V. Problem Presentation and Advice-giving on a Home Birth Helpline: A Feminist Conversation Analytic Study

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The rate of home births in the UK is very low (around 2%) and many women who would like to give birth at home find it impossible to get midwifery cover or are advised of medical contraindications. The Home Birth Helpline offers support and expertise for women in this situation. Based on the analysis of 80 recorded calls, this article uses conversation analysis (CA) to explore how callers present their reason for calling the helpline, and what this shows about the culturally shared medicalized culture of birth. This research is an example of feminist CA in that it contributes both to the study of childbirth as a key women's health issue and to the study of helpline interaction from a conversation analytic perspective

Key Words: *childbirth, conversation analysis, feminism*

> Man knows no more degrading or unbearable misery than forced labour.
> Friedrich Engels (1993)

Ursula was pregnant with her second child when she first called the Home Birth helpline. She reported having been warned against giving birth at home on the grounds of suspected gestational diabetes and having been told that, in any case, there were no midwives available to attend her at home. Not only were her health care providers opposed to her birthing at home, but also 'my friends and my mum and just about everybody else I meet apart from my husband, look at me in complete horror when I tell them I want a home birth'. After her first call to the helpline (and in part as a consequence of the assistance offered by the home birth helpline), Ursula demanded a second diabetes test and was found *not* to have gestational diabetes. Then, armed with the knowledge that she was legally

entitled to give birth at home, she insisted on her rights and found midwives who were happy to attend her. When Ursula called the helpline a second time some weeks later, it was to report on a successful home birth. She described it as 'a really wonderful, positive experience' and 'so different to having my little boy who I had in hospital. I just felt so relaxed. And she popped out like a little poppet!'

The Home Birth Movement was established in the 1980s and is an organization of consumers and professionals that campaigns for choice in childbirth. Run by the birth activist and author Sheila Kitzinger, the organization encourages women to take a more active role in their birth care and emphasizes autonomy, access to information and choice with regards to alternatives. Its Home Birth helpline is staffed by volunteers who are dedicated to ensuring that women are informed about their right to give birth at home. As a service for women planning a home birth, it aims both to 'empower women around home birth' and to 'effect change in wider society' (Kitzinger, n.d.).

In the UK, a woman has the right to give birth at home, regardless of whether she is expecting her first or subsequent child and regardless of any perceived 'risk' factors. In the UK, if she opts for a home birth, her local health authority (or health board in Scotland and Northern Ireland) has a legal obligation to ensure that she is attended by a qualified practitioner (usually a midwife). Although provision for a home birth is not explicitly stated (Trusts have not had a statutory duty to provide a domiciliary birth service since the National Health Service (NHS) was reorganized in the 1970s), there is no doubt it is UK government policy to promote a home birth service (Royal College of Midwives, 2002: 2). According to the government's national framework for maternity services (Department of Health, 2004), it is a 'marker of good practice' that 'all women are involved in planning their own care with information, advice and support from professionals, including choosing the place they would like to give birth and supported by appropriately qualified professionals who will attend them throughout their pregnancy and after birth' (Department of Health, 2004: 5). However, the rate of home births is currently very low (approaching 2%, Olsen and Jewell, 2003) and many women don't know how to go about arranging midwifery cover for a home birth. Further, their attempts to do so may be blocked by health professionals and their decision to birth at home may be regarded as risky or bizarre by those close to them. We found that many women calling the Home Birth helpline had (like Ursula) been told that they couldn't have a home birth based on claims about spurious medical contraindications and staff shortages. In this context, the Home Birth helpline offers a vital source of support and expertise for women wanting to choose home birth.

