The interactional organisation of talk in naturopathic interviews

Candidato
Dott. ssa Letizia Cirillo

Coordinatore del Dottorato
Prof. ssa Gabriella Di Martino

Relatore
Prof. Christopher Guy Aston

Correlatore
Prof. Peter Gordon Mead

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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Table of contents</td>
<td>ii</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>vi</td>
</tr>
<tr>
<td><strong>INTRODUCTION</strong></td>
<td></td>
</tr>
<tr>
<td><strong>THE STUDY OF DOCTOR-PATIENT INTERACTION: FROM THEORETICAL ACCOUNTS AND FACTOR ANALYSES TO THE EXAMINATION OF NATURALLY-OCCURRING TALK</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>1.2 A necessary asymmetry: the Parsonian model and its modifications</td>
<td>5</td>
</tr>
<tr>
<td>1.3 Factor analyses and information exchange: control, compliance, satisfaction</td>
<td>8</td>
</tr>
<tr>
<td>1.4. A change in perspective: philosophy and method</td>
<td>12</td>
</tr>
<tr>
<td>1.4.1 Preventive medicine and shared responsibility: the “two-way swap”</td>
<td>12</td>
</tr>
<tr>
<td>1.4.2 Focus on naturally-occurring talk</td>
<td>14</td>
</tr>
<tr>
<td><strong>DOCTOR-PATIENT INTERACTION AND DISCOURSE ANALYSIS</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Introduction</td>
<td>18</td>
</tr>
<tr>
<td>2.2 Labov and Fanshel: speech situations, speech events, speech acts</td>
<td>19</td>
</tr>
<tr>
<td>2.3 Miscommunication at work: contextualization and frames</td>
<td>22</td>
</tr>
<tr>
<td>2.4 Miscommunication at work: the role of discourse structure</td>
<td>24</td>
</tr>
<tr>
<td>2.5 Micro-political and macro-political aspects of doctor-patient interaction</td>
<td>26</td>
</tr>
<tr>
<td>2.5.1 The suppressed topic</td>
<td>27</td>
</tr>
<tr>
<td>2.5.2 The voice of medicine vs. the voice of the lifeworld</td>
<td>27</td>
</tr>
<tr>
<td>2.5.3 Knowledge structures and language use: the interpenetration of communicative contexts in organisational settings</td>
<td>29</td>
</tr>
<tr>
<td>2.5.4 Power and resistance</td>
<td>32</td>
</tr>
<tr>
<td>2.6 Interdisciplinarity and a thick description: ethical challenges in the study of medical discourse</td>
<td>34</td>
</tr>
<tr>
<td><strong>DOCTOR-PATIENT INTERACTION AND CONVERSATION ANALYSIS</strong></td>
<td></td>
</tr>
</tbody>
</table>
3.1 Introduction

3.2 Conversation analysis: a brief overview
   3.2.1 “Notes on methodology”
   3.2.2 Some key concepts: turn-taking, conditional relevance, preference

3.3 Focus on long sequences
   3.3.1 Story-telling in conversation
      3.3.1.1 Story prefaces: local occasionedness and sequential implicativeness
      3.3.1.2 Constraints on story-tellers
      3.3.1.3 Constraints on story-recipients
      3.3.1.4 Second stories
   3.3.2 The sequential organisation of troubles-talk

3.4 Applied conversation analysis: from ordinary conversation to institutional talk

3.5 What makes institutional talk institutional? Examples from doctor-patient encounters
   3.5.1 Turn-taking in doctor-patient dialogues
      3.5.1.1 The ‘disproportionate’ tendency of doctors to interrupt patients
      3.5.1.2 The dispreference for patients’ questions
   3.5.2 The overall structural organisation of medical encounters
      3.5.2.1 The delivery and reception of diagnostic news
      3.5.2.2 The transition from problem presentation to information gathering
   3.5.3 The sequential organisation of medical interviews
      3.5.3.1 The question-answer-question cycle
      3.5.3.2 Doctors’ missing assessments after patients’ answers
      3.5.3.3 Patients’ expanded answers to doctors’ questions
   3.5.4 Turn-construction design: medical agenda and patients’ concerns
      3.5.4.1 And-prefaced and okay-prefaced questions
      3.5.4.2 The perspective display series
      3.5.4.3 Patients’ displays of uncertainty as a way to pursue a response
   3.5.5 Lexical choice in doctor-patient interviews

3.6 Doctor-patient interaction: asymmetry revisited
4 DATA AND METHOD: THE UB SAMPLE

4.1 Introduction: selecting the site 102
4.2 What is naturopathy? 102
4.3 Arranging the visit to the UB clinic 104
   4.3.1 Confidentiality 105
   4.3.2 Time 105
4.4 Observing the ‘field’ 106
4.5 Data collection and transcription 109
4.6 Approach to data analysis 111

5 THE INTERPENETRATION OF ‘VOICES’ IN NATUROPATHIC INTERVIEWS

5.1 Introduction 114
5.2 Overlapping talk and interruptive behaviours 115
   5.2.1 Collaborative overlaps 116
   5.2.2 Competitive overlaps 124
      5.2.2.1 Competitive overlaps and face-saving strategies 125
      5.2.2.2 Competitive overlaps and agenda mismatches 130
5.3 When patients ask questions 135
   5.3.1 Accomplishing a request without making one: doctors’ multi-turn responses to patients’ solicits 136
   5.3.2 Missing responses to patients’ questions 142
5.4 When patients answer more than the question: doctors’ responses to patients’ elaborations 150
   5.4.1 Patients’ expanded answers: addressing difficulties in responding, adding details, pre-empting negative inferences 151
   5.4.2 Narrative expansions in response to doctors’ questions: the case of troubles-talk 157
5.5 Summary 175

6 ‘WHY THAT NOW?’ NEGOTIATING ACTIVITIES AND ROLES IN NATUROPATHIC INTERVIEWS

6.1 Introduction 176
6.2 Structuring the interview through displays of interactional asymmetries 176
   6.2.1 Co-constructing the chief complaint: the transition from problem
presentation to history-taking 177
6.2.2 Co-constructing the chief complaint: the negotiation of topic shift 181
6.2.3 Delivering diagnostic news: the interactional value of perspective display series 189
6.3 When activities are ‘out of order’: how patients and doctors orient to the dispreferred position of their initiatives 193
6.3.1 Changing troubles-talk into problem-talk: how patients pursue their agenda of concerns ‘late’ in the interview 194
6.3.2 Responding to patients’ narratives: doctors’ second stories as a resource for ‘premature’ advice-giving 202
6.4 Summary 215

7 CONCLUSIONS
7.1 Aim of the chapter and caveats 216
7.2 Rethinking asymmetry: the interview as interactional achievement 217
7.2.1 Patients’ active participation in shaping discourse 218
7.2.2 Doctors’ displays of emotive communication as a way of doing agreement 221
7.3 Implications for practitioners and future research 223

References 226
Appendix A: transcription conventions 240
Appendix B: the UB sample 244
Appendix C: feedback questionnaires 566
Appendix D: consent forms 578
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INTRODUCTION

In the last thirty years studies of talk and interaction have become increasingly interested in specialised forms of human activities, often arising within particular organisational or institutional settings. A very productive area of investigation is the study of doctor-patient interaction, which has caught the interest of sociologists, anthropologists, psychologists, and linguists.

The natural locus of observation of doctor-patient interaction is the medical interview. This has traditionally been conceived as a rigidly structured, doctor-dominated activity with little room (if any) for patients’ initiatives. Such a view seems to be largely dependent on a methodological bias, i.e. the tendency to focus almost exclusively on doctors’ communicative practices.

Contrary to this tendency, the present study analyses patients’ initiatives throughout the interview and how these are responded to by doctors. The hypothesis suggested by the analysis is that patients actively contribute to shape the interview, the latter being an interactionally negotiated achievement in which doctors’ and patients’ agendas interpenetrate.

The data examined is a sample of interviews collected in a non-conventional setting, namely a naturopathic clinic. This choice breaks with traditional linguistic research on doctor-patient encounters, which has generally been confined within the boundaries of allopathic (‘conventional’) medicine. The approach adopted for data examination is conversation analysis, which, as we will see, consists in a fine-grained investigation of situated talk.

Chapter 1 presents an overview of early literature on doctor-patient interaction. In particular, I will consider theoretical accounts concerned with doctors’ social control over patients, and practice-oriented studies focusing on outcome variables like patient satisfaction and compliance. At the end of the chapter I will briefly introduce research based on the careful examination of naturally-occurring doctor-patient talk, and explain how this differs from previous approaches.
Chapter 2 sketches out the various panorama of discourse analytical studies on doctor-patient interaction. The most influential works will be reviewed, ranging from analyses that are based on key pragmatics notions (like speech act and frame) to more ideologically-oriented accounts dealing with the structural context in which medical encounters occur and the socio-cultural models affecting them. A few final words will be spent on the need to adopt an interdisciplinary perspective and address specific ethical challenges.

Chapter 3 focuses on the analytical approach chosen in the present dissertation, namely conversation analysis. After illustrating conversation analysis’ main tenets, I will focus on story-telling and troubles-telling sequences, which (as we will see in chapters 5 and 6) make it possible to observe patients’ initiatives, and doctors’ responses, over long stretches of talk. In so doing, I will gradually move from considering ordinary conversation to dealing with conversation in institutional settings, specifically doctor-patient talk. Finally, I will review the conversational literature in the field highlighting the features that shape the medical interview, i.e. turn-taking organisation, overall structural organisation, sequence organisation, turn design, lexical choice, and interactional asymmetries.

Chapter 4 deals with the methodological aspects of the study. It includes a sketchy description of the modalities and principles of naturopathic medicine, an outline of the arrangements characterising naturopathic visits in the setting where interviews were recorded, a detailed account of the difficulties encountered and the issues addressed during the negotiation of data collection (e.g. confidentiality), a particularised description of the sample (including recording and transcription procedures), and a final section explaining how data analysis was conducted.

Chapters 5 and 6 illustrate the communicative patterns identified in the UB sample in the light of the theoretical framework outlined in chapter 3 and the research parameters described in chapter 4. In observing how the naturopathic interview is interactionally constructed by the parties involved, I will show that doctors’ medical priorities and patients’ ‘lifeworld’ concerns interpenetrate (chapter 5) and that participants know exactly what is appropriate and at what stage of the interaction (chapter 6). Specifically, we will see how doctors speak with the voice of the
lifeworld by aligning as recipients of patients’ stories and troubles, and patients orient to the medical agenda by displaying procedural knowledge of the interview.

Chapter 7 draws on the findings presented in chapters 5 and 6 to compare and contrast them with the results obtained by past research. The observations thus made will lead us to reconsider the roles of patients and doctors within the medical interview and discuss possible implications for practitioners and for future research.
1 THE STUDY OF DOCTOR-PATIENT INTERACTION: FROM THEORETICAL ACCOUNTS AND FACTOR ANALYSES TO THE EXAMINATION OF NATURALLY-OCCURRING TALK

In the contemporary clinic, communication issues come to the fore, in light of medical uncertainties about new illnesses defying diagnosis or definitive prognosis. This leads to a shift in healthcare from diagnosis and cure towards prevention and care. (Sarangi, 2004: 2)

1.1 Introduction

Doctor-patient interaction has received considerable attention since the early 1950s. The literature in the field is huge and, as mentioned in the introduction, embraces disciplines as diverse as sociology, anthropology, psychology, and linguistics. However, as noted by Ainsworth-Vaughn (2001: 453), most studies tend to be atheoretical about language, oriented as they are toward medical praxis, or in any case failing to recognise talk as data. It is only in the 1970s, with the emergence of so-called “discourse literature” (ibid.), that communication stopped to be neglected, becoming in fact the primary focus of a number of analyses of medical encounters. In this chapter we will see how doctor-patient talk gradually came to the fore. Before that, however, I will briefly sketch an outline of the most influential studies among those that are atheoretical about language. This type of research, despite its bias toward either abstract models or medical praxis, has often been quoted in the discourse literature on doctor-patient interaction, and deserves, therefore, to be at least mentioned. I am referring here specifically to the kind of literature that is either strongly influenced by sociological theories (cf. 1.2), or based on the observation of outcome variables (cf. 1.3). Finally, in line with the main focus of the study – i.e. the
communicative practices adopted by patients and doctors – I will introduce two different perspectives, namely discourse analysis and conversation analysis (cf. 1.4), which will be dealt with at length in chapters 2 and 3 respectively.

1.2 A necessary asymmetry: the Parsonian model and its modifications

Theoretical accounts of doctor-patient relationship are largely indebted to Talcott Parsons’ (1951) work on the organisation of social systems in Western societies, where medical practice is a subsystem of the larger structure of social action. Parsons’ model centres on the idea of illness as a form of disturbance of the normal functioning of the whole social organism. This notion presupposes institutionalised roles for patients and practitioners, which are associated with a set of behavioural expectations for both. On the one hand, being sick patients cannot carry out their normal social functions and are therefore obliged to seek competent medical advice and to comply with therapeutic treatment, in order to return to health and normal social relationships. On the other hand, by virtue of special training and experience, physicians are agents capable of eliminating or minimising adverse effects of disease upon individuals and society, and are therefore legally responsible for restoring patients to a non-pathological state.

This idealised picture of doctors’ and patients’ roles and responsibilities attaches a God-like status to the former and a passive, deferential stance to the latter, giving an essentially asymmetric character to the relationship between them. According to Wolinsky (1980),¹ this asymmetry has three major sources, which could be summarised as inequality of health condition (sick vs. healthy), knowledge (ignorant vs. knowledgeable), and professional prestige (lay vs. expert). To be more precise, patients are in a position of situational dependency, in that they need help, which they cannot provide for themselves. At the same time, doctors are in a position of situational authority, in that they are the only ones qualified to provide such help, i.e. they possess the knowledge and skills to treat patients. Finally, owing to these

qualifications, practitioners are assigned the special social status of “licensed healers” (West, 1984b: 18), which allows them to dominate interpersonal encounters.

Parsons sees practitioners’ power over patients as crucial to the success of medical practice: only physicians’ control of the interaction can guarantee patients’ compliance with the prescribed medical regime. This view is shared by M.S. Davis (1968), who also equates interactional dominance over patients with the ability to treat them, affirming that passive patients are more likely to follow medical advice, whereas more active patients tend to be noncompliant. Such a claim, although lacking adequate empirical validation, is implicit in a number of accounts of physician-patient relationships, which have tended to reduce doctor-patient interaction to a well-rehearsed confrontation, where participants are no more than actors playing their parts from a script of pre-established expectations and behaviours (see for instance Wilson, 1970).

To sum up, Parsons’ model and its subsequent applications emphasise the idea of illness as social deviance, and the role of practitioners as maintainers of normal social functioning, who deal with objective problems in an objective, scientific manner. In other words, medical knowledge and practice as conceived by Parsons are disease-centred, collectively oriented and morally neutral.

The rigidity of this framework has been criticised by Freidson (1970a, 1970b, 1975), who calls for physicians’ particularistic (rather than universalistic) orientation to professional action. Specifically, he maintains that medical sociology should address itself to the varied circumstances of medical practice (instead of enumerating the required or desirable characteristics of the clinician), and that, in order to fully understand doctor-patient relationship, attention should be paid to lay conceptions of illness (rather than taking into account just practitioners’ definitions of it). This new approach has informed a number of empirical studies that have focused on the clash of perspectives between doctor and patient, and, drawing on examples from language use, have claimed that meanings such as health and illness derive from the interaction

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between healthcare providers and consumers (for an overview of these studies, see Anderson & Helm, 1979).³

As pointed out by West (1984b: 21), these studies, despite their interest in the social production of meanings in medical contexts, have only considered talk as a resource for sociological investigations rather than as an object of analysis in itself. Similarly, Silverman (1987: 19-20) notes that, despite the necessity to understand the context of talk as provided by a particular institutional setting, talk cannot be reduced to a mere product of setting-specific factors. The need to base research on actual clinic talk will be dealt with in greater detail in 1.4.2. Before returning to this point, however, I would like to spend a few lines to describe further sociological research that has been influential to the study of doctor-patient interaction, but which presents some notable differences from the works illustrated so far.

1.3 Factor analyses and information exchange: control, compliance, satisfaction

As mentioned in 1.1, a very productive area in the study of doctor-patient interaction is research oriented toward medical practice. Within this a prominent role is played by what West and Frankel (1991: 174) have called “factor analyses”, a substantial body of research, which in the course of the 1960s and 1970s concentrated on the relationship between consultation processes and outcomes. These studies are not relevant just for “praxis literature” (Ainsworth-Vaughn, 2001: 453; cf. 1.1) but also for a significant portion of discourse literature in the medical field, which has borrowed from them some key notions and terminology like ‘satisfaction’ and ‘compliance’, as well as the subdivision of the medical interview into different stages (see below).⁴

Overall, factor analyses view doctor-patient encounters in terms of physician control, patient compliance, and patient satisfaction, and address such issues in the light of the information exchange taking place during the medical encounter.

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⁴ Unfortunately, it is not uncommon to hear terms like ‘satisfaction’ and ‘compliance’ being employed as empty buzzwords. On the other hand, these have also been revisited and assigned new meanings by some analysts (cf. 1.4.1, note 10).
Questionnaires and interviews were largely employed to gather doctors’ and patients’ opinions on this exchange, which has often been shown as disappointing to both parties. Korsch and Negrete (1972) argued that what makes doctor-patient communication poor, and causes patient dissatisfaction with the medical encounter, is a lack of personal rapport or empathy on the part of the doctor, the failure to take into account the patient’s concerns and expectations, the lack of clear explanations concerning the cause of illness, and the use of medical jargon. Unlike M.S. Davis (1968; cf. 1.2), Korsch and Negrete found that the practitioner’s friendliness contributed positively to patient satisfaction, and that patients who participated more actively in the consultations, as opposed to uncritical patients waiting to be helped, were more likely to comply with medical recommendations.

Some of the concerns expressed by Korsch and Negrete are echoed in subsequent research, which has variously reported on communication breakdowns, and misunderstandings. For instance, the issue of medical jargon as a barrier to smooth communication has attracted significant attention. According to Foucault (1973), the development of hospital-based medicine, together with increasing specialisation and technological advances, has contributed to the creation of a new clinical discourse that is inaccessible to the patient. As to the clarity of information about illness, Waitzkin and his associates (Waitzkin & Stoeckle, 1972, 1976; Waitzkin & Waterman, 1974; Waitzkin et al., 1978)\(^5\) suggest that the more the patient is informed by the clinician about her/his illness, the more s/he tends to follow medical advice. For this reason, one major task of practitioners is to decide how much information should be given depending on the patient’s disease, life conditions, beliefs, and so on. In this respect, Waitzkin et al.’s approach seems to perpetuate the asymmetric model proposed by previous investigators (cf. 1.2). In fact, the physician’s control over the informative process is a way to exercise professional dominance over decision-making, thus sustaining an unequal relationship with the patient.

However, doctor-patient encounters involve much more than just diagnosis and treatment of physical disease and are not exclusively concerned with the transmission of information. This idea, which was pioneered by Balint (1964), is at the heart of

what came to be known as ‘biopsychological model’, as opposed to the then prevailing ‘biomedical model’ (cf. Engel, 1977), and paved the way to what we would now call ‘patient-centred’ medicine. To be more precise, Balint maintains that patients approach doctors for reasons that are not entirely physical, but embrace as well their emotional and social existence. Consequently, physicians (especially general practitioners) should reconsider their relationship with patients in the light of the latters’ ever-changing psychology, and base their diagnoses as much on biographical as on pathological studies. This approach is also supported by Byrne and Long (1976), who seem to advocate the acquisition of psychotherapeutic-like skills on the part of clinicians. In their review of over 1800 British general practice consultations, Byrne and Long discovered that doctor-patient exchanges lasted on average only eight minutes, during which the physician was supposed to establish rapport with the patient, find out the reason for the visit by interviewing the patient and performing a physical examination on her/him, formulate a diagnosis, set up a treatment plan, and terminate the exchange. Byrne and Long pay special attention to question-answer sequences, showing how patient behaviour rarely appears to be causative as “all of the patient’s replies to questions have been absorbed by the doctor who has never used any of the information given to develop further responses” (ibid.: 11-12). On the whole, British GPs were criticised for sticking to rigid agendas, thus neither properly listening to patients’ stories nor openly discussing treatment options with them. Contrary to this practice, Byrne and Long’s position encourages clinicians to give patients more “room to speak” (Roberts et al., 2003), treating them as whole persons and listening to their own accounts and worries instead of just looking at symptoms.

The relevance of Byrne and Long’s study for subsequent research on doctor-patient interaction is largely dependent on the introduction of a phase model to divide the medical interview into separate stages. These are: (1) relating to the patient; (2) discovering the reason for attendance; (3) conducting a verbal or physical examination or both; (4) consideration of the patient’s condition; (5) detailing treatment or further investigation; and (6) terminating. Ever since it was first conceived, this model (or slight modifications thereof) has been employed by all
analysts investigating medical interviews (cf. 3.5). According to ten Have (1989: 199; 179), the “anchor point” of this format is stage (2), which he has referred to as “complaint”. This is voiced by the patient either during the ongoing interview or on earlier occasions, and serves as a request for a service, thus making the ordinarily ensuing questioning by the doctor relevant. As we will see in the next few chapters, such an anchor point also accounts for the widespread use of narratives throughout the interview in the form of either ‘story-telling’ or ‘troubles-telling’ (cf. 3.3.1; 3.3.2; 5.4.2; 6.3.2).

Taken together, the studies mentioned in this section may lead to conclude that there are clear-cut devices to make physician-patient communication straightforward: a) the elimination of medical jargon (see for instance Foucault, 1973; Waitzkin and his co-workers, 1972, 1974, 1976); b) the cultivation of sociable conversation (cf. Korsch & Negrete, 1972); and c) the lengthening of consultations (cf. Byrne & Long, 1976). The tendency to produce ‘how-to’ manuals to solve problems of communication between practitioners and their patients characterises a number of popular magazines as well as medical journals and textbooks. The former give tips to potential patients on how to provide doctors with the information they need to make diagnoses, how to ask them questions, and how to get doctors’ instructions right. The latter present methods for ensuring that patients express their complaints, obtain the information and reassurance they seek, and understand the clinician’s recommendations (for further details on these aspects, see West, 1984b: 2-5). The result is a simplistic model, where patients are described as ‘good’ or ‘bad’ historians, their interactive styles are grouped into stereotypical, or even judgmental, categories (e.g. ‘orderly and controlled’, ‘guarded and paranoid’, ‘dramatic’, etc.), and doctors are given cookbook-like advice on how to improve their interviewing skills adapting them to each of the categories identified (see for instance Coulehan & Block, 2001: 196ff.).

Unfortunately, no recipe is as yet available and even the three clear-cut suggestions listed above present some problems. For instance, eliminating medical jargon could be seen as underestimating patients, who now tend to be more and more informed and may have learned technical terminology from sources like the press, TV
or the Internet. In addition, sociable conversation and a friendly attitude are no guarantee that the patient will not withdraw crucial information or mention important details only at the end of the interview (the so-called ‘oh-by-the-way’ or ‘hand on the doorknob phenomenon’; cf. Coulehan & Block, 2001: 44). Finally, longer sessions alone do not necessarily solve interactional problems and certainly do not satisfy many practitioners, for whom time is a precious resource. All of these critical comments are well-founded and underscore some of the major shortcomings of the studies presented thus far. In the following section I will move to a more systematic consideration of these shortcomings from a perspective that is more relevant to my study.

1.4 A change in perspective: philosophy and method

The works reviewed in the preceding sections, be they theoretical accounts or empirical studies, have attracted two major criticisms, one related to the philosophy of doctor-patient interaction on which they are based, and the other concerning some crucial methodological issues. In 1.4.1 and 1.4.2 I will try to clarify some of the critical remarks presented by different authors with respect to these two main standpoints.

1.4.1 Preventive medicine and shared responsibility: the “two-way swap”

In the foregoing, we have observed the emergence of a growing interest for the subjective aspects of health and illness (e.g. patients’ life conditions, beliefs, feelings, etc.). According to Armstrong (1984), such an interest started to be significant once mental and psychosomatic disorders were discovered and epidemiology became established, i.e. when doctors had to acknowledge the importance of emotions on health conditions, and the influence of social factors and family life on morbidity. However, the fact that patients are incited to speak does not automatically mean that they gain assertiveness and are assigned an active role. Indeed, as suggested by

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6 In fact, doctors are faced with a dilemma, especially in these times, when the need to clearly inform patients is all the more urgent, as any omission or unclear segment of information could lead to a malpractice charge.
Foucault (1979), power works as much through encouraging speech as repressing it. Ultimately, even ‘patient-oriented’ studies based on new forms of knowledge have generally continued to privilege a model where doctors are agents and patients are recipients of doctors’ actions and decisions. In this model the patient’s view is at best seen as a “measure of medical effectiveness” (Armstrong, 1984: 741). It is only when the focus shifted to patients as experiencing subjects that their views started to be seen as an issue in its own right and mutual participation became central to doctor-patient relationship.

This turn corresponded to an increasing emphasis on prevention, which has radically changed the delivery of healthcare (see for instance von Raffler-Engel, 1990b: xxxii-xxxv). Crucially, preventive medicine is considered to depend largely on the power of the word, and the information exchange between doctors and patients is envisaged as a “two-way swap” (West, 1993 [1983]: 128). To put it simply, in order to give medical advice, doctors have to gather as much information as possible from patients, who clearly possess experiential knowledge, i.e. they have privileged access to a whole range of details concerning their own habits, needs, problems, etc. By the same token, doctors, who possess professional knowledge, should use the information at their disposal to educate patients to the principles of a healthy life.

These tenets fit into the rationale of naturopathic medicine, as illustrated in 4.2, which also puts forward a teacher-student relationship between doctor and patient. Contrary to the traditional picture of a “not-to-be-questioned” (West, 1984b: 151)

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8 In a recent paper, Christopher Candlin (2004) has advocated the shift from a model based on compliance to one based on “concordance”. Candlin heavily criticises the compliance model, with its focus on command and obedience, for being paternalistic. Moreover, he associates such a model with low rates of adherence to treatment and a fair amount of inconsistency, wastage of resources, and failure to educate patients in informed choice. Conversely, the concordance model, he argues, is characterised by agreement and collaborative decision-making, thus showing a co-constructive nature. The change from one model to the other cannot be abrupt, but has to go through so-called “adherence”, i.e. basically an intermediate stage marked by negotiating processes. During this transition the conditions for concordance can be established. These conditions include: rethinking the nature and degree of participants’ agency, taking into account lay knowledge and patients’ perspectives (cf. Sarangi & Wilson, 2001: 3.5.2; 3.5.3; 3.5.4), the capacity and willingness on the part of clinicians to explain the significance of their actions, and the consideration of professional, social and moral issues to contract and fulfil a “therapeutic alliance”.
9 An earlier version of West’s paper (apart from the first edition of Todd & Fisher’s volume, in which it appears) is part of her 1984 collection entitled Routine Complications: Troubles in Talk between Doctors and Patients.
doctor and a dependent, helpless patient, this new approach fosters the achievement of patient education through the creation of an “environment that preserves the patient’s ‘face’ as a person with choice” (Ragan et al., 1995: 190). The attainment of this objective requires an interactive style in which the patient (not just the practitioner) offers examples and ask questions, and the doctor phrases recommendations as suggestions about preferred patient behaviour (rather than directives), presuming the patient’s ability to reason and choose. Ragan et al. (ibid.) argue that such an interactive style helps practitioners gain insight into patients’ real understanding of what has been recommended, and enable patients to improve their compliance with medical advice. More importantly, this model incorporates patients in the clinical decision-making process and makes them accountable for their own health, thus promoting shared responsibility and mutual trust (ibid.: 193, 205).

1.4.2. Focus on naturally-occurring talk
At the end of section 1.2 we have seen how early accounts of doctor-patient interaction have been criticised for not placing actual talk at the centre of their investigation. This can also be said of more empirical studies, which have failed to pay critical, detailed attention to the features of doctor-patient communication. In section 1.3 I mentioned that the mainstream tradition of research in the social and behavioural sciences, and its applications to doctor-patient interaction (e.g. M.S. Davis, 1968; Korsch & Negrete, 1972), has largely been based on questionnaires. As explained by West (1984b: 29), these may be sufficient to reconstruct practitioners’ and patients’ perceptions of their communication, but not to assess their actual behaviours. In addition, the bias towards the information exchange between doctors and patients has led many investigators to “abstract the ‘what’ and ‘how much’ of speech events from the ‘when’, ‘where’ and ‘why’ of their occurrence” (ibid.).

10 It must be clarified here that what Ragan et al. consider is the interaction between patients and nurse practitioners (NPs). However, given the tasks performed by NPs and the special ‘doctor-like’ status attached to them, the observations emerging from their study may well apply to physician-patient encounters. Nurse practitioners are registered nurses with advanced academic and clinical experience, which enable them to diagnose and manage most common and many chronic illnesses, either independently or as part of a health care team. In the United States, a nurse practitioner provides some care previously offered only by physicians and in most states has the ability to prescribe medications. (cf. http://www.nurse.org/acnp/facts/whatis.shtml; visited August, 8 2005).
This methodological criticism is taken one step further by Mishler (1984), who notes how even reports that are based on large samples of tape-recorded consultations and include excerpts (or complete texts) from medical interviews (e.g. Waitzkin & Stoeckle, 1972, 1976; Waitzkin et al., 1978; Byrne & Long, 1976) neglect transcription methods. Mishler’s (1984: 26) complaints concern two main aspects: a) transcripts which provide normalised versions of situated speech cannot adequately illustrate actual interactions; and b) no statement is made to describe what transcription procedure has been adopted and why. Hence, Mishler calls for recognition of the gap between speech and text and a focus on transcription to enable a methodical, detailed examination of recorded exchanges.

This proposal was put into practice with the emergence of discourse analytical and conversation analytical studies, which will be reviewed at length in chapter 2 and chapter 3 respectively. What is of interest to us here is to notice what distinguishes these two approaches from previous research, and what makes them different from each other. Both discourse analysis and conversation analysis (henceforth DA and CA) are based on a close inspection of naturally occurring data. When applied to the study of doctor-patient interaction, such a characteristic implies that conventional concerns for outcome variables like compliance and satisfaction are abandoned in favour of a systematic investigation of the social production of talk in situated contexts. However, there is a fundamental difference between DA and CA, in that while the former considers social roles and identities as reflected in discourse, the latter sees them as shaped by discourse itself. Thus, although both take into account the sequential nature of interaction, DA attends to speakers’ intentions and states of mind, as well as variables like gender, class and ethnic group and the related issues of authority and power, even when these are not immediately detectable in talk and text, whereas CA is concerned with the systematic organisation of talk as a topic in its own right, and only refers to social and contextual ‘material’ insofar as it is observably oriented to by the interactants. These and other features of DA and CA will be dealt with extensively in the next two chapters.
2 DOCTOR-PATIENT INTERACTION AND DISCOURSE ANALYSIS

2.1 Introduction

The following few pages are devoted to discourse analytical research on doctor-patient interaction. All the studies reviewed focus on language use and social interaction in the context of actual medical encounters, and have a common interest in the complexity of role relationships in institutional settings (such as hospitals and outpatient clinics) and their effect on communication between patients and their physicians/therapists. The contributions discussed represent linguistics as well as other academic disciplines, like sociology, anthropology, and psychology. Despite a fair amount of overlapping between these different fields and the incredible variety of possible applications that such an overlapping brings about, I have tried to group discourse analytical investigations of medical encounters into different, although not clear-cut, categories. Such a categorization has been guided by the consideration of the salient features and main influences characterizing the approach of each investigation. The studies reported in 2.2-2.4 have considerably benefited from pragmatics and sociolinguistics concepts, such as speech acts and contextualization. In particular, section 2.2 illustrates the pioneering work by Labov and Fanshel, who have applied speech act theory to the study of therapeutic discourse, while sections 2.3 and 2.4 focus on the issue of miscommunication between doctors and patients as affected by often conflicting frames (associated to different footings), and familiarity with a specific discourse structure (namely the interview). The works in 2.5 draw on psychology and sociology to examine both micro-political and macro-political aspects of language use in the medical setting. Finally, section 2.6 briefly comments on a group of interdisciplinary, loosely affiliated approaches to the study of medical discourse, which try to harmonise various perspectives and address specific ethical challenges.
2.2 Labov and Fanshel: speech situations, speech events, speech acts

A significant number of discourse analytical accounts of practitioner-patient communication has moved from the assumption that talk is social action, and has therefore set out to investigate what speakers do with words. A much quoted work representing this group is Labov and Fanshel (1977), which contains what can probably be considered the first fine-grained analysis of a clinical encounter. To be more precise, the whole book is based on the investigation of a 15-minute long segment from a psychotherapeutic session with a girl (Rhoda) suffering from anorexia nervosa.

Acknowledging Hymes (1962), the authors move from the consideration of the therapeutic interview as a *speech event*, i.e. “a routinised form of behavior, delineated by well-defined boundaries and well-defined sets of expected behaviors within those boundaries” (Labov & Fanshel, 1977: 30). Therapeutic sessions fall within the larger class of interviews, where a person (the interviewer) extracts information from another person (the interviewee), which is contained in the latter’s biography. The interviewer may go to the interviewee, as in market surveys, journalistic interviews or police interrogations, or vice versa, as in legal, medical, and therapeutic interviews. Specifically, in the therapeutic interview patients/clients go to the therapist for help and give her/him information from their biography that will be used to help them. Following Hymes (1962; 1972b: 56), Labov and Fanshel recognise the *speech event* ‘therapeutic interview’ to occur within the *speech situation* ‘psychotherapeutic course’ (or, more generally, ‘psychotherapy’), and to comprise *speech acts* like requests, challenges, retreats, and so on (cf. Labov & Fanshel, 1977: 58).

The authors chose these units of analysis in order to focus on discourse as interaction. In this respect, their work is also deeply influenced by Goffman (1967; 1974), who sees conversation as a form of human interaction taking place within a given social framework. Like Goffman, Labov and Fanshel (1977: 26) recognise the importance of defining the *situation* in which conversation occurs before undertaking any linguistic analysis of it and establishing discourse rules. To put it simply, they are trying to reply to Goffman’s leading question “what is going on here?” (cf. 2.3),
which can only be done once the rights and obligations of each partner in
conversation are well known. Against this backdrop, the therapeutic interview is a
type of social occasion with its own arrangements and expectations, which make it
possible to interpret the actual words being spoken.

As mentioned above, the therapeutic interview is a speech event initiated by the
patient/client seeking help from the therapist, who is supposed to provide such help
by eliciting talk from the patient/client to obtain information on her/his biography.
This configuration of the situation makes therapist-client interaction inherently
asymmetrical and is responsible for a deep paradox characterizing psychotherapy. In
fact, while patients are marked by social stigma, in that they are not fully able to look
after themselves, not only do therapists stand as persons that are perfectly able to take
care of themselves, but they have also been trained to help others do the same. Thus,
while the former are placed in a subordinate position, the latter are assigned a
privileged role. This asymmetry is reinforced by any form of help that is given by the
therapist to the patient, which brings us to a fundamental contradiction: if it is true
that the primary goal of therapy is to enable the patient to function independently,
how come s/he is taught not to need help precisely by giving her/him help? (cf. Labov
& Fanshel, 1977: 32). Apparently, this paradox and the tensions it creates influence
patients’ verbal and non-verbal behaviour. To use one example from Labov and
Fanshel’s analysis, Rhoda often uses mitigated language to conceal her real feelings
(e.g. she says she is “annoyed” or “bothered” instead of “angry”). By employing
downgrading devices, she somehow denies the severity of her condition, thus
resisting therapy. This seems to support Labov and Fanshel’s claim that the defining
characteristics of the therapeutic situation directly affect the discourse patterns of the
therapeutic conversation.

Once the situation has clearly been defined, Labov and Fanshel move to the
microanalysis of the interaction. They divide the interview into five episodes – each
organised around a main theme or topic – which are in turn grouped into smaller
sequences and, at a lower level, utterances.¹ In explaining their interest for the

¹ This partitioning is indicated on the left hand side of the transcribed interview by means of a
combination of numbers and letters
sequential aspects of interaction, Labov and Fanshel (1977: 25) pay tribute to the work of Sacks, Schegloff and Jefferson (1974) on turn-taking, which will be discussed extensively in 3.2.2. Nevertheless, their approach differs from Sacks et al.’s for two main reasons. On the one hand, Labov and Fanshel (ibid.: 73) question the strong tendency to limit the use of contextual information in the analysis of talk – a tendency that is an essential guiding principle for research in ‘pure CA’ (cf. 3.2). On the other hand, they claim that the application of rules of discourse, including sequencing rules, depend on the participants’ shared knowledge regarding their own needs, abilities, rights, obligations, and changing relationships in terms of social organisation. This knowledge shapes the rules for making requests, challenges, retreats, and so on. Rules are therefore seen to operate at a more abstract level than the utterance or sequence of utterances (ibid.: 350). In short, Labov and Fanshel’s ‘declaration of intent’ reads as follows: “we are searching for the most general rules that we can write; but to know they are the correct rules, we must have enough contextual information to be sure that they apply in any given case” (ibid.: 73).

This search is a critical step in Labov and Fanshel’s analysis of the interaction. It must be stressed here that what is meant by ‘interaction’ is essentially “action which affects (alters or maintains) the relations of the self and others in face-to-face communication” (ibid.: 59; my emphasis). The action is in turn “what is intended in that it expresses how the speaker meant to affect the listener, to move him, to cause him to respond and so forth” (ibid.; emphasis in original). Clearly, this approach is heavily influenced by speech act theory, particularly the works of Austin (1962) and Searle (1969), and is reflected in the underlying question “what did she really mean?” (Labov & Fanshel, 1977: 346). Given this relation between words and acts, what the authors found in their analysis is that most utterances perform several speech acts simultaneously. Hence, conversation cannot be seen as a chain of utterances but has to be considered as “a matrix of utterances and actions bound together by a web of understandings and reactions” (ibid.: 30). In this multi-layered structure, linguistic means of communication are complemented by a wide variety of paralinguistic features, ranging from voice characteristics (stammering, whining, smiley, etc.) to hesitations. These are carriers of emotional stances that can modify the meaning of
utterances, and cannot therefore be overlooked if one is to understand the speaker’s intentions. The key role played by these signals prompted Labov and Fanshel to pay special attention to the transcription of the interview. So, for instance, pauses are transcribed as dots, each dot representing half a second, and bits of talk uttered in a non-standard way are spelled in the text as they are heard (e.g. “jis’” instead of ‘just’, or “she s’d t’m’” instead of ‘she said to me’).

Incidentally, these paralinguistic features are termed “cues” (see for instance index on page 80) and bear a striking resemblance, not just because of the name, to Gumperz’ contextualization cues, a phrase that was first used by Cook-Gumperz and Gumperz in 1976, the year before Labov and Fanshel’s work was published. In fact, Gumperz’ “contextualization cues” covers a larger body of verbal and nonverbal signs, including prosodic features (e.g. intonation and stress), paralinguistic signs (e.g. tempo, laughter, and hesitation), formulaic expressions (e.g. opening or closing routines), and extralinguistic behaviour (e.g. gestures). These cues are assigned context-bound meanings, and support speakers’ foregrounding processes and listeners’ inferential processes (cf. Gumperz, 1992a). Hence, they are fundamental to interpret utterances in their particular locus of occurrence, i.e. to contextualise language, which is also, ultimately, to understand “what is going on here”.

2.3 Miscommunication at work: contextualization and frames

The microanalysis of linguistic and paralinguistic cues is central to another often quoted sociolinguistic investigation of medical interviews, i.e. Tannen and Wallat’s (1993 [1983]) analysis of misunderstandings in a paediatric interaction. The encounter analysed is an example of multi-party interaction, where a paediatrician

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4 See also Tannen and Wallat (1987).
5 Tannen and Wallat (1993 [1983]: 34) move from the assumption that the distinction between understanding and misunderstanding has often been idealised. Instead, they argue that in actual interaction “speakers and listeners achieve varying degrees of understanding of each other’s intentions and linguistic devices”. These and other issues related to misunderstanding are addressed in a recent special issue of the Journal of Pragmatics (cf. Dascal, 1999).
performs a medical examination on a child in the presence of the latter’s mother. In addition, reference is made to interaction in an interprofessional setting, as a portion of talk occurring during a meeting of the medical staff is reported. The rationale for Tannen and Wallat’s work is Goffman’s (1974) frame analysis, which is used to account for the participants’ different beliefs and expectations, and explain how these affect communication between them. More specifically, the authors found the exchange to be shaped by various, often conflicting, frames associated with distinct footings characterised by the use of identifiable linguistic registers. For the sake of clarity, it is worth here spending a few words on the key notions of frame and footing.

Goffman’s (1974) definition of frame can be summed up as follows: anything that one has in mind every time s/he is trying to answer the recurring, more or less conscious question “what is going on here?” or, in short, frames are mental entities that structure human experience. Given a specific communicative event, in our case the medical interview, participants will have precise cognitive expectations about what is going or not going to happen (e.g. the doctor will expect the patient to have a chief complaint). They will thus adapt their behaviours to precise rules and obligations governing that particular event (e.g. the patient will have to reply to the questions posed by the doctor), experiencing and expressing emotional states appropriate to the situation (e.g. the doctor will express empathy with the patient for her/his condition). Finally, their acts, changeable as they may be as far as content is concerned, will inevitably fall into specific types or categories and develop according to a typical sequence, i.e. they will be arranged according to a peculiar interactive format (e.g. doctor’s question – patient’s answer – doctor’s question).

Generally speaking, frames are constructions of the society and culture in which we live, and the repertoire of frames that each of us possesses is influenced by social position and biographical experience. In other words, they are shared social constructions that can be variously modulated by each person individually. What is relevant to our discussion is that while ordinary conversation is characterised by a combination of frames, every social institution, and the talk occurring within that institution, seem to be marked by a macro-frame dictated by the ultimate goal of the institution itself (in a clinical context the recognised objective is that of establishing a
diagnosis and a corresponding treatment on the basis of the information gathered from the patient and the medical examination). Despite the dominance of one frame giving a ritual character to the exchanges occurring in institutional settings (cf. 3.4), participants (even in the most formally organised types of interaction) may draw on other, more specific frames to move away from the main frame. For instance, the patient may tell a joke or ask the doctor for personal information in an attempt to establish rapport with him/her. Changes of frame within an interaction may involve changes in footing (cf. Goffman, 1981: 124-159) and have to do with participants’ “projected selves” (ibid.: 128). Thus, a paediatrician may address a child as a doctor, or simply as an adult, s/he may talk as a parent or even as a friend. These shifts do not need to be massive, but can also be very subtle. In any case, they involve some kind of “code switching” (ibid.), i.e. changes in lexical and grammatical patterns, and more often in pitch, rhythm, volume, and tonal quality.

Going back to Tannen and Wallat (1993 [1983]), their main point is that, in balancing and shifting among various frames, physicians employ different registers characterised by distinct linguistic and paralinguistic devices (e.g. tone of voice, rate of speech, lexical choice, etc.), which may enhance, limit, or exclude patients’ participation and understanding. As Tannen and Wallat put it (ibid.: 34), “any such device can fail to establish rapport, distance or whatever its user intends when listeners are not accustomed to its use for that purpose”. In the specific case analysed, the patient is a child with cerebral palsy who has been discovered to have an arteriovenous malformation. The paediatrician uses three different registers: “motherese” when talking to the child, reporting register when performing diagnostic procedures, and everyday conversation when addressing the mother. Tannen and Wallat note how the use of a reporting register inhibits the mother’s participation in the interaction (1993 [1983]: 41), and how the paediatrician minimises the danger of the patient’s condition by means of different linguistic and paralinguistic devices, such as fillers, repetitions, reformulations, conditional tense, and so-called “buffer language” (e.g. “anything like that”; ibid.: 43). According to the authors, all these cues display “a) the pressure of cognitive processing in verbalizing the diagnosis; b) the need to monitor the diagnosis, which is not yet complete; and c) the desire not to
upset the mother”. (ibid.). The fact that the paediatrician has deliberately chosen to limit the amount and the type of information the mother can receive is proved by some comparative evidence. Tannen and Wallat (ibid.: 43-44) include in their discussion an excerpt from a meeting where the same paediatrician is reviewing the case with some colleagues. The comparison between the two occasions reveals that in the latter the doctor’s language is much less hesitant and conditional, indicating a greater concern than she showed to the mother. The kind of complexity illustrated by Tannen and Wallat is only evident from sociolinguistic microanalysis, which, however, is beyond the scope of the present section. Suffice it to say here that the data they present demonstrate how speech style can vary depending on the clinical context, and how changes in footing can interfere with a successful exchange of information.

2.4 Miscommunication at work: the role of discourse structure

Shuy (1976; 1993 [1983]) also focused on miscommunication as a contextually located issue. In his analysis of medical encounters he found that communication failures depend on three main areas of interference, namely use of jargon, cultural differences, and structure of discourse. Technical vocabulary has traditionally been indicated as one of the main sources of problematic communication (cf. 1.3), but it is not the only obstacle. According to Shuy (1976), sociological variables also affect the medical interview and, more generally, the delivery of medical care. For instance, vernacular Black-English-speaking patients were found to be devalued as speakers of a dialect, tended to be considered ignorant, to be told what to do (instead of asked what they would like to do), and even to wait longer for service and get worse treatment. The structure of discourse itself can hamper effective communication. In his 1993 [1983] paper, Shuy draws the reader’s attention to issues like topic

6 In a more recent study, Roberts et al. (2003), report on misunderstandings in general practitioners’ consultations with linguistic minority patients. They found that GPs and patients have difficulties in understanding each other because of linguistic and cultural differences. These difficulties, however, do not seem to be connected in any way with the use of medical jargon. Understanding problems caused by GPs include grammatical complexity, ellipsis, and metaphors, whereas understanding problems caused by patients often fall into the categories of word stress and rhetoric.
introduction and topic response. If we contrast the medical interview with “normal” conversation, he argues, we will find an imbalanced participation in the former, which is expected to contain overwhelmingly questions by one speaker and answers by the other. The point is that patients, like children, are not used to being interviewed, so when they go to the doctor, exactly like children beginning school, they can only call on their knowledge and experience of normal conversation. They then learn the “rules” for communicating in these new settings (the clinic, or the classroom), and modify their speech accordingly (ibid.: 21). For instance, they learn that the doctor (or teacher) controls the flow of topics, and that they are not allowed to interrupt her/him. This generates considerable fear or, at best, anxiety, which, as claimed by Shuy (ibid.: 24), can interfere with the accuracy of the information exchange. For this reason, it is in the doctor’s interests to try and make the patient comfortable by making the style of the encounter more conversational and less like an interview (ibid.).

2.5 Micro-political and macro-political aspects of doctor-patient interaction

Research on doctor-patient interaction received a new impetus in the 1980s thanks to a wide variety of studies that could be grouped under the headings “phenomenologies of talk” (West, 1984b: 30) and “cognitive sociologies of discourse” (Cicourel, 1973). The former have highlighted the connection between language and context, by suggesting that language use in the medical setting is micro-political, in that it both reflects the larger structural context in which it is framed (basically, the asymmetry of the doctor-patient relationship) and helps to sustain that context (cf. 2.5.1 and 2.5.2). The latter, while sharing this view, have demonstrated a more distinct interest for the macro-political context, by focusing on the role of socio-cultural models in shaping doctor-patient interaction, and explicitly taking into account the participants’ mental representations of roles and identities. Within this group I have made a further distinction between Cicourel’s unique cognitive sociology, with its focus on the effects of often hidden aspects of information processing on members of a given culture (cf. 2.5.3), and more ideologically-oriented accounts of the asymmetry of
doctor-patient interaction (most of them influenced by feminist theories), which centre around the political superstructure of power (2.5.4).

2.5.1 The suppressed topic
An example of so-called phenomenologies of talk is Paget’s (1993 [1983]) study on misunderstanding. Like Tannen and Wallat (1993 [1983]) and Shuy (1993 [1983]), Paget focuses on problematic talk, noting the pervasiveness of misunderstandings and distortions in medical interviews. The author attributes misunderstandings to doctors’ control over the flow of topics (cf. 2.4), especially their questioning practices, which, she claims, unilaterally construct the meaning of patients’ illnesses (Paget, 1993 [1983]: 108). In particular, she focuses on three encounters between a physician and a female patient who has undergone nephrectomy and is concerned about the spread of her cancer. The doctor employs requests for explanations and clarifications to introduce, develop, and terminate discourse topics, often ‘brushing off’ the patient’s expressions of concern. The doctor’s responses to the patient’s replies tend to “dissolve her answers back into the exam” (ibid.: 119). Moreover, not only does he not address the patient’s concerns about possible metastases, but he also refrains from making reference to the operation, and does not even mention the word “cancer”, thus literally ‘suppressing’ the topic. Instead, he explains the patient’s symptoms in terms of psychological problems or, to use the exact expression contained in Paget’s data, her “nerves” (ibid.: 124). The conclusion of Paget’s study is that in the medical interview’s dialectic of questioning and answering, interpretations of diseases often reflect the doctor’s rather than the patient’s point of view (ibid.). A similar conclusion is reached by Mishler (1984) in his book on the dialectics of medical interviews The Discourse of Medicine.

2.5.2 The voice of medicine vs. the voice of the lifeworld
In Mishler’s (1984) book a basic distinction is made between two conflicting “voices” characterizing medical interviews, i.e. the “voice of medicine” and the “voice of the lifeworld”, intending the technical-scientific assumptions of medicine
and the natural attitude of everyday life respectively. Mishler champions a patient-centred approach that gives primacy to the latter, particularly patients’ contextual understandings of their own problems. Conversely, the voice of medicine reflects a biomedical model based on the analysis of symptoms, which disregards patients’ biographical situations and contextually grounded experiences, and is used by physicians to direct the turn-taking system and the sequential organisation of the interview (Mishler, 1984: 76). Incidentally, the author slightly changes his position later in his book (ibid.: 103-104), where he argues that both physician and patient can speak in either voice and switch voices not just between utterances and turns but also within them. However, while clinicians are communicatively competent in both “codes”, patients are competent only in one. Therefore, it is the physician’s responsibility to “translate” statements in one voice into statements in the other, in order to facilitate understanding (cf. (b) in the list below). Doctor-patient encounters are then shaped and organised by the two voices interrupting and interpenetrating each other. In any case, it is the voice of medicine that seems to confer the status of a discourse type with specific features on the medical interview. Particularly, as noted by Mishler (ibid.: Chapter 3), the interview is based on interrogative units of the kind question-answer-evaluation/assessment-question, where open-ended questions are typically absent. This structure enables doctors to control both the turn-taking mechanism and the flow of content, discouraging patients’ self-elaboration of topics (cf. 2.5.1). By the same token, patients’ replies are often preceded by pauses, signalling that patients are caught off guard by a switch to a new topic (Mishler, 1984: Chapter 3).

Contrary to this well-established fashion of conducting a medical interview, whereby the patient’s voice is basically ‘silenced’, Mishler suggests alternative ways, including (a) the use of open-ended questions to give voice to patients’ accounts; (b) the explanation of medical agendas and the use of patients’ own words to improve their understanding and participation in the encounter; (c) the avoidance of

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7 Here Mishler draws on the notion of communicative competence, as developed by Hymes (1972a). According to Hymes (ibid.: 277), “a normal child acquires knowledge of sentences, not only as grammatical, but also as appropriate. He or she acquires competence as to when to speak, when not, and as to what to talk about with whom, when, where, in what manner”.

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interruptions in favour of improved listening to patients’ descriptions and explanations (ibid.: Chapter 5). This list of suggestions exposes Mishler’s work to one main criticism, in that while strongly supporting a social perspective “in which patients’ relationships and involvements in family, community, and work settings have primary significance” (ibid.: 194), he is caught, exactly like his predecessors (cf. 1.3.), in the trap of prescriptivism, i.e. he ends up compiling a list of ‘dos’ and ‘don’ts’ for practitioners.

A last brief remark on Mishler’s monograph concerns the issue of transcription. As we have seen in 1.4.2, he is rightly critical of previous empirical studies that are based on recorded interviews but neglect transcription methods. In Chapter 2, citing Sacks et al. (1974) and Schenkein (1978), he shares conversation analysts’ interest for the microanalysis of real exchanges, and praises their transcriptions because they allow readers to see what is being referred to in the analysis. Unfortunately, his own transcripts do not appear to satisfy the level of accuracy that he calls for and no list of transcription conventions is included in the volume.

2.5.3 Knowledge structures and language use: the interpenetration of communicative contexts in organisational settings

In 2.3 we have seen that the notion of frames is defined by Goffman in terms of cognitive expectations, rules and obligations, emotional states, and interactive format. A rather more general definition of frames is used by Cicourel (1993 [1983]), who sees them as distinct knowledge structures and belief systems. In analysing the way physicians transform patients’ verbal descriptions into written medical records, Cicourel notes how competing frames can cause communication failures. For instance, the knowledge base or beliefs of the patient can significantly limit the scope of her/his answers to the physician’s questions, just as the doctor’s limited knowledge of specific socio-cultural and psychological issues can lead her/him to overlook non-medical problems that may impact on the patient’s state of health. According to Cicourel (ibid.: 63), frames are “mental models about the nature of the events, 8

At the same time, Mishler’s (1984: 53) attitude is critical of conversation analysts for their “context-stripping” approach to the analysis of conversation. In contrast, he calls for a far closer attention to the role that clinical practice has in shaping the medical interview (ibid.: 161).
objects, or situations we confront in our everyday lives”. Such models often interact to form integrated, “hierarchically structured abstractions or predications that are updated as new or contradictory information is received” (ibid.). This, however, does not always happen, as frames may prove extremely resistant to “new or contradictory information”. In the medical setting this is true for both patients and doctors. In the example provided by Cicourel (ibid.: 56ff.), a female patient who has undergone hysterectomy suspects that she had no cancer and a mistake was made (despite considerable medical evidence, including biopsies). Surprisingly enough, she also believes that she might have contracted the disease from her husband, who died of pancreatic cancer. The doctor on his part converts the patient’s often ambiguous and emotional language into fairly abstract categories, using a notation system made of unambiguous factual statements and specific medical terminology. The way he produces objective progress notes (or brief history) shows that he is pursuing his own inferences about what is happening to the patient (for example, he refers to her as “depressed”). In so doing he ignores some of her symptoms, while misunderstanding others, or reinterpreting them to fit his prior or emergent knowledge base (ibid.: 55).9

As noted by West and Frankel (1991: 181), in comparing doctors’ notes and patients’ verbal descriptions, Cicourel contrasts two forms of literacy, namely “bureaucratic problem-solving” and “commonsense reasoning”. Notes do not appear to accurately report patient’s concerns because they only code medical interviews for their content. The conclusion of Cicourel’s analysis is that the professional-bureaucratic setting causes doctors’ mental models to prevail over patients’. The “abstraction by recoding principle” (ibid.: 64) creates information constraints and resources for the physician, but tends to reduce the patient’s communicative ability, ultimately leading to doubts and misunderstandings. Hence, if it is true that legal-medical texts produced by doctors can tell us something about health care delivery in formally organised settings, it is also true that the actual interviews tell us a great deal about societal patterns of information control and social stratification (ibid.: 49).

9 Incidentally, as observed by Cicourel (1999: 186), doctors’ interpretations are often guided by their own folk notions about patients as “good or poor historians” (cf. 1.3).
This brings us to a methodological issue, in that all considerations about patterns of information control and social stratification require that the researcher specify the environmental conditions in which the language practices s/he examines are embedded. Cicourel’s concern for methodology is clearly expressed in his 1992 paper, where he calls for an interpenetration of contexts, especially when dealing with organisational settings. In other words, he claims that the analysis of the “narrow” context of locally negotiated interaction should go hand in hand with some knowledge of the “broad” context in which the interaction is situated, i.e. its institutionalised framing. Such a framing is made of prescriptive standards of behaviour “that pressure and/or channel people with designated titles, presumed competencies, duties or responsibilities into certain physical spaces at certain times in order to engage in a finite number of specifiable activities” (Cicourel, 1992: 294-295).

In recent years, Cicourel’s attention to bureaucratic environments has prompted him to address the role of a number of physical and organisational arrangements within the clinical setting, like the number of beds available and of personnel on duty at different times, the need to schedule appointments and fill in charts, etc. (see for instance Cicourel, 1999; 2004). All these factors may create stress for patients and healthcare delivery staff, interfering with their information processing. For example, Cicourel (1999) notes that the information patients give to receptionists or nurses may affect physicians’ interpretations. Moreover, he observes fairly patterned exchanges between patients and receptionists, with the receptionist’s questions requiring a fair amount of improvisation on the part of the patient, thus imposing a greater “cognitive load” (Cicourel, 2004) than might be relevant for the immediate situation. Overall, organisational constraints seem to limit the patient’s ability to recall past experience or problems and express them in a coherent manner, and, what is perhaps more serious, to limit their access to healthcare provision. Healthcare personnel may function as gatekeepers, who rely on common sense to establish how urgent each request is on the basis of their own perceptions of the described symptoms. To put it bluntly, as Cicourel (1999: 217) does, the clinical routine starts with the discourse practices of staff not trained in healthcare delivery.
2.5.4 Power and resistance

The works presented in 2.5 share a strong interest for the cognitive and social aspects affecting doctor-patient interaction. This interest is especially prominent in a number of studies that are more ideologically-oriented than the ones reviewed thus far. I am referring here to some papers by Silverman, K. Davis, Todd, and Fisher, which were all published in the collection *The Social Organization of Doctor-Patient Communication* edited by Todd and Fisher (1993 [1983]), and which I will now briefly consider.

Silverman (1993 [1983]) examines an adolescent diabetic clinic where a ‘whole-person’ approach is adopted and a more humane kind of medicine is practiced (cf. 1.4.1). He reviews three areas where reforms have been suggested and implemented in the clinic, making it an example of good practice. These are: changing doctors’ consulting styles, broadening the care team, and introducing patient support groups (ibid.: 231ff.). In spite of a greater attention for the psychological aspects of healthcare, and a shift from a doctor-centred to a patient-centred clinical practice, Silverman argues that in the clinical site under investigation social control is still exercised over patients, although in a subtler way. He concludes that no counter-discourse can challenge existing strategies of power, if it is not grounded in institutions and in practical struggles by subjects “fighting” to make their voices heard (ibid.: 240).

K. Davis (1993 [1983]) similarly focuses on the issue of patient invisibility, which is the expression of an intrinsic asymmetry of doctor-patient relationship, even when physicians are seen as “nice doctors”. Davis recognises an essential power imbalance between men and women in diverse social contexts, including the medical setting, where men tend to “hog” the conversational floor, getting their topics initiated and talked about more often than women, who, by contrast, have more difficulties in getting the floor and tend to be interrupted (ibid.: 247).10 Such discrepancies,

10 These observations are supported by West’s (1984b: 51ff.) analysis of turn-taking in doctor-patient interaction. (cf. 3.5.1.1).
however, do not lead Davis to see doctors and patients as blindly driven by social forces beyond their control. Rather, she considers both as competent and knowledgeable social actors who are able to find their way about in social life. For this reason, she calls for a reconsideration of asymmetric relations in the light of women’s resources and strategies to resist power. The empirical observation of such resources and strategies, limited as they may be, provides a way to rethink inequality and avoid top-down analysis of power and oppression (ibid.: 258-261).

According to Fisher (1993 [1983]a), the power imbalance between patients and their physicians increases when patients are perceived as poor and powerless and practitioners are residents rather than staff physicians. She also notes a clash of practical concerns, with patients concentrating on the meaning of their medical problem and how it will impact on their everyday lives, and doctors “budgeting” and orienting their time toward making a diagnosis and recommending treatment (ibid.: 168). Fisher investigates the participants’ questioning, presentational, and persuasional strategies observing how these interact to accomplish treatment decisions that ultimately reflect relations involving domination and subordination.

A similar conclusion is reached by Todd (1993 [1983]a), who notes doctors’ control over patients in the prescription of contraception, as reflected in the physician’s questioning and directive strategies. The author goes as far as to say that the doctor “truncates the patient’s social understandings with clinical, technical definitions and with stereotypical social definitions of women’s proper roles”, including when and how to be sexually active, to be reproductive, and to use birth control (ibid.: 206).

Finally, Todd (1993 [1983]b) and Fisher (1993 [1983]b) look more closely at the issues of power, resistance, and gender. In particular, Fisher (ibid.), moving from the assumption that medicine is a gendered profession bolstering the authority of practitioners and placing patients at a disadvantage, compares two models of social action. One considers social interaction as the reflection of social structures or systems, whereas the other considers social interaction as the product of responsible agents resisting within the constraints of an established institutional order. The main risk of the first model resides in seeing those who are in a subordinate position (in
this case women patients) as passive victims of a repressive system. The danger entailed in the second is that of downplaying the significance of the structural context of power and losing the impetus for social change. The debate on which theory should be adopted is still open.

2.6 Interdisciplinarity and a thick description: ethical challenges in the study of medical discourse

In the previous sections we have seen how discourse analytical approaches to doctor-patient interaction, diverse as they may be, share a tendency to combine the linguistic microanalysis of real encounters with social, political, and moral concerns regarding participants’ roles and identities. In fact, some of the studies reported, although they have been divided into categories for ease of reference, successfully integrate different theoretical frameworks and methodologies (e.g. Labov & Fanshel, 1977). The search for an integration of this kind has also inspired a number of collections on doctor-patient communication, which have tried to bring together the interests of various disciplines and stakeholders (e.g. Todd & Fisher, 1993 [1983]; von Raffler-Engel, 1990a; Morris & Chenail, 1995).

The harmonization of different perspectives and an active collaboration of all those involved in the delivery and reception of healthcare has been increasingly invoked by discourse analysts. As indicated by Sarangi and Roberts (1999b: 32), discourse analysis and its recent variant, critical discourse analysis (CDA), are oriented to the broader socio-political context of talk, which is employed as a resource to account for local events. In addition, CDA research into aspects of institutional life is declaredly “founded on a critique of institutions with a view to unmasking the relations of domination embedded in it” (Roberts & Sarangi, 1999b: 395). Against this backdrop, the ultimate objective envisioned by CDA researchers in clinical settings is a more effective and more just delivery of healthcare. One example of this mentality can be found in recent work by Mishler, who has dealt with issues of poverty, social exclusion, and inequality in the provision of healthcare services.

11 For further details on critical discourse analysis, see Fairclough (2001).
Specifically (cf. Mishler, 2004: 97), he has advocated a dialectical relationship between two ethical perspectives: an ethics of humane care (supported by practitioners and researchers alike) and an ethics of social justice (championed by public health researchers and policy makers). The former underpins the critique of “differentials” between healthcare providers and patients in their respective levels of control over communication and collaboration in clinical encounters. The latter informs the critique of the structural basis of social inequality, poverty, and violence causing racial, ethnic, and class “differentials” in levels of health. Unfortunately, such an ambitious project has not yet been translated into action, and CDA has been generally criticised for a tendency to engage with wide social movements while lacking an immediate impact on the modification of institutional arrangements. Moreover, as noted by Roberts and Sarangi (1999b: 395), CDA tends to focus on media and document analysis neglecting the institution as a site for doing fieldwork.

