in that it deals not with issues of "knowing" but with the rights and responsibilities,

the entitlements and obligations that "knowingness" entails. Stefanovic and Perakyla (2012, p. 299) discuss the ways in which deontic authority is distributed between both parties throughout the call in a constant renegotiation that involves the use of linguistic ambiguities and other implicit practices. Issues of deontic authority are less manifest in the data that I have analysed, since the status of both parties as institutional professionals places them on an "equal footing"; however the "right" to put forward confirmable statements is an instantiation of the "right to propose", and is utilized by call-takers despite their position as knowledge-seeker (vs the caller's role as knowledge-provider).

The "unspeakable phenomenon" of child sexuality (or what makes emergencies extraordinary)

Conversation analysis is a method that focuses on the "how" of interaction, analysing the "machine" that produces various social norms through specific interactions. In this analytic framework, the social norms themselves are merely the product, and as such, analysis of this product and its functions may be considered secondary. However, as Antaki (2012, p. 498) suggests, "It can certainly be worthwhile to make a bridge between how something is done in talk and what institutional interests it might serve"; so that while this analysis is primarily concerned with the observable mechanisms by which institutional norms are adhered to (and reproduced) or deviated from, it is still fruitful to inspect the deviations for the functions that they serve. In this research report, it emerges that one of the social norms produced by the "machine" of the interaction between emergency service professionals in the institutional setting is the norm of the "sacred status of the child in society" (Bowman, 2010), through the treatment of cases of child sexual abuse as "extraordinary emergencies". It is to a possible *account* for the construction of this type of extraordinary emergency, in which the violation of the sacred child takes place, that I now turn.

The following quotes that I will use in developing my discussion are from the UN Convention on the Rights of the Child, written in 1989, and serve to confirm this construction of the child as a particular type of social being. I would like to explore some of the assumptions inherent in this document. I would like to state that the only intention I have in unpacking these assumptions is to destabilise some forms of "taken-for-granted" knowledges that our society shares specifically with regard to children, for the purposes of describing more fully the processes that collectively contribute to this knowledge.

The sacredness of the child is a social construction that corresponds to the beginning of the secularization of a medieval and agriculturally-based society (Aries, 1962), which governance derived its power from regulating its citizens, specifically through "the health and welfare of children and the sexual and reproductive activities of its population" (Bowman, 2010, p. 447). In this society, sexuality

becomes "carefully confined" and is placed in the custody of "the legitimate and procreative couple" (Foucault, 1976, p. 3), since its function is purely reproductive. Evidence of sexuality that is unregulated or that does not conform to this designated space is "driven out, denied, and reduced to silence" (p. 4), since it indicates an irregularity in the state apparatus that seeks to control it. For the purposes of my analysis, it is important to note that sexuality that is enacted with a "child" (or a person who is biologically and sexually immature) would not serve any reproductive purpose and is thus seen as deviant. The child in this society represents the product of (regulated) sexuality and acts as a symbol for the perpetuation of the population (Aries, 1962, Foucault, 1976); state-mandated protection of the child is thus a logical extension of its status as a sacred citizen, and allows for a plethora of institutional mechanisms to be put in place that contribute to, and reproduce, this construction of sacredness. Various social institutions, such as the educational, legal and health systems, suggests Aries, have been incorporated into this idealized construct and together form the institutional reality of modern childhood as a distinct life stage which we treat today as an *a priori* fact. As Aries (1962, p. 125) states in his seminal work on the cultural construction of childhood, "in medieval society the idea of childhood did not exist" and the "modern conception of childhood as a separate life stage emerged in Europe between the fifteenth and eighteenth centuries" (Aries, 1962, p. 62).

The United Nations Convention on the Rights of the Child (1989) describes a child as "every human being below the age of eighteen years" (Article 1) and lays out across a preamble and 54 separate Articles the various rights to which the child is entitled. Among these rights are included the right to education, to health care, to a loving family, to an identity, the right to assemble peacefully, the right to leisure and the right of free expression. Various authors (see Aries, 1962, Kincaid, 1992 and Stephens, 1995) have presented evidence for the suggestion that this conceptualization of the child (as a citizen with inherent rights) is a relatively new one, and also one that is directly informed by other constructs of a modern era, such as individuality, privacy and the family. The conflation of these constructs, informing and justifying one another, can be seen as an effect of (or an instrument of) a capitalist infrastructure, and a society informed by "discipline, work, constraint, and rationality" (Stephens, 1995, p. 6). Thus, today's child is constructed by the state as a citizen with all the rights and entitlements that this status confers. Historical accounts of other eras (Aries, 1962; Stephens, 1995) suggest that this was not always the case and that in fact the child was for a long time seen merely as the prelude to his or her adult self and thus irrelevant until he or she reached that point. For this reason, reports on the Victorian era suggest that there was no such thing as "children's clothes" or "toys"; in other words, there were no social practices that differentiated the child from the adult and, necessarily, as Kincaid (1992, p. 62) puts it, "he can spot nothing in the past that he would, personally speaking, call a child". Obviously this is not meant to suggest that there were no small humans populating the planet in our past; rather that the child as imagined today simply did not exist in previous eras.

The notion of childhood is thus one directly supported by state mechanisms, and this is reflected in the language utilized by the UN Convention on the Rights of the Child, where "the state" takes the place of the bodiless adult who assumes custodial responsibility for "the child". This point is relevant to my research, which studies the bureaucratic (or state-relevant) contexts in which childhood is reproduced as a sacred phenomenon, and children as deserving of extra protection from exploitation and abuse. The rationale for the legislation of the rights in the UN Convention is found in the preamble to the document:

"the United Nations has proclaimed that childhood is entitled to special care and assistance"

"the need to extend particular care to the child has been stated in the Geneva Declaration of the Rights of the Child of 1924"

"the child, by reason of his physical and mental immaturity, needs special safeguards and care, including appropriate legal protection"

The UN Convention, if it is inspected for its discursive actions, works to situate the child as a small but legitimate citizen of the world; at the same time asserts that by virtue of his or her "physical and mental immaturity" the child requires "special safeguards", "particular care" and "assistance". In fact, not just the child, but childhood itself, is entitled to this "care and assistance", thus categorizing children within a specific phase of "childhood" that is rendered sacred through its need for special care on behalf of those citizens who are unable to care for themselves, echoing Holt's (1975) reflections of the "walled garden" that is childhood. Special laws, such as those detailed in the UN Convention on the Rights of the Child, ensure the protection of the child even to the extent that the state may remove a child from parents who are deemed unfit to perform their custodial duties. The child is produced as belonging to the state, beyond its belonging in a particular family, and thus the state (and all its citizens) may be seen as custodians of its innocence and well-being.

This construction of the child as distinct from (and biologically inferior to) the adult is enabled by what Kincaid (1992, p. 70) calls "the collective illusion that the child is a biological category", such that the function of biological empiricism is its undeniability, its factualness. Ways of defining the child are thus biologically informed on the basis of sexuality (or lack thereof) – so that the first demarcation between "child" and "non-child" is the presence of sexual readiness in the reproductive organs: menstruation in the female, semen-production in the male. Castoriadis' (1975) work further explores the relationship between social institutions and nature, suggesting a "leaning on" nature by the social world, in that the natural world with its biological absolutes sets limits and constraints upon the social; however, the way that these limits and constraints are made meaningful in a particular way is a function of the discursive actions that describe them. With reference to the fact of the biological immaturity of children, and the determinism utilized in fixing the child in a particular biological category, it may be

understood from Castoriadis' (1975, p. 145) writing that "not only is the signification of being a child instituted in each case in a different manner and with a different tenor - not only is this signification seldom unitary - but the institution can do practically anything it likes with the supports and stimuli it finds in the natural facts of maturation". In other words, biological determinism provides structures, but the utilization of these into categories and the meaning attached to these categories are socially constructed. It is important to note that Castoriadis does not necessarily essentialize the natural stratum, but rather sees it as a mutually constructed institution in itself, due to its location in a particular discursive or historical sphere. What he does say about this natural world and its constraints is that "it cannot be eliminated … [since it fixes] the terms of marking without which … significations would have no points of reference" (p. 146). This biologically-centred conceptualization, besides its difficulty to refute, also performs an additional function in demarcating the status of the child: it casts the child as a non-sexual being, a citizen of the world in whom sexuality is absent, or at least silent. The "sacredness" of the child (Bowman, 2010, p. 460), indeed of childhood itself, is merely a logical extension of this construct which situates the child as a category clearly distinct from, and (biologically) inferior to, the adult; as Holt calls it, the mythic "walled garden" of "Happy, Safe, Protected, Innocent Childhood" (Holt, 1975, pp. 22-23).

The UN Convention continues in this document to articulate the rights of the child with regard to its asexual citizenship in a sexual world, a sexual variation on its established theme of protection and innocence, and one that can be understood by reference to the importance granted to both the notion of sacred childhood, and of reproductive sexuality.

Article 19

"State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse"

Article 34

"State parties undertake to protect the child from all forms of sexual exploitation and sexual abuse [including] the inducement or coercion of a child to engage in any unlawful sexual activity."

The child is, therefore, paradoxically constructed as an entity in which inheres a certain type of sexuality – qualitatively distinct from that of the adult – while at the same time necessitating the control and management of this sexuality, thereby legitimising "interventions in the lives of children as necessary for their best interest and protection" (Egan & Hawkes, 2008, p. 356). In modern society, while the sexual nature of the child cannot be denied due to the psychologization of infantile sexuality and childhood sexuality, there is an uncomfortable tension in that the expression of this sexuality would indicate a breakdown of the normative order of things, and the exploitative expression of child sexuality

even more so. When I speak of the "unspeakable" nature of child sexuality, what I mean is something in between the seminal idea proposed by Foucault (1976) about sexuality as the invisible core of discourse, an unnameable centre drawing all constructs towards it; together with Kincaid's suggestion that "silence excludes the possibility" [of sexuality] at the same time that it "can operate not as an opposite of what is said and done but in complex cooperation with [them]" (p. 37). Thus on display are two discourses, at once separate and intertwined: the discourse of the child, and the discourse of sexuality – the same discourse, the one that suggests that the seed of sexuality sprouts in childhood but can be acknowledged only insofar as it is protected; a contradiction of acknowledgement, denial and repression that views child sexuality as a threat to the social order; an admission of the presence of an underlying structural devastation; an inability to maintain the institutional reality that is our shared moral order. What does this silence accomplish? Is it the silence of unrelatedness (Kincaid, 1992), the silence of doability (Weeks, 1981), the silence of excluding the possibility, or the silence that is the centre, around which all discourse revolves? As Weeks (1981, p. 19). suggests:

> …with repression at hand we were able to read silence. If all else failed, silence could be felt as a form of denial, signalling at some deep level actual assent... without repression, we still want to speak of silence, still suspect that we cannot write history without interpreting the unsaid, without some means for rejecting the face value of things, locating that which, hiding behind silence, was shameful or private and therefore sexual. We were tempted to assume that even the refusal to talk about it [sex]... marks it as the secret and puts it at the heart of discourse.