The research reported here is drawn from the doctoral thesis of the first author (Shaw, 2006), which was supervised by the second author. It is based on the analysis of 80 calls (between one call-taker and 56 callers) to the Home Birth helpline. In working with naturally occurring helpline interaction (instead of self-report data collected from, for example, interviews with callers and call-takers

after the event), we avoided the issue of to what extent reports of those interactions accurately reflect what actually takes place and, by having recordings available for repeated examination, we avoided losing the details of the interactions. The doctoral thesis is a paradigmatic example of 'feminist conversation analysis' (Kitzinger, 2000) in that it contributes both to the study of childbirth as a key women's health issue and to the study of helpline interaction from a conversation analytic perspective. The thesis begins with an overview of the feminist and home birth literatures (Chapter 1), outlining some key conceptual and empirical issues. The second chapter is a thematic analysis of the kinds of problems raised by callers and the ways in which the call-taker seeks to address these; it describes the content of the calls in a fairly 'broad-brush' way and as such lays out the groundwork for the conversation analytic studies that follow. (A version of this second chapter is published as Shaw and Kitzinger, 2005.) The first conversation analytic chapter (the third chapter of the thesis) is an analysis of the 'phases' of the calls, showing the way in which the calls unfold from their 'pre-beginning', through the 'opening', 'problem presentation', 'solution', 'pre-closing' and 'closing' phases. It provides a sense of the movement through the calls, as caller and call-taker negotiate why the call has been made, what the call-taker can offer and what each undertakes to do as the call comes to an end. (See Shaw and Kitzinger, forthcoming for a version of this analysis). The next conversation analytic chapter (Chapter 4) is a study of the way in which caller and call-taker handle the issue of what is remembered from previous calls when callers make 'repeat' calls; this turned out to be a difficult issue for a call-taker who is taking dozens of calls a week and for whom remembering any one woman's story can be a challenge. (See a version of this chapter published as Shaw and Kitzinger, 2007.) Another conversation analytic study of the calls (Chapter 5) focuses on the 'emotion work' done by the call-taker in complimenting callers on their 'courage', 'determination' and 'good sense' in pursuing home birth. Finally, a concluding chapter considers the implications of the findings for feminism, for birth activism and for CA and reports on the practical outcomes of the research, which include a leaflet for distribution in GP surgeries about women's right to home birth and a training package for use in training volunteers on the Home Birth helpline.

Here we focus on one particular aspect of calls to the Home Birth helpline: the way in which callers present their reason for calling. We show how, in doing so, they display their expectations (or lack of them) about what the helpline can offer, and we address the ways in which their problem presentations display an orientation to (and thereby, for the analyst, reveal) a shared taken-for-granted medicalized culture of birth.

In studying helpline interaction, we are following a long tradition of interest by conversation analysts in calls for help, and in what are now called helplines. Much of the early work in CA by its inventor, Harvey Sacks, was based on recordings of telephone calls made to a suicide prevention centre in San Francisco. His (unpublished) thesis 'The Search for Help: No One to Turn To'

investigated the delicacies of call openings (how and why callers withhold their names) (see Sacks, 1995, Vol. 1: 3), the difficulty for callers of seeking help from strangers (see Sacks, 1995, Vol. 1: 75) and the 'institutionality' of such interactions (in terms of how certain types of talk are understood with reference to particular contextual roles and how such expressions as 'May I help you' are 'manifestly organisational') (see Sacks, 1995, Vol. 1: 10). Since Sacks, a number of studies have attempted to describe helpline interaction. This includes the classic work on calls to the emergency services (Frankel, 1989; Sharrock and Turner, 1978; Whalen and Zimmerman, 1990, 1998; Whalen et al., 1988; Zimmerman, 1992), as well as more recent work on a variety of helplines including primary health care, technical support, emotional crisis, tourist accommodation, consumer rights, telecommunications and the emergency services (Baker et al., 2001, 2005; Drew, 2006; Edwards and Stokoe, forthcoming; Houtkoop et al., 2005; Pudlinski, 2002, 2005; Raymond and Zimmerman, forthcoming; te Molder, 2005; Torode, 1995, 2005; Whalen and Zimmerman, 2005).

We begin by displaying the transcripts of two calls to the Home Birth helpline from the beginning of the recordings we have of them. The call-taker answers the telephone in her own home and does not have a dedicated Home Birth line. This means that calls are usually not recorded from the very beginning (as in the following two instances), since the call-taker first needs to identify the call *as* a home birth call and to gain permission for recording: it also means that these calls have a distinctively 'personal' flavour to them.