Despite these criticisms, the need remains for a comprehensive approach to talk and interaction within social institutions, in order to understand them in all their complexity. This need is acknowledged by Sarangi and Roberts (1999b: 1), who call for a “thick description” of communicative practices, which “reaches down to the level of fine-grained linguistic analysis and up and out to broader ethnographic description and wider political and ideological accounts”. According to Candlin (2003), if we apply this claim to the study of communicative practices within the medical setting, which is complicated by a myriad of hotly debated ethical issues (for instance, confidentiality and informed choice, to mention but two), research should focus on more than just professional-client interactions. A holistic approach to the study of medical discourse has to include the identifications of themes and objects of study, and the selection of sites (for example, collegial medical talk, rather than doctor-patient interviews, has been examined by Atkinson, 1999; 2004 and Erickson, 1999). Further considerations include the choice of analytical frameworks, the ways in which findings may be formulated, and, last but not least, the practical relevance of research. Candlin argues that the prerequisite for the accomplishment of all these tasks is an active cooperation between discourse analysts, healthcare professionals,
and patients, that accounts for the different interpretations and categorizations warranting their behaviours (see also Sarangi & Candlin, 2003, Sarangi, 2004).

Ultimately, this means bringing together the two approaches identified by Haberland and Mey (1981: 108): that of the professional clinician who wants to provide better treatment for her/his patients to improve their conditions, and that of the professional linguist who believes that anchoring her/his research in institutional settings will make it more relevant to society’s problems. Unfortunately, the risk of this perspective, which is shared by DA and CDA alike, is a tendency towards premature categorization and theory construction, which, as we will see in the next chapter, is heavily criticised by conversation analysis.
3 DOCTOR-PATIENT INTERACTION AND CONVERSATION ANALYSIS

3.1 Introduction

In the previous chapter different discourse analytical approaches to the study of talk in doctor-patient interaction have been reviewed, all sharing the basic talk-as-social-action assumption, but each focusing on various aspects of the interaction (e.g. the intentions of the speakers, the influence of knowledge base and beliefs on language encoding and decoding processes, the role of social structures in shaping discourse, etc.). These approaches have been heavily criticised by conversation analysts, who have blamed DA among other things for considering language on each occasion as the product of a single speaker and a single mind, dealing with utterances’ illocutionary force rather than their perlocutionary effects on the listener. Above all, however, as anticipated in 1.4.2, discourse analysts consider talk as the result of extrinsic, constraining factors like gender, ethnicity and class, which, they claim, inform participants’ communicative practices. By contrast, CA rejects the deterministic notion of talk as the product of social structures to focus instead on talk as a collaborative process (cf. 3.1 and 3.2). To do so a rigorously empirical approach is adopted whereby recurring patterns are examined across large collections of naturally occurring conversations. According to Levinson (1983: 287), the procedures employed by conversation analysts have proved “capable of yielding by far the most substantial insights that have yet been gained into the organization of conversation”, and, I should argue, into the organisation of doctor-patient interaction, as we will see in 3.5. Before moving to doctor-patient interaction, however, I would like to explain the conversational model of analysis in some detail. For this purpose, the remaining sections of this chapter are organised as follows: in 3.2 I will briefly introduce CA’s main tenets; in 3.3 I will consider long sequences of talk; in 3.4 I will deal with so-called ‘applied CA’, i.e. roughly speaking the application of CA to

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1 An articulate discussion of the strengths and limitations of discourse analysis as compared to conversation analysis is beyond the scope of the present study. For further details on this topic, see for instance Levinson (1983: 286ff.) and Drew and Heritage (1992b).
institutional settings, of which doctor-patient interaction is one example; in 3.5 and its subsections I will discuss the parameters against which the institutionality of talk can be measured, and I will illustrate them with examples from medical encounters; finally in 3.6 I will reconsider the already discussed asymmetry of doctor-patient interaction (cf. 1.2, 1.3, chapter 2)

3.2 Conversation analysis: a brief overview

The origins of conversation analysis date back to the end of the 1960s, when a group of scholars known as ‘ethnomethodologists’ broke away from mainstream American sociology. The reason for the breach was that they refused to accept traditional quantitative approaches based on the imposition of ad hoc categories on the data analysed. Instead, they claimed that sociological investigation should rely solely on the observation of the techniques (or ‘methodology’) used by members of a society (hereby the prefix ‘ethno-’) to construct and interpret social interaction, i.e. the jointly produced activities making up their daily lives (cf. Garfinkel, 1967: Chapter 1).

This preliminary observation on the object of study of ethnomethodology and conversation analysis deserves further explanation. First, nothing is unilaterally determined in conversation as talk is interactionally built by the parties involved. Elements of the interaction are seen as intersubjectively performed “actions that are [methodically] shaped and reshaped over the course of the talk” to achieve mutual understanding and agreement (Zimmerman & Boden, 1991: 10; emphasis in original). Second, although the idea of talk as a vehicle for social action is not a hallmark of CA (cf. chapter 2), the innovative character of the conversational approach consists in recognizing that utterances are understood by reference to their placement and role within sequences of actions. In other words, what an utterance actually ‘does’ depends on its sequential position. It is precisely this discovery that legitimises the analysis of the turn-by-turn organisation of talk per se. Third, the fine-grained analysis of talk led to the observation that conversation is a highly structured, intelligible phenomenon, “not

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2 For a thorough discussion of the relationship between ethnomethodology (particularly Garfinkel’s work) and conversation analysis see Clayman and Maynard (1995).
merely in terms of who speaks to whom in what language, but as a little system of mutually ratified and ritually governed face-to-face action” (Goffman, 1964, quoted in Sacks et al, 1974: 697n). This order is locally produced and interactionally controlled by the parties involved, i.e. competent members engaged in situated practices that are “detectable, countable, recordable, reportable, tell-a-story-aboutable, analyzable – in short, accountable” (Garfinkel, 1967: 33; emphasis in original). Fourth, the focus on everyday activities makes ordinary conversation a topic of investigation in its own right. Even more so, conversation becomes “a major, if not THE major, locus of a language’s use” (Sacks et al., 1974: 722; emphasis in original), i.e. the bedrock out of which all other forms of interaction are built. The issues that I have introduced so far have a number of theoretical and practical implications, which are illustrated in the two following subsections.

3.2.1 “Notes on methodology”

In sections 1.4.2 and 3.2 we have seen how conversation analysts address ordinary talk as an object of study in its own right. Some important methodological consequences can be drawn from this observation. One obvious consideration is that CA accounts cannot be based on ad hoc items of language made up by researchers in laboratories, but has to rely on the qualitative analysis of recorded naturally occurring data. Another is that the analysis should not (at least initially) be constrained by prior theoretical assumptions. In other words, theory should be data driven and research should begin with what Sacks (1984: 27) has called a process of “unmotivated looking”, whereby no single item of talk can be dismissed as trivial before it has been subjected to the analyst’s observation. By virtue of this inductive approach such a priori sociolinguistic variables as age, gender, social class and the like are excluded from conversational accounts, and social or contextual ‘material’ is only referred to insofar as it is demonstrably oriented to by the interactants.

Clearly, this does not imply that conversation occurs in a vacuum, since talk both informs and is informed by the social activities being performed. The focus on activity (which will be dealt with in 3.4) prompts a terminological remark. So far the terms ‘talk’ and ‘conversation’ have been used interchangeably, but it is probably worth mentioning
here that a number of conversationalists (cf. for example Hutchby & Wooffitt, 1998) prefer to use the expression “talk-in-interaction”. The reason for that choice is that CA is not exclusively concerned with ‘mundane’ talk, as the term conversation would imply, but with a wide range of forms of talk produced in “actual occasions of organizational circumstances” (Garfinkel, 1967: 32; emphasis in original). Ordinary conversation nonetheless remains the basic locus for socialization (cf. 3.2) and its primacy over other forms of talk makes its turn-taking system the default option that interactants in any given ‘context’ routinely conform to or depart from. It is to turn-taking and other key concepts of conversation analysis that the following section is devoted.

3.2.2 Some key concepts: turn-taking, conditional relevance, preference

In 3.2 conversation has been referred to as an orderly phenomenon. Such a claim is based first and foremost on the fairly obvious observation that participants in a conversation talk in turns. In their seminal paper on turn-taking in conversation, Sacks et al. (1974) note that, although speakers change and the length and ordering of turns vary, overwhelmingly one party talks at a time. Moreover, finely coordinated techniques are used to allocate turns so that the transition between one speaker and the next occurs with as little gap or overlap as possible. Broadly speaking, turns of talk are constructed from so-called “turn-constructional components” or “turn-constructional units” (also referred to as TCUs) identified by syntactic and prosodic (particularly intonational) criteria (ibid.: 702, 720). Whatever the unit uttered, it will have points of possible unit completion, which are predictable or “projectable” (ibid.: 720) before their occurrence by virtue of the same criteria determining each unit type. Speaker transfer happens precisely at these points, which for this reason are called “transition-relevance places” (or TRPs; ibid.: 721). It is not the aim of this section to provide a detailed account of the turn-taking mechanism, which is best illustrated by means of real examples (cf. 5.2). Suffice it to say here that there are techniques for selecting speakers, and that these techniques are interactionally oriented to by the parties in conversation following three main rules: current speaker may select next speaker; next speaker may self-select; and if neither of the two options happen, current speaker may (but need not) hold the floor. Clearly, this system is not immune from errors and violations, however there are repair
mechanisms available to correct them. Again a discussion of repair would be pointless here. What is worth highlighting is that correction devices are intrinsic to the system and are employed to deal with a whole range of trouble sources that are not exclusively of a turn-taking sort (i.e. essentially gaps and overlaps) but include incorrect word selection, slips of the tongue, misunderstandings, mishearings (or even non-hearings), and so on.³

If the length and ordering of turns can vary but are interactionally controlled by participants, the same holds true for turn content. Basically, what parties say is not specified in advance but this does not mean that there are no constraints on what may be done in any turn. To put it simply, a current speaker’s turn projects a relevant next action (or range of actions) to be accomplished by another speaker in the next turn. Perhaps the best examples of this phenomenon, which is known as “conditional relevance” (Schegloff, 1972a: 363ff.), are so-called “adjacency pairs” (Sacks et al., 1974: 716), such as question-answer, request-grant, instruction-receipt, etc. Adjacency pairs have a normative nature, in that the utterer of a first pair part will monitor whatever utterance follows to see how that utterance works as a relevant second pair part, therefore considering the non-occurrence of any such second as a noticeable absence and making inferences about this absence. Thus, not replying to a question, for example, might at best be seen as implying a failure to understand the previous utterance as being a question. Alternatively, it might be considered as rude or snobbish, or it might be interpreted as reticence and explained in terms of mistrust or a feeling of guilt, embarrassment, etc. Incidentally, adjacency pairs also regulate the turn-taking mechanism, in that they provide for speaker selection. More precisely, a first pair part isolates a relevant next speaker, thus complying with what has been described above as the “current speaker selects next” rule.

The fact that a given utterance projects for the following turns a range of relevant next occurrences (be they utterance types, speaker selections, etc.) means that it has sequentially organised implications. The recognition of this “sequential implicativeness” (Schegloff & Sacks, 1973: 296) presupposes both competence and accountability of the participants in conversation. In monitoring expected alternative seconds and drawing

inferences about their non-appearance, conversationalists recurrently address the question “why that now?” (ibid.: 299). Competence thus refers to the ability of participants to understand what is going on in conversation, i.e. how orderly sequences of talk are generated, and to display to each other their understanding of this orderliness (ibid.: 290). In this respect, paired utterances of the kind described above constitute an important methodological resource for both conversationalists and conversation analysts, i.e. what Sacks et al. have called a “proof procedure” for the analysis of turns:

When A addresses a first pair-part such as a ‘question’ or a ‘complaint’ to B […] A selects B as next speaker, and selects for B that he next perform a second part for the ‘adjacency pair’ A has started, i.e. an ‘answer’ or an ‘apology’ (among other possibilities) respectively. B, in so doing, not only performs that utterance-type, but thereby displays […] his understanding of the prior turn’s talk as a first part, as a ‘question’ or ‘complaint’. (Sacks et al., 1974: 728)

The sequential organisation of talk makes the contextualization of utterances an essential procedure “which hearers use and rely on to interpret conversational contributions and […] speakers pervasively attend to in the design of what they say” (Heritage, 1984: 242). Against this backdrop, Drew and Heritage (1992b: 18) argue that the production of talk is doubly contextual: it is context-shaped in that speakers and hearers draw on preceding talk to produce their utterances and to make sense of what has been said, and it is context-renewing in that every single utterance will provide the here-and-now definition for subsequent interaction.

However, the fact that conversation is organised in sequences does not imply that participants are “judgmental dopes (...) programmed to enact the requirements of sequential structure in lock-step fashion” (Zimmerman & Boden, 1991: 10). It is here that accountability comes in. To go back to one example we have already made, if it is true that a question strongly projects an answer, it is also true that the recipient of that question may well ignore it or challenge it. By choosing not to reply s/he will initiate another sequence (e.g. arguing or blaming), thus shaping the course of subsequent interaction. In short, co-participants are morally responsible agents, whose actions are
neither determined nor random, but are designed and used in terms of the activities being negotiated in the talk.

This idea of responsible conversationalists choosing their responses among a large set of possibilities may seem to contradict the regulatory character of adjacency pairs. Their structural importance is nonetheless “revived” by the concept of preference. According to Levinson,

> not all the potential second parts to a first part in an adjacency pair are of equal standing: there is a ranking operating over the alternatives such that there is at least one preferred and one dispreferred category of response. (Levinson, 1983: 307; emphasis in original)

It must be stressed from the outset that preference does not relate to the motivations of participants but refers, technically, to the turn-organisational features of conversation. Typically, preferreds are pursued and dispreferreds are avoided or repaired. Thus an invitation, for instance, can be either accepted or refused, as both acceptance and refusal are possible alternatives available to the recipient of an invitation. However, the initial act of inviting someone strongly projects acceptance as a response from that someone. In other words, acceptance is a preferred whereas refusal is a dispreferred answer to an invitation. This non-equivalence is evident if we observe how dispreferred actions are constructed. As noted by Schegloff et al. (1977), dispreferreds are usually delayed and somehow mitigated or made less direct (as opposed to preferreds, which are structurally simpler and “contiguous” with previous turns; cf. Sacks, 1987a). To go back to our example, refusals may be prefaced with “appreciative person assessments” (Pomerantz, 1984b: 101n) to avoid offending the inviting party. Hence, the relevance of preference lies in allowing the notion of adjacency pair “to continue to describe a set of strict expectations despite the existence of many alternative seconds to most kinds of first parts” (Levinson, 1983: 308).

Two things clearly emerge from the foregoing discussion of preference: first, preference bears resemblance to the linguistic notion of markedness, preferreds being unmarked and dispreferreds occurring in marked format; second, and perhaps most
important, preference seems to match the principles of cooperation and politeness postulated by Grice (1975: 45-46) and Leech (1983: 132). According to Heritage (1985b), preferred options generally maintain “social solidarity”, while dispreferred options threaten the faces and the relationships of participants in the interaction. In this respect, the idea of preference expresses a strong orientation of the interactants to the who and why of the interaction, and is closely connected to another key concept of CA, namely recipient design. This is defined by Sacks et al. (1974: 727) precisely as the general principle whereby “the talk by a party in a conversation is constructed or designed in ways which display an orientation and sensitivity to the particular other(s) who are the co-participants”. Such a principle provides for ways in which parties can individualise the interaction at different levels (e.g. topic and word selection, ordering of sequences, etc.), thus achieving a sense of shared understanding concerning the interaction itself. It is the principle of recipient design that allows the adaptation of the (apparently) rigid turn-taking machinery to the specificity of each conversation, and it is to ‘special’ conversations that the final sections of this chapter are devoted. Before turning to this topic, however, I would like to consider in some detail two typical resources of mundane conversation, which, as we will see in chapters 5 and 6, are largely employed in our sample of naturopathic interviews. These are story-telling and troubles-telling sequences.

3.3 Focus on long sequences

In 3.2.2 we saw how turn-taking regulates conversation, making it an observably orderly phenomenon. Although this orderliness is best seen in the turn-by-turn organisation of talk, the object of a significant portion of my analysis are longer sequences, i.e. what Sacks (1992b: 354) calls “big packages”. The investigation of these “packages” will make it possible to observe how patients’ initiatives and doctors’ responses to these initiatives interact over long stretches of the interview, providing for an overall textual and rhetorical orderliness of the interaction.

In particular, two types of sequences will be examined, story-telling and troubles-talk. These lend themselves to be dealt with together in that they present many analogies.
Both are *locally occasioned* and *sequentially implicative*, i.e. they emerge from and re-engage turn-by-turn talk (Jefferson, 1978: 220). Both involve an extended holding of the floor, as they momentarily suspend the basic turn-taking mechanism. This suspension is achieved thanks to specific procedures whereby the would-be teller offers to tell, and the recipient accepts to be told (cf. “story preface” and “premonitor/announcement response” in 3.3.1.1 and 3.3.2 below). Both are interactional achievements, in that they need someone to play the role of teller, but also someone else aligning as recipient. Both tend to include evaluative language, particularly assessments. Finally, as anticipated in 1.3 and 3.2.2, both are widely used in our sample of doctor-patient interviews.

Having said that, since the management of sequences cannot but be local, the investigation of turn-taking mechanisms remains central to show participants’ convergence, or lack of convergence, as to both the context and content of their talk (cf. 7.2). In this respect, we will see how stories- and troubles-recipients (be they doctors or patients) monitor tellers’ talk for possible transition-relevance places, and how disruptions in the turn-taking machinery (especially overlaps and pauses) – which violate the two basic rules ‘one party talks at a time’, and ‘transition from one speaker to another occurs with as little gap as possible’ (cf. Sacks et al., 1974) – can indicate non-understanding or non-affiliation. Before examining the data, however, it is necessary to shed some light on how story-telling and troubles-talk operate.

3.3.1 Story-telling in conversation

One obvious prerequisite for a story to be considered such is to take more than one utterance to be told. According to Sacks (1992b: 18), a story-teller has to attempt to control the floor across an extended series of utterances. This presupposes that there is someone who keeps the floor at turn-transition-relevance points, but that there is someone else who refrains from taking turns in the meantime. The fact that a party is telling a story is an important thing for others to recognise and is, in fact, the result of a negotiation between speaker and hearer. The telling is usually negotiated in so-called *story prefaces*, which link stories to preceding talk and announce what their completion will make relevant. In this respect, prefaces provide for stories’ *local occasionedness*
and sequential implicativeness (cf. above), therefore they cannot but be considered part and parcel of stories themselves. Let us briefly see how story prefaces work.

3.3.1.1 Story prefaces: local occasionedness and sequential implicativeness. First of all, the story preface announces that “one intends to be talking in alternate positions until the story is finished” (Sacks, 1992b: 18). The words “in alternate positions” are crucial to understand how talk proceeds during the telling of a story. What must be highlighted from the outset is that stories are not unilaterally imposed by a teller on a recipient, but are the products of the moment-by-moment interaction of the participants in conversation, i.e. they are locally occasioned. In fact, as pointed out by Jefferson (1978: 245), a story is rarely (if ever) a block of talk, rather it is made of segments in which teller’s talk alternates with recipient’s talk. Hence, technically speaking, a story is an attempt to control a third slot of talk from a first, in that the teller allows others’ contributions during her/his talk, but wants the floor back after each is finished. This happens from the very beginning, i.e. in the preface, where the would-be teller asks for the right to produce a more-than-one-utterance-long bit of talk. For instance, s/he may say something like “I’ve got something incredible/terrible/etc. to tell you”, “have you heard about x?”, “you won’t believe what happened to me...”, etc. As can be noticed, these utterances are not simply requests for permission, but also include a “promise of interestingness” (Sacks, 1992b: 226). Once this promise has been made and any such “interest arouser” (ibid.) has been uttered by the prospective teller, it is up to the other participants to indicate whether they accept or reject the request to tell a story and whether they are interested. The most common ways to do that is by means of continuers (e.g. “uh huh”, cf. below), markers of surprise (e.g. “really?”, cf. West, 1984a: 114), or explicit questions (e.g. “what happened?”), all of which remind us that stories are interactively constructed. We will return to this characteristic later in this section.

A second significant function performed by the story preface is that of suggesting what it will take for the story to be finished and what should be done at the end of it (Sacks, 1992b: 19). I have in fact anticipated this point in the preceding paragraph when talking about interest arousers. Prospective tellers, when characterizing their stories as “terrible”, “wonderful”, “unbelievable”, and so on, are intendedly informing the hearers
about what to expect from the telling, and instructing them on how to react when the
telling is over (cf. Sacks, 1992a: 766-67). As a consequence, hearers have to monitor the
following talk to find out what will turn out to be “terrible”, “wonderful”, or
“unbelievable”, and respond accordingly. In this way, prefaces also provides for stories’
*sequential implicativeness*, in that they anticipate a return to a state of talking together
upon story completion. What prefaces also make clear is that stories are not merely
narratives, i.e. a “recital of events and circumstances” (Polanyi, 1985: 189), but have to
communicate a message with a bearing outside the storyworld, particularly on the
interaction between story-teller and story-recipient, as we will see in 3.3.1.2-3.3.1.4.

So far, the issue of stories having tellers and recipients has been taken for granted
and mentioned only in passing, however there is no story without a speaker venturing
into telling it, just as there is no story without a hearer aligning as a story-recipient.
Moving from this assumption, story-telling imposes constraints on both the former and
the latter.

### 3.3.1.2 Constraints on story-tellers.

The story-teller, first of all, has to produce a story
that is *tellable*. In other words, the events reported have to be significant enough (at least
for the teller) to legitimise telling a story. In fact, stories normally concern an important
change of state affecting the teller’s lifeworld (her/his actions, opinions, etc.). That is
why the teller is usually also the principal character in the story, or is somehow involved
in the events s/he recounts. At the same time, the teller designs the story so that the
recipient can be reminded of her/his own experience, showing the recipient that the
telling is done with an orientation to whom it is being told (cf. Sacks: 1992b: 230).

On a more formal level, the teller has to make sure that her/his story is a *topically coherent*
story. In a coherent bit of talk one can find a significant number of content
words (essentially nouns, verbs and adjectives) selected by reference to each other, i.e.
*co-selected* (Sacks, 1992b: 19) or standing in *co-class membership* with each other
(Sacks, 1992a: 757). These words can also be chosen by reference to some *stateable thing* or *topic*, although talking topically does not correspond to talking about a topic. As
Sacks (1992b: 19) put it, the point is not so much talking about something but how you
talk about that something. For instance, “*how* you talk about cars when you’re ‘talking
about cars’ is distinctive from how you talk about cars when you’re ‘talking’ about something else (…) for example (…) ‘talking about a wreck’” (ibid.; emphasis in original). Overall, then, not only does a topically coherent story logically depict a course of action, but it must also have a clear connection with preceding talk.

This last point warrants so-called “entrance talk” (Sacks, 1992b: 222ff.), i.e. transitional talk used by the would-be-teller or any other story elicitor to announce the telling of a story and its relevance to the preceding exchange. As noted by Jefferson (1978: 220; 224), entry into a story can be done “economically” or “elaborately” depending on whether the story is “triggered” by something said at a particular moment during conversation, or “methodically introduced” over longer stretches of talk. In the former case entry is achieved through story-prefixed phrases like “I know what you mean” or “As a matter of fact” (ibid.: 224-25), whereas in the latter case the story appears not only as topically coherent but with coparticipants specifically aligning as story-recipients, as in the case of story prefaces described above.

Relevance to the preceding and following talk, and to the participants’ lifeworld in general, is ordinarily condensed in a moral, i.e. the point the teller tries to make or the maxim s/he tries to illustrate through the telling. The moral is a recognizable ending format, which invites for agreement or disagreement from story-recipients (cf. below) and provides for the resumption of the normal turn-taking machinery (cf. Levinson, 1983: 324).

A good story-teller will also use appropriate linguistic devices to evaluate the circumstances s/he is describing, thus enabling the hearers to recover the gist of the story. This can be done from the story preface throughout the story and in its final stage (the moral) by means of characterizing adjectives (e.g. “incredible”, “amazing”, “terrible”, etc.; cf. 3.3.1.1), but also via so-called assessments, which involve taking up a position towards the event or entity being assessed – the assessable – and displaying the utterer’s experience of that event, including his/her affective involvement in it (cf. Goodwin & Goodwin, 1992: 155).

3.3.1.3 Constraints on story-recipients. Moving to recipients, they first have to accept to hear a story, i.e. they have to align as story-recipients. As mentioned above, acceptance
is shown in different ways at the entrance stage (for instance by means of continuers or markers of surprise; cf. 3.3.1.1), by replying to the would-be-teller’s request for permission and promise of interestingness.

Once the story-telling has started, recipients should listen to the story for two main reasons. On the one hand, as any current utterance might select next speaker, they have to listen to find out whether they have been selected. On the other hand, if no one has been selected to speak next, they have to listen to find points of possible completion where they might self-select (cf. Sacks, 1992b: 226).

If the story has not come to a recognizable completion, recipients usually refrain from taking turns, but at sentence completion points they can indicate attentiveness and understanding or ask for clarifications. As Sacks (ibid.: 227) put it, “recipient’s talk at various places in the story is talk that deals with the recognition that a story is being told”. 

Continuers like “uh huh”, “mm”, “yeah”, etc. are employed by recipients precisely to show that they see telling is in progress and not yet finished (cf. Schegloff, 1984: 44; Sacks, 1992b: 9).

Moreover, if it is true that tellers design their stories in order for recipients to identify with them (particularly with the tellers’ status within the story; cf. 3.3.1.2), it is also true that recipients have to listen in such a way as to be reminded of their own experience, as explained by Sacks in the following passage:

One routine task of participants to a conversation is to be able to show that they understood something another said. In doing that, what they do in part is to analyze what the other said so as to then find something to say which can exhibit, to one who will analyze what this one says, that he has understood what the other said. And one large source of things to be used to show that one understands are ‘things you already know about’, i.e., things that you are reminded of. (Sacks, 1992a: 768)

Eventually, when the telling recognizably comes to an end, recipients have to demonstrate that they have understood the point of the story and that they either agree or disagree with the teller. As we have seen, the telling of a story involves the use of assessments and evaluative language, which, especially in the final part of the story,
strongly invite agreement (cf. above; Levinson, 1983: 336; Pomerantz, 1984b). We may therefore say that stories have agreements with their point as preferred responses. These are produced by recipients upon story completion and often take the form of assessments, or, if they follow those already formulated by the teller, of second assessments (cf. Jefferson, 1978; Pomerantz, 1984b; Goodwin, 1992). Content-wise, the production of assessments is a very delicate interactional matter, especially when we consider that stories are not just about the people who are telling them, but also those who are hearing them (cf. above). Therefore, when producing assessments, recipients have to take into account the teller’s investment in the story and her/his sensitivity about this investment (cf. Sacks, 1992b: 171).

Another way to show agreement with the point is a second story (cf. Sacks, 1992a,b; Ryave, 1978). This stands as an analysis of a first story, in that it is similar to that first story and its teller plays a similar role to the one played by the teller of the first story. Second stories show that story-telling is an interactional business, as they are naturally produced by recipients who are reminded of their own experiences during the telling of first stories, and use second stories precisely to show understanding of and agreement with first stories.

3.3.1.4 Second stories. ‘Second’ is a technical term in two main respects. On the one hand, a second story is not any which story, and on the other hand, it may well be a third or fourth, etc. Let us look at the salient features of second stories.

First, a second story is topically coherent with the first that gets told. Thus, if the first story is about someone achieving something extraordinary, like for instance winning an international competition, the second story will also be about victory or success (cf. Sacks, 1992b: 3ff.).

Another key element is the selection of characters, in that a second story will have the same kinds of characters as a first story. So, in our example, if the teller of the first story is the winner of the international competition that s/he is telling about, the teller of the second story, i.e. the recipient of the first, will also have to be the winner in her/his own story. Hence, not only does the second story-teller construct her/his story by reference to the first story, but also by reference to what the first story-teller did in the first story,
thus making the second story *interactionally relevant*. Recounting a similar experience seems to be the easiest way to show understanding and agreement, i.e. ultimately what second stories are supposed to do. Should a teller of a second story fail to make the characters of her/his story fit those of the first, then there would be no point in telling a second story. This presupposes active listening on the part of the teller of the second story, who has to monitor the first story to produce a matching telling.

One additional thing that can be noticed concerning the relationship between first and second stories is that they are *sequentially adjacent*. In other words, a second story is told within “conversation time” (Sacks, 1992b: 7), i.e. it is spoken out immediately after the first. By virtue of this proximity stories can form *clusters* or *series* (Ryave, 1978: 120). As we have seen, however, their relationship goes beyond sequential adjacency and includes topical coherence and interactional relevance. Recurrently conversational participants orient to current stories so as to construct their own succeeding stories. A general procedure to construct stories that display a series-of-stories relationship with preceding stories is to organise them around a *significance statement* (ibid.: 127). This is an assertion that is occasioned by the recounting of a story and serves to formulate the import of that story, while at the same time functioning as a prefatory remark for a succeeding story (cf. 6.3.2). Significance statements can be recycled, totally or partially, over the course of the series, thus chaining each story to the next. The way significance statements work enables us to conclude that the source and relevance of second stories is embedded in previous stories, a conclusion that in turn brings us back to the initial observation about story-telling being a situated social activity.

3.3.2 The sequential organisation of troubles-talk

In 3.3.1 we have seen how stories are recognizable structures shaped by previous talk and shaping subsequent talk, i.e. “sequenced objects articulating with the particular context in which they are told” (Jefferson, 1978: 219). We have also seen that story-telling is an interactional business and that its organisation can only emerge through the fine-grained analysis of talk-in-interaction. The same observations apply to the troubles-talk sequence, which develops in a way that is similar to story-telling. It is to troubles-telling that I now turn.
Talk about troubles has been extensively investigated by Gail Jefferson (e.g. Jefferson, 1980; 1984a; 1984b; 1988; Jefferson & Lee, 1992), who has found it to be characterised by a number of regularities. In particular, she noticed how a series of recurrent elements occur in a standard order, thus conferring a strong sequential character to troubles-talk. Having observed recurring patterns across a large sample of data, she proposed a candidate troubles-telling sequence that could account for the overall design and function of troubles-talk (cf. Jefferson, 1988). This model will be briefly outlined in this subsection and substantiated with data from the sample of doctor-patient interviews in 5.4.2.

According to Jefferson (ibid.), a troubles-telling sequence can be roughly divided into six stages: approach, arrival, delivery, work-up, close implicature, and exit. Within these segments various components can occur individually or in combination.

The approach stage, which roughly corresponds to a story preface (cf. 3.3.1.1), can be further divided into initiation, trouble premonitor, and premonitor response. During initiation a coparticipant can either inquire into the status of a trouble of which s/he has prior knowledge or notice a possible trouble that has somehow emerged in the course of the exchange. Alternatively, if the coparticipant is not aware of (or suspect) a potential trouble (or the continuing state of an already-known trouble), s/he may be oriented to its presence by a so-called trouble premonitor uttered by the speaker. This ‘signal’ can be a downgraded response to an inquiry (e.g. “How are you feeling now.” “Oh::? (. ) pretty good I gue:$:ss,”), an improvement marker (e.g. “How is your mother by: the wa:y ·h” “We'll she’s a:ha bit bette:r”), or a lead-up hinting at something unexpected (e.g. “what’s new with you.”, “·hhh Oh I went to the dentist”). Premonitor responses are also of different kinds, as a coparticipant can be either “troubles-resistant” or “troubles-receptive” (cf. Jefferson 1984b). A rather common premonitor response is a continuer (e.g. “uh huh”, “yeah”). Continuers are especially interesting because they do not express a clear position on the part of the coparticipant, who can use them to show alertness to subsequent talk, while at the same time not committing herself/himself to hearing a trouble possibly underway. As pointed out by Jefferson (1980), and as we will

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4 All examples in this subsection are taken from Jefferson (1988: 422).
5 Cf. also Gardner (1997).
see in 5.4.2, this sort of ambiguity/neutrality displays a general alignment to “business as usual” and an ambiguous orientation to troubles-talk.

The arrival phase consists of announcement of the trouble and announcement response. The latter can be of two types: one that elicits further talk on the subject but does not necessarily align recipient as a troubles-recipient (e.g. “His mother’s real low.” “Oh really.”), and one that, by showing empathy, proves recipient to be troubles-receptive (e.g. “We got burgled yesterday.” “Nah: no:.”).

Delivery is the relational heart of troubles-talk, in that it exhibits a clear focus on the part of interactants on the trouble and on each other. Delivery is made up of exposition, affiliation, and affiliation response. After the troubles-teller has exposed the matter, the troubles-recipient, unlike the story-recipient, will not express agreement with the point (a point or moral being in fact absent from troubles-telling), but will usually produce an expression of empathy and/or an affiliative formulation. These expressions are uttered as preferred responses to the exposition of troubles, i.e. without being delayed or mitigated in any way (cf. 3.2.2; Levinson: 1983: 334). They are actual affect displays (Goodwin & Goodwin, 1992: 155), which can take the form of assessments (e.g. “And uh w-h-h-en I lie down or when I get up it feels like the m:: flesh is pulling off of my bones.” “How awful.”), and are important resources for the interactive organisation of further troubles-talk. In fact, following affiliation and in response to it, the troubles-teller will recurrently engage in “emotionally heightened talk” (Jefferson, 1988: 428), for instance by confiding in the recipient. As noted by Jefferson (ibid.), the interactional distance between the participants in troubles-talk diminishes as they move from the approach to the delivery stage, where they reach the highest level of intimacy and reciprocity. Vice versa, distance progressively increases as the troubles-telling sequence develops from the delivery stage to the exit from troubles-talk.

Work-up is the first step towards closure of troubles-talk and re-engagement with business as usual. It covers a number of different activities ranging from diagnoses, to reports of similar or contrastive experiences, prognoses, etc., which appear to reposition the trouble focussed upon in the delivery stage within more general circumstances, and bring the conversation back to a more standard interactional distance between the participants. Although the delivery of troubles cannot be said to have a point like the
moral in stories, and although preferred responses to the exposition of troubles are affect displays instead of agreements with the point (cf. above), the work-up stage may include activities that, if performed by troubles-recipients, seem to be similar to those carried out to show understanding and agreement in story-telling. I am referring to reports of similar experiences and to formulations, the former resembling second stories and the latter looking like significance statements (cf. above).

Formulations consist in the production of a gist or upshot of the preceding stretch of talk, thus offering a candidate reading for what participants have been saying (cf. Heritage & Watson, 1979). The primary function of formulations is to demonstrate understanding and to invite reception of that understanding by means of confirmation or disconfirmation. However, what is of interest to us here is to note that formulations are often characterised by speaker self-selection, which makes them an economical solution to the re-engagement in turn-by-turn talk (ibid.: 153). Ultimately, formulations, by foreshadowing withdrawal from troubles-talk and return to business as usual, can be said to be midway between the work-up stage and the close-implicature stage.

*Close-implicature* elements strongly project a move out of troubles-talk and include optimistic projections, invoking the status quo, and making light of the trouble, all of which tend to achieve what Jefferson (ibid.: 433) calls “a where-are-we-now topical negotiation”.

*Exit* from troubles-talk can be divided into boundarying off and transition into other topics. Overwhelmingly, interactants seem to consider troubles-talk as a topic after which there is not much to be said, which would explain why the most common way to exit from troubles-talk is entering conversation closure (cf. Jefferson, 1988; Schegloff & Sacks, 1973). Alternatively, there may be a conversation restart, which, however, is usually associated with the participants having some kind of interactional troubles. Participants can also opt for the introduction of pending biographicals, a technique that, unlike conversation restart, does not start the conversation afresh, but introduces “an especially warranted new topic” (Jefferson, 1988: 436), thus showing “deference” to troubles (ibid.). Another possibility, which is in fact a rather common sequel to troubles-talk, is invoking intimacy or making reference to being/getting together. The devices
used to this purpose display affiliation, while at the same time paving the way for *transition into other topics.*

Clearly, the foregoing template for the organisation of a troubles-telling sequence is not intended to be slavishly applied to any instance of troubles-telling, as various versions of the sequence can be realised in talk-in-interaction. Nevertheless, as we will see in 5.4.2, interactants appear to be constrained by the above-mentioned set of elements, which make troubles-telling at least “vaguely orderly” (ibid.: 419).

### 3.4 Applied conversation analysis: from ordinary conversation to institutional talk

At the end of 3.2.2 we mentioned that recipient design is the major basis for the variability of conversations, i.e. their “context-sensitivity”. From what has been said so far, however, it is not clear to what extent speakers can depart from the basic structure of conversation, which, as we have seen, is constrained by a highly organised turn-taking system, a formal apparatus that retains its invariant character regardless of context. In noting that the main aspects of turn-taking organisation are “context free”, Sacks et al. (1974) use the word ‘context’ to mean the “various places, times and identities of parties to interaction” (ibid.: 699n). Contrary to what might be expected, *context-free* and *context-sensitive* are not mutually exclusive options:

> [i]t is the context-free structure which defines how and where context-sensitivity can be displayed; the particularities of context are exhibited in systematically organized ways and places, and those are shaped by the context-free organization (Sacks et al., 1974: 699).

Hence, the immediately local configuration of talk is not the only context that participants rely on to design their interaction. The one thing that conversationalists have repeatedly highlighted is that talk is always situated and turn-taking is a flexible mechanism that adapts to the properties of the ‘contexts’ in which it operates. This rather loose idea of context has been later refined by analysts doing so-called ‘applied CA’.
Differently from the initial ‘pure CA’, which was concerned with discovering ‘primordial’, general aspects of sociality, ‘applied CA’ turned to task-related, institutionally-oriented forms of talk ranging from courtroom interaction to medical discourse, from business meetings to TV or radio interviews, etc. Against this background, the idea of context adopted by applied CA coincides with that of “activity type” as developed by Levinson (1992). This concept is extremely functional to the conversational approach, as CA studies the interactional accomplishment of particular social activities (cf. 3.2). Specifically, applied CA moves from the analysis of conversational organisation as it functions in everyday conversation to its specification or modification in diverse settings, where it constructs and animates a variety of social formations. This perspective is heavily dependent on a systematic comparison between ‘mundane’ conversation and its counterparts in more formal settings. As noted earlier (cf. 3.2), conversation is the most pervasively used mode of interaction in social life and the form within which language is first acquired. In this respect, it constitutes a benchmark against which other more formal or ‘institutional’ types of interaction are recognised and experienced. This comparative approach moves from the perspective of the participants in the interaction, particularly from their orientations to the institutional settings where their talk is situated. In other words, context is not a definitional criterion of institutional interaction, but “interaction is institutional insofar as participants’ institutional or professional identities are somehow made relevant to the work activities in which they are engaged” (Drew & Heritage, 1992b: 25).

Having said that, institutional talk can be broadly categorised according to its level of formality/informality. Settings can thus be divided into formal types and non-formal types (cf. Heritage & Greatbatch, 1991). Examples of the former can be found in courts of law (cf. Atkinson & Drew, 1979), broadcast news interviews (cf. Heritage & Greatbatch, 1991), job interviews (cf. Button, 1992) and other ceremonial occasions, whereas the latter are represented by less structured although still work-related, lay-professional encounters, like medical consultations (see for instance Atkinson & Heath,

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6 Applied CA can also be conceived of as “the efforts to apply CA findings and/or specific studies to advise people and organizations how specific practical problems might be handled in order to facilitate smooth and effective practice” (ten Have, 2001a: 3; cf. also ten Have, 1999: Chapter 8).

7 See also Schegloff (1992).
sessions (cf. Peräkylä, 1995), or service encounters in shops (cf. Gavioli & Mansfield,
1990). It may be argued that the word ‘institutional’ does not fit all of the settings listed
above. In fact, some analysts (see for instance Sarangi & Roberts, 1999b) refer to work-
related settings (or “workplaces”) and prefer to talk of professions rather than
institutions, as ‘institution’ is generally associated with an orderly arrangement of things
rather than conveying the idea of people as active agents (ibid.: 14). Throughout this
thesis the term ‘institutional’ will be used to refer to forms of talk – and interaction –
that are oriented to as institutional by participants themselves (cf. above) and display
some recognisable features. Typically, institutional talk – diverse as it may be – has
three main characteristics, as illustrated by Levinson (1992): it is goal-oriented, it is
shaped by a number of constraints, and it is associated with inferential frameworks. The
combination of these three features makes up the main frame associated with the
interaction at hand (cf. 2.3). Let us analyse these three characteristics in greater detail
drawing on examples from the medical setting.

The most evident aspect of institutional talk is that it is **goal-oriented**. The
participants understand the meaning of the actions that each is performing and of the
words that each is uttering by reference to the institutional tasks or manifest purposes of
the interaction in which they take part (e.g. the delivery and reception of healthcare).
This understanding is based on normative expectations regarding the nature of the
occasion and participants’ roles within it (cf. Drew & Sorjonen, 1997: 103). Hence, each
institutional form of interaction has a unique “fingerprint” (Heritage & Greatbatch,
1991: 95) made up of interactional practices “differentiating each form both from other
institutional forms and from the baseline of mundane conversational interaction itself”
(ibid.: 96). Interactional practices are conventional in character, which does not solely
mean that they are culturally variable, but also that they are subject to a number of
constraints.

**Constraints** are related to the specificity of the task being performed and of the
institutional setting in which it is performed. There are, however, some substantial
differences in the ways lay and institutional participants perceive and perform their
tasks. As pointed out by Drew and Heritage (1992b: 23), the conduct of institutional
participants is guided by professional and organisational constraints and accountabilities, which are not necessarily known to their lay counterparts. The fact that specific constraints limit allowable contributions to the business at hand is another salient feature of institutional talk. For instance, in doctor-patient interviews the procedures required for gathering data may be affected by time constraints (e.g. the doctor’s full schedule and the resulting attempt to obtain factual information from the patient as quickly as possible), economic constraints (e.g. the patient’s insurance scheme), legal constraints (e.g. the need to carefully compile medico-legal records and have the patients sign informed consent forms), and so on.

The fact that interactional talk is goal-oriented presupposes, at least in theory, some degree of cooperation between the participants towards “a common purpose or set of purposes, or at least a mutually accepted direction” (cf. Grice, 1975: 45). Although some forms of institutional dialogue may be overtly non-cooperative – for instance a police interrogation – cooperation lies mainly in the participants’ understanding of each other’s utterances by reference to the activity in which they are engaged. This shared knowledge results in a number of inferential frameworks that are associated with the context where the exchange takes place. Let us consider the question ‘how are you?’ In ordinary conversation such a question usually occurs at the beginning of the exchange immediately after greetings, or as a “greeting substitute” (cf. Sacks, 1975). In both cases it is normally perceived as ritual and responded to with a conventional ‘fine’, which leaves the floor open for the initiator of the sequence, i.e. the person who has asked the question. If instead of a ‘neutral’ fine, the recipient of ‘how are you?’ replies ‘awful’, ‘lousy’, ‘wonderful’, ‘great’, etc., then the initiator of the sequence will “have to” ask for the reasons determining such a state, i.e. s/he will enter a “diagnostic sequence” (ibid.: 74). However, the recipient of the initial enquiry may feel that the enquirer does not want to or should not hear the particular piece of news or trouble affecting her/his state, or hear it at that stage of the conversation. S/he will therefore avoid the diagnostic sequence by choosing a social answer (‘fine’), even when this implies telling a lie (ibid.).

8 Replies to greeting substitutes are powerful tools: since they can project different trajectories, they put those who utter them in a position of directing the following interaction (cf. Sacks, 1975).

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likely to be a doctor’s genuine enquiry into the patient’s state of health and is thus expected to be answered with a genuine account of how the patient is actually feeling. Indeed, as pointed out by Heath (1981: 84), the doctor’s use of ‘how are you’ in new appointments could be ambiguous for the patient, who may well interpret it as a polite, proper greeting substitute. By contrast, in return visits ‘how are you?’ is commonly heard as a topic initiator rather than a ceremonial formula requiring a ceremonial return.

What has been said so far requires a caveat: institutional talk is not as ‘rigid’ as it may seem and often includes instances of ‘mundane’ conversation (for instance jokes may be told in the course of a medical encounter). As we have already seen (cf. 2.3), such a relaxation of conventions in favour of more informal behaviours is normally associated with a change of frame. For this reason, it is extremely difficult, if not impossible, to clearly separate institutional talk from ordinary talk, especially in situations that are not highly formal, i.e. when the content of conversation is not pre-established and turns are not pre-allocated. What is possible, as already mentioned, is to systematically compare institutional talk with everyday conversation. It is to this comparison that the remaining sections of the chapter are devoted.

3.5 What makes institutional talk institutional? Examples from doctor-patient encounters

In 3.4 we saw that applied CA looks at the restrictions on “‘institutional’ usage of ‘conversational’ options” (ten Have, 1995: 251) to find out how social institutions are managed in interaction, i.e. how they are “talked into being” (Heritage, 1984: 290), and we have seen how important a comparative analysis is to this purpose. At this point one may wonder which criteria should be used for a systematic comparison between ordinary and institutional talk. Heritage (1997: 164) lists the following conversational features as the places to probe the institutionality of talk: a) turn-taking organisation, b) overall structural organisation, c) sequence organisation, d) turn design, e) lexical

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9 As a consequence, doctors may choose not to use ‘how are you?’ with first-time patients (cf. Heath, 1981: 84).
10 By the same token, ordinary conversation is not necessarily symmetrical, at least not completely. In fact, all social interaction must be asymmetric on a moment to moment basis to make communication possible. If it was not so there would probably be no need to communicate at all (cf. Lobley, 2001: 121).
choice, and f) epistemological and other forms of asymmetry. Let us consider these categories in detail.

In some kinds of institutional interactions turn-taking procedures are significantly different from ordinary conversation. According to Heritage (ibid.), it is very important to look at these special turn-taking systems because “they have the potential to alter the parties’ opportunities for action, and to recalibrate the interpretation of almost every aspect of the activities that they structure”. For instance, in many institutional occasions the types of contributions that participants are expected to make are restricted to one party asking questions and another answering them. Such an organisation is normatively oriented to by participants, and departures from it can be sanctioned. This is the case of interactions in formal environments like the court (cf. Atkinson & Drew, 1979), the classroom (cf. McHoul, 1978; Mehan, 1985), and the news interview (cf. Heritage, 1985a; Heritage & Greatbatch, 1991). As we will see (cf. 3.5.1; 3.5.4), doctor-patient interaction is rather different in this respect, in that although one party (the doctor) does most of the questioning and the other (the patient) does most of the answering, such a division is largely dependent on the task in which the parties are engaged (cf. Heritage, 1997: 165).

The fact that institutional interaction is normally task-oriented makes it possible to divide it in some typical phases corresponding to different sub-goals, i.e. to identify its overall structural organisation. Following Byrne and Long (1976) and ten Have (1989), routine medical encounters can be separated in the following sections: opening, complaint (i.e. discovering the reason for the visit), examination (i.e. medical history and physical exam), diagnosis, treatment or advice, and closing (cf. 1.3). Each of these phases is associated with particular types of contributions: ‘small talk’ (cf. Coupland, 2000a,b) is employed in openings and closings; questions and answers for discovering the reason for the visit and conducting the history and physical exam; medical assessments and explanations for diagnosis; and instructions for treatment. This linguistic description of the structure of a medical encounter corresponds roughly to the structure of the medical interview as described in the research and teaching literature in the field of

11 In fact, as pointed out by Drew and Heritage (1992b: 44), the six-stage sequence “rarely appears in full and in its canonical order because certain stages are optional and the overall structure may be disordered by a range of contingencies”.

61
medicine. Aldrich (1999) and Coulehan and Block (2001), for instance, list the following: introduction/greeting, chief complaint, history, review of systems and symptoms, physical exam, impression/diagnosis, treatment plan, closure.\textsuperscript{12,13} A more detailed discussion of the medical interview in terms of its constituent phases is presented in 3.5.2.

A crucial aspect of conversation analytic work is \textit{sequence organisation}. The term sequence denotes the “organization of more than one utterance by more than one speaker, such that the utterances display conditional relevance to each other” (Hopper, 1995: 68; cf. 3.5.3). Technically speaking, an adjacency pair is a basic (i.e. unexpanded) sequence type. More generally, a sequence is a unit across which a given activity is achieved, meaning by activity “a relatively sustained topically coherent and/or goal-coherent course of action” (Heritage & Sorjonen, 1994: 4). To analyse sequence organisation means essentially to look at how specific actions are initiated, progressed and concluded by the participants in the interaction and, as Heritage (1997: 169) put it, “how particular action opportunities are opened up and activated, or withheld from and occluded”. To make one example, turns at talk in doctor-patient encounters are largely linked together in question-and-answer sequences, whereby the doctor is the questioner and the patient is the answerer (cf. 3.5.1). By virtue of what Sacks (1992b: 264) has called a “chaining rule”, the participant who has asked a question has a “reserved right to talk again after the one to whom he has addressed the question speaks. \textit{And}, in using the reserved right, he can ask a question” (ibid.; emphasis in original). This rule provides for the occurrence of an indefinitely long conversation of the kind Q-A-Q-A-Q-A-etc. In medical encounters the chaining rule enables the doctor to pursue her/his goal of

\textsuperscript{12} Within the history phase several areas are identified, i.e. history of present illness, other active problems, past medical history, family history, and social-psychological history or patient profile, the latter including ‘embarrassing’ topics concerning occupation, lifestyle, use of tobacco, alcohol and ‘recreational’ drugs, spirituality and beliefs, relationships, sexual history, etc. As to the review of systems and inventory of symptoms, this is typically organised by organ systems (skin, blood and lymph, respiratory, cardiovascular, gastrointestinal, etc.) or by working head down as the physical examination takes place (head, eyes, ears, neck, throat, chest, heart, abdomen, genitalia, skin and extremities) (cf. Aldrich, 1999; Coulehan & Block, 2001).

\textsuperscript{13} Incidentally, and perhaps not surprisingly, the phase model structure is similar to the organisation of written medical records according to the four SOAP categories, i.e. “Subjective (the patient’s statement of his or her condition), Objective (the physician’s observation of the patient’s condition), Assessment, and Plan” (Fleischman, 2001: 477).
eliciting information from the patient by engaging in repetitive cycles of questioning (cf. 3.5.3), thus having a direct control on the conversation.

Another important aspect to take into account when examining institutional talk is turn design. As mentioned in 3.2.2, talk is oriented to the who and why of the interaction, and how turns at talk are constructed displays such an orientation. As highlighted by Heritage (1997: 170), when we refer to interactants designing their turns we are considering: “(1) the action that the talk is designed to perform and (2) the means that are selected to perform the action”. An example of (1) can be found in the above-mentioned work by Heath (1981), where the author deals with the use of first topic initiators in general practice consultations. In one of the excerpts discussed an encounter between a GP and a return patient opens with the doctor asking “Ah, it’s your foot isn’t it?” and the patient replying “Hm, it’s still swelling up: but I don’t think it’s been quite as bad, but it hurts more.” (Heath, 1981: 80). The fact that the consultation is a follow-up visit allows the participants to design their turns so as to orient to some shared knowledge regarding the reason for the visit. Thus, the doctor formulates a specific enquiry instead of a generalised offer of help (as in new appointments), which elicits patient’s talk on the progression of an already known complaint. An example of (2) is provided by Drew and Heritage (1992b) citing a work by Heritage and Sefi (1992) on the interaction between health visitors (i.e. nurses) and first-time mothers (and fathers). In one of the instances reported by Heritage and Sefi a health visitor has been asking the parents whether the child has begun to look around and gaze at them, and the parents have confirmed that he has. The health visitor responds by saying that they will be amazed at the baby’s progress, at which point both parents produce an agreement nearly simultaneously. However, the mother says “Yeh. They learn so quickly don’t they.” while the father says “We have notices hav’n’t w-” (Drew & Heritage, 1992b: 34). According to Heritage (1997: 172), the mother’s agreement is formulated in general terms to avoid taking the “novice” position, whereas the father’s agreement denotes his eagerness to prove to the health visitor that they are alert in noticing their child’s behaviours. What this example makes clear is that there are alternative ways of

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14 To be more precise, the exchange reported occurs between line 7 and line 9 of the transcript, lines 1-6 being occupied by ‘preliminaries’, i.e. greetings and a brief check of the patient’s name.
performing the same action (in this case agreement) and that interactants have different means at their disposal to shape their verbal behaviours. One of these means is lexical selection.  

**Lexical choice** is one of the most obvious ways to orient to institutional contexts. In 1.3. and 2.4 we have seen how the use of medical jargon by doctors has been traditionally considered a barrier to effective communication. However, technical or semi-technical terms may be oriented to by both doctors and patients as appropriate to the situation ‘medical interview’. For instance, in interview 12 (cf. Appendix B) the doctors use the term “gugo” and the patient, after getting recipient designed explanations of what kind of remedy gugo is (“gugo is for the heart”, “it’s also good for er any type of difficulty with fats”, “it’s a lowering agent, for cholesterol”), uses the same term as the correct word to refer to one of the medicines he is supposed to take. It is not my intention here to challenge the widely shared view that medical jargon can cause miscommunication, but, as will be evident from the discussion in chapters 5 and 6, patients are often not just to understand technical terms, but also to use them correctly. Another type of lexical choice involves what is known as “institutional euphemism” (Heritage, 1997: 174). In 2.2, when reviewing Labov and Fanshel’s work, I have briefly referred to the euphemistic “annoyed” used by Rhoda (instead of “angry”) as a defence mechanism. A rather different use of euphemisms is what Caffi (2001: 398) calls “empathic mitigation”, which is typically used by doctors or therapists rather than patients/clients. Euphemisms of this kind include downgraded expressions like “a little tuberculosis” (ibid.: 267) or “uncomfortable”, rather than painful (cf. Heritage & Sorjonen, 1994: 26n), which, as noted by Heritage and Sorjonen (ibid.), have a normalising function. In addition, the use of address terms and pronouns in medical (as well as other institutional) settings seems to be particularly context-sensitive. For instance, a doctor may refer to herself/himself as ‘we’ not ‘I’ because s/he is speaking on behalf of an organisation (the clinic or a medical staff). Finally, lexical choice also involves the selection of grammatical structures; for instance, passive constructions like “I was told” may be used by both doctors and patients to disclaim responsibility or quote

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15 Further examples of turn design in clinical encounters will be analysed in 3.5.4.
16 For further details on mitigation, see Caffi (1999).
an external authoritative source of information without committing too much to the truth of what is being said. These matters will be dealt with in greater detail in 3.5.5 and illustrated by means of examples in chapters 5 and 6.

Moving now to the last point in Heritage’s (1997) list, interactional asymmetries can be further divided into: (1) asymmetries of participation; (2) asymmetries of interactional and institutional know-how; (3) epistemological caution and asymmetries of knowledge; and (4) rights of access to knowledge.

As to (1), although the differences between mundane conversation and institutional talk tend to be oversimplified (cf. note 10 above), it is possible to find in the latter a generalised asymmetry of participation linked to specific roles and tasks. These inform the rights and obligations of participants so that, for example, doctors ask questions that patients are required to answer. This particular turn-taking organisation limits patients’ initiatives and secures physicians’ control over initiation, shaping and change of topics (cf. Mishler, 1984 in 2.5.2; 3.5.1.1; 3.5.1.2).

One kind of asymmetry that often causes considerable tension between professionals and their clients in clinical settings is (2), i.e. asymmetry of interactional and institutional know-how. As exemplified in the already mentioned study by Heritage and Sefi (1992), a mismatch can emerge between the professional’s agenda and the client’s personal experience. For instance, health visitors tend to give advice and support to first-time mothers in a normative way that is resisted by their clients. By virtue of their special training and experience health visitors recurrently adopt an approach whereby problems are identified and treated, and the inexpert parents are considered as routine cases. In contrast, mothers feel the unsolicited visits to be a form of social control and tend to reject advice that challenges their competence as parents.

Type (3) of asymmetry concerns knowledge and epistemological caution. Both doctors and patients can be very tentative when making claims, the former because they want to avoid committing themselves too much and the latter because they are aware of the gap between their lay opinions and the authority of medical knowledge (cf. Heritage, 1997; Lobley, 2001; see 3.6). According to Silverman (1987: 24-25), the asymmetry of knowledge in doctor-patient relations is assumed in the legal requirement for informed
consent: “I need to be informed because I know less. I give my consent to another’s proposal because he has the knowledge to make such proposals” (emphasis in original).

In institutional environments, knowledge may not be enough, but one must also be entitled to knowledge, i.e. one must possess what in point (4) above has been called rights of access to knowledge. A telling example is provided by Strong (1979), who records how doctors accompanying their children to paediatricians “suspend their medical expertise and act ‘like parents’ when dealing with the attending physician” (Heritage, 1997: 179). This and other forms of asymmetry, together with all other features providing for the institutionality of discourse illustrated in this section, will be substantiated with other examples from medical encounters in the next few subsections. In this way, an attempt will be made at categorizing the main findings in the conversational literature on doctor-patient interaction according to the various levels at which the interaction itself is organised.

3.5.1 Turn-taking in doctor-patient dialogues

A large number of studies focusing on the institutional character of doctor-patient interaction have dealt with data in which the institutionality of talk is embodied first and foremost in its form, most notably in turn-taking mechanisms which depart from the way in which turn-taking is managed in ordinary conversation. The following two subsections are devoted to two specific aspects regarding turn type, length, and order, which have previously been hinted at, namely interruptions (3.5.1.1) and question-and-answer pairs (3.5.1.2).

3.5.1.1 The ‘disproportionate’ tendency of doctors to interrupt patients. Physicians have generally been found to prematurely interrupt patients’ problem presentations to progress to the information gathering phase of the interview (cf. Beckman & Frankel, 1984; 3.5.1.2 below). Interruptive behaviours on the part of doctors are also found in a rather extensive study by West (1984b) on the distribution of physician-initiated vs. patient-initiated interruptions. 17 Here, however, the asymmetric pattern is complicated

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17 Incidentally, the word “initiated” is a rather unfortunate lexical choice. The expression is used by West (1984a; 1984b; 1993 [1983]) in combination with interruptions and questions, and by Frankel (1990) in combination with questions and utterances (see below), and is only employed here as a faithful
by considerations regarding patients’ race and gender. Before discussing West’s results, let us consider what is meant by ‘interruptions’. According to West (1984b: 55), an interruption is “an initiation of simultaneous speech which intrudes deeply into the internal structure of a current speaker’s utterance; operationally it is found more than a syllable away from a possibly complete unit-type’s boundaries”. This definition is further refined as the term ‘interruptions’ is only referred to as “violations of speakers’ rights” (ibid: 55; 166n), thus other types of simultaneity are excluded from the count. Example of the latter include simultaneous starts, continuations of prior incomplete turns, and displays of active listening.\textsuperscript{18,19}

Out of 21 transcribed exchanges (for a total of 532 pages), West found 188 instances of interruptions to occur in encounters between patients and male physicians. Of these, 126 (67 percent) are initiated by doctors as opposed to 62 (33 percent) patient-initiated interruptions (West, 1984b: 56-57). Further, the ratios of practitioners’ to patients’ interruptions are 1.1 for white male patients, 1.8 for white female patents, 2.6 for Black male patients, and 4.4 for Black female patients (ibid.: 56). The situation is exactly reversed with female doctors, i.e. 32 percent (19 out of 59) of interruptions are physician-initiated and 68 percent (40 out of 59) are patient-initiated, with same-sex interactions (between women doctors and women patients) approaching symmetry of relationship (see West, 1984b: 58 for aggregate figures). These findings led West to conclude that the use of interruptions by male physicians is a display of dominance and control over the patient, suggesting the primacy of gender even when other power relations (here professional status) are involved. Unlike Parsons (1951; cf. 1.2), West (1984b: 58-61) contends that doctors’ interactional control over patients is likely to hinder effective care: by “systematically and disproportionately” interdicting patients’ contributions, doctors also cut off potentially valuable information on which they must

\textsuperscript{18} Among those, West (1984b: 54) indicates displays of independent knowledge, whereby a hearer says the same thing at the same time as the speaker. A contribution of this kind is cooperative rather than competitive in nature, in that recipients can show not only that they are attending to what is being said, but also that they are listening carefully enough to predict what is coming next (ibid.).

\textsuperscript{19} Unfortunately West does not clearly distinguish between ‘violations of speakers’ rights’ and other forms of simultaneity, and only refers the readers to a complex coding scheme designed in a previous study (cf. West, 1978; 5.2)
rely to formulate a diagnosis and work out a treatment plan (cf. 3.5.2). What has been said so far seems to support the general claim that doctors talk more than their patients, who, being interrupted, produce shorter turns and generally tend to have their voice silenced (cf. 2.5.2). This asymmetry of participation does not concern solely turn length but can also be measured in terms of turn types and order, as we will see in 3.5.1.2.

3.5.1.2 The dispreference for patients’ questions. As already mentioned (cf. 2.2; 3.5.1.1), much of the medical encounter, together with other forms of interview-like interactions, is shaped by the alternation of questions by an interviewer (the physician) and answers by an interviewee (the patient). According to Frankel (1984b; 1984c), the micro-analysis of the adjacency pair structure of discourse can provide considerable insight into the ways in which participants initiate, sustain and complete sequences of dialogue. In particular, the analysis of the organisation of doctor-patient talk into questions and answers can shed some light on interactants’ participation options.

In her paper on queries and replies in physician-patient dialogues, West (1993 [1983]) points out the task-oriented character of the question-answer division (cf. 3.5), which she justifies in terms of information exchange: patients are physicians’ best sources of information “regarding the subjective experiences of their health and illness. So, it is understandable that doctors would be predisposed to question their patients” (ibid.: 127-28). Assuming that the medical encounter is based on the exchange of information, the author notes that patients should, at least in theory, behave in a similar way, i.e. one would expect them to ask doctors for information that only the latter can provide. However, medical interviews rarely seem to be a “two-way swap” (ibid.: 128). West’s investigation of 21 medical encounters yielded the following results: 91 percent of all questions were initiated by doctors as opposed to only 9 percent patient-initiated questions. Moreover, patients were found to answer 98 percent of doctors’ questions.

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20 In West’s work, as well as in the work of other analysts (e.g. Frankel, 1990), questions are defined not just in terms of syntactic or intonational criteria but by virtue of their sequential implicativeness as first pair parts. In other words, the presence or “noticeable absence” of an answer is considered a “proof procedure” for the analysis of some preceding utterance as a question (cf. 3.2.2). In fact, the category ‘questions’ has been shown to be a highly problematic linguistic construct and setting clear limits to it is a nearly impossible task. The difficulty in treating ‘questions’ as an analytic category in medical encounters is dealt with by ten Have (1991: 146-47), who notes that patients often seek information from physicians in a variety of ways other than questioning them directly. For instance, they often formulate their
whereas physicians replied to only 87 percent of patients’ queries. Doctors’ failure to respond is tentatively explained with their engagement in collateral activities regarding the physical examination on the one hand, and in the processing of information regarding patients’ condition (and leading to a diagnosis) on the other (ibid.: 151-52). Differently said, doctors are presumed to consider patients’ queries as interruptive of their deductive thought process. Interestingly, patients also seem to orient to the troublesomeness of their questions, as shown in West’s sample, where 46 percent of patient-initiated questions exhibit some form of speech disturbance (ibid.: 147-49).