Although Foucault and Weeks explain it well in their description of sexuality as a central, invisible, discourse, Castoriadis (1975, pp. 148-149) allows an even more theoretical description when he suggests that:

> What *does not exist* for society is not always, and not necessarily, pure non-being, absolute non-being, that which could never enter into the universe of discourse, even if it is only to be denied. Quite the opposite, the being of non-being, or non-being as such, always exists for society; into its universe of discourse enter entities whose being is or has to be negated, positions that must be asserted by means of explicit negations or that are presented only to be negated . . . everything has to *signify* something, has to be endowed with signification, and what is more, it is always already grasped in and through the possibility of signification, and it is only as a result of this possibility that it can finally be defined as devoid of signification, insignificant…

In other words, there are particular phenomena present today whose unspeakable nature is *constitutive* of them, that they exist only in and through their negation; they exist *so that they may* be denied. As I

will suggest in my forthcoming analysis, child sexual abuse occupies such a space in present-day discourse.

As my literature review suggests, a conflation of discourses positions the child in society as a non-sexual citizen deserving of the protection of the state (as adult) to ensure its safeguarding from unlawful or coercive sexual activities. And this knowledge has become so obvious, so "known", that it is one of the moral benchmarks of a society: a civilized society protects its children from sexual predators. In my analysis, it emerges that in the renegotiation of competing roles, where the call-taker must continually align herself with multiple agendas, specifically the institutional agenda which frames her work and the "personal" agenda which is a function of the social action of the phone call, call-takers will recurrently abandon the institutional work they are producing in order to collaborate, collude or comment on the violation that is the incident describing child sexuality. Far from a United Nations convention that describes our legislative and policy-relevant practices on a macro-level, constituting the sacred status of the child, these interactions are the specific instantiations of a locally-produced, jointly reconstructed orientation to this knowledge that occurs minute by minute, on a turn by turn basis, across a range of interactions, and that display the observable mechanisms by which the unspeakable phenomenon of child sexuality is stabilised and re-established in society. Thus what we see is that the maintenance of the normativity of an institution becomes a moral affair since its senseless interruption threatens the possibility of a shared world and thus of the entire social order in which we act. Specifically in emergency medical services, this morality may be linked to the taken-for-granted assumption that the participants are supposed to be doing a job, performing a life-saving service, and constant deviations from this would make this goal difficult to accomplish. Child sexuality therefore becomes a recognizable and accountable reason for the deviation from the institutional norm of efficient information gathering.

Method

Sample

The larger corpus of data from which the data-set for this research has been chosen consists of 178 phone calls occurring over an unknown period of time and provided by EMS Western Cape division (a state-funded organization) to the Health Communication Research Unit at the University of the Witwatersrand for the purposes of a broad spectrum of research to be performed upon the data. While communication with the manager of the this particular call centre suggests that over 1500 calls are placed to the centre within each 12-hour shift (Timm, personal communication, 14 November, 2013), the data set is sufficiently varied in terms of its incident types to inform a meaningful analysis of the range of its possible variation in its content.

The data used in my analysis were purposively chosen following a repeated and careful listening of all the phone calls in the data-set. The first listenings were carried out over a period of three months and offered a range of interesting topics for potential analysis. My own research interests that tend to the sociological study of bureaucratic institutions in general, and medical institutions in particular, encouraged a listening of the data that oriented to institutional practices in both verbal and written form, including practices of categorization, agency, and other mechanisms of institutional talk. Further immersion in the data demonstrated a "business-as-usual" approach to ordinary emergencies typical of most of the incident descriptions, with deviations from this approach contributing to the construction of a certain class of "extraordinary emergencies". Practices of constructing "ordinary" and "extraordinary" emergencies were telling in both their verbal and written instantiations and were, in every inspection, systematically conducted and oriented towards by participants in the call. The data used in my analysis are thus purposively chosen to contrast with one another in their construction of ordinary and extraordinary events that will allow for an investigation of their occurrence, as well as the broader implications that they may hold.

I have used data from 10 of the phone calls in the entire set of data, focusing my analysis on verbal incident descriptions and their documented counterparts in the dispatch package form created for their dispatch and record-keeping functions. As I have stated earlier, the analysis is limited to calls occurring between two professionals: the EMS call-taker and the 107 operator, because these are the sorts of calls that might be expected to be "hyper-institutional", making the orientations to "extraordinary emergencies" that I have found in my analysis particularly noteworthy.

Analytic methods

This research implements a three-part analysis of the emergency phone calls included in the study. The first step utilizes Conversation Analysis techniques to perform an analysis of the phone call itself, by drawing on Conversation Analysis in both theory and analytic method, as well as drawing on the discursive elements of language in order to deepen the scope of the study and relate the mechanisms of institutional practices described by the phone calls, to larger considerations of social structures and the legitimacy they grant these institutions. The selected telephone calls have been transcribed according to the Jeffersonian method of transcription (Jefferson, 2004) that assists with a careful reading and analysis of the data. The transcriptions have been analysed using a conversation analytic methodology that allows for the careful study of interactional practices in the call. Reliability has been ensured by having the transcriptions peer-reviewed by other members of the Health Research Communication Unit as well as careful and painstaking transcription of each segment of data that are used, based on repeated listening and use of Jefferson's (2004) conventions.

The second part of the analysis focuses on the documentation of the phone call in the dispatch package form. Due to the textual elements of this research, namely the analysis of accounts of events as transposed onto institutionally relevant forms and records, I have utilized a textual analysis to analyse the way that these spoken descriptions are translated into written texts.

Lastly, I have analysed the transposition or interface of the phone call onto the written text of the form. The analysis does not, however, proceed in segmented and differentiated steps, but rather flows between various analytical methods in order to produce a coherent and holistic understanding of the interaction as a whole, including talk, text and the space in between the two.

The phone calls included in the research study have been chosen based on their ability to deliver observable discrepancies and/or accomplishments in both the verbal and written incident descriptions in the interactions. That is, data that display either an observable adherence to institutional interests or data that demonstrate systematic deviations from this agenda, will be analysed in order to draw out the different actions that each interaction produces. This research project also works to identify the ways that these interactions draw on broader discourses, specifically normative discourses of the child, and identifies the ways in which these dominant discourses are served within the interactions, with regard to the dominance and authority granted to governmental institutions such as this emergency call centre (EMS) and the ways in which situated practices reinforce categorization and classification in particular directions.

Conversation Analysis

Erving Goffman (1955, 1983, quoted in Heritage, 1997) has offered the assertion that "social interaction embodies a distinct moral and institutional order that can be treated like other social institutions" (p. 222), presumably in the sense that it, like all social institutions, can be critically inspected for its functions. The institution of language and interaction is rendered distinct, however, through its function as the vehicle by which all other institutions are reproduced, thus underpinning the character of each social institution that we inhabit (and produce) by forming the bedrock of its activities (Schegloff, 1992). For this reason, a growing number of theorists from various disciplines such as sociology, linguistics and anthropology turn to the study of interaction in its own right as a way of detailing the mechanisms by which society in its entirety, ceaselessly and seamlessly, functions.

Conversation analysis, the detailed study of locally produced talk in interaction, has been influenced by (at the same time that it has influenced) an ethnomethodological approach that was first theorized by Garfinkel in 1967. Garfinkel's central assertion, captured succinctly by Heritage (1984, p. 248) is that "both the *production* of conduct and its *interpretation* are the accountable products of a common set of methods or procedures" (emphasis in original).

A few central points that emerge from my understanding of various texts on conversation analysis are the following:

1. There is a symmetry inherent in interactions, the embodiment of which is found in the basic interactional unit of the "adjacency pair", a conversational unit that comprises two speakers, where the first speaker's utterance (or turn) can be followed by the second speaker's utterance and this second utterance orients to the nature of the turn just previous. This tightly organized structure presumes the notion of "order at all points" (Sacks, 1992, p. 484).
2. The sequential nature of turn-taking in which each turn orients to the one directly before it demonstrates that the context in which the interaction is being played out is locally reproduced, and is thus both a "project and product" (Drew & Heritage, 1992, p. 19) of the interaction, in that utterances cannot be understood except in relation to the context to which they orient, and yet the context itself is only renewable by virtue of the utterances that orient to it.
3. Naturally occurring data that have been carefully transcribed are the most preferable for conversation analytic methods as they allow the analyst access to events as they occurred as well as the ability to constantly reference the data and not rely on memory or intuition for support.
4. Utterances are social actions that are analysable for the work that they accomplish. Every utterance performs a function beyond the linguistic, and recipients of this utterance will typically orient to the utterance for its social meaning rather than the linguistic.
5. Deviations from normative interactional procedures are made accountable, in that the person performing them may be called to account for why he is doing so. However, built into most normative proceedings are the range of deviations and their possible accounts, as a way of protecting and maintaining our institutional realities (Heritage, 1984).
6. Lexical choices (including the uses of particular categories) are designed to perform specific functions. From a range of possible descriptors, one is invariably chosen as most relevant, and the work that it does situated in a particular turn or utterance is available for inspection and analysis.