Extract 1 [Marion 19-I][1]

(Beginning of the call was not recorded.)

01	Mar:	>... spoke to you a few minutes ago about [( )]
02	Clt:	[Ye:s: hi:]
03		hi:! Thank you for letting me just finish the
04		stra(h)wberries.=That's marv[ellous.
05	Mar:	[Huh huh.huh hu[h [( )]=
06	Clt:	[W- [well]=
07	Mar:	=[( )]
08		=[we've got a-] we're gonna be ni:ne peo:ple.hhh so
09		I've got a hea::p a: hu:ge heap of strawberries.=I thought
10		you know (.) it's the £easiest way of doing pud£.
11	Mar:	Yeah definitely. Huh huh. Uhm (.).hh I found your
12		number in so:me information I was given about home bi:rth
13	Clt:	[Hm mm]
14	Mar:	[and uhm] uhm I don't- I don't know anything about what it
15	→1	is that you do: [uhm but] I'm interested in having a home=
16	Clt:	[.hhhh]
17	Mar:	=bir[th] myself and just need mo:re informat[ion]=
18	Clt:	[Yes] [Ye:s!]=
19	Mar=	[(what's the best) route [you know] all this sort'v=
20	Clt:	=[That sounds very sensible [yes.]

21 Mar: →2 =thing (.) because I don't think- I don't think my
22 midwife was terribly kee:n on it.

Extract 2 [Meg 02-1]

01 Clt: Oka:y. Ri:gh[t.]
02 Meg: →1 [(Ri]ght) W'l (.) ba:sically I really
03 would like a home bi:rt[h:]
04 Clt: [Mm] hm,
05 Meg: →2 But my GP isn't- (.) that kee:n.
06 (0.2)
07 Meg: I've just been to see him toda:y.=So I just wondered
08 (.) you know how would I go about it [if my GP]=
09 Clt: [Mm hm]
10 Meg: =isn't really keen.

The opening sequences (e.g. where she thanks the caller for calling back at a more convenient time and provides an account for why this was necessary, Extract 1) are analysed elsewhere (Shaw, 2006). Once these opening sequences are completed, callers normally provide the reason for calling the Home Birth helpline and the way in which they most commonly do this is exemplified by Extracts 1 and 2 above.[2]

Most commonly, callers present the reason for the call through *two statements* (1 and 2) *that set up a dilemma*: (1) I want to have (or planned to have) a home birth and (2) now there are impediments to me doing that. For example, in Extract 1, Marion says she is (1) interested in a home birth (lines 15 and 17), but (2) doesn't think her midwife is keen (lines 21–22). In Extract 2, Meg says she would (1) really like a home birth (lines 2–3) but (2) her GP is not supportive (lines 5–10).

Similarly, in Extract 3, the caller says she has (1) opted for a home birth (lines 1–2) but (2) has reached 'stumbling blocks' (9–11).

Extract 3 [Rachel 11-I]

01 Rac: →1 ... I'm having a- I've- I've opted for a home
02 bi:rth.
03 Clt: Brilliant!
04 Rac: And uhm (.) I've I- just saw your number at the back I
05 mean I have been in touch with uhm (.) AI:MS 'n I've=
06 Clt: [Good.]
07 Rac: =[got] their little booklet.
08 Clt: [Good.]
09 Rac: →2 [A:nd] uhm.hhh uh but that's- y'know that's about
10 it. But I'm:- I've now got to the stage where I'm
11 sort'v reaching stumbling blocks.

Typical of other calls, the first component of the problem presentation in Extracts 1 to 3 foreshadows a problem ('I'm interested in', Extract 1, 'I really would like', Extract 2 and 'I've opted for', Extract 3) and then move more or less succinctly to a statement of the problem. The second component is presented as an overt complaint ('I've now got to the stage where I'm reaching stumbling blocks', Extract 3) or a 'complainable' is hinted at ('I don't think my midwife was terribly keen on it', Extract 1 and 'if my GP isn't really keen', Extract 2).