The dispreference for patient-initiated questions is confirmed by Frankel (1990), who observes how the turn-taking system of doctor-patient talk is routinely restricted with respect to turn types and speaker identity. Like West (1993 [1983]), Frankel (1990: 232) underscores how participants’ behaviours are organised by reference to the specific activities performed and tasks accomplished in the interview. This determines the assignment of turn format types to speaker types. Specifically, Frankel found that in ambulatory care visits between adult patients and general practitioners the vast majority of physician-initiated utterances were questions, and less than one percent of patient-initiated utterances were “free-standing”. By free-standing the author means not simply utterances that occur in turns by themselves, but also utterances that are topically disjunctive, and/or produced at a “phase completion boundary” (ibid.: 260n) and start a new topic (or restart a just completed topic), and/or introduce new information by topic initiation, extension, or modification after a speech relevant pause (ibid.). Frankel found patients’ questions, and more in general utterances, belong to four categories: sequentially modified questions, i.e. questions prefaced by items like a “request to query” (e.g. “I wanna ask yih”; ibid.: 241) or a “noticing” (e.g. “That’s pretty int’resting.=How come you do that examination (.) sitting u:p?”; ibid.); questions in response to solicits (e.g. “There anything else y’ wanna show me while yer in here.=” “=Uhm, (0.2) No but let me j’st ask you if y’think I have (.) va- a vaginal infection at all”; ibid.: 244); initiations at boundaries marked by announcements (e.g. Dr: “ignorance” or “doubts” (ibid.) about medical matters using utterances that do not have a question form and do not establish the conditional relevance of an answer in the next slot, but might be taken up by doctors immediately or later in the encounter.

According to Frankel (1990: 244-45), solicits are devices used by physicians to constrain patients’ responses and operating as “last calls” for information.
“Awright dat’s disease one.” Pt: “Oka:y. (0.3) So- wai-yer gunnuh write down Metamucil or Kellogg’s All Bran”; ibid.: 246; simplified version) or by interruptions (e.g. after a phone call “Now-you asked me ‘bout the sleeping”; ibid.: 247); and initiations in the form of multi-component answers (e.g. Dr: “Did y’feel sjck.” Pt: “A little bit. Ye:s” Dr: “Mmh hmm. Right. ‘hh Now c’n yih tell me-” Pt: “An I wz very white.”; ibid.: 250; simplified version).

In her article on mishearings, misgivings and misunderstandings in physician-patient dialogues, West (1984a), while agreeing with Frankel (1990) on the dispreference for patient-initiated questions (particularly during history-taking; see also ten Have, 1991: 148-49), notes that patients recurrently produce requests for confirmation, requests for repair, and markers of surprise. The first type of request is aimed at checking understanding of a prior item produced by patients themselves. Thus, requests of this kind occur in the standard form ‘declarative utterance + items like you know?, okay?, right?, etc.’ (e.g. “It hu:::ts, okay:?”; West, 1984a: 113; simplified version). Requests for repair include items like “What?”, “Hunh?”, “Pardon?”, or repetitions of parts of prior trouble sources (ibid.: 112). Finally, surprise markers correspond to what has elsewhere been called ‘newsmarks’ (e.g. “Really?”, “Yea::ah?”; cf. 3.5.4.3). According to West (ibid.: 114), the major difference between the three categories just illustrated and questions is that while both are conditionally relevant, the former look backward whereas the latter look forward in sequential time. What is of particular interest in West’s sample is that the distribution of requests for confirmation/repair and markers of surprise (which she groups under the name of “conditionally relevant queries”; ibid.: 118) between doctors and patients is virtually symmetrical (for aggregate figures see West, 1984a: 117). In other words, contrary to the author’s previous findings regarding the asymmetrical distribution of questions (cf. West, 1993 [1983] and Frankel, 1990 above), the use of conditionally relevant queries does not seem to be constrained by speakers’ identity. Focusing on the conditional relevance of patients’ queries, West suggests that since these invite a second pair part, they afford speakers – be they doctors or patients – “the greatest freedom to invite expressions of mishearing, misgiving, or misunderstanding from recipients” (ibid.: 119; emphasis in original). This is an important resource for participants in interaction, as the “provision of opportunity for
response facilitates the possibility of ongoing production of talk that is mutually understood” (ibid.: 120).

So far, we have considered a series of studies revealing the paucity of patients’ questions and, in a number of cases, their failure to elicit physicians’ answers. Contrary to these studies, F. Roberts (2000) argues that it is not patients’ questions per se that are dispreferred but rather their design and position with respect to the larger purpose of the visit. Roberts’ analysis is based on 21 audiotaped conversations between breast cancer patients and oncologists recorded at a teaching hospital associated with a comprehensive cancer centre. The author has found that questions formulated by patients before the physical exam can be essentially of two kinds: those seeking reassurance about the cause of the disease, and those seeking information relative to treatment. The former receive an immediate answer, whereas the latter are “deferred” by the oncologist (ibid.: 153). These deferrals are shaped as “pre-insert expansions” in which the doctor mentions one or more clinical activities to be performed before actually initiating them (ibid.), as in the following example:

216 PT 96 Well (is there) other treatment besides this type
217 of (0.5) er doctor [Mc] he explained to me- he told
218 me, (1.0) that (..) he- if I needed it, he would give
219 me chemotherapy or, I could take a pill.
220 (2.0)
221 DR 10 There- right there are, there are other, uh, not all of
222 this adjuvant therapy is chemotherapy- some of it is is
223 hormonal therapy for [example.
224 PT 96 [uh huh.
225 (2.0)
226 DR 10 Why don't I examine you though and then we can
227 talk more about
228 PT 96 Okay.
229 DR 10 about what we definitely would recommend in
230 your case.
231 PT 96 Okay.
232 DR 10 Okay?
233 PT 96 mm?
234 DR 10 There should be a gown for you in the back room
235 there.
236 PT 96 Alright.

Here the patient asks a direct yes/no-question bolstered by a third party attribution (she invokes the authority of another doctor; ll. 216-19; cf. 3.5.4), but the physician treats her query as unanswerable at the moment while promising that an answer is forthcoming (ll. 226-30). Specifically, he mentions a clinical exigency, i.e. the need to visit her before recommending treatment. Once her request has been marked as “out of order” (F. Roberts, 2000: 160), the patient does not further pursue her enquiry (ll. 231, 236), thus cooperating in the order of events invoked by the physician in line with the conventionally established agenda of a medical encounter. According to Roberts (ibid.), this display of agenda setting makes the asymmetry of knowledge and tasks visible, in that it establishes who is “in charge” of the interchange, what is relevant for discussion and at which particular time. In other words, as pointed out by Sacks (1972), participants draw on their understanding of category-bound activities to make sense of what is happening at some particular moment (“why that now”; cf. 3.2.2) and to recognise when something is “out of order” or strange. This interactionally constructed order is the topic of 3.5.2.

3.5.2 The overall structural organisation of medical encounters

The conversational study of doctor-patient interviews in terms of their separate stages (cf. 3.5) is relatively recent. A significant contribution in this sense comes from Heath’s work on the opening stage of medical encounters (1981), which we have already discussed in 3.4, and on diagnoses (1992a), which will be reviewed in the following subsection. More recent studies have focused on other portions of the interview, particularly on the problem presentation (or complaint) stage, as we will see in 3.5.2.2.

3.5.2.1 The delivery and reception of diagnostic news. The most quoted among Heath’s ground-breaking studies on the structural organisation of medical interviews is probably his 1992 paper on the diagnostic stage of general-practice consultations. Drawing on Byrne and Long’s (1976) pioneering study, the author notes that the part of the medical encounter where the physician describes, evaluates, and actually names the patient’s condition tends to be particularly limited. Despite this datum, Heath (1992a: 237-38) argues that not only is the authoritativeness of the diagnosis not compromised, but it is
precisely by virtue of such brevity that the asymmetries of the relationship between doctors and patients are maintained. On the one hand, the very position of the diagnosis determines its status, in that it marks the completion of the data-gathering stage and paves the way for the elaboration of a treatment plan. On the other hand, both doctors and patients contribute to make the diagnosis short and somehow indisputable. Let us consider this last point in greater detail.

The most remarkable finding documented by Heath is that medical assessments are often met with silence: patients tend to withhold immediate response even if doctors leave a gap immediately following the conveyance of diagnosis and are visually available for patients’ contributions (i.e. when they are not engaged in collateral activities like writing prescriptions).\(^{22}\) Alternatively, patients produce a “downward-intoned, often muffled, *er or yeh*” (ibid.: 240), which leads to doctors moving directly to the management of patients’ complaints. Such a behaviour is all the more striking when contrasted with ordinary conversation, where newsworthy informings are normally met with *news receipts* (such as ‘oh’ or ‘oh’ + assessment)\(^{23}\) or *newsmarks* (such as ‘really’).\(^{24}\) In fact, the patients’ apparent reluctance to reply can be overcome by posing the diagnosis as a question in what Maynard (1991a; 1991b; 1992) has called a perspective display invitation. I am not going to dwell on this strategy, which will be dealt with at length in 3.5.4.2. Suffice it to say that even when patients do respond to a diagnosis by providing their own versions they design their accounts so as to preserve the differential between their lay conception and individual experience of the illness and the scientific opinion and expertise of practitioners. For instance, they may use

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\(^{22}\) Patient attitude seems to be rather different during the treatment recommendations stage, when responses are substantive and entail acceptance or even rejection, with patients resisting more or less actively to physicians’ directions (cf. Stivers, forthcoming).

\(^{23}\) Heritage (1984) defines ‘oh’ as “a change-of-state token” used by recipient of an announcement to mark the newsworthiness of the prior informing act. More precisely,

[w]ith the act of informing, tellers propose to be knowledgeable about some matter concerning which, they also propose, recipients are ignorant. Correspondingly, in proposing a change of state with the production of “oh”, recipients thus confirm the presupposition, relevance, and upshot of the prior act of informing as an action that has involved the transmission of information from an informed to an uninformed party. (Heritage, 1984: 304).

\(^{24}\) For a thorough discussion of news receipts and newsmarks see Maynard (1997: 107ff.).
Tentativeness markers such as ‘I think’, ‘I believe’, ‘I guess’, etc. to introduce their statements, thus minimizing disagreement (cf. Meehan, 1981: 114; 3.5.3.).

According to Heath (1992a: 252), in remaining ‘passive’ patients avoid halting the progression of the visit and (re)introducing topics which are more appropriately dealt with during the history-taking. Further, in giving cautious replies they avoid challenging clinicians’ authority. Should this authority and the asymmetry of doctor-patient roles be questioned, the very grounds for seeking medical help would be undermined (ibid.: 262). Hence, diagnoses while providing the basis for elaborating a treatment plan also legitimise patients’ claims of being ill. Ultimately, what Heath’s article demonstrates is a sensitivity on the part of both doctors and patients to what is acceptable and/or suitable and when (at what stage) in the particular circumstances of the medical encounter. The same conclusion can be reached by looking at other phases of the medical encounter.

3.5.2.2 The transition from problem presentation to information gathering. In a recent article Robinson and Heritage (2005) investigate the problem-presentation (or complaint) stage in over 300 visits between general practitioners and patients with acute problems. The article revolves around a specific portion of the complaint, namely the presentation of current symptoms. The authors argue that participants mutually orient to the presentation of current symptoms as a “locus of transition between the patient-controlled problem-presentation phase of the visit and the physician-controlled information gathering phase” (Robinson & Heritage, 2005: 481). Such a claim is documented with seven types of evidence, which I will now briefly review.

(1) Doctors often make reference to current symptoms in their opening questions; in particular, they tend to reiterate the words recorded by nurses in patients’ records, which frequently belong to patients themselves (ibid.: 483).

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25 Tentativeness markers, as well as claims of insufficient knowledge (e.g. “I don’t know”; cf. 3.5.3; 3.5.4.) are also used by doctors. As noted by Heath (1992a: 247-48), physicians can employ such devices to mark their diagnoses as tentative, thus encouraging patients’ contributions. However, when patients do respond with their own candidate diagnoses, and when these do not correspond to the diagnoses suggested by physicians, the latter recurrently preface their following assessments (i.e. often reiterations or elaborations of previously formulated diagnoses) with items like “in fact” or “actually”. As pointed out by Heath (ibid.: 251), this design of medical assessments displays the doctor’s “sensitivity to the incongruence between his qualified understanding of the condition and the version presented by the patient” – an incongruence that, as we have seen, is also oriented to by patients (for a detailed discussion of turn design see 3.5.4.2).
(2) Practitioners and patients often treat responses that do not contain current symptoms as incomplete. This evidence can be roughly categorised in four different classes: (a) claims to not know; (b) requests for diagnostic or physical-examination procedures; (c) simple past tense formulations; and (d) glosses of concrete symptoms (ibid.: 484-86). Classes (a) and (b) are self-explanatory in that patients may simply tell doctors that they are not aware of the nature of their problems (e.g. “What’s happenin’ to ya Clarisse” “I don’t know sir”; ibid.: 484; simplified version), or they can request specific actions outright (e.g. “How can I help ya today.” “You c’n check my ears.”; ibid.; simplified version). Class (c) is made up of descriptions in the simple past. Quoting Labov and Waletzky (1997), Robinson and Heritage point out that when one person solicits a telling from another it is customary for the latter to start a narrative by means of the simple past tense, which indicates that the teller will not be finished until s/he recounts events in the present tense (Robinson & Heritage, 2005: 485). Class (d) includes ‘low-resolution’ descriptions, or glosses, of current symptoms such as “I have something wrong”, “I’m falling apart”, etc. (ibid.: 486). In all these cases physicians tend to avoid jumping directly into the history-taking phase, but somehow wait for patients to present at least one concrete, current symptom. Robinson and Heritage’s study documents that they may do so by pausing, gazing at patients, and producing “continuers” (e.g. ‘uh huh’; cf. Schegloff, 1982), which signal their orientation to the incompleteness of patients’ responses (even when these are syntactically and intonationally possibly complete; ibid.).

Going back to the list of evidences, (3) consists in practitioners treating patients’ arrival at current symptoms as completing problem presentation, i.e. basically doctors’ moving to history-taking and/or examination (ibid.). In this respect, doctors’ shifts into information gathering prior to current symptoms may be treated as premature, which provides for evidence (4). This is best illustrated by a telling example:

01 DOC: What = you up to:. = h
02 (.)
03 PAT: I’ve gotta bad foot that I can’t- (. ) get well.
04 (0.2) ((Doctor moves his chair close to foot))
05 DOC: [Which part.
06 PAT: [((Patient begins to move foot back & away from physician))

75
PAT: >Okay.< (0.2) about five weeks ago I went to Disneyland
an' I wore a pair of sandals that weren’t very supportive.


Here, despite the incompleteness of the patient’s initial response in line 3 (a mere gloss; cf. above), the doctor moves closer to the patient to examine her foot and asks “which part” (l. 5), thus projecting a “shift out of problem presentation into information gathering” (ibid.; emphasis in original). The patient does not relinquish the interactional floor, but ‘fights’ for her right to present current symptoms. Her resistance is evident in her moving the foot back and away from the doctor (l. 6) and her providing no reply to his question but initiating “an illness narrative framed in the simple past tense” (ibid.; ll. 7-9). This example proves that the presentation of current symptoms is subject to patient manipulation. In other words, by delaying the introduction of current symptoms patients can negotiate an extended problem presentation slot.

(5) involves a situation that is the reverse of the one just illustrated, i.e. physicians may not shift to information gathering after presentation of current symptoms, in which case patients tend to indicate their completion (ibid.: 488). To do so they produce so-called exit devices (cf. Jefferson, 1978) such as “that’s why I’m here today”, which “encapsulate and reiterate” the preceding presentation (Robinson & Heritage, 2005: 488; simplified version).

(6) “[P]atients prospectively orient to the completion relevance of current symptoms” (ibid.: 489). For instance, when they have more than one current-symptom unit to present – which Robinson and Heritage found to happen in 78% of the visits they analysed – they utter the first unit with level intonation (a practice for indicating a lack of turn completion) and/or tend to speed up their talk to rush through the transition-relevance space between one unit and the next (ibid.).

(7) is made up of distributional trends, which, for the sake of brevity, I shall not dwell on. Suffice it to say, that such statistical evidence documents the strong tendency on the part of physicians to initiate transition into history-taking or examination “at patients’ first or Nth articulation of current symptoms”, and the corresponding tendency of patients “to treat such initiations as ‘legitimate’” (ibid.: 490). To conclude, the fact that
both doctors and patients orient to the presentation of current symptoms as a transition space between the complaint stage and the history-taking/examination suggests that prior research (cf. 3.5.1.1) may have overestimated the frequency with which patients do not complete problem presentation because of doctors’ interruptions.

The problem presentation stage of the interview is the focus of another recent article by Halkowski (forthcoming). The author addresses what he calls “discovery accounts”, in which patients report on how their symptoms have accumulated to the point where their decision to seek medical assistance is justified. Halkowski suggests that problem presentation is probably the most crucial phase of the interview for both patients and doctors. The former are concerned with proving the doctorability of their complaints (cf. 3.5.4.3) and the fact that they are competent (i.e. neither too worried nor careless) perceivers and reporters of their bodily states and sensations (cf. 3.5.3.3). The latter have a precious occasion to understand these concerns, as dismissing them could lead to inaccurate diagnoses ultimately jeopardising the effectiveness of clinical care (see also Drew, 2001; Frankel, 2001).

In the complaint stage, as well as during the history-taking, patients may present their own theories about illness, i.e. their “lay diagnoses” (Sarangi & Wilson, 2001), which doctors are expected to confirm or disconfirm. However, as noted by Gill and Maynard (forthcoming), when physicians have not yet completed the history-taking and the examination they may be reluctant to consider patients’ proposals and to proffer an authoritative response. The risk is that patients’ candidate explanations may become lost in the course of the interview. In this respect, ten Have (2001b: 257) argues that practitioners are faced with a dilemma: on the one hand, their immediate reactions “may display their understanding of and empathy with patients’ viewpoints and experiences, [on the other] such contributions may hinder speedy and efficient data gathering, and therefore adequate professional action”. According to Gill and Maynard, a solution to such a dilemma may be for doctors to mark at least their hearing of lay diagnoses to return to them at a later stage, and to let patients know that consideration of their concerns will only be delayed.

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26 These theories tend to be introduced in a tentative and indirect fashion (cf. 3.5.3.3; 3.5.4.3).
27 This tendency had already been pointed out, although only in passing, by Heath (1992a: 238).
3.5.3 The sequential organisation of medical interviews

In the following three subsections we will look at how medical interviews are sequentially organised focusing on the roles of doctors and patients as interviewers and interviewees and considering to what extent the question-and-answer structure affects the progression of the interview.

3.5.3.1 The question-answer-question cycle. In 3.5.1 we have seen that the basic structural organisation of interviews relies on pairs of questions and answers. We have also seen that, by virtue of the “chaining rule” (cf. 3.5.2), once a question has been asked and responded to with an answer, the floor is returned to the questioner. According to Frankel (1990: 234-35), in a standard two-party interview this rule limits speaker types to turn types and creates a deference structure, whereby the questioner controls the unfolding of the exchange. By contrast, casual conversation provides a number of other options that modify the chaining rule; for instance, “insertion sequences” (Schegloff, 1972b) or “side sequences” (Jefferson, 1972) may be interposed between a question and an answer. Moreover, a turn at talk may legitimately perform more than one activity.

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28 Given the conditional relevance property that holds between the two parts of the QA adjacency pair, one could expect that a question followed by either silence or talk not formulated as an answer would be a sufficient reason for a repetition of the question, or for some inference on the absence of the answer (cf. Schegloff, 1972b: 76-77). However, empirically this is not always the case, as proved by the frequency with which so-called “insertion sequences” can be found in naturally occurring talk. These are question-answer sequences inserted between an initial question and its answer, as in the following example:

A: Are you coming tonight?
B: Can I bring a guest?
A: Sure.
B: I’ll be there.
(Schegloff, 1972b: 78).

Jefferson’s (1972) “side sequences” occur within a wider variety of sequence types than Schegloff’s insertion sequences. A side sequence is defined as a “break” in an ongoing activity, specifically “a break in contrast to a termination; that is, the on-going activity will resume” (Jefferson; 1972: 294). One example is the following game between three children:

STEVEN: One, two, three (pause) four, five, six, (pause) eleven, eight
Nine, ten.
SUSAN: “Eleven”? – eight, nine, ten?
STEVEN: Eleven, eight, nine, ten.
NANCY: “Eleven”?
STEVEN: Seven, eight, nine, ten.
SUSAN: That’s better.
Whereupon the game resumes.
thus a question may be appended to an answer turn, or a second answer component may be attached to a first answer component (cf. Frankel, 1990: 236-38). Nonetheless, Frankel argues, doctor-patient communication unfolds largely as an indefinitely long Q-A sequence (see also Frankel, 1995).

In another paper dealing with turn allocation and speaker selection in the medical interview, Fisher (1984) compares the sequential organisation of doctor-patient talk to the way a classroom lesson is structured. The author draws on Mehan’s (1979) division of classroom discourse in sequences of the kind “Initiation Act-Reply Act-Evaluation Act”, and divides medical interviews accordingly into “Initiation Act-Response Act-Comment Act” (or I-R-C) sequences (Fisher, 1984: 204-5). According to Fisher, the main difference between classroom talk and doctor-patient talk is that “while doctors comment on the information patients provide, [unlike teachers] they do not usually evaluate the correct content of the reply” (ibid.: 207). The comments they make can be of four kinds: corrections, comments on the interaction, backchannels, and overlaps. Corrections have a teaching function (and are therefore closest to evaluations), in that they correct either patients’ pronunciation of technical terms or their understanding of medical problems. The class named comments on the interaction is a rather ill-defined group comprising a number of different items (including assessments; cf. 3.5.3.2) uttered by both physicians and patients and aimed at showing that the hearer is following the interaction or has some information to add. Backchannels (which have elsewhere been referred to as “continuers”; cf. 3.5.2.2) have a similar function but they take the form of “clucking noises” (Fisher, 1984: 209). Finally, overlaps are instances of simultaneous speech indicating a struggle for the floor. According to Fisher, all forms of comment act, especially corrections, reflect the asymmetry of the doctor-patient relationship. Ultimately, Fisher’s article is aimed at demonstrating that it is those who produce the initiation act and the comment act, i.e. those who have the first and last word (in our case doctors) that have control over the interaction. Nonetheless, Fisher’s argument does not seem to have a sound empirical base and its definition of the structure of doctor-patient discourse appears to be predetermined by external considerations regarding authority and power.
3.5.3.2 **Doctors’ missing assessments after patients’ answers.** A much more empirically-grounded piece of research is Jones’ (2001) paper on (missing) assessments in medical interviews. In everyday conversation assessments are often employed as displays of alignment, affiliation, and support. Also, in offering speakers’ interpretation of some previous conversational object, they display analysis of ongoing talk. Assessments convey an evaluative orientation, elicit responses from co-participants, and can accomplish a number of social actions (e.g. complaining, insulting, praising, etc.). Assessments can occur at various points in a conversation. Typically, as pointed out by Maynard (1997), they follow informing acts. In particular, they are part and parcel of so-called “news delivery sequences”, which consist of announcement, response, elaboration, and assessment (Maynard, 1997: 97). Within this kind of sequence, and together with the other three parts of it, assessments are employed by participants to converge on newsworthiness and valence, i.e. to “achieve accountable (mutually visible and oriented-to) good or bad news” (ibid.: 123). What is of particular interest for the present work is the use of assessments in troubles-talk and story-telling, which will be discussed in 5.4.2 and 6.3.2 (cf. also 3.3; 5.4.1). Suffice it to say here that assessments can be used to express support (e.g. empathy, encouragement, etc.) after some troubles-telling, thus aligning as a recipient, or they can be used after a story’s punch line to signal understanding and appreciation of preceding talk. Overall then, assessments are widely-used interactional devices aimed at sustaining social solidarity (cf. 3.2.2). Jones (2001), however, finds that such a precious resource is rarely employed by doctors when interviewing their patients.

Jones’ analysis is based on the data-gathering portion of 25 videotaped interviews between general practitioners and their patients. Overall, the author finds physicians remain silent or produce minimal acknowledgment tokens in response to patients’ answers to their questions. Let us consider one example where a patient has hurt his back in a work accident:

1. **Dr:** What- <what did you notice hurt after (0.2) after the accident
2. **P:** (We:ll) just- (0.4) right up (0.3) in: the back- (0.2) lower part of mah- (0.7) my (0.2) back here? [from-
Dr: [Mm hm]
(0.5)
P: From here down, (0.4) pt and I can’t turn from side to side like I usually do because it, it gets real painful you know I can turn so far and then I just can’t go that way anymore
(0.5)
I’m just wondering because I never had any back problems before (0.2) what the problem is (0.5)
Dr: Okay ‘h you noticed that immediately
(0.4)
P: Yes ma’am

(Jones, 2001: 128).

The patient’s answer to the doctor’s question (→ 2) consists in a first part where he locates the pain in his back, and a second part where he describes how the accident has limited his range of movements. The first part is met with the doctor’s continuer (Mm hm) elicited by the patient’s rising intonation and occurring in overlap with his “from”. The patient completes his description of pain location uttering “from here down” and then pausing. Since neither the pause nor the use of deixis (note the repetition of “here”) elicits a response from the doctor, the patient moves on to describe his condition. What is of interest is to note how the patient marks this second part of his answer as sufficient waiting for an assessment of some kind, which, however, is noticeably absent (cf. 3.2.2), as can be demonstrated by looking at the transcript more carefully.

First of all, conversationally speaking, the arrowed pause following the patient’s report (→ 3) is a long gap. Most turn taking occurs within two-tenths of a second (cf. Jones, 2001: 127), and a silence longer than this is likely to signal that something unexpected or troublesome is happening. Moreover, the patient’s telling gradually builds up to a climatic formulation (“I just can’t go that way anymore”), reached through a narration that is made dramatic by means of pausing, stretching (“re:al”), emphasis (“painful”, “so far”), and lexical choice (“real painful”, “just can’t”). A possible completion point is marked by “you know” which offers the doctor a possibility to respond and opens a “monitor space” for the patient to examine what happens or does not happen (cf. Davidson, 1984: 117). Ultimately, the way the patient designs his
contribution allows for confirmations on the part of the doctor, i.e. the patient is providing for his report to be “a mutually endorsed version” of what his problem is (Pomerantz, 1984c: 157). Since the patient does not receive any uptake from the doctor, he requests a response, which in this case is also a diagnosis (“I’m just wondering […] what the problem is). Again a pause of half a second follows (which does not even elicit a non-verbal response like a nod or gesture), after which the doctor produces an “okay-prefaced question”. This only minimally acknowledges the patient’s answer and steers the conversation back “on track” to the routine activity of history-taking (cf. 3.5.4.1).

Jones (2001: 130, 135) notes that when doctors do not remain silent they may use minimal acknowledgment tokens (e.g. uh huh), which, in that they do not provide the support or feedback being sought – exactly like silence – do not always function as ‘go-ahead’ signals prompting additional information from patients. Once doctors have failed to “take advantage of an ‘empathic opportunity’” (ibid.: 132), patients can try different ways of pursuing a supportive response: they can continue with an upgraded answer that makes their reports somehow more dramatic; they can request a response or diagnosis (as in the example just discussed), or they can offer a self diagnosis (as we will see later in this same subsection).

What is probably the most crucial aspect of the discussion on missing assessments in medical interviews is that of explaining why they are lacking. Jones (2001: 137ff.) identifies various possible reasons. One of these draws on previous research on institutional interviews, where there appear to be a limited number of items in the post-question-answer slot, especially in news interviews. Specifically, interviewers tend to avoid assessments, news receipts, newsmarks, and the like after interviewees’ answers, and instead follow up with another question (cf. Heritage, 1985a; Heritage & Greatbatch, 1991). Heritage and Greatbatch (ibid.) explain missing assessments in terms of two distinctive tasks of news interviews: (a) the production of talk for an overhearing audience; and (b) the maintenance of a neutral stance towards the interviewees’ positions. While the former explanation is not applicable to medical encounters, the latter may be plausible, in that doctors are trained to appear as objective professionals withholding “expressions of surprise, sympathy, agreement, or affiliation in response to
lay participants’ describing, claims, etc.” (Drew & Heritage, 1992b: 24). According to Jones (2001: 141), another possible explanation can be found in external factors, specifically time constraints: given the average length of a medical visit (fifteen minutes in the United States), it is understandable for doctors to follow a line of questioning, formulate a diagnosis, and establish a treatment plan in the time available trying not to get “side-tracked” by talk concerning patients’ personal stories (ibid.). Overall, doctors’ missing assessments seem to depend on several constraints, rather than being attributable to a lack of responsiveness or sensitivity. Nonetheless, as we will see (cf. 5.4; 6.3.2), assessments are important resources for eliciting patients’ elaborations, which could be helpful in the formulation of a diagnosis, and for showing understanding and support for patients’ conditions, which could generally make care more effective. While doctors may not affiliate with patients’ tellings as interactants in everyday conversation might, these tellings provides physicians with an opportunity to learn more about patients, thus improving their education and care. In fact, as demonstrated by Stivers and Heritage (2001), patients’ tellings can offer more information than was asked for.

3.5.3.3 Patients’ expanded answers to doctors’ questions. In 3.5.1 and 3.5.2 we have seen that the investigative stage of the interview is restrictive for patients’ contributions. During history-taking doctors ask a whole range of questions on patients’ present illnesses or chief complaints, past medical problems, family, diet and nutrition, habits, etc. (cf. 3.5). The interaction unfolds through a series of questions and answers that are sequentially chained, i.e. they are linked in time and structural organisation via a set of resources and constraints known as “sequential implicativeness” (cf. 3.2.2). Moreover, when questioning and answering are the major ongoing activities, as in medical interviews, an additional rule applies, which instructs the recipient of a question to provide a direct answer and then give the floor back to the questioner (cf. 3.5.3.1). Such

29 Similarly, Sacks (1992a: 768) notes that therapists are trained to listen without reacting along the lines of their own problems or experience.
30 Despite doctors’ displays of neutrality, Sorjonen et al. (forthcoming) argue that medical interactions contain a more or less explicit moral element. As Maynard and Heritage (2005: 433) put it, Sorjonen et al. in their article on lifestyle questions (use of tobacco, alcohol, drugs, etc.; cf. note 12 above), have found patients to “display an orientation to a normative priority of certain habits”, which affects their answers.
a rule tends to limit each speaking turn to a single speech activity, i.e. either one question or one answer, and according to Frankel (1990), this also limits speaker types to turn types, therefore attributing a ceremonial character to a speech exchange system where one party (the questioner) recurrently imposes upon another party (the answerer). This idea is consistent with a large part of doctor-patient interaction literature, in which the patient is often seen as a passive recipient of doctors’ initiatives, particularly in the history-taking context (see for instance Mishler, 1984; West, 1984a; Frankel, 1990). Hence, although doctors’ questions are designed to elicit information from the patient that may be relevant for the management of her/his medical condition, they are also constructed in a way that discourages any elaboration on the patient’s lifeworld concerns and favours minimal “no problem” responses (cf. Sacks, 1987a; Heritage & Sorjonen, 1994; 3.5.3.3). During history-taking, patients’ immediate and minimal answers, not just to yes/no-questions but also to wh-enquiries, guarantee adherence to the medical agenda. The need for immediate and minimal responses is made even more compelling by the line of questioning, which can evolve into a “build-up” of lexical items referring back to an initial question, the series of questions thus shaped having a clear “checklist status” (Stivers & Heritage, 2001: 153). This is probably most evident in first-time visits, where physicians conduct so-called “comprehensive history-taking”, as opposed to history-taking aimed at diagnosing a specific problem (cf. Stivers & Heritage, 2001: 181n).

Stivers and Heritage thoroughly investigate the comprehensive (medical) history-taking stage of a single primary care doctor-patient encounter and, contrary to what was reported in the previous paragraph, find that on a number of occasions the patient volunteers more information than is requested by the physician. Patients’ elaborations are essentially of two kinds and can have various functions. Stivers and Heritage draw a first distinction between expanded answers and full-blown narratives. Expanded answers can be used to perform three main tasks: addressing difficulties in responding, supporting responses by adding details, and pre-empting negative inferences.

The first class includes second answer components that elaborate on previous responses characterised by epistemic uncertainty (ibid.: 155; cf. 3.5; 3.5.2.; 3.5.4). In other words, expanded answers of this kind are attempts at ‘fixing’ dispreferred turn shapes that display the patient’s inability to provide information to which s/he has
limited access, as in the following case, where the physician is asking the patient about her siblings:

1    DOC: Are they in good health? er hh
2       (0.5)
3    PAT: Tlk=Yeah I thi
4           know they’re over uh long period uh time. but-
5    DOC: [Mn hm,
6    PAT: .hh Yieah: (,)


The patient’s answer is designed from the outset as dispreferred (cf. Pomerantz, 1984a; Sacks, 1987a) in that it is delayed by a pause of half a second and a lipsmack (“Tlk”). The initial “yeah” is followed by “I think so：“, which qualifies it as an uncertain response warranting subsequent elaboration. The patient does elaborate on her answer with an account of her difficulty in providing a generalised response, which she explains as depending on the age range of her siblings.

The second class of expanded answers is used by the patient to provide additional information, which, despite not being solicited by the doctor, is relevant to the immediate medical agenda set by the doctor’s preceding question, as in the following example from my sample of doctor-patient interviews:

1    PR  erm what about er well you do wear glasses. what about
2    P  yeah. [(slb slb)]
3    PR   [ erm a ]ny pain in your eyes, pain behind your eyes,
4    P oh my eyes really bugged me this fall because i couldn't have my
5       allergy medi[cation.]
6    PR       [uh huh.]
7    P so i went i w= i was going (slb slb).
8    PR  uh huh.
9    P i was sick for six weeks this fall with like a wicked bad [s]inus
10   PR       [uh hu.]
11   P type junk you know [going on,]=
12   PR      [ uh huh.]=
13   P =i did have like eye infection [(that have)] (slb) my eyes=
14   PR        [ uh huh!]
15   P =that i had never had my whole life. [not of] a daily type of=*
16   PR        [o kay,]
The doctor’s (PR) question about ocular pain in line 3 warrants a minimal response (like the preceding question) but is instead followed by the patient’s multi-turn answer (see arrowed lines). This starts in line 4, where it is introduced by the “disjunct marker oh” (Jefferson, 1978: 221) as a device producing a “display of sudden remembering” (ibid.: 222), and continues through subsequent expansions until line 22. Although the patient’s expanded answer consists of volunteered information, it clearly links back to the topic introduced by the doctor (i.e. eye problems). Further, the continuing intonation of PR’s turn in line 3 enables the patient to make inferences on possible incremental additions to the doctor’s enquiry about problems connected to her eyes (e.g. burning, itching, etc.). She therefore adds information, which she probably believes to be useful for the doctor to correctly evaluate her present situation in order to arrive to a treatment plan.

The third and last category of expanded answers groups responses that work towards pre-empting negative inferences. According to Stivers and Heritage (2001: 161), expansions of this kind are employed to avoid criticism and explicit counselling. Recurrently, they occur when delicate issues are at stake, especially issues associated with social stigma, like alcohol or drug consumption, and more generally when issues of preventive health care are being discussed. Let us consider a short example:

(Stivers & Heritage, 2001: 161).
Here the patient’s response in line 3 indicates her awareness that self-examination is a prerequisite for answering the doctor’s question, and “treats the question as holding her accountable for performing this action” (ibid.). With the addition in line 5, the patient acknowledges her failure to do what she “should” have done, thus displaying knowledge of her self-care obligations while at the same time preventing the doctor from topicalising the issue, by either expressing a negative evaluation or giving his professional advice.

A different kind of patients’ elaborations is what Stivers and Heritage (2001) call narrative expansions (or, as mentioned above, full-blown narratives). For the sake of brevity no instance will be reproduced here, as narratives were dealt with at length in 3.3 and examples thereof will be discussed in 5.4.2 and 6.3.2. Nonetheless, a couple of introductory remarks are due. Unlike expanded answers, narrative expansions present information that is “neither licensed by a question nor does it expand on an answer” (ibid.: 165). Instead, they address concerns that patients independently treat as issues to be acknowledged and place doctors in the role of story (or trouble) recipients, moving away from the interactional organisation of history-taking (and medical interviews in general) and closer to that of everyday conversation. What is of interest for the purposes of the present section is to note doctors’ responses to patients’ elaborations, be the latter expanded answers or narrative expansions. In their single-case analysis Stivers and Heritage (2001) have observed the doctor’s failure to provide responses invited by the patient’s elaborations and recurrently projected by similar elaborations and tellings in ordinary conversation. These missing responses are basically assessments (cf. Jones, 2001 above), and second stories (cf. 3.3.1.4). Instead, the doctor produces minimal acknowledgment tokens and, at points, even disregards the patient’s tellings by looking away, trying to shift the focus back to the routine activity of history-taking. To do so, he continues his questioning shaping his enquiries in a way that discourages the patient from pursuing her agenda of concerns. For instance he prefaces his questions with “okays”, which function as disjunct markers projecting the beginning of a new activity.

32 The delay in line 4 suggests that the doctor is giving her this opportunity.
(Frankel, 1990; Beach, 1995). These and other turn-shaping devices will be discussed in greater detail in the next subsection.

3.5.4 Turn-construction design: medical agenda and patients’ concerns

In 3.5 we have seen that the way turns at talk are constructed can tell us a lot about the activities performed in the course of the interaction. Specifically, we have noted that the shape of turns is the result of participants’ choices (lexical, syntactic, etc.) reflecting the task-orientation of the exchange and addressing their priorities. The following three subsections report on turn-construction devices used in clinical settings by professionals (3.5.4.1-3.5.4.2) and patients (3.5.4.3).

3.5.4.1 And-prefaced and okay-prefaced questions. The foregoing discussion on turn-taking and sequence organisation (cf. 3.5.1; 3.5.3) has highlighted the central role of questions in medical interviews. Question design is another important feature to understand how the interaction between clinicians and their patients unfolds. Heritage and Sorjonen (1994) observe the use of and-prefaced questions in informal medical encounters between health visitors and first-time mothers. A first, significant finding is that this kind of questions seems to be much more frequent in the medical context (and, more in general, in institutional settings) than in ordinary conversation between peers or acquaintances. Occurring at turn-initial position, ‘and’ is a crucial resource for the sequential organisation of conversation, in that it projects current turn’s shape and type (and relevant next action) and invokes a relationship with preceding talk (cf. Schegloff, 1987: 71-73).

In early visits to first-time mothers the task of health nurses is to gather fact sheet information on the health condition of both mother and child. Heritage and Sorjonen (1994) have found that health visitors’ enquiries are largely based on and-prefaced questions, and argue that these are primarily used to maintain participants’ orientation to the “official business” of the encounter (ibid.: 5-6). In other words, the nurse treats questions as routine or agenda-based, i.e. as members of a series she has in mind, or as externally motivated components of a bureaucratic task (specifically filling in a form). In addition, and-prefaced questions recurrently mark previous answers by mothers as
unproblematic and sufficient, moving the talk forward to a “next unit” and thus registering progress within the information-gathering activity (ibid.: 6). However, transition from one unit to the next is not always smooth, as unexpected or problematic responses may emerge during the questioning. When this happens nurses typically address the problematic response by formulating contingent or follow-up questions. These, however, are not and-prefaced, as in the following example:

7  HV: 1- Your tail’s alright.
8   (0.7)
9  M:    Yes.
10  (.)
11  M:    Lot more comfortable now.
12   (0.7)
13  HV: 2- Did you have stitches.
15  HV:    Hmm.
16   (2.1.)
17  HV:    And uh y- you’re having salt ba:ths.

(Heritage & Sorjonen, 1994: 8).

Here the nurse’s enquiry in line 1 projects a preferred minimal and immediate no-problem response (cf. Pomerantz, 1984a; Sacks, 1987a; 3.5.3.1). However, the affirmative reply by the mother occurs with a substantial delay (see the pause in line 2) and is followed by an expansion suggesting some previous and not yet resolved discomfort (l. 5). Such a response, which was not anticipated by the preceding enquiry, is met with a contingent question by the nurse (l. 7), which formulates the possible cause for the problem raised by M. Hence, when there is a problematic response contingent (or follow up) enquiries are produced as ad hoc questions that sustain “the topical focus of the preceding question/answer sequence (…) [treating] the prior response as embodying some problem that needs to be dealt with” (ibid.: 11). Once the problem has been addressed, and-prefaced questions are typically used to return to the main line of enquiry associated with the visit, as in line 11 above, where the nurse asks a question on salt baths (i.e. a routine therapy for new mothers).

According to Heritage and Sorjonen (ibid.: 19ff.), by virtue of their agenda-based character and-prefaced questions can have a “normalizing” function. For instance, they
can be strategically used to deal with potentially face-threatening enquiries into delicate matters. In the health visit context, they are also employed by nurses to express the contrast between the official task they have to carry out and the bureaucratic requirements they have to satisfy on the one hand, and a more general attempt at establishing an affiliative relationship with the mother as a “helper” and “befriender” on the other. Regardless of single uses of and-prefaced questions, which are clearly rooted in the specificity of each encounter, what can be said by way of a generalisation is that the particular design of these questions makes it possible to invoke their routine character as parts of a larger course of action, thus facilitating the accomplishment of this same course of action.

A similar conclusion is reached by Beach (1995) in his paper on the usage of ‘okay’ in medical interviews. The author notes the “remarkably repetitive” use of ‘okays’ exclusively by medical authorities and especially as a preface to physicians’ next questions (ibid.: 264). Overwhelmingly, ‘okays’ appear in third turn position in sequences of the kind ‘Question-Answer-OK+Next Question’ to signal adequate receipt of prior turn and the possibility of closing it down to move on to next (ibid.: 266). In other words, while working as acknowledgment tokens, ‘okays’ (just like ‘yeahs’; cf. Jefferson, 1984c) are also clear displays of a recipient trying to “disengage from a topic in progress in order to introduce some other matters” (ibid.: 28). According to Beach (1995), physicians use ‘okays’ to keep the interview “on track” with the “official business” of the encounter (cf. Heritage & Sorjonen above). Against this backdrop, doctors’ ‘okays’ may either simply treat patients’ turns as adequately responsive, or they may precede partial repeats and/or requests for confirmation or clarification, thus showing that “certain unspoken implications are understood and even agreed upon as a prerequisite to topical movement” (ibid.: 284). ‘Okays’ can also be repeated and recycled in turn-transitional position as a way to deal with some interactional trouble, i.e. essentially trying to terminate patients’ continuations to proceed with the clinical agenda. In this respect, “okays-in-a-series” seem to realise the rule that the more ‘okays’, the more serious the interactional trouble (ibid.: 281). This discursive practice of doctors has contributed to engender complaints on the part of patients, who have often accused their physicians of impatiently ‘brushing off’ their answers and disregarding
their stories (ibid.: 285). Beach’s conclusion on this issue is that since ‘okays’ pursue the accomplishment of official clinical business, they inevitably preserve physicians’ options while constraining patients’ contributions and even closing down patient-initiated actions. Nevertheless, until the “focus and priority” of the clinical agenda is “eliminated altogether”, which is highly improbable, “the reliance on [‘okays’] (and other resources) as recruited components for controlling and shaping topical progression will undoubtedly continue” (ibid.: 286).

3.5.4.2 The perspective display series. The preceding two examples of turn-design concern doctors’ and nurses’ questions, which occur mainly in the ‘investigative’ phase of the interview. Another example of concentration and specialisation of turn types in clinical discourse is provided by Maynard (1991a; 1991b; 1992), who analyses the diagnostic stage of the medical encounter, particularly what he has called perspective display series (PDS). The PDS consists of three turns: (1) speaker’s opinion-query, or perspective-display invitation; (2) recipient’s reply or assessment; and (3) speaker’s report or assessment. The series is a device used in everyday conversation when giving bad news, and it works in such a way as to allow the bearer of the news to deliver some clues (in turn 1), after which the recipient can make a guess (turn 2), which the bringer of the news can then simply confirm, therefore avoiding stating the news straightforwardly (cf. Maynard, 1992: 333). The first two turns of such a mechanism operate like a pre-sequence (cf. Sacks, 1992b: 685-91) projecting two alternative trajectories: the asker can follow the recipient’s reply with her/his own report (or further questions and then the report), in which case the third-turn report is similar to a “news announcement” (cf. Button & Casey, 1984); or s/he may follow the reply with further questions without announcing any independent information but leaving the floor open for the recipient to do extended topical talk until the recipient ends up pronouncing the news herself/himself (cf. Maynard, 1992: 334).

When the perspective display series is adapted to clinical settings – where it has a concentrated distribution in the diagnostic stage for the obvious reason that making a diagnosis often involves giving bad news – the relationship between the first two turns and the third seems to be more rigid: after asking patients for their views, the physician
will “unfailingly” provide her/his report or assessment (ibid.: 335). This claim is corroborated by Maynard’s analysis of “informing interviews” (cf. Maynard, 1991a: 164) recorded in two clinics for developmental disabilities. During these interviews doctors have to inform parents of highly charged diagnoses concerning their children, as in the following example:

1. Dr. E: What do you see? As-as his difficulty.
2. Mrs. C: Mainly his uh-the fact that he doesn’t understand
3. everything and also the fact that his speech is very hard to
4. understand what he’s saying, lots of time
5. Dr. E: Right
6. Dr. E: Do you have any ideas WHY it is? are you-do you?
7. Mrs. C: No

In line 1 Dr. E. invites D’s mother to formulate her son’s problem, which she does in lines 2-4. Dr. E. confirms what Mrs. C. has said (l. 5) and, after a short question-answer sequence on the possible causes of the child’s condition (ll. 6-7), proceeds to reformulate the mother’s complaint in lines 8-10. In these three lines Dr. E. topicalises what he thinks is the child’s main deficit, i.e. language (note the emphasis on “BASICALLY”, “MAIN”, “DOES” and “LANGUAGE”). In particular, the emphasis on ‘does’ is a way to reinforce the previously expressed agreement (l. 5). Mrs. C. replies with a “continuer” (cf. Schegloff, 1972b) in line 11, which is strongly invited by Dr. E.’s repeated “you knows”. The doctor further elaborates the diagnosis in lines 12-14 incorporating a term already used by Mrs. C. (“understand”) and employing the expression “express his

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33 ‘You knows’ are also used by patients to explicitly give doctors the opportunity to respond to some prior request, announcement, etc. (cf. Gill et al., 2001: 77n).
thoughts”, which is a “close version of Mrs. C.’s reference to ‘speech’ [l. 3]” (Maynard, 1991b: 468).

This example shows that the delivery of diagnostic news is a jointly constructed achievement: by asking what the mother sees as the child’s difficulty, Dr. E. invites a “my side telling” (Pomerantz, 1980) on her part, thus co-implicating her knowledge and beliefs in the diagnostic news, i.e. giving room to her lay diagnosis (cf. 3.5.2.2). According to Maynard (1991a: 165), this “circuitous” way of giving bad news has a twofold effect. From a structural point of view, it exhibits the participants’ orientation to the asymmetry of the lay-professional encounter (particularly, the social distribution of knowledge that accounts for the patient’s right and obligation to seek advice from the medical expert), by establishing an alignment regarding (a) the existence of a clinically relevant problem (i.e. the reason why the patients have come to see the doctor), and (b) the clinicians’ expertise in dealing with such a problem. At an interactional level, the PDS presents diagnoses in a non-conflicting manner, thus working to preserve “social solidarity” (cf. 3.2.2). In other words, the PDS makes it possible to produce reports or assessments in a fashion that is sensitive to recipients’ understanding and opinions, and at the same time maximises agreement. Such a “mutuality of perspective”, as Maynard (1991b: 466) called it, is even more evident when the first turn in the series, i.e. the perspective-display invitation, is pronounced in an unmarked format. In the previous example Dr. E. refers to the existing problem by mentioning the child’s “difficulty”. In fact, not all queries are so direct: in another excerpt the physician asks the parents of a child named Marvin if they have any questions or “anything you wanted to tell me about how things have been since I first saw you and Marvin” (Maynard, 1991a: 185; simplified version). Such an unmarked query is less presumptive than marked invitations in that it provides the parents with the opportunity to discuss the child in more general terms than the focal aspect of the interview, which, as mentioned, is the presentation of clinical findings and the formulation of a diagnosis.

As we will see (cf. 5.4.2; 6.3.1), patients’ talk about some general concerns and/or troubles indicates that there may be other things to be discussed, and that patients themselves may have “something to talk about besides ‘problems’ for which the clinic may have solutions” (Maynard, 1991a: 184). Patients’ contributions of this kind are not
only located in diagnostic environments but can occur throughout the interview. According to ten Have (2001b: 258), expressions of patients’ problematic experience are important resources for at least two reasons. On the one hand, they often make reference to pre-clinical thinking and talking accounting for the reason why patients request for medical attention. On the other hand, they can be used for later elaboration and decision-making. Clearly, such contributions tend to be un-medical in character, but patients are often “acutely conscious” of the lay nature of their considerations and theories, and thereby treat them as “delicate” initiatives, which need to be conducted in a way that does not overtly challenge the doctor’s authority (Drew, 2001: 264). This brings us to patients’ use of turn design.

3.5.4.3 Patients’ displays of uncertainty as a way to pursue a response. In 3.5.2.3 we have seen that patients can ‘break away’ from the restrictive environment of history-taking to pursue their own agenda of concerns by answering “more than the question” (Stivers & Heritage, 2001: 151; cf. 3.5.3.3). In this respect, turn design is used to implement specific projects, and can be a very subtle tool for patients to make initiatives.

In 3.5.2.1 we have seen that patients tend to mark their theories and explanations about illness as tentative. In her analysis of the encounters between fifteen patients and four doctors in a general internal medicine outpatient clinic, Gill (1998) has found that in 90 percent of the explanations in her sample, patients downplayed their knowledge about the causes of their problems. Recurrent techniques to “claim insufficient knowledge” (Beach & Metzger, 1997) or show uncertainty include expressions like ‘I don’t know if’, prefices like ‘whether’ and ‘whether or not’ to indicate the possibility of an alternative, verbs like ‘think’, ‘believe’, ‘guess’, and so on (which have elsewhere been defined ‘tentativeness markers’; cf. 3.5.2.1), and ‘neutralistic’ attributions to third parties realising a shift in footing (e.g. ‘Doctor X says that…’). Such displays of agnosticism cannot be confused with the cognitive state of ‘knowing’ (cf. Drew, 1991). In fact, patients display their lack of entitlement to a specific type of knowledge, namely

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34 For further details on the use of footing to achieve neutrality, see Clayman’s (1992) study on news interviews.
knowledge about causation (cf. Gill, 1998: 345), which they treat as “normatively belonging” to doctors (Drew, 1991: 39). While still presenting their own versions, patients design them in such a way as to avoid committing themselves straightforwardly to a particular perspective. Rather than asserting an objective state of affairs, they make smaller claims using cautious forms: “reporting my limited experience is … and an authoritative source said … are both ways of mitigating sensitive actions” (Pomerantz, 1984a: 625; emphasis in original.), thus maximising agreement and minimising disagreement. What expressions like ‘I don’t know’ seem to be doing is “providing that I’m not entitled to say this’, that is to say, ‘I cannot defend it professionally’, if it’s a matter of professional information” (Sacks, 1987b: 218).

Ultimately, patients orient to the asymmetry of layman-professional interaction by distinguishing between the former, who is entitled to have opinions, and the latter, who has an exclusive access to medical knowledge (ibid.). However, when it comes to describing first-hand experience (e.g. timing, duration, and location of symptoms) patients express themselves in a rather more confident way, presenting simple proposals or assertions. In this respect, the doctor’ role as questioner in the data-gathering portion of medical interviews “relies on and reinforces” patients’ legitimate entitlement to another type of knowledge, i.e. the “empirical realm of knowledge” (Gill, 1998; 349). In short, doctors and patients “collaboratively enact an asymmetrical social organisation wherein patients are authorities about their experiences” and doctors about why patients’ health problems occur (ibid.: 342).

Another thing that patients’ displays of “ignorance” or “doubts” (cf. note 20) can do is make their informational needs known to the doctor without explicit questioning. In other words, “my-side telling” (i.e. the practice of telling “how I know”) is a “fishing device” (cf. Pomerantz, 1980; 1984a; 1988) used to solicit doctors’ responses. As we have repeatedly seen, the question format determines the conversational appropriateness (or rather imperativeness) of a response. By imposing limitations and obligations on subsequent courses of action, questions establish the conditional relevance of answers. Gill (1998: 346; 357) argues that patients rarely question their doctors precisely because

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35 Gill’s observations are consistent with Halkowski’s (forthcoming) claim that patients mitigate their causal theories for fear of raising medically irrelevant matters, striving to appear as sensible patients presenting doctorable problems (cf. 3.5.2.2).
they do not want to constrain doctors’ response options or set the stage for disaffiliative actions associated with ‘not being answered’. Requests are thus formulated in a variety of shapes other than questions.

In another article, Gill et al. (2001) show precisely how patients can accomplish a request without making one. The paper moves from a thinly veiled criticism of previous research on patients’ requests and clinicians’ responses, which is ‘blamed’ for reducing requesting and responding to discrete categories. Contrary to an alleged dispreference for patient-initiated requests (particularly during history-taking; cf. Frankel, 1990 in 3.5.1 and 3.5.3.1), Gill et al. note various ways in which patients can request medical action, despite the surface form of their utterances not being interrogative, since in the medical setting making a request is typically considered to be “doctor’s work” (Gill et al., 2001: 57). In addition, requesting presupposes “some determination of a candidate health problem (...) [and] open[s] the door to the awkward if not face-threatening prospect of being refused” (ibid.). For all these reasons patients design their requests with ‘due precautions’. Gill et al.’s paper focuses on a first encounter between a middle-aged female patient and a younger male physician recorded at a general internal medicine outpatient clinic. The patient implicitly requests a diagnostic test for HIV, which she believes she might have contracted during a hysterectomy, when she received a blood transfusion. The methods used by the patient to raise the question are various. First, she downplays the issue by delaying her request: she does not express her concern when she initially has the possibility to do so, i.e. when the doctor enquires about the hysterectomy, but only mentions it at a later stage of the interview, thus minimising the risk of appearing excessively worried. Second, she tests the waters by reporting the circumstance, i.e. she merely inform the doctor of the blood transfusion, thus giving him the opportunity to formulate its possible upshot. Third, she avoid ownership of the concern, by attributing it to her children and further distancing herself from it through the insertion of laugh tokens, which mark the possibly perceived medical irrelevance of the concern as opposed to her reasonableness as patient.36 Fourth, she reports what the

36 On the use of laughing particles by patients to ‘fix’ possible ‘cracks’ in the self-image they project see Haakana (2001).
children have said by means of the question “Did you ever get tested for AIDS?”, thus establishing the conditional relevance of an answer (ibid.: 61-65).

The doctor’s response emerges as gradually orienting to the patient’s concern. First, he declines to produce an upshot for the patient’s report by responding with continuers. Then he does not reciprocate laughter, showing he understands the strategic use that the patient makes of it. Finally, at a later stage of the interview, when the patient has already hinted at the HIV test, he proposes doing some blood and screening tests. However, he does that immediately after discussing some of the patient’s symptoms associated with menopause, and suggests that he doesn’t think “we need tuh worry about AIDS” (ibid.: 74). By using “we”, the physician transforms the ownership of the concern from the patient’s children to include the patient and the doctor, therefore treating the issue as a legitimate (‘doctorable’) matter to discuss during the visit. In this way, he simultaneously achieves two results: in prescribing the tests he avoids discounting the patient’s fears and provides reassurance about AIDS, and in addressing such fears “en passant he tunes his plan to the key in which the request is made” (ibid.: 75).

The conclusion that can be drawn from Gill et al.’s discussion is twofold. On the one hand, whether or not a series of activities amount to a request is not predetermined but is cooperatively established by the participants in interaction. On the other hand, patients seem to be cautious when making initiatives, and orient themselves to the delicacy of initiative-taking in a way that displays their awareness of the asymmetry of knowledge and activities involved in doctor-patient interaction (cf. 3.6).

3.5.5 Lexical choice in doctor-patient interviews

The present section deals with various aspects of lexical choice in doctor-patient interviews. As the issue of word selection is wide-ranging and involves lexical as well as grammatical categories, no extensive treatment is possible here, and only aspects specifically addressed in chapters 5 and 6 will be presented.

In a 1981 paper on the use of medical terms by doctors and patients, Meehan criticises previous research on the topic for moving little “beyond abstract theorizing about the phenomenon” (Meehan, 1981: 107). In contrast, he sets out to analyse how doctors and patients organise their talk for each other on a turn by turn basis. As a first
general observation, Meehan notes that patients use and display an understanding of medical jargon by producing “successful” answers to doctors’ questions containing specialised or technical language (ibid.: 109). Such a finding, Meehan maintains, is not unproblematic, in that showing understanding does not necessarily correspond to achieving understanding (ibid.: 111). Looking more carefully at transcribed data, he finds that while medical interviews do include patients’ displays of problems with jargon, these displays are typically located in the “repair environment”, i.e. in sequences where troubles of some sort are in evidence (cf. 3.2.2) One example is the following:

01 Dr.: Have you had any palpitations;
     (2.0)
02 Pt.: Whatta yuh mean by a –what is a palpitation, I
03 really don’t know.
04 Dr.: Any–(1.0) poun//ding in your chest?


The term “palpitations” in line 01 is a trouble source in that its meaning is not known to the patient. After the turn bearing the problematic term, or candidate repairable item (CRI) as Meehan calls it (ibid.: 114), the patient topicalises the problematic nature of “palpitations” by producing a next turn repair initiator (NTRI) in lines 02-03 that directs the exchange towards an explanation of the term on the part of the doctor (1. 04). An NTRI is what Schegloff et al. (1977) refer to as other-initiated repair, as opposed to self-initiated repair, i.e. repair initiated by the speaker of the trouble source/repairable (here the doctor). In line with Schegloff et al.’s finding of a preference for self-over other-initiated repair in conversation, Meehan documents a tendency on the part of patients to avoid NTRIs. In particular, he finds that NTRIs are often only resorted to after other devices have been used. The preferred option is self-initiated repair by the doctor immediately after CRI and before turn completion. If this “anticipatory” (Meehan, 1981: 120) device is not employed, the patient may remain silent, as in the example above where there is a two-second gap before the actual NTRI is uttered. As pointed out by Meehan (ibid.: 118), silence is a means to provide evidence of a trouble source while allowing the speaker of that trouble source to initiate repair by producing an explanation or reformulation. If the speaker fails to recognise the repair implicativeness of silence, as
does the doctor in the example above, the recipient (i.e. the patient) answering a question that contains unknown medical terminology may also mark the trouble in her/his turn initial component (TCI) by using fillers like ‘erms’ and ‘uhs’, or drawls, which may prompt an explanation on the part of the doctor. If not even these signals work, then the patient will engage in an NTRI to display her/his problem of not knowing the terminology’s meaning. Meehan has found NTRIs to be used not just by patients but also by doctors when trying to clarify patients’ usage of medical terms. Specifically, the latter employ NTRIs to solicit more information about patients’ particular usage of jargon. Overall, the relevance of Meehan’s study resides in highlighting how, once a trouble has been identified (displayed), doctors and patients collaborate over repair sequences to achieve an understanding of the meaning of the troublesome term.

Another issue to do with lexical choice in doctor-patient encounters is the use of what goes under the general label “descriptive terms” (Drew & Heritage, 1992b: 30-32). These have been found to be context-sensitive; for instance, references to time or place may be formulated differently in “institutional” and “conversational” environments depending on the topic being discussed, the activity performed, the participants’ agendas, and their knowledge of the world, which is organised by membership categories (cf. Schegloff, 1972b; Sacks, 1972). Address terms are also selected by participants depending on their “membership analyses” of each other (cf. Watson, 1981: 97). Thus the various ways of naming people in any given institutional setting (e.g. by first name, surname, title, etc.) is contingent on their roles within that setting. What is of particular interest for the medical context is the use of pronouns. A doctor may refer to herself/himself as ‘we’ instead of ‘I’ to make her/his institutional identity relevant to the business at hand, i.e. basically indicating that s/he is speaking on behalf of an organisation (e.g. the clinic). In this respect, ‘we’ is often used by physicians to disclaim personal responsibility for a decision, a course of action, a mistake, etc. (cf. Silverman, 1987: Chapter 3). In our sample the first person plural pronoun is also employed to empathise with patients (cf. interview 5, l. 1291 “we’re all on the same boat”) or as a way to actively involve them in the treatment decision and make them responsible for their own health (cf. interview 1, ll. 1991-92 “we’re gonna get to do some deep breathing”; ll. 2017-19 “let’s do the crataegus solid extract and see where we get”;

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simplified versions). Interestingly, ‘we’ is also employed by some student clinicians in opposition to ‘they’ to distinguish naturopathic doctors from allopathic doctors (cf. interview 6, ll. 392-406).37

3.6 Doctor-patient interaction: asymmetry revisited

In 3.5 and its subsections I have illustrated the categories proposed by Heritage (1997) to analyse the institutionality of discourse by means of real examples from medical encounters. In so doing, I have ‘reserved’ one subsection to each category, although overlaps are far from absent (for example, instances and features of turn-design can be found in 3.5.1 and 3.5.3., and lexical choice is also dealt with in 3.5.2 and 3.5.4). The only category to which a separate subsection has not been devoted is that of asymmetries (cf. 3.5). In fact, as pointed out by Heritage (1997: 179), asymmetry is a “wild card”, in that it is “embodied at all other levels of the organisation of interaction”. Examples thereof can be found throughout the discussion conducted in 3.5: asymmetries of participation are referred to in 3.5.1 and 3.5.3; asymmetries of interactional and institutional know-how are mentioned in 3.5.2 and 3.5.5; epistemological caution and asymmetries of knowledge are among the topics discussed in 3.5.2 and 3.5.4.; finally, rights of access to knowledge are discussed in 3.5.4.

What has clearly emerged from the review of conversational literature on doctor-patient interaction, particularly from the ‘microscopic’ analysis of turns at talk, is that asymmetry is interactionally achieved. This conclusion contrasts with previous sociological explanations of doctor-patient asymmetry. As we have seen in 1.2 and 1.3, patients’ subordination and physicians’ domination were accounted for in terms of professional authority and socio-political structures (see also Maynard, 1991b: 454ff.). Thus, doctors were considered gatekeepers of medical knowledge and agents of social control able to restore the sick to health and normal social relationships, and this inequality of patients’ and doctors’ roles was believed to constrain communication between them. It is only with discourse analytical and conversation analytical studies

37 The full texts of the interviews quoted in this subsection, as well as elsewhere in the thesis, can be found in Appendix B.
that communication between doctors and patients has stopped being seen as a “by-product” (West, 1984b: 34) of authority relationships and socio-political structures, and the nature of asymmetry as ‘co-construction’ has been made clear. In particular, conversation analysis, with its focus on turn-taking, has shown how asymmetries of various kinds are “created and sustained by members as endogenous features of interaction” (F. Roberts, 2000: 153). As pointed out by Maynard (1991b: 486), “the asymmetry of discourse in medical settings may have an institutional mooring, but it also has an interactional bedrock”. In other words, if it is true that one can identify rules for participants’ communicative behaviours within specific settings, it is also true that these rules are not followed but oriented to. It is only in situated interactions that participants in medical encounters “talk institutions into being” (cf. 3.5), producing asymmetry in various ways and to a variable extent (cf. ten Have, 1991: 139).