Conversation analysis is a useful way of studying interactions as it offers a detailed and empirically-based method of analysing data based on the sequential unfolding of the interaction which reproduces context on a turn-by-turn basis and, for the purposes of this research, offers evidence for the ways that the institution is reproduced through talk that orients to or deviates from it. Conversation analysis abandons the "bucket theory" (Drew & Heritage, 1992, p. 19) of context, which imagines context as a pre-existing space in which interactions occur and in which, inevitably, these interactions are shaped and reproduced by the contexts in which they occur. Rather, conversation analysis is a method that sees utterances as social actions that are "context renewing" (p. 18) in that orientations to a particular contextual framework are reproduced in a sequential manner, with each utterance orienting to its prior

turn, and in this way constantly "renewing" and reproducing the context to which it orients. Crucial to the CA perspective is the notion that this context is "locally produced" and thus "transformable at any moment" (p. 19). This method is thus appropriate to an analysis that seeks to demonstrate the observable practices in which the institution is made visible and relevant, as a basis for evaluating the practices by which other contexts or orientations are made visible by participants and the systematic nature of these (non-institutional orientations). Through this method, the delicate and subtle negotiations of context-renewal and role-specific orientations enacted by participants are made visible and describable, allowing for an empirically-based analysis that can serve as the basis for a meaningful discussion.

My analysis draws on the features of conversation analytic methodology that have been explicated more recently by various authors (Drew & Heritage, 1992; Schegloff, 1992) with regard to interaction in institutional settings, and thus focus more specifically on the institutional "context" (insofar as it is oriented to by participants in the talk) and the intricacies thereof; where institutional talk is defined as "an orientation by at least one of the participants to some core goal… conventionally associated with the institution in question" (Drew & Heritage, 1992, p. 22). In the same paragraph, the authors I have just cited hasten to clarify that they "do not accept that there is necessarily a hard and fast distinction to be made between the two [institutional conversation vs ordinary conversation] in all instances of interactional events, nor even at all points in a single interactional event" (p. 21). This assertion relates to a point I have made repeatedly in my analysis, that what my data suggest first and foremost is that the institutional role of the call-taker is subject to tensions from competing contexts in which she finds herself, and that the delicate and constant renegotiation of roles and reorientation to institutional pursuits is an observable and systematic practice through which the institution is constantly reproduced and recreated.

Textual analysis

In emergency call centres, dispatch package forms are generally used as written representations of a verbally related event. They are structured in such a way that they may enable efficient service delivery, and they thus generally maintain the use of medically-relevant language as an efficiency practice. In instances of my analysis when medically-relevant terminology is abandoned in favour of euphemistic language and/or the omission of particular words in the written record, there is evidence displayed that the call-takers are orienting to particular events as remarkable or deserving of actions that go beyond the institutional. Documents are social artefacts, organized in ways that reflect the norms and assumptions of a particular culture (Prior, 1997). Institutional documents that contain bureaucratically organised information can be seen as particular and varied instantiations of the institutions they represent. In my analysis, a dispatch package form is both "product and project" (Drew & Heritage,

1992, p. 19) of the interaction: its institutional presence shapes and structures the interaction, but its institutional function is only optimised by means of the very same interaction.

Atkinson & Coffey (1997) note that documents do not exist independently, but rather inherently refer to other texts and therefore other realities. They suggest that it is imperative to look beyond separate texts to see how they are all interrelated. This point is crucial to my analysis, as it allows me to demonstrate that the form filled in by the call taker is not merely descriptive of an emergency, but rather produces categories, genres, and realities that are key in the reproduction of "ordinary" emergencies and their institutional context, or "extraordinary" emergencies and the social or moral orders that shape and influence them. In addition, the dispatch form is one of the key sites at which emergencies are produced as "extraordinary" (versus the way that they are regularly produced as "ordinary" or routine), suggesting that institutional writing, along with institutional talk, contributes to the way that emergencies are constituted and treated.

"The order on the page is invariably tied into forms of social order" (Prior, 1997, p. 79). Thus, when institutional documents are used in ways that do not adhere to their requirements, they produce an alternative social order in the reality that they "talk into being" (Heritage, 1984). This is evident in my analysis, in instances where non-medical language is used in the written record and thus serves to reproduce an agenda that is not wholly institutional. In these cases, where euphemistic descriptors are utilized, call-takers display orientations to forms of social order that are often demonstrably "other" than the institutional; what I refer to in my analysis as "personal" work, or work oriented to by the interactants that does not further the institutional agenda, and may even temporarily halt or obstruct it. Atkinson & Coffey (1997, p. 69) suggest that documents de-contextualize events, transforming the specific and local into "facts" and "records", often transmuting into the "official" or "real" version of the event. Thus, when euphemistic language is used in recording an incident, a crystallized piece of institutional reality becomes fixed, thereby contributing to the institutional reproduction of the "unspeakability" of child sexual abuse.

Ethical considerations

The Health Communication Research Unit has been given ethical clearance for this research project, and my research report falls under the auspices of this ethical approval and does not require a separate ethical clearance. However, the ethical considerations that apply to any research project are acknowledged and maintained scrupulously in this research report.

Both the telephone calls and the dispatch forms provide personal details of callers and patients Therefore, although the data as I have received them do not preserve anonymity, I will be reporting them anonymously in my research report (Wassenaar, 2006).

The data are kept confidential and non-disclosure agreements have been signed by all researchers working on the project, as a result of the private and sensitive nature of the calls (Wassenaar, 2006). The data have been stored on my private computer which is password-protected.

Data analysis

The data that will be analysed here consist of parts of sequences that make up the primary portion of the interactions in 107 calls; that is, a description of the incident or emergency. As noted in the literature review above, the "incident description" sequence is made up of a request, or number of requests, for a description on the part of the call-taker, and a furnishing of this description in one or more instances on the part of the caller. The institutional nature of the phone calls is evidenced by three key features in this sequence: their brevity, their impersonality and their use of institutionally relevant language. It is likely that the two latter elements are functions of the former, i.e. that impersonality and medical language are mechanisms by which efficiency in the call is maximised. This format applies to both the verbal interaction and its written record. Signalling the satisfactory completion of this particular sequence is a request for an address or telephone number and/or the provision of a reference number. In the calls I have analyzed, the mutual professionalism of both parties lends a characteristic fluency to the interactions; interruptions of this fluency are therefore indicative of some kind of breach in the normative order that deserves closer inspection.

My analysis of the data is divided into two general sections: the first examines those calls where the work being done refers predominantly to the institutional task at hand, and the second focuses on those calls where the institutional work is temporarily halted in the pursuit of a different agenda; I refer to this as "personal" work. It is important to note that emergency calls are the setting where a very specific type of task is sought to be accomplished, a fact which lends every one of these interactions an "institutional" feel (in the sense that there is an institutional accomplishment to be reached). However, due to the delicately ambiguous task that the bureaucratic role entails, most institutional action carries with it a layering of a different type of action, devoted to the personal interaction being played out minute by minute in the call. This "personal" action can be located in greetings, small jokes and other token acknowledgements of the interaction. Sometimes, however, these personal actions work in a different way: they recruit the participants of the interaction into the reproducing of social and moral norms, generally as a by-product of their stated or obvious purpose (in this case, the reporting and acting upon of an emergency). There are various mechanisms through which this social and moral work is accomplished, the examination of which will be the focus of this analysis.

Ordinary emergencies

This section establishes the use of efficiency-relevant practices recurrently used in emergency calls, thereby producing described incidents as "ordinary emergencies". The following excerpt has been selected to establish several baseline norms enacted within emergency phone calls from 107 professionals. What I focus on evidencing here is that there is a question by the call-taker that opens the interrogative sequence, an orientation by the caller to this question's action, a provision of relevant

information to the call-taker, and a concluding remark to indicate the successful completion of the sequence. The fluency of the exchange is most notable in calls between professionals and serves in this analysis as an instance of prototypical cases from which deviations can occur.

Excerpt 1a:2011031310403

1	CT:	Okay what's your medic↑al
2		(2.4)
3	C:	U:h it's a (.) three year old boy
4		(2.2)
5	CT:	What is wrong with him?
6		(2.4)
7	C:	they query (.)fractured (.) left leg (.) he was ah
8		he=slipped while playing (1.8) slipped and f↑ell
9		(9.6)
10	CT:	Where's this?

Excerpt 1b:2011031310403

Incident Type Description

Trauma - Accidental Injury – Domestic

Incident Description

M 3 YRS ? # LEFT LEG SLIPPED & FELL MENIGITIS PT

In this phone call, a caller is reporting a medical emergency regarding a small child. The call-taker begins the incident-description sequence with a general question, "What's your medical?", a question that is designed by the call-taker to elicit information from the caller about the incident. The caller orients to the action that this question performs: it is not asking only what the medical emergency is, but is in fact a request for all available information from the caller, thus an orientation to the need to collect all information relevant for providing the service. Thus the caller, in lines 3 to 5, provides the age and gender of the patient as well as utilizing medical terminology to describe the incident; she also pauses in between each detail, displaying an orientation to the knowledge that this information is being recorded by the call-taker as they speak. The preliminary furnishing of such additional information is indicative of the 107 callers' professional status and familiarity with the required format for

information-giving. It is thus a feature of many 107 phone calls, but is not always a foregone conclusion and must occasionally be elicited by the call-taker. In line 9, there is a pause that ostensibly indicates the call-taker recording a written version of the incident. This is borne out in line 10, where the caller asks, "Where's this?". With this question she indicates that the incident-description sequence has been successfully completed so that they are able to move on to the next sequence in the phone call.

The description of the emergency is captured accurately in written form, and includes age and gender, short-hand for fracture ("#") and details thereof, as well as a medical history ("meningitis") (excluded from the excerpt). This short-hand method of capturing information is one of the features of institutional communication and is also characteristic of this particular emergency centre, understood by the dispatchers and paramedics and leading to quite a seamless and well-facilitated communication. This method is also a good example of the way that bureaucratic work is often accomplished creatively and manages to avoid the unnecessary inefficiency that may characterise such interactions (Von Holdt, 2010).

This initial example of an emergency call reflects an "interactional synchrony" (Whalen et al., 1988, p. 346) where both participants are aligned with the appropriateness of the procedure that is being enacted in this interrogative sequence. A crucial point to make here is that both participants are institutional professionals who both treat this interrogative sequence as facilitating (Whalen & Zimmerman, 1987) the provision of assistance rather than delaying it. Rather than frustration at a seeming digression from the problem at hand, both parties orient to this often lengthy insertion as a crucial element of the service request and response.