By virtue of the first component (a statement of the desire to have a home birth), callers are orienting to the potentially troublesome nature of this request. It would be difficult to imagine callers to a maternity service opening with, for instance, 'I would like to have a hospital birth'. Callers to the Home Birth helpline present their desire to have a home birth in more or less 'confident' terms. For example, in Extract 1, Marion is 'interested' in a home birth (line 12), rather than 'planning', 'wanting' or 'having' one. In contrast, Extract 3 (line 1) is an example of a caller sure of her position and determined; proclaiming that she is 'having' a home birth (although notably repaired from 'I'm having' to 'I've opted for' as an orientation to the fact that there is some problem in achieving this goal).

In the majority of the calls, the '1 then 2' format occurs with very minimal response from the call-taker between the two components. Instead, the call-taker waits for the problem presentation to come to a point of possible completion. This form of un-interruptive listening is similar to that in other helpline calls, where the call-taker is concerned not to bring the problem presentation to 'premature termination (which might cut off important future material) or to a premature judgment (which might need to be changed in the course of the call)' (Potter and Hepburn, 2003: 211; also see Pudlinski, 2005). For instance, in Extract 2 (above) the call-taker's only utterance between the first and second components of the problem presentation is a continuer ('Mm', line 4).

However, in addition to her more minimal responses such as continuers, understanding checks, prompts for elaboration and 'where-type' inserts (about geographical location, names of hospitals, consultants and midwives[3]), intimacy and openness is achieved in these calls through the deployment of other conversational devices such as empathetic receipts ('Oh lovely', 'Oh how dreadful', data not shown), reaction tokens ('Oh::!', data not shown, Wilkinson and Kitzinger, 2006) and positive assessments of the caller, her actions or her attitude ('Yes that sounds very sensible', Extract 1, lines 15–16; 'Brilliant', Extract 3, line 3).

Gail Jefferson and John Lee (1981) argue that in institutional advice-giving encounters, empathetic receipts (such as 'Oh lovely' or 'Oh how dreadful') are misplaced. Their analysis centres on a single call to a suicide prevention centre, in the course of which the advice-giver's empathetic utterance ('Oh my') reduces the caller to tears. This attempt to 'humanize' the institutional encounter, they argue, results in an 'elephantine travesty which is effectively neither troubles telling nor service encounter but a worst possible version of each; namely, unwarranted affiliation compounded by inept servicing" (Jefferson and Lee, 1981:

421). However, in the context of calls to the Home Birth helpline (in common with other helplines dealing with emotional difficulties, e.g. Potter and Hepburn, 2003; Pudlinski, 2005; Kitzinger, 2006), items such as empathetic receipts and reaction tokens enable call-takers to perform their professional task (of information and advice provision) while also maintaining the affiliative orientation of a service that aims to 'empower' women around home birth.

In Extract 4 (which is a continuation of Extract 2), the call-taker's first substantive insertion into the talk after the caller's problem presentation (that (1) she'd like a home birth, lines 2–3, but (2) her GP isn't keen, lines 7–8), is the provision of information about the caller's rights (she doesn't need to have a GP, line 11, she only needs a midwife, line 13), followed by a solution to the problem (she should contact the director of midwifery, lines 15–18).

Extract 4 [Meg 02-I]

01	Clt:	Oka:y. Ri:gh[t.]
02	Meg: →1	[(Ri]ght) W'l (.) ba:sically I really
03		would like a home bi:rt[h:]
04	Clt:	[Mm] hm,
05	Meg: →2	But my GP isn't- (.) that kee:n.
06		(0.2)
07	Meg:	I've just been to see him toda:y.=So I just wondered
08		(.) you know how would I go about it [if my GP]=
09	Clt:	[Mm hm]
10	Meg:	=isn't really keen.
11	Clt:	[Mm You don't have to have a GP you know that do you.
12	Meg:	Yeah.
13	Clt:	You only need a midwife.
14	Meg:	Ri[ght]
15	Clt:	[.hh] And you get in touch with the s:- with thee uh
16		director of midwifery at your local hospital and say
17		that you're planning on having a home birth: and she-
18		can she please make sure that you have mid- uh
19		midwifery cover

This kind of response is typical of many calls to the helpline; the call-taker's first substantive insertion after the caller's problem presentation is routinely an adumbration of the solution in the form of information about the caller's rights, which is very often an unequivocal and unmitigated statement (as in Extract 4). For instance, in Extract 5, the second component of Tanya's problem presentation, that the health care professionals have said they 'couldn't allow a home birth' (line 1), is met with the assertion that she has the 'right' to a home birth (lines 2–4).