Ultimately, convergence on the nature of roles and relationships takes work, and this work can only be revealed by a careful, turn-by-turn analysis. In chapters 5 and 6 we will carefully examine different portions of the transcripts of naturopathic interviews reproduced in Appendix B to try and figure out how roles and activities are negotiated by doctors and patients. In so doing, we will consider all conversational features described by Heritage (1997; cf. 3.5) and discussed in 3.5.1-3.5.5. In particular, in chapter 5 we will focus on turn-taking and sequential organisation, whereas in chapter 6 greater attention will be paid to the overall structural organisation of talk.
4 DATA AND METHOD: THE UB SAMPLE

4.1 Introduction: selecting the site

In the introduction, I have outlined the aim of this study and the nature of the data examined (i.e. doctor-patient interviews), as well as the approach adopted (i.e. conversation analysis). In the present chapter, I will illustrate the methodological procedures adopted for the collection and analysis of the data, and explain the theoretical and practical reasons behind these procedural choices.

The data were collected at the University of Bridgeport Naturopathic Medical Center (Bridgeport, CT). The choice of this specific institution can be motivated in terms of both research interests and issues of accessibility. As my research project is part of a PhD programme in English for Special Purposes (ESP), choosing a work-related setting was somehow a predetermined option. Further, I had already been ‘inspired’ to study the medical setting during the collaboration to a previous project. One may wonder, however, why a naturopathic clinic was chosen. The reason is twofold. On the one hand, the fact that linguistic research on doctor-patient encounters has traditionally been confined within the boundaries of conventional (allopathic) medicine prompted me to gather information from ‘alternative’ contexts. On the other hand, approaching the University of Bridgeport (henceforth UB) was possible thanks to an informant, a previous colleague who happened to be a student of Naturopathy at the above-mentioned University. This contact made it easier to get in touch with the Clinic Director, with whom I discussed ethical issues and agreed on practical arrangements. Before going into the details, however, it is probably necessary to spend a few words to define naturopathic medicine.

4.2 What is naturopathy?

Throughout this dissertation the term ‘naturopathy’ is used to refer to a type of complementary and alternative medicine that emerged in the United States at the end of the nineteenth century. From its inception, naturopathy has proved to be effective with
chronic disease and many kinds of acute disease, and has been widely used as preventive medicine. The naturopathic approach to health is often said to be ‘holistic’, in that it is strongly influenced by a patient-centred model whereby the whole person – rather than the disease – is at the heart of the medical practice. In line with this approach, naturopathic doctors (hereafter NDs) are trained to use a number of diagnostic and treatment techniques that include highly patient-centred traditions, like Chinese medicine, Ayurvedic medicine, homeopathy, chiropractic, and physical therapy. Murray and Pizzorno (1998), whose volume is a classic reference for NDs, summarise the modalities adopted by naturopathic medicine as follows:

a) **Diagnosis**: all of the conventional clinical laboratory, physical diagnosis, and imaging (i.e. X-ray, etc.) techniques, as well as holistic evaluation techniques;

b) **Counseling**: lifestyle, nutritional and psychological;

c) **Natural medicine**: nutritional supplements (i.e. all food constituents), botanical medicine, and homeopathy;

d) **Physical medicine**: hydrotherapy, naturopathic manipulative therapy, physiotherapy modalities, exercise therapy and acupuncture;

e) **Family practice**: natural childbirth, minor surgery, natural hormones, biologicals, and natural antibiotics. (Murray and Pizzorno, 1998: 41)

The philosophical foundation of these therapeutic styles is stated in the six principles of naturopathic medicine. These are:

1) **The healing power of nature**: *vis medicatrix naturae*. Nature acts powerfully through healing mechanisms in the body and mind to maintain and restore health. Naturopathic physicians work to restore and support these inherent healing systems when they have broken down, by using methods, medicines, and techniques that are in harmony with natural processes.

2) **First do not harm**: *primum non nocere*. Naturopathic physicians prefer non-invasive treatments that minimize the risks of harmful side-effects. They are trained to know which patients they can treat safely, and which they need to refer to other health care practitioners.
3) **Find the cause:** *tolle causam*. Every illness has an underlying cause, often in aspects of the lifestyle, diet or habits of the individual. A naturopathic physician is trained to find and remove the underlying cause of a disease.

4) **Doctor as teacher:** *docere*. A principal objective of naturopathic medicine is to educate the patient and emphasize self-responsibility for health. Naturopathic physicians also recognize and employ the therapeutic potential of the doctor-patient relationship.

5) **Treat the whole person.** Health or disease comes from a complex interaction of physical, emotional, dietary, genetic, environmental, lifestyle, and other factors. Naturopathic physicians treat the whole person, taking these factors into account.

6) **Preventive medicine.** The naturopathic approach to health care can prevent minor illnesses from developing into more serious or chronic degenerative diseases. Patients are taught the principles with which to live a healthy life; by following these principles they can prevent major illnesses. (Murray and Pizzorno, 1998: 42)

(3), (4), and (5) are especially relevant for communication between naturopathic doctors and patients. Adherence to these principles emerges from the analysis of the data, as we will see in chapters 5 and 6.

### 4.3 Arranging the visit to the UB clinic

Having clarified what is meant by ‘naturopathy’, I return to the negotiation stage of data collection with the University of Bridgeport. First of all, my informant introduced me to the Director of the Naturopathic Medical Center, Dr. Christina Arbogast, who expressed interest in the research proposal. In particular, she suggested that recordings of the encounters between patients and student clinicians could be subsequently used for teaching purposes, for instance in doctor-patient relationship classes. I then wrote a formal letter to Dr. Arbogast to explain the objectives of my research in general terms and the data collection process in a more detailed fashion. A number of e-mails and phone calls followed to discuss practical arrangements.
After a direct contact was established, it immediately became clear that the two biggest hurdles would be confidentiality and time. In other words, I had to provide guaranties of anonymity of the participants in the study, and minimal disturbance of the clinic’s routine activities.

### 4.3.1 Confidentiality

Bridgeport, like most United States universities, has an Internal Review Board (hereafter IRB), and requires all research projects involving humans to comply with formal consent procedures. A draft consent form was therefore prepared. This was a reproduction of a template developed by Susan M. Ervin-Tripp at the Psychology Department of the University of California at Berkeley (cf. ten Have, 1999: 220-21 for the full form). As pointed out by Tripp herself (personal communication), the template employs what is called a Guttman scale of permissions increasing in ‘intrusiveness’. The scale is based on the researcher anticipation of future uses when s/he will no longer be able to find the informants. Unfortunately, the University of Bridgeport IRB responded unfavourably to the consent form, but it did provide detailed guidelines for the drafting of a form that could meet UB informed consent requirements. A second form was thus designed in four slightly different versions, so as to cover the two categories of subjects who were expected to participate in the study, namely patients and doctors, and the two possible recording formats, i.e. video or audio depending on the participants’ willingness to be filmed (see Appendix D).

### 4.3.2 Time

The planning of the consent process raised another issue of concern to the Clinic Director. Dr. Arbogast feared that the need to explain the nature of the study to the participants and gain consent from them would probably take an excessive amount of time with respect to the actual interviews. This problem could only partially be solved by including a brief explanation of the experiment in the consent forms, and it was finally decided that I should present my research project publicly, a few days before starting the actual recordings, during the so-called ‘Grand Rounds’. These are regular

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1 ‘Doctors’ here is also used to refer to the student clinicians who participated in the project.
meetings between student clinicians and supervising doctors that are held weekly at the
UB College of Naturopathic Medicine. The talk gave me the opportunity to outline the
content, method and aim of the research to all students and staff, in order to encourage
them to participate and think of patients who might, in their turn, be willing to
deliberate. Another preliminary step consisted in preparing a short notice to be placed at
the Clinic reception desk for all patients to read. The notice informed all visitors that
linguistic research on doctor-patient communication was being conducted and that all
interested patients could ask their primaries for further information on how to get
involved.\footnote{The term ‘primaries’ refers to fourth-year student clinicians (cf. 4.4).}

4.4 Observing the ‘field’

Once the recording of “frontstage” data (Sarangi & Roberts, 1999a: 19ff.) was agreed
upon, I felt that the successful completion of the study required some kind of access to
“backstage” data (ibid.) and the workplace in general. Hence, I also asked permission to
observe interprofessional communication during clinic shifts, and to attend various
courses held at the College of Naturopathic Medicine, including doctor-patient
relationship classes. This – I thought – would give at least some knowledge of the
environment, and a passing understanding of the activities observed as well as the

In this respect, it is perhaps worth mentioning a few aspects of the medical
consultation routine at the Naturopathic Medical Center in Bridgeport. Appointments are
scheduled by the reception staff directly with patients, who can ask to see a student
clinician of their choice. This student clinician, however, has to be a primary, i.e. a
fourth-year student. Indeed, patients are normally seen by two students: a primary and a
secondary, the latter being a third-year student. Primaries are in charge of conducting the
actual interview (including filling in the patient’s file), whereas secondaries usually deal
with side-activities, like taking the patient’s vitals, going to the dispensary to collect
medications, etc. Further, a supervising physician oversees the case, by ‘popping in’ the
exam room to check that everything is going on smoothly. The duration of his/her
presence into the room varies from case to case, depending on patient’s condition, students’ requests, etc. Clinic shifts are held from Monday to Thursday from 2 pm to 7 pm and on Friday from 9 am to 1 pm. The first 30 minutes of every shift are dedicated to so-called ‘case preview’. During this time supervising doctors (usually two for each shift) ask student clinicians to present their cases. These can be divided into two main categories: first-time patients and return patients, the corresponding visits being intakes and follow-ups respectively. Upon arrival each patient is met by his/her primary at the front desk and accompanied to the exam room which they have been assigned. Visits last approximately one hour, which means that each student cannot see more than four patients per shift. Although the structure of the consultation can vary, it can be said, by way of a generalisation, that the actual interview tends to precede physical examinations or medical procedures of any kind. The last 30 minutes of the shift are allocated for case review. At this stage students discuss cases with their colleagues and supervising doctors, commenting on aspects as different as patients’ complaints, test results, diagnoses, nature of doctor-patient communication, etc.

What immediately caught my attention was the proxemics of doctor-patient interviews at the UB clinic. In the encounters that I witnessed, including those that I recorded and transcribed, student clinicians and patients were sitting at about one metre from each other, at approximately a 45-degree angle, and without any barriers (e.g. a large desk or a movable tray) in between. According to Mitchum (1990: 138), diagonal spacial arrangement and a reduced distance between the participants facilitate conversation and cooperation (as opposed to direct cross-seating on the two sides of a desk, which is confrontational and creates greater interactional distance). Unexpectedly, on some occasions patients were sitting on the exam table, i.e. at a higher level than student clinicians. Finally, supervising doctors, who only spent a short time in the exam room (see above), were standing. Overall, seating and more in general spatial arrangement denoted a high level of flexibility and informality.

Having outlined the main arrangements that shape clinic activities, we can now go back to what I have termed the negotiation stage. As emerges from the preceding brief

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3 During the interviews student clinicians tended to remain seated unless otherwise required by physical exam procedures.

4 Except the supervising doctor for interview 10, who was sitting on the exam table.
description, during our living-in period at the Naturopathic Medical Center I was able to gain some background knowledge, which was relevant – if not essential – to my purposes. I also brought together a fair number of fieldnotes (particularly from student clinicians) which, despite not systematically collected and filed, made it possible to grasp the reality of the participants in the consultations, their concerns, relevancies, and so on. Although gathering additional information was useful, it was clear from the outset that this might also be dangerous, in that it could cause me to have a positive bias towards naturopaths. This prompted me to look for some kind of feedback from the participants in the study. I therefore devised two different anonymous questionnaires for student clinicians and patients respectively. These are multiple-choice questionnaires adapted from existing interaction scales and reviewed by Dr. Arbogast, who helped in making statements clear and non-judgmental. Rather than aiming at getting a detailed reconstruction of ‘the facts’, questionnaires were intended to obtain the participants’ general perception of the preceding encounter from a communicative point of view. With this objective in mind, I prepared a list of statements ranging from “the doctor used words that I did not understand” to “the doctor considered my individual needs when treating my condition” for the patient questionnaire, and statements regarding patients’ interactive styles (like “the patient’s style was focused and systematic”) for the student clinician questionnaire (cf. Appendix C for full versions). Clearly, the ‘focal data’ for the study remains the actual recordings and the corresponding transcripts, but the questionnaires made it possible to gather the participants’ opinions about and attitudes towards interactions that I did not witness (cf. 4.5), as well as to compare them with the impressions deriving from the transcription and analysis of the consultations. I decided to administer the questionnaires immediately after the visit, so that if, as argued by Heritage and Atkinson (1984:2-3), this type of interview data is inevitably the result of the informants’ “manipulation, selection, or reconstruction, based on preconceived notions of what is probable or important”, it is also true that I would at least gather interpretations and comments produced in the same setting as the original.

5 No questionnaire was administered to supervising doctors, as the time they spent in the exam room was limited (with a couple of exceptions) and the amount of talk on their part small compared to the duration of the entire interview. 
6 Like fieldnotes, questionnaires were not crucial to the analysis, but were a useful tool to improve my understanding of the setting where data was collected.
4.5 data collection and transcription

The actual data collection took place in November 2003. A total of 14 interviews between student clinicians and outpatients were recorded, of which 11 are videos and 3 are audios. The total running time is 10 hours and 54 minutes, the average length of the recordings being 46 minutes. In this respect, it should be underlined that the duration of recordings does not correspond to the duration of consultations, the former always being shorter than the latter. The conversation between primaries and their patients started at the front desk (cf. 4.4 above) well before entering the exam room where recording equipment was set up. Recordings were also often interrupted during physical examinations (when filming would be inconvenient or not appropriate), or when student clinicians left the room to talk to supervising doctors.

Interviews were filmed using a digital camcorder fixed on a tripod and two clip-on microphones, one for the patient and one for the doctor who would do most of the talking, i.e. overwhelmingly the primary. Before starting the participants were asked to read and sign the consent forms, of which two copies had been made, one for the UB IRB and one for them to keep. While they were reading I would set the recording equipment and answer their questions, if any. After collecting the consent forms I would switch on the camcorder and leave the room. I would then wait for the end of the consultation, or for one of the students to come and call me, to switch off the camcorder and administer the questionnaires.

The subjects involved in the recordings are 13 patients and 26 doctors. Among the former 10 are return patients and 3 are first-time patients, whereas the latter are 6 supervising doctors, 12 primaries and 8 secondaries. The only criterion for participant selection was their willingness to be filmed. Sociological variables like gender, class, age or ethnic group were not taken into consideration, nor was the fact that some of the patients were students of naturopathy themselves.

The 14 interviews thus recorded were ready to be transcribed. 5 of these were excluded for the following reasons. As most recordings were videos, I decided to exclude the 3 audios to make the sample more homogeneous. A fourth interview was left
out due to the bad quality of the recording, and a fifth because it involved exactly the same participants as a previously recorded encounter. The 9 .mpg files of the remaining interviews corresponded to a total running time of 6 hours and 10 minutes.

The 9 files were fed into Transana version 1.21, a tool that supports the transcription and analysis of audio-visual data. The software displays four different windows: video, sound, transcript, and data. In the video window the video can be played, paused and stopped; the sound window shows the waveform of the audio track for a given piece of video; the transcript window is where a transcript can be inserted, displayed and edited; and the data window is where data can be viewed, organised and manipulated. (cf. Transana manual, 1995-2002).

Transana proved extremely helpful with pause measurement, as the transcriber can highlight portions of the waveform and then click on a zoom button to determine their length. Pauses can then be inserted in the transcript by clicking on the ‘selected’ button, which also automatically rounds them up to tenths of seconds and assigns them a time code, so that pauses in the transcript are synchronised with the corresponding clips.  

The videos were transcribed using standard American spelling and Conversation Analysis conventions (cf. Sacks et al., 1974: 731-34; Atkinson & Heritage, 1984: ix-xvi; ten Have, 1999: 213-14). Features transcribed (of which a complete list can be found in Appendix A) range from overlapping to intonation, from laughter to extralinguistic phenomena. Last but not least, all transcripts were made anonymous by removing sensitive references to people and replacing them with invented names containing the same number of syllables as the originals. The complete sample (henceforth UB sample) can be found in Appendix B. Each interview was given a code made up of “UBNMC” (i.e. the acronym for University of Bridgeport Naturopathic Medical Center) and “INT”, followed by the progressive number of the interview and the date of the recording in a mm/dd/yy format (e.g. UBNMC: INT1-11.04.03).

7 In order to exclude articulatory pauses, a lower cut-off point was set to 0.2 seconds (cf. Goldman-Eisler 1958: 99; Towell et al., 1996: 91).
4.6 Approach to data analysis

As already mentioned, interviews were selected according to practical availability and subjects’ willingness to participate (cf. 4.1 and 4.5), and a corpus was assembled by making detailed transcriptions of the complete recordings (cf. 4.5). I then moved on to analyse data in a systematic fashion using what has been called ‘comprehensive data treatment’ (cf. ten Have 1999: 133). The analysis started with a process of “unmotivated looking” (cf. 3.2.1), whereby general remarks were made on an arbitrarily chosen sequence of the transcribed data. In particular, I noticed that in the selected sequence the patient did not provide minimal “no problem” responses to doctor’s questions (cf. 3.5.3.3), but often held the floor for several turns without being interrupted (cf. 3.5.1.1). Moreover, the patient did not refrain from asking questions (cf. 3.5.1.2), which were not ignored by the doctor, who, instead, often responded with multi-turn answers (cf. 3.5.3.1; 3.5.3.2). The observations thus formulated were extended to the entire recording/transcript, and the provisional findings emerging from the single case analysis suggested focusing my study on turn-taking organisation and sequence organisation. Therefore, I proceeded to look for similar instances in other interviews. In so doing, I validated my observations through proof procedure and deviant case analysis (cf. Peräkylä, 1997). In other words, drawing on the key notion of conditional relevance (cf. 3.2.2), I looked systematically for participants’ initiatives and responses by coparticipants, and examined cases where “things go differently” (Peräkylä, 1997: 210).\footnote{For instance, in the case of interruptive behaviours, after observing the paucity of overlaps and their non-competitive nature, I analysed the exceptions and explained them in terms of face-saving strategies and agenda mismatches (cf. 5.2.2.1 and 5.2.2.2).} I then gradually extended the analysis beyond turn-taking organisation and sequence organisation, to include the other conversational features indicated by Heritage (1997: 164) as the “basic places to probe the institutionality of interaction”, namely overall structural organisation, turn design, lexical choice, and interactional asymmetries (cf. 3.5). Finally, I tried to formulate some suggestions that could account for repetition and variation in the patterns identified.

To conclude, a few final words need to be spent on non-verbal communication. This was not systematically transcribed and examined in order not to make transcripts
unreadable. However, non-verbal behaviour like gaze and gesture (and on a few occasions spatial arrangement) was taken into consideration when it was clearly “relevant, sequentially, to the accomplishment of the activity at hand” (Heath, 1997: 188). For instance, as documented by Goodwin (1980) and Heath (1992b), gaze and head nods may be used to elicit participation in the ongoing activity. In any case, the meaning of non-verbal behaviour is inextricably tied to the context in which it arises, as we will see in the next two chapters.

\footnote{Cf. also Heath (1984), Psathas (1990b), Kendon (1992), and Frankel (1993 [1983]).}
5 THE INTERPENETRATION OF ‘VOICES’ IN NATUROPATHIC INTERVIEWS

5.1 Introduction

As noted in chapters 1-3, the literature on doctor-patient interaction has traditionally emphasised the doctor-dominated character of the medical consultation as determined by its primary goal (i.e. the delivery and reception of healthcare). Overall, and to use Mishler’s (1984) terminology, the medical interview has been considered to be shaped by the “voice of medicine” (championed by doctors) taking over from the “voice of the lifeworld” (represented by patients). By virtue of this dominance, in most studies, with the exception of a few recent conversational works, doctors are depicted as those who decide what to do and at what stage of the medical interview, while patients appear as passive recipients of doctors’ initiatives.

In the present chapter I will try to demonstrate that this generalisation does not apply to naturopathic interviews by comparing previous findings against the evidence provided by the UB sample. The analysis will take into account both patients’ initiatives and doctors’ responses to them, focusing specifically on turn-taking and sequential organisation (with observations on turn design and lexical choice). In particular, the following interactional features will be considered: a) interruptions (and overlaps) (is interruption a prerogative of doctors?); b) questions and answers (is questioning a prerogative of doctors? do patients ask questions? Do doctors respond to patients’ questions?); c) answers and evaluations/assessments (do patients provide unwarranted information in response to doctors’ questions? Do doctors express their emotions in reaction to patients’ accounts?). The three main aspects under investigation correspond to the three main sections into which the chapter is divided, namely 5.2 dealing with interruptions, 5.3 focusing on patients’ requests and doctors’ responses to them, and 5.4 discussing patients’ extended contributions and doctors’ reactions to these.
5.2 Overlapping talk and interruptive behaviours

One of the most widely analysed phenomena in the study of doctor-patient interaction is interruption. A preliminary operation that needs to be done before presenting any results from the sample is to try and find a working definition for ‘interruption’. In 3.5.1.1 we mentioned West’s (1984b) definition of interruptions and we saw that, although this is operationally very precise, it does not make it possible to clearly distinguish interruptions proper, i.e. “violations of speakers’ rights” (ibid.: 55), from other forms of overlapping speech. Defining what counts as an interruption has always been a hotly debated issue, and various parameters have been adopted by different analysts, for instance the duration of the overlap (a long overlap corresponding to an interruption), the effect of the overlap on the current speaker’s turn (the overlap being an interruption if it causes current speaker to relinquish the floor to next speaker), and the location of the overlap (considering as an interruption an overlap occurring at a non-transition-relevance place).\footnote{For a review of the most influential studies on interruptions see Zorzi (1990: 84ff.).} However, given the subjectivity, and therefore instability, of these criteria (where is the borderline between a long overlap and a short overlap? what counts as a relinquishing of the floor? how can we establish with certainty the position of a TRP?), it seems extremely difficult to define the concept of interruption in unambiguous terms.

Such a difficulty prompts a terminological remark and a methodological consideration. First, since interruptions do not constitute a discrete category and all definitions would inevitably be tentative, it seems more appropriate to speak of interruptive behaviours. Second, the only way to resolve doubts about ‘presumed’ interruptions is to carefully look at the individual instances in question and validate any observations through next turn (cf. 3.2.2; 4.6). To put it differently, the presence (or absence) of a given interruption cannot be established without analysing participants’ behaviours as producers and receivers, or rather co-producers, of the interruption itself. For this reason, in what follows I will examine instances of overlapping talk taken from the UB sample, trying to isolate and explain interruptive behaviours. In other words, to use a traditional categorisation – loose as it may be – I will try to separate collaborative
overlaps from competitive overlaps. To do so, the easiest way is probably to start by looking at what in the broad category of overlapping talk does not count as an interruption.

5.2.1 Collaborative overlaps
A cursory, initial inspection of the UB sample prompts a first general observation: a fair amount of simultaneous talk is justified by the fact that most interviews (or at least portions of them) are examples of multi-party interaction, i.e. they involve more than two speakers. As mentioned in 4.4, the participants in a naturopathic interview at the UB clinic are normally one patient, two student clinicians (a primary and a secondary), and a supervising doctor, who ‘pops in’ at some point to check that the interview is going on smoothly and efficiently. Sometimes these are found to talk ‘on top of each other’, as in the following example:

Excerpt 1

```
792 PR .hhh so he had a little er a bit of ((PR points at P’s left arm
793 and SD shifts gaze from PR to P)) [(it er er) and some on the ]
794 P ((lifting arm)) [was o ver here a lot less]
795 PR [ other
796 P but er showed up the itch.
797 ((SD looking at P)) (0.5)
798 PR ((pointing at P’s right leg)) [and (slb)]
799 P ((pointing at his right leg)) [erm one ] spot right here.
800 SD are these new eruptions? [or] are these [(slb slb)]
801 P [no] [these are] old ones.
```

(UBNMC, INT10-11.19.03).

This exchange takes place between a return patient with eczema, his primary, and the supervising doctor. The latter has entered the room a few minutes before and is now gathering information on the patient’s condition by formulating direct questions while at the same time examining the rashes.

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2 In conversations with at least four participants we sometimes observe a phenomenon known as ‘schism’ or ‘schising’ (see for instance Egbert, 1997), occurring when the conversation splits up into two or more conversations. One example of schism can be found in interview 1 in lines 625-76 (cf. Appendix B), where two parallel conversations are going on between the patient and the supervising doctor on the one hand, and the two primaries and the secondary on the other.
In the first two lines the primary mentions the location of some of the eruptions and indicates the patient’s left arm, at which point the supervising doctor turns his head towards the patient, who starts speaking in overlap with the primary (l. 794). The patient’s contribution, however, cannot be considered interruptive of the primary’s turn for at least two reasons: first it confirms and completes the content of the primary’s turn; second, it is prompted by the supervising doctor’s gaze shift (cf. 4.6), which is in turn determined by the primary pointing at the patient’s arm.

In lines 798-99 something similar happens. Here it is even more difficult to establish who is being interrupted, in that both PR and P self-select as next speakers after a pause and start speaking simultaneously. Again the patient takes over after the primary has prompted him to do so (although this time the latter does not finish the utterance as in line 795, but leaves the floor almost immediately). It may be that it is the primary who is interrupting the patient, the latter having been selected as next speaker by the supervising doctor looking at him (l. 797). Unfortunately, however, it is not clear from the video whether SD (who is sitting on the exam table) is looking straight at P (who is sitting on a chair like PR, i.e. at a lower level than SD) or at his legs, which SD examines immediately after PR and P have pointed at the latter’s leg (ll. 798-99).

In any case, the overall impression conveyed by these two instances of ‘interruptions’ is that the patient and the primary collaboratively construct a report to inform the supervising doctor of the evolution of the patient’s condition. In particular, the primary seems to prompt the patient (in lines 792-93 and 798), who then provides first-hand (and therefore more detailed) information on the nature and location of his symptoms (in lines 794, 796 and 799). The supervising doctor can then proceed with his information-gathering activity by asking a question about the onset of the eruptions (l. 800), to which the patient replies in partial overlap (l. 801), this time however at points that are clearly ones of possible completion.

Other instances of overlapping talk that are not interruptive can be grouped under the general heading “displays of active listening” (West, 1984a). These can be of different kinds, and are produced by both patients and doctors at either TRPs or non-TRPs. Let us consider some of them in greater detail.
In the lines preceding excerpt 2 the doctor (PR) has asked the patient about any tingling or numbness in her hands or feet, and the patient has told him that a few days before the visit she grabbed a hot pan without feeling the heat, while her husband did the same but felt the pain.

In line 1924 P starts producing what seems to be a lay diagnosis accounting for the personal anecdote she has just told. In doing so, she prefaces her explanation (in line 1927) with an evaluative expression (the truncated “interest-“ in line 1924) and a typical “i don’t know” claiming insufficient knowledge (which she employs twice in line 1924). In the meantime PR produces two continuers in overlap with P (ll. 1925 and 1926), signalling that he is listening to the patient’s account and inciting her to go on with it. P’s hypothesis in line 1927 is formulated in a rather tentative way (note the false starts “if i’m getting if i’m sensory” and the hesitation immediately following them) and is not syntactically complete (note also the continuing intonation). This uncertainty may be one of the reasons why in line 1929 PR provides a collaborative completion (see for instance Stivers & Heritage, 2001: 175) overlapping with P at a non-transition-relevance place. This overlap does not seem to be perceived by P as an interruption. Rather, the patient completes her prior incomplete turn with an elliptical sentence (“my left foot is”), which implies “losing sensitivity”, thus acknowledging receipt of the doctor’s suggestion.

Like continuers and collaborative completions, assessments can also be used as displays of active listening, as in the following excerpt:

Excerpt 3
756   P   tzt (0.3) i am (. ) making a ↑soup for tonight chicken,
Here the doctor’s evaluations in lines 757 and 759 do not seem to disrupt the patient’s speech flow, especially since they occur at possible completion points: the patient is listing the ingredients she is using to prepare a soup and the doctor places his comments between one item of the list and the next. Moreover, besides showing understanding, the two assessments clearly signal appreciation of what the patient is saying (and doing). As we will see in 5.4.2 and in 6.3.2, the fact that reports by either patients or doctors are interspersed with assessments by the other party in interaction makes the exchanges similar to ordinary conversations.

Another frequent occurrence of non-competitive overlapping talk is what could be labelled knowledge-confirming repetition. This device is a display of active listening used by doctors and patients to underline reference to some shared knowledge or common subject.³ Excerpt 4 below is an example of knowledge-confirming repetition uttered by a patient:

Excerpt 4

³ Within the general knowledge-confirming function, repetitions of this kind are likely to be used in slightly different ways by patients and doctors. The former tend to employ such a device to display their familiarity with medical matters, whereas the latter use it to acknowledge the patient’s familiarity with those same matters.

(UBNMC, INT12-11.20.03).
In lines 966 and 968 the primary is explaining the function of one of the supplements that the patient is taking (gugo), but before she can complete her utterance in line 968 (note the continuing intonation) the patient produces a partial repetition of the previous turn, which he reinforces by adding “yeah” (l. 969). The repetition, especially since it is pronounced with a falling intonation and followed by “yeah”, is employed to show that the patient has previous knowledge of what the doctor is talking about, i.e. he already knows what a lowering agent is.

Knowledge is also at issue in other examples of overlapping talk. In excerpt 5 a primary is conducting comprehensive history-taking with a first-time patient. In lines 632-35 she is enquiring about cases of high blood pressure in the patient’s family enumerating different possibilities. In line 634 the patient starts producing an answer before the doctor completes her utterance.