A range of ordinary emergencies

The following excerpts reinforce what I have established above in its most regular instantiation; namely that over a range of medical emergencies, both actors collaborate in producing these as "business as usual", emergencies that do not deviate from the normative baselines that emergency workers construct, complete with institutional practices that maximise efficiency as demonstrated in the above excerpt. One of the benefits of this mutual action might be increased efficiency in recording the information; another might be, the tendency towards "normalizing" one's surroundings and the difficulty in treating each of a large number of reported emergencies as remarkable. The first two of these excerpts differ from the previous one in that they involve reports of an assault upon one person by another, as opposed to emergencies that are accidental or naturally-occurring. These reported assault emergencies contain more violence than the others that I have analysed; yet institutionally they are treated similarly as ordinary emergencies, and this reproduction of a "normative event" is accomplished through many of the same mechanisms used above: brevity, institutional language, impersonality and the like. Another, related, element of these interactions is the way that the incident description is continually and

systematically refocused upon the patient (as the service-seeker) as opposed to the perpetrator or the crime itself, thereby presumably contributing to the efficiency of the exchange and retaining its service-oriented focus.

Excerpt 2a: 2013010510230

1	CT:	For-for ↑what type of patient is [th↑a]t
2	C:	[U:m]this is a
3		gentleman=was stabbed on Th:ursday=in the head with a
4		knife (.) now came in u:m with seizures (.) um and uh
5		temperatures above forty degrees Celsius
6	CT:	[Uh uh oh]
7	C:	[Intercer]ebra:l brain
8		abscess
9	CT:	Oh head injury
10	C:	Ya
11	CT:	Intubated
12	C:	Ya intubated yes
11	CT:	Chopper is not at present available

In this excerpt, a report is made about a man who has been stabbed in the head with a knife and the caller is requesting helicopter transport for the patient. Line 1 begins the interrogative series with a request for the incident description, which is furnished in lines 2 to 5. The next slot made available to the call-taker gives him the opportunity to request further information or accept the information he has been given. However the call-taker does neither of these and instead makes an utterance that is not immediately recognizable to the caller (line 6). Although this may be an expression of surprise, the way in which it is negotiated indicates that it may be due rather to some hesitancy or uncertainty on the part of the call-taker and that requires further clarification, specifically regarding the medical details involved here. In other words, the hesitancy seems to be institutionally linked rather than constituting an "assessment" or "evaluation" of the information. Indeed in line 6 the caller orients to it as such by providing a more medically relevant terminology, rather than, for example, treating the utterance as an invitation to collaborate on the extremity of the incident. This use of medical terminology also serves to reinforce the role of institutional language in the exchange, and this is taken up as something recognizable by the call-taker in line 9 who is then able to continue with the sequence as he produces a confirmable ("Oh, head injury") which the caller confirms at line 10.

In line 11 the call-taker uses the confirmable ("Intubated") as a standard efficiency practice that serves to expedite the efficiency of the call, and upon confirmation, the matter of the original request for helicopter transport is addressed as the second part of the request sequence, and to indicate the closing of the interrogative sequence.

In the written description (see Excerpt 2b) below, this tendency towards brevity and medical language is borne out with the description being termed as an "ex assault" followed by details of the treatment the patient has received but excluding further details of the incident itself, to suggest that the incident is being treated as "business as usual".

Excerpt 2b: 2013010510230

Incident Type Description *Neurological complaint*
Incident Description *K DAVIDS 18YRS.*
EX ASSAULT
INNTUBATED AND VENT.
BP 180-130, P.150 TEMP.41 SATS 46
ON O2

The following excerpt brings further evidence of the tendency of institutional workers towards brevity in the exchange, even in the face of slot openings to accommodate personal evaluations. These slot openings occur on lines 2 and 3, and offer the call-taker some time to capture the information being given, but also offer a space for the call-taker to offer evaluative or assessing comments of the information being given.

Excerpt 3a: 2011032210862

```
1     CT: Okay Nondi=whats=your=medical?
2     C:  U::::m (2.0) eighteen=year=old female (3.2) stabbed on
3         back tw:ice (2.4) feeling dizzy=but she's still conscious
4     (13.4)
5     CT: Whe:res this?
```

Excerpt 3b: 2011032210862

Incident Type Description

Trauma - Assault - Weapon(Other)

Incident Description

F 18 YRS STAB BACK FEELING DIZZY STILL CONSCIOUS

In this phone call, a 107 caller reports a stabbing incident. The call-taker, in line 1, requests an incident description. In response, the caller once again offers the age and gender of the patient (cf. Excerpt 1 above). She also pauses briefly in between each phrase, which allows the call-taker to capture the information effectively. The fact that in this case the call-taker does not ask any follow-up questions and moves straight to close the sequence, indicates an unusually efficient completion of the interrogative sequence. These two orientations together, the provision of age and gender, and the deliberate delivery of the description, display an orientation to shared knowledge of the institutional procedures of the call. The call is oriented to as ordinary despite its character as a violent assault, and proceeds with no deviations from the institutional agenda. The written record displays no deviations from the verbal description, and can be understood similarly to Excerpt 2 above).

In the following exchange, an emergency is reported that is not immediately obvious as an obstetric complaint. This case is significant because of the variety and severity of the symptoms as well as the presence of HIV in the medical history, all of which are unproblematically accepted as part of the description.

Excerpt 4a: 2013011710867

1	CT:	Vanguard drive, (.) and what's happening there
2	C:	Okay I've got Nonhlanhlo (.)
3	CT:	↑Mmmmm
4	C:	Who is a twenty=nine year old female (3.2) she's got body
5		weakness hh (.)and she's got a swollen (.) r:ight (.) breast
6		(1.0) and she's got (.) headaches
7		(1.0)
8	CT:	She's got a swollen
9	C:	Right (.) breast
10		(3.2)
11	CT:	[Uh]

12 C: [He]adaches
13 (2.4)
14 CT: Mmm
15 C: And body weakness
16 (2.6)
17 CT: Mmm (3.2) did she=just have a baby?
18 C: N:o
19 CT: Mmmm
20 C: She is seven months pregnant
21 CT: Seven (2.0) months (.) pregnant
22 C: Mmmm↑ HIV positive on treatment
23 CT: Mmm
24 (2.4)
25 C: And that's all medical history
26 CT: Okay .hhhhhh u::::m hold=on=for=me=hey
27 C: Okay
28 (24.6)
29 CT: Okay your reference number is one zero eight six seven

Excerpt 4b: 2013011710867

Incident Type Description

Obstetric Complaint

Incident Description

Nonhlanhlo-29y female

swollen right breat-headaches and body weakness

7 months preg

hiv+ on treatment

This phone call is not initially identified as an obstetric emergency, but comes to be identified as such midway through the call as the call-taker begins to relate the symptoms being ascribed to some obstetric difficulty. In line 1, the call-taker asks the question that elicits an incident description, "What's happening there?" The caller orients to this as a request for all pertinent medical information, and in his response (lines 2 – 6) supplies the name, age, gender and symptoms of the patient, allowing for brief pauses between each symptom to facilitate the call-taker's written capturing of the data. Lines 8 - 16

are devoted to follow-up details, with the typical use of confirmables seen in previous excerpts. In line 5, the call-taker makes a statement that is unfinished, providing a slot for the caller in line 6 to complete the sentence, which she does. In line 11 the call-taker's comment "Uh" is seen by the caller as an indication that the information given has been received, and thus that the caller can continue with the remainder of the symptoms, which the caller does in his next few utterances. This time, the caller repeats the symptoms and after each, the call-taker makes a sound of acknowledgement (lines 8 - 16). In line 17 after acknowledging the last symptom described by the caller ("body weakness") the call-taker introduces a new medically relevant condition by asking if the patient has just had a baby. Evidently, the patient's age and gender combined with her specific set of symptoms, leads the call-taker to hypothesize that this may be the case, with the question both revealing the hypothesis and serving as a way of testing it. Her question, "Did she just have a baby?" is treated by the caller as a place to not only confirm or deny the proposed hypothesis, but also to proactively add information that would be relevant to said hypothesis. This is demonstrated in line 18 when the caller replies "No", but then adds "but she is seven months pregnant", indicating that this information is relevant at this point despite the fact that it has not been directly asked by the call-taker. The call-taker in line 21 repeats the information, preparing the slot in line 22 for the caller to confirm or correct the information. The caller uses the slot to confirm the information but also utilizes it as a place to offer additional information, in this case the medical history of the patient which includes an HIV-positive status. The call-taker's "Mmm" in line 23, and the absence of any other statement and/or question, indicates that this information is sufficient. The caller uses his next slot to indicate that he has finished giving all the information relevant to the patient's medical history ("That's all medical history"), and that the call-taker may now move on to the next phase of the call. The mutual understanding that this phrase concludes the information-giving portion of the call is borne out in the rest of the interaction. The call-taker responds "Okay", indicating that she understands the completion of this phase, and then "Please hold for me" to indicate that she is recording the information and preparing for a further response to the caller. In the last line of this sequence the call-taker offers a reference number, signalling the successful conclusion of this part of the call.

In the written description, the call-taker puts the patient's name, age and gender on the first line, the patient's three symptoms - described before the information about her pregnancy - on a second line, the information about the pregnancy on the third line, and the medical history on the fourth line. This format echoes the structure of the phone call, with patient details being offered first, symptoms second, follow-up third, and in some cases a medical history coming last. At no point does either party suggest that this set of symptoms is unusual or extreme, suggesting that according to these parties this is an ordinary emergency and can be managed as "business as usual".

This excerpt also marks the end of this second set of calls, where I have demonstrated that the procedure of emergency calls is not derailed across a range of varying types of emergencies, and that the institutional aim of efficient service delivery is not compromised. In fact, not only is the interaction not derailed across this range of phenomena, but virtually everything that happens is institutionally-oriented, and even on the odd occasion where "non-institutional" things creep in, they are brief, not pursued beyond one turn-at-talk per person, and are not reflected on the written document. The last call, which indicates this, also introduces the following group of excerpts, where I establish evidence for the routine unfolding of this sequence across a variety of obstetric emergencies as well as the reproduction of an "age-norm" in obstetric cases.

