

Pamela J. McKenzie and Tami Oliphant
Faculty of Information and Media Studies
The University of Western Ontario
London, Ontario N6A 5B7

The presentation of complementary and alternative medicine information in Canadian midwifery care

Abstract: This paper uses discourse analysis to consider midwives' and pregnant women's discussions of conventional and complementary and alternative medicine interventions for inducing labour. Participants distinguished between "natural" and "medical" methods and used information sources based on both biomedical evidence and women's experience to justify and challenge authority claims.

Résumé : Cet article utilise l'analyse du discours pour examiner les conversations des sages-femmes et des femmes enceintes au sujet des interventions en médecine traditionnelle, douce et alternative pour assister l'accouchement. Les participantes ont fait la distinction entre les méthodes « naturelles » et « médicales » et ont utilisé des sources d'information basées aussi bien sur les évidences biomédicales que sur l'expérience de femme pour justifier et remettre en question les autorités concernées.

1. Introduction

This paper analyzes interactions between information providers and users in a specific community. We use discourse analytic techniques (Potter 1996, Wetherell and Taylor 2001) to provide insight into the ways that midwives and their clients seek and provide information about alternative health care interventions.

Despite the findings that most patients would prefer to receive their health information from a doctor (Williamson 1998), physicians may ignore or dismiss complementary and alternative medicine (CAM) therapies because these are not as strictly regulated as allopathic therapies (in Canada, for example, there was very little regulation of the industry until the Natural Health Products Regulations passed in January 2004), many CAM products or practices lack empirical evidence to support beneficial claims or have shown to be ineffective in clinical trials (Dwyer 2004), and physicians may be uneducated about CAM therapies and therefore uncomfortable about discussing them with patients (Windslow and Shapiro 2002).

Furthermore, studies of patient-health practitioner communication show that patients typically do not disclose CAM use to their conventional medical providers and that clinicians do not typically ask about CAM use. In a systematic review of the literature Robinson and McGrail (2004) found that the rate of non-disclosure of CAM use to health practitioners was as high as 77% in some cases. The primary reasons for non-disclosure cited by patients were concerns about a negative response, the belief that the practitioner did not need to know about CAM use, and that the practitioner did not ask. However, other studies have shown that when patients view their practitioner as using participatory styles, they are more likely to divulge CAM use (Sleath *et al.* 2005).

Midwifery advocates a participatory and holistic care model that treats birth as a natural occurrence and supports women's choices. The provision of information for client decision-making is at the heart of this model (College of Midwives of Ontario 1994). One might therefore anticipate midwives to be more open to raising CAM as an issue and providing information about CAM interventions than physicians.

Midwifery is licensed and government-funded in the province of Ontario, and the profession is therefore both discursively placed within medical and "natural" narratives (Foley and Faircloth 2003), and organizationally placed in collaboration with (and sometimes in conflict with) the profession of obstetrics. This makes the midwife-client setting an ideal one for analyzing the ways in which CAM interventions are framed and the kinds of information provided about them.

Burkell and McKenzie (2005) analyzed midwives' provision of information about a diagnostic test considered part of standard obstetrical practice. This paper builds on that research to analyze the ways that options not considered mainstream obstetrical practice are taken up by midwives and clients. Data come from transcripts of audiorecorded clinic visits between midwives and clients. From these transcripts we have selected midwives' and clients' discussions of interventions in response to a specific issue: encouraging the initiation of labour at the end of a pregnancy.

We analyze the discussion of the interventions proposed, both those that fall within standard obstetrical practice and those that do not, including both recognized CAM interventions, for example, herbal and homeopathic remedies, and discussions of changes in lifestyle or everyday habits, such as modifications to food and activity. We consider the ways that such alternatives are introduced and by whom, the ways that interventions are framed, and the kinds of information provided about them. We consider the use of positive and negative language, the degree to which potential interventions are presented as options and alternatives are presented, the kinds of justification provided, and the information sources called on in creating the explanation (e.g., McKenzie 2003).