Excerpt 5

```
632  PR  erm so i'm gonna just ask you erm about is there any: family
633  P  history of of high blood pressure? like yer mother or father or,
634  P  no [ i know] we got a-
635  PR  ["siblings"]
636  P  =i know i have a family history of diabetes.
637  PR  okay.
638  P  you know and i don't know if it skips a generation or not but i
639  P  know that a few people who have diabetes,
640  PR  [o kay]
641  P  [er er] erm it's in our family so [they can't] really deal-
642  PR  [ o k a y, ]
643  P  =with the sugar and the salt and all that stuff.
644  PR  okay who has diabetes? ["in your fam-º]
645  P  [ i know my ] aunt, and my cousin and
646  P  my grandmother. my grandmother had a history of diabetes.
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(UBNMC, INT6-11.12.03).

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4 The same repetition uttered with either a rising or continuing intonation would have probably expressed doubt and counted as an indirect request for clarification.

5 In this sense such a device is similar to a “display of independent knowledge” (West, 1984a: 54; cf. 3.5.1.1, note 18), although in that it is prompted by the preceding speaker’s turn it also bears some resemblance to a “display of sudden remembering” (Jefferson, 1978: 222; cf. 3.5.3.3).
Similarly to what happens in excerpt 3 above, response to current speaker’s utterance starts before current speaker is finished but at possible completion, i.e. between two items of the same list (PR is providing alternatives as to who in P’s family may suffer from high blood pressure). The patient replies with a minimal no-problem response (“no” in l. 634; cf. 3.5.4.1), immediately followed by the expanded answer (cf. 3.5.3.3) “but i know we got a i know we have a family history of diabetes” (ll. 634-36), which anticipates what would have probably been (one of) PR’s next question(s). In this way he proves himself to be knowledgeable not just of the medical situation of his family, but also of the content and structure of medical history-taking, and the roles that doctors and patients play within this particular stage of the interview. Let us examine these aspects in greater detail.

First, the contiguity and minimality of the initial part of the patient’s answer in line 634 indicate that he is orienting to the peculiar nature of history-taking, particularly the role of the doctor as questioner who needs to gather fact sheet information on different aspects of the patient’s health in rapid succession. Second, the expanded answer that follows shows that he is also aware of his role as the doctor’s best source of information, which he is entitled to provide, even when no explicit request is made, should he believe it to be relevant for the successful completion of history-taking. In this respect, his epistemic certainty is signalled by the two instances of “i know”, of which one is produced in line 634 in overlap with PR’s “siblings” completing the utterance initiated in 632, and the other in line 636 as a preface to “i have a family history of diabetes”. The latter is particularly interesting in that it functions as a “recycled turn beginning” (cf. Schegloff, 1987). The repetition of “i know” projects the turn to be a continuation of what P was saying in line 634 and pre-empts additional overlapping talk by PR, i.e. it is a “pre-placed overlap absorber” (ibid.: 79-80). In other words, the patient is using it to claim his right to the floor, thus further bolstering his role as responder, and ultimately treating the doctor’s ‘innocent’, whispered turn completion in line 635 as if it was an interference with the production of his answer, i.e. a competitive overlap.

Significantly, in the subsequent few lines the primary leaves the floor to the patient until the latter’s response has clearly come to an end. P further expands his answer in lines 638-43 (note the pre-placed overlap absorber “you know” in line 638) by giving a
generalised explanation of the problems that his family members suffering from diabetes have (i.e. “the can’t really deal with the sugar and the salt”). PR only utters minimal acknowledgement tokens (the ‘okays’ in lines 637, 640, 642), treating each component of P’s expansion as a sufficient answer while carefully refraining from interrupting him. She only produces her next question after the patient’s generic “all that stuff”, which is a recapitulating expression signalling that he has come to a possible completion and is willing to give the floor back to the doctor. The primary’s cautiousness in dealing with the completeness of the patient’s answer is confirmed by what happens in lines 644-45. Here PR formulates a new enquiry, but at the first possible completion P starts answering in overlap with her, thus replicating the case examined above (ll. 633-35). This time, however, the primary does not complete her utterance, relinquishing the floor to the patient almost immediately (note the self-interrupted “in your fam-”), therefore acknowledging the latter’s right to speak.6

What distinctly emerges from the examples discussed thus far is the difficulty in clearly defining an interruption, particularly in systematically attributing interruptions to single speakers. This difficulty further supports the choice of referring to interruptive behaviours (cf. 5.2), the nature of which, as we have seen, is jointly constructed by the participants in conversation.

Overall, it seems, overlaps are not casual disfluencies, but can be “finely tuned” devices (Schegloff, 1984: 29) used to perform specific actions. For instance, they may be used to show understanding (as in excerpts 2 and 4 above) or appreciation (cf. excerpt 3); or they may be employed to favour the accuracy of the information that is being exchanged (as in 1 and 5). Ultimately, such overlaps contribute to maximise agreement and improve the effectiveness of the tasks in which the parties are engaged (e.g. the gathering of information), thus working towards the attainment of the final goal of doctor-patient encounters, which is the delivery and reception of healthcare.

Despite the difficulty in attributing interruptive behaviours to either party, the analysis conducted on the UB sample does not seem to support West’s (1984b: 58) claim that doctors “systematically and disproportionately” interrupt patients’

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6 Incidentally, PR’s enquiry in line 644 is an “okay-prefaced question”, which as we have seen in 3.5.4.1, indicates a return to the main line of questioning (cf. also excerpt 22e).
contributions. Indeed, even when there is a fair amount of overlapping talk, doctors generally tend to display a particular attentiveness to what patients are saying and to their very right to speak. Let us consider the following example, where the patient is talking about her younger brother:

Excerpt 6

1280  P   i grew him alri- so tzt i'm glad he had a good childhood.
1281  PR  uh huh. [how was your relationship with him,]
1282  P   [i pa- i parented my parents.]
1283  PR  okay. [o kay you were a  parent]
1284  P   [i was a pa rent since i] was eight years old.
(UBNMC, INT13-11.21.03).

In line 1281 the primary is enquiring about the patient’s relationship with her brother, but the patient anticipates him by producing the utterance “i pa- i parented my parents” in overlap with PR’s question (l. 1282), which is also an extension to the first part of her turn in line 1280 (i.e. “i grew him alri-”). At this point, and despite the long overlap, PR acknowledges receipt of P’s preceding contribution by reformulating it (“okay you were a parent”, l. 1283) with a final rise in intonation that seeks confirmation from P, while the latter confirms and further expands on her statement (l. 1284).\footnote{Here P’s response again overlaps with PR’s preceding turn. However, given its repetitive nature and the fact that it occurs at a transition-relevance place, the overlap cannot be considered interruptive.}

A similar display of attentiveness can be found in the following excerpt:

Excerpt 7

314  PR   okay what kind of workout do you do at the gym?
315  P   er depend it d- erm i just focus on the body part that i wanna
316   workout as far as erm three  weeks
317  PR   okay so [do] you do any cardiovascular,
318  P   [er]
319   (.)
320  PR  i'm sorry i interrupted you [but,]
321  P   [yeah] tzt see that would this this
322  P   school damn they they don't have [any]
323  PR   [uh,]
324  P   cardiovascular machine!
325  PR   yeah (. ) i [know.]

7 Here P’s response again overlaps with PR’s preceding turn. However, given its repetitive nature and the fact that it occurs at a transition-relevance place, the overlap cannot be considered interruptive.
In this case, as in many others, it is extremely difficult to establish who is interrupting and who is being interrupted, or indeed if it is possible to talk of interruptions at all. Similarly to what happens in excerpt 6, the primary’s response in line 317 is elicited by a rise in intonation at the end of the preceding turn by the patient. PR treats P’s previous answer as sufficient by uttering an “okay”, to which, however, she appends a *yes-no* question that further enquires into the type of exercise that the patient does at the gym (note also that the question is prefaced by “so”, which like “okay” and “and” is commonly employed by doctors to resume the agenda associated with the visit; cf. 3.5.4.1). Simultaneously with the beginning of PR’s question, i.e. at a transition-relevance place, P produces a hesitation (l. 318), which may be interpreted as projecting a continuation of the preceding turn. In other words, both the primary and the patient self-select as next speakers. At this point, however, the primary realises that the patient is probably willing to expand on his previous answer and stops before completing her utterance. A short pause follows (l. 319), after which the primary apologises for interrupting the patient, thus encouraging him to resume talking, even if we cannot state with any certainty that his right to speak has been violated.

Attentiveness on the part of physicians seems to be confirmed by responses to the patient questionnaires (cf. 4.4; Appendix C). Two questions in particular are relevant to the present discussion, namely n. 2 and n. 8. For the former, “the doctor seemed to pay attention as I described my condition”, 7 patients out of 9 chose the option “strongly agree”, one ticked the box corresponding to “agree” and the other was “unsure”. For question 8, i.e. “the doctor seemed to be rushed”, 7 patients out of 9 strongly disagreed, the remaining two opting for “disagree”.

5.2.2 Competitive overlaps
In the previous subsection we have seen how establishing interruptive behaviours and attributing them to a particular participant can be very problematic. Having said that, various examples of collaborative overlaps have been discussed and explained in terms of participants’ engagement with specific tasks and of the goal-oriented character of the
interaction. By contrast, very few overlaps in the UB sample seem to violate speakers’ rights, i.e. very few are competitive interruptive behaviours. These are heterogeneous in nature in that they can be attributed to both doctors and patients and occur at various stages of the interview. Nevertheless, close inspection makes it possible to find some common features. In particular, in all instances analysed some kind of disagreement/misalignment seems involved. This can be expressed by either participant (a) in the form of a face-saving strategy triggered by something that the co-participant has said; or (b) as a way to pursue a different agenda from the co-participant’s. Such a conclusion is in line with Zorzi’s observations on interruptions in service encounters, interruptions being described as local resources employed by the participants in conversation to solve potential interactional problems (1990: 92). Type (a) and type (b) competitive overlaps will be dealt with in 5.2.2.1 and 5.2.2.2 respectively.

5.2.2.1 Competitive overlaps and face-saving strategies

Excerpt 8

<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>915</td>
<td>SD</td>
<td>you're waking up sluggish in the morning. it's a [(slb slb)]</td>
</tr>
<tr>
<td>916</td>
<td>P</td>
<td>[ no it's]</td>
</tr>
<tr>
<td>917</td>
<td>P</td>
<td>it's not sluggish that i'm getting up in the morning. it's bec-</td>
</tr>
<tr>
<td>918</td>
<td>P</td>
<td>i'm letting out the dog, i'm i'm you know i'm not fixing my</td>
</tr>
<tr>
<td>919</td>
<td>P</td>
<td>lunch at at the night before,=</td>
</tr>
<tr>
<td>920</td>
<td>PR</td>
<td>=({clears throat})=</td>
</tr>
<tr>
<td>921</td>
<td>P</td>
<td>=i'm fixing my lunch in the morning! jennifer and i are pushing</td>
</tr>
<tr>
<td>922</td>
<td>P</td>
<td>each other with the elbows, try(h)ing to ge(h)t the sa(h)me</td>
</tr>
<tr>
<td>923</td>
<td>P</td>
<td>ki(h)nd of space .hh erm</td>
</tr>
</tbody>
</table>

(UBNMC, INT5-11.10.03).

In the lines preceding excerpt 8 the supervising doctor (SD) has been urging the patient to find the time to take some exercise; specifically he has suggested going to the swimming pool early in the morning before classes (P is a student at the College of Naturopathic Medicine). As a response the patient has mentioned her difficulty in getting up early, but the doctor has replied that all she needs to do is getting accustomed to a different daily routine, which she will find to be beneficial (SD’s point being that exercise will help her feel more energetic).
In line 915 the doctor is making an inference on the patient’s feeling of tiredness and laziness as she wakes up. In doing so, he uses the rather negatively connotated term “sluggish”, which the patient takes as a face-threatening insinuation (note the falling intonation, which makes SD’s utterance sound like a statement rather than a guess requiring confirmation). At this point P interrupts SD by expressing her disagreement outright (ll. 916-17), and then moves on to list the things she has to do when she wakes up which prevent her from making exercise part of her morning routine (ll. 918-23).

Later on in the same interview in excerpt 9, the patient has a similar reaction after a much less assertive utterance by the primary. In this case the medical encounter is coming to a close: PR has recommended some supplements to P, who is here mentioning the ones she already takes:

**Excerpt 9**

1638 P i said i take a hundred and fifty (co_q ten) a day, i take er
1639 eight hundred er er i_u_c_v >i started taking c i hadn't been
1640 taking c because i had (slb slb slb slb)< (. ) but now i
1641 understand i need ↓it for (solid) [ re pair! ]
1642 PR [{don’t know}] if there’s any
1643 correlation that they found between vitamin [c and your stones.]
1644 P [well i was told ]
1645 there there [ was.]
1646 PR [yeah.]

(UBNMC, INT5-11.10.03).

Among other things the patient mentions that she has started taking vitamin C (l. 1639) explaining the reason why she did not take it before (unfortunately the last part of her explanation is unclear), and adding what has motivated her decision to start taking it (ll. 1640-41). Her statement sounds like a final say, its assertiveness being conveyed by the choice of the verb “understand”, and the sudden fall in intonation coupled with the emphasis on “it”. These devices can be read as displays of knowledge that is not just experiential but also technical: the patient is also a naturopathic student and clearly has access to the medical information she claims to possess. In line 1642 PR tentatively questions P’s assertion (note the claim of insufficient knowledge “don’t know” and the third party attribution “they”), but P interrupts him (l. 1644) as if she felt her medical
knowledge was being directly challenged by PR expressing his doubts (note “well”, which is a commonly used preface indicating that disagreement may be forthcoming, and the passive construction “i was told”, which like “they” in line 1643 is used to make reference to an external, superior medical authority).

These last two examples have shown how patients can express their disagreement with doctors in a rather straightforward fashion when they feel that their face is somehow being threatened.\(^8\) However, doctors’ face can also be threatened, and physicians may react accordingly, as happens in the following two extracts.

Excerpt 10

54 P you er (0.4) it said on the paper one dose.
55 (0.9)
56 P and i didn't know if that meant one or the little container
57 with a magnifying glass,
58 PR ahhh
59 P says take five.
60 (2.4)
61 PR okay one dose er you mean five pills?
62 P yeah.
63 PR okay. er the the whether we gave you, i think three pills .hh
64 whether you took three or f- the little \(\Downarrow\) pills
65 P it didn't say on the \{pill (slb slb slb)\]
66 PR ((glancing at chart))[ o kay er would] er
67 SC (little,)
68 P little blue.- \{(PR turns to SC)\}
69 SC -(slb slb)
70 PR yeah.
71 P if i got \{(slb slb slb slb)\]
72 PR ((to P)) [ and i showed you] how to do that and i [showed]
73 P [yeah. ]

(UBNMC, INT10-11.19.03).

\(^8\) The two excerpts just discussed come from one of the two interviews where the primary declared that communication with the patient was difficult, the other case being interview 13 (cf. excerpt 12 below). The primaries (for interview 5 and interview 13) both chose “agree” in response to the statement “Communication with this patient was difficult” (cf. Appendix C, post-encounter questionnaire for (student) clinician: item n. 2).
Excerpt 10 is taken from the opening stage of an interview between a primary and a return patient. After the doctor’s first topic initiator “how are you doing” (interview 10, l. 11), the patient replies with a “reasonably well” (ibid.: 13), followed by a complaint that is not medical in nature. In fact, he mentions some problems of communication that he has had with the clinic, among which he reports the “confusion” (ibid.: 52) regarding the dose of one of the homeopathic remedies that he is taking, namely sulphur. As soon as the patient introduces the topic ‘sulphur’, the primary lifts her head and starts looking straight at him. It is here that the excerpt begins (for the entire duration of the excerpt the primary keeps her gaze on the patient except where the opposite is explicitly indicated).

In line 54 the patient refers to the instructions of the remedy (“the paper”) saying “one dose”. In the following lines (56-59) he explains that, not knowing what one dose was, he had a look at the container, which indicated five. A long pause follows in line 60 (during which PR is still staring at P), indicating that there is something wrong (note also the pause in line 55). In fact, there is a misunderstanding as to what exactly five refers to (doses or pills), which is clarified in lines 61-62. In line 64 the primary enquires about the aspect of the pills, probably to make sure that she is referring to the same remedy the patient is talking about. However, the patient insists on the dosage claiming that the instructions are not clear (l. 65). At this point the primary starts speaking in overlap with the patient (l. 66). Her reaction seems confused and embarrassed (note that she moves her gaze away from the patient to quickly look at the chart and hesitates). The secondary (SC) intervenes by refining the description of the pills in lines 67-68 (“little blue”), which the primary confirms in line 70. The patient adds some unclear words, which are probably the continuation of what he was saying in line 65. In line 72 the primary interrupts the patient again – this time more assertively – claiming that she has shown him how to dose the sulphur. The impression that this second interruptive behaviour is violating the patient’s right to speak seems to be supported by the repetition (“and I showed”), which strengthens the primary’s claim. The general idea that we can get from this excerpt is that the primary is probably feeling somehow accused of having

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9 In fact, as mentioned in 4.4, given the specific arrangements of the UB Naturopathic Medical Center regarding clinic shifts, all recordings start in medias res. Therefore, the beginning of each encounter is inevitably missing from the transcript.
failed to provide sufficient and/or correct information to the patient, and therefore reacts to deny such a possibility and disclaim any responsibility for the patient’s mistake.

In excerpt 11 the primary is facing an analogous implicit accusation. The patient has previously mentioned that she has not measured her sugar in a while because she cannot find her glucometer. She has also said that a previous student clinician had told her that the clinic could get her a free one, however the primary has disclaimed any knowledge of such a possibility.

Excerpt 11

55 P oh sh- i was told that you ought to help me get a free one.-
56 PR =uh=
57 P =coz i don't even know where it is and i certainly .hhh do not
58 have an extra fifty dollars to go out and by a new
59 PR .hhh[hhhhh]
60 P [gluco]meter. [(fifty or hundred.)]
61 PR [well i'll ask the ] i'll ask the clinic
director but that's news to me have you heard that? (..) at Tall
(UBNMC, INT5-11.10.03).

In line 55 the patient insists on this point (note the third party attribution, and the choice of the modal “ought”) and she then complains about the price of glucometers (ll. 57-60), which she has no intention to buy as she cannot afford them (note the use of “certainly”). In line 61 the primary starts speaking in overlap with the patient opposing her accusation. This disagreement is foreshadowed in line 59 by the long in-breath signalling unease on the part of PR (note also the “well” at the beginning of his turn in line 61). The primary says he will ask the clinic director (thus shifting responsibility onto higher authority), confirms his ignorance about the information presented by the patient, and asks the secondary if he knows anything about it (l. 62).

The patient goes on insisting on the fact that she cannot find her glucometer (cf. interview 5, ll. 65-77) and that she has been told by one of the student clinicians that the clinic could offer her one (ibid.: 90-92), giving up the topic only when the primary once again disclaims knowledge and responsibility (ibid.: 88-89, 93-95) and tells her where to buy a cheaper glucometer (ibid.: 78, 82, 84-86).
Overall, it appears that in both excerpt 10 and excerpt 11 the two primaries feel threatened in their role as competent doctors, who are supposed to provide all the necessary information for patients' self-care. In order to counter such a threat, they both overlap with patients' ongoing turns to claim their right to speak in self-defence. However, tensions of this kind associated with overlapping talk are very scarce in the UB sample. As we will see in 6.3.2, silence seems to be a much more common (and reliable) indicator of disagreement, particularly during advice-giving activities.

5.2.2.2 Competitive overlaps and agenda mismatches. Besides initiating face-saving strategies, competitive interruptions can also be associated with conflicting agendas, especially during history-taking and physical examination. Excerpt 12 is a portion of the comprehensive medical history-taking of a first visit, where the patient expresses her disagreement with the physician. However, the patient is not trying to defend against a potentially face-threatening act on the part of the doctor, but to pursue her own agenda of priorities. Let us look at the excerpt in greater detail.

Excerpt 12

1793 PR .hhh any gall bladder disease [a nything,]
1794 P [oh yes i ] got a (slb) loaded
gall bladder [full of] stones.=
1796 PR [uh huh.] -uh [huh.]
1797 P [that] didn't come out which i
1798 they don't wanna cause i'm not having surgery ha but,
1799 PR [ o kay.]
1800 P [is that] a bad thing? [ to ]
1801 PR [.hhh]
1802 P be going round with a full gall bladder.=
1803 PR =yeah it's not good [yeah.]
1804 P [ oh ] seriously?=
1805 PR =yeah yeah [i think you will have to definitely.]
1806 P [con si de ring that it's surgery ] that i've been
1807 waiting avoiding,
1808 PR well we'll have to bring that up and you know kind of look at
1809 what we can do on this and [to avoid ] the sur[gy yeah.]
1810 P [i'm really,] [yeah i do.]

(UBNMC, INT13-11.21.03).
P is reporting on the condition of her gall bladder, which she describes as “loaded” and “full of stones” (ll. 1794-5), explaining that the stones did not come out because she is “not having surgery” (l. 1798). Lines 1800-2 are occupied by a request for a medical opinion: the patient asks if a full gall bladder is a bad thing and the primary replies affirmatively (l. 1803). The patient’s newsmark in line 1804 invites further confirmation from the doctor, who confirms his previous answer and starts expanding on it (l. 1805). However, as soon as the expansion starts P resumes talking in overlap with PR (l. 1806), who eventually relinquishes the floor to her. In lines 1806-7 P shows her resistance to what we can reasonably assume to be the solution foreshadowed in PR’s interrupted utterance in line 1805 (i.e. surgery), firmly reiterating the position already taken in line 1798. Finally, the primary mitigates the assertiveness of his previously-stated position leaving the door open to a treatment other than surgery (note the inclusive “we” signalling cooperation and shared responsibility). This reconsideration seems to smooth things out in favour of an agreement (note P’s reply in line 1810).

Ultimately, what follows the patient’s question in lines 1800-2 leads us to reconsider the question itself. Although this is shaped as a request for medical evaluation, it may in fact be a request for a very precise course of action, i.e. a cure for gall bladder stones that does not involve surgery. The way the patient reacts to the doctor’s confirmation (which she has in fact solicited) indicates that patients may have their own agenda of priorities, which they try to pursue until they have them addressed (or at least acknowledged) by doctors, even if these priorities may be in contrast with the physicians’ agenda.

Another example of conflicting agendas is excerpt 13, which is taken from the physical examination stage of a medical encounter. Here the patient keeps ‘interfering’ with the doctor’s teaching activity until the latter explicitly acknowledges her contributions:

Excerpt 13

683 PR2 erm tzt okay so erm,

10 This hypothesis is also supported by some external observations. In fact, P’s question is rather rhetorical in character: not only is it a well-known fact that a full gall bladder can cause problems (as confirmed by P’s subsequent description of her difficulties in digesting fats; cf. interview 13, ll. 1817ff.), but, P being a nurse, it seems highly unlikely that this is a ‘genuine’ enquiry.
132

(2.2)

PR2 so.

(1.2)

SD ((pointing at scars)) the right.

PR2 i see yeah. i see these scars, okay [this is ve ry very,]

P [you know there's another]

PR2 one on the other side too.

PR2 uh huh [i'll ask,]

P [in case ] you want to get [a look.]

PR2 [o kay ] wow! okay now now i

have the picture.

P yeah.

PR2 okay.-

P =i wanted you to get it doctor!

PR2 but i have the full picture okay .h and i was expecting this

scar to be continuous with these but i see we have one two three

four major scars .hh

P [four]

PR2 [we ] also have, ((coughs))

P doctor patton said

PR2 [yeah.]

P [what ] i complained that he didn't [match the]

PR2 [ hu. tzt]

P seams too well [you] see he=

PR2 [hu.]

P =had to cut around this:,

PR2 right.

P belly.

PR2 we also have these three are distancing. now (.) that,

PR2 oh there's an app- appendectomy scar there.

PR2 erm yes i i i appreciate that .hhh erm so we have these three

distancing and that too erm is: a significant scar. so in in

brief wha- what is the biological significance of of .hh of of

these scars, and the answer is that given that (. more than

ninety percent of the autonomic neurofibers [of the]-

PR [uh huh]

PR2 body are located in the skin,

SD ((to P)) *(sib sib sib)*

P hu?

PR2 [ at thee ]

SD [(sib sib ]sib)

P hu

PR2 at the dermal epidermal junction just below that junction i

talked about this many times,
PR2 is a naturopathic student and a medical doctor with a specialisation in dermatology. He has been called into the exam room by the supervising doctor, who has asked him to look at the patient’s abdominal scars (the result of Abdominal Aortic Aneurism surgery).

PR2 starts visiting the patient, who is lying on the exam table, with the other two student clinicians and the supervising doctor observing the physical exam taking place. The first overlap occurs in lines 688-89, where P indicates the presence of a scar that PR2 has not yet noticed. PR2 has just started to formulate his opinion on the scars (“I see these scars,”, “this is very very,””) when P interrupts him at a non-TRP. P completes her contribution, but PR2 does not resume talk from where he was interrupted. Instead he briefly acknowledges receipt of P’s suggestion and initiates a new utterance in line 691. P interrupts him for the second time in line 692, and again PR2 does not complete his utterance. In line 693 PR2 ‘okays’ and then expresses appreciation for the scar indicated by P, which enables him to “have the full picture” (l. 695). In line 698 PR2 starts
describing what he sees and counts “four major scars”. At this point P expresses surprise and requests confirmation (note the upward shift in intonation in line 701). PR2 starts uttering what is probably a response to P’s request, but before he can finish P resumes talking mentioning the doctor who has operated her and the fact that she was unhappy with the way he stitched up her wounds (ll. 703-10). During P’s account PR2 only provides minimal acknowledgement tokens, which do not seem to encourage P to go on (note the systematic use of a falling rather than continuing intonation). Moreover, in line 712 he resumes his description of P’s scars as soon as she completes her account of the surgeon’s work on her wounds. Although PR2 has self-selected as next speaker, P starts elaborating on her previous contributions once again (ll. 712-13). Their turns do not overlap, but P clearly interrupts PR2’s speech flow (note the continuing intonation at the end of PR2’s turn, l. 712) by introducing a new piece of information prefaced by a display of sudden remembering (“oh” in line 713). Overall, the patient seems eager to provide details for the doctor (even if the latter has not requested them) as if she wanted to prove that she is a knowledgeable and collaborative patient (note the use of the technical term “appendectomy” in line 713 and the remark “i wanted you to get it doctor!” in line 697 referring to PR2’s previous “now i have the full picture”).

In line 714 PR2 expresses appreciation for P’s contributions and finally manages to pursue his own agenda. In lines 715-38 PR2 illustrates the effects of P’s scar tissue on the functioning of the neurofibers located under the skin, and the consequent importance of specific treatment. He is addressing all the participants but especially the other student clinicians, who will have to start treatment on P’s abdomen with a special device that helps break down the scar tissue. PR2 thus assumes a teaching role and holds the floor for a considerable number of lines. His style is focused and systematic and includes strategies that clearly serve didactic purposes, for instance the use of emphasis (ll. 716, 717, 726, 729), and of a rhetorical question (ll. 716-17). During the explanation SC, SD and P remain silent (with the exception of a brief exchange between SD and P in lines 721-25), and PR only produces continuers (ll. 728, 732, 735). In line 740 SD interrupts PR2 to correct him on P’s name and then starts laughing (the patient had previously mentioned that she is not usually called by her full name, i.e. Lizabeth, but prefers Libby instead). However, SD’s correction seems to interfere with PR2’s teaching activity.
Significantly, her laughter is not reciprocated (the laughter of SC in line 747 occurs too late to be considered a response to SD’s own laughter, and is probably elicited by P’s turn in line 746), and when PR2 asks for confirmation of P’s name in line 742, P utters an animated “oh no!” followed by the invitation to go on (l. 744), which she clarifies and reformulates in line 745 (“I’m used to it for the time here don’t’ be bothered.”). In so doing the patient displays her alignment with PR2’s agenda and her orientation to his current role as a teacher, who has to be listened to and cannot be interrupted. In fact, PR2 does not seem to be bothered and in line 748, in overlap with P’s utterance and SC’s laughter, he resumes his line of reasoning from where it was interrupted.

PR2’s extended holding of the floor in excerpt 13 is an example of how the voice of medicine can prevail over the voice of lifeworld. However, as we have seen, the control of the former over the latter cannot be imposed by the physician but has to be accepted (aligned with) by the patient, i.e. it has to be interactionally negotiated. Similarly, the voice of the lifeworld can take over from the voice of medicine only if the doctor shows a collaborative orientation to the concerns expressed by the patient, as happens during troubles-talk. Cases of this type will be discussed in 5.4 when dealing with patients’ expanded answers (and narrative expansions) to physicians’ questions. Before turning to these, however, let us first consider the roles of naturopaths and patients as questioners and answerers.

5.3 When patients ask questions

As noted in 3.5.1.2 and 3.5.3.1, in the institutional occasion ‘medical interview’ doctors do most of the questioning whereas patients do most of the answering. Such a division of activities is motivated by the primary task being performed in the speech event ‘interview’ (cf. 2.2), i.e. the gathering of information. In the clinical setting, as already mentioned, this task is in turn oriented to the attainment of the basic goal of delivering (and receiving) healthcare, which determines the shape of doctor-patient interaction in terms of constraints and inferential frameworks associated with the roles of the participants, particularly as either interviewers or interviewees (cf. 3.4). In this respect the UB sample of naturopathic interviews is no exception; however, contrary to the
findings presented by West (1993 [1983]) and Frankel (1990), it is not possible to establish a clear dispreference for patients’ questions (and, more in general, their initiatives). In other words, patients do ask questions, and they do so in different ways and for different purposes at different stages of the interview.

What might be expected at this point is a classification of patients’ questions according to their design, function, and location. No such classification will be attempted for three reasons. First and most important, as pointed out by Gill et al. (2001), the activities of requesting and responding cannot be reduced to discrete categories. To do so, I would argue, runs the risk of ‘obscuring’ the interactional work on which these activities rely. The only rule that seems to hold is that the positioning of patients’ questions within the interview (e.g. during complaint, history-taking, advice, etc.), their shape (i.e. whether or not they are free-standing, prefaced by markers of uncertainty, or followed by reasons for asking, etc.), and above all the actions they perform (e.g. an enquiry about a medical term and/or concept, a request for diagnoses or medical recommendations, etc.) are established interactionally. In other words, what questions and answers do, or do not do, is collaboratively constructed by participants (i.e. both patients and doctors) on each occasion. Second, from a practical point of view, a classification of patients’ questions would be pointless, if not impossible, considering the lack of stable criteria to define what a question is (cf. 3.5.1.2, note 20). Third, given the limited size of the sample (particularly in terms of the total number of participants involved), a classification of patients’ questions would run the risk of presenting as generalisable results findings that may in fact be largely determined by idiosyncratic behaviours.

In the light of what has been said so far it is worth considering a couple of examples in order to show how the actions performed by patients’ questions are negotiated on a turn-by-turn basis, making participants’ contributions both context-shaped and context-renewing.

5.3.1 Accomplishing a request without making one: doctors’ multi-turn responses to patients’ solicits

Excerpt 14

352 P the licorice is gone end of last week,
Okay, that one you will [have to get.] [and the tincture i have just a little bit]

Okay. Right. Hhh now

Bromelin is almost gone,

Okay. Right. Hhh now

[i] can't see any change in the veins (.)(during that)

That was to clear up the veins

(0.3)

the bromelin?

Yes

Erm

If the: Erm (0.5) [(slb of blood slb slb slb)]

And everything but that's gonna take a while i mean,

[yeah.]

[that] doesn't happen,

Okay.

[i]h hh erm

[nothing's] happened there.

Yeah. How can i see your right [leg]?

(Sure!)

Coz and the horse chestnut was for the veins,

Yeah.

(F lifts trousers and PR looks at leg) (0.7)

That would be long term though that's something that hhh oh it

does look better. Does look a lot better.

(0.5)

It's [ softer.]

[and it's] much softer.

Yeah.

-Yeah.

((PR examining P's leg)) (0.8)

See your body is reabsorbing all that blood you had a

(.

[yeah.] [huge] amount of blood that is in there.

(UBNMC, INT10-11.19.03).

In Excerpt 14 the patient and the primary are reviewing the supplements that the patient is taking to make a list of the ones he has run out of. In line 361 P asks clarification
about the last supplement that has been mentioned (bromelin) enquiring about its function ("that was to clear up the veins"). This query (which is formulated as an upward-intoned statement requiring a yes/no-answer), instead of being a mere request for information/confirmation, seems to express the patient’s doubts about the effectiveness of the supplement. Such a hypothesis is supported by the use of the past tense ("was") indicating uncertainty (and shifting the focus from a generally valid truth, i.e. the basic function of the supplement, to the reason for prescribing it in that specific case), and by the observation prefacing the query ("I can’t see any change in the veins"). which expresses P’s concern about his particular medical problem (i.e. Deep Vein Thrombosis or DVT). This, as we will see shortly, is a way to “accomplish a request without making one” (cf. Gill et al., 2001: 55).

The patient’s query is followed by an insertion sequence in which the primary seeks and (obtains) confirmation that the patient was referring to bromelin (ll. 363-64). PR’s hesitation in providing a reply (ll. 365-66) prompts P to further refine his observation as to what exactly has not improved in the overall condition of his veins with the reference to blood in line 367. In line 368 PR explains why bromelin is used, implicitly providing the confirmation sought by the patient (note the use of “also”) and giving additional information (“and also for the the cs- scar tissue”). Immediately after this explanation, however, without further delay or elicitation from the patient, PR addresses P’s doubt about the effectiveness of the bromelin by mentioning the long-term nature of the cure (ll. 369-71). The patient acknowledges receipt of the primary’s explanation (ll. 370 and 372) but insists on his concern about the situation not having changed (l. 374). At this point PR asks to see P’s leg (l. 375), thus collaboratively taking the patient’s use of “my-side telling” (Pomerantz, 1980; 1984a; cf. 3.5.4.3) in the preceding lines (360, 367, and 374) as an indirect request to explicitly deal with the situation he is worried about. In line 380 the primary reformulates her statement about the long-term nature of the treatment (i.e. the need to wait before seeing any result), and while examining the patient’s leg finally reassures him about the condition of his veins ("it does look better does look a lot better"); note the emphatic “does” and the repetition. PR’s assessment, however, is not met with any second assessment or minimal acknowledgement token by P, who remains silent (l. 382). PR then produces another, less generic, statement ("it’s
softer”) which is partially overlapped by P’s agreeing “it’s much softer” (note the reinforcing determiner “much”). P’s overlapping assessment here is particularly interesting in that it is a display of independent knowledge, indicating that the patient has in fact competently noticed an improvement in his leg (despite having just claimed the opposite) and is probably only looking for reassurance on the part of the doctor. The latter’s gradual orientation to this trajectory culminates with the examination of the patient’s legs, which elicits an evaluation of their state (ll. 381-84) and an explanation of how the treatment is working in the right direction, i.e. towards healing (note PR’s utterance in line 388, especially the initial “see”).

A similar instance of an interactionally constructed request can be found in excerpt 15. As in the previous example, the primary is reviewing with the patient the supplements that the latter is on.

Excerpt 15

686 PR .hhh now are you also taking the last last week you were
687 P taking (.) erm a (triple_s) [\herbal ]
688 [uh yeah.] yeah i was er er i’m on
689 PR [er]
690 P =thing yeah.
691 PR you are [ tak ]ing that [still?]  
692 F [yeah.] [ yeah.]
693 PR [o   kay do]
694 P [but i don't] (.) think: so far i don't see er .hhh i don't see
696 this is disturbing something maybe you know er [er]
697 PR [o ]kay do you
698 notice any improvement (.) tak[ing that or ] any \changes=
699 P [hnh: er:m hhh]
700 -(slb slb) oh they says it takes almost: two weeks before you can
701 see er improvement you know,
702 PR tzt okay.
703 P because apparently they [said]
704 PR [ i ] think it’s been almost two weeks
705 P [yeah some thing like that.]
706 PR [that you’ve started that.]
707 P yeah so er no i don’t think much you see: but: apparently erm they
708 probably see something erm create some kind of problem: er .hh
709 probably they find out i believe the i believe er this kind of
710 things that they give probably disturb the the the heart so that

139
The patient is expressing doubts about the triple-s herbal formula, which not only does he not find beneficial but also thinks might cause some problems. Let us look at the transcript in greater detail.

In line 695 P anticipates PR’s question about the effects of the supplement. In particular he disclaims having noticed any improvement (note the repeated elliptical utterance “i don’t see”, the sense of which is made clear in the subsequent question by the primary in lines 697-98 and in the patient’s reply to it in lines 700-01), and produces a first tentative hint at the possibility that the supplement may have some contraindications (note the use of the downgraded adjective “disturbing” and of the adverb “maybe”). Once the doctor has formulated her question (l. 698) the patient somehow justifies his failure to notice any improvement with a generic third-party attribution (“they says”), which is probably employed to pre-empt negative inferences on the part of the doctor regarding the possibility of the patient not having paid attention to his bodily reactions following the administration of the supplement.
In lines 704-06 the primary, while acknowledging the patient’s candidate explanation for the lack of improvement over a period of time shorter than two weeks, points out that the patient has in fact been on the triple-s for about two weeks, thus cautiously expressing disagreement (note the use of the mitigating devices “I think” and “almost”). After agreeing with PR in line 705 (although not wholeheartedly: note the use of “something like that” matching PR’s “almost”), in line 707 P ventures into a disorderly explanation of his doubts about the triple-s formula (the actual beginning of P’s explanation is probably the interrupted utterance in line 703). The way he designs his utterances seems to support the idea that he is trying to accomplish more than a mere request for a medical opinion. After confirming that he has not noticed any improvement since he started taking the triple-s (l. 705) he formulates his opinion on the supplement by avoiding ownership of concern (cf. 3.5.4.3) and attributing it to a generic third party (“they”). This seems to correspond to some external source of knowledge (probably medical doctors, or other naturopathic doctors), the attribution working to boost the doctorability (cf. 3.5.2.2; 3.5.4.3) of the patient’s concern. The patient also expresses his epistemic uncertainty by means of a number of tentativeness markers (e.g. “apparently”, “probably”, “I believe”). These are used in parallel with the third-party attributions, seemingly with the same goal, i.e. to elicit a response from the doctor.

Overall, it takes the patient five lines (from line 707 to line 711) to ‘spit out’ his request, which he only whispers at the end of his turn. At this point the primary starts providing a response to the request. On the one hand, she appears to reject the possibility that the triple-s may have some contraindications (note the contrastive use of “actually” in line 712 and the reference to an empirical and therefore objective “double check” in line 716). On the other hand, she tends to modulate the assertiveness and authoritativeness of her statements in favour of a solution to the patient’s concern which can save his face while at the same time reassuring him (note especially the use of “should” in line 712). Finally, she aligns with the patient’s concern by explicitly acknowledging his doubt (l. 722), by acknowledging a possible connection between the triple-s and P’s heart problems (in line 730 she mentions P’s “palpitations” – of which they had been talking a few lines before excerpt 14 starts – as opposed to P’s general reference to heart problems), and by granting him the possibility to decrease the dosage.
of the triple-s (ll. 725-26). Ultimately, the fact that P was precisely asking for such a possibility to be given is supported by his repeated displays of agreement (ll. 724, 727, 729, and especially the “absolutely” in line 731, which follows PR’s recipient-designed mention of palpitations).

The last two excerpts analysed, together with excerpt 12 above, show that doctors can produce multi-component answers that are similar to patients’ expanded answers (cf. 5.4. below). The only difference between the two seems to be that while patients tend to volunteer their expansions, doctors generally formulate additional information after patients’ solicits. In any case, as we have seen in excerpts 14 and 15, the way doctors and patients negotiate the actions performed by their utterances indicates that:

a) that patients tend to pursue their own agenda of concerns until agreement is reached on a specific state of affairs or course of action;

b) that doctors generally pay great attention and provide responses to requests that might be implicit in patients’ queries (such responses often occupying more than one turn).

5.3.2 Missing responses to patients’ questions

The examples discussed so far seem to contrast not just with West’s (1984) and Frankel’s (1990) claim of a “dispreference for patient-initiated questions”, but also with West’s (1993) finding that doctors fail to respond to patients’ queries (cf. 3.5.1). In fact, only three instances of ‘missing responses’ were found in the UB sample, two of which occur in interview 1 (which, incidentally, is also the interview with the largest number of patient’s questions). Let us consider these two first.

Excerpt 16

1159 P  "i gue- [was it where] i said it ↓was-
1160 SC         [he  he  he  ]               =it's yeah it is that's
1161 pretty much exactly you have your optic disc right here it's
1162 just about at around eleven ten eleven o'clock from your optic
1163 disc.
1164 P  tzt
1165 SC so,
1166 →P ((to PR)) "what's my optic disc!*
1167 PR [hu hu  hu]
Here the secondary is examining one of the patient’s eye to see if the haemorrhage she has had for some time is reabsorbing. In lines 1160-63 SC indicates the location of the haemorrhage relative to P’s optic disc at which point P, looking at the primary, asks for a clarification (l. 1166). Both the primary and the secondary initially reply to the patient’s query with laughter (probably elicited by P’s animated tone), but then the secondary acknowledges the question while marking it as somehow interfering with the physical exam and postponing the answer to a later stage (l. 1170). The patient okays and drops the subject in order to allow the visit to proceed.\(^{11}\)

The other case where the patient’s question is not answered is rather different, as can be seen in excerpts 17a and 17b.

Excerpt 17a

\begin{verbatim}
143 SD  -so anyway to you (.) how are you doing?
144 (.)
145 P  okay i guess, well you know the hemorrhage is still there.
146 (1.0)
147 SD  uh huh.
148 → P  but erm how long do you think do you have any idea of how long
149  it will take to absorb if it does.
150 → SD  well i think ((to PR and SC)) did you take a look
151 PR  not yet.
152 SC  not yet we've just [started.]
153 PR  [yeah we ] just started.
154 SD  okay. okay. [erm]
155 P  [erm] only what do they call-
156 SD  -what if it does?
157 P  know what it was i asked doctor z- oh i got to tell ((pointing
158  at SD)) you what happened to me down at park city i were with
159  (slb slb)
\end{verbatim}

\(^{11}\)Excerpt 16 is an example of agenda mismatch in which the patient immediately relinquishes her agenda to orient to that of the doctors. However, as noted in 5.2.2.2, mismatches of this kind may also give rise to competitive interruptions, especially by patients, who may pursue a response from doctors until they have their own (often hidden) agenda of priorities addressed.
This excerpt marks the transition from the opening stage to the complaint stage of the interview. In the lines preceding the excerpt the participants in the interaction (the patient, the supervising doctor, the primary and the secondary) are engaged in a digression on some books the patient has been reading.

In line 143 the supervising doctor (SD) projects a new course of action by formulating a first topic initiator (i.e. the enquiry on P’s state of health) prefaced by the end-of-digression marker “so anyway” (note also the emphasis on “you”). P’s reply is ‘less than optimal’ (a cautious “okay” to which the tentativeness marker “I guess” is appended) and is immediately followed by the dispreference marker “well” and a reformulation of P’s chief complaint (l. 145). SD acknowledges receipt of P’s utterance only after a fairly long silence, probably expecting the patient to continue with her complaint (note the continuing intonation at the end of P’s turn). In lines 148-49 P formulates a query regarding the healing process of the haemorrhage in her eye, but SD turns to the student clinicians to ask if they have already checked P’s eye (l. 150). In so doing, the supervising doctor marks the patient’s question as “out of order” (cf. Roberts, 2000), being reluctant to provide an authoritative response before the physical examination takes place (see also Gill & Maynard, forthcoming; 3.5.2.2). As in excerpt 15, the patient duly drops the subject, this time to introduce a new topic (ll. 157-59). However unlike the patient in excerpt 15, this patient (who is presumably more concerned about the haemorrhage in her eye than about not knowing exactly what her optic disc is) reformulates her question a little later in the interview:

Excerpt 17b

1344 SD th- the crataegus,  
1345 SC yeah.  
1346 SD that’s good for that.  
1347 P really?  
1348 SD yeah it it helps with vascular integrity,  
1349 →P do you have any idea of how long it will take because I can  
1350 still see ye you know,  
1351 (. )  
1352 P red.
This excerpt opens with the supervising doctor explaining that one of the supplements the patient is taking, namely crataegus, helps restoring vascular integrity (ll. 1344-48). In line 1349 the patient seizes the opportunity to reintroduce the related problem of the haemorrhage in her eye. At this point the examination has already been performed (cf. excerpt 15) and the patient feels entitled to ask for a diagnosis. SD, who was not in the room during the examination of P’s eye, turns to the student clinicians for a response.
The latter can only reply to P’s second question (l.1354) and both confirm that her eye is still bleeding (ll. 1357-58). In line 1359 the secondary disclaims responsibility for providing an immediate answer to the patient’s request for a diagnosis, justifying the missing response by mentioning that she has not seen the eye on the preceding visit (and implying therefore that she could not observe the evolution of the haemorrhage). In line 1364 SD finally addresses P’s request directly by ‘confessing’ that she cannot give a precise answer and adding a generic “it all depends on the different factors”. In line 1366 P acknowledges receipt of SD’s reply and starts producing an utterance (“you didn’t have your”), which she continues in line 1368. The short gap in line 1366 and the hesitations in line 1368 (note the drawl followed by the filled pause) suggest that P is probably looking for the right word(s) to complete her utterance. In line 1369 the supervising doctor offers a collaborative completion orienting to a possible topicalisation of the missing diagnosis on the part of P, and produces a fairly long out-breath, which might indicate slight discomfort at having failed to provide an authoritative medical opinion. The patient, however, completes her utterance by mentioning the device that was used to check her eye, the name of which (ophthalmoscope) finally comes to her mind. P’s utterance seems to release SD from the pressure of having to provide a response (note the laughter in line 1371). The focus shifts to the ophthalmoscope, which becomes the subject of a short anecdote on how conventional roles have been inverted (one of the student clinicians is going to teach the supervising doctor how to use the ophthalmoscope). The anecdote elicits laughter by all participants (excluding PR, who is oriented to the pursuit of the medical agenda; ll. 1372, 1374, 1385) and the topic ‘haemorrhage’ is dropped.

At the beginning of this subsection reference was made to three instances of missing responses. In both of the cases so far considered the patients’ questions are not ignored, but acknowledged as legitimate and therefore requiring an answer, which is put off to some later stage. The third case of a missing response, from interview 14, differs from the previous two in that the patient does not explicitly formulate a question but only an indirect request, which the doctor seems to disregard altogether.

Excerpt 18

125 PR any vaginal discharge? (slb slb slb) itching, or burning?
126 → P  no but, i kind of wonder if i don't have like a (.) chronic
127  bacterial vaginitis.
128  PR  °okay.°
129 → P  and i want to buy a,
130  PR  okay.
131  P  test for that.
132  ((PR writing)) (2.7)
133 → P  just because of the smell?
134  PR  okay.
135 → P  i don't know if you can get, i think you can i'm not sure but it
136  would be very long term chronic if it was.
137  ((PR writing)) (2.8)
138  PR  and when do you notice the discharge.
139  P  it's not really even just like a normal,
140  PR  okay.=
141  P  =vaginal discharge,
142  PR  okay.
143  P  but just the smell of it?
144  PR  ((nodding)) o[kay.]
145  P  [just] coz i know that.
146  PR  ((nodding)) ri:ght,(.) okay.=
147  P  =coz of my background i know that smell [you know,]
148  PR  [ o kay. ]
149  P  and just kinda wonder.
150  PR  okay. (.) any pain during sex?

(UBNMC, INT14-11.21.03).

The excerpt is taken from a short interview preceding a routine gynaecological visit, during which the primary is asking standard questions with a clear checklist status (cf. 3.5.3.3) while compiling a chart.

In line 125 PR’s unmarked yes/no question (or rather portion of a question) includes three different enquiries (maybe four, depending on the content of the unclear segment). The patient’s minimal no-problem reply comes straightaway but is immediately followed by a reservation introduced by “but”. What follows is an expanded answer (cf. 5.4.1 below), which occupies more than one turn (see arrowed lines) and is used by the patient to address what she believes is a medical problem to be included in the agenda. In lines 129 and 131 she offers a pragmatic solution to the problem (at least for the definition of the problem as such) by declaring her intention to buy a test for bacterial vaginitis. She then describes her condition and the main symptom (i.e. the smell), as
well as her practical approach to the presumed vaginitis, in a very confident way (“i want to buy a test for that” and “i know that smell” in lines 129-31 and 147 respectively), thus portraying herself as a competent perceiver and reporter of her bodily states (cf. Gill, et al., 2001: 72). P provides a justification for her assertiveness in line 147, where she makes reference to her previous experience of vaginitis.

Incidentally, her experiential knowledge is supported by her medical knowledge, as she is also a clinician (a third-year student, i.e. a secondary). This puts her in a doubly privileged position, which could potentially challenge the role of the primary in delivering a diagnosis, giving advice, and dispensing medical knowledge in general. In fact, although the patient’s knowledge and observations have led her to formulate an explicit causal theory for her state (i.e. bacterial vaginitis), she treats such a theory as “delicate” (ibid.: 73) and downgrades its epistemic certainty by using items expressing ongoing consideration and doubt like “i kind of wonder if” (l. 126), “i don’t know if” and “i’m not sure” (l. 135), and “just kinda wonder” (l. 149). This interpretation is consistent with the literature on lay diagnoses (see for instance the contributions in Sarangi & Wilson, 2001) – although the example discussed here would better be defined as self-diagnosis – and supports the idea of the patient’s concerns being somewhat independent of the doctor’s agenda (Drew, 2001) and/or conflicting with it.

We can also notice the mismatch of agendas in this excerpt by considering a couple of aspects on which I have not dwelt yet, namely the physician’s responses to the patient’s expanded answer and the two pauses in line 132 and 137. PR writes in P’s chart as the latter adds new information. She acknowledges receipt of the patient’s addition by uttering “okay” in line 128, after which P proceeds with her line of reasoning. Before the next transition-relevance space PR utters another “okay” (l. 130), which can again be interpreted as an acknowledgment token but also as a disjunct marker projecting a new course of action. P completes her utterance and is probably waiting for some kind of reaction on the part of PR. However, a long pause follows, after which P adds a piece of

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12 The mitigation of P’s assertions (in terms of the truth of their propositional content) could also be seen as a deferential behaviour (Goffman, 1967: 56ff.) towards a colleague of higher status, i.e. a fourth-year student. In fact, one of the main interests of excerpt 18 resides in the way P tries to strike a balance between her role/identity as clinician and her contingent role/identity as patient (cf. Strong, 1979: 3.5), orienting to the complementary and asymmetric nature of roles and responsibilities within the medical encounter. The issue of interactional asymmetries will be dealt with extensively in chapter 6.
factual information that accounts for her diagnosis (l. 133). PR uses another “okay”, which P probably does not consider as signalling enough attention from PR, and she adds another piece of information concerning the duration of the condition that she is describing. This information is again met with silence (l. 137), after which PR finally produces a clarification-seeking question (l. 138). P offers clarification in lines 139 and 141 and reiterates the information already given in line 133 with a rising intonation (“but just the smell?” in line 143) as if inviting PR to express her opinion on the hypothesis thus formulated. PR’s remaining turns from line 142 to line 148 are occupied by almost mechanical repetitions of the item “okay”, which project the initiation of a new topic (l. 150). The only exception is line 146, where “okay” is preceded by a lengthened “right,” uttered with a continuing intonation and a short pause, the whole turn being accompanied by PR’s nods (who also nods in line 144).

Apparently the patient’s search for feedback from her clinician clashes with the latter’s attempt to rapidly conclude the interview stage. The primary may also be reluctant to express a medical opinion on the issue raised by the patient before conducting the physical exam (cf. excerpts 17a and 17b above). According to ten Have (2001b: 257), patients tend to have a preference for immediate expression, whereas doctors may refrain from offering immediate reactions, as such contributions, while displaying understanding of and empathy with patients’ experiences and points of view, “may hinder speedy and efficient data gathering, and therefore adequate professional action”. It must be noted, however, that although the patient’s implicit request is not answered (i.e. PR neither confirm nor denies P’s hypothesis), the primary at least acknowledges the patient’s concern and the validity of her candidate explanation by nodding (ll. 144 and 146). It cannot therefore be claimed, as initially hypothesised, that P’s request is completely ignored. There is, however, no evidence of its being taken up later on in the encounter.

Overall, as we have seen in 5.3.1, patients’ requests (be they explicit or implicit) are normally explicitly addressed by doctors, who often produce subsequent elaborations on their initial answers in an attempt at reassuring patients (cf. excerpts 14 and 15).

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13 The same function seems to be performed by P’s displays of uncertainty throughout the excerpt, which clearly solicit a response on the part of PR (particularly “i wonder” in line 126, which introduces an indirect question and is reiterated in line 149).
Incidentally, such receptiveness and sensitivity on the part of doctors is confirmed by patients’ answers to the feedback questionnaire. In particular, considering item n. 10, (“The doctor seemed to brush off my questions”), 8 patients out of 9 chose the options “strongly disagree” or “disagree” (with one patient indicating “not applicable”). These replies match those to item n. 8. (“The doctor seemed to be rushed”), with which 7 patients out of 9 strongly disagreed and 2 disagreed.

5.4 When patients answer more than the question: doctors’ responses to patients’ elaborations

We have seen that a large part of the literature on doctor-patient interaction sees the patient as a passive recipient of doctors’ initiatives, especially in the history-taking context and in first visits, when doctors’ questions are designed in such a way as to favour minimal, immediate responses and discourage unsolicited elaborations on the part of the patient (3.5.3.3). We have also seen, however, that patients may volunteer more information than is requested by producing what Stivers and Heritage (2001) have called “expanded answers” and “narrative expansions”. In any case, as noted by them and by Jones (2001), physicians tend to remain silent after patients’ expanded answers, or to produce minimal acknowledgement tokens, and recurrently try to bring the conversation back to the main line of questioning. That said, the aim of the present section is to show that patients do engage in unsolicited elaborations during the information-gathering stage of the interview, as suggested by Stivers and Heritage (2001), and that these elaborations, contrary to what emerges from Stivers and Heritage’s and Jones’ analyses, are often met with aligning assessments on the part of physicians. For the sake of clarity, the discussion will be presented in two subsections: expanded answers will be dealt with in 5.4.1, whereas narrative expansions will be analysed in 5.4.2.

Interestingly, the patient who thought that the question was not applicable is that from interview 14, from which the last excerpt analysed is taken. The reasons for this choice may be found in the length and character of the interview as well as the role relationship between the doctor and the patient. The interview is very short, being aimed at collecting fact sheet information before a routine gynaecological check. Moreover, as we have seen, the patient is herself a student clinician working during clinic shifts, who at no point asks any explicit questions.
5.4.1 Patients’ expanded answers: addressing difficulties in responding, adding details, pre-empting negative inferences

Stivers and Heritage (2001) suggest that patients produce three types of expanded answers, depending on the task performed, namely:

a) to address difficulties in responding;

b) to support previous responses by adding details;

c) to pre-empt negative inferences.

The first category is well represented by excerpt 19:

Excerpt 19

309  PR   but just a little irritation
310  P    yeah [it’s:: ]
311  PR    [uh like] a crusty? [you †said] [er   er] it’s something:,
313  (2.1)
314 → P   well in an (slb slb) er this morning i was feeling something when
315   i walking but: now i don’t feel nothing er when i touch it no.
316  ((P touching his leg)) (0.9)
317  P    it’s not sensitive any more i guess ((looking at PR)) †no
318 → PR  [good. good.]
319  P    [ and i f-] according to him he must do [ he ]
320 → PR  [good.]
321  P    (probably doesn’t say “you know he [just slb*])]
322  PR    [.hhh th- ] yes
323  P    uh-
324  PR    =he may just he may want to just watch it [to   see if see if ]=
325  P    [yeah yeah uh uh uh,]=
326  =[uh    uh uh,]
327  PR    =[there’s any ] changes.
328  P    yeah he said that yeah.

(UBNMC, INT12-11.20.03).

In the lines preceding excerpt 19 the primary enquires about the healing process of some ulcerations on the patient’s legs. The patient explains that during a visit at the hospital he was told that the ulcers had healed. On that occasion, the boots he had been wearing to help the ulcerations heal were removed, but they had apparently irritated his skin.
In line 309 the primary asks the patient to confirm the “little irritation”. The patient replies affirmatively and starts a new utterance, probably in an attempt to explain what he means by irritation (note the prolonged “it’s::”). In line 311 the primary offers a collaborative completion (“uh like a crusty”) and again asks for confirmation (“you said”). Such a request strongly projects a minimal, immediate response, but P’s reply in line 312 is delayed and extremely vague. First P hesitates in overlap with PR’s tag, then he tentatively refers to the irritation as “something”. This word is pronounced with a drawl of the final ‘g’ and a continuing intonation signalling that the patient is trying to keep his turn, however a long pause of over two seconds follows. Overall, P sounds unsure and confused, but PR does not self-select as next speaker, thus giving P the possibility to proceed with his clarification. In line 314 P addresses his difficulty in responding by initiating self-repair (note the use of “well”; cf. Scheglof et al., 1977). In particular, he adds some details on the occurrence of pain or discomfort related to the irritation, saying that he was feeling something while walking that same morning, but he cannot feel anything if he touches his legs. Finally, to give his answer a definite character, he touches his leg confirming that he cannot feel anything, and offers a lay diagnosis (“it’s not sensitive any more”) that is mitigated by the tentativeness marker “i guess” and by the request for confirmation from the doctor (“no”). In so doing, the patient shows himself to be a competent perceiver and reporter of his bodily sensations while at the same time soliciting a response from the primary. In line 318 and 320 the primary responds with assessments showing appreciation of the information received. In the meantime (l. 319) the patient has started further elaborations using a third-party attribution (he is reporting what the doctor told him at the hospital). Again his answer is rather tentative (note the self-interruption, the repetitions and the use of “probably”). At this point the primary, instead of disregarding the patient’s contribution by remaining silent or formulating an okay-prefaced query to restore the main line of questioning, offers a second collaborative completion (ll. 324-27), which the patient accepts as the correct version of what he was trying to say (ll. 325-26 and 328).

Besides expanded answers addressing difficulties in responding, the UB sample also includes numerous instances of expanded answers used by patients to simply add further details to previous responses. Excerpt 20 starts with a general enquiry that a primary
addresses to a return patient after a considerable portion of the history-taking has already been conducted.

Excerpt 20

445  PR  hhh [a ny]thing else?
446  (0.4)
447  → P  no i’ve been feelin really good sleep good.
448  (0.5)
449  PR  great.
450  P  bowel movements fine. (slb slb [ slb slb slb] no blood)
451  PR  [good no blood, no (slb),]
452  → P  nothing [with that.]
453  (0.8)
454  P  thee: erm (0.9) erm that thing that help you your bowel movement
455  (0.4)
456  be regular,
457  (0.9)
458  P  (is this)?
459  PR  the f[î]ber
460  P  yeah.
461  PR  psy[l]l Supported
462  P  psyllium.
463  PR  yeah.
464  P  [yeah.]
465  PR  [ uh ] huh.
466  (0.6)
467  P  i’ve ta[ken it, ]
468  → PR  [.hhh that's]
469  P  once in,
470  → PR  [that's great!]
471  P  [ three weeks.]
472  → PR  that's great!
473  P  yeah.
474  PR  coz when you first came here you were ta[king it,]
475  P  [ oh er]
476  PR  more ofîten
477  P  i was taking it every day.
478  PR  yeah-
479  P  -or sometimes twice.
480  → PR  that's fabulous!
481  P  yeah (. ) have no problem.

(UBNMC, INT10-11.19.03).
The primary’s question in line 445 strongly projects a minimal “no-problem” response (cf. 3.5.4.1), which the patient provides in the first part of his turn in line 447. However, a series of successive expansions are appended to the preferred “no”, whereby the patient answers various implied questions regarding his health, thus proving himself knowledgeable about the way history-taking is routinely constructed (cf. excerpt 5 in 5.2.1). He says that he has been feeling good and has had no problem with either sleep or bowel movements (ll. 447 and 450). The primary replies with an assessment in line 449 and another in line 451 which is immediately followed by a closed question requiring further confirmation and clarification (ll. 451-52). The patient provides the confirmation requested in line 450 in overlap with the primary’s question and starts elaborating on his answer in line 453. In the following lines (up to line 471) he explains that in three weeks he has taken only once the supplement he was given for constipation. This piece of information is marked as newsworthy by the doctor, who starts producing another assessment in line 468, formulates it completely in line 470 and reiterates it in line 472, overlapping in all three instances with parts of P’s turn. She then accounts for her positive evaluation by mentioning that the patient used to take the supplement more often (ll. 474-76). The patient confirms and refines PR’s statement adding that he was taking it once or even twice a day (ll. 477-79). The primary formulates another assessment in line 480, which is acknowledged by the patient (see also line 473), who finally recaps his condition with a generic “have no problem” in line 481. Overall, we can say that the patient is able to take initiative as he shares the doctor’s agenda, and that his adding details makes him a competent reporter of his condition (cf. Gill, et al., 2001: 72), and can therefore be considered a face-gaining strategy.

The third and last category of expanded answers is made up of responses that work towards pre-empting negative inferences. As mentioned in 3.5.3.3, expansions of this kind are employed by patients to avoid criticism and explicit advice. Recurrently, they occur when sensitive issues are at stake, especially ones associated with social stigma, like alcohol consumption.

Excerpt 21

1141 PR okay okay. have you ever like drunk alcohol in the morning? during
[like week or something,]

1142 [oh no! i ne ver] do that.

1143 P

1144 PR okay.

1145 P alcohol,-

1146 PR =okay=  

1147 →P it's just it's just something (that's easy to go by) it if i know

1148 if i'm at the point that i'm drinking alcohol early in the

1149 morning, [like for,]

1150 PR [uh huh]

1151 P breakfast and s- then i know i have a problem.

1152 PR uh! [o kay.]

1153 P [and stuff] so i'll [never]

1154 PR [okay]

1155 P no that's something i'll never do.-

1156 PR =okay=

1157 P =not even on the weekends.

1158 PR okay. [o kay.]

1159 P [i won't] do that i'll wait till like after five.

1160 PR [uh huh okay.]  

1161 P [and stuff i you] know and stuff so:

1162 →PR okay. that's good. that's good. .hh so have you ever thought about

1163 just i mean coz you thought you said you thought about quitting,

1164 have you thought about just kind of reducing like drinking every

1165 other weekend or drinking just one night a week instead of two

(UBNMC, INT6-11.12.03).

Here the primary is seeing the patient for the first time and is asking him routine questions on his lifestyle and habits as part of the history-taking stage of the interview. Just before excerpt 21 PR has learned that P consumes alcohol and has therefore pursued the topic to further investigate P’s drinking habits. In particular, she has asked him about the exact amount of alcohol consumed, the way he drinks (alone or with other people), and the consequences of his drinking (e.g. hangovers). She has also enquired about the ideas and feelings that the patient associates with drinking (e.g. guilt), and his intention to quit. P has explained that he only drinks very expensive bottles at weekends, defining this habit “acquired taste” (interview 6, l. 1133), that he has never felt ashamed about drinking and has never tried to give up, although he has thought about it on a couple of occasions.

In lines 1141-42 PR asks P whether he has ever drunk in the morning or during week days. P immediately denies this possibility in line 1143. His reply is designed in a very
precise and assertive fashion (note the lack of hesitation of any kind and the use of “never”), formulated in partial overlap with PR’s turn, and uttered, at least in its first part, with an animated tone (note also the exclamation “oh”), all suggesting that P is trying to save his face from PR’s potentially threatening utterance. The primary treats P’s answer as sufficient by uttering an “okay” in line 1144. However, P starts expanding on his previous response explaining that if he ever started drinking in the morning then he would definitely have a problem (ll. 1145-51). In so doing, not only does he further limit the scope of his drinking, but he also highlights that: a) he is aware that drinking in the morning means suffering from alcohol addiction; b) he is aware that since he does not do that alcohol addiction is not his problem (note the use of “i know” expressing epistemic certainty); and c) he is therefore sensible enough to make judgments as to what is good and what is bad for himself.

In line 1152 the patient’s statement is met with PR’s newsmark, which is immediately followed by “okay”, again treating P’s answer as sufficient. Despite this acknowledgement on the part of the doctor and her successive “okays”, which can be heard as attempts to go ahead with the interview (ll. 1154, 1156, 1158, 1160), the patient makes his previous responses more explicit to avoid any negative inferences. In particular, after repeating that he never drinks in the morning (l. 1155), he adds that he does not even do that at weekends (l. 1157) and specifies that he drinks only after five in the evening (l. 1159). The primary okays again in line 1162 and then produces two successive assessments expressing appreciation before moving to enquire about P’s intention to reduce his alcohol consumption (ll. 1162ff.).

In excerpts 19-21 we have seen how patients can answer more than the question during the history-taking stage of interviews, even in first visits (as is the case for excerpt 20), and how their expanded answers are designed in such a way as to perform different tasks. Moreover, we have seen that doctors do not necessarily ignore patients’ elaborations, as suggested by previous studies, but instead formulate assessments that express alignment and affiliation with patients (e.g. understanding, support, encouragement, etc.), in a way analogous to everyday conversation. Such a use of

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15 See also the excerpt taken from interview 13 in 3.5.3.3.
assessments will be further discussed in the following subsection, which is devoted to patients’ narrative expansions.

5.4.2 Narrative expansions in response to doctors’ questions: the case of troubles-talk

In 3.5.3.3 and 5.4 it was briefly mentioned that besides expanding on an initial answer (for the reasons we have seen in 5.4.1), patients may respond to doctors’ questions by engaging in fully-fledged narratives (or narrative expansions) that address what they independently treat as issues to be acknowledged by doctors. This subsection focuses on one type of narrative expansion, namely troubles-talk. A long extract from one of the interviews was analysed using Jefferson’s (1988) model of troubles-telling sequences (cf. 3.3.2). The aim of the analysis is to demonstrate that sequences of this kind are collaboratively constructed by both patients and doctors, the former giving voice to their lifeworld concerns and the latter taking these concerns into account and using them for later elaboration and decision-making. Doctors are not, in other words, passive or neutral recipients of patients’ expressions of concern, but rather they produce affiliative, empathic responses (assessments) thus strongly aligning as troubles-recipients.