The following excerpt reproduces the characteristic efficiency and fluency of the exchange between professionals, and also indicates the absence of reaction to the description, which reports the pregnancy of a fifteen-year-old. Tellingly, the patient is referred to as "lady" (line 2), situating the 'symptom' as relevant, a match between patient and problem. This can be contrasted to descriptions of patients where a "mismatch" between age and state is displayed (cf. Excerpt 13 below).

Excerpt 5a: 201212261055

```
1     CT: It's a maternity
2     C:  Ya, um, lady's name is Lulando, she is fift↑een years of
3         age, first pregnancy, term, water broke, booked for Delft
4        (20.2)
5     CT: One zero double five
```

Excerpt 5b: 201212261055

Incident Type Description

Obstetric Complaint

Incident Description

15 YRS TURM BKD DELFT RUYPT MAMBRAIN LAB PAINS BABRA 107

In this phone call a 107 caller reports a maternity case. Maternity cases are common and encompass any type of emergency relating to pregnancy, from miscarriage to full-term labour to other symptoms experienced by a pregnant woman. In this call a full-term labour is reported and a request is made for an ambulance to transfer the patient to her hospital. In line 1 the call-taker who has gotten the information that this is a maternity call earlier on in the phone call now makes a statement to confirm

this, in the manner of interactions I have shown above (cf. Excerpts 2 and 3). The caller correctly treats this slot not only as a place to confirm or deny the statement in the previous slot, but also as a place where a request is being made for further details, which she produces along with her confirmation. This is further evidence once again of the strong orientation that participants in this exchange have to the institutional structures that underlie them. The information is delivered in clear verbal "short-hand" medical language, and the absence of follow-up questions, as well as the long pause indicating written capturing, and the following provision of a reference number, reinforce the joint accomplishment lent to these exchanges between professional parties. What is observable here is that particular maternal ages, including ages as low as fifteen, *can* be treated as within the bounds of "ordinary emergencies", which contrasts with other cases (cf. Excerpt 13 below) in which maternal ages are treated as "extraordinary". Another defining feature of this call is its explicit orientation to converting a lay verbal description into its medically relevant written counterpart, so that "waters broke" (line 3) is recorded as "*RUYPT MAMBRAIN"* (sic) in the written record.

Thus far in my analysis I have established two things. The first is a general order of business in emergency phone calls, indicating the various formats used by call-takers receiving calls from 107 professionals. From the analysis it is clear that these formats are designed to maximise the efficiency of the phone call. Two other institutional methods of achieving brevity in the call are the use of medically relevant language as a way of furthering clarity and communication (and the conversion from lay to medical terminology as and when it is required); and impersonality as a way of "staying on track" to expedite the call's length. Looking at the phone calls in these terms, it seems clear why, in the description sequence, one question by the call-taker often suffices to elicit all the relevant patient/incident information from the caller. In addition, follow-up questions are often phrased as "confirmables", creating a format where confirmation of the data is able to be given efficiently and clearly.

The second thing that I have established is that this procedure holds over a range of medical emergencies, including obstetric emergencies. The institutional aim of delivering a service as efficiently as possible creates a very structured format to the interaction. This format is very valuable because its intense structure allows any deviations to be evaluated for their purpose, which lends insight into the reproduction of norms in the emergency context.

The following section contains deviations from the institutionally prescribed procedure that I have established above. These deviations are visible because, in a tightly structured exchange with the mutually recognized goal of efficient service delivery, they stand out as doing the opposite. That is, they often observably decrease the efficiency of the interaction and prolong the information-gathering

exchange, demonstrating their orientation to another, competing (non-institutional) agenda: that of fulfilling their orientations to social concerns in their role as social actors in an interaction.

Extraordinary emergencies

Emergency call-centres are spaces where emergencies become routinized through various institutional practices designed to manage them effectively. As I have described in my literature review, workers systematically (and observably) orient to institutional practices that serve to normalize and routinize these events. One of the demonstrable benefits of (or reasons for) such an orientation is the increased efficiency which it produces. This necessary normalization of "abnormal" events creates a structure where call-takers have a more encompassing treatment or orientation to emergencies than the average person would; so that most emergencies that might qualify to a layperson as extreme, are treated of necessity by call-takers simply as "ordinary" emergencies. When call-takers orient to a case as being unusual, in any way, it indicates that the *institutional* normativity of emergencies has been violated and that a different response is warranted for this case. In other words, in contrast to the co-construction of a range of emergencies as ordinary or "business-as-usual", some cases are treated as extraordinary by callers and call-takers, and this can be seen in deviations from the institutionally oriented-to (and efficiency-driven) practices that are typically followed in other cases. Both the characteristics that make such cases special or different, as well as the specific mechanisms that have been jointly constructed to mutually treat them as such, are the subject of the remainder of my analysis. Since emergency call centres are architectures where the unusual becomes routinized and disaster becomes institutionally codified, any indication that this proper transmutation of an event into an institutionally recognized and relevant format is being abandoned in any way, even temporarily, is evidence for an occurrence beyond the bounds of the ordinary. The systematic orientation to particular types of emergencies as extraordinary may therefore indicate something about the social organization within which it operates.

There are various practices through which participants deviate from the structural prescription of the call. The three that I have identified in my analysis I will refer to as (1) naming the perpetrator, (2) the use of euphemistic descriptors, or the conversion of medical to lay terminology, and (3) the use of evaluative assessments.

These practices often co-occur at the site of a description concerning child sexuality and/or the presence of an assault. I will thus examine a few cases in which one or another of these mechanisms is made visible, finally examining two cases concerning child sexuality where a number of these mechanisms are conflated into the production of these particular emergencies as extraordinary.

The perpetrator made visible

I begin my analysis of the construction of extraordinary emergencies with a brief demonstration of one type of deviant mechanism, the naming of the perpetrator.

Medical emergencies fall under two very broad categories: those that are "naturally occurring" (such as childbirth or illnesses), versus those that are "inflicted" (and thus have a perpetrator as their specific causal mechanism). For the purposes of a medical or service-oriented institution, the identity of the perpetrator him- or herself is irrelevant since it contributes nothing to the overarching aims of the exchange, i.e., provision of a service, and may in fact hinder the efficiency of the exchange. One of the ways, therefore, that deviations from the institutional agenda are made visible is through the "naming" of the perpetrator in an incident description. The absence of the perpetrator, specifically in sexual crimes, is common in emergency phone calls, and its presence is often a signal of a different agenda at play.

Excerpt 6a: 2011031310863

1	CT:	What's the medic:al?
2	C:	A:::h twenty four year old ma:le
3	CT:	Yes?
4	C:	Assaulted (.) by girl=by his girlfriend (.) with a b:eer
5		bottle (0.4) on his head (1.2) so he have bleeding they
6		saying
7		(11.4)
8	CT:	Whe:re's this?

My analysis of this excerpt focuses on the incident description found in lines 4 to 6. In it, the caller provides details for what has happened to the "twenty-four-year-old male" referred to in line 2. She begins by describing the incident as an "assault" (line 4) and then continues with the words "by girl" which is repaired to "by his girlfriend". The next three pieces of information, "with a beer bottle" (lines 4-5), "on his head" (line 5) and "he have bleeding" (line 5) can all be argued to be medically relevant, and their appearance on the written record confirms this relevance. However, the naming of the perpetrator is treated as medically irrelevant by the call-taker and absented from her written description. What this suggests is that the caller is providing an opening for the call-taker to collaborate with her on the extraordinariness or unusualness of the event by using this particular non-institutional mechanism. The call-taker, however, opts for an adherence to the institutional agenda in her next slot (line 8) and in her written record of the event, so that there is no further orientation to this emergency as "extraordinary" in the remainder of the call.

Excerpt 6b: 2011031310863

Incident Type Description

Trauma - Assault - Weapon(Other)

Incident Description

M 24 YRS ASSULTED WITH A BEER BOTTLE HEAD INJ

The use of non-medical terminology

Bergmann (1992) suggests that one method utilized by professionals is the use of euphemistic descriptors as a way of practising discretion to sensitive subjects. The systematic orientation to managing particular incidents discreetly can be analysed for the work it does in the specific locality of its instantiation. As Bergmann suggests (1992, p. 154) this analysis "take(s) these elements of discretion reflexively as providing for an implicit account of their use… by describing something with caution and discretion, this "something" is turned into a matter which is in need of being formulated cautiously and discreetly… the delicate and notorious character of an event is constituted by the very act of talking about it cautiously and discreetly". In other words, orientation to an event as "sensitive" or "requiring discretion" locates it as not-ordinary, and is thus a practice used in the co-construction of the extraordinary emergency. The "euphemistic descriptor" (Bergmann, 1992, p. 154) used in emergency interactions can occur in either the verbal or written form of the incident description, and can occur from either party. In some instances a verbal euphemism is directly transposed into written form, and in others a medically relevant term will be converted into its lay counterpart. These ways of "talking around" a subject are important, for the act of omitting a particular terminology or translating a medical term into its lay counterpart is counterintuitive in this medical setting and reflects a disinclination to speak freely of particular topics, specifically for the purposes of this research "to speak freely of child sexuality"; and locates child sexuality as both "product and project" (Drew & Heritage, 1992, p. 19) of the talk. What I mean is that child sexuality is oriented to as a contextual reference that deserves discretion, and the practices used to achieve this reproduce it as a topic deserving of discretion.

The practice of converting lay terminology to its medical counterpart is an important element of institutional recording, featured as one of the key mechanisms towards the maximisation of efficiency in the interaction. It tends to occur in the act of translating the verbal description into a written record. In the calls that I listened to when writing this research report there are many examples of this lay-to-medical conversion, and in fact, due to its crucial role in expediting emergency service, it has become an inherent part of the very act of institutional record keeping. For example, a first pregnancy in an obstetric complaint is translated to "primigravida" or "G1 P0". "Ruptured membranes" are the medical terminology for the lay term "waters broken" (cf. Excerpt 5b).