This work will contribute both to the literature on clinician-client communication and to the literature on the collective construction of information needs, seeking, and use within specific discourse communities.

2. Methods

This paper is based on an ongoing study of information practices associated with midwife-client visits in Ontario. The study has been funded by The University of Western Ontario and the Social Science and Humanities Research Council of Canada, and data collection and analysis conform to both organizations' ethical guidelines on research on human subjects. All participants are identified by pseudonyms.

Data for the larger study include transcripts of audio-recordings of 40 midwife-client clinic visits from 15 midwifery practices in southern Ontario communities ranging from the city of Toronto, with a community population of over 2 million and access to a number of tertiary-care teaching hospitals, to towns and rural areas with fewer than 50

000 residents and a small local hospital or access to a hospital in a neighboring community only. Participating clients ranged from 14 weeks pregnant to two weeks postpartum, and midwives ranged from new registrants in their first year of practice to senior midwives with more than 20 years of experience. Several visits included midwifery students, from first-year students observing the interaction from the client's point of view to more senior students who took increasing responsibility for the visit under the supervision of a midwife preceptor. Clients' children, partners, and other support people also attended.

From these transcripts, we identified discussions of *interventions*, which we consider to be any action the client might take, or which might be taken on her behalf, outside of the routine physical examination in the clinic visit itself, that is raised by one or more participants as a potentially legitimate strategy for diagnosing a problem, relieving a symptom, or maintaining wellness. In determining whether something counted as an intervention, we therefore considered the nature of the action to be less significant than the manner in which that action was presented and responded to by participants.

Such a definition allows us to consider *interventions* in the widest possible sense and to include such activities as reading a book, joining a mothers' group to meet people in a new community, or engaging a babysitter to provide a woman some childcare relief. For the present analysis we have eliminated routine obstetrical tests and interventions from our consideration (these were considered in Burkell and McKenzie 2005) so that we could focus on those interventions that are not represented in the standards of practice of the Society of Obstetricians and Gynaecologists of Canada.

We identified interventions of this type in 37 of the 40 transcripts, in response to routine physical concerns (e.g., indigestion, swelling, fatigue or physical discomfort in pregnancy or postpartum, pain management in labour, infant colic, breastfeeding), psychosocial issues (loneliness, relationship concerns, physical and emotional support for infant care), and more serious clinical issues (for example the management of a fetus presenting in a non-standard position). For this paper, we opted to focus on discussions of interventions related to a single concern, the encouragement of labour as the woman reaches the end of the pregnancy. We chose this concern because it was discussed by a large enough set of midwives and clients (9 of the 37 mentioning interventions) to provide us with a sufficient data set, and also because the issue of encouraging labour highlights some important discursive and structural characteristics of Ontario midwifery.

Our analysis comes out of a constructionist theoretical perspective, which emphasizes the interpersonal and interactional practices whereby participants co-construct information needs and negotiate the authority of information sources. It therefore builds on McKenzie's (2003) analysis of the ways that pregnant information seekers represent biomedical authoritative knowledge and knowledge which derives its authority through the lived experience of the information source.

3. "Getting labour started"

A woman late in pregnancy may have several reasons for hoping that she will go into labour sooner rather than later: the physical discomfort of late pregnancy, scheduling concerns such as upcoming family events or her primary midwife's on- and off-call or vacation times, or the lack of predictability associated with the spontaneous onset of

labour. In addition, however, there are significant clinical issues associated with a pregnancy that goes beyond 41 weeks gestation. Babies born “post-dates” are likely to be larger and at greater risk for surgical birth (forceps or caesarian deliveries) as well as for complications related to placental insufficiency. In such cases, artificially inducing labour “has been shown to reduce the likelihood of perinatal death” (Crane, 2001).