Excerpt 22 is taken from a forty-minute-long interview between an elderly lady (referred to as Mandy in the transcript), who has been a regular patient of the clinic for several months, and two student clinicians, a primary (Denise) and a secondary (Mel). In the portion of transcript preceding excerpt 22 the doctors have tried to reassure the patient about two polyps she has recently had removed (which have not yet been biopsied), but they have expressed their concern about her tendency towards osteoporosis and have suggested that she takes some physical exercise.

At this stage PR is looking at P’s most recent blood pressure chart, in which figures seem higher than usual. A long troubles-telling sequence follows, initiated by the primary enquiring about the possible causes of the rise. For ease of reference the excerpt has been divided into five shorter fragments (22a-22e).

16A supervising doctor was also present in the first part of the encounter (from approximately minute two to minute twelve of the interview), but she does not appear in excerpt 22, which is the transcription of minutes 27-35 of the recording.
Excerpt 22a

968  PR  so these numbers look like they, they're a little bit higher than past charts.
969  (0.6)
970  PR  i'm wondering if you:, (1.3)
971  PR  you know,
972  (1.9)
973  PR  before the whole colonoscopy,
974  (1.4)
975  PR  thing. mandy were you feeling,
976  (0.8)
977  PR  you know extra stress about any particular event?
978  PR  well,
979  (0.9)
980  P  you know with my son and all that stuff [uh,]
981  PR  (looking at P and nodding) [ o ]kay, okay,
982  P  and, i don't know i think: you know it's getting closer now to:
983  P  (. ) gonna be a year of my husband's death and i don't know, i
984  P  think about that more often now.
985  PR  ((shaking head)) that is,
986  (0.6)
987  P  [ in ] fact i was in church saturday. and this lady got sick in
988  P  church and: oh i just felt like crying. and i j- just hoped that
989  P  she wasn't gonna, (. ) collapse.
990  P  yes:,
991  PR  so they just took her out of church but,
992  (0.8)
993  PR  [ i ] was so upset.=
994  PR  [yeah,]
995  P  =you [know?]
996  PR  [yeah,] yeah,
997  P  and those things bother you every once in a while.
998  PR  sure!
999  P  [uh huh.]
1000  P  [and you ] know the anniversary especially the first anniversary,
1001  P  u:h,
1002  PR  [is]
1003  PR  known to be very tough.
1004  P  uh,
1005  PR  you know but this is, (1.0) i mean the whole year you've been
1006  P  working on,
1007  (. )
At the beginning of excerpt 22a the observation of P’s chart prompts PR to approach a
presumed trouble by enquiring about any stressful event that might have altered the patient’s blood pressure. The *inquiry* corresponds to one grammatical sentence occupying lines 973-979 of the transcript. This sentence is broken into smaller chunks by four long pauses, which make PR’s request rather hesitant and give the impression that she is rather embarrassed in formulating a question that might intrude into the patient’s private life, and also that she is being very tactful in eliciting personal information, of which she has some prior knowledge and which might somehow affect P’s sensitivity.\(^\text{17}\)

P’s “well” in line 980 and the subsequent pause function as a *trouble premonitor* anticipating a fairly long contribution by the patient. In line 980 the trouble is introduced, but the vague reference to it, especially the expression “all that stuff”, supports the idea that despite the enquiry just formulated, the primary is already aware of the patient’s troubles. Her response to the *announcement* of the trouble comes immediately in partial overlap with it and consists of repeated nods and two “okay”s (l. 983). This *response* is ambiguous in that, while signalling attentiveness to what is being said, it also shows that the topic is not new to the recipient and might therefore discourage any development on the part of the teller. In this respect the use of “okay” would normally project a trajectory in which the primary holds the floor and changes topic; however PR does not take the floor and simply keeps eye contact with the patient, thus aligning as troubles-recipient.

The troubles-telling sequence proceeds with the *exposition* of the trouble itself. In lines 984-86 P elaborates on her previous answer by mentioning the first anniversary of her husband’s death and how that affects her (she thinks about it more often). PR responds by shaking her head and producing the beginning of what seems to be an assessment (“that is,”), followed by a pause of six tenths of a second (l. 988) and a false start (“tha-”). The pause probably makes the patient feel entitled to self-select as next

\(^{17}\)Incidentally, this impression seems to be confirmed by PR’s gazing pattern and gestures, which are clearly visible in the video and somehow fill the gaps left by the primary (note the pauses in lines 972, 974, 976). PR is alternately looking at P and the chart and tentatively moving her hands first slightly forwards and backwards, one at a time and with the palms facing each other, as if meaning “more or less”, and then keeping her right hand still (holding the chart) while having the back of her left hand facing the patient and rotating her wrist forwards, as if miming something going on.
speaker (l. 990), and the truncated word uttered by PR in partial overlap with P’s turn makes it reasonable to believe that the primary is temporarily abandoning her project, whatever this may be, to give room to the patient. The latter starts recounting a short anecdote which works as a story (cf. 3.3.1) illustrating the trouble.

The story occupies ten lines (990-1000), in which P explains how the fact that a lady felt sick in church a few days before the interview has upset her. During the story PR provides minimal acknowledgment tokens (ll. 993, 997 and 999), which indicate alertness to further talk but are neutral with respect to occasioning additional troubles-telling. P provides the point of her story in line 1000 (“those things bother you once in a while.”) and PR immediately claims agreement with it (“sure!”). In lines 1003-07 the claim is turned into a display of agreement as the primary elaborates on the patient’s previous account of the effects of the first anniversary of her husband’s death. This elaboration is a work-up of the trouble that positions it “by reference to more general circumstances” (Jefferson, 1988: 430). By including the patient in the overall category of those who are upset by the first anniversary of the death of a loved one and referring to such an occurrence as very tough, the primary seems to imply that the patient’s situation is absolutely normal, thus probably trying to reassure her while at the same time trying to bring the conversation back to “business as usual” (Jefferson, 1980). In lines 1003-07 the commonplace remark on the first anniversary being very tough is an indirect assessment of the patient’s situation. This evaluation, however, despite the emphasis on the words “known” and “very”, does not elicit a second assessment on the part of the patient, who only provides a minimal signal of receipt (“uh,” in line 1008).

What follows is an additional elaboration on the anniversary topic by the primary in an attempt to get some sort of response on the part of the patient. This time PR moves from the general condition of those affected by the first anniversary back to the specific situation of P. In lines 1009-1014 she provides some sort of ‘recap’ acknowledging the efforts made by the patient in the preceding year to feel better, which clash with the anniversary “sending things flooding back” (l. 1016). In line 1020 PR is again trying to empathise with P by saying that what she is feeling is inevitable, but the latter’s only reactions consist of minimal acknowledgment tokens (ll. 1013, 1015, 1019, 1021). At this point PR reiterates her agreement with the patient on what might have caused her to
feel extra stress (ll. 1022-28) by reformulating the latter’s response to the initial enquiry (ll. 982-86). Once again P reacts minimally (ll. 1023, 1026, 1029) even when the primary tries to elicit her response (note “you know?” and the emphasis on “could” in line 1025).

In line 1031 PR formulates an assessment explicitly addressing P (“a tough time.”), to which the latter finally reacts by re-engaging in troubles-talk. From line 1034 to line 1044 the focus is on her two sons, the one who died and the one who broke his back. In these ten lines and in the remaining eight of excerpt 22a the two participants in conversation probably reach the highest level of intimacy of the whole encounter. Suffice it to consider the two strong expressions of empathy uttered by PR in line 1035 (the stretched “o:h,”) and in line 1047 (“oh boy!”) to get a sense of the “emotional heightening” (Jefferson, 1988: 428) reached during the encounter. PR’s affiliation response to P’s troubles-telling is ‘packed’ in line 1051, where she acknowledges the significance of the latter’s troubles using the expression “a lot of stuff”, which also refers back to P’s “all that stuff” in line 982.

Excerpt 22b

1053 PR [yeah.]
1054 P [yeah,] and he was in the process of moving and it was just like one catastrophe after another. [hhh hhh]
1055 SC (uh huh,] uh huh,=[hh)
1056 P -(hh)and he just, (0.5) he finally moved in there last month but: he's still doing stuff he's just: (.) their place has been ha
1059 ((PR writing)) (1.3)
1060 PR uh u:h
1061 P sometimes i would say to him drew don't even tell me about it i
1062 PR don't wanna hear it today.
1063 PR i, hhh [yeah!]
1064 P [ ha ] [ha ha ha ha .hhh]
1065 PR [you reach a point where] you just can't [take]
1066 P [ hu ]
1067 PR any more, upsetting [\news]
1068 P [ i ] know! [ uh, ]
1069 PR [yeah,] yeah,
1070 P i mean you couldn't believe it but hhh i mean they we- they were in the process of fixing the house .hh and what happened was the roof wet and a leak right in the bedroom and ruined the furni[ture,
Excerpt 22b opens with the patient recounting a new trouble. In lines 1054-1058 she introduces the problem without yet mentioning it, although the word “catastrophe” in line 1055 anticipates and condenses the subsequent story. Her use of this strongly evaluative term at the outset of her story is a clear cue for its recipients. As we will see, it will help the recipients monitor the story-telling in order to find out what is referred to as a catastrophe and identify the maxim of the story, and it will also inform their response to the story itself (cf. Sacks, 1995: 766-67).

P’s utterances in lines 1054-58 are interspersed with laugh tokens. This apparent amusement by the troubles-teller might seem out of place, however, as pointed out by
Jefferson (1984a: 351), laughter is specifically employed in these cases to exhibit troubles-resistance. In other words, the patient is showing that all the troubles she is talking about are not getting the better of her, but this does not necessarily mean that she is inviting her recipients to laugh with her. In fact, neither PR nor SC laugh, rather they produce continuers (ll. 1056 and 1060), thus affiliating with P’s stated position on the narrated troubles (“one catastrophe after another”). PR’s “uh ↓u:h” is of particular interest in that it encourages P to go on after a long pause, but is also pronounced with an abrupt fall in intonation and a stretched vowel sound, therefore functioning as an empathic response to what has still to come.

The announced catastrophe seems to be put off for a while as P explicitly formulates her resistance to troubles explaining that sometimes she does not even want to listen to her son telling troubles (ll. 1061-62). In line 1063 PR starts showing understanding, but the patient bursts into laughter in partial overlap with her, again exhibiting troubles-resistance (l. 1064). This laughter does not seem to interfere with the primary finishing her utterance, which can be considered the point of P’s story (ll. 1065-67). Again the primary declines to laugh and moves away from the patient’s personal experience to make a generalisation (“you reach a point where you just can’t take any more upsetting news”) as a way to show troubles-receptiveness.

P continues with her story in lines 1070-1075 revealing the already announced catastrophe (the leak that ruined her son’s house). PR’s first reaction when the story has finished is a lip smack (l. 1074) followed by SC’s “oh!” in line 1076. The level of intimacy between the participants escalates from the primary calling the patient by name and exclaiming “oh god” in line 1077, through her offering an assessment in line 1081 (“that’s ↓terrible”), to the patient letting go in lines 1082 (“i know isn’t ↑it”), 1087 (“oh my ↓go:sh”), and 1092, where she complains about not being able to do anything to face the situation. Her “there’s nothing i can do about it” is also a reference to the sense of impotence already expressed by the preceding “i think it’s inevitable” uttered by PR a few lines before (cf. 22a, l. 1020).

Excerpt 22b ends with PR enquiring about P having someone to confide in (ll. 1097-99). This rather general enquiry is abandoned ‘midway’ and is turned into a specific

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reference to P’s meeting with her sister and a friend to pray (ll. 1098-100). The new topic develops as follows:

Excerpt 22c

1103 PR  do do is that erm pfff help?
1104 P yeah! yeah.
1105 PR okay. okay coz,
1106 P yeah. that's where i'm going tonight.
1107 →PR  oh [ go (h)od. ] [ go (h)od. ]
1108 SC  [ (you (h)u ) [ go (h)od].]
1109 P [ ha ha ] ha ha [ha ha .hhh]
1110 PR  [ o kay. ha] ha ha .hhh
1111 P ha
1112 PR yeah,
1113 P [ ha ha ]
1114 →PR  [yeah. coz ] right now it seems like these things,
1115 (.)
1116 PR  [(slb slb) different issues.]
1117 P [and then i have you know,] a couple of close friends that i can share with [ you ] know?-
1118 →PR  [good.]
1119 PR =good.=
1120 P =so,=
1121 →PR =that's so important. i'm glad [you] have that. [yeah.]
1122 P [uh,] [ uh, ]
1123 (.)
1124 →PR  o[kay.]
1125 P [pat ] my friend called me from arizona, ha ha she hasn't called
1126 P  me in a while and i [unloa]ded on her.=
1127 PR  [o:h,] =oh oh!
1128 P [ha ha ha ha ha ha .hhh]
1129 PR ((smiling)) [you unloaded i thought you were] gonna say she[gave]=
1130 P [ ha ]=
1131 PR =me bad news.
1132 SC hhha
1133 P no:!
1134 SC hh
1135 P no she had good news. she's been having a house built she's gonna
1136 P  be moving in a few weeks [but,]
1137 PR  [ oh,]
1138 P ha ha ha ha [ha .hhh]
1139 PR  [o kay.]
1140 P but i unloaded on her. .hhh ha [ ha ha]
The first few lines of excerpt 22c are devoted to the topic introduced at the end of 22b. After P has confirmed the piece of information that PR remembers from a previous interview (i.e. that she meets with her sister and a friend to pray; cf. 22b, ll. 1098-102), the latter enquires into the praying meetings being of any help (l. 1103). The patient replies affirmatively and adds that she is going to one of those meetings that same night (ll. 1104-06). PR expresses appreciation for P’s initiatives in line 1107. Her positive assessment includes laugh tokens that are probably caused by her not expecting P’s reply in line 1106 (note also the surprise marker “oh” in l. 1107). PR’s laughter prompts laughter first from SC and then from P, the three parties laughing in partial overlap with each other (ll. 1107-109), the joint laughter relieving some of the tension built up by the previous troubles-telling. In lines 1114-16 the primary ‘recycles’ a point already made by acknowledging the existence of various troubles in the patient’s present life (cf. also 23a, l. 1051). Her general remark functions as a work-up summing up the whole situation illustrated by the patient and preparing for closure of the troubles-talk.

P aligns with the work-up activities by mentioning her remedy for the upsetting
feelings caused by the many troubles presented. Her statement about confiding in a
couple of close friends (ll. 1117-18) is an expanded answer to the question only partially
formulated by PR in lines 1098-99 of excerpt 22b. Such an answer is met with positive
assessments in lines 1119, 1120 (“good.”), and 1122 (“that’s so important.”). In spite of
the “okay” in line 1124, which foreshadows exit from troubles-talk and entry into a new
topic, P elaborates on her previous answer by giving one example. In lines 1126-27 she
tells how she got her problems ‘off her chest’ talking with a friend over the phone. In so
doing she uses the word “unload” and bursts into laughter (l. 1129), after which PR
expresses her surprise (l. 1128) as she confesses she was expecting further troubles (l. 1130). P’s laughter is reciprocated by PR’s smile and SC’s laughter (ll. 1130, 1132 and
1134), which are also probably elicited by PR’s acknowledgement of a wrong inference.
P corrects the inference by contrasting it with the telling of good news regarding her
friend (ll. 1136-37), and then repeats the word “unload” and continues laughing. At this
point the primary offers a maxim (“that’s what good friends are there for”), maybe in an
attempt to close troubles-talk. The patient adds that she and her friend have known each
other since school days (l. 1150), this addition being met with markers of surprise (ll.
1150-52) and more laughter. The three parties are laughing together for the second time
in lines 1153-1155 (ll. 1107-109 above), prolonged laughter working again as a ‘break’
within the troubles-telling sequence. On both occasions laughter is initiated by one of
the student clinicians (specifically the primary), although the joint laughter in lines
1153-55 is somehow anticipated by the patient’s amused tone throughout lines 1126-47.
What is worth noticing is that, differently from what happens in lines 1056-57 (cf. 22b
above), where the clinicians decline to laugh with the patient while the latter is engaged
in serious reports, in 22c the participants in conversation are taking a *buffer topic* initiated by the
troubles-teller (ll. 1126ff.). In this case P introduces an anecdote (the relationship with
her friend) that is somehow tangential with respect to the trouble, although still related to
it.

Excerpt 22c ends with PR expressing appreciation for P’s long-standing relationship
with her friend and refining the preceding maxim accordingly (the underlying argument
being: if it is true that good friends are there to listen to your problems, it is all the more
true that there is nobody who understands you better than friends from childhood).

Excerpt 22d

1162 PR than someone that's been with [you]
1163 P [uh,]
1164 PR since [you know?]
1165 P [oh a] nother thing. and then my other best friend from
1166 (. ) grammar school, her son died.
1167 ((PR nodding)) (0.8)
1168 P just:
1169 →PR o::h!
1170 P like a month and [ a half a go. ]
1171 PR [(slb slb ↓slb) uh ] huh,
1172 P tzt so i went to the wake and funeral and all that?
1173 PR yeah,
1174 P so:,
1175 PR yeah,
1176 P uh.
1177 →PR uhhhff it would be a good idea to erm you know?
1178 (0.7)
1179 PR just gi- subject yourself to some public thi- things.
1180 (0.6)
1181 PR like funny movies,
1182 P [yeah,]
1183 PR [ or, ] you know just going out with friends.
1184 P [oh yeah.]
1185 PR [i know ] d- that you make an effort to do that.
1186 P yeah,
1187 PR right know i think it would be a really good thing for you coz you
1188 need to balance all the [hea]vy-
1189 P [uh,]
1190 PR -emotions [with,]
1191 SC [ uh ] huh.
1192 PR [some]thing-
1193 P [ uh ]
1194 PR a little bit lighter for yourself.
1195 P [uh, ]
1196 PR [yeah] [and i think,]
1197 P (yeah i tried ) to get out you know, like i went to dinner,
1198 (0.7)
1199 PR [yeah.]
1200 P [ on ] a saturday night [you know?]
1201 →PR [ yeah. no] i think you do a good job of
1202 that. [just]
so you aware that i, [that] you know it's probably important. now really [im]portant now=
because, (0.4)
uh, yeah well, i have .hhh lot of different things coming up especially with christmas [now.]
right, right,
you know?
okay (good. that's good) [coz i be ]long to the auxiliary there [and now,]
and they're gonna have a christmas party, and then the organization's gonna have a christmas party, .hhh which,
twentieth (0.8) it will be on the twentieth and my husband died on the twenty first and that's where he died but,
:o:h! [oh!]
[ ha] ha ha [but,] [ so ] that may be a little, u:h,=
=emotional? [ for you.]
[ i think:] i'll get through it.
yeah.
ha ha
yeah.
and you will get through it.
uh,
you're doing very well.
[uh,] [and] just continue surrounding yourself [with people=
who love and support you.
yeah.
that is the best thing you can do.
and knowing [that] you're gonna get through all of this.
[uh, ]
The cheerful atmosphere created in excerpt 22c is dimmed by further troubles-talk in excerpt 22d. In lines 1165-66 P proceeds with the troubles work-up by reporting a relevant similar experience by a friend of hers. The report is met with PR nodding in line 1167 and producing an empathic “o::h!” in line 1169. The primary then initiates an advice-giving sequence in line 1177: she gives P practical suggestions on how to feel relieved of the burden of so many upsetting news (1177-94). Advice-giving is clearly closing implicative and is probably employed here to resume the routine activity of questioning, which constitutes the bulk of the standard interview. PR’s suggestions are interspersed with P’s minimal acknowledgement tokens (ll. 1182, 1184, 1186, 1189, 1193, 1195) and are followed by the patient explaining that she has tried to do precisely what the primary is suggesting ("i tried to get out you know, like i went to dinner,"). In line 1201 The primary praises the patient for the efforts she has made in trying to go out and meet people (note the previous similar acknowledgement in 22a, ll. 1009-14) and strongly reaffirms the importance of such initiatives (note the emphasis on “now”, the use of “really” and the repetition of “now” in line 1208). P reassures PR by mentioning “a lot of different things coming up especially with christmas” (ll. 1211-12) and the latter expresses her appreciation with another assessment in line 1216. The patient then proceeds to illustrate her plans for Christmas with the Christian association she belongs to, she then hesitates for a moment (note the in-breath in line 1220 and the pause in line 1221) before re-engaging in troubles-telling.

In lines 1222-24 she explains that the place and time of the Christmas party where she is going coincide with the place and time of her husband’s death. PR shows her understanding and empathy in lines 1225 (“o:h! o:h!”) and 1227-29 (“so that may be a little, emotional? for you.”). P’s laugh particles in line 1226 probably signal again her willingness to take the trouble lightly, and are again not reciprocated by the student clinicians (cf. 22b above). At this point the patient orients to exit from troubles-talk by using an optimistic projection in line 1232 (“i think i’ll get through it.”). The secondary, who has not spoken much so far, seems to encourage P’s initiative. She produces an
expression of agreement that reinforces P’s projection in line 1236 (“and you will get through it.”), an expression of praise that draws on PR’s previous contributions in line 1238 (“you’re doing very well.”), a piece of advice that seems to conclude the whole work-up stage initiated in 22a (“just continue surrounding yourself with people who love and support you.”, etc.; ll. 1240-45), and a moral that would serve well as a *boundarying-off* device (“life goes on.” in line 1250). Nevertheless, the closure of the troubles-telling sequence is postponed again, as can be seen in excerpt 22e.

Excerpt 22e

1251 P    oh [i ↓know ]
1252 PR    [it will.][yours]
1253 P    [ oh ] [ri(h)ght do(h)n’t] i know [that!]
1254 SC    [ ha ha ha ha] [yeah.]
1255 i'm [sure you do.]
1256 P    [ ha ha ha ] ha [ha]
1257 SC    [ha]
1258 PR    you've [learned] that.=
1259 SC    [ ha ha ]
1260 P    =[oh yeah]
1261 PR    =[in the ] past few year right?
1262 P    uh,
1263 PR    [ and and through,]
1264 P    [through all these] years [ oh yes. ]
1265 PR    [yes. yeah] you, ((to SC)) mandy's
1266 lost a number of siblings. right mandy?
1267 P    well lot of relatives and things like that.
1268 PR    yeah,=
1269 P    =in one year i lost, (. ) in five years in the five year time that
1270 i think it was like eight.
1271 →SC oh no!=
1272 P    =eight you know, ((PR nodding)) like nephews, e:rm my brothers, my
1273 sister in la(h)w my brother in law. hh
1274 (0.7)
1275 P    ((PR nodding)) two brother in laws, ye:ah and then my husband was
1276 killed at that time too. my first husband.
1277 →PR [oh!]
1278 P    [ i ] already went through two husbands! hhha
1279 PR    yeah, yeah,
1280 P    so,
1281 PR    so you know
1282 P    [yeah!]
PR [that] you're capable [of getting] through,-
1284 P [oh i ca- ]
1285 P -yeah. it's just-
1286 PR -anything.
1287 P -a matter [of time.]
1288 PR [you know,]
1289 P you know? and
1290 PR yes.
1291 P i think as you get older it's a little bit harder.
1292 PR uh huh.
1293 P you know i really feel sorry for people that have been married for
1294 PR [*oohh*!]
1295 P [ fifty ] sixty years, [ and ]
1296 PR [right]
1297 P then all of a sudden, for the first time they lose somebody.
1298 PR uh [ huh, ]
1299 PR [that's] really tough.
1300 PR that that is. yeah. i i can [imagine that.]
1301 P [i started at] a younger age. ha ha
1302 PR [ha ha] ha ha [ha so i can] [ha] [i could] [ha]
1303 PR [uh huh] [but you know not] not [to] [mi ni ] [mi] ze-
1304 SC [ha] [ ha ha ]
1305 P [ i could ha-]
1306 PR *[that. at all!]
1307 P well no! but i mean er i think i was able to handle it better. ha
1308 PR right,
1309 P than if it start happening now you know, that whole process.
1310 PR right after [you'd been] together for,
1311 P [ i mean,]
1312 (.).
1313 P yeah,
1314 PR sixteen years or so. yeah, [fifty ]
1315 P [right.]
1316 PR yeah,
1317 (.)
1318 PR okay. well i think you, [you know?]
1319 SC [ uh huh. ]
1320 PR ((P nodding)) i think you know what to do to keep yourself like
1321 P mel said [ sur ]rounded=
1322 P [yeah,]
1323 PR =with people who love and support you.
1324 P uh,
1325 PR that that is the best thing i agree.
1326 ((P lowers head and looks at chart)) (1.1)
1327 PR okay erm, why don't we check your blood pressure now?
Excerpt 22e opens with P and PR’s affiliating responses to SC’s “life goes on” at the end of excerpt 22d (ll. 1251-52). P’s statement in line 1251 (“oh i know”) is supported by SC in line 1255 (“i’m sure you do.”) and confirmed by PR in line 1258 (“you’ve learned that”). I am not going to dwell on the laugh particles in P’s turns in lines 1253 and 1256, as their function has already been discussed above. However, this time the patient’s laughter invites two completely different reactions from the student clinicians, which seem to be informed by the different knowledge they have of the patient’s background. SC only met P for the first time a few weeks before, therefore she does not possess all the information PR has already gathered in her numerous encounters with the patient. What happens in this portion of the interview is that SC reciprocates P’s laughter in lines 1254, 1258 and 1260, whereas PR proceeds to briefly illustrate to SC P’s loss of a number of family members. She then asks P to confirm that the information she has is correct (l. 1266) and P starts listing relatives who have passed away. The additional information gets two markers of empathy from SC and PR respectively (ll. 1271 and 1277) and a prolonged display of understanding by the latter, who nods at P’s words while constantly keeping eye-contact with her (ll. 1272-76).

In lines 1281-86 PR prepares for exit from troubles-talk by stating an optimistic projection. This is stronger than P and SC’s preceding projections in line 1232 and 1236 (“i think i’ll get through it.” and “you will get through it.”) as it presents a forecast as a fact. Note the emphasis on the word “know”, the use of the present tense, i.e. “you’re able” as opposed to the preceding “i’ll” and “you will”, and the use of the word “anything”. Such a projection also contrasts the sense of hopelessness expressed in 22b (ll. 1092). In line 1285 P agrees with PR’s previous statement (ll. 1281-83) adding that it is just a matter of time. She then reports another relevant experience, which, unlike the one reported in lines 1165-66 (cf. 22d above), neither refers to a specific person nor is similar to her own experience. She expresses her sympathy for the people who, unlike her, lose somebody at an older age, and considers their situation to be very difficult (ll. 1291-97). The presentation of a contrastive experience works towards the attainment of
agreement, which is displayed in line 1307 (“i think i was able to handle it better.”) in accord with PR’s projection in lines 1281-86. In the meantime, P clearly projects the closing of the sequence by making light of the trouble (“i started at a younger age.”) and bursting into laughter once again, which is reciprocated by the secondary (l. 1304) but, surprisingly enough, not by the primary, who does not change her troubles-receptive position (“but you know not to minimise that. at all!”). Only upon P’s elaboration in line 1307 does she orient to closing.

Troubles-talk is closed in the last ten lines of excerpt 22e. A closing-implicative “okay” in line 1318 introduces PR’s agreement-claiming quotation of her colleague (ll. 1318-25). By reinvoking a matter that has already been developed (“i think you know what to do so keep yourself like mel said surrounded with people who love and support you.”) and by formulating a summary assessment (“that is the best thing i agree”; cf. Jefferson, 1984a: 211), PR provides for entry into closing and re-engagement into business as usual. As noted by Jefferson (1988: 438), such exit devices are both “topically disjunctive and interactionally cohesive/affiliative”. In other words, they tactfully break away from talk about a trouble by exhibiting attentiveness to the other. In this way the role of the patient as the focus of the interaction is maintained and the reciprocity created during troubles-talk is preserved.

Re-engagement in the routine activities of the visit is anticipated in line 1325, where PR lowers her head and glances at P’s chart. The latter does the same immediately afterwards, thus aligning with the doctor (note also the “okay.” in line 1328). PR finally announces return to business as usual in line 1327 (“why don’t we check your blood pressure now?”).

What emerges from the discussion of excerpt 22 is that the actions making up troubles-telling, like those involved in any other sequence of talk, are interactionally coordinated on a moment-by-moment basis. It is the mutual orientation of participants to troubles-talk that determines its occurrence. In the specific context analysed, it is the alignment of student clinicians as troubles recipients that makes it possible for the troubles-telling to unfold over such a long portion of the interaction. This alignment is achieved first and foremost through affect-laden language, specifically assessments. These are employed by the two doctors to respond to the troubles-telling trajectory.
initiated by the patient in a way that, by displaying a “coming together” and a “sharing” between the participants (Jones, 2001: 123), may well lead to ‘mistake’ excerpt 22 for an instance of mundane conversation.

5.5 Summary

In the present chapter I have tried to demonstrate that the voice of medicine and the voice of the lifeworld interpenetrate in naturopathic interviews, and that this alternation is not unilaterally decided but interactionally negotiated by participants on a turn-by-turn and sequence-by-sequence basis. Participants – it seems – do not speak with a single voice (i.e. patients with the voice of the lifeworld and doctors with the voice of medicine), but collaboratively orient to one or the other. In particular, we have seen how doctors do not necessarily ‘stick’ to the medical agenda, but give patients room to speak about their concerns. Moreover, contrary to what claimed by previous researchers (cf. 3.5.3.2), doctors do not refrain from reacting to patients’ elaborations. Rather, they show their understanding and even involvement by means of empathic responses like assessments, thus in fact speaking with the voice of the lifeworld. At this point one may wonder if the reverse is also true, i.e. if patients can speak with the voice of medicine. This issue will be addressed in the next chapter.
6 ‘WHY THAT NOW?’ NEGOTIATING ACTIVITIES AND ROLES IN NATUROPATHIC INTERVIEWS

6.1 Introduction

Chapter 5 has shown how the voice of medicine and the voice of the lifeworld interpenetrate in naturopathic interviews. In particular, we have seen that doctors do not silence their patients but give them room to speak about their concerns and, in so doing, may themselves speak with the voice of the lifeworld, using conversational resources – specifically assessments – that make it possible to reach a high level of intimacy with patients. In the present chapter I will try to demonstrate that if it is true that doctors can speak with the voice of the lifeworld it is also true that patients can speak with the voice of medicine. In other words, patients seem to be equipped not just with interactional knowledge of mundane conversation, but also with some technical medical knowledge and, above all, with knowledge of the medical interview structure. What I will argue is that patients, exactly like doctors, know what is acceptable or correct and at what stage of the interview, and design their contributions accordingly.

6.2 Structuring the interview through displays of interactional asymmetries

In the present section we will examine what Heritage (1997) has called “interactional asymmetries” (cf. 3.5) to show that these are not a priori constraints on the medical interview but an interactionally established condition shaping doctors’ and patients’ roles and activities with respect to the tasks being performed. To be more precise, we will look at how patients may claim or disclaim knowledge and rights of access to knowledge depending on what they deem appropriate to the circumstances. Particularly, in 6.2.1 and 6.2.2 we will see how they actively cooperate with physicians in the construction of the chief complaint (cf. 1.3; 3.5), whereas in 6.2.3 we will observe that they may play a crucial role in the delivery of diagnostic news.
6.2.1 Co-constructing the chief complaint: The transition from problem presentation to history-taking

One of the most delicate moments in a medical interview is the transition from the patient-controlled complaint stage to the doctor-controlled information-gathering stage (i.e. the combination of history-taking and physical exam). Typically, this transition corresponds to what has been referred to by Robinson and Heritage (2005) as “presentation of current symptoms”. Such a portion of the interview is crucial in that by presenting current symptoms patients justify their decision to seek medical help. In so doing, they hand over responsibility for dealing with their problems to the doctor, who gains control of the encounter by initiating her/his questioning activity (cf. 3.5.2.2). This shift is negotiated by doctors and patients, as can be seen in the following excerpt from a first visit.

Excerpt 23

297  P   i stopped taking the meds,
298  PR  okay.
299  P   obviously!
300  PR  uh huh,
301  P   dropped a hundred pound
302  PR  uh huh,
303  → P  but now i'm frustrated as i get out trying to get my life back.
304  PR  uh huh.
305  P   tzt a:nd er in the meantime all these other things
306  PR  uh huh,
307  P   have [ appeared. ]
308  PR  [cropped up.]
309  P   so and so i'm now i'm forty eight .hhh and wonder do i really
310  P   have p.m_d_d,
311  PR  uh huh,
312  P   tzt o:r it is just a byproduct of [everything that ha ]ppened.
313  PR  [everything uh  huh.]
314  P   [you know?]  
315  PR  [ o kay. ]
316  P   so .hhhh ((pointing at PR)) [you have qui]te,
317  PR  [uh  huh, uh,]
318  P   [hhh hhhh   ha ]
319  PR  [quite i know you're] the typi[cal pa- pa]tient-
320  P   [ha  ha ha ]
321  PR  -that comes in [to] see naturopaths [yeah.]
The patient has been reporting on her medical problems and her difficulties in coping with them. She has presented her complaints by narrating a series of events and personal experiences in the past tense. During the presentation the primary has been taking notes and has responded mainly with continuers signalling his orientation to the incompleteness of the patient’s account.
In the lines immediately preceding excerpt 23 the patient has listed a number of psychiatric drugs she had been on until one year prior to the visit. After mentioning that she stopped taking the medicines and consequently lost weight (ll. 297-301), the patient moves on to talk about her present situation. Although she does not describe physical symptoms proper, she makes reference to the serious repercussions that her medical condition has had on her life, particularly on her state of mind. By mentioning her frustration in line 303 she basically assumes the role of the ‘helpless’ patient, thus justifying her visit to the clinic in search of professional advice. In so doing, she shifts from the past tense to the present tense and uses the deictic “now”, which she also emphasises. After the continuer uttered by the primary in line 304, she refers back to the previously mentioned problems by grouping them under the general heading “all these other things”. The primary utters another continuer in line 306 and offers a collaborative completion in line 308 (“cropped up” in overlap with the patient’s “appeared” in line 307) as a display of active listening. In lines 309-12 the patient is clearly trying to draw some conclusions from the preceding account: her concluding remarks are introduced by the conjunction “so” and include a candidate diagnosis, in which she presents her lay theory that her current symptoms either indicate Premenstrual Dysphoric Disorder (PMDD) or are the result of the combination of all of her medical problems rather than a single pathology. In offering this diagnosis, the patient uses the verb “wonder” (l. 309), which has the twofold function of expressing doubt, and therefore claiming insufficient knowledge, and indirectly requesting an opinion from the doctor. “Wonder” is reinforced by the immediately following direct question, which establishes the conditional relevance of an answer on the part of the doctor. In line 311 the doctor produces another continuer signalling that he knows the patient has not yet completed her utterance, whereas in line 313 he offers a collaborative completion, anticipating the patient’s hypothesis and confirming it with an acknowledgement token (note the falling intonation of “uh huh” as opposed to the continuing intonation of previous ‘uh huhs’). P’s “you know?” in line 314, which is typically used to check understanding (cf. 3.5.1.2), elicits PR’s “okay” in line 315, the latter projecting a new course of action. In line 316 the patient explicitly hands over responsibility for her treatment to the doctor (note the emphasis on “you” which is reinforced by P’s gesture) and in line 318 she
bursts into laughter before completing her utterance (where, it seems reasonable to infer, she is making reference to the hard job awaiting the doctor). Note that the primary does not reciprocate the patient’s laughter but immediately takes control over the interaction seizing the opportunity to reassure the patient, explain the standard procedure, and work toward a definition of the chief complaint. First, in response to P’s self-truncated “you have quite,” he acknowledges the difficult nature of his task (note the repetition of “quite” and the use of “i know” in line 319). Second, he tells P that the fact of presenting different symptoms related to more than one complaint makes her a typical patient of the clinic (ll. 319-25). Third, he explains how naturopaths at the UB clinic deal with cases like hers (ll. 327-30). In so doing, however, he does not only express interest in the medical problem and its properties, but he also demonstrates a special attention to the patient’s opinions and specific needs (note the emphasis on “you” and the reference to “your quality of life” in line 328). In lines 331-32 he explicitly asks the patient to mention what she thinks is the most urgent complaint to be addressed. P mentions neuropathy and depression (ll. 333-44), the first part of her answer being rather cautious and the second much more direct. The reference to neuropathy is made tentative by the use of the self-truncated “probab-”, and the expressions “i think” and “i don’t know”, both downgrading the epistemic certainty of her utterance (l. 333). Such a tentativeness is justified by the presentation of two possible causes for neuropathy, namely either mercury fillings, in which case P thinks the neuropathy could be addressed straightaway, or low back problems, in which case there would probably be no immediate or simple solution. As mentioned, the second part of P’s answer is not as hesitant as the first; in fact, P clearly identifies depression as the most pressing complaint (“i can’t take the depression” in ll. 340-42). At this point PR, after acknowledging receipt of P’s contributions (ll. 335, 337, 339, 441, 443), moves to the history of the two complaints\(^1\) and, as suggested by P, makes reference first to the depression and then to the low back (ll. 347-48). P, however, produces a fairly long in-breath, which might show uneasiness in responding, possibly related to the delicate nature of the topic (depression and psychiatric problems in general). Given the lack of an

\(^1\) Comprehensive history-taking will be conducted at a later stage of the interview (cf. excerpt 12 in 5.2.2.2).
immediate response, the primary shifts the focus to the neuropathy, thus again showing attentiveness to the patient, who starts providing a response at PR’s first possible completion (l. 351), demonstrating that the low back is for her a less difficult topic to talk about.

Overall, excerpt 23 shows how doctors and patients collaboratively construct the chief complaint and how this joint effort at defining the reason for the visit marks the transition from the problem presentation stage to the history-taking stage which begins at the end of the excerpt. As we will see in the following subsection, this joint construction can also be observed within the history-taking stage when moving from one medical problem to the next.

6.2.2 Co-constructing the chief complaint: the negotiation of topic shift
As in 6.2.1, in the present subsection we will analyse data from an intake interview in order to show how doctors and patients collaboratively define the chief complaint (cf. 1.3; 3.5). In this case, however, we will focus on the transition occurring at topic level between two distinct complaints, namely an isolated asthma attack, which occasioned the visit, and the issue of weight, for which the patient is seeking medical advice. At first glance this transition may appear as a sudden shift caused by the doctor abruptly changing topic. In fact, micro-analysis of the transcript reveals that the participants jointly decide what is the most pressing issue to the patient (i.e. the chief complaint). Specifically, the topic shift is carefully introduced and oriented to by both parties and is based on the negotiation of interactionally relevant asymmetries of knowledge. In particular, the patient alternately performs as ‘expert’ and ‘lay’ participant (or ‘knowledgeable’ and ‘ignorant’; see also excerpt 5 from the same interview in 5.2.1) depending on the urgency with which he is trying to have specific concerns addressed by the doctor.

Excerpt 24a

659 PR okay, erm does anyone else have asthma in your family?
660 (1.7)
661 P i think my sister do. we di- erm we didn't find out until late.
662 (.) sometime this year,
663 (1.2)
Okay. How old is she.

She's thirteen.

Okay where did you grow up by the way around here,

[O:R,]

Yeah hartford connecticut.

Okay.

Okay where did you grow up by the way around here, [O:R,]

Yeah hartford connecticut.

Okay.

Okay.

Okay.

Okay.

Okay.

Okay.

Okay.

Okay.

Okay.

Okay.
As mentioned above, PR has been conducting the history on P’s asthma (she has asked about previous attacks and the drugs used to prevent them from happening, she has enquired about the related problem of eczema, and so on). In lines 659-70 she enquires about what may have contributed to P’s asthma (a family history of asthma and general environmental factors). P provides minimal, immediate responses (ll. 665 and 669), except in line 661, where he expands on his answer (“di- erm we didn't find out until late sometime this year,”) to address his difficulty in responding (note the display of uncertainty in “i think my sister do” and the long pause preceding it; cf. also 5.4.1).

In line 672 the primary projects a new trajectory by announcing that she is going to ask the patient about his diet. P replies with a continuer uttered with a falling intonation (l. 674), signalling both his awareness that PR is going to hold the floor (note the continuing intonation at the end of her turn in line 673), and his willingness to switch to the new topic proposed by the doctor and answer her questions about it. In lines 675-76 the primary solicits an explicit acknowledgment on the part of the patient by asking him to confirm that he is looking for professional advice on nutritional issues. P provides the confirmation required in line 677 and reinforces it in line 679. In lines 682-86 PR reassures P that she is not dismissing the previous topic (asthma and eczema) but expresses her intention to deal with the issue of diet first, and again asks for confirmation on the part of the patient (“so that’s where you wanna start?”), as if she was looking for an explicit approval on the new course of action just projected. The patient okays and nods (l. 687), thus accepting PR’s proposal, but does not clearly verbalise his agreement. At this point the primary herself expresses a positive evaluation (“that’s a good idea”) in response to the patient’s reply and starts asking specific questions on the patient’s nutritional habits. By producing a positive assessment the primary seems to sanction a decision that she has in fact made on which the patient has not expressed a clear opinion (although, as we have seen, this has been repeatedly solicited). Such a decision, however, is not imposed on the patient, who explicitly
orients to it a few lines later. His answer to PR’s first question about diet (“what do you eat for breakfast usually?”) occurs in a dispreferred format (it is delayed by the initial laughter, the vague “depend” and the hesitation “erm”). After mentioning what he had for breakfast on the day of the visit, P expands on his answer by ‘confessing’ that he eats pancakes and sausages and justifying what is generally considered a poor food choice as a ‘consolidated’ habit (“i know me”, “i’m just traditional”). In lines 696-98 he explains that he has had cereals for breakfast since someone (note the third-party attribution “they”) told him that he should try and eat something different (from the traditional pancakes and sausages). He makes reference to “oatmeal bread cereal” and asks the doctor to confirm the term he has just used (“what they call it”). The primary briefly confirms the correctness of the term (l. 699) and the patient further specifies his answer by describing the kind of oatmeal he eats (note the repetition of “a little” used to highlight that the cereals are only slightly sweetened and therefore healthy). Finally, in lines 704-08 P explicitly states that he is not an expert on dieting (note the repeated “i don’t know” claiming ignorance on the specific topic discussed). By disclaiming knowledge on dieting P somehow justifies his ‘inappropriate’ nutritional habits and aligns to the asymmetry of technical knowledge holding between himself and the primary, thus providing the actual reason for the visit (he is overweight and is seeking medical advice on nutritional issues) and ultimately legitimising the primary’s professional authority as advice-giver, which the latter confirms in lines 709-11 (“well we are. so we’re gonna help you”).

The significance of the patient’s role in the construction of the chief complaint, and therefore in determining the main lines along which the interview will develop, can be best appreciated if we compare his behaviour in excerpt 24a with what he does in a previous portion of the transcript, reproduced here as excerpt 24b:

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2 In the light of these considerations, it is worth spending a few words on P’s laughter in line 690 and PR’s non-reciprocation of it. In this respect, and in line with Haakana’s (2001) observations (cf. 3.5.4.3, note 36), it seems that P’s laughter and PR’s non-reciprocation of it are not evidence of social or emotional distancing between the patient and the doctor, but signal their awareness of the activities in which they are involved. In particular, P is aware that he is portraying himself unfavourably and that this activity ‘involve[s]’ delicate’ interactional business in need of possible remedy or even legitimization” (cf. Beach, 2001: 17).
Excerpt 24b

570  PR  [and] do you know i don't know if you've heard or not. i'll tell
571  you a little bit more about this since you're curious,
572  P  uh huh,
573  PR  but normally i don't know if i would tell the patient too much
574  a[bout this if they weren't really curious, erm but have you
575  heard anything about there being a link between eczema and asthma?
576  (1.0)
577  PR  do you know about that?
578  P  [yeah! ]
579  PR  [(slb)?] you do?
580  P  i think i know that yeah.
581  PR  o:kay. okay.-
582  P  =coz erm (. i i see i used to see dermatologists so often,
583  PR  [ uh huh. ]
584  P  [and stuff.] and there i can easily tell (slb slb) there's a link
585  bet[ween,]
586  PR  [ uh, ]
587  P  yeah. i know the [link ] between the two.-
588  PR  [yeah.]  =yeah. okay. okay. so
589  it's something that we can kind of approach. you know we can help
590  you with. .hh erm so that's something that if you wanna come back
591  and keep going you know, getting our help with ↑that
592  P  uh huh.
593  PR  it won't. it's not something we can address right away.
594  P  no.
595  PR  i mean it's not it will take some time. we would have to like try
596  some things, and .hh you know it just er er it's it will be a
597  gradual kind of process. [("slb slb")]
598  P  [ yeah. i ] know coz i see,
599  PR  [okay.]  
600  P  [erm ] i: er whatever it er for me whatever (pertain) i mean i'm
601  not, i don't read everything that's medical [ o::r, ]
602  PR  [uh huh.]
603  P  you know but anything pertaining to asthma,[o:r]
604  PR  [uh ]huh.
605  P  you know or eczema,-
606  PR  =yeah.-
607  P  =i read it coz erm i don't know coz it could be something that i
608  make that give me a reaction or, [much]
609  PR  [ uh,]
610  P  of that very often it could be life treatment.
611  PR  yeah.
612  P  so i i wish so i could be a way for myself.
613  PR  yeah. okay good! that's good. coz you know patient's
responsibility. that's, you know we really encourage people to be in charge of their own health.
yeah.
you know that's part of the whole, difference in philosophy in alternative [versus ] conventional medicine—
[uh huh,]
you know they, they erm in conventional medicine they don't really encourage people to be very active about their own health. but we do.
yeah.
so, that's great. that you already are. .hh but i'm not gonna i'm gonna kind of change topics coz i don't wanna tzt spend too much time on this. coz erm what we probably will focus on today in this visit is talking about your diet.
uh huh.
erm and your lifestyle factors. and especially it sounds like you wanted some advice. with diet.
yeah.

(UBNMC, INT6-11.12.03).

In lines 570-77 the primary initiates a pre-sequence, with a pre-announcement in its typical form “do you know…” (cf. Schegloff, 1980: 1988), which projects the telling of some newsworthy information (the link between asthma and eczema). In so doing, PR invites P to align as recipient of the news that is about to be told and establishes – both syntactically and intonationally (l. 575) – the conditional relevance of an answer on the part of P. In this respect, the latter has two possibilities as a recipient of a pre-announcement: if he can detect what news is forthcoming and already knows the information, he will tell the news or make a guess; otherwise he will simply answer ‘no’ and wait for the news to be told (cf. Schegloff, 1988: 58). In this case, however, the patient remains silent for one second (l. 576), this gap prompting the primary to reformulate her question (l. 577). In line 578 P finally answers, his minimal affirmative reply causing PR’s surprise and request for confirmation in line 579. PR provides a hedged answer (“i think i know yeah”), which somehow downplays his claim, and motivates his access to knowledge about the matter discussed (the link between asthma and eczema) by expanding on his response in line 582 (“i used to see dermatologists so often”). By reporting his experience as a dermatological patient while at the same time referring to an authoritative source (“dermatologists”), P mitigates a sensitive action,
namely claiming knowledge which may challenge PR’s authority as the one who is normatively entitled to possess such knowledge (cf. 3.5.4.3). This interpretation could also explain why the patient remains silent after the primary’s pre-announcement in the opening lines of the excerpt: it may well be that P is interpreting the pre-announcement as a rhetorical question (and her claimed impression of him “since you’re curious” as a captatio benevolentiae) simply introducing a technical explanation, which he does not want to ‘heckle’ so as to avoid hampering PR’s role as teacher.\(^3\)

At this point (ll. 584-87) the patient becomes rather more assertive (‘i can easily tell” and “i know the link between the two”), probably in an attempt at discouraging further elaborations from the doctor. In lines 589-97 the latter explains that finding an effective therapy for asthma and eczema requires a long time and normally involves trying various remedies. In line 598 the patient once again shows himself knowledgeable about the topic and again motivates his knowledge by referring to external authority, in this case publications on asthma and eczema (ll. 600-07).\(^4\) He then mentions a possible cause for his asthma and eczema (“something that i make that give me a reaction”) referring back to a discussion on environmental exposure earlier in the interview, particularly on asthma and eczema as possible reactions to the use of specific chemicals, and to PR’s ensuing questions on hygiene products as a way to figure out what caused P’s symptoms (cf. interview 6, ll. 408ff.) In line 610 P shows understanding of and agreement with PR’s definition of the kind of treatment needed for asthma and eczema (the “gradual kind of process” in line 597) by reformulating PR’s explanation as “very often it could be life treatment”. In addition, he expresses his commitment to self-care (“i wish so i could be a way for myself”), which the doctor praises in line 613 (note the repeated assessment). The topicalisation of patient responsibility in lines 613-14 gives the primary the opportunity to play her role as teacher turning away from asthma and eczema, and to engage in a more general explanation about the differences between the

\(^3\) Even if he has not even implicitly solicited an explanation from the doctor on the connection between asthma and eczema.

\(^4\) Note that P disclaims his knowledge about and interest in medical matters in general (“i don’t read everything that’s medical”) restricting the scope of his statement to “anything pertaining to asthma or eczema”.

187
naturopathic approach and its allopathic counterpart (ll. 614-22). During the explanation P acknowledges receipt of PR’s turns and expresses agreement with her (ll. 616, 619, 623). In line 624 PR produces another assessment (“that’s great”) before moving to a new topic, namely diet and lifestyle factors, which she announces as the main focus of the visit. In so doing, she makes reference to pre-interview talk with the patient (“and especially it sounds like you wanted some advice. with diet.”, ll. 629-30) as a way to seek agreement from him on the agenda of the visit (note also the switch from the first person singular pronoun to the inclusive “we” in line 626 and from this to “you” in line 629), which the patient accepts in lines 628 and 631). Overall, lines 624-31 are a first agreement towards the joint construction of the chief complaint which, as we have seen in excerpt 24a, will be further negotiated a few lines later.

To conclude, in excerpts 24a and 24b we have observed how patients can use displays of knowledge and ignorance to affect the doctor’s course of action and how doctors may seek legitimisation for their initiatives by “co-implicating” (Maynard, 1991a: 168) patients’ views. This co-implication, together with the explanation of the standard procedures for dealing with patients’ problems and of patients’ own responsibilities within these procedures, is a resource not just for topic organisation and for the correct unfolding of the interview, but also for an appropriate response to patients’ medical problems, in terms of the development of a treatment plan that involves both medical assistance and self-care. In other words, co-implicating patients’ views is a way for the doctor to share the burden of responsibility for treating the patient with the patient her/himself. In more general terms, we could say that co-implicating patients’ views works towards a shared understanding of the activities in which both parties are engaged (e.g. information exchange) and their final goal (the delivery and reception of healthcare). The UB sample includes numerous occasions of doctors investigating patients’ opinions and beliefs. These occur at various stages of the interview and can have a major interactional significance: besides contributing to a shared understanding of the tasks performed, they can also maximise agreement by establishing a “mutuality of perspective” (cf. 3.5.4.2), particularly when presenting a

5 Interestingly, P had disclaimed knowledge about naturopathy and showed interest in it at the beginning of the interview (“I’ve never done alternative medicine but I read I read something about it and so I wanted to give it a try.”; interview 6, ll. 119-20).
diagnosis, as we will see in the following subsection.

6.2.3 Delivering diagnostic news: the interactional value of perspective display series
In the previous subsection we have seen how doctors may strategically include patients’ opinions in decision-making processes regarding how to conduct the interview and, more in general, how to deal with the medical problems presented. Asking for patients’ opinions, however, may also serve specifically interactional purposes, for instance it can be used to handle delicate initiatives in a non-conflicting manner, as in the case of diagnoses. The following excerpt lends itself easily to illustrate what Maynard (1991a; 1991b; 1992) has called “perspective display series” or PDS (cf. 3.5.4.2). Nevertheless, the series in question is rather atypical, as can be noticed by looking at the transcript (from the arrowed line onward):

Excerpt 25

236  PR  okay. [ and your]
237  P  [(slb slb)]
238  PR  colitis is fine, you saw the doctor didn't [you,]
239  P  [ i ] saw the doctor
240  the day before;,
241  (0.5)
242  P  er mondy.
243  (0.5)
244  P  and: he said (slb) he did tell me you'll never get rid of colitis,
245  (0.5)
246  P  it's something that's in your system. that's there forever.
247  (0.6)
248  P  even to the point that it's:: (1.0)  erm (0.6)  i don't know for
249  instance colitis that my brother had a section removed.=
250  PR  uh huh.
251  P  erm (0.3) he says you still have it. coz it’s in your whole
252  system.
253  (0.7)
254  P  erm (0.5) but i've had no (0.6) problem,
255  (0.5)
256  P  at all.
257  PR  okay.
258  P  erm (0.9) none,
259  (0.6)
260  P  at all. ["(slb slb slb)"]
The excerpt is taken from a follow-up visit and, as part of the information-gathering stage, the primary is recapitulating together with the patient the latter’s condition and how he ‘has been doing’ since their previous encounter.

In lines 236-38 PR is enquiring about P’s colitis and asks him to confirm that he has seen his doctor. P replies affirmatively specifying when he saw his doctor and what the latter told him (ll. 239-52). In particular, he mentions the chronic nature of his colitis as described by his doctor (“it’s something that’s in your system. that’s there forever.”),
contrasts his colitis with his brother’s (“my brother had a section removed.”), and repeats his doctor’s opinion (note the shifts in footing in lines 244-251 from “you’ll never get rid of colitis” and “it’s in your system” to “I don’t know” and “my brother” back to “you still have it” and “it’s in your system”). His contributions are met with silence (ll. 241, 243, 245, 247, 253), which may indicate uneasiness on the part of PR in accounting for a condition that has been described as permanent and incurable, thus implicitly challenging the role of medicine, and therefore her own role, in treating it. Another possibility is that PR is orienting to the incompleteness of P’s account and is waiting for him to report on his current symptoms (on which she has implicitly enquired a few lines before in “and your colitis is fine,”). The presentation of current symptoms, or rather the claim of their absence, occurs in lines 254-56, where P somehow reassures PR on his condition (note the contrastive use of the conjunction “but”, the emphasis on “no”, and the additional emphasis provided by “at all”), thus replying to the primary’s implicit query in lines 236-38. It is only at this point that the primary reacts by uttering an “okay” (l. 257). P reinforces his statement in lines 258 and 260 probably in an attempt to solicit an assessment on the part of PR. The latter, however, produces a perspective display invitation partially reproducing P’s preceding report (“and what do you think of that? do you think you can never get rid of it? do you believe it”), which is followed by a first reply by the patient (“oh! I don’t know”), an acknowledgment token by the primary (“yeah.”), a second reply by the patient, which includes an assessment (“er if it stays like this it’s fine!”), and a second acknowledgment token by the primary (“yeah.”). In this respect, a few remarks are in order regarding the atypical nature of this perspective display series.

It may be argued that the position of this PDS is unusual in that it occurs at an early stage of the interview, when the primary is collecting information on the patient’s state of health, rather than at the diagnostic stage proper, as normally happens in medical interviews (cf. 3.5.4.2). Contentwise, however, the PDS does involve the formulation of a diagnosis, which is prompted by the patient’s report on a previous visit with another doctor. In other words, the participants are making reference to the diagnostic stage of
The evaluation of another doctor, together with the fact that PR has already seen the patient on a number of occasions, provide PR at least in theory with all the data by which she can judge P’s medical condition. Nevertheless, PR does not produce any evaluation, and that is another reason why the PDS may be considered atypical. As mentioned in 3.5.4.2, after asking the patient for her/his opinion(s), the physician will “unfailingly” provide a medical assessment or report (cf. Maynard, 1992: 335). In the example discussed here, however, the diagnosis (chronic colitis) has already been formulated by another medical authority and PR does not have much to say or do except confirm it. Therefore, it may well be that she is using a perspective display invitation as a way to make sure that P has ‘digested’ the bad news. In other words, she is employing it to handle a delicate matter in a way that is sensitive to his understanding and creates a “mutuality of perspective” (cf. 3.5.4.2), ultimately maximizing agreement.

In any case, both participants orient to the brevity and especially the indisputableness of the diagnosis (cf. also Heath, 1992a). PR, as we have just seen, does so by simply agreeing with it, whereas P when asked to give his opinion says he does not know (l. 263). In this way he claims his lack of entitlement to a specific knowledge and activity, namely the possibility of forecasting his future medical condition, confining himself to declaring that if his colitis remains the same he will be fine (l. 265). At this point PR moves to the related although less delicate topic of the treatment used to alleviate the symptoms of colitis asking the patient whether his doctor has suggested that he goes on with the same therapy (l. 268). P’s reply is delayed by a long pause and solicited by PR in line 270, a possible explanation being that P is in fact waiting for a final assessment by PR on his colitis. The delicacy of the topic is confirmed by a following portion of the transcript (ll. 279-82), where P makes reference to cancer and the possibility that he might have it. He does so once again by reporting his doctor’s words, and once again PR’s reaction is minimal and does not seem to convey any emotion (except maybe for the out-breath in her “ok(h)ay” for which, however, any interpretation would need to be supported by additional data that the transcript alone cannot provide). This time the lack

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6 In addition, one should not forget, as pointed out by Drew and Heritage (1992b: 44), that the various activities conducted in a medical interview can rarely be framed in a six-stage sequence occurring in full and in standard order.

7 The lack of such assessment is made even more clear by the patient’s solicit in line 267.

8 Incidentally, at a later stage of the encounter P will mention that his mother died of pancreatic cancer.
of an assessment is probably justified by the fact that cancer is only a hypothesis, which needs to be tested against medical evidence. For this reason, PR cannot but listen to P providing information about the tests for which he has been scheduled (ll. 284-92).

To conclude, in excerpt 25 we have seen how both parties orient to the specific nature of the activity in which they are engaged (making a diagnosis) and use specific mechanisms (the perspective display series) to deal with such activity, even if this occurs in a non-standard position (at an early stage of the interview). Similarly to what has been observed for the chief complaint in 6.2.1 and 6.2.2, both doctors and patients carefully employ displays of interactional asymmetries (specifically asymmetries of knowledge and access to knowledge) to collaboratively shape their roles and activities as appropriate to the circumstances. There may also be occasions, however, when doctors and patients orient to the inappropriateness of their activities with respect to the overall structure of the visit. In these cases, as we will see in the next section, they may use the conversational resources at their disposal to make their initiatives fit the agenda of the visit and avoid possible disagreement.

6.3 When activities are ‘out of order’: how patients and doctors orient to the dispreferred position of their initiatives

In the previous section we have seen how doctors and patients cooperate to shape their roles and activities with respect to the goal-oriented nature of the interview and especially the task-related character of its different stages. There are cases, however, when agreement on the nature of the roles being played and the activities being performed requires a lot more interactional work than has been discussed thus far. This happens when one participant is not aligned with the main activity warranted by the current interview stage (e.g. information-gathering during history-taking and physical exam, or advice-giving during advice and treatment, etc.), therefore causing agenda mismatches. In the following two subsections we will see that when participants take initiatives that are ‘out of order’, they seem to be fully aware of their dispreferred position, and of the disagreement this may cause, and may therefore try to ‘fix’
mismatches by taking remedial and/or pre-emptive actions aimed at seeking agreement while at the same time pursuing their own agenda.

6.3.1 Changing troubles-talk into problem-talk: how patients pursue their agenda of concerns ‘late’ in the interview

Participants in mundane conversation are routinely involved in the telling of their everyday experiences and concerns, including events that may be stressful for, or even disruptive of, their lives, i.e. ‘troubles’. Engaging in talk about troubles normally entails disclosing personal information and feelings (often about sensitive issues), and seeking affiliative responses (e.g. empathy, encouragement, etc.) from the troubles-recipients (cf. 3.3.2).

However, as noted by Jefferson and Lee (1992) and Maynard (1991a: 177-79), the convergence of troubles-talk and service encounters (including doctor-patient encounters) may be problematic in that the clinical experience involves the seeking and giving of professional help and advice to solve specific problems (rather than the seeking and giving of comfort related to troubles-telling). Despite this general dispreference for troubles-talk in institutional settings, we have found naturopathic interviews to be interspersed with fairly long troubles-telling sequences during history-taking, with doctors aligning as troubles-recipients (cf. 5.4.2). Having said that, the mismatch between trouble-telling and advice-giving remains, particularly during the advice and treatment stage of the interview, i.e. when advice-giving is the preferred activity.

In the present subsection we will look at how patients, being aware of the unfitted nature of troubles-talk during the advice stage, and therefore expecting doctors to adopt the role of advice-givers rather than troubles-recipients, may change troubles-talk into problem-talk, thus fitting their contributions to the current agenda of the visit while at the same time having their concerns acknowledged by doctors.

Excerpt 26 is taken from a follow-up visit with a patient whose chief complaint is hypertension. Throughout the interview the patient repeatedly provides a candidate explanation for her medical problem motivating it in terms of anxiety about and frustration for the difficulties she is facing in her everyday life. In particular, she uses
her blood pressure as a pretext to open a window on her worries, which regard primarily her sister (who has had cancer). The patient’s attempts at initiating a troubles-telling sequence occur at different stages of the encounter, even during advice, as shown in the transcript below.

Excerpt 26
1862 SD is th- i mean we're you
1863 know we your blood pressure has always been of concern, but when
1864 we're heading up into you know very dangerous territory. and i
1865 don't want and especially since with your eye
1866 P yeah,
1867 SD you know it's it's one of those things where it's we need to get
1868 it. we need to get it down. and what we're doing isn't bringing
1869 it down as hh much as we would need it to be.
1870 P yeah. so?
1871 →SD so: i just want you to check it when you get home, and erm
1872 actually i'd like you to give me a call, and let me know. (.).
1873 P [here?] [if it's gone down. uh huh. tzt you can call erm, let me find
1874 SD out what extension this i- cause i don't have my extension any
1875 more. so erm actually i'm gonna call you tonight. that'll work
1876 out, that'll be easier.
1877 P okay.
1878 →SD okay?. h and then we'll decide how to proceed.
1879 P yeah.
1880 SD okay?
1881 P yeah well it's erm that i- erm we've had erm a couple of very
1882 SD bad days with of course you know, two those yesterdays affect me
1883 P today.-
1884 SD =right, exactly .hh but er i don't wanna you know we talked
1885 P [a bout this,]
1886 SD [you're getting ] nervous.
1887 P well i don't want there to be something catastrophic to happen,
1888 SD P yeah.
1889 SD and you know we,
1890 P yeah.
1891 SD and: i it would just make everything worse.
1892 P yeah.
1893 SD okay?
1894 →P well i b- i: but i it's so is she? and i wanted to talk to you
1895 P about that anyway because she wakes up,
1896 (0.9)
1898  P  like, four o'clock in the morning maybe? .hhh and she calms and
1899  she say just (0.8) i'm erm (0.6) fearful you [know, sh-]
1900  SD                  [ uh huh.]
1901  P  i'm afraid she said. she so we sit and talk and she say put your
1902  arm around me and just ((miming putting head on shoulder)) rest
1903  it on my [shoulder. and then]
1904  SD                                              [ uh huh. uh huh.]
1905  P  she calms down! .hhh and this happens when she wakes up!-
1906  SD  =uh huh.-
1907  P  =and i think what is going on? i said this is ye (0.3) i f- uh
1908  huh i feel almost if it's a physical thing going on.
1909  SD  uh huh.
1910  (0.3)
1911  P  you know, we sa- maybe it's some blood sugar drop, or something
1912  like that. [you know,]
1913  SD                  [uh huh.]
1914  P  because she she's [(slb slb slb slb)]
1915  SD                   [have you talked ] to your doctor? [i mean]
1916  P     [e:rm ] i
1917  no! well we didn't tell the er doctor.
1918  (.)
1919  P  erm
1920  PR  ((to P)) this is your number right?
1921  (.)
1922  P  yeah that's right.
1923  SD  ((to PR)) thank you.
1924  P  anyway she: (1.4) erm she's gonna see him wednesday. and it's
1925  gonna be a tough week for me anyway, yer-
1926  SD  =okay.-
1927  P  =you know.
1928  SD  well er- have you been (.) smelling the flowers and blowing
1929  out the candles?
1930  P  no i haven't had the time.
1931  SD  well we'll do it right now. it tha- wa- that has helped in the
1932  past so, ((taking a deep breath)) .hyyyyyyyy
1933  P  erm i know. okay i will.
1934  SD  ((breathing out)) pfhhhhhh
1935  P  [ not now.]
1936  SD  [ o kay? ] not now?
1937  P  i don't feel like to now.
1938  SD  okay.
1939  P  i'm not an exhibitionist.
1940  SD  okay alrighty. so erm but do do go ahead and (. ) monitor it and
1941  i'll ll give you a call.
1942  P  yeah.
1943  SD    alright?
1944  →P  okay. yeah well when i would you, now do you have any idea my
1945    sister, (.) could could be?
1946  SD    erm,
1947  P what could be? coz she she's going nuts with it. you know,
1948  PR    uh huh,
1949  P why did she wake up with these, i guess they're like a panic
1950    attack! she come into it right away!
1951  PR    but she's on the chemo right now right now.
1952  P  hu?
1953  PR    she's on the chemo right now. right?
1954  SD    that could be cortisol levels.
1955  P  hu?
1956  SD    it could be cortisol it's hard to say. it's hard to say.
1957     [coz it's,]
1958  P    [it could] be what?
1959  SD    i was thinking cortisol levels in her dreinals, maybe just
1960    pumping up the cortisol. and it's making her incredibly anxious.
1961  P    oh she's anxious!
1962  SD    yeah.

(UBNMC, INT1-11.04.03).

In lines 1862-69 the supervising doctor is expressing her concern for the patient’s high blood pressure, particularly in relation to the haemorrhage in her eye, which has been dealt with in a previous portion of the interview (cf. 5.3.2; cf. also interview 1, ll. 1319-34). In doing so, SD does not use mitigating devices of any kind (cf. 3.5) but states her concern explicitly (l. 1863) and refers to the possible consequences of P’s condition as “very dangerous territory”. In line 1866 the patient utters a continuer after which SD explains that P’s pressure has not been brought down as much as it should have been. Note, however, that SD does not employ the passive voice but uses the first-person plural pronoun “we”, which refers to the medical staff that is taking care of the patient but may well include the patient herself. P acknowledges receipt of the doctor’s report (“yeah.”) and invites her to draw a conclusion from it (“so?”). In lines 1871-74 SD makes clear what P’s role and responsibility in dealing with her medical problem is, thus also clarifying the inclusive nature of the preceding occurrences of “we” (note the emphasis on “you”, and the use of ‘I want to/I’d like to’ to give instructions to the patient in “i just want you to check it” and “i’d like you to give me a call”). After
negotiating with P the details regarding the phone call and establishing that the best solution is to call P rather than having her call (ll. 1874-78), SD seems to conclude the topic by declaring that they will decide how to proceed after the call, that is after P has checked her pressure at home (note again the ambiguity of “we” in line 1879).

In lines 1882-83 P provides a candidate interpretation of her high blood pressure mentioning a generic “couple of very bad days” which might have affected it. Here she is referring to her situation at home, which includes a sister who has had cancer and is undergoing chemotherapy (see ll. 1951-53), and a number of difficulties in coping with her stressful daily routine which frustrate her (e.g. the fact that she lives in a residential area and does not have transportation; cf. interview 1, ll. 1734-73; 1804-08). SD accepts P’s explanation but again highlights her concern for P’s current state of health and the possible repercussions that this might have in the future (ll. 1885-1892; note that she insists on using heavily connotated words like “catastrophic”). In line 1895 the patient shifts the focus to her sister in what seems to be an incomplete question to the doctor (“so is she?”). The reference to her sister, despite its vagueness, seems to be clear to P’s interlocutors not just from previous talk (P has already mentioned earlier in the interview, first to PR and then to SC, that her sister wakes up at night and feels anxious), but also because the participants in the interaction can draw on some shared knowledge (specifically, since P has been visiting the clinic for nearly three years, the clinicians are informed about her sister). In lines 1895-96 P uses a pre-sequence (“and i wanted to talk to you about that any way”) to reintroduce the topic of her sister’s insomnia when SD is also in the room. In the following lines she gives a detailed description of what happens when her sister wakes up at night (ll. 1898-1905) employing shifts in footing (alternately speaking with her sister’s voice), and in line 1908 she offers a “my-side telling” (“i feel almost if it’s a physical thing going on”; cf. 3.5.4.3) During her report the supervising doctor responds with minimal acknowledgement tokens (ll. 1900, 1904, 1906 and 1909). After a short pause P signals her intention to keep the floor with the “pre-placed overlap absorber” (cf. Schegloff,