These lay-to-medical conversions are important because they are an institutional mechanism that aids in expediting the delivery of the service in question (ambulance dispatch), and as such reflect the underlying institutional agenda for which they work. At times when this mechanism is not utilized, or resisted in even more explicit ways such as conversions from medical to lay terminology or the abandonment of medical language altogether, it suggests that a different, even conflicting, agenda is being pursued: the reproduction of a particular event as "unspeakable". As I suggested at the beginning of the analysis, there is often a tension between the differing roles required of the bureaucratic civil servant: on the one hand, the institutional role must be competently fulfilled, yet on the other hand the call-taker's engagement in a social interaction holds him or her accountable for fulfilling his/her role as a social creature in a particular social context.

The following excerpt demonstrates the use of a verbal euphemistic descriptor in describing the details of a sexual assault. This excerpt demonstrates that callers and call-takers may find it difficult to speak of female anatomy openly and consistently collaborate to present the information in a way that elides some of the explicit details of the incident.

Excerpt 7a: 2013010110410

1 CT: It's a query rape but eh what happened what (.) [what uh]
2 C: [She just]
3 shouting ainaainaaina
4 CT: So that means [it's a]
5 C: [It's a::] =that=lady said it looks as if she
6 was raped because (.) u:m (1.8) she's showing ↓down ↑there
7 (5.8)
8 CT: Hold on for a reference please

Excerpt 7b: 2013010110410

Incident Type Description

Trauma - Assault - Sexual

Incident Description

FEMALE

20 YRS -----? RAPE------ SERVERE PV BLEEDING --- SAPS INFORMED

In line 1 the call-taker provides a medical category to contain the information given by the caller thus far, but then finds it difficult to form a more specific question in order to elicit details. This is demonstrated in the repair from "what happened" to "what uh" (line 1) suggesting that the original "what happened" is being treated as not the most appropriate way of asking the question, the "uh" itself displaying difficulty finding an appropriate way to ask, and ultimately the failure to complete the question before the caller comes back in to respond (line 2). The collusion around this disinclination to broach the topic in a medically relevant and possibly graphic manner is evident in lines 2 to 6. The call-taker is answered in line 2 by the caller describing what the patient is "doing" and absenting the caller from the task of translating the incident into something medically recognizable. In line 3 the call-taker aligns herself with this way of handling the description and says, "So that means it's a" – leaving the caller to fill in the blank: the description each participant has evaded throughout the interaction, given reluctantly after a pause in line 5; "She's showing down there". This is sufficient for the call-taker who indicates completion, after the customary pause, by providing the caller with a reference number. The discomfort at broaching the salient details of the incident is evident here, and stands in stark contrast to the relative ease with which previously presented calls are handled. It is important to note that the call-taker successfully converts the lay term "she's showing down there" into the more medically relevant "servere PV bleeding" (sic) and that only one type of deviation occurs in this interaction. This disinclination to speak directly to a detailed description of a sexual assault, or of any incident involving the female anatomy, will be established more concretely in further examples.

Evaluations and assessments

Another type of deviation involves verbal evaluations or assessments of incident descriptions. These occur in various slots during the sequence and also take different forms. Some are nothing more than a muttered assessment while others are a direct elicitation for an "acknowledgement of extraordinariness" from the other party. Both, however, serve to perform a similar type of action that pursues a non-institutional agenda and can therefore be examined accordingly.

The following excerpt explicitly demonstrates the lengths to which an institutional worker will go in deviating from the institutional agenda at hand. It contains multiple instances of one specific type of deviation, an assessment or evaluation of the incident as extraordinary in its breach of both normative consensuses around maternal ages and moral consensus around child sexuality. It suggests that an occurrence where the child is subject to something perceived as inappropriate or morally unacceptable is grounds for deviating from the agenda at hand and pursuing the "social" or "personal" agenda that I have described at the start of this section, where the role of the institutional worker becomes less defined and a competing requirement becomes apparent and difficult for him or her to ignore.

Excerpt 8a: 2013011910255

C: Charlene one=oh=seven I've ↑got a thirteen year old uh girl who's pregnant with labour pains
CT: Okay hhu::h did=her water break↑?
C: No:t yet
CT: Okay no: ruptured membranes
C: Mm mm
CT: ((clears throat)) Okay give me the- w- u:hhow ↓old is she↑?
C: .hh One thr:ee
CT: One=three (.) one three↑
C: One (.) three
CT: °Yoh° Uh what is the initial and surname?

((All information pertaining to location and caller details has been omitted))

CT: I already notified the dispatcher (.) I just can't believe its a thirteen=year=old chi:ld [who]
C: [.hhh] Edward(.) my friend
CT: I don't know ((Afrikaans))
CT: Okay (.) hold on one moment
(6.2)
CT: [U::m]
C: [Agh]but this=is what the ↓Bible says in the last days these things will happen
CT: I don't know
C: ((Afrikaans))
CT: ((laughs))
CT: Uh your reference number is one zero two double five

In this excerpt, the caller begins by identifying herself as a 107 caller, and then offers an outline of the emergency which she is reporting: an obstetric emergency. In this opening turn, there is clear evidence for what I have suggested previously, that participants have a difficult time relating an adult type of "activity" such as pregnancy to someone they treat as a child. In this case, the caller introduces the patient as a "thirteen year old". She then hesitates or stumbles, evidenced by the word "uh" and finally settles on the word "girl" to describe the patient. The term "girl" specifically identifies/treats the patient as a child and accounts for the hesitation just prior to it, which suggests a search for an appropriate term, and difficulty finding one. This difficulty can be understood by reference to what is being reported here – someone who is pregnant (which could be understood as an "adult" kind of activity) but whose age (13) is that of a child. The word "girl" stands in stark contrast to the rest of her sentence, "who's pregnant with labour pains". Together with empirical observations made in the rest of my analysis, there is evidence that the difficulty being displayed by the caller can be tied to this mismatch of age and state.

In response to the caller's brief description in lines 1 and 2, the call-taker responds by asking follow-up questions that are appropriate to the incident being reported. He asks if her water has broken, and when he is informed that it has not, he replies "no ruptured membranes", a conversion from lay to medical terminology that is carried through to the written description of the incident. He then carries on in line 7 and asks, "Okay give me the-", and then falters, seeming to realize something that he didn't notice earlier. His repair from "give me the-" to "How old is she?" works to display his surprise, showing that he suspects that he could not have heard correctly the age given in line 1. His question elicits a response from the caller which orients to this surprise and disbelief: she answers "one three" (line 8) as a way of confirming the previous information as correct, as well as collaborating with his disbelief at this unlikely age of a pregnant patient.

The repeated reference to the patient as a "girl" or "child" serves as a plausible account for why this case would be constructed as extraordinary: the sexually related mis-match between age and state, or the sexually mature state of the asexual child (Kincaid, 1992). It also serves as a signal between participants that they are "on the same page" with regard to the fact of its extraordinariness. There are various other evaluative practices which identify this case as "made extraordinary". One instance of this is in the expressing of disbelief by the call-taker ("I just can't believe it's a thirteen-year-old child", lines 12-13), and the use of repetition in describing or displaying disbelief or the orientation to something unusual ("One three one three", line 9). Another is the use of language to indicate shock, surprise or dismay. The first of these is "Yoh" (line 11), an evaluation of the incident as remarkable. Even more explicit is the use of assessments that invoke a religious theme, such as, "Agh but this is what the Bible says in the last days these things will happen" (lines 16-17), an alignment with the call-taker to the remarkable character of the incident, introducing a moral tone to the evaluation that speaks to the nature of child sexuality as morally unacceptable but pervasive in times of pre-apocalyptic

anomie. Lastly, the caller references the call-taker as "my friend" (line 14) signalling a clear break from the work they are doing as professionals to the new work they are doing as reproducers of the common-sense morality which is in danger of being threatened. The identification and explication of these practices offers insight into the orientations of the two parties regarding their definition of the "child", their mutual orientation to this category of patient being "out of place" in this kind of emergency situation, and a joint construction of the event and its location in the discourse of child sexuality as extraordinary.

Excerpt 8b: 2013011910255

Incident Type Description

Obstetric Complaint

Incident Description

F 13... RONEL... 7 MONTHS PREG LABOUR PAINS NO RUPTURES MEMBRANE

The written description of this incident contains no reference to the incident as an extraordinary emergency: it describes the patient as a female ("F") and her symptoms in a medically recognizable format. In this instance, the call-taker does not retain his orientation towards an "extraordinary" emergency but rather returns to an institutional format in the written record after departing from it in the verbal interaction. This evidences the degree to which this orientation to an "extraordinary"emergency is realised, relative to cases where it is evident in both the call and the written record (cf. Excerpts 9a and 9b, and 10a and 10b).

The three mechanisms that I have explicated above, namely making visible the perpetrator, using euphemistic descriptors or non-medicalized language, and evaluations and assessments of incidents being described, have been identified in this analysis as practices by which the institutional agenda is systematically abandoned in service of another: namely, the social or personal agenda which signals the opportunity of its reinforcement or reproduction at various points in the interaction. These practices of deviation occur most explicitly and with the highest degree of complexity in calls that involve emergencies relating to child sexuality. That is, in calls of this nature, multiple instances of each of these deviation practices are found to occur. In the final section of my analysis below I examine a number of cases in which this kind of complexity in deviations occurs.

Child sexuality (sexual exploitation made unspeakable)

The following excerpts both involve sexual assaults upon children. In them, all three mechanisms that I have explicated above, namely making visible the perpetrator, using euphemistic descriptors or non-medicalized language, and evaluations and assessments of incidents being described, are utilized concurrently and multiply during the verbal interactions as well as on the written records of these interactions. The systematic, multiple and concurrent use of these three deviation practices describes and produces the following two events as extraordinary through their breach of the sacredness and innocence of the child; their exploitation of the asexual child in the exploitative sexual encounter.

The following excerpt, a report of a sexual assault upon a seven year old female, is a first example detailing the construction of child sexuality as extraordinary by concurrent use of all three of the identified deviance practices.