Midwifery practice is integrated into the Ontario health care system, and midwives work collaboratively with other health care professionals, consulting with obstetricians and negotiating a transfer of care when complications arise. In Ontario, an induction of labour -- “the artificial initiation of labour before its spontaneous onset for the purpose of delivery of the fetoplacental unit” (Crane 2001) -- is such a case, as midwife Elspeth explained to her client, Lois:

Elspeth: Um, which would mean a consult with an obstetrician and a transfer of care to the obstetrician, for that induction. And the midwife would stay in sort of a supporting role.

In addition to emphasizing this change in the midwife’s role, midwives and clients also discussed the risks associated with an obstetrical induction:

Lois (client): I would rather go into labour naturally,

Elspeth (midwife): Well of course most people would

Lois: because if they trigger it, it seems to me it’s not right,

Elspeth: Mhmm

Lois: ready for some reason.

Elspeth: Yeah, that’s right. The and, with the, having an induction of labour also has its risks as well. You know, your body isn’t ready, the baby isn’t ready. Therefore that also increases the risk of, you know, requiring interventions. Such as, you know, epidural anaesthesia, you know, uh, operative births like vacuum extractor

Lois: Mmm.

Elspeth: forcep delivery, or caesarian section’s also increased.

Lois: Mmm.

Elspeth: So you’re sort of between a rock and a hard place

Lois: [laughs]

As is the case with some clinical tests (see Burkell and McKenzie 2005), the midwife and client share a goal of avoiding undue obstetrical interventions and it is therefore in the interest of both to attempt to prevent a pregnancy from going post-dates:

Iona (midwife): I think with all of that, you know, our goal would be to increase the chances of having a vaginal birth. Or, increase the chances of avoiding induction, increase the chances of having the baby at home. All the, you know, trying to avoid interventions.

This goal may be difficult to achieve, however; as Elspeth notes, little is known about the mechanisms by which labour is triggered at term:

Lois: What triggers you to, is it my body or the baby that triggers--

Elsbeth: The baby triggers labour.

Lois: Okay

Elsbeth: And they have not identified, they've been doing lots of research over many, many many years and have not been able to identify exactly what it is that does that.

Lois: Hmm.

Elsbeth: If they had been able to identify that someone, some drug company would be making a fortune

Lois: [laughs]

Clark (Lois's partner): Yeah, right.

Elsbeth: Because that's what, you know they seem, I mean people have been trying to control this for years, especially with things like inductions and things like that.

Both midwives and obstetricians have interventions at their disposal to try to influence the pregnant woman's cervix to soften and efface in preparation for labour ("ripening"), and for the induction of labour itself. Although we framed the introduction to this paper in the binary terms of CAM and allopathic medicine, there is in fact a considerable amount of overlap between the interventions proposed by midwives and clients and those addressed in systematic reviews and clinical practice guidelines such as those produced by the Society of Obstetricians and Gynaecologists of Canada (SOGC) and the Cochrane Collaboration. Figure 1 illustrates this overlap:

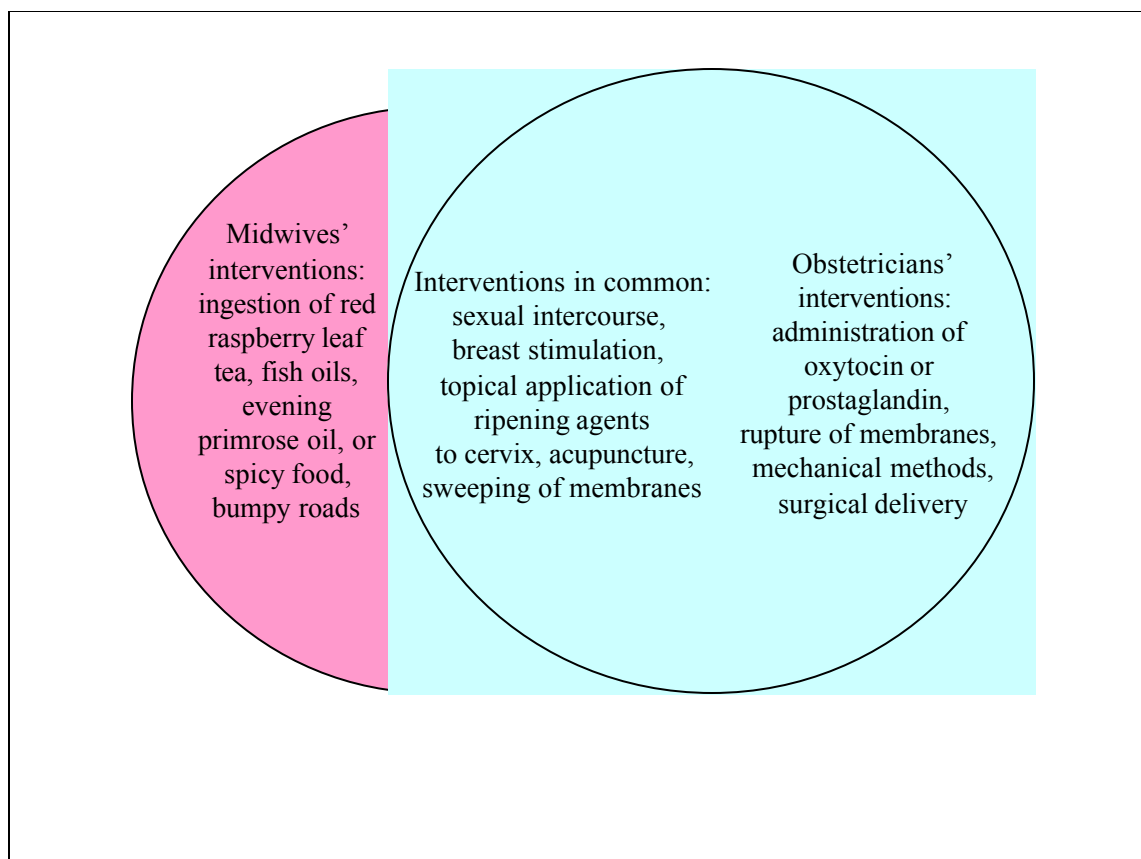


Figure 1: Overlap between midwives' and obstetricians' interventions

The SOGC practice guideline on induction of labour at term (Crane 2001, 2-3) reviews

several methods for cervical ripening and the induction of labour, including mechanical methods which apply pressure to initiate cervical dilation, manual sweeping of the membranes (“stretch and sweep”), and the intravenous or topical administration of hormones (oxytocin and prostaglandin). In addition to these methods, a search of the Cumulative Index of Nursing and Allied Health Literature revealed Cochrane and other systematic reviews on sexual intercourse, breast stimulation, and acupuncture for cervical ripening and induction.

Nine clients and their midwives discussed interventions related to triggering labour. These included stretch and sweep, traditional Chinese remedies such as acupuncture, acupressure/reflexology, and moxibustion, lifestyle interventions such as sexual intercourse, eating spicy foods, physical activity, homeopathic regimens, and herbal remedies such as red raspberry leaf tea (a uterine tonic) and fish oil or evening primrose oil.

The remainder of this paper analyzes those discussions, noting the manner in which interventions are introduced, the range of interventions presented as options and the claims made for each, and the information sources used to justify the various alternatives.

4. Findings: Framing interventions

Interventions for the stimulation of labour were raised in several different ways: in response to a client’s request for such information

Wendy (client): If I get close to my due date, can you give me something to help me, get this, baby out? [laughs]

Ellen [midwife]: [laughs]

Wendy: I don’t want to go over.

Ellen: Yeah. There’s a few, there’s a bunch of natural things

Wendy: Yeah

Ellen: you can do.

Wendy: So you’ll help me out with that if I, get to that point?