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9 See also INT1: 240.
10 Cf. interview 1, ll. 1580-81; 1666-77.
11 To be more precise, the patient has known the supervising doctor for nearly three years, has been seeing the primary for over one year, and has also seen the secondary a few times.
“you know,” (cf. 5.2.1) and formulates a lay diagnosis for her sister’s anxiety (“some blood sugar drop”). She then utters a generic “or something like that” indicating that she has come to a possible completion, and another “you know,” probably inviting the doctor to assess her candidate explanation. SD only provides a continuer, after which P adds some other detail (l. 1914). Finally SD utters an articulated response (in partial overlap with P’s turn) consisting in a question on whether or not P has mentioned the problem to her medical doctor. The patient replies negatively (l. 1917) but adds that her sister is going to see the doctor soon (l. 1924). She then comments that the subsequent week is going to be “tough” for her, the adjective “tough” referring back to the “bad days” in line 1883. Both evaluative phrases (“bad days” and “tough week”) are a key for the doctor on how to react to the patient’s account, presumably inviting her to show affiliation (note also the repeated use of “you know”); however both fail to trigger empathetic responses (e.g. second assessments) to what seems to be an attempt at entering a troubles-talk sequence.

In this respect, it is probably worth mentioning that P has repeatedly inserted ‘chunks’ of troubles-telling in the course of the interview, but has not been successful at having her interlocutors align as troubles-recipients. Specifically, she has told the student clinicians (first PR and then SC) that “everything is going wrong” (interview 1, l. 1734), that she is “falling behind at home” (interview 1, l. 1761), and that the whole situation is a “constant frustration” to her (interview 1, l. 1773). The only thing she has achieved is having student clinicians agree with her candidate explanation regarding “frustration” (and stress in general, together with the ensuing problems of anxiety and lack of sleep) as a possible cause of her high blood pressure.12

Like PR and SC, SD does not align as troubles-recipient and orients instead to advice-giving (ll. 1928ff.; note also the “okay.” in line 1926 projecting a new activity), by suggesting that the patient does some breathing exercises to help her feel less anxious before showing the patient how to breathe (ll. 1932-34). The way SD designs her suggestion indicates that she has already given this kind of advice to the patient on a previous occasion. Note the use of the present perfective progressive in “have you been () smelling the flowers and blowing out the candles?” (ll. 1928-29), which conveys the

12 Cf. interview 1, ll. 1679; 1730-32; 1773-76.
“iterative sense of temporary habit up to the present” (Quirk et al., 1985: 212), implying the repetitive character of the exercise, as well as the possibility that this may continue in the future. Note also the use of the determiner “the” used to refer to something that is already known to both speaker and hearer (ibid.: 265). SD’s suggestions sound reasonable (“that has worked in the past”) and are made in a reassuring way. Note, for instance, the use of the inclusive “we” in line 1931, indicating commitment to help the patient and highlighting the joint effort in trying to improve her condition, thus ultimately working to pre-empt disagreement. These devices, however, do not seem to convince the patient, who appears somewhat annoyed by SD’s advice (ll. 1930, 1933, 1939) and resists her instructions (ll. 1935, 1937). Having failed to obtain alignment on the breathing exercises, the doctor reiterates the decision on which she has already reached an agreement with the patient (the fact of P monitoring her pressure at home and SD calling her; ll. 1940-41).

SD is clearly trying to wrap up the interview, advice-giving being strongly close-implicative (cf. Jefferson & Lee, 1992: 531). P, however, who is probably not satisfied with SD’s responses to her lay diagnosis (see ll. 1907-39), shifts the focus back on her sister’s insomnia in lines 1944-45. This time, however, she explicitly asks for a medical opinion on the part of SD, her direct question establishing the conditional relevance of the doctor’s answer. SD briefly hesitates and P repeats her question and provides further elaborations by explaining that insomnia is driving her sister crazy (l. 1947) and offering another candidate diagnosis (the “panic attack” in lines 1949-50). PR offers his own interpretation (a possible effect of chemotherapy) and SD finally mentions cortisol levels but disclaims responsibility for what is only one of the possible interpretations (l. 1956). In lines 1955 and 1958 P solicits clarification of the technical term just employed by the doctor by means of the two next turn repair initiators “hu?” and “it could be

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13 This use of the present perfective progressive and of the definite article ‘the’ are also consistent with the instructive/didactic character of baby talk. For further details, see Snow and Ferguson (1977).
14 This use of “we” to indicate in fact the recipient alone is well documented in baby talk (cf. Wills, 1977: 276; 284). As noted by Ferguson (1977: 230-31), baby talk is widely employed “with hospital patients, elderly people and adults being tended by nurses, doctors, attendants, technicians, or family”, its use conveying a nurturant, caretaking message while at the same time serving a persuading strategy (as is the case here, where SD is trying to convince P to do her breathing exercises).
16 Note that in line 1907 she had also formulated a question but in a rather less direct fashion, as if talking to herself (“and i think what is going on?”).
what?” (cf. 3.5.5). SD explains her hypothesis in greater detail mentioning that a high cortisol level could be what makes P’s sister anxious (l. 1960), the anxiety being immediately confirmed by the patient in line 1961.

What emerges from the discussion of excerpt 26 is an agenda mismatch between the supervising doctor and the patient. The former is instructing the patient on what she expects her to do before the next visit, whereas the latter is trying to have her concerns addressed. As already mentioned, no remedy is sought in troubles-telling (see above) or, to use Jefferson and Lee’s (1992: 534) words, “the categories advice-giver and troubles-teller do not constitute such a fitted pair”. Therefore the rejection of advice on the part of the patient (ll. 1930-39) could be read as a way “to preserve the status of the talk as a troubles-telling” (ibid.: 535; emphasis in original). The patient is looking for reassurance rather than remedy and insists on describing certain circumstances until she has at least her concerns explicitly acknowledged by the doctor (ll. 1954ff.). However, seeing that the doctor does not align as troubles-recipient, she tries alternative ways of pursuing her ‘hidden’ agenda. Her insistence on details regarding her sister’s state of mind makes it reasonable to assume that she is attributing to her sister what may well be her own feelings (“she’s going nuts”, “she’s anxious”). In this respect, reference to her sister seems to be strategically employed to pre-empt further advice-giving. In addition, by formulating lay diagnoses on her sister’s condition (ll. 1911-12, 1949-50) and directly questioning the doctor about it (ll. 1944-50), the patient transforms troubles-talk into problem-talk. In other words, she treats her troubles ‘diagnostically’ proposing them as problems for which the clinic may have solutions, thus orienting to the rights and obligations that organise the help-seeking event ‘medical interview’ (cf. Maynard 1991a: 178), but also (through an explicit request for a professional opinion) ‘forcing’ the doctor to hear her voice and pay attention to what she autonomously treats as concerns to be addressed.

6.3.2 Responding to patients’ narratives: doctors’ second stories as a resource for ‘premature’ advice-giving

As shown in the previous subsection, patients may reject doctors’ suggestions and recommendations to try and initiate, or continue with, a troubles-telling sequence. As we
will see in the present subsection, doctors’ advice may also be resisted for its prematurity, regardless of the quality and applicability of the advice itself. Specifically, patients may ‘uncooperatively’ remain silent after advice given during the information gathering portion of the interview, when they frequently provide lengthy elaborations on their answers, often disclosing sensitive information about themselves or giving voice to their thoughts and feelings about specific situations in their lives. In these cases, doctors may have to look for alternative ways of seeking agreement on the advice they are trying to give. One possibility is to respond to patients’ narrative expansions (cf. 3.5.3.3; 5.4) with second stories, which, by recategorising patients’ own narratives (i.e. giving interpretations by accentuating certain features, placing others in parentheses, creating new relations between the narrative components, etc.), essentially co-implicate their views as co-authors of the advice-giving sequence, ultimately making advice more acceptable.

The following excerpt, which has been divided into seven smaller fragments numbered from 27a to 27g for ease of reference, is an example of a series of stories (cf. 3.3.1.4). The only interactants for the entire duration of the recording are a primary and a patient, who is also a student at the University of Bridgeport College of Naturopathic Medicine (she attends the first semester). They are not meeting for the first time here, as she has been a patient of the clinic since the semester started (i.e. for over two months) and the primary has been her doctor ever since. The patient’s main problem is weight gain. The excerpt is preceded by approximately forty lines in which the primary enquires about the patient’s physical exercise in the previous seven days, and the patient explains that she has walked on three occasions and has also attended three classes of yoga. Thereafter, the following occurs:

Excerpt 27a

201 PR how do you feel after? after that after yoga how do you
202 ((slb) after walking.)
203 P [ d- after yo ga ] i feel, hhh gosh! there's no drug that
204 it can be the way yoga it is.
205 PR uh huh.
206 P not that i have experienced any drugs like ↑that [but he]
207 PR [uh hhh]
208 P ((PR smiles while writing on chart)) he .hhh erm
209  (0.8)
210  P  it's very relaxing very,
211  (1.1)
212  P  i didn't go for the spiritual or meditative,
213  PR  uh huh.
214  P  purposes.
215  PR  [uh!]
216  P  [but] it happens anyway.
217  PR  it happens yeah.
218  (0.4)
219  P  [yeahh,]
220  →  PR  [ and ] how what do you think of that? did it help
221  with {"this slb slb")}
222  P  [ i think it ] helps a great deal. [it's ]
223  PR  [good!]
224  P  making me feel b- er more comfortable in my skin. [a:nd ]
225  PR  [good!]
226  F  ((sniffs))
227  (0.4)
228  P  erm
229  (0.6)
230  →  P  uh the: concept that it's you know,
231  (0.8)
232  P  mostly in your mind it's all mental. erm (.) she was:, a lot
233  of other people are having problems with certain positions
234  that, require like hand stand or balance.
235  PR  uh huh.

(UBNMC, INT7-11.14.03).

Excerpt 27a starts with PR asking P how she feels after yoga and walking. P replies that yoga is better than any drug and clarifies the comparison by adding that it is very relaxing. This statement is followed by a pause of over one second (l. 211) whose function could be twofold. On the one hand, it may signal on-line processing, as P might be looking for the right word to complete the utterance in line 210 with another adjective (this interpretation could account for the repetition of “very”). On the other hand, however, the pause may also indicate that she is waiting for a second assessment on the part of PR to confirm her own evaluation. Since the clinician fails to produce a second assessment on the part of PR to confirm her own evaluation. Since the clinician fails to produce a second assessment, P expands further on her answer. She says “i didn’t go for the spiritual or meditative, purposes. but it happens anyway.”, which is met with a continuer (“uh huh.”
In line 213, a newsmark ("uh!" in line 215), and a repetition claiming agreement ("it happens yeah." in line 217).

In line 220 PR elicits additional information from P regarding the way yoga helps her from the meditative point of view. The patient replies affirmatively to the clinician’s yes/no question and the primary provides the positive evaluation remark “good!” (ll. 223). P then elaborates her answer and PR reiterates his positive assessment (ll. 224 and 225 respectively). After hesitating for a short while (ll. 226-229), P initiates a story that substantiates what she has just asserted. The telling opens with a statement that is also the point of the story ("uh the: concept that it’s you know, mostly in your mind it’s all mental."). This assertion is what Ryave (1978:127) has called a *significance statement*, i.e. a statement, with which the story culminates and in which it is condensed, that is also variously ‘recycled’ for subsequent versions of the story itself and for recipient’s second stories. As can be noticed from reading the excerpt, the reformulations of P’s general statement in lines 230-32 provide for the global coherence of the entire excerpt. This is achieved particularly through the use of repetitions as lexically cohesive devices, the reiterated words belonging to the same semantic fields, i.e. revolving around the same idea of achieving one’s goals by using the power of the mind ("mind", "mental", "mentally", "goals", "accomplishment", "successfully", "powerful", etc.). These key concepts are not introduced in line 230 for the first time, as shown in excerpt 27b, which is taken from a preceding portion of the interview.

Excerpt 27b

<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Transcript</th>
</tr>
</thead>
<tbody>
<tr>
<td>109</td>
<td>P</td>
<td>i was working on, looking at myself.</td>
</tr>
<tr>
<td>110</td>
<td></td>
<td>(1.1)</td>
</tr>
<tr>
<td>111</td>
<td>P</td>
<td>and (look) just,</td>
</tr>
<tr>
<td>112</td>
<td></td>
<td>(0.9)</td>
</tr>
<tr>
<td>113</td>
<td>P</td>
<td>straight at me and trying to: (.) visualize that,</td>
</tr>
<tr>
<td>114</td>
<td></td>
<td>(2.5)</td>
</tr>
<tr>
<td>115</td>
<td>P</td>
<td>erm impression of myself to be,</td>
</tr>
<tr>
<td>116</td>
<td></td>
<td>(0.4)</td>
</tr>
<tr>
<td>117</td>
<td>P</td>
<td>better.</td>
</tr>
<tr>
<td>118</td>
<td>PR</td>
<td>uh huh.</td>
</tr>
<tr>
<td>119</td>
<td>P</td>
<td>erm</td>
</tr>
<tr>
<td>120</td>
<td></td>
<td>(0.8)</td>
</tr>
<tr>
<td>121</td>
<td>P</td>
<td>and i think i: got there. &quot;almost there&quot;.</td>
</tr>
<tr>
<td>122</td>
<td>PR</td>
<td>good.</td>
</tr>
</tbody>
</table>
Here P is talking about the work she has been doing and the results she has obtained in trying to improve the impression she has of her physical appearance (ll. 109-21). PR, after praising P’s results (122-26) and acknowledging the difficulty of the task (ll. 128-
29) – a point that he will resume later in the interview 17 – is trying to focus P’s attention on the power of the mind by drawing on P’s personal experience (ll. 131-42). In this respect, the patient’s story starting in line 230 of excerpt 27a is a reformulation and reinforcement of the primary’s statement in line 140-42 of excerpt 27b.

Having highlighted the power of the mind in achieving goals, the primary moves on to give advice to the patient (ll. 146-57). He does so by addressing her with imperatives (“keep working …and getting”) encouraging her to stay focused on her goals (“where you wanna be. how you wanna look.”, “how you wanna stand.”, and “how you wanna present yourself.”). His suggestions, however, are met with fairly long pauses (ll. 150, 152, 154 and 158) indicating P’s disagreement, or at least non-alignment with the role of advice recipient. In this respect it is reasonable to assume that the patient is resisting advice for its close-implicature rather than for its applicability (the doctor is only inviting her to keep working on what she is already doing!). Given P’s response, or rather absence of response, PR drops the subject and re-engages in history-taking proper (l. 159). In excerpts 27c-27e, which are the continuation of 28a, we will see that the primary resumes his advice-giving activity, but with a different modality, namely replying to P’s story with another story.

Excerpt 27c

230 → P uh the: concept that it's you know,
231 (0.8)
232 P mostly in your mind it's all mental. erm (.) she was:, a lot
233 of other people are having problems with certain positions
234 that, require like hand stand or balance.
235 PR uh huh.
236 P and they see it as: er strength exercise but she was trying
237 to teach us that it's more, ((miming two pans in a balance))
238 (1.2) a combination of flexibility and strength.
239 not all strength.
240 PR [sure.]
241 P [ but ] some.
242 PR yeah!
243 → P but if you alter your perception of what it is you're
244 trying to do then it'll be easier to do. (.) a:nd
245 PR ex [ actly.]

17 Cf. interview 7, ll. 638-85.
I'm not having problems with any of the positions except for:

(0.5)

something called the tripod? Not tripod, it's where it's a hand balance you're basically,

(0.6)

[ba]lancing on the hands with your knees on the back of your elbows?

gotcha.

and we've only tried that once a long time ago and I don't know you know at this point if I can try again but she suggested not [to hu]

[do you?] do you do is it something that you would like to do?

yoga?

that particular,

tzt position.

position.

hh I think at this point because I was unable to do it successfully in my eyes the first time,

uh huh,

that it's I'm I'm eager to try it again.

[great!]

[to] see if I can get there.

(0.9)

a:nd,

(1.1)

mentally ((PR nods)) I know what I have to do and how I can do it and I see myself in the position? er even if it's for a couple of seconds,

[uh huh:]

[(slb slb) slb] out there? But erm,

(1.0)

and I don't wanna hurt myself either so I'm not trying any of the,

yeah,

very difficult positions

[uh huh:]

[outside] of class.

→

(2.0)

good.

(0.6)

(UBNMC, INT7-11.14.03).
In line 232 P continues the story initiated in excerpt 27a by talking about people in her yoga class having problems with certain positions and thinking of those as strength exercises. In contrast, she mentions that her instructor is trying to teach them that yoga is not just strength but a combination of flexibility and strength (ll. 236-238), adding that it will be easier to do what you are trying to do if you change your perception of it (ll. 243-44), and thereby clarifying the concept already expressed in line 232 (“it’s all mental.”). The primary lets the patient speak without interrupting. He only provides a continuer in line 235 and three other items claiming understanding and agreement (“sure.” in line 240, “yeah!” in line 242 and “exactly.” in line 245). The patient proceeds by mentioning her difficulty with a particular position. She explains what it is called (the tripod) and what it involves (ll. 249-54). Once again the clinician pays attention to what is being said (he is also looking straight at the patient) and claims understanding (“yeah,” in l. 253 and “gotcha.” in l. 255).

At this point something unexpected happens: the patient says she does not know whether she will be able to try the tripod position again, and adds that her instructor has suggested she does not do so (note the emphasis on “not” in line 258). This seems to contradict the idea of accomplishment formulated in lines 243-44 (and already mentioned in ll. 232 and in excerpt 27b, l. 140), to which both partners in conversation have so far oriented, and to project a trajectory of ‘failure’ as opposed to the ‘success’ trajectory pursued by the primary. In order to redirect the conversation towards the key notion of accomplishment, PR elicits further considerations from P, by enquiring if the patient really wants to achieve that position (ll. 259-60). The patient, who asks for clarification (l. 261) and collaboratively completes PR’s question (l. 262), explains that she is “eager” to try again (l. 268) precisely because she has failed the first time (note the phrase “in my eyes” in line 266, which refers back to the “impression of myself” of excerpt 27b, l. 115). The primary is satisfied with P’s response, which he approves by formulating an assessment (“great!” in l. 269) at the first transition-relevance place and in partial overlap with P’s subsequent turn.

In lines 274-79 the patient applies the general idea of a powerful mind working towards the achievement of goals to her own experience: she says that what she has to
do is clear in her mind, as she can actually see herself in the tripod position. PR nods when the word “mentally” is reiterated (l. 274) and encourages P to go on in line 276. However, the patient insists that she does not intend to try difficult positions outside of class because she is afraid of hurting herself. A two-second pause and a delayed assessment follow (ll. 287 and 288 respectively), which signal that a disagreement is “in the works” (Sacks, 1987a: 65). Another pause follows (l. 289), after which PR resumes talking:

Excerpt 27d

290 → PR  erm you know life life is very,  
291 (0.5)  
292 PR  life forcing goals. and people who really accomplish  
293 anything (.) they constantly have goals and if you read any  
294 motivational book or er any er self er (.) personal  
295 coaching book or any personal coach will tell you that, (.)  
296 w- we need we function on goals. so if it's something that  
297 you know again that you wanna accomplish,  
298 (1.3)  
299 PR  coz coz life is also about achieving things.  
300 (0.8)  
301 PR  and for whatever we achieve this is is important to us. or  
302 whatever i achieve is very important to [ me. ]  
303 P  [yeah.]  
304 PR  whatever you achieve is very important to you is very  
305 individualized very subjective. so,  
306 → (1.6)  
307 PR  c- certainly if  
308 (0.9)  
309 PR  if something as  
310 (0.7)  
311 PR  as important or mo- or as minor to other people but  
312 important to you as making making you know doing that  
313 position in yoga,  
314 (0.4)  
315 PR  and if that's truly important to you that's you should have  
316 that as one of your goal.  
317 (0.4)  

(UBNMC, INT7-11.14.03).

In line 290 the primary corrects the trajectory projected by P’s turn for the second time
(see ll. 259-60 in 27c). This time he does so by resuming the idea that “we function on goals” (l. 296), thus further elaborating the point formulated in the preceding few lines. He makes his statement generally valid by referring to “people”, “we” and “life”, while specifying that goals are very subjective (ll. 301-5). At the end of line 305 “so,” is presumably employed to request some kind of comment from the patient (cf. Jefferson, 1978: 231), but the request is met with silence (l. 306). The clinician responds to P’s pause by adjusting his claim once again: he turns what he has presented as a generally true statement into something relevant to the patient, by adapting it to her own specific situation. In lines 307-316 he states that if something is really important to her, like that position in yoga, she should consider that as one of her goals. Hence, by mentioning the yoga position once more, the primary has incorporated a component of P’s story and used it to formulate a ‘customised’ moral, which he will later illustrate with a second story in excerpt 27e.

Excerpt 27e

318 → PR i i i'll tell you long ago i had you know i had never (slb slb slb) and decided i wanted to run a marathon.
319 slb slb slb (0.8)
320 PR that meant nothing to other people.
321 (0.5)
322 PR for me it meant the world.
323 (0.8)
324 P °right°.
325 (0.8)
326 PR and i kept >running running running running< and i (slb slb slb slb slb slb slb).
327 slb slb slb slb slb slb slb (0.6)
328 PR and this summer i i (thought get out of here i won i won a 
329 → cool marathon) the point in being is that things like that 
330 (1.0)
331 PR fill your spirit so much, this is a spiritual exercise.
332 P uh,
333 (0.6)
334 PR and physical obviously but mostly spiri- spiritual. coz 
335 (0.5)
336 PR you're like i did it.
337 (0.5)
338 PR is that feeling like i did it you know?=
339 P =uh huh,
340 PR nothing er er is it's a powerful feeling.
341 (0.3)
and you don't get that feeling every day. (1.0)

you know? you don't get that feeling every day you only get those feelings like every now and then.

right.

you know that feeling of accomplishment i had a friend who just ran the new york city marathon. she did it in four hours and about twenty minutes.

she she was high. [she]

[uh,]

was she was high.

"exactly."

(UBNMC, INT7-11.14.03).

Immediately after he has referred back to P’s story, PR initiates a second story that recounts his own personal experience, when he took part in a marathon (ll. 318ff.). The marathon story culminates with the primary explicitly stating its point (ll. 330-32), which is a logical development of the point he has elucidated before (in excerpt 27c, lines 292-99). In fact, the attention shifts from the willingness (or even eagerness) to attain a given objective to the feeling that one has once that objective has been achieved. PR’s story, including its moral, is met with minimal acknowledgement tokens by the patient (ll. 324, 333, 339, and 346). The clinician insists on the feeling of accomplishment that you get as a result of a spiritual exercise. In particular, he highlights the exceptional nature of such a feeling, which he has just mentioned in lines 338-45, by recounting another story. This is very similar to the immediately preceding story, in that it is based on the same maxim and is also about a marathon, although it has a different protagonist (a friend of PR’s). In evaluating the feeling of accomplishment that his friend had after running the New York City marathon, the primary employs the expression “she was high.” (ll. 351-53; note the repetition), which is semantically linked to the patient’s playful reference to drugs in line 203 of excerpt 28a. In line 354 P produces a first weak signal of agreement (she whispers “‘exactly.’”), after which the following occurs:

Excerpt 27f

because she did something that really not everybody in the
world could do or everybody could do but er they don't.

so you know,

if that's one of the things that you personally wanna do,

and you can't,

and along with with with your weight loss program, probably
when you start with losing just a few pounds, you're

[go ]nna= 
[uh,]

be able to do that

[uh,]

position. coz,

uh huh.

you know, [pro-]

[[ e ]xactly.

right?=

well that's the thing! she said that my mental block of

course was there's no way i'm getting this,

hhh .hhh myself into that position,

right.

w- with as heavy as i am.

right.

erm

but,

erm

she dismissed the, er she i didn't even vo- ver- vocalize it

but she said,

erm

i don't know. (. ) maybe felt that i was thinking it, or

[uh huh,]

[because] i may have seen str- pressure that i couldn't get

into this (slb tion),

uh huh,

erm

(0.5)

just stated that it wasn't,

(1.6)

you know, there is no reason you can't get into it
regardless of your size regardless of your,

(0.7)

P stature height whatever. hh you should be able to get into

it if you want to. and you know just working on the lower

belly, and the muscles are a little weak down there, i’m not

doing any push up chair or sit ups right now. but erm,

(1.5)

(UBNMC, INT7-11.14.03).

Moving from the second marathon story and the extraordinary feeling of accomplishment that his friend had (ll. 351-53), PR gradually returns to what the patient wants to do and how she can achieve it (note P’s claim in excerpt 27c, line 274), namely the yoga position and weight loss (ll. 364-70). These remarks seem to trigger a more assertive reaction on the part of the patient, who finally expresses her agreement explicitly in line 373 and initiates a third story (l. 375). Here the patient acknowledges that what is preventing her from reaching her goals is a mental block. To be more precise, she believes she will not be able to do the tripod position as long as she is so heavy (see ll. 376-80). In what follows (ll. 398-405) she explains that it is her yoga instructor who has pointed this out to her, and has tried to convince her that she can do it regardless of her weight if she wants to, by just exercising a little to reinforce her muscles. In recounting these details P holds the floor for a long time: her turns occupy over thirty lines and are only interspersed with PR’s continuers (ll. 379, 381, 392, 395). Thereafter the following occurs:

Excerpt 27g

408 P it was encouraging to hear her say that and,
409 PR good.
410 (0.7)
411 P put me back in my mind to make you know to know that,
412 (1.4)
413 → P i can achieve anything that i put my mind to.
414 PR absolutely! absolutely and th- er you get that feeling that
415 i was just talking about. a feeling of i can.
416 P deter[mi na tion?]
417 PR [the feeling ] of i can.
418 P uh,
419 (0.8)
In line 408 P says that she has found the words of her yoga instructor encouraging. The primary’s contiguous “good.” is uttered in appreciation of what has just been said and is followed by the patient’s explanation of how the above-mentioned words have triggered a change in her way of perceiving what she can do and how. The significance of the whole series of stories clearly emerges in line 413 with P’s self-assured conclusion (“I can achieve anything that I put my mind to.”). This signals P’s uptake of PR’s previous suggestions and constitutes a final agreement (note the immediately following matching show of agreement on the part of the primary in line 414-15). At this point P ‘wraps up’ the series of stories by referring back to his own description of the powerful “feeling of I can” (ll. 414-22), which is the leitmotiv of the series of stories. Having reached agreement on the fact that P can achieve anything that she puts her mind to (see l. 413), PR can finally resume explicit advice-giving in lines 428-30, which echo the suggestions already made in excerpt 27b (ll. 146-57).

To sum up, patients may fail to orient to doctor-initiated advice-giving when this occurs early in the interview. However, the potential contrasts resulting from this non-alignment can be smoothed by engaging in a jointly authored process of story-telling, whereby participants collaboratively make sense of “specific situations and their place in the general scheme of life” (Ochs & Capps, 2001: 2), gradually bringing the conversation onto a ground where agreement can be more easily found. Such a conclusion seems to be in line with the observations made by Fasulo and Zucchermaglio.

18 Note also the emphasis given by the long pause preceding P’s words.
(2005) on the use of narratives in institutional, and more in general, work-related settings. In particular, the primary’s second stories in the excerpts just analysed, by “evoking concrete instantiations of possible worlds” (ibid.), help to envision a solution for the problematic course of action described by the patient, thus facilitating next moves (in this case premature advice-giving).

6.4 Summary

In the present chapter I have discussed patients’ and doctors’ initiatives in the light of the overall structural organisation of the medical interview and of the interactional asymmetries characterising it. What has emerged from the discussion is the procedural competence of participants, whose intersubjectively performed actions are methodically shaped and reshaped over the course of the talk to achieve mutual understanding and agreement (cf. Zimmerman & Boden, 1991: 10). In particular, I have tried to highlight that patients, like doctors, show themselves to be fully aware of what is appropriate and at what stage of the interview, thus achieving the observably orderly character of the interaction.
7 CONCLUSIONS

7.1 Aim of the chapter and caveats

In this final chapter I will comment on the results presented in chapters 5 and 6 in the light of the similarities and differences emerging with respect to previous research, as well as the implications for future research on doctor-patient interaction. In particular, I will focus on the interactional work conducted by the participants to collaboratively construct roles and activities throughout the naturopathic interview, and on the way conversational resources may be used within task-oriented activities (e.g. history-taking or advice-giving) to attain specific interactional goals (specifically, agreement). In so doing, I will call for a redefinition of doctor-patient interaction away from the traditional asymmetric, doctor-centred model towards a complementary idea of communication, where initiatives by either participant and responses to those by the co-participant are equally considered. Finally, I will make some terminological and methodological considerations that are in line with this change in perspective and further support the approach adopted in the present work. Before moving to the discussion, however, a few caveats are in order.

First, the final remarks presented here are to be read as interpretations of the patterns of regularities found in the previous two chapters, and are as such tentative generalisations regarding the organisation of doctor-patient interaction as can be seen in the data analysed. In other words, the aim of this study is not to identify prescriptive, causal rules determining doctors’ and patients’ behaviours (thus establishing ‘codes of conduct’), but rather to formulate general, descriptive principles accounting for the regularities discovered, without, however, discounting the fact that any instance of talk-in-interaction is a “unique achievement here and now” (ten Have, 1999: 41).

Second, and in line with CA’s qualitative approach, no attempt at quantifying findings has been made. Hence, issues of how frequently particular phenomena occur have been set aside in the interest of “discovering, describing, and analyzing” how
conversational order is locally produced and normatively oriented to by participants in interaction (ibid.).

Third, given the limited size of the sample, the generalisations made have to be taken with extreme caution, i.e. they will need to be validated against further evidence from comparative analyses across a number of settings. This does not mean that the hypotheses formulated are invalid – their validity relying primarily upon proof procedure, deviant case analysis, and questions about the institutional character of the interaction (cf. 4.6.).¹ It simply means that they should not be assumed to be more generally applicable.

Fourth, although the present study is based on the ‘applied’, rather than ‘pure’, CA approach (cf. 3.4), it is not advisable to ‘apply’ its results to non-CA purposes, without running the risk of setting up inconsistent arguments. The findings illustrated in this dissertation are in no way intended to be evidence for any correlation between the phenomena under scrutiny (e.g. interruptions and the distribution of questions among participants) and fixed categories deriving from social structures or external considerations of any kind (e.g. gender, age, ethnicity, class, and the related issues of power and authority, cultural differences, functions of linguistic forms, etc.). Thus, ‘applied’ as they may be, the considerations made here have an essentially conversational character, their focus being on the procedural infrastructure of talk-in-interaction (cf. 1.4.2 and 3.1).

### 7.2 Rethinking asymmetry: the interview as interactional achievement

In chapters 5 and 6 we have dwelt on a number of patients’ initiatives and on doctors’ responses to such initiatives, showing how patients are much more active than they have traditionally been depicted and doctors can be less detached than they are normally trained to appear. In so doing, we have exploded two myths characterising a significant share of the previous literature, namely patients’ passivity with respect to doctors’ initiatives, and doctors’ neutrality towards patients’ concerns. This enables us to adopt a different perspective on doctor-patient interaction based on collaboration and exchange

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¹ For a thorough discussion on validity in conversation analysis see Peräkylä (1997: 207ff.).
rather than dominance and control. Before drawing some general conclusions, however, let us briefly sum up the main results emerging from the analysis conducted on the UB sample.

As demonstrated in the previous two chapters, not only do the voice of medicine and the voice of the lifeworld interpenetrate (cf. 5.2; 5.3), but participants cannot be associated with a single voice. Specifically, we have observed how (a) patients can speak with the voice of medicine, by showing communicative competence and capacity with respect to the speech event ‘medical interview’ (6.2; 6.3.1); and (b) doctors can speak with the voice of the lifeworld, by proving themselves ‘emotively’ responsive to patients’ concerns (cf. 5.4; 6.3.2). These two points will be examined in the following two subsections.

7.2.1 Patients’ active participation in shaping discourse
Historically, research into doctor-patient interaction has focused on how doctors manage the agenda of the consultation and structure the interview, i.e. basically how they maintain control over the interaction (cf. Beach, 2001; Drew, 2001). Paradoxically, as noted by Drew (2001: 262), even studies that have criticised medical practice for silencing the voice of the patient have largely neglected the role of patients in their interactions with doctors. Only very recently have a few works started to redress the analytic balance by incorporating a patient’s perspective (cf. Sarangi, 2001: 3). Among these studies, the collections of articles in Sarangi and Wilson (2001) and in Maynard and Heritage (forthcoming) deserve special mention for their contribution towards a more patient-centred approach. The present study has followed the lead of these ground-breaking works in abandoning the simplistic view of a doctor-dominated encounter, and has tried to apply a more genuinely interactive approach to the relatively unexplored terrain of non-conventional medicine.

Contrary to what has been claimed by previous investigators (for instance Jones, 2001), this study has shown that patients are aware of the ways in which the various parts of the interview are arranged and fitted together, and actively contribute to their overall organisation. In other words, patients – exactly like doctors – know what is appropriate and at what stage, and are able to use all resources at their disposal to
produce the observable orderliness of conversation. Drawing on the notions developed by two famous linguists, namely Hymes and Widdowson, we may well say that patients display both “competence” (knowledge) and “capacity” (ability) with respect to the structure of the interview (cf. Hymes, 1972a; Widdowson, 1983). By virtue of these qualities, patients collaborate substantially to the moment-by-moment definition of activities and roles within the medical encounter. For instance, they carefully employ displays of interactional asymmetries to fit their contributions to the sequential phases of the interview (cf. 6.2 and 6.3). Doctors’ and patients’ convergence on activities and roles is achieved locally through the turn-taking machinery and involves what Aston (1988: 123ff.) has called “agreement as to context”, i.e. “the mutual accessibility and acceptability of participant worlds as a current context” (ibid.: 127). Hence, if it is true that the medical interview – like other forms of institutional discourse – is shaped by interactional asymmetries, it is also true that these asymmetries are not pre-determined but negotiated in situ by doctors and patients alike, who cooperatively decide on each occasion with which voice to speak. This conclusion is consistent with the statements by ten Have (1991) and Maynard (1991b) on the reconsideration of asymmetry in doctor-patient interaction (cf. 3.6), and contradicts previous claims regarding patients’ alleged passivity (cf. chapters 1-3 for an extensive review of the literature).

Operationally, the findings illustrated in chapters 5 and 6 support the micro-analysis of naturally occurring talk as a reliable instrument to make sense of participants’ initiatives, and demonstrate the methodological bias of doctor-focused research, particularly sociologically-oriented accounts (with their tendency to explain interactants’ behaviours in terms of socio-political structures) and factor analyses (with their tendency to provide recipe-like advice to doctors on how to improve their interviewing skills). Incidentally, talking about literature that is oriented toward medical practice – or “praxis literature” as Ainsworth-Vaughn (2001) has called it (cf. 1.1) – naturopathic principles as listed in Murray and Pizzorno’s Encyclopedia of Natural Medicine (cf. 4.2) could be rephrased to match the analytic perspective just illustrated. In particular, the three principles that directly concern doctor-patient communication and relationship, namely “find the cause”, “doctor as teacher”, and “treat the whole person”, could be reformulated so as to emphasise the interactional character of the work underlying the
medical interview. For instance, given the preventive character and holistic approach of naturopathic medicine, as well as its focus on patient responsibility, one may well expect to read among its principles not just that physicians should investigate the possible causes of patients’ problems (including for example lifestyle, environmental, and emotional factors), but also that naturopathic patients should provide all relevant information to their doctors regarding these same factors, thus actively collaborating to the discovery and removal of the underlying cause(s) of their problems. Modifications of this kind would ultimately result in a setting-specific adaptation of Grice’s *cooperative principle*, which requires participants to “[m]ake [their] conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which [they] are engaged” (1975: 45).

The reconsideration of the concept of asymmetry in doctor-patient interaction cannot but lead to a reconsideration of the appropriateness of the word ‘asymmetry’ to define the relationship holding between the participants in a medical interview. In fact, the terms ‘asymmetry’ and ‘asymmetric’ reflect the traditional bias of the literature towards the balance of power between patients and doctors (see above), power being the control over the emerging discourse, as well as over future action (cf. Ainsworth-Vaughn, 2001: 453-54). Saying that the relationship between doctor and patient is asymmetric does not just imply identifying two distinct positions within the dyad, i.e. a ‘superior’ one for the doctor and an ‘inferior’ one for the patient, but has also often resulted in a tendency to equate these descriptive terms with heavily connotated labels like ‘strong’ and ‘weak’, indicating premature categorisation of roles and identities, which are seen as constraining the interaction rather than being shaped by it (cf. 1.4.2 and 3.2.1). By contrast, as our analysis has shown, the nature of the doctor-patient relationship emerges from situated talk: if it is true that doctor-patient interaction functions on the maximisation of difference – or “interactional asymmetries” to use Heritage’s (1997) terminology – it is also true that such difference is constantly negotiated by participants, whose “dissimilar but fitted behaviors evoke each other” (Watzlawick et al., 1967: 69). For this reason, the term *complementary* seems more suitable to describe doctor-patient interaction and role relationship, bearing in mind that
[o]ne partner does not impose a complementary relationship on the other, but rather each behaves in a manner which presupposes, while at the same time providing reasons for, the behavior of the other: their definitions of the relationship (...) fit. (Watzlawick et al., 1967: 69)

7.2.2 Doctors’ displays of emotive communication as a way of doing agreement

One of the main concerns of the teaching literature in the field of medicine has always been that of training doctors to be objective professionals able to gather accurate data about patients’ thoughts and feelings, by carefully listening to them (and letting them know that they are being heard), while at the same time withholding personal opinions and emotions (see for instance Coulehan & Block, 2001: Chapter 2). This long-flaunted neutrality is also explicitly acknowledged in many conversational studies on doctor-patient interaction (cf. 3.5.3.2) and, more in general, on discourse in institutional settings. For instance, Drew and Heritage (1992b: 46-47), in presenting the contributions included in their volume *Talk at Work*, claim that “the professional participants in institutional interactions design their talk so as to maintain a cautiousness, or even a position of neutrality with respect to their co-participants”. In this respect, the UB sample provides some evidence that the reverse is true.

To be more precise, we have observed that naturopaths – like their patients – do not refrain from using evaluative language, and we have found numerous displays of involvement and affiliation (essentially assessments) in response to patients’ expansions and elaborations. Given the constraints characterising the medical interview (especially time constraints; cf. 3.4), it may be claimed that such displays hinder speedy and efficient data gathering, thus compromising effective communication. Consequently, one may wonder why doctors employ evaluative language in the first place. On a first general level, the use of evaluative language in response to patients’ concerns could be explained in terms of the naturopathic principle “treat the whole person”, whereby the physician should not be interested solely in the patient’s medical problem and its properties, but s/he should also show interest in the patient’s life and personal experiences. From a practical point of view, this special attention to patients’ concerns is reflected in the time spent talking with them, which is on average forty-six minutes (cf.
as opposed to the average length of primary care consultations, which varies between Byrne and Long’s (1976) eight minutes (cf. 1.3) and Jones’ (2001) fifteen minutes (cf. 3.5.3.2). However, to take the argument one step further, the point is: does evaluative language really hamper efficiency? There are various reasons for arguing that this is not the case.

First, the use of evaluative language in the UB sample should not be confused with so-called “emotional communication”, i.e. the “spontaneous, unintentional leakage or bursting out of emotion in speech” (Caffi & Janney, 1994: 328). Rather, it is an example of “emotive communication”, i.e. the “intentional, strategic signalling of affective information in speech and writing (…) in order to influence partners’ interpretations of situations and reach different goals” (ibid.). Second, to understand how emotive communication works one has to look at where and when it is used. As we have seen, evaluative language is extensively employed during troubles-talk and story-telling sequences (cf. 5.4.2; 6.3.2) by patients and doctors alike. In particular, we have observed how doctors’ empathic use of assessments in response to patients’ troubles-telling and during second stories (in response to patients’ first stories) contributes to create a degree of intimacy between the participants which may seem unusual in institutional encounters, even if less frequent than in mundane conversations. As Tannen (1990: 26) put it, intimacy is “key in a world of connection where individuals negotiate complex networks of friendship, minimise differences, try to reach consensus, and avoid the appearance of superiority, which would highlight differences”. Overall, doctors’ and patients’ engagement in archetypal conversational activities like troubles-talk and story-telling, with the high degree of intimacy that these involve, arguably facilitate agreement within task-oriented activities like history-taking and advice-giving, which may generate miscommunication or conflict. In other words, the use of resources from everyday conversation, specifically evaluative language, provides evidence of agreement as to the cognitive and affective contents of the interaction, and thus its primary goals (cf. Aston, 1988: 123ff.), and cannot therefore be considered a waste of time. Ultimately, the collaborative construction of troubles-telling and story-telling sequences shows that

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2 As pointed out in 4.5, this datum refers to the average length of the recordings, the actual encounters being longer.
3 These two figures refer to the UK and the US respectively.
doctor-patient talk may have an institutional imprint, but it also has a strong interactional base.

7.3 Implications for practitioners and future research

The contents and methodology presented in this study may have some implications for practitioners in terms of both everyday clinical practice and communication skills training. These could benefit in many ways from a linguistic examination of real exchanges with patients. For instance, the micro-analysis of recorded interviews could help practitioners appreciate the ways in which patients actively contribute to the structuring of the encounter with their physicians, thus increasing expectability of what may happen during the interactions. Similarly, a fine-grained investigation of the evaluative language employed in the interviews could help them “recognize and enhance the deeply remedial potential of emotional reciprocity” (Jefferson & Lee, 1992: 546). In this respect, what Sarangi calls “discourse practitioners”, with their specific competences, could be involved in the design of medical curricula, so as to include analyses of naturally-occurring interviews (rather than just role-plays) within communication skills courses.

Overall, a greater awareness of conversational mechanisms would contribute to a better management of potential conflicts, ultimately facilitating agreement. It must clarified, however, that agreement is intended here as convergence on both the context and content of emerging discourse (cf. 7.2.1 and 7.2.2) and not as convergence on future action. Against this backdrop, agreement between doctor and patient during the interview does not necessarily lead to greater patient satisfaction or compliance with the treatment. The correlation between agreement on emerging discourse and agreement on future action could only be measured by conducting longitudinal studies that compare the results obtained from the analysis of a series of interviews with the same participants collected over a long period of time with the results of feedback questionnaires. This brings us to the issue of future research.

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4 Cited in Candlin (2003).
One possibility that deserves consideration is a direct, systematic comparison between naturopathic and allopathic settings aimed at verifying to what extent the conclusions reached in this study may also apply to more conventional contexts. Another possibility is the comparative analysis of the communicative patterns shown by trainees and professional physicians (in the present work no distinction has been made between student clinicians and supervising doctors). In this respect, pioneering research had been conducted by Anita Pomerantz and her associates (cf. Pomerantz et al., 1995; 1997), who have discussed the interactional problems that the co-presence of interns and preceptors in a general medicine clinic poses in terms of who the parties are to each other. Specifically, the authors have focused on the preceptor’s responsibility for enacting the roles of senior physician, supervisor, and teacher while still preserving the intern’s role as the patient’s physician and as a competent professional. Last but not least, a very productive research area within applied CA seems to be the use of narratives in medical and therapeutic contexts, as well as in other institutional settings. Overall, narratives seem to be employed by participants in institutional interactions to establish a frame of understanding (cf. Kjaerbeck, 2005); in a number of work-related settings they emerge in problematic courses of action, when difficult decision-making processes are involved or in the presence of contrasting views (cf. Fasulo & Zucchermaglio, 2005); finally, in therapeutic talk narratives may signal clients’ uptake of therapists’ formulations (cf. Bercelli et al., 2005; Rossano et al., 2003).

To conclude, the issues I have raised are by no means exhaustive and will need subsequent reformulation and further investigation. However, I do not believe that these can be ignored, particularly with the emergence within healthcare delivery of a patient-centred approach that places communication at the heart of the medical practice.

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5 For further details on conversational analysis applied to the study of therapist-client interaction, see Leonardi and Viaro (1990) and Bercelli et al. (1999). For an extensive treatment of narrative-based medicine, see Hurwitz and Greenhalgh (2004) and Giarelli et al. (2005).
REFERENCES


228


232


APPENDIX A: TRANSCRIPTION CONVENTIONS
Transcription conventions

Interview code
UBNMC: INT#-mm.dd.yy The interview code indicates the place where the interview was recorded (the University of Bridgeport Naturopathic Medical Center), the progressive number of the interview (e.g. INT13), and the date in which it was recorded (e.g. 11.21.03).

Speaker codes
P Patient
PR Primary (fourth-year student clinician)
SC Secondary (third-year student clinician)
SD Supervising doctor
R Researcher

Sequencing
= The ‘equals’ sign indicates the ‘latching’ that occurs when one utterance follows another without any intervening pause.
[ ] Square brackets mark the onset and end of temporal overlap of different speakers’ utterances.

Timed intervals
( . ) A dot in parentheses indicates a time gap shorter than 0.2 seconds.
(0.3) The number in parentheses indicates a time gap in tenths of a second.

Characteristics of speech delivery
- A dash indicates the sharp cut-off of the prior word or sound.
: One or more colons indicate lengthening of the previous sound. The more the colons the longer the sound.
. A period indicates a falling intonation.
, A comma indicates a rise-fall in intonation.

1 Adapted from Sacks et al. (1974: 731-34), Atkinson and Heritage (1984: ix-xvi), and ten Have (1999: 213-14).
? A question mark indicates a rising intonation.
!
An exclamation mark indicates fall-rise in intonation.
↓↑ Pointed arrows indicate a marked falling or rising intonational shift. They are placed immediately before the onset of the shift.

h/hh/hhh An ‘h’ or more ‘h’s’ indicate an audible out-breath as in laughter, sighing, etc. The more the ‘h’s’ the longer the out-breath.

.h/.hh/.hhh A dot before an ‘h’ or more ‘h’s’ indicates an audible in-breath. The more the ‘h’s’ the longer the in-breath.

tehxt One or more ‘h’s’ in parentheses within words indicate breathiness within words, as in laughter, crying, etc.

Text Underlining indicates speaker emphasis.

tex_underscores within a word indicate that the word is being spelled or is spoken as individual letters (as in abbreviations).

°° Degree signs indicate that the talk they encompass is spoken noticeably more quietly than the surrounding talk.

TEXT Upper case indicates talk spoken noticeably more loudly than the surrounding talk.

> < ‘More than’ and ‘less than’ signs indicate portions of talk delivered at a noticeably quicker pace than the surrounding talk.

< > ‘Less than’ and ‘more than’ signs indicate portions of talk delivered at a noticeably slower pace than the surrounding talk.

tzt ‘Tzt’ indicates a lipsmack.
gk ‘Gk’ indicates a guttural sound.

Transcriber’s doubts and comments

(text) Single parentheses enclosing one or more words indicate a reasonable guess at an unclear word/segment.

(slb) Single parentheses enclosing one or more ‘slb’ indicate the number of syllables in an unclear segment (for which no guess was made).

((( ))) Double parentheses enclose either non-verbal activity or the transcriber’s comments on contextual or other features.

→ Arrows in the left-hand margin of the transcript point to a phenomenon of interest.
APPENDIX B: THE UB SAMPLE
SC ((pointing at file held by PR)) so we'll just follow up from last week.

PR yeah so:

P hhhha!

PR how were you doing erm with your ((touching his hip)) hip pain it came up with this [week,]

P [yeah,]

PR o[kay]

P (yeah] (slb) but i had forgot to take the ( slb slb slb) too!

(1.0)

P [so,]

PR o[kay]

((researcher leaves)) (2.2)

P she's not gonna be here!

(1.0)

P (yeah.)

(2.2)

SC =hha ((researcher comes back))

P here she is. .hhha

(1.0)

PR ((talking to himself)) (º slb slb slbº) the same kind of pain?

P oh ↓yeah you ↓know

PR [yeah.] usually right=

P =you know what.

PR =anything new?

(2.8)

P anything new,

(1.6)

PR as far as pain,

(2.1)

P no: no not that i remember. ((researcher leaves))

PR uh huh.

P but you should remember that i have a high pain threshold so i [might] have had=

PR [ yes.]

P =pain and not felt it.

PR uh huh.

SC ((smiles at P))

(1.2)

P maybe it's of use to have (0.9) a high pain threshold.

((PR writing on P's file)) (5.8)

PR do you have pain right now?

P huh?

PR do you have pain right now?

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P now? [no!]

PR [yeah] now okay,

P no it it seems hhh (h) i d(h)on't know why it seems to hit me
when i'm cooking, (.) .hh i guess maybe i assume a certain
position.

SC [uh huh.]

PR [uh huh.] [ o  Kay.  o.kay. o]

P [you know at the ] stove.

PR huh,

P and: (1.3) that's that maybe is it does seem that way you know
that most ( slb slb slb) is when i'm cooking.

PR [uh huh.]

SC [uh huh.]

P huh,

((PR writing)) (5.5)

PR a:nd how's your eye, i remember the last time you told me,=

P =the eye,

PR [uh huh,]

P [well it] i don't know how long, i- it it's still there.

PR still there.=

P =i can still see [it you ] know?= 

PR [uh huh.]

P =and: (1.3) ((knocks at the door)) somebody [knocked.] 

SC [come  in]

P [where is my bag?]

SD [(was wondering) ] o:h (slb) ↓it

P books?

SD yeah.

P yeah.

SD could you (slb slb slb)?

P no you can put it in.

SD (slb slb)

P she's quite erm a cr- erm quit- erm
cure for [all (slb),]

SD [huh i ] have heard that name before.

P she's quite a history!

SD (slb slb)

SD (1.3)

SD okay.

P her ↓tool
SD you'll bring us okay?
P uh huh.
SD right,
P doctor halliburton agreed to translate the books for me.
SD ha ha ha ha ha ha .hah hha
P they're in english but i cannot [i can't] [sort of]
SD [ha ha ] [ ha ha]
PR [ hu hu]
SC [ he he ][ he he ]
P [i don't] i

don't have the background.
SD [that's it.]
P [really to ] read them she's a real a little bit florid in her
write to to my,
SD =uh huh,=
P =but you know a lot of florid people could be telling the truth
too! [yeah.]
SD [sure!]
P bec- she is a [ p_h_] d in physiology.=
SD [sure.]
SD and she's not always southern as you are,
P huh yeah.=
SD =you don't see yourself as (slb slb slb slb)
P yeah! well i mean attitude.
SD huh that's it.=
P =look when i say southern i mean genteel.
SD oh, okay.
P i've heard something this week and i said oh maybe if i tell
that story i'll tell doctor: .hh halliburton ((covering her ears
with her hands)) to cover her delicate ears.
PR hhhu hhu
P okay where were we?
SD >wait wait wait< so what's the story
P i can't remember.
SD ↓a:h [ ha ha ha ha ha ha]
PR [ hu hu hu hu hu hu] [.hu]
SC [ha ha ha ha ha ha ] [.he]
P [but] it was colorful
SD [e liza ]bethan.=
SD [oh okay.]
P =i asked my niece if if the nurse used old english or: (.)
elizabethan and she said it's been a while since i studied i
can't tell you.
SD okay.
P i was gonna further [define that question.]
P [yeah that's,]
SD [and that's] where in like (slb slb slb), on the coast and also in the (slb slb slb) you know,
P [yeah yeah (it's up there too)].]
SD =so anyway to you. (. ) how are you doing?
P okay i guess, well you know the hemorrhage is still there.
SD uh huh.
P but erm how long do you think do you have any idea of how long it will take to absorb if it does.
SD well i think ((to PR and SC)) did you take a
PR not yet.
SC not yet we've just [started.]
PR [yeah we ] just started.
SD okay. okay. [erm]
P [erm] only what do they down at park city i were with (slb slb)
SD oh did you go to park city with her,
P oh yes i did.
SD ↑uh↓uhm
P and of course they scheduled me for thee: er ultrasound on a
doctor: gillian he's trying gently
text but somewhere you know the nurse told me that the survival of the triple a is only fifty per↑cent
SD huh!
P and er coz her father died from that.=
SD =huh okay.
P but anyway i was talking to doctor: to push me toward (1.0) thee: allopathic medication,
(0.9)
P and i told him no!
P i said i'm terrified of it.
(. )
P .huh but anyway i i guess and that's when thee: er er the triple surgery came up ((miming stitching up a cut)) OH MY ARGH! I WON'T KEEP MY SEE IT. what is a bypass or something? down here the groin you know [coz they] went in,
The term is you know that the: it's perfectly okay even if it's no easy.

P you know it's i guess he's going through [(this way).]

SD yeah he wou- i was a teaching tool i'm lying there,

P =almost flapped up and they were all putting their stethoscopes in my groin!

SD okay. well thaa-tha- that's that's something that (. ) is teaching us definitely.

P oh sure! sure but he didn't tell me he was gonna do it neither did he ask my permission.

SD °i'm surprised.°

P huh?

SD i'm surprised.

P well (. ) how many times he got a living triple a survivor you know, well i didn't mind i thought it was funny.

SC ((smiles))

SD [he ] he he .hh=

PR [hhu]

SD =and you're definitely a good sport.

PR .hh [ .hh ]

P [ huh ]

SD definitely a [good sport.]

PR [ .hh .hhhh ]

SC ((smiles))

P ↑well you know they they can↓learn=

SD =yes. [ab so lutely.]

P [you know and i] recognize too you know there're so many names round this place. you know where everybody it seems, not everybody but most begin, (. ) down in the dispensary some girl
P .hh spoke to me to call me by my name and i sai- do i know you know?

PR ↓u:h

P .hhh but then i’m a fixture down here on tuesdays. and er and i said i i’ve seen her who is she? and i’ve seen her who is she?

SD =also did he recommend an ultrasound?

P oh yeah!

SD okay.=

P =and i’m scheduled for it when i can’t go coz [ er] [uh uh.]

SD =o[kay just]=

P [and i ]=

PR [uh uh. ]

SD =just keep trying.

P yeah he figures three w(h)eeks ha .hh he said three, come back in three weeks and he'll discuss it with me.

SD yeah.

P shall i carry a tape recorder for you?

SC [((smiles))]

PR [ hhhhh ]

SD [ ha ha ] ha .hhh ha .hh you can report back and i'll get i'll get i'll get one version or another. [ha ha ha ] [yeah. hh huh] okay.=

P =he he he .hh

SD [but thank you i'm] glad that you're following up with that.=

PR [oh it's o kay.]=uh huh

(.)

P I DONT’T GET THIS! i don't get it the other day you thanked me for talking pleasantly [to doctor sandler,]

SD [ha ha ha ha ] [ha ha ha ha ] [hhh ]

PR [hu hu hu hu hu hu]

SC [((s m i l e s))]

PR =[.hhh hu]

SD =why did] you ↑(slb) ↓it i know that it's it’s not what you you know that it's something that you're you're (0.3) trying to balance the two different approaches.

((knocks at the door)) (0.4)

SD and so that's,

P wh-two which two approaches?
SD ((going to the door)) allopathic and the naturopathic ones.

P ((SD opens the door)) i'm trying to balance it

SD ((to someone who is outside)) yes

PR tzt so you haven't had the ultrasound yet, huh?

SC you've not had the ultrasound yet.

P no no [no they ] it was they scheduled it for friday.=

PR [alright.] =o[kay ]

SC [this]

SD ((to someone who is outside)) coming fri day

P yeah.

SC and so you're gonna have to reschedule it.

P yeah i have to reschedule it.

SC [o kay.]

PR [uh huh] okay.

SD okay so [have ] you done the vitals?=

P [yeah,] =huh?

SD have you done vitals yet.=

P no [we've just been talking. ]

SD [ ( slb slb slb slb) you guys started. okay can i give you time to do vitals and then i would like will graham to take a look at your scar do you remember i was telling you he does the scar therapy?

P oh yes something to stress,

SD right. (.) right.

P [o(h) kay.]

SD [so (slb)] (slb slb slb slb) you must be [tired (slb slb slb slb)]

P [i am a teaching tool ] around here!

SC he [he he .hh]

SD [ha ha .hh] oh thank you for that and c(h)an i thank you for that ha

P ((nodding)) [ tshh ]

SD [ ha ] ha=

PR [smiles]

SC [smiles]

SD .=hhh okay. [so,]

P [so.]

SD so we will well i'll i'll come back after erm with will. (.)

SD okay?

P okay.

SD thank you.
You go— you don’t have any film or what, do you want film too? We— you have Letisha bring her over and, you have her bring her over. And on top of that it was such a bad day I think I’ll chase a shower so he’s taken his.

Okay.

And on top of that it was such a bad day I think I’ll chase a shower so he’s taken his.

Okay.

Okay. Ah Mel can you—

Is it a man?

Yeah.

Yeah.

Is he a doctor?

Yeah.

Yeah.

Is he the he’s an M.D right?

Yes.

Huh good! I admire him.

(to PR) Give me the watch,

For anyone who is— anyone who ha— you know any medical person is really flying in a (place of things),

Well you do (.) you we— you were what a a,

I’ve been a medical assistant and a teacher.

Teacher of what?

Bio(anthropogenous) biology

I remember the medical assistant you worked in a hospital,

Uh huh. Uh huh.

((sniffs)) Do you get fish eyes?

From your friends?

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P like you're a little wacky?
SC yeah. he hh but i've always [done those.]
P [you get used to it. believe me
SC [ i i've got those ] since i was young [so, he] he he=
P [oh well] =oh
SC you're follow- you're not following my lead but you= 
SC =well i'd like to now try now that i know you.
P ha [ha ha]
SC [he he] [he]
P (no] you know what i mean [you ] you're a beginner= 
SC [.hhe] =he
P he he
SC when you choose to be.
P ((to SC while PR is filling in P’s file)) i was thinking about
you remember i was telling you about you i don't think you knew
that (salvator),=
PR =((to SC)) can you take the blood pressure?
SC ((to PR)) yeah.
PR ((SC turns round to get stethoscope)) yeah okay.
P ((SC still showing her back to P)) i didn't i think i surprised
you when i told you that (slb slb) salvator was mended on long
PR ↑island
P when i was talking to you one time?
SC yes.
P .hh and they had: there was a program on u_ boats in the second
world war,=
SC =uh huh.=
P =and they mentioned they mentioned that one too you know again
SC that they were mended by: more than they (. ) who were mended on
PR on long island.
PR how's this erm lesion?
P oh i don't know where!
PR huh!
PR (.)
P i don't know it's been there a couple of weeks since i noticed
PR it. no::!
PR uh uh uh,
P no.
PR .hh okay let's [take this.]
P [ i don't ] see two things and twins.
PR uh huh [hhu hu] .hhh
SC [he he]
neither this here she only dislocates one shoulder at
[ a time. ]
[ that's right. ] [(slb slb slb)] [ he ]
[ hhh hh hu ] [.hhh]
[how ] did you ↓fall [hu]
[i:] i slipped in the bathroom and i went to reach out,
o:::h!=
=and i continued slipping so i went down and my arm was
[uh ] uh [huh,]
[hu] that's a mean one you could have done [a    lot more] damage!=
[i could have]
yeah,
boy!
(2.7)
°okay.° can i ask you to roll it on? great!
(( SC measuring blood pressure)) (23.6)
=okay.=
=or something like that she (slb slb),
okay.
(tight?)
=they're tighter than usual yeah.
(1.9)
well the other day when the nurse took my blood pressure it was
up far a hundred and eighty.=
=okay.=
=or something like that she (slb slb),
okay.
she said not too bad.
(2.3)
and i said what do you consider ↓bad she go two thirty hh ha
ah↓ah
(23.3)
pr: huh? i don't hear anything.
(1.9)
you didn't hear anything oops.
(3.0)
opthalmoscope! that's,
SC yeah ophthalmoscope.
P yeah i started to (slb slb) whether it was an ophthalmoscope.
SC ((turning to PR who's checking if stethoscope works)) no it's different.
PR uh,

SC ((turning to PR who's checking if stethoscope works)) no it's different.
PR uh,

SC ((turning to PR who's checking if stethoscope works)) no it's different.
PR uh,

SC ((turning to PR who's checking if stethoscope works)) no it's different.
PR uh,

SC ((turning to PR who's checking if stethoscope works)) no it's different.
PR uh,
PR  yeah.
505 P  okay.
506 SC  (slb do) the blood pressure (slb slb slb)
507 SD  okay. okay. and then what did you get ginko?
508 PR  i got,=
509 SC  =he was having difficulty hearing in the stethoscope.
510 PR  i got one eighty over ninety two. i mean ninety two.
511 SD  okay.
512 PR  [so it's high!]
513 SD  [(slb slb) this ] is (. ) so we'll erm we can double check
514 before:,
515 SC  okay. [that's good.]
516 PR  [ uh huh. ]
517 SD  so lizabeth this is will.
518 P  gk doctor ↓stein
519 SD  huh?
520 P  doctor stein?
521 SD  doctor ↑stein
522 P  ah?
523 SD  this is will. ha hh
524 PR2  [hi. ]
525 PR  [doc ]tor graham.
526 P  hi doctor!
527 PR2  [hi:!]
528 P  [how ] [ are you?]
529 SD  [ ha ] [ ha ha]
530 PR  [ hu ] [ hu hu] [.hh hu]
531 SC  [ he ] [ he he] [he he]
532 PR2  (slb ↓slb)
533 P  stern?
534 PR2  ↓sterm
535 P  stein.
536 PR2  ↓stein
537 P  i [don't know!]
538 SD  [(slb slb) ] [(slb slb ]slb) [will.]
539 PR2  [ neither.]
540 P  [ ↑uh ]
541 PR2  will.
542 (.)
543 PR2  just will.
544 SD  he he he .hhh
545 P  is that informal or proper?
546 SD:  he he=
547 PR2  =that's totally proper. i'm a student.
548 (.)
549 P  but you're also a doctor aren't ↑you
PR2 of naturopathy?

P no.

PR2 well, [(slb slb)]

SD [we just] have him here as a student.

P [uh?]

PR2 [you] see i'm a student.

P so:

PR2 it doesn't matter if i'm an architect,

PR hhh

PR2 or erm or a conductor,

PR h [hu]

PR2 [what] i was before is irrelevant. i'm a naturopathic student now.

P okay.

P got it. i've been put in my place maybe.

SD hhh he

PR2 no [no no! i've been] put in mine!=

SD [no he has been.] = he he [he he]

P [ha ha]

SD [.hhe he he]

P [ha that's right.]

PR [hh hu hu]

PR2 may i may i see your scar?

(1.1)

P this has been on display twice this week. oh no! last week too,

SD you're popular.

P yeah!

SD he he

P well with a fifty percent [mor]tality rate,=

PR2 [(when)]

SD = he he [he hhh]

P [you know e]ven you can see yeah.

PR2 that's pretty it's impressive.

P yeah the nurse looked it and she was surprised you know?

((P unbuttons shirt)) (1.1)

P hh hhhhh oh xcuse me erm you wanna look at this way or lying down doc?

PR2 maybe that's that's fine.

(.)

PR2 okay and is this incision much longer than i see?

P [ha ha ha] ha ha it goes all the way down to ↓here

PR2 [(slb slb slb)] it ↓does=

SD = yeah.

P and then what do they call it? when they take that out resection?

no .hh
SD: yeah they used erm as far as the er [(slb slb slb)]

P: [yeah in the] groin they went into the groin. =

PR2: =o:h my goodness! okay alright so that,=

P: ha-

PR2: [now that,]

P: [have you] seen enough or you wanna see the rest?

PR2: er even even i can extrapolate from what i'm seeing, now i understand

P: [jee-]

PR2: [what we're dealing with.]

P: [i haven't heard that] since i was studying \\

PR2: =that's right.

SD: hhh he

SC: [he ]

PR2: [that's] right. that's right. okay okay so that's a:

P: oh g- goo-oKay i don't mind

PR2: no if you if you erm .hh erm okay show me show me more of this

scar [please.]

P: [ha ]

SD: [i ]

P: [i knew it!]

SD: [think you could] lie down.

PR2: yeah.

P: i knew this here.=

PR2: =yeah.=

SD: =yeah why don't we have you, why don't you put your [head] here=

PR2: ((turns to PR)) [so.]

SD: =so,
what what we've been (slb) ((P lies on exam table)) so we don't use the mike then so it would be here here lizabeth. you know i have to inform all of you of somethin, when i was a kid when i heard the name lizabeth called to me, i went the other way.

treatment called neural therapy. ([sorry. he he he .hhh]

which the closest thing in of a historical fact. any
time i heard that,

what's called trigger point

became well known through

treatment called neural therapy. [i went the op]posite way.

the writings of doctor janet

trevell, who happened to be the personal physician [ ha ]ha ha no!

to john_f_kennedy.

((turning back to P))

Interesting. (P lies on exam table and yeah.

PR2 starts examining her abdominal scars))

[head that way].)

[i was going ] the other Way.

[alright.]
P [alright.]
SC you needing a hand
SD ((P hits SD's watch)) oops! he he he
P no i'm at.
SD alrighty.
(.)
P alright.
SD where did you go? to a
summer fest?
P uh?
SD where did you go a
summerfest
P oh that's an old (slb slb slb
of keeping these d-) new
t_shirts,
SD ah ah
P (we have to wear) new
t_shirts
with the weather because we
don't have a drier,

NOTE. The table above illustrates a case of schising (cf. 5.2.1, note 2), i.e. the two columns correspond to two conversations occurring at the same time (C1 on the left hand side and C2 on the right hand side). The two parallel conversations finish at approximately the same time, but participants in C1 speak at a much slower pace than participants in C2.
SD  oh damp!
SC  would you be more comfortable if i could (slb slb) this
P  okay.
PR2  ((turns to P who is lying on the exam table)) a::h! okay so,=
P  =i'm okay.=
SC  =okay. =
PR2  =erm tzt okay so erm,
(2.2)
PR2  so.
(1.2)
SD  ((pointing at scars)) the right.
PR2  i see yeah. i see these scars, okay [this is ve ry very, ]
P  [you know there's another]
one on the other side too.
PR2  uh huh [i'll ask,]
[ in case ] you want to get [a look.]
PR2  [o kay ] wow! okay now now i have the picture.
P  yeah.
PR2  okay.=
P  =i wanted you to get it doctor!
PR2  but i have the full picture okay .h and i was expecting this
SC  to be continuous with these but i see we have one two three
four major scars .hh
P  [four]
PR2  [ we ] also have, ((coughs))
P  doctor patton said
PR2  [yeah.]
P  [what ] i complained that he didn't [match the]
[ hu. tzt]
PR2  seams too well [you] see he=
PR2  [hu.]
P  =had to cut around this:,
PR2  right.
P  belly.
PR2  we also have these three are distancing. now (.) that,
P  oh there's an appendectomy scar there.
PR2  erm yes i i i appreciate that .hhh erm so we have these three
distancing and that too erm erm is: a significant scar. so in in
brief wha- what is the biological significance of of .hh of of
these scars, and the answer is that given that (.) more than
ninety percent of the autonomic neurofibers [of the]=
PR  [uh huh]=
PR2  body are located in the skin,
SD  ((to P)) °(slb slb slb)°
P  hu?

263
at the dermal epidermal junction just below that junction I talked about this many times,

uh huh,

given that I could just say in shorthand they cut this is disrupting the communication to acupuncture meridians.

whether you wanna speak of acupuncture meridians or (.) autonomic circuitry of the skin,

I think we're talking about practically the same thing. so it would: it would be of enormous benefit erm to to lizabeh for us to treat these. esp-

libby.

er,

[er lib] by? [libby?] [hu hu]

oh no! go ahead.

[lizabeth.]

[i'm used] [to it for the] [time] [here don't be bothered.]

[he he he he] [he]

=especially since this: especially since the, and the treatment is is painless [also.]

[uh huh.]

so erm we will we will go over the this: erm (slb slb) alpha stem unit that's used and how it's operated it's extreme- er very very simple and: and I think this would be a a wonderful help.

(1.9)

you can pull up

(.)

tzt

[okay.]

[may i ] make one observation?

yeah.

you're spunky.

[ha ha] [ha ha ha] [ha]

[he he] [he he hh hh] [hh]

[hu hu] .hh hu

[why(h) did you] say that=

[hhh hh] =.hh he

because you are.
SC [ he he ] he he =
770 PR [.hh hu]
771 SD =we like that. [ he he ]
772 PR2 [thank you.]
773 P you're [welcome.]
774 PR2 [it was ] very nice to meet you,
775 P and meet my ↑scar↓ too
776 PR2 [and met your scar!]
777 SD [ha ha ha ha ] ha ha ha .hhh
778 PR o↑kay [nice meeting both of you!]
779 SD [{slb slb} you can sit up.]
780 P oka(h)y [he he] [right] [will,]
781 PR2 [okay.]
782 SC [ha ha] [ ha ]
783 SD [he he] [ he ] [.hh ] .hh .hh
784 [ {slb slb}] too sit up for that,
785 PR2 [ thank you. ]
786 (.)
787 SD alrighty.
788 P i (slb slb slb slb round) here but i’m spunky!
789 PR [hu hu hu ]
790 SD [yeah ab so]lutely absolutely. so so today we’re just we’re
791 just assessing and i just wanted him coming in have him coming
792 in get hi- his opinion .hh and then next week we’ll start
793 treatments, and [erm],
794 P [on ]what?
795 SD .hh basically well erm erm it’s it’s essentially working with
796 your scar tissue, to help break down the scar tissue?
797 P yeah.
798 SD and it’s using this erm alpha stem unit which is erm it’s it’s
799 just it’s like this little erm .h battery operated erm (..) unit,
800 P what it gonna do massage↑it
801 SD .hh erm [it wi-] actually it works to break down the scars.
802 PR [ to: ]
803 P yeah.
804 SD so [that's] yeah. [that's]
805 PR [ uh, ]
806 P [ and ] you're gonna have fun coz that’s a
807 long one!
808 SD it is (..) it is no it’s probably gonna take quite a few .hh
809 treatments but hopefully it’ll affect your blood pressure and
810 bring it down.
811 P REALLY?
812 SD yeah that’s what we're hoping.
813 P REALLY?
814 SD uh huh.
P you mean my scar may be creating my blood pressure or just