Excerpt 9a: 2013010710862

CT: Okay is it a male or female?
C: .hhh okay this=is a::: fe::male (.) Sarah=seven=years=old (.) she's got (.) u:m sexually=assaulted and raped by her grandpa hhh
(2.0)
CT: °hm!°
C: So she's bleeding
CT: It's Sarah
C: Ya
CT: What did you say (.) um=she's got what?
C: She got raped (.) by her grandpa↑ she is bleeding (4.2) from the pri:vates
(17.4)
CT: Do you know of any medical history

Excerpt 9b: 2013010710862

Incident Type Description

Trauma - Assault - Sexual

Incident Description

APHTON 107=== F SARAH 7YRS RAPED BY GRANDPA BLEEDING FROM PRIVATE PARTS NO MED HX

In this excerpt the caller begins by outlining the emergency for the call-taker. The first instance of difficulty arises in the very beginning of the incident description sequence, where the caller is presented with two possibilities for describing the patient: "male or female" (line 1). The caller observably struggles to define the patient as a female in line 2, evidenced by the stretching of the word "female" and the word just prior to it ("a"). This difficulty is accounted for in the next part of the caller's turn. In it, she orients to the institutional agenda of information gathering by providing further details relevant to the information gathering sequence. However, her description of the patient includes the information that she is "seven years old" (line 2), a pause and the word "um" before the utterance "sexually assaulted and raped". Two significant elements of this description are the double use of "sexually assaulted and raped" to describe the incident; also the particular reference to the perpetrator as a "grandpa" (lines 4 and 11) as a specific category of person, as opposed to the more formal "grandfather", locating the perpetrator in a certain category ("familiar grandpa") that contrasts sharply with the information of his sexual assault. The naming of the perpetrator itself constitutes the first clear piece of evidence for the construction of this incident as extraordinary, while the specific use of this category locates it as a moral breach, evidence of which is displayed throughout the interaction by both parties (cf. lines 6 and 12). The call-taker observably orients to the sensitive nature of the incident, and the difficulty being experienced by the caller, as she emits a sound ("hm!") to indicate possible disbelief, or disapproval at what she is hearing (and having to document). This assessment by the call-taker at the unbelievable nature of the information she is being given can be seen as a collaboration with the caller's displayed difficulties in describing the incident. It is also further evidence of the construction of this incident as extraordinary.

In her next turn (line 7) the caller states, "So she's bleeding", indicating a temporary realignment with the institutional agenda at hand. Although it is difficult to explicate the use of an omission in a description, it is fair to suggest that the caller is orienting to a euphemistic descriptor deviation practice by leaving out the specific location of the bleeding, something that she references directly later on in the call in line 12 ("from the privates"). The call-taker aligns with this reorientation to the institutional script in her next turn where she uses a confirmable to ascertain the patient's name. Then in line 10 the call-taker displays a need for further information (or the repeat of information) from the caller. This is done through the use of a follow-up question. In this case, however, the formulation of the question is similar to the one found in Excerpt 10a, with a repair from "What did you say?" to "Um she's got what?" displaying an uncertainty about the best way to form the question and evidencing an orientation

to the topic as delicate or deserving of discretion; something not to be spoken. The caller responds to this request, however, by offering a description that orients to the institutional agenda: giving the information clearly with pauses in between each phrase. She delivers three of the details in this methodical fashion ("raped", "grandpa", and "bleeding"), with brief pauses in between. There is then a significantly longer pause in line 11, after which she explicates for the call-taker, "from the privates", replacing the earlier omission of where the patient is bleeding from with a euphemistic descriptor here. Also significant is direct reference to the word "rape" in line 11, contrasted with the earlier description that utilizes "sexually assaulted and raped" as a mitigator (Bergmann, 1992) in describing the incident. With regard to the end of caller's turn in line 12, the call-taker regards the description of "from the privates" as demonstrably acceptable by using her next turn to perform the conclusion of the incident description sequence by beginning a new topic; however, it is nevertheless a non-medical terminology that is being utilized. The call-taker transports the entire description into the written record, verbatim, changing only the word "privates" into "private parts". Here there is evidence for both parties orienting to a usage of non-medical terminology when referring to the female anatomy in this incident. In the data analysed, this is the first case where a verbal euphemism for vaginal bleeding has not been converted into medical language in the written record (cf. Excerpts 7a and 7b). This absence of medical terminology in both versions of the incident description serves as further evidence for the participants' orientations to the extraordinariness of the event.

The following excerpt also describes the concurrent use of all three identified deviation practices, which together construct the rape of a child as an extraordinary emergency.

Excerpt 10a: 2013010110238

1	C:	Hi Desree complainant u:h reporting a:::: (.) chi:ld abu:se
2		or a rape
3	CT:	Child abuse (.) um w-what is the perso:n's name?
4	C:	U:::h Griselle is the c:aller
5	CT:	Griselle (0.8) And her c[on]tact number?
6	C:	[Do]
7	C:	Oh=eight three (3.8) two nine three
8	CT:	oh=eight=three=two=nine=three
9	C:	Seven one zero eight
10	CT:	Seven one zero eight (.) And you said I'm speaking to?
11	C:	Rual
12	CT:	Ru:al (4.2) Okay=u::m

((All information pertaining to location has been omitted))

13 CT: How old is the:: um
14 C: They say it's a female three years o::ld
15 CT: (Shhhhhhh) (2.2) Three=yea:rs
16 C: Uh the child was lost last night=in the Danoon a:rea (1.0)
17 and they found the child
18 (2.0)
19 CT: :Mmm?
20 C: U:::h but=then=they=said=they=have spe::rm coming out of
21 her vagi:na (.) and the=child is n-not well at a::ll
22 CT: So they found (2.2) [baby]
23 C: [They]
24 C: Ya that was lost (.) last night in=Danoon (2.0) The police
25 found the chi:ld (.) cos they were looking for the chi:ld
26 CT: Shhh:: (.) [and]
27 C: [Rep]orted=missing or so:mething (4.2) But
28 (.) the caller says he kno:ws who the suspect i:s and
29 that=I've already informed the police but I told them I must
30 inform the ambulance as [well]
31 CT: [Hmmmm]
32 CT: Okay (.) u::m Ooh that's=ve:ry te:rrible=hey↑?
33 C: Mmmm
34 CT: ((makes a sound)) I just wanna (5.6) so the police[i:]s there
35 [The]
36 CT: with her (.) at the moment
37 C: police are going out there no:w

Excerpt 10b: 2013010110238

Incident Type Description

Trauma - Assault - Sexual

Incident Description

Female 3yrs

child was lost lastnight ...

so she they found child and sperm coming out

05h24 --ir 36307

The call begins with the caller's provision of the nature of the emergency. In it, he displays an orientation to his institutional work with the use of the word "complainant", as well as the orientation to the sensitive nature of the incident with his hesitancy ("a::::" and a pause) before his description of the incident as a "child abuse or a rape", indicating care being taken in choosing the best term. The call-taker, similarly, orients to the institutional script by repeating the categorization of the incident in line 3 ("child abuse") but then displays difficulty in the next part of her turn where she struggles to formulate a question appropriate to the information gathering sequence.

My analysis continues after the provision of the caller's details and location (omitted for purposes of brevity), where there is a brief return to the institutional agenda of information-gathering, and resumes in line 13. The call-taker's question formulation in line 13, "How old is the um", indicates a difficulty, once again (cf. line 3), in finding the right words to enact the information gathering sequence further. The stretching of the word "the" and "um" after he asks "How old is the" indicates that what is typically a routine question is being treated as something requiring discretion and sensitivity, through the search for an appropriate word and the failure to actually find one. In previous excerpts, we have seen reference to patients, including small children, as "female", "child", "girl" or simply "patient", and have discussed how each term is chosen to perform specific actions. The absence of a word performs its own action, and provides evidence for the difficulties experienced by these professionals when confronted with a mismatch between "age and state" of the patient, i.e. the framing of the asexual child in the sexual (and exploitative) encounter.

The caller replies to this unformulated question with the words "female" and "three years old" in a format similar to that found in excerpts described above. The slot made available by the call-taker through her non-institutional question format is not taken up by the caller as an opportunity to align with the call-taker's treatment of the topic as sensitive – he rather utilizes it to provide the institutionally relevant information in the face of the call-taker's wavering in this regard (and continued non-institutional response).

The call-taker responds with a sound to indicate disbelief ("Shhhh"), followed by the repetition of the words she finds most significant ("three years"), thereby specifically displaying what it is that she is treating as unbelievable – the age of the victim. This is very strong evidence displaying the call-taker's orientation to the breach of a normative morality: the sexual violation of a small child, who the call-taker later refers to as a "baby" (cf. line 22), reinforcing her orientation to the gravity of the breach by consistently invoking the status of the patient as someone very young and thus very innocent. This display (in line 15) provides an account for the call-taker's hesitation in formulating her question in line 13. These evaluative assessments of the incident as unbelievable and worthy of remark are deviant practices that are being used explicitly by the call-taker to construct the incident as extraordinary, despite the lack of reciprocity from the caller. That this deviation clearly works against the institutional imperative of efficiency in the call, by halting the call's trajectory and thereby delaying service provision, suggests that an alternative agenda is being pursued here by the call-taker in her reflection and evaluation of the emergency at hand. This alternative agenda is described by the deviations that it utilizes, i.e. its evaluative practices construct the incident as one deserving evaluation and disbelief.

The caller's next turn does not explicitly take up this parallel agenda but rather adheres to the institutional one, by providing additional information about the incident. This is significant because it shows how the participants in these "deviant cases" do not both necessarily orient to them as "extraordinary" - they can be produced as such by virtue of the actions of one party or another, or by both acting collaboratively. However, there is a subtle shift in his alignment made visible in his reference to the patient as a "child" (cf. lines 16, 17 and 21), whereas before he described her as a "female three years old". Thus, despite his adherence to his institutional duty of information provision in this sequence, we see evidence of a subtle transition to the call-taker's orientations which is made more explicit in the remainder of the call.