Ellen: Yeah.

or description of a problem or symptom,

Molly (client): And, I feel like [the birth]’s imminent. Not that I know, what that [laughs] feels like but. Uh, I feel like things are changing.

Dolores (midwife): And we can give you a handout today actually about how to get the labour started.

as part of what might be expected to be discussed at this time in pregnancy or arising from discussion of a related procedure, for example the offer of a vaginal exam often prompted discussion of a stretch and sweep:

Sonia (midwife): I can do a vaginal exam today if you want [...] I can actually try to do a bit of a stretch and sweep, so basically, ((inaudible)) your cervix a bit, put my finger inside, and try to sweep the area, sweep

between the cervix and the membrane, so basically 'cause they're both moist they just sit against each other, like they're not attached.

Celeste (client): Ok.

Sonia: The theory is it releases local prostaglandins and, makes, research shows women who have stretch and sweeps repeatedly are more likely to go into labour sooner than women who don't have them done at all.

A common strategy was to discuss several potential interventions at once, as a menu of alternatives. Renée was hoping to avoid a second caesarian section and contributed to the list of options with suggestions of her own:

Iona (midwife): So um, but evening primrose oil is certainly helpful. And then um, stretches and sweeps if the cervix is open and we aren't just kind of getting labour going. These are all sort of gentle induction methods that are done near the clinic or home but we can talk about it later. But I think that's important to realize that I don't think we should just kind of let you stay pregnant and just be expectant about it, I think we should be pro-active. That's my opinion. You may disagree with it.

Renée: No, I think it's a great idea.

Iona: Yeah.

Renée: And I've heard good things about acupuncture

Iona: Yeah, exactly.

Renée: Even moxibustion

Iona: Yeah, moxibustion's the best too. "I'll try that."

Renée: Yeah.

Iona: Yeah.

Renée: I've had good results with acupuncture for other things, so I'm, I'm certainly willing to give it a try.

Iona: That would be great. Yeah. So there's, there's a lot of stuff that, that can be utilized, and that you can utilize later on.

Renée: Mhmm.

Iona: To be proactive about it.

The handout (McKenzie 2006) provided by Dolores (see above) included alternatives in addition to those discussed:

Dolores (midwife): You can try any of those things. And they're natural things. They just, have, you know give you that little bit of pressure to go in

Molly (client): Mhmm

Dolores: It's like, hot meals, having intercourse, long walks, being active, those things and some, homeopathy or natural remedies in there?

Molly: Right

Dolores: That you can read and see if you feel comfortable, you can go ahead and do them from next week.

Molly: Okay

However midwifery interventions were introduced, in all but one case they were framed by midwives and clients alike using words that minimized the impact of the intervention: "natural," "gentle," "nudge," "get labour started/going." This

minimization is most evident when descriptions of “natural” interventions are compared with descriptions of obstetrical interventions. The latter were collectively constructed as the beginning of a slippery slope likely to lead to further and more invasive interventions and potentially to a different role for the midwife at an induction or a surgical birth. Even the anomalous case, an intervention for which the midwives acknowledged and cautioned against fairly significant negative side effects, was presented as preferable to the obstetrical intervention it was designed to preclude [the symbol // indicates two or more participants speaking at once]:

Joe (Molly’s partner): Castor oil!
Dolores (midwife/preceptor): [laughs]
Joe: My favourite!
Dolores: [laughs] My fav// ourite! //
// Sharon (midwifery student): We use it as a last resort //
Joe: Myyy favourite. [laughs]
Sharon: Uh, we do provide uh, you know, some, qualifiers with that in there, letting us know, for instance before, before you, you take the castor oil
Molly (client): [laughs]
Sharon: Uh, knowing that it does often cause some, you know, pretty serious diarrhea or will cause //sometimes //
// Molly: cramping //
// Sharon: vomiting for women //
// Joe: Oh yeah. //
Sharon: Uh, so there’s, the recipe in there but I think we’d probably like to get a heads-up before somebody, // takes castor oil. //
// Dolores: And honestly this is the last resort //
Sharon: Yeah
Dolores: Like if you’re planning for an induction in the hospital
Molly: Mhmm.
Dolores: tomorrow?