Extract 5 [Tanya 28-I]

01	Tan: →	..then they said "oh no: we couldn't allow (.) a
02		[ho:me [birth."]
03	Clt: →	[.hh Oh [well] it's >actually not a question of<
04		whether they allo:w you.=You have a ri:ght to it.

At the same time, and in common with other helplines (Potter and Hepburn, 2003; Pudlinski, 2002, 2005), the call-taker works to retain a strong orientation to the caller's own autonomy and expertise, routinely avoiding taking full responsibility for providing a 'solution' by presenting advice in a mitigated form, 'built off' the caller's own words. For example, in Extract 6, the call-taker's advice ('I think I'd query it, it seems to me to be medicalizing your pregnancy unnecessarily', lines 21–22) echoes the caller's concerns early on in the call (lines 1–2).

Extract 6 [Ursula 13-I]

01	Urs:	And it just felt immediately as if: I was being
02		taken o:ver [comple:tely.]
03	Clt:	[Yes of] cou:rse!

// ((approx. 30 seconds omitted for presentational purposes, during which the caller describes having to self-test for suspected gestational diabetes))

21	Clt:	Well I would- I think I would query it. [It seems]=
22	Urs:	[Mm. Wel-]
23	Clt:	=to me to be medicalising your pregnancy unnecessarily.

These findings contribute to the conversation analytic literature on helplines and also have implications for support work around home birth and maternity services. Collectively, the Home Birth calls convey a strong sense of the power of the medical model of birth as the 'backcloth' to the conversations. The findings presented here highlight the way in which the helpline is a context in which the call-taker and caller collaborate to produce choosing home birth as reasonable and understandable, in a cultural milieu where it is neither of these things.

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NOTES

1. For a transcription key and for an introductory overview to the feminist CA special feature of which this article is a part, see Kitzinger, this issue.
2. There are two other methods callers use for presenting their reason for calling. They ask a *question* or make a *request*, as in the extract below, where the caller asks a question about where to get a birth pool (her first pair part at lines 1–2) and the call-taker answers that a birth pool can be hired from a company in Radley (her second pair part at line 6).

   [Maeve 70-I]
   01 Mae: → But: uhm (.) I wo:ndered if you had any: uhm (0.2) ideas
   02 about hiring a bi:rth pool.< I hired a birth pool for my
   03 la:st one an' had it [at home]
   04 Clt: [Mm hm.] Mm hm.
   05 Mae: Uh::::m (.)
   06 Clt: → .hhhhhh There is somebody in Wilkey who has a birth-
   07 birth pool.

   Alternatively, callers present their problem in the form of a *narrative* or extended description that builds toward a characterization of the problem (for example Petra 10, whose problem presentation is discussed in Chapter 5 of Shaw, 2006).
3. The call-taker often orients to the interruptive nature of these 'where-type' inserts in a third turn (line 7, in the example below), providing an explicit account for why she has asked the question. This is often that she possesses independent (expert) knowledge that may be useful (although in the example below, this turns out not to be the case; she doesn't in fact know this midwifery unit).

   [Alena, 15-I]
   01 Ale: …my GP's quite supportive of home bi:rth even though he
   02 doesn't provide antenatal ca:[:re]
   03 Clt: [Mm] hm
   04 Ale: And we have a local uhm (.) delivery unit (.) [( )]
   05 Clt: → [A::h which]
   06 unit is that¿
   06 Ale: → It's: (.) uh William Turnbull Rye.
   07 Clt: → A:h. No I don't know that group. Mm.

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