After his explanation in lines 16 and 17 of the child's disappearance and finding, there is a pause where the call-taker is ostensibly recording the information, borne out in her following turn where she says "Mmm?" (line 19) to indicate to the caller that this information is relevant and he may continue, signifying the call-taker's temporary reorientation to the institutional script. The caller orients to this acknowledgement by the call-taker and continues to provide further information about the patient, signifying his own reorientation to the institutional agenda at hand. However, at the same time, the caller displays elements of a non-institutional agenda through his use of the word "child" (line 20) and the rapidity with which he utters the following sentence. In this sentence, he is faced with the task of describing the patient's condition in detail. His use of the word "Uh" (line 20) and then the rapidity of his words ("but=then=they=said=they=have") (line 20) indicate some anxiety about delivering the information, and the rapid nature of his delivery stops once he reaches the word "sperm" (line 20).

The call-taker responds to this turn by repeating the information that the patient has been found, formulating her first direct reference to the patient in question as a "baby" (line 22) after a significant pause signalling her search for an appropriate description. As I have suggested previously, the taking up of a particular category of description is always available for an analysis of what it does (Schegloff, 2007b), and in this case it explicitly formulates the patient as a baby in contrast even to the caller's description of the patient as a child, situating the patient as the most extreme depiction of young age with regard to its qualities of helplessness, vulnerability, innocence and purity. These references to the patient as a child or baby offer strong evidence of a breach in all previous and subsequent deviation practices that occur in the exchange. The caller continues to fill out his description in lines 24 and 25, though explicitly referring to the patient twice as a "child" (line 25), and continuing with the use of the word "police" (lines 24 and 29), both as an orientation to his institutional duty of reporting the incident to the police as well as situating the emergency in the category of "crime": which further emphasises deviation practices earlier in the interaction. In addition, the situating of this event as a crime acts as a precursor to the caller's deviant practice in line 28 when he names the perpetrator of the incident. The call-taker interrupts the caller's description in line 26 to repeat the evaluative utterance "Shhhhh" that confirms her orientation to the event as extraordinary and remarkable.

In line 28 the caller produces another deviation practice when he references the perpetrator ("the caller says he knows who the suspect is") which he accounts for subsequently by invoking the police and its allusion to the criminal nature of the incident. He also displays an orientation to the sense of a personal duty, one that goes beyond his institutional requirements, when he says in lines 29-30, "but I told them I must inform the ambulance as well". The use of the word "I" here is significant, since it counters the more typical use of "we" when referring to oneself as an institutional agent. It suggests evidence for the caller's experience of a moral duty that accompanies his institutional obligations, and provides an account for the multiplicity of deviation practices that are enacted in this interaction.

The call-taker makes use of her following turn to align with this sense of a mutual construction of moral duty to resist or protest the act being reported, when she offers an evaluative assessment of the affair with her words "Ooh that's very terrible hey?" This utterance, apart from demonstrating the call-taker's orientation to the incident as a contravention of the normative morality of child sacredness, also invites the caller to collude with her in this regard, (which the caller does in line 33 when she makes use of the assessment, "mmmm"), thereby positioning both of them, finally, as co-constructors of the immorality of sexual exploitation of the child. After the establishment of this mutual alignment, the call-taker returns to the institutional agenda, by using confirmables to expedite the efficiency of her information gathering, and the caller realigns with the return to the institutional script by negating her assertion and providing an alternative explanation.

In the written record, the call-taker translates the description of "they have sperm coming out of her vagina" (lines 20-21) to "and sperm coming out" in written form. Here, then, is evidence of another deviation practice being utilized: the use of non-medical terminology via the omission of a medically relevant term for female genitals. For the purposes of this analysis, an omission may be termed a type of euphemism since its function serves the same purpose as a euphemistic descriptor, in that it talks around the subject that it describes. This omission is analysable because in the contrast between the words used by the caller and the words recorded on the form, the omission of "vagina" is the only difference between them. It may be interesting to note that although the use of a euphemistic descriptor (in this case an omission) is unusual in written descriptions, it reflects the call-taker's initial and recurrent treatment of this event as sensitive and extraordinary, in contrast to the caller's initial treatment of it as a "business as usual" incident. From the unfolding of this interaction, we see constant negotiation of the mutual demands of getting the institutional work done and providing a service, versus reflecting the extreme and remarkable nature of the emergency. This delicate renegotiation is where the institutional worker comes to life as both social actor and professional service provider and is the location of the actual moment-to-moment instantiation of norm reproduction during the maintenance of institutional realities (Heritage, 1984).

Conclusion

The production of the "ordinary" emergency is an interactional accomplishment, serving to maintain the institutional reality within which it is produced, and contributing to the overall efficiency imperative that is at the core of health-related service delivery. Emergencies are produced as routine through the use of institutional language, including goal-oriented talk that utilizes medical terminology, constrained interaction that follows an institutional structure (in this case, the dispatch package form) and special inference or reasoning mechanisms that preclude the need for evaluative or emotional assessments. This production of the "ordinary" emergency, that can be contained in the dispatch form and that is made processable through its routinization, therefore, does not only contribute to the efficiency imperative that is the overarching institutional agenda of these interactions, but in fact is a *key and constituting* feature of it.

In certain instances, however, these institutional features of talk are breached or temporarily abandoned, indicating that an alternative agenda is being pursued: what I term in my analysis the "personal" agenda. The personal agenda is characterised by its own imperative, one that works for the reproduction of social or moral norms and sees itself as accountable to them. While institutional settings are characterised by orientations to their own unique set of social and moral norms, the personal agenda I refer to is characterised by a move away from these (institutional) concerns and toward a more "lay"

orientation to the emergencies at hand. In addition to this, the personal agenda generally acts *against* the institutional agenda, since its pursuits involve using non-medicalised language, offering evaluative assessments and offering or pursuing information about the perpetrator; all practices that do not work for efficiency and in fact tend to lengthen the service-delivery process. Since the production of the ordinary emergency is a key identifying feature of most incident reports and thus of institutional behaviour in general (in this context), the co-construction of an event as *extra*ordinary is unusual, and it is thus valuable to look both at *what* is being produced as extraordinary (and offers possible accounts for this), as well as *how* it is being produced as such, which in fact is the focus of my analysis.

A review of the literature that I have presented suggests possible accounts for why child sexual assault is reproduced as an extraordinary emergency even between service-delivery professionals in the health sector, who generally have a direct interest in adhering to an institutional agenda.

Sexuality is the site of censorship and repression in society today (Foucault, 1976). I have argued in the literature review that this may be a function of state-initiated self-regulation. Whatever its origins, the highly regulated nature of modern sexuality puts it, as Foucault argues (1976), at the heart of discourse, its invisibility and silence a function of its power. The child is rendered distinct in the population through a scientific rhetoric that constructs the child's (unarguable) biological immaturity as a categorical distinction, and adds layers of meaning upon this distinction. Crucially, one of the meanings derived from the child's biological immaturity is its need for protection. The child today exists as a sacred and precious citizen deserving of (and in need of) state protection. This protection (the duty of the state and all its citizens) is reproduced as a moral duty, positioning the absence of protection as a moral aberration, and the active non-protection (or the exploitation) as a moral unacceptability. Illegitimate *sexuality* that is enacted upon the innocent child is seen as a breach of society's most normative and agreed-upon rules, and constitutes a rupture in the maintenance of the social institution. Child sexual abuse, in its infringement upon society's two most heavily regulated institutions, emerges as a complex and contradictory phenomenon; unavoidable yet threatening, present yet not possible. These assumptions about the nature of childhood, and the nature of the child, create the conditions where the maintenance of the knowledge of the child's need for protection is seen as our moral and social calling, and lend valuable insight about the function performed by deviations in EMS calls about child rape or exploitation: this deviation demonstrates a shared orientation towards an important moral duty, the reproduction of the child's sacred and protected place in society, and thus is not really a "deviation" at all: its presence accounts for itself, and its absence might, in fact, be regarded as a moral aberration. This fits perfectly with Garfinkel's (1967) understanding of institutional realities and their maintenance in the face of deviations or breaches: the deviations are always "accountable-for" in that they are built into the original fabric of the normative order of things. In other words, the deviation from an institutional agenda to mark a case of child exploitation as extraordinary is not a

deviation at all; it is an orientation to a shared morality of cognition without which, in fact, the institutional reality it purportedly deviates from could not be maintained. Emergency calls are thus a locus of institutional "order at all points" (Sacks, 1992, p. 484) and their deviations to the extraordinary are as systematic as their practices of ordinariness.

The conversation analytic method that I have used in my analysis has allowed the identification of significant deviation practices in the interactions and written records of the data I have analysed. I have explored each of these in depth in my analysis, and have displayed the ways that the naming of a perpetrator in an incident description, the use of non-medical terminology in the verbal or written description, and the use of evaluative assessments in emergency reports, all contribute to the *lengthening* of the interaction, serve no demonstrable purpose in contributing to the fulfilment of service provision, and in fact prolong the effective dispatch of an ambulance service, thus serving to obstruct and hinder the institutional agenda for which they work. The use of one or another of these deviation practices is made visible across a range of incident reports, and typically display an orientation by the interactants to something "unusual" about the emergency. However, these deviations are fleeting and represent nothing more than a temporary attendance to a competing agenda.

However, what I consider to be the key finding of my research and analysis is the following: confluences of these three deviation practices occur at the site of one particular type of emergency: that of child sexual abuse. In other words, these three recurring practices indicate deviations from an institutional agenda, and the use of all three of these practices simultaneously or concurrently in the same interaction occurs only in emergencies where a child sexual assault is being reported. In the data that I have analysed, incident descriptions of child sexual assault are consistently followed by the naming of the perpetrator of the act, the use of morally or emotionally evaluative assessments, and finally, the use of euphemistic descriptors, conversions from medical to lay terminology, or actual omissions of particular words or phrases in the description of child sexual assault.

This finding allows for the identification of one of the precise locations at which this social and moral norm is reproduced in action, as well as displaying the methods and mechanisms through which this norm is attended to by institutional actors and reproduced in daily life as a shared morality of cognition (Garfinkel, 1967; Heritage, 1984).

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Appendix A

Plagiarism Declaration

I, Daniella Rafaely, Student number 338473, hereby declare that this is my own, unaided work. I have not previously submitted this work for any other purpose at any other institution.

_____