Although midwives were generally the ones to initiate the description of a procedure as “natural,” it is important to note that none of the participants challenged this construction. This is particularly significant when we recall that the designation of “natural” may equally apply to those interventions addressed in the SOGC practice guidelines (the stretch and sweep and the topical application of a ripening agent to the cervix) when these are performed by a midwife or a client.

Evening primrose oil is introduced as a natural dietary supplement (“not a drug”) that facilitates the body’s production of the hormone prostaglandin:

Bianca (midwife/preceptor): Would you be able to take three times two evening primrose oil, just to increase your essential fatty acids?
Shelley (client): Mhmm.
Bianca: And that’s not a drug basically it’s an oil which would help your body to produce more prostaglandin. And that would be a better chance that your cervix is changing.

Shelley: And startinnng-- Now? Or closer
Bianca: You can start that now. That's not gonna
Nikki (midwifery student): That's just like a dietary, if you're not getting it from eating fish you can get it from eating these supplements. It's just one of the components that makes up prostaglandin, the natural prostaglandin. So if you have it on board when it's ready to be made the materials are there to make it.
Bianca: And it's available without prescription.
Shelley: Okay.
Bianca: Three times two.

However, the physical procedure of applying evening primrose oil to the cervix is very similar to the topical application of prostaglandin gel to the cervix, an intervention administered by obstetricians and addressed in the SOGC guidelines:

Ellen (midwife): [laughs] But what you can do now is that you could start evening primrose oil? Have you heard of that?
Wendy (client): I've heard of primrose oil, you get it in the drugstore, right?
Ellen: Yeah. And it's in gel caps?
Wendy: Okay
Ellen: in gel, capsules. And what you do, there are two hundred, and fifty milligrams I think [pages turning]. So what you do is you take one with each meal
Wendy: Okay
Ellen: Breakfast, lunch, and dinner. And then at bedtime, you just break it open a little bit and insert it into your vagina.
Wendy: Oh. Just with your finger kind of thing?
Ellen: Mhmm. And so what the evening primrose oil does is it softens your cervix?
Wendy: Okay
Ellen: And gets it ready for contractions. So that, when you start to have contractions it's easier for your body to dilate and (()) the cervix
Wendy: Okay
Ellen: So, take one orally with each meal... (())... [banging] (()) vaginally. And the other thing you can do is, have intercourse.
//Wendy (client): Right //
// Ellen: Which // usually is not everybody's favourite thing to do at this point in the pregnancy, um, and if, but if you were going to have intercourse, put the gel cap in, to your vagina before you have intercourse?
Wendy: Okay
Ellen: Because then for sure it's gonna get massaged right onto the cervix?
Wendy: Okay
Ellen: And that's the best thing to do.
Wendy: Okay.

This exchange illustrates the three seemingly small but significant discursive distinctions midwives and clients make between the two types of interventions. In addition to being

constructed as gentle and natural and designed to prevent a more invasive or technological procedure, the interventions administered by midwives and clients were presented by both types of participants as freely chosen by the client and possibly administered by her in a setting of her choice. This joint construction is consistent with other researchers' findings about the reasons why patients choose CAM: they are dissatisfied with conventional treatments because they are ineffective, produce adverse effects, or are impersonal or too technologically oriented; they seek greater "personal control" or "empowerment" over their health-care decisions or wish to leave no option untried; and alternative medicine is more compatible with patients' worldviews, values, or spiritual/religious philosophies, or it is perceived as more "natural" than allopathic medicine (Astin 1998).

5. Justifying interventions

Midwifery interventions for "getting labour started" occupy a discursive place that challenges a fixed distinction between allopathic and CAM therapies, and midwives likewise referred to a diverse set of information sources to strengthen or justify their claims. McKenzie (2003) found that pregnant women used a combination of biomedical authoritative knowledge and the authority derived from their own and others' lived experience to accept or contest information received from others. In choosing information sources to bolster claims about the effectiveness of an intervention, participants likewise called on midwifery's respect for women's experience and wisdom as well as its position with regard to biomedicine. Midwives used both forms of knowledge when presenting themselves as authoritative information sources.

As Sonia did in describing the stretch and sweep, above, midwives used biomedical research evidence to explain or justify an intervention. In addition to referring directly to research evidence, midwives supported their claims and explanations with unspecified references to "reading":

Iona (midwife): that is something we usually recommend at thirty-seven weeks just because, I mean, what I've read it is safe throughout pregnancy too.

In this example, Iona's use of the words "we" and "usually" additionally situates her discursively within a larger midwifery community. Midwives and clients alike alluded to unspecified sources to support claims, as Renée did ("And I've heard good things about acupuncture," above):

Sabina (midwife): And you know what? If, if a stretch and sweep works you were gonna do it in the next couple of days anyway. If you were meant to have your baby a week and a half from now,

Leah (client): And very obviously it, didn't

Sabina: Exactly.

Leah: It wasn't ready last week so.

Sabina: *We* think it sort of can make a twenty-four hour difference but not more.

Leah: I know.

Ellen called on the broader midwifery community more explicitly by referring to a specific midwife, a longtime and oft-published childbirth advocate:

Ellen (midwife): There's um, a midwife out there, I don't know if you've heard of her, Ina May Gaskin? She is like, *the* midwife in the midwifery world? And um, she's always, she's known for saying "It took lovin' to get that baby in there, it's gonna take lovin' to get it out."

// Wendy: Yeah. That was part of the [prenatal class]. //

// Peter (Wendy's partner): Yeah, that's what we heard // in our course.

Wendy: In our course [the instructor, a midwife from another practice] said "The way you get it in is the way you get it out." So.

Ellen: Yeahhh,

Wendy: Okay

Ellen: exactly.

Peter and Wendy's reference to their prenatal instructor, a midwife from another practice, builds a body of evidence (McKenzie 2003) by corroborating Ellen's claim with evidence from an independent source.

Ellen's support of the other midwife above does not necessarily indicate that she considers that midwife a cognitive authority on getting labour started (McKenzie 2003). Later in the visit, Ellen used evidence from clinical research, or in fact the *lack* of disconfirming evidence from clinical research, to discount that same midwife's claim:

Ellen (midwife): [paper rustling]. And you did your, your classes with [midwife from another practice], right?

Wendy (client): Yeah.

Ellen: Well you know what [other midwife] doesn't, recommend using [red raspberry leaf tea] for ((inaudible)).

Wendy: Oh she doesn't?

Ellen: She, says that it increases bleeding after the birth?

Wendy: Oh.

Ellen: But I have looked and looked and looked for research

Wendy: ((inaudible))

Ellen: and I can't find it anywhere so.

Wendy: Oh okay

Ellen: There's no research for that either. So [laughs, C laughs] So red raspberry leaf tea is um, is best if, the fresher it is, the better it is.

Midwives' own authority may also be demonstrated through their experience with multiple clients over a long period of time:

Dolores (midwife): And one of the things, is a stretch and sweep that Sharon mentioned?

Molly (client): Yeah

Dolores: Most of the time that really helps.

Molly: Does it? Okay.

This short excerpt is interesting because Dolores' "most of the time" frames her expertise around her experience. First, her claim suggests that she has performed this

intervention enough times to be able to speak with authority about the experience of many women. The account therefore serves to position her as an experienced professional. Additionally, however, her claim is based on the implied experience of many unnamed women, and therefore refers indirectly to women's knowledge or wisdom over time.

As research evidence was not always available for the procedures discussed by the midwives, women's wisdom – both that of the experienced midwife and that of millennia of birthing women, including the present client – was an important source for supporting the authority of claims. Ellen countered a lack of research for an intervention in two ways, by pointing out that there is neither any research demonstrating it to be ineffective or harmful, and by calling on the client to use her own wisdom (“logically it makes sense”) to evaluate the intervention:

Ellen (midwife): The research that's been done, does not provide evidence that this works.

Wendy (client): Okay.

Ellen: But. It doesn't say it doesn't work either.

Wendy: Okay.

Ellen: So.

Wendy: And it doesn't do any harm.

Ellen: Doesn't do any harm and. Logically it makes sense that it would work?

Wendy: Okay

Ellen: But there's been no research to prove it.

Raven uses a variety of information sources to create a complex justification:

Raven (midwife): [Red raspberry leaf tea] falls in that category of things that have kind of, always been used?

Marisa (client): Yeah

Raven: But because of uh, because drug companies don't make it?

Marisa: Right

Raven: There hasn't been a lot of so there's no research [laughs] done on it,

Marisa: Right

Raven: There hasn't been randomized controlled trials on

Marisa: Yeah

Raven: the effects of red raspberry leaf tea on pain. But by all accounts that we know so far? It seems to be [effective] and it doesn't seem to have any side effects.

First, she highlights the authority of women's wisdom by emphasizing the long history of the intervention, and places red raspberry leaf tea in a category with unspecified other “things that have always been used.” Simultaneously, however, she undermines the credibility of randomized controlled trials by suggesting an inappropriate conflict of interest between those conducting clinical trials and drug companies (“interest management,” Potter 1996).

This discounting makes it discursively straightforward to dismiss the lack of research as

insignificant; the unstated implication is that research itself might be untrustworthy. Again, however, Raven uses contrast, this time to present independent evidence of the effectiveness of the intervention: “by all accounts that we know so far.” Like Iona, she uses an unspecified “we” and the phrase “it seems” to suggest a larger community of expertise. The final component of her justification is the evidence that the intervention does not seem to have side effects. All of these information sources are woven into claims and counterclaims that together create a convincing case for the intervention.

Because midwives are both discursively and organizationally located at the intersection between biomedical authority and women’s embodied wisdom, both of these discourses are present in the information they provide about interventions and in the information sources on which they draw in justifying their recommendations. As with pregnant women in another study (McKenzie 2003), midwives and clients together constructed flexible justifications for the authority of a wide variety of information sources.

6. Conclusion

In discussing options for encouraging the onset of labour, midwives and clients both make the distinction between “natural” methods and “medical” procedures. Accepting midwifery interventions as “natural” means that participants draw on various forms of evidence as authoritative. Midwives and clients do refer to the authority of the randomized controlled trials preferred by allopathic medicine. However, they also turn to sources such as women’s wisdom that reflect midwifery’s feminist orientation, particularly in cases when a claim for an intervention includes evidence that it can do no harm.

Discussions about getting labour started can therefore be seen as discussions about the boundaries of midwifery and obstetrical care. Presenting midwifery interventions as “natural” stakes territory for midwives based on women’s wisdom and a respect for birth as a natural process. This construction makes it possible for midwives and clients both to dismiss the randomized controlled trial as the gold standard and to rely instead on the individual and collective authority of women (midwives and clients both) when justifying claims. However, midwifery also operates in the biomedical world and, where research evidence was available, it was referred to and was largely given precedence.

This, of course, is only one intervention of the many discussed by midwives and clients in the transcripts we analyzed. Other interventions are likely to be presented and justified in different ways, and participants may use different kinds of information sources as evidence for their claims. A fuller analysis of the ways that midwives and clients provide information to introduce and frame interventions and call on information sources to lend authority to an argument will provide further insight into the complex discursive ground midwives and their clients must cover in negotiating care as regulated health professionals.

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