SD contributing to =
P no kidding!
SD uh huh.
P how many points?
PR .hh hu .hh
SD well we're gonna find out coz we'll just keep monitoring it.
P u:h!
SD because=
P =oh i thought hey i don't know (. ) that's interesting! i didn't
PR [yeah because]
P planning to:
PR well (this guy) is.
P proceed on that.
PR yeah he's explaining you know the nervous system,
P (. )
PR and the skin,
P i heard him say meridian i know [that's] something in here.=
PR [yeah. ]
SD =but the nervous system,
PR nervous system.
SD as well,
P oh the autonomic. [ remember hearing ] [that one.]
SD [ e xactly. auton ] [omic nerv]ous
PR [(slb slb slb slb) yeah]
SD system so,=
P =what is it i forgot.
SD that is it's it's broken into parasympathetic and sympathetic,
PR and sympathetic is your (slb slb slb) (. ) (neurons) you know you
SD [that can] (slb) your pressure so high. so,=
P [uh huh,] =uh huh
SD it's basically thee, [fi- ninety perc-]
P ((pointing at SD's chin)) [did it do a ] (good) work on that
SD Scar?
SD it did alright.=
P =yeah okay.=
SD =ninety percent of erm er it's of the autonomic nervous system
SD it's under the skin so that when you have a scar it interrupts
SD the circuitry.
P oh yeah!
SD and so if you break down the scar tissue then you can have you
SD know a a circuit that doesn't that isn't interrupted.
SD (0.9)
SD it's it's like acupuncture but it's,
SD it's more direct as far as your skin.

P and I told me he didn't match the seams too well, (.).

P because it does say want me to (slb slb slb)

[you'll see it stay]

SD [ he he he ]

P ↑erm

SD .hh .hh no I sa(h)w it [ that's o ] [k(h)ay]

PR [ hu hu ] [ .hh ] [ hu]

SC [ he: ] [ he ] [ he]

P [ you ] [can] see when I'm ↑down

SD you showed me he he he [.hh]

PR [.hh] hh

SD so [that's it. ]

P [ o kay. ] but it [does say!]

SD [ but i ] think I think he did a pretty (slb) good job though I have to say.

P oh yeah I guess so.

SD yeah.=

P =anyway er (0.9) you know ↓me

SD i know [you.]

P [you ] know how [brash i am,]

PR [ .hh hh hh] hh [ .hh hh .hh hh ]

SD [i know. i know.]

P and it er he he's a big man you know doctor ↑kutcher

SD no.

P he's a big ma:n i mean he you know he could take m- medical advice to lose (. ) w- weight.

SD ha ha [.ha ha]

P [a ny]way. (h) he said(h) he said what are you complaining a↓bout and then he said I had to go round your belly button and I said these seams still don't match.

SD [ he he ] he that's it.

P [tss hh]

P he (slb slb) that I was you know just (slb slb)

SD spunky.

P yeah [that one.]

SD [ he he ] he

P (slb slb slb) had you told him about me before?

SD no:. no I said he that he would enjoy you.
P oh yeah! hh (. ) [ good. ]
SD [ slb ] slb) so erm so i'm not gonna be here next week.
P yeah i thought you were not gonna be here this week.
SD no next week next week so erm so (. ) probably erm doctor madi¬son
P that's good. [ who ] is he?=
SD [ well ] =she's the clinic director i don't know if you've met her [ before. ]
P [ no i ] haven't.
SD erm she might be the person who's gonna be the supervising doctor but you'll see the same people.
P "yeah" but is isn't today your reception?
SD today's my rec- no tomorrow tomorrow is that. . hh but then i'm going i'm going out to i'm going to to portland and seattle for a: erm
P beg[ging tour?]
SD [ a board ] meeting. he he . hh f(h)or a for: for our national association (. ) so,
P [ did you ] say board meeting?=
SD [ i ( slb ) ] =yeah.
P you're on the board
SD yeah.
P wow!
SD yeah i'm a marketing ( slb ). i'll give you a report.
P [ yeah sure. ]
SD [ he he ]
PR [ hu hu ]
SC [ he he ]
SD so erm so so bu- we'll start they'll start it next week.
P okay.=
SD =you just you know ask any questions.
PR doctor graham is going to bring his ↑ device
SD will.
PR will.
SD uh huh.
PR [ is gonna bring his device,]
SD [ tzt actually we have one. ] [ here. ]
PR [ oh ] we have one,
SD yes we have one so you can you can erm this week play with: with doctor madison get [ get her to ] show you more.=
PR [ oh okay. ] =i have [ no idea that's, ]
P [ now wh- this is ] what is is like an acupun¬ture
SD oh yeah it's,=
P =a ma¬chine
yes yes i mean this is it's it's stimulates it's the principles are very similar. (. ) let's just put it that way.

and it stimulates it, right.

( . )

because i'm my sister is going to ask me and i have to be able to explain it to her.

it stimulates in this in into under the car scar tissue?

uh huh.

( . )

( . )

( . )

( . )

( . )

because that's interesting.

but it doesn't penetrate the skin.

no i- it's, =

=er right.

it doesn't like acupuncture needles it doesn't go into the skin it's gonna be on top.

really?

uh [ huh. ]

[ yeah. ]

yeah exactly.

[ uh huh. ]

[ and it's] a stimulate the breakdown of the scar tissue,

uh [ huh. ]

[ uh ] huh.

well you got a good one to work on here.

he [ he he he ]

[i that's wha- ] oh that's exactly what i thought.

hu . hh

yeah.

so erm so you're gonna go ahead you're gonna take a look [ and, ]

[ yeah. ]

erm [ eyes and repeat the blood ] pressure,=

[ eyes and: blood pressure a gain. ] =again,

alrighty?

yeah.

yeah okay.

and so i'll see you in a couple of weeks.

[ alright. ]

[ and::, ]

okay.

big shot.

kh ha ha [ ha ha ] ha=

[ hh hh]
PR =sh- she's running out the crataegus tincture
SD tzt okay,
PR and: we are,
SD oh well!
PR discussing about changing to solid extract. [because that's,]
SD [i think that's ] a
PR good idea.
SD doesn't [have ] alcohol.=
P [what?]
SD =to have <crataegus solid extract>
P right.=
SD =rather than the crataegus tincture. erm because i think that it
PR okay? to go erm with the extract, rather than the tincture,
SD [ i mean do you think are you
PR am i okay, i'm not the one!
SD i'm s- i this is my recommendation.
PR alright that's enough for me.
SD it's it's an unusual taste. it's a little tart.
(0.9)
SD he he .hh he probably it tastes better.
P [well i like vinegar! ]
SD [ is that is? that o kay,] is tha- i mean do you think are you
PR okay? to go erm with the extract, rather than the tincture,
SD am i okay, i'm not the one!
SD i'm s- i this is my recommendation.
PR alright that's enough for me.
SD okay.
PR °huh,"
SD [thank you.] 
P [because, ][yeah sure!] i mean [i don't come down] here to tell
PR [ o kay. ] [hu hu hu hu ]
P [you what]
PR [.hh hu ]
PR [what you should do!]
SD [ he he he he ]
PR hu
SD that's it okay so erm so,
PR are you gonna have fun out there too?
SD i hope [so.]
PR [in ] portland?
SD yeah but i heard it was snowing there the other day.
PR snowing?
SD [uhhuh even {{if it was}} seven[ty ]
PR [so how mu- ] [how] much you gonna dispense?
SD [erm]
SD [oh ] do you me want to oh!=

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PR =yeah.
SD isn't it th- it's in a container isn't it,
SC yeah but should we do, (. ) do you [want?]
PR [just,]
SC just three quarters of a: teaspoon?
SD txt
SC once a ↓day
SD yeah. uh huh uh huh. and: er i need to sign this report. [(slb)]
PR [right]
SD [(slb slb)]
P     [ how ma ]ny times a day?
SC once it will be once a day so you're not,
SD yeah.
P     ( .)
SC and this is another one that you wanna: drink some water
SD yeah. uh huh uh huh. and: er i need to sign this report. [(slb)]
PR [right]
SD [(slb slb)]
P     [ how ma ]ny times a day?
SC once it will be once a day so you're not,
SD yeah.
P     ( .)
SC and this is another one that you wanna: drink some water
SD yeah. uh huh uh huh. and: er i need to sign this report. [(slb)]
PR [right]
SD [(slb slb)]
P     [ how ma ]ny times a day?
SC once it will be once a day so you're not,
SD yeah.
P     ( .)
SC and this is another one that you wanna: drink some water
SD yeah. uh huh uh huh. and: er i need to sign this report. [(slb)]
PR [right]
SD [(slb slb)]
P     [ how ma ]ny times a day?
SC once it will be once a day so you're not,
SD yeah.
P     ( .)
SC and this is another one that you wanna: drink some water
SD yeah. uh huh uh huh. and: er i need to sign this report. [(slb)]
PR [right]
SD [(slb slb)]
P     [ how ma ]ny times a day?
SC once it will be once a day so you're not,
SD yeah.
P     ( .)
SC and this is another one that you wanna: drink some water
SD yeah. uh huh uh huh. and: er i need to sign this report. [(slb)]
PR [right]
SD [(slb slb)]
P     [ how ma ]ny times a day?
SC once it will be once a day so you're not,
spontaneous with the patient and explain.

well thank you.

i like that part about it too.

sure! you can form a relationship.

that's it.

right.

uh huh.

you know with the patient and,

[i] is!

it's important.

oh it's it's it's the only way it goes as far as i'm concerned.

it is especially with someone like me.

.hh he he he he [he .hh]

[ o kay.] well have [ a good ] trip.=

[ bye bye ] =thank you.

[ he he he ]

[ are you go]nna be

begging too?

(,)

no i don't think so not this trip.

okay.

there will be that's i'll let you know with the next protocol.

ha ha ha o(h)kay ha ha ha

(slb slb slb)

bye have a good trip. {{SP leaves}}

okay.

okay. (slb slb)

jee! she's on the national board uh?

she ↓is

oh!

(0.8)

she doesn't act it does↓she {{PR turns down the light}}

oh.

too dark?

too dark erm perhaps can we p- yeah that's a good idea.

(1.3)

that's perfect.

(1.0)

okay.

now you're gonna look into my eye.

i am going to,

.hh i thought you i don't know that erm erm ginko erm ginko

couldn't find it erm coz doctor: erm halliburton was used to a

different one.
SC yeah.
P and then i think when doctor sandler when doctor sandler came in
i said i think it's up here.
SC okay.
P i [think]
SC [ al- ] al[right i'll t- ]
P [it it seems] to me.
SC i'll take a look so if you can look straight ahead,
P uh huh.
SC and i'm gonna just ignore the bright lights. just keep looking
SC straight okay?
((SC examines P's eye)) (13.8)
SC oh sure.
P hu?
SC i do see it.
P uh huh,
PR (you see it),
SC uh huh.
P uh huh.
SC okay.
PR okay.
SC ((to PR)) okay do you want this, do you wanna use try this=
P =i gue- [was it where] i said it was=
SC [he he he ] =it's yeah it is that's
SC pretty much exactly you have your optic disc right here. it's
SC just about at around eleven ten eleven o'clock from your optic
SC disc.
P tzt
SC so,
P ((to PR)) °what's my optic disc!°
PR [hu hu hu]
SC [ha ha ha] ha
PR .hh hu
SC we can show you that afterwards.
P okay.
SC so what you wanna do erm,
PR okay.
SC don't touch this one you only touch this.
P uh huh okay.
SC [focus on something over here.]
P [i had a feeling it was up] there!
PR right.
P is that yours ginko?
(0.5)
P no that's mine.
PR it's not mine.
SC so you're focused on 1183
(1.0)
PR okay.
1186 P is i-
SC okay? so once you're focused on something you wanna come have a
look straightforward. and you're gonna be coming in.
1189 PR uh huh.
1190 SC this way.
1191 PR uh huh.
1192 SC and just look for the red reflex.
1193 (18.7)
1194 SC no?
1195 (1.0)
1196 PR erm no.
1197 SC you don't see it okay we'll work on that later. [hh he]
1198 PR [uh o(h)]kay.
1199 SC i'm gonna look in your other eye too.
1200 (9.3)
1201 P you're experienced in this
1202 SC i've been practicing.
1203 P oh [is that what] it is=
1204 SC [ he he he ] =yeah okay so again just look,
1205 P uh huh.
1206 SC over my shoulder.
1207 (4.4)
1208 SC °sorry for the cold hands.°
1209 (7.9)
1210 SC okay just: your [right eye.]
1211 P [yeah yeah.] ye- you know though i'd i th- i was
1212 thinking, because .hh hh my father lost his eye. (...) it was shot
1213 out when he was erm delivering something to,
1214 SC [uh huh.]
1215 P [the kid]
1216 shot in the eye would (slb slb slb) so he lost his eye my mother
1217 my mother's eye, i don't know which one but anyway they: erm she
1218 was doing something a photography and the eye pull (.) down
1219 in the eye.
1220 SC oh,
1221 P and i know my father us erm and occasionally would wear a patch.
1222 SC uh huh.
1223 P txt and mother sometimes or maybe she had later erm later she
1224 had erm a hemorrhage or someth- coz she would she wore glasses
1225 and she put a a,
1226 SC shade to cover her [eye
1227 P shade to cover her eye. .hhh and i i it isn't bothering me today
1228 it doesn't pain.

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SC [uh huh.]
1230  P  [ or a ]nynthing like that you know? but it's uncomfortable.
1231  SC  right even when you lean forward no pain
1232  P  no!
1233  SC  okay.
1234  P  no i 'll lean backward forward,
1235  SC  oka(h)y. he he he
1236  P  alright.
1237  SC  don't don't fall back
1238  P  alright. [ha ha ha ]
1239  SC  [he he he ] .hh
1240  P  but no the- then you'd have to (slb) my bottom as well!
1241  SC  he he that's rights. .hh=
1242  P  =anyway erm so i was wondering the only part of it that seem to
1243  SC  to bother me, to erm
1244  SC  okay,
1245  P  you know not terribly but irritatingly you know?
1246  SC  uh huh.
1247  P  and i tha- (slb slb) can't do that you know, so (slb) i w- i was
1248  SC  wondering if if erm if i should wear a pa- it does affect my
1249  P  sight you know because it does affect [ it. ]
1250  SC  double vision?
1251  P  no.
1252  SC  er- you're just or you're just havin- whether when you say
1253  that
1254  SC  it affects your sight how,
1255  P  oh well it we- it sometimes it blurs,
1256  SC  okay,
1257  P  alright. and then when i'm looking with both eyes it affects
1258  thee: the other part i mean if i cov- if i cover my eye my
1259  vision i'll my left eye is perfect.
1260  SC  right.
1261  PR  °uh huh.°
1262  P  you know but sometimes it will do that,
1263  SC  .hh erm
1264  PR  decrease the vision?
1265  P  ...
1266  PR  side?
1267  P  hu?
1268  PR  decrease the vision.
1269  P  (.)
1270  PR  ((indicating right side of eye)) here.
1271  SC  let's try.
1272  P  ...
1273  SC  hold that for a moment. .hh okay well i'm gonna ask you to look
straight at me.

on your nose?

right at my nose.

okay.

and tell me when you can see that my fingertips i'm gonna be moving them like this. [okay?]

[i can] see you.

hh okay.

now.

okay.

now.

hh hh i can't do the other arm. hh ha

i'll do it.

uh?=

=i should have thought about that so if you stand, erm

(0.9) there you can look at me and ginko is gonna do the hands.

coming from back?

yeah.

(0.5)

yep.

did you see em on both sides=

=yeah.

okay.

(2.1)

yeah.

(2.2)

yeah.

okay.

both sides.

okay.

(2.0)

yeah i did [yeah.]

[ o- ] okay you looked,

i looked but i saw it [before i looked.] 

[okay you saw it ] okay. .hh th-

seems to be fine.

seems to be fine okay. just follow my erm the tip of my finger.

(.)

just with your eyes.

(6.6) ((knocks a the door))

come in

(slbl slb slb slb slb)

okay. .hh

i just wanted to get you going so you didn't miss

[(slb slb slb slb)] the dispensary.=

[ the dispensary, ] =okay erm she's still i
didn't see the hemorrhage last week in her right eye but it's definitely [still there.]
[ i told ] her where it was!
she knew exactly where it was too.
i told doctor sandler.
(i)
i said it's over here.
uh huh.
i think you [know ] that's all i could say.=
[yeah.]
i said i think it's over there.
uh huh. uh huh.
so,
yeah well it just, to me it's just: er erm another indication
that we have to hit your blood pressure.
oh yeah. i know i know.
[(slb slb) to the dispensary [(slb slb)]
[ i'll i'll look it up]
[ o kay ]
okay that's you've read enough i say.
[yeah.]
[right] yeah yeah. you think you keep it on mind i know that so,
okay.
right so,
th- the crataegus,
yeah.
that's good for that.
really?
yeah it it helps with vascular integrity,
do you have any idea of how long it will take because i can
still see ye you know,
(.)
red.
uh huh,
(it's it still bleeding by the way)
did you see something?
in i-
it's still bright red so,=
=right red.=
i don't know again i didn't see it last [week ] so i [don't]
[right] [right]
know what the=
=yeah erm
[and you di- you d- ]
[i don't know the answer to that and i think it just it all
depends on the different factors that is all,
P uh huh uh huh ye- you didn't have your, (.).
PR okay so,
P with your pulse and blood thee: erm
SD diagnose. hhhh
P [ophthalmoscope.]
SD [ he he he he ] [actually] there's somebody who told me was
PR [okay i, ]
SD gonna teach me how to [ use ] that one. ha
PR [check]
SD ((looking at SC)) and that was you. i [thought] [ it was.]
P [ ha ] [ ha ha ]
SC [ he he ]
P [ha ha ]
SC [he .hh]
SD she's gonna teach me and,
P [ha ha ]
SC [hh hh ]
SD right. (slb slb)
P [ but that ]
PR ((talking to himself)) [ºcheck the] blood pressure againº,
P that will is a doctor is he ↓not
SD he is but he:
PR ºhe's a m-º
SD he would  [ rather just be will. ]
PR [º me di cal doctor,º]
P hu,
SD he'd rather just be will here.
P okay.
SD so we don't usually call him [(slb).]
SD yes.
P but he kept insisting the other way i got him,
PR hu hu
SD that was kind of winking. ((h)slb slb) going no i'm just will,
SC he he he
SD that's it. okay so,=
P =what type of what type it's did he have a specialty as a,
SD dermatology.
PR dermatologist.
P dermatology?
SD yes but he's come over to this side.
P huh!
(0.8)
SD way over to this side.
P yeah.
SD okay so you guys are almost done.
SC [yeah.]
P [al] right.
SD good.
(.)
SD bye bye.
P bye.
(1.1)
P where is she gonna see you?
(.)
P because i wanna get some kali bichromium for my sister.
SC oh (.). erm that you can just go down and,
P i know that. [i ] know that. =
SC [yeah.]
P =but she said she was gonna see you. is she gonna meet you down
at the dispensary or what?
SC no.
P oh no,
SC she's gonna see us later on check out. i'm gonna get this for
you?
P ye- could you pick up the kali bichromium i'll give you the
money for it,
(.)
SC sure.
P i get to pay for it.
SC yeah you gonna have to pay for it first let me, (.). i'll be
back erm let me see the:
P we- you know what i did last time i called doctor erm doctor
pitt,
SC uh huh,
P .hh and i said (.). you know it's gonna be a flying trip.
SC right.
P and she said well i'll put the bill at the desk and:
SC yeah.
P so she can do that and i'll pay for it.
SC okay okay.
P okay?
SC yeah.
PR ((measuring blood pressure)) yeah i have to do it again so,
P erm i'm sorry.
SC is it in[to] way you got it the right way yeah?
P [my]
PR =yeah.
P pfwouoi!
P pfwouoi!
SC hh .hh hh
P
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participated like a volunteer work?

yeah

and: i went to ghana in africa.

really

yeah it was it was quite experience

[what did ] you say the peace corp

ghanah in africa.

no- do you went to ghana.

yeah

how did you go to ghana? why did you go to ghana?

because there's a volunteer work and i par- i'd i participated

like that's an interasia's some kind of erm group erm

yeah

sponsoring? and: you know all kind of from the all over the

place slb slb slb together .h discussing all kind of issues

and exchanging their view and belief, and then looking for like

a construction,

what- what slb slb slb group or just

erm i don't know exactly but i think so (. ) erm=

really

yeah we worked at the hospital helped those patients.

yeah,

and i really enjoyed it!

that's great!

yeah

so i began to realize you know maybe medicine will be,

uh huh

you know a really excellent field.

well did ye in well in ghana, erm did you er did you get into

herbs and things like that?

erm no we didn't discussed about that but you know you know like

people that i met,

[yeah]

[it's] really beautiful.

yeah,

and i really enjoyed it (. ) [ so ]

[uh! ] slb slb slb slb slb slb was

he slb) he was in ghana wasn't he

yeah [yeah yeah. ] yeah right. right right.=

[yeah yeah. ]

=but tha- that was

before your time.

uh huh yeah.

that's longer ago than,

yeah so let me [get the blood pressure.]

[that's interesting. did ] you get there from
japan? or,

PR  erm from japan yeah.
P   yeah
PR  uh huh.

((PR puts on the stethoscope)) (5.3)

were you a hippie?

((PR is measuring blood pressure)) (30.8)

how was that?

PR  yeah it's high erm that's=
P   =i wonder why=
PR  =that's your right arm,  

((PR writing on P's chart)) (5.3)

PR okay

((P blows her nose)) 

PR okay

P i mean you [had be]come an accountant a:nd still you were still,  

PR            [so:: ]

PR  uh huh

P hu!

PR  lizabeth how's your stress you know?
P   how's my what
PR  how's your sleep,  

P .hh you know i g- well uh uh pf- my sister will wake me up and break into my sleep coz of nerves you know?

((PR checks pulse first on left and right sides of P's neck then on her chest)) (54.0)

P o'kay

((P blows her nose)) 

PR .hh yeah seems to be fine,

PR            (.)

PR  a:nd

P you checked my carotids.

PR  uh huh.

P okay.

PR  yeah so you know all that right? or [may ] be,=

P [well] =doctor doctor

halliburton sai- said

PR  [uh huh.]
1597 P  [ca ro ]tids.
1598 PR  right.
1599 P  so,
1600 PR  so:, ((SC comes back))
1601 SC  hi.
1602 P  hi.
1603 PR  okay.
1604 SC  okay i wanted to just check with you before they printed
1605 everything out.
1606 P  hu?
1607 SC  the crataegus solid extract,
1608 P  na-
1609 SC  is approximately twenty nine dollars
1610 P  pfui! i [brought a lot of money.]
1611 SC          [ it it's o kay it's a ] larger container.
1612 P  yeah.
1613 SC  so that's okay?
1614 P  yes yes.
1615 SC  and wha- erm the you want a kali bic
1616 P  yeah.
1617 SC  what potency do you know?
1618 P  thirty six [is what] she usually takes.=
1619 SC          [o kay.] =okay i will go ahead and
1620 (.) print up the bill for you then.
1621 P  okay.
1622 SC  °okay° are you all set?
1623 PR  tzt yeah erm i took the blood pressure on (pulse) and:,
1624 SC  okay.=
1625 PR  =i got two twenty over eighty one ten over ninety two.
1626 SC  okay.
1627 PR  so=,
1628 SC  =yeah that's,
1629 (1.?)
1630 PR  that's really high and:,
1631 P  WHAT? TWO ↑TEN
1632 PR  [uh huh.]
1633 SC  [and two] twenty!
1634 PR  two twen[ty yeah.]
1635 P  [really? ]
1636 PR  on this side so should [we just speak to ] doctor,
1637 P  [why would that ↓be]
1638 PR  halili[burton before ] we,
1639 SC  [yeah i think so.]
1640 P  what?
1641 SC  we're gonna talk to doctor halliburton before we send you out of
1642 here.
why? just because that is a change in your blood pressure from the last time you were here.

yeah [i] [was] one sixty eight or something,

[uh] [huh.] ={right}

just wanna erm check it with her befo:re,

sure!

we send you on your way.

okay.

okay.

(3.5)

okay i'll be back

shortly.

uh huh. {{SC leaves}}

so you said your sister keep waking you up

huh?

your sister keep wake wake you up?

oh yeah.

yeah?

yeah she wake up in the night like this morning i think it was i sat with her for a while she gets this this is something,

right,

she wakes up,

uh huh,

and then becomes frightened.

uh huh,

and very nervous.

okay.

so she won't calm.

uh huh.

you know and: (0.8) yeah she does she does wake me up.

uh huh.=

maybe that's what's causing it you know,

okay.

and: (1.8) .hh ye you know something though

((PR writing on P's chart)) (2.0)

my cuff my cuff was higher than usual but it wa(s)nt like that.

what do you mean there

erm yeah my cuff i have a cuff you know? e:r

uh huh. was higher

we- higher than,
PR at home?
P w- yeah it u- not higher than that.
PR uh huh.=
P =not higher than that.
PR okay.
P but it it's it's consistently lower.
PR constan[tly lower.]
P [but it was ] it went down after a while.
PR huh okay.
P so,
PR .hh okay.
P why should it be that high,
PR uh huh.
P i don't know.
PR yeah erm it's really high and,
P [yeah i know.]
PR [so you should] pay attention to that number.
P that's erm two twenty
PR yeah two twenty over eighty .hh this number it will be same but
PR this higher num[ber
P uh huh,
P it's a little high.
P a little h[igh
PR ((smiley voice)) yeah not little but it's really [high. high.]
P [it's high.]
PR yeah i know i know.
P so;
P especially coz i told doctor: gillian i remember that it was
PR one fifty eight,
P [uh huh,]
P [o ver ] something last time.
PR right right okay.
P who knows,
PR erm did you eat today?
P yeah.
PR yeah, breakfast and lunch?
P hu?
PR breakfast and lunch?
P well er we- i had a meal [for breakfast and ] then i had this=
PR [o kay. uh huh.]
P =peanut butter sandwich.
PR okay.
P and: (1.2) .hhh i really i'm very frustrated.
(0.3)
P and that is probably pushing my blood pressure up.
PR uh [huh]
[may] because i: (1.8) everything is going wrong [you know?]

(0.5)

and i wanna get things done and something is stopping me,

(0.2)

uh huh=

=mh i'm very frustra- and then another thing that really
frustrates me is we don't have transportation.

(0.3)

uh huh= [uh huh]

[you know] a car and if you live where i live,

(1.1)

.hhh you are in the middle of a desert.

(0.3)

[uh huh.]

=i think i'd like to live over on east side Bridgeport.

right right. ((SC comes back))

=uh huh,

(0.5)

=and i haven't got transportation so,

(0.8)

you know if i: (1.2) and i keep thinking so if i if i could get
there, i could do it, if i could get there and it's a constant
constant frustration to me. that may be contributing,

[i d- i think all of ] those things do.=

[to the high blood pressure.] = yeah,

and the fact that you're not sleeping, and: yeah.

Yeah, ((knocks at the door SD comes back))

we have to actually get you downstairs to [to] pay for the the con-

you have to get me downstairs [to pay]
PR: hu hu
SC: yeah and so that's coz they're gonna be going home soon and
P: what time is it?
SC: it's five twenty five.
P: wow!
SD: yeah. (. .) erm (. .) i'm sorry.
SC: that's okay.
SD: yeah erm so your blood pressure is higher than its high normal
today.
P: oh yeah.
SD: and: erm=
P: =i don't think i've ever hit two hundred here.
SD: u:h, you have before. (. .) you [have before.]
P: [oh i have,]
SD: yeah erm=
P: =but it it's lower at home.
SD: .hh well that's what i want that's what i want you to do. i i
have a feeling it's kind of th- it's a little bit because of the
excitement we're doing kind of new things today and i'm
[that what i'm] thinking,=
P: [that's possible!]
SD: =.hh but what i want you to do is when you get home, (. .) i want
you to check it because it's you know anything else going on as
far as i mean it's just regular stressful things that are
happening
P: hh hh regular stressful things for real are pretty=
SD: [yeah.]
P: stressful!=
SD: =yeah.
P: now my sister my sister will wake up maybe you know something
like this,
SC: i'm gonna excuse myself and just maybe i'll take your the money=
SD: =order [yeah]
P: [sure]
SC: erm so [that] they can go home and we can make sure [you'll] get
P: [sure] [ sure ]
SC: your supplements.
SD: right.
P: anyway. erm (0.9) my sister is a nervous type anyway and she's a
worry. well anyway she's she wakes up in the middle of the
night,
SD: you have erm for for mel i think she needs to,
P: hu?
SD: the- er everybody's leaving. (h)as far [as (slb)slb]
P: [o kay! ]
we just wanna make sure you get you know, your supplements and, \( \text{P YEAH YEAH YEAH YEAH YEAH!} \)

the kale bic for your sister.\( \text{SC [the ka li bic for your sister.]} \)

alright where am i where am i? where am i what am i doing here, i had money here (slb slb slb) all those're ones right no \( \text{P [ alright where am i where am i? ] where am i what am i doing here, i had money here (slb slb slb) all those're ones right no} \)

don't °where is it where," ((drops some banknotes))

oops my goodness. okay well so erm basically, \( \text{SD oops my goodness. okay well so erm basically,} \)

you see? i came prepared to pay. \( \text{P you see? i came prepared to pay.} \)

the kale bic for your sister.\( \text{SD [the ka li bic for your sister.]} \)

so you do want you to check, and your follow up were they rescheduling thee:, \( \text{P yeah and he,=} \)

-ultrasound .hh and when do you have a follow up at park city, \( \text{SD =ultrasound .hh and when do you have a follow up at park city,} \)

yeah in three weeks from last week. \( \text{P yeah in three weeks from last week.} \)

okay. \( \text{SD okay.} \)

he wrote it down. \( \text{P he wrote it down.} \)

okay. \( \text{SD okay.} \)

in doctor's script. \( \text{P in doctor's script.} \)

okay. hh \( \text{SD okay. hh} \)

°in [doctor's script think i told you°] \( \text{P °in [doctor's script think i told you°]} \)

[because i you know i this ] is th- i mean we're you know we your blood pressure has always been of concern, but when we're heading up into you know very dangerous territory. and i don't want and especially since with your eye \( \text{SD [because i you know i this ] is th- i mean we're you know we your blood pressure has always been of concern, but when we're heading up into you know very dangerous territory. and i don't want and especially since with your eye} \)

yeah, \( \text{P yeah,} \)

you know it's it's one of those things where it's we need to get it. we need to get it down. and what we're doing isn't bringing it down as much as we would need it to be. \( \text{SD you know it's it's one of those things where it's we need to get it. we need to get it down. and what we're doing isn't bringing it down as much as we would need it to be.} \)

yeah. so? \( \text{P yeah. so?} \)

so: i just want you to check it when you get home, and erm
actually i'd like you to give me a call. and let me know. (.)

P [here?]

SD [ if ] it's gone down. uh huh. tzt you can call  erm, let me find
out what extension this i- cause i don't have my extension any
more. so erm actually i'm gonna call you tonight. that'll work
out, that'll be easier.

P okay.

SD okay? .h and then we'll decide how to proceed.

P yeah.

SD okay?

P yeah well it's erm that i- erm we've had erm a couple of very
bad days with of course you know, two those yesterdays affect me
today.=

SD =right, exactly .hh but er i don't wanna you know we talked
[ a bout this,]

P [you're getting] nervous.

SD well i don't want there to be something catastrophic to happen,
P yeah.

SD and you know we,
P yeah.

SD and: i it would just make everything worse.

P yeah.

SD okay?

P well i b- i: but i it's so is she and i wanted to talk to you
about that ↑any↓way because she wakes up,

(0.9)

P like, four o'clock in the morning maybe? .hhh and she calms and
she say just (0.8) i'm erm (0.6) fearful you [know, sh-]

SD                                              

P i'm afraid she said. she so we sit and talk and she say put your
arm around me and just ((miming putting head on shoulder)) rest
it on my [shoulder. and then]

SD           

P she calms down! .hhh and this happens when she wakes up!=

SD =uh huh.=

P =and i think what is going on? i said this is ye (0.3) i f- uh
huh i feel almost if it's a physical thing going on.

SD uh huh.

(0.3)

P you know, we sa- maybe it's some blood sugar drop, or something
like that, [you know,]

SD [uh  huh.]

P because she she's (((slb slb slb slb))

SD [have you talked ] to your doctor? [i mean]

P [e::rm ] i

289

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1919  
1920 P  erm
1921 PR  ((to P)) this is your number right?
1922 (.).
1923 P  yeah that's right.
1924 SD  ((to PR)) thank you.
1925 P  anyway she: (1.4)  erm she's gonna see him wednesday. and it's
1926 gonna be a tough week for me anyway, yer=
1927 SD  =okay,=  
1928 P  =you know.
1929 SD  well er- have you been (.). smelling the flowers and blowing
1930 out the candles?
1931 P  no i haven't had the time.
1932 SD  well we'll do it right now. it tha- wa- that has helped in the
1933 past so, ((taking a deep breath)) .hhhhhhhh
1934 P  erm i know. okay i will.
1935 SD  ((breathing out)) pfhhhhhhh
1936 P  [ not now.]
1937 SD  [ o kay?] not now?
1938 P  i don't feel like to now.
1939 SD  okay.
1940 P  i'm not an exhibitionist.
1941 SD  okay alrighty. so erm but do do go ahead and (.). monitor it and
1942 i'll give you a call.
1943 P  yeah.
1944 SD  alright?
1945 P  okay. yeah well when i would you, now do you have any idea my
1946 sister, (.). could could be?
1947 SD  erm,
1948 P  what could be? coz she she's going†nuts with it. you know,
1949 PR  uh huh,
1950 P  why did she wake up with these, i guess they're like a panic
1951 Attack! she come into it right away!
1952 PR  but she's on the chemo right now right now.
1953 P  hu?
1954 PR  she's on the chemo right now. right?
1955 SD  that could be cortisol levels.
1956 P  hu?
1957 SD  it could be cortisol it's hard to say. it's hard to say.
1958 [coz it's,]  
1959 P  [it could] be what?
1960 SD  i was thinking cortisol levels in her dreinals, maybe just
1961 pumping up the cortisol. and it's making her incredibly anxious.
1962 P  oh she's anxious!
1963 SD  yeah.
1964 P  with the doctor keeps pun- oh i forgot there was a protocol two
into the bridgeport paper yesterday, .hh and it says you: to
overcome weight gain you take this drug,

SD uh huh,

P and then that affects your (slb slb slb). so you take a drug to
(slb slb slb slb) and it comes right to the end and it says
the last one they give you will increase weight. you know but i
was (slb slb slb slb) but it it's so true.

SD uh huh uh huh.

P you know it is so true. you're taking so many drugs! [well]
[uh:,

SD

P you know me on drugs anyway but:,

SD i know i know. but if we don't get your (.) blood pressure
down, i mean that's i know doctor gillian talked to you about
that [that' s:,]

P [oh yeah! ] he did. also didn't i say

SD absolutely not!

P i \downarrow know but let's let's ((tapping head with finger)) (0.7)
[i don't wanna bore,]

P [ab so lu te ly ] look !

SD i know,

P i'm [the one that]

SD [ha ha ha]

P had this.

(0.3)

SD right. no but: i'm i'm concerned about combination. (0.3) of
what's going [on.]

P [oh,] i'm sorry doctor.

SD i \downarrow know well so we're gonna get to: (0.4) do some
[deep breathing, and all this,]

P ((shaking head)) [erm  erm mh  and i went ]

through. when i did and i so told him

SD uh huh.

P gave him the wrong figures.

PR uh huh,

P but i saved all of thee the strips that came in.

(.

P i had three courses of norvasc.=

SD =uh huh.

P which has a side effect of muscle weakness.

SD uh huh.

P and then a- avopro.

SD uh huh.

P side effect [of mu]sclle weakness.=

SD [uh huh!] = (slb slb)

P and i looked ta him and i said, (.) i told him that. i was wrong
in my er in i'd said six b- anyway. and i w- and i said and what

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is an aneurysm?

((nods))

(1.9)

that's what i am thinking.

uh huh,

.hhhh and you will find that i am extremely stubborn.

((0.6))

i: know that. well and also i think let's do the crataegus.

((0.3))
solid extract and see where we get.

okay!

okay?=

=alright good.

alrighty! i'm not i'm not here to do battle. ha [ ha]

[hu?]

i'm not here to do battle i'm just:

i won't do you any good.

i know it. ha ha ha ha ha .ha [okay.]

[so w-] [i'm ter]ified. =

[uh huh.]

i am i mean taking that stuff would raise my blood pressure!

uh huh. also i'll give you a call. coz erm i wanna check it and

see what it is,=

=okay!=

=and so when you get out of here and there's,

yeah.

less excitement.

uh okay.

i've seen this he he alright.=

=jee- this this this discuss the one on ^tape hu

hu hu.hh [so you wanna, ]

[(slb slb slb) ] [ he he ] he=

[long time]

=so lizabeth you wanna say something at last,

[no oh!]}

[he he ] [ he he]

[to the] camera? hu hu

actually i think le[tisha's got some ]thing she wanted you to

[i'm the moon star,]

fill[out something,]

[ no tape star.]

hu?

letisha will have something to (slb slb). hey here she is.

(.)

alright.

okay.

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okay so you're i think you're all done.

[o ] [kay eah.]

[hi ] [le ti]sha!=

[hi!]

=alrighty bye bye.

((to the camera)) thank you very much. [hu hu hu]

[he he he]
that was that wasn't thee e_r. it was the: gk (.) erm
(slb slb slb) [chi ro ] clinic.
[uh huh.] (0.6)

.hhh i erm hhh

°that's not my pen.°
(0.8)

started da (0.5) the cranberry juice and i just:
did so much cranberry juice, and i er and the symptoms
were being relieved.
(0.6)

before erm the medication (kept down)
(0.8)

they put me on (seperol).
(seperol)?
((PR writes on P’s file)) (2.2)
five hundred milligrams twice a day five days.
((PR still writing)) (5.7)
and carol: (1.6) cultured my urine
(1.3)
on (0.5) monday.
(0.8)

and there was no infection. she said that thee (0.4) the
p_h was
five which was low, the specific gravity was like one
point three
five which is high
(0.5)

.hh and at the same time i went over i and played with
your blood
sugar. then and a couple of hours after eating my blood
sugar was
two thirty::
(0.9)
two, two thirty four.
(0.7)

after two hours?

after two hours.=
=yeah it's a bit high.

but (0.5) .hh erm er normally i'm really careful about
what i eat,
(1.6)
P  erm i had a caribbean salad, (0.4) which they probably
43 loaded with
44 sugar and i didn't (even) think about that.
45 (0.7)
46 P  so i don't know what my sugar's been like,
47 (1.1)
48 P  .hhh coz i <can't find my glucometer!>
49 (1.8)
50 P  a:nd once upon a time i [ was ]
51 PR ((talking to SC)) [thanks.]
52 P  told that you (here) would be able to help me get a free
53 one.
54 PR  i have no idea about ↓that
55 P  oh that would that was [what a  previous=
56 PR  [because erm,]
57 P  =naturopath told me.
58 PR  coz if we were able to get a free one, i think we would
59 a:ll be on
60 a (bandwagon) to get a free one.
61 (1.0)
62 P  oh sh- i was told that you ought to help me get a free
63 one.=
64 PR  =uh=
65 P  =coz i don't even know where it is and i certainly .hhh do
66 not
67 have an extra fifty dollars to go out and by a new
68 PR  .hhh[hhhhh]
69 P  [gluco]meter. [(fifty or hundred. )]
70 PR  [well i'll ask the ] i'll ask the
71 clinic
director but that's news to me have you heard that? (. ) at
72 all
73 SC  well i know you can get (0.4) (slb slb slb refunds on)
74 (0.5)
75 (slb)[(slb slb slb)]
76 P  [ but you go ]tta find it. i mean (0.4) i
77 stopped using it (c)oz the battery died,
78 right,
79 P  i went out to buy a new battery (slb slb) the battery
80 (slb) now
81 SC [the strips?]
82 P  find (slb slb) but (that's not) [the] strips.=
83 SC    [no,]
84 P  =i can't even find a glucometer!
okay.

((sniffs))
i have no idea where it is.

i mean i picked one up at c_v_s for fifteen bucks.

[fifteen]

[yeah.]

[what] kind was it?

c_v_s brand.

oh [ o kay.]

([it's their] their model which was guaranteed to be as
good as

any any other one. so they just .hmm ye know they just

want you to

buy the things that (you use buying) these,

[thee strips,]

[( slb slb )] so (0.5) erm i have no as i said i have

not heard

that. i didn't know never heard that in the clinic [so,]

[oh!]

gary

yeah?

had said that it was possible,

.hhh no. ((clears throat)) i'll ask that's all i can do

and

[ uh huh.]

[find out] about that °o[kay?]°

[ are ] you dressed up for this,

did you

know this was happening?

erm no:. she says actually i'm underdressed and should be

wearing

a tie °(slb slb slb)°

oh this is a nice shirt!

oh thank you.

((PR is writing on P's file)) (4.5)

and of course we have a glucometer down in the lab. so

yeah.

erm that can be used whenever we can check your glucose,

erm when

you come in.

((PR is writing on P's file)) (4.5)

.hhh hhh a(hh)nyway hhh (0.8) tzt ((clears throat))

(0.5) so what

else is going on any ANY, erm
changes since you've had thee, erm

well let's say i noti- i noticed a couple of things one,

i got really angry and i liked bitched at jennifer and we we
talked

over some stuff and it was stuff that had been irritating

me for a

long time. .hhh and i c- i cs- then i realized

is jennifer the erm house (slb)?

that was yes. that was jennifer brando my roommate.

okay.

(0.6)

tzt and: (0.5) then i went hey wow! you know i took this

stuff

maybe it had something to do with it, .hhh and:

and that that anger was out of the ordinary? or it [just]

[ oh ]

yeah. i

mean she held up something and i punched at it. i fe(h)lt

mu(h)ch be(h)tter!

[uh,]

[ha ] ha .hhh i don't do that often.

°u:h° okay.

erm=

=so it's kind of unprovoked anger, more or less?

(0.3)

oh, it was like fed up.

(0.3)

the the,=

=so,=

=straw that brought the [ cam ]els=

[(slb)]

=back and and: (1.2) you know? no. (1.7) i i figured her

husband's

a saint and i'll be up for my my medal when [when]

[ hh ]

she moves out in a year and a half.

(1.5)

okay .hhh and=

=because she's daft!

(0.9)

.hh hh

she's ↑what
what does that mean, (1.2)

"ha ha ha ha ha" .hh she just has a different way of doing things.

right .hhh "uh so" other than that, what else has you noticed?

(0.6)

erm (1.2) .hh then er i went out and ate some stuff that i wanted
to i didn't feel guilty about i,

(0.4)

i din't, (0.5) referred to it as i've been bad,

(0.6)

although a cou- er er later on i did but [but]

[was] it bad

food?

(0.6)

i mean was [it something that we nor ma]lly=

(oh it was something it was,)

=say i(h)s bad,

.hh no. it was: ins- it was something with carbohydrates

in it.

(0.7)

(chai,)

which i don't normally eat.

(0.5)

what was the food what was it (slb slb)?

oh i don't (. ) remember [(slb)]

[don't] remember or don't want to
tell me,

(0.4)

no it's okay. it's only i don't remember. [this is]

[ okay. ]

(0.4)

just=

=so,=

=about two weeks [ago. ]

[okay.] so it just something that in the past you

were saying maybe >i shouldn't have and kind of feel a
little bad about it and (this [time slb slb])?

[no er i ] didn't feel

[(slb slb) [(slb slb)]

[ gui lty] a[ bout it.] i just went back and you know

tried to eat normally i i had been badly (this desire) to go for

chinese fo(h)r

a fe(h)w da(h)ays, .hhh it does happen occasionally he he

.hhh

like hhh ha i haven't had any food to go out in a

restaurant,

(1.1)

erm hh (1.1) tzt i haven't had coffee for two weeks now.

really?= =SINCE SINCE (1.1) the wee- the monday before i got the

pills.

(0.8)

well the monday that week.

(0.9)

okay? [i haven't]

[uh huh. ]

had any coffee i guess it's this is what week three now.

uh huh.

(0.8)

and still i'm enjoying the taste.

(1.6)

i still have my diet coke on occasion but i'm not having

that

every day.

(0.4)

sometime. sometime.=

=you you you were having it every day

i generally i would have [ one ]

[yeah,]

a day, skip a day,

(0.8)

but i haven't had one for, (0.9) few days.

(1.7)

and i still have a twelve pack in my house.

(0.5)

"okay."°

ha ha ha ha .hhh but i've like been fixing yogi tea,

(0.7)

.hhh and having that.
tzt .hhh a::nd erm hhh (2.7) oh! i do have (0.8) erm (0.6) tzt
some form of (0.8) erm skin irritation under my armpits::,
okay.
and carol doesn't know whether it's a s- strep or (stapper), or
yeast or whatever, it's something i've been playin with
for month.
i honestly think it would be more towards (1.7) (slb slb
slb slb)
a yeast. because .h (0.7) i'm er heavier than i had been,
[uh huh.] [ a:nd ] my arms aren't getting the air that they might
have
before. because i'd also had some at the size of the
[ aprons ]
[((sniffs))][((clears throat))]
((clears throat))
[( slb slb )] (you’re familiar
with the term),
(0.5)
yeah.=
=er that yeah okay the fat pad and (slb slb) round okay so
i had
some ((touches waist and lower back)) here and here
earlier in the summer. .hhh
okay.=
=and i i was dealing with thee acupunctures for that, and
they
were gettin me on some sort of (1.0) herbal, (0.7) and:
(1.0)
anyway i still have some [under]
[okay.]
my arms.
both arms?
both [yeah.]
[ is ] one worse than the other?
(0.7)
tzt i like to think so, or i don't like to think s(h)o
whatever.
.hhh erm but erm i haven't shaved my pits for a while
ei(h)ther.
s(h) o yo(h) u mi(h) ght hav(h)e to . h judge fo(h)r
yourse(h)lf.

(1.8)

PR [uh  huh,]

P [i i'm] not a big armer pit shaver er er pit shaver
(light)

shaver.

but that's not new that's that's something you've been
dealing

with for a while,

yeah several months.

(1.7)

P but it doesn't itch

((PR writing)) (2.4)

just sort of (bear),

(2.6)

PR okay. anythin [else,]

P at ] one po- at one point i thought was

related
to er (0.4) i'd bought some new clothes and i hadn't

washed them.

PR uh huh,

(0.8)

P ((touching armpits)) and i had done this and i thought

maybe it

was part of the an irritation with that.

PR okay.

erm

((PR still writing)) (3.7)

P anything else?

(1.1)

P not that i can really think of. erm you know i've been
tired,

(1.0)

P but erm

(1.5)

P i haven't gotten sick like th- besides the ur- u(h)rinary

tract

infection, i haven't got any sick like the students in my

class=

PR okay.

P everything is my (. ) immune system's like (shut) but

that's

another story.

PR ((writing)) tzt
.hhhh tzt well you know erm of bowel movements, erm

how often are you going,

uh uh two three times a day.

two three times a day

uh huh. which is the normal for me.

((PR writing))

((sniffs))

formed, loose, watery?

e:rm generally formed.

uh huh.

erm i can't tell you if the if the fl- i'm i was going to assume

that they're sinkers because the erm landlord put in a

new toilets (and stuff), and the(h)re's not a poo(h)l water

hh

[ºokay.º]

[or lot ] of a pool water in there any more. .hhhh erm hh

so

sometimes they are less formed than others.

okay.

but they have not been watery.

okay. do you have to wipe a lot?

(1.8)

e:rm

do you get it easy?

yeah, w- d- depend. er

so at times is

yeah,=

=multiple wi(h)pe,

oh yeah. but er i would probably do a multiple wipe even

if i
didn't have to because [  i ]

((slb))

would want to be:,

right but er,

(careful).

so sometimes, okay. (0.5) well sometimes i ask somebody

when they

go well you know if it's loose or formed and i guess (slb
slb slb)  
another way of .hhh figuring that out is if they have to  
wipe more  
than normal.  
no i i haven't [      a l m o s t      ]  
[((clears throat))]  
crapped my pants no.[it's not]  
[o kay.]  
that bad. excuse my French.  
.hhhh and erm other than the fact you've had the urinary  
tract  
Infection, how's y- your urination normally?  
well i've been trying to drink a little bit more water so  
of course i'm drinking,  
uh huh,  
er more and i'm peeing more.  
so how many times a day roughly? on average,  
o:h,  
(1.1)  
erm i i try to if i feel an urge to avoid go between  
classes or at  
the break. .hh even er don't even if it's just a little  
don't wanna (0.8) dance in my hhh s(h)ea(h)t. (slb slb)  
uh huh.  
because if i'm in class i'm drinking fluids and,  
uh,  
.hh like this is,  
((clears throat))  
it's like this is artif- artificially sweetened peach tea  
that they they sell from (selby), .hhh it makes me  
thirstier. you know  
if i drink water i'm not as=  
=so [you're drin]king=  
(thir sty. ]  
=diet, that's a diet drink?  
(0.6)  
the- this particular one yes.  
sounds [like there's sa]ccharine=  
[it's the (slb)]  
=and (slb slb slb slb)or something  
[((it's slb slb slb slb))]
[i think it's probably sorbitol.]

[uh,]  

*[okay.]*

(0.5)

.hhh normally i'm if i'm at home i use (slb slb).

(1.1)

[i don't]

[uh huh.]

i don't use any any kind of saccharine or anything like that at home.

{(PR writes on file)}(3.2)

but i've been drinking this and it was (0.4) one of those twenty ounce bottles and this thing full of ice.

(0.9)

and i had a full thing of water today.

(1.3)

so,

(slb slb slb slb slb slb)?

(0.6)

oh i had some water before i left. but .hhh

(0.9)

erm we're talking i probably drank sixty ounces of water t- er fluids today.

(3.3)

coz that's thirty two ounces.

(2.5)

and with the ice it got filled completely and then i poured some more stuff in it.

*[okay.]*

so it's over sixty ounces of fluids. so no wonder (slb slb) i'm going (slb slb).

(0.8)

but i er i'm like every two hours probably. if if i'm not taking a tremendous amounts i have been dri- getting i have been drinking (0.9) during the evening (0.7) and having to get up at night. [in the middle]

[did you stop that]

[of the night] {(slb slb)}

[ did you] stop drinking at night?

(1.2)

e:rm no coz i'm up until eleven twelve o'clock,
but you still gonna have to go before you wake up in the morn^ing<

oh yeah!
yeah,

but

just er you know (then you don't) fall back asleep (slb slb slb),

hell no!

no.

ah hah

the only thing that keeps me awake is you know like these gun shots going off and,=

=no it's it's the trash man that (comes round).

okay.

three o'clock in the morning (until) the trash comes around.

(slb slb) so er so how often are you having diet products as far as beverages?

tzt well i had been having an atkins drink, in the morning probably for five times a week.

and on occasion i was having an atkins bar and that was it as far as diet products.

i mean diet sodas.

diet sodas, [ oh, ]

[yeah.]

i'm sorry.=

diet sodas, diet drinks, that kind of thing.

it's arl- artificially sweetened (with other than sugar),

maybe once a day.

yeah? okay.

and and not even that often. .h i prefer er seltzer

uh huh.

to erm (0.8) you know to a soda i like the the sodas because i can
normally burp by myself, an i like to be able to burp on
occasion,
((PR writing)) (1.3)

P tzt and: (0.5) s- sodas and seltzer (what it'll) do ↑for
you
((PR still writing)) (5.7)

P and:
((PR still writing))(3.0)

P no i got i got this coke,
(1.0)

i bought it in the summertime it's still hanging around!
(0.6)

PR okay.

PR .hhhhhh okay e:rm hhh tzt now last time you told me when
you ate er, this was er basically breakfast you said was
like er (2.2) er soy paddies atkins type diet, erm lunch
with protein with the salad no carbs, fruit with veggies
(0.5)

PR for di↑nner

P uh huh.

PR does it sound about right?

P [ yeah. ]

PR [ still?]?

P erm i haven't had the soy paddies for a little bit coz we
ran out.
(0.8)

P but like today i had an a- erm

PR ((sniffs and clears throat))

P atkins drink.

PR uh huh.

P (1.5)

P erm

P .hhh i had a bowl of soup from the school,
(0.6)

P full cream and broccoli.

P (2.2)

P i had one and a half (0.6) chicken erm breast,
(0.9)

P that i had cooked up without skin and i got some (slb slb)
and some erm relish from the cup from (slb slb). and i
sort of cut it off and i ate that together.
(0.7)

P did i have anything in class,
((rhythmic lip smack)) tz-tz-tz-tz-tz-tz-tz- yesterday or toda- today, i think it was yesterday i had an atkins bar. it's last of my atkins bars.

okay.

i don't think i had anything in in: (0.6) my class, although i was probably looking for something coz the atkins drinks (slb slb slb two hundred) calories.

(1.8)

erm

and then i've had wa

(0.6)

and that: (selby) diet tea, and

[ o kay. ]

[that's all] i've eaten today.

((writing on file)) ((sniffs))

(hhhh what are you planning (slb) for dinner,

(0.4)

.hh that's a good question, i don't know.

uh, what did you have last night,

(0.6)

.hhh o:h,

(0.4)

last night i sort of (1.2) i had: three s- eggs scrambled in olive oil,

(0.5)

.h and some leftover,

(0.7)

erm (1.0) t-t-t- ((rhythmic lip smack)) bean thread that i had er rehydrated and i put some brown butter on it because i've been trying to experie- experiment with cooking it, so i can take it down at my folks house and see how i can make it up coz i won't eat noodles but only the bean thread,

uh huh.

(0.5)

instead of the noodle. and i'd love it like (step up step down) between now and (0.5)

uh huh.

(doomsday) tzt what else did i, ha- i had some olive oil that i sipped on,
PR sipped on olive oil
P I'll yeah. I drink olive oil on occasion.
(PR writing) (1.7)
P even had the doctor tell me I should.
PR how often do you drink olive oil?
P every day.
(PR writing) (1.8)
P I'm not saying I drink a quarter of a cup,
(l.4)
P I'm only saying I drink it.
(l.4)
P (slb slb) the cup I might have a tablespoon,
(l.4)
P maybe two tablespoons,
PR did you choose that over say fish oil? or flax oil or
P something like that or,
(l.3)
P yeah.
PR uh,
P =well first of all I'm (slb) not gonna go up and get fish
(l.4)
when you just can't drink it.
PR well they have flavored fish oils.
P yeah I know. er (slb alexanders)
PR yeah. [(slb slb slb slb)]
P [(slb slb slb slb ] slb slb)
PR yeah right. and there's also some other norwegian er you
know,
P yeah but er no. erm no erm this is just a little bit to
sip and (slb) I have some, and then I give the rest to the
dog it's fair trade and,
PR "okay."
P it's sort of a mother daughter type of thi(h)ng. ha ha
(l.4)
P ha ha .hhh
(l.7)
P .hhh that look exactly like my rottweiler.
(l.3)
PR [(slb)]
P [ my ] rottweiler loo(h)ks exactly like me!
P .hhh why do you know, why are you doing it?
PR taking drinking olive oil? other don't you like it,
(l.0)
PR

P .hhh erm (0.5) originally it w- was i started doing stuff
with olive oil w- to get rid of gallstones many many many
years ago.
PR uh huh.
P and i use olive oil instead of butter (.). now for the most
part.
PR (0.8)
P on occasion i do (.). use butter,
P (0.5)
P and that's what i use for (↑slb slb)
(1.1)
P so (normally) i put it on the salad but (0.5) sometimes i
don't
have lettuce in the house i just have a little olive oil, oh! and i had: (1.3) a small piece of goat cheese about
this big, (0.6) about that high (1.1) because i had the
other oh [that's it!]
PR (cough)
P i had the other half of that goat cheese today er in in
class.
P (0.6)
P before ten o'clock.
P (1.0)
P i knew it i came up with something.
P (0.6)
P tzt and: i think i had a piece of soy cheese,
P (1.1)
P you know,
P (0.7)
P wrapper.
P ((PR writing)) (3.0)
PR wrapper
P yeah it's preformed you know like ch-=
PR =oh you mean like a mozzarella's thick type thing,
P well no this is it's flat like american ↑cheese
PR >oh oh oh oh! <er okay that crappy fake er(ghee),
P well this is [this is]
PR (he ) he he tasty! (he)
P (this is) soy cheese
PR (slb slb)
P i'm used to it.
PR "hu hu hu hu hu hu" .hhh ((clears throat))
P (2.0)
PR that just that? i mean just snack on soy cheese,
PR  °uh° .hh now this is the second time i'm going over diet
with you
and i really don't see much erm (0.6) fruits or
vegetables,
(0.9)
P  .hh erm i did not have any apples today i had them
yesterday, i
had them the day before,
(1.3)
P  e:rm (0.4) yesterday i had: a s- salad,
PR  ((clears throat))
P  er erm (1.1) i went to the dining hall,
PR  uh huh.
P  apple s- some salad vegetables mixed in with the chicken,
(0.8)
P  e:rm (slb slb slb slb slb slb slb) something rather
(0.7)
P  erm tzt i had a couple of pieces of sliced turkey without
cheese i used mustard and mayonnaise .h and i put it on my
lettuce leaves so i rolled it up,
(0.4)
P  to make a sandwich with the the long romaine or: (0.7)
green lettuce leaves,
(0.9)
P  so that's what i had yesterday.
(1.2)
PR  okay.
(0.7)
P  and:
PR  ((croaky voice)) (are you) are you living on dorm here or
are you off >{slb slb slb [ slb or slb]<}=
P  [ (slb slb slb)]=
PR  =>{slb slb plan for the dorm here on you< [or])
P  [ i ]
i have erm money i
put on i think i put a hundred and fif[ ty dollars.]
PR  [[o kay so,]] (just
to)
this. [(go o ver there,){(clears throat)}]
P  [term i go o ver there ] once a week
maybe and,
PR  okay.
PR: hhh erm do you not have the time to prepare meals?

P: i do all the cooking in the house.

PR: but i mean as far as? erm, erm, erm,

P: =well last night i was studying for micro exam so i didn't
give a damn! h

PR: right.

P: and i [ di dn't ]

PR: [(slb slb)]

P: go and had any any kind of chips oh er (0.4) i ha- and i
had (0.6)

PR: tzt some nut butter yesterday too.

P: almond butter.

(1.8)

PR: okay.

P: but

(0.8)

P: you know i was studying for exams, and and: pulling out
the lettuce and spending a lot of time fixing the salad
was not my thing yesterday.

PR: okay but in general?

P: generally i have vegetables broccoli cauliflower,

(0.4)

P: erm

(0.6)

P: green beans erm from the can,

(1.1)

P: u:h it depends on what jennifer buys.

(0.6)

P: erm i've got: i make home made soups,

(3.1)

PR: °okay.° hhh erm=

P: =soup of potatoes a a little sweet potato,

(2.5)

P: including the meat.

(0.4)

P: and i'll i don't put any can stuff in there besides
cinnamon.

(0.8)

P: but i would not eat thee inside of a white potato i will
eat the skin.

(1.2)
i put olive oil on it.

°hu hu°

(0.9)

°(slb slb slb slb slb)°

it's good!

no. and there's no exercise really you're not walking or anything,

i know ye[sterday you walk-]

[on ly a round] only around here. [uh ]

[erm]

had you start

started to walk with carol? or is that [erm]

we we did but

(went) way down the tubes.

yeah?

(0.7)

yeah when the weather got bad.

(0.5)

or cool.

is there any place you can g- [start to walk?]

my house

at night.

(0.7)

what [about day?]

[or during ] well i'm not home during the day.

= i'm here from eight until five

i realize that. but what about: you have no breaks when

you can

you can walk along the water, or something or

[i have a]

[i just wa]nna get you mo[ving. °(slb slb slb slb)°]

[ <i have an hour off>]

(0.7)

<five days a week two of them are spent in class.> because

the

professors have (looped) the class time.

(2.3)

and then i have erm k_four_i,(.) doctor joey's leadership

program, s_g_a and (saka)

((clears throat))=

=that are going in my lunchtimes.

the you need all those

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well since i'm an officer in two of them and doctor joey wants me in the leadership program, (0.5)

P yes. (1.1)

P so i have like one (1.0) lunch period a week. (0.6)

that's mine to sit and relax and quite frankly i sit and relax. (1.5)

PR ((taps pen on file three times)) what about: i mean i know you got a (slb slb) in the evening how are you (close to the mall) or any thing

P i'm probably about twenty five minutes away. (0.6)

PR "right. .hhh"

P and i will not walk around my neighborhood. "yeah i don't."

P i live on (silent) street you know same street as (city dump).

PR uh .hhh (slb) the thing is if you could get you to some at least some place that's lit up and in the close in the evening, at least we you know and kinda like .hhh picking on your way home before you get home just to (take up),

P uh huh.

PR just to get you moving.=

P =yeah. [ oh ]

PR [(slb] slb slb basis slb slb)

P yeah and and two two night a week i have a study partner that i meet here in the library and then i go up go out. (0.5)

P a:nd:

P i work friday saturday and sunday until eleven except this week i'm working saturday until one a_m on sunday. (0.9)

SC do you have a tape recorder?

SC no. (0.5)

SC because er the one thing i i do i put on a tape recorder either things i want to study, (slb slb) time i walk and listen to (0.4) to a tape recorder,
well that sort of m- means that you got to go ahead and be
looking at it to [tape record it.]
((oh it'll just ] be lectures you know
(slb) lectures erm
micro, (histology slb slb slb) erm
(2.2)
uh huh.
(1.9)
well, (.) doesn't always work.
doesn't always but it's (nice to be listening),
o no i had, i don't have a tape recorder.
(slb slb)
((PR turns towards SD who has come in))(5.3)
so er er are you thinking about exercise options, are the-
(these are) exercise that you like to to do,
i like to swim.
SD  you like to swim,
PR  [((clears throat))]
P  [ i actually ] have a bathing suit in my (carry on).
yeah?
P  as we speak.
SD  okay. =
P  =and a towel.
(0.4)
and you (slb) at a nice pool,
(0.7)
so i here.
SD  ah here [ i ne ver,]
PR  [it's it is] [ i- it's]
SC  [(slb slb) [slb slb]]
P  [ so the] [ the the]
the last [ couple of]
PR  [it is (slb)]
P  times i've been there they've been closed it's been [ a ]
SD  semester since i've been there.
(0.7)
SD  erm
(1.3)
can er can you: er i'll tell you what i do (slb slb slb)
erm i'm sorry i missed your name.
i'm i'm franc sheridan.
PR  it's the supervising doc[tor.]
SD  [i'm ] the doctor.
(0.6)
I assumed as much.

ERM hhh ha ha ha . hhh i was i actually a competitive swimmer at college,
(0.6)
so (slb slb slb slb for you) and (0.5) when i
we- when i went (slb slb slb) school,
(1.0)
erm one of my classmates was a swimmer and we turned out
that we were the same (calendar) swimmer, we'd go in the pool and then (slb slb slb slb) you know i have to (slb slb slb) each other (slb slb slb) so,
(0.5)
we (slb slb) up and we just decided (slb slb slb we'll swim) every day at lunch.
(0.6)
so we did. we went to pool we had you know dried from the pool (slb was outside)
((clears throat))
(we got a slb from a slb slb get out slb slb) pick up some lunch and went back to class and eat lunch in class,
uh huh.
right? so we never ate lunch at lunchtime we always were eating lunch in class.
(0.5)
er er most most days were at: (slb slb slb slb) or
something erm hhh ha ha ha . hhh
(0.5)
((P and PR smile))
thee: (2.3) but getting in the pool is is a great you know it's a great a great way to you know to relax and take some stress off your joints and get really good exercise.
(0.6)
and so if you can couple all these things together er and if it's something you already enjoy, then simply carve out some time for it and even if this is as little as fifteen minutes, (slb) actual full time,
(0.9)
y- you know you you could you could you know (slb slb slb slb),
(0.7)
uh huh.
i i would urge you to do that at least three times a week.
(0.9)
so you can come in,
you know come in earlier and start your day with a swim.

see,

[you don't see don't bother] you don't bother with your morning routine. you get out of bed you go[to] the pool, (.)=

[you jump in the water,]

[hu]  

[hu]  

[hu]  

[hu]  

[hu]

[hu]

[hu]

[hu]  

[hu]  

[hu]  

[hu]  

[hu]  

[hu]  

[hu]  

[hu]  

[hu]  

[hu]  

[hu]

(you get out of the pool, do your hair, (0.8)

(and run off) to class.

uh huh

right. that way y- (0.5) you're not you're not doing the shower thing twice.

uh huh.

right. and get more efficient.

(0.7)

and and you you get to erm you get to get some activity

and and when you do it first thing in the morning, (0.6)
y- you'll be primed to (slb) for the rest of the day.

(0.3)

you'll be (feeling) pretty good.

(0.7)

it's it's hard for me to get up in the morning.

yeah.

it's it's a good idea.

yeah i would [i]

[i] mean i did make it with carol,=

{slb slb slb slb} that [at least]

{pro ba}bly for a week.=

=here's the thing!

(2.5)

when you when you do this, (1.0) what you'll find is (0.6)

when you get er as you get accustomed to getting up

earlier in the morning and you get accustomed to going to bed earlier at night,

(0.5)

what that's gonna do to ya, is put you in a position where

you are {slb slb slb slb} (.). regardless of the amount of exercise that you do.

just because your (body coefficient)

has has has come back to {slb slb slb slb normal}.

uh huh.
you're waking up sluggish in the morning. it's a
[(slb slb)]
[ no it's] it's not sluggish that i'm getting up in the
morning. it's bec- i'm letting out the dog, i'm i'm you
know i'm not fixing my lunch at at the night before,=
=((clears throat))=
i'm fixing my lunch in the morning! jennifer and i are
pushing each other with the elbows, try(h)ling to ge(h)t
the sa(h)me ki(h)nd of space .hh erm
yeah. so, [(slb slb slb)]
[(slb slb) i'm] reading [reading something]
[[the question is]] can
you get creative enough, to carve out the time for
yourself to get moving,
(1.0)
right?
uh huh.
(go take) carve out some time to go for a swim,
(0.7)
and can you get? (.3) creative enough to figure out when to
get all the other things in, that you got to fit in in
your very busy schedule,
(0.5)
and er thee and this is important for you coz you're a
student now and when you're done being a student,
guess what?
(1.9)
it doesn't get any easier. you
[ hh hh ]
[just get] busier.
(1.4)
so (0.3) what you're what you're doing is making a l- is
is really carving out what your priorities are. and tha's
(slb slb slb slb) exercise and that movement has to come
up on your priority list. and you have and you have to
figure out where you can get it in.
(0.3)
and that's gonna take some creativity and use of your own
imagination.
(0.6)
and then (slb slb slb) you have practice to get it on the
way.
(1.7)
uh huh.
we can help with suggestions (slb slb slb slb)

(0.5)

until you until you (enact them) and you really you really

sit back and think erm okay. (0.4) i'm committed to this

now i (slb my war),

(0.5)

i'm gonna be (slb slb) make it happen,

(1.1)

insist.

(0.6)

uh huh.

(0.9)

it has to become a part of you (.) part of your life part

of your routine.

(1.5)

otherwise you're not gonna be successful.

(3.5)

right if you go oh i (slb slb slb) i guess i need it i

need the exercise,

(0.5)

you know as opposed to that's that's different than you

know i need to be someone who exercises. of course this

you know you know i i'm someone who (ex- takes) exercise

regularly i'm an exerciser,

(0.5)

uh huh.

(0.5)

right?

(0.6)

see the difference?

P yes.=

=you have to really incorporate that into who you are.

(3.2)

when you do that, (2.7) you will have you'll be happy.

(0.7)

for doing it one one one thing i think you'll have more

energy and i think that your your metabolism will kick up

(slb slb).

uh huh.

(0.4)

(it's all way) up to go.

right [and]

[ha ]

[and i]

[hu hu]
and i i expect that,

and i did exercise last two days i was racking the yard,

(1.0)

that's good.

(0.7)

[(slb slb slb)]

[(slb slb slb ] that's good work okay).

yes the no. maybe fifteen twenty mi(h)nu(h)t(h)es at a
t(h)ime because i i hadn't done it for a long time i

didn't want to: kill my body.

(0.6)

but erm tzt i did the racking.

(2.8)

any other s- stuff,

.hhh ouch yeah it's it's it's a time this is (slb) a time

issue.

[yeah.]

[erm ] a[ ny ] suggestion=

[yeah]

=that's it it's

[( just a time i ssue) ]

[ a ny su ggestion] seems to be erm

yes,

seems to be countered with erm a time issue. erm

yes you know it's i had this i had this a conversation

(slb slb slb slb) last night, w- with one of my patients

my my (slb slb slb slb),

(0.6)

we were talking about resistance.

(0.4)

and and (. ) and (. ) and all the way that it's just (slb

slb) a part of it of resistance factors. we were talking

about erm metabolism (slb slb slb slb some hormones slb

slb slb slb slb slb slb) but when he when he was

trying to extrapolate that out to to to erm to what's

happening (to him) emotionally here's resistance. what

you're what you're describing is your (slb slb slb slb)

resistance (to making suggestion).

(0.8)

and there's erm there's an excuse for everything (. )right?

that's in that's for resistance.

(0.8)

so thee ultimately if you wanna if you wanna change

metabolism, change the whole resistance picture you have to

you have to do it by by working with the system not
and so part of working with the system is, you know you're working, as okay this is a pattern.

right? now can we change the pattern. how do we change the pattern,(.) and the opposite of resistance is (1.0)
sensitivity. right and if we're talkin about (.). about increase in sensitivity, that means when you're in a
or in a conversation with somebody, (0.6) (you also do that) you increase your sensitivity you listen.

and not just hearing you're listening.

right. and you're listening with an open mind. that's increase in sensitivity.

okay many of us also have have high levels of sensitivity for erm certain things. other things can you know our sensitivity's gonna be (0.5) oh that's bad. oh oh that's good. i'm gonna do that. (.)

right? and so and sometimes all the waters get crossed.

[((clears throat)]

[(( slb slb slb))] as waters get crossed so there'll be questioning times. you have to you have to be again open minded to evaluate where this sensitivity (slb slb hot spots are to go) does that make any sense?

in (0.3) today's world

there's a lot of (other) patterns,

(slb slb slb) a long long time ago. 

and have to do with with resistance.

[right?]

[ i ] have to tell you part of your discussion with me was like listening to my mother. and there was resistance in that part of the discussion.

sure! so this,=

=coz this was like,
right so that that's that's a recognition on your part
that there's that there's some resistance to this. this
some way that i'm communicating oKay and and it doesn't
er gk to to me you know o- okay that's that's it. what
what's interesting to me i- is that you you recognize it,
oh yeah!
okay? and so that's that's the first step you go. (0.4)
now now
(sl) who(h) who(h) wa(h)nts the resistance?
(0.9)
right, what what is that and is that still a useful you
know,
(0.5)
er tool for you?
(2.1)
i ha- i have these really long apron strings sometimes, it
is hhhh ha ha ha ha .hh ha just don't need to transfer it.

Yeah [so is it?]
[ha ha .hhh]
is it useful for you in this situation,=
=no it's not.
right.
(0.4)
and that's it. open (slb slb) conversation (slb slb)
communication
so you see this again and again and again and [a gain.]
[uh huh.]}
(0.4)
and
(0.9)
so when when and what what (slb slb slb slb slb) is she
she was far more resistant than than you are. (slb) you've
already er er compared to (slb slb slb) you got a lot more
open minded (since) you've recognized your resistance
already. .h so be erm
(0.8)
what i (slb slb slb slb slb but you may wanna) consider as
well is when you come into this environment,
PR ((sniffs))

SD you're coming with an open mind.

(0.4)

SD which means you're prepared to listen to suggestions and instead of being resistant right away, you're which is which is which we recognize as essentially a defense mechanism.

P °uh huh.°=

SD =okay,

(0.5)

SD and the whole i guarantee you. (0.6) you come in with an open mind and you go (0.5) hu well that works. (coz i slb slb slb with)

SD you know and you go through that that that (slb) pattern whatever that is which is sensitivity. okay you go yeah, oh okay (he has interesting suggestions). maybe maybe i'll listen to what he has to say right?

(0.6)

SD and

(0.8)

SD w- will that work in my life (or that) can i do that, that's sensitivity okay?

(0.4)

SD and then (0.4) it may ultimately be like well (0.7) you know erm it may ultimately (slb slb slb slb) well that's that's not gonna work but a piece of that (will work).

P °uh huh.°

(0.7)

SD right?

(0.7)

SD and as you develop that sensitivity and keep that open mind, (.) that's when you open yourself to change.

(0.6)

SD when you resist it and you're not entertaining opp-

opportunities,

(0.7) there will be no change.

(0.5)

SD and i will guarantee if you don't make any changes with with with this stuff,(.) your way is not gonna change (slb slb). ((knocks))

(0.6)

SD because (0.5) (slb slb slb slb slb slb slb slb slb slb slb slb)

(0.6)

323

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P u:h .hhh erm one of the er er you need to have a a vacuum
to something to come in. you have to throw something
out .h in order for something new to come in.
SD no not necessarily.
P well [that that,]
SD [ coz we ] can
P that's how it's been explained to me.
SD we can you you can keep gathering and and and it's not
too hard to throw something out if it's not, if it's you
you know if you're done with it.
(0.5)
P hhh ha ha ha ha ha .hhh hhh
SD right so that's that's why that's why you you're beginning
to develop your sensitivity because you you gotta you
gotta you gotta
go in this, in this instance for example when we go (slb)
you sound like my mother, right? resistance.
(0.7)
SD and i say [what is]
P [how of]ten have you been
SD [ is ]
P [told] that? hh=
SD =is this
(1.8)
SD is this useful for me right now, right because what i'm
saying may actually be really useful to you if you were
listening.
(0.4)
SD if you're resistant you're not hearing ↑it not listening
erm you don't you just (slb slb slb slb).
(0.5)
SD then you've completely missed it and you've probably
missed a real (slb slb).
(0.8)
P .hhh but: if i was here for it my subconscious has heard
it and i may not be er ready to hear it hear it now. but
it would be there for me to recall.
SD yeah exactly. exactly. that's right now thee: erm (3.3) i
wou- i would ask you if you when you come in at the next
time, that you that you that you come in with an open
mind. and that you you and that you you consider that
between now and then.
(0.6)
P uh,
(1.5)
okay?

P okay.

and: (0.5) and i would you know also ask you to you know
to help (slb slb slb any changes slb slb slb).

(3.5)

that you're here, (0.6) that's a good sign.

uh.

(0.6)

(slb slb) say how committed are you to make these changes
in your life?

(3.4)

tzt fairly.

okay.=

=not a hundred percent.

okay.

(1.7)

(o[kay].]

[you ] can think about that between now and our next
meeting as well.

.hh hu hu

(1.2)

okay?

P okay.

coz when you when you're when you're absolutely committed
to changes that will happen. (and it will happen slb).

(2.1)

(^okay,^)

(4.4)

is that feasible?

yes.

(0.8)

so erm (0.6) so you're on your way to start a new course
in your life.

okay.

(1.5)

that

(1.5)

erm

okay.

(ready to wrap up),

okay.

(1.3)

uh huh.

okey dokey.

(slb slb slb slb)

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((clears throat)) tzt

((P looks at watch while SD signs files))(5.8)

((smiling at P)) (it's late).

(1.9)

okay.

that's it.

((SD leaves))

PR  alright.

well i mean er er (.i) mean he said it more elegantly

than i i could, oh as far as the whole situation and and

as he says when i (0.4) have been making suggestions i've

been (0.5) the wall's gone up. you know .hh it seems like

it's it's it's hard to you know,

(0.7)

er to say let's try to get a little er walking or exercise

or something into it. and you know then the whole the

whole the whole of this comes down as far as as

you know i er i hadn't thought of it that way.

((SD leaves))

((smiling at P)) (it's late).

((SD leaves))

PR  alright.

okay.

(((SD leaves)))

PR  alright.

well i mean er er (.i) mean he said it more elegantly

than i i could, oh as far as the whole situation and and

as he says when i (0.4) have been making suggestions i've

been (0.5) the wall's gone up. you know .hh it seems like

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er to say let's try to get a little er walking or exercise

or something into it. and you know then the whole the

whole the whole of this comes down as far as as

you know i er i hadn't thought of it that way.

((SD leaves))

((smiling at P)) (it's late).

((SD leaves))

PR  alright.

well i mean er er (.i) mean he said it more elegantly

than i i could, oh as far as the whole situation and and

as he says when i (0.4) have been making suggestions i've

been (0.5) the wall's gone up. you know .hh it seems like

it's it's it's hard to you know,
what's a better (0.3) balance for you as
far as, (i know) i don't know what time thee the the the
gym opens i don't know what time the pool opens. .hh
[yeah i have to go over]
[ i i know it's open]
there and find out.=
=i know it's open after (0.4) after class for you. and
you're probably getting out like at fourish most [days
four,=]
five thirty,
okay whatever.=
six o' clock.=
whatever day it might be but even if it's like you say if
you could get over there for half an hour,
[uh,]
[be ]fore you go home you know make a part of it your day.
(0.5)
you gonna go over there you gonna get moving you gonna
feel better because you did that. and it's also gonna take
some stress out.

uh huh.

and you'll be more set up for the evening.
(0.8)
you know .hhh and then if we can somehow (0.6) pr- you
know i i mean to say you know it it's a (time consuming)>i
mean who wants to go over to the gym, and then who wants
to go home and make supper, and then who wants to go home
and sit and study,< (0.3) you know >it's it's it's it's
'it's< it sucks you know?

uh huh.=
=it's: and then you know and then you know if you have to
catch up on the weekend and you're working. .hh you know
and and th- and and that's that's not easy. it's [not
easy. by any means. .hhh so,

uh huh.

you just take it,=
=say there's no money either!
and there's no money. and there's no money. [which is]
[ hh hh ]
also another complicating issue in the whole (slb slb),
but you don't need money to do the exercise.

ha ha ha .hhh=
=that's something you don't need money for. so,

run over and find out what the schedule is (that),
((slb slb that you like) i mean i mean (how much))

[ i will run o ver and find out the schedule.]

you want you like to swim, you said you have a (0.4)

P

a suit and a towel.

PR

a suit and a towel in your carry on you're ready to go!

1488 you [know?]

P

[yes. ]

1490 SC

(you like) the steamer?

1491 P

it erm i like the steamer, i like the sauna, i wish they

1492 had a jacuzzi,

1493 PR

hu hu hu=

1494 P

=and i don't know if they lo(h)wer(h)ed the

1495 t(h)emperat(h)ure of the steame(h)r,

1496 PR

[uh]

1497 P

[be]cause it was (slb slb slb) high ha .hhh

1498 PR

yeah i don't like steam heat ((slb slb slb))

1499 SC

((slb slb slb)) sometimes

some days it's higher than others and (not so good. i mean

it it)

1501 (0.5)

1502 P

uh huh.

1504 PR

°so, °

1505 SC

(in the sun)

1506 (0.9)

1507 PR

what time do you get up in the morning?

1508 (1.1)

1509 P

erm six six thirty.

1510 PR

uh do you know, i don't know erm [if ]

1511 P

[and] (about) go to bed

1512 at you know eleven thirty.=

1513 PR

=yeah.=

1514 P

=twelve o'clock [whate]ver,

1515 PR

[ i er]

1516 P

i probably spend tzt erm (1.6) forty minutes or or so on

1517 the phone maybe some times more, .hh coz i talk to my

1518 mother my sister and my daughter.

1519 (1.0)

1520 P

sometimes a girlfriend.

1521 PR

uh huh.

1522 (0.5)

1523 P

and that's that's important.

1524 PR

no ho if that's, i mean like he says you gotta like he says

1525 you gotta carve out what you wanna do.

1526 P

uh huh.

1527 PR

check the schedule out,
I will [do so.]

[if if ] it works in the morning (ask) i think that will work great for you just because you could just just set that damn alarm for five thirty and get up you know, .hh you can get up do you think and get out er before er before (slb slb slb you were mention)ing

[ i have ] jennifer and i have teddy.

well i mean you you can get out it's hopefully before they get get going or whatever. at least that won't be that much of a battle in the morning. .hh and i mean you know and then if not, [(slb slb slb slb)]

[ oh if i t- if] i take a shower over there then i don't need i don't [have to fight for the b- ]

[yeah so that, right so that's] so there's [(slb slb slb)]

[ te ddy and ] i take showers in the morning.

and [(slb slb)]

[so there's] you know there's a little window it sounds like (this) depending on what time they're open. (. ) i don't know if they open at at at the right time for you that's that's the thing.

so just run [ over and get the schedule,]

[(slb slb slb slb) ]{(seven)}

oh they open that early

er er

sometimes i've heard (someone) say five but,

i don't think [they o pen at five.]

[five would be (slb slb)] [(slb slb)]

[(slb slb)] (slb slb)=

maybe [six.]

[se ven or six.

six thirty maybe.

but you know six thirty would be great you know and that six to seven range would be great for you. you can get up (0.5) you know .hh i mean if you're making a meal the night before make an extra and just throw it in a container and bring it for lunch.

uh huh.

you know,

.h did you want me? (0.6) hell i don't wanna ask this. did
you want me to stop eating my Atkins shakes in the morning? 

.hhh ermm what I would like you to do, (1.4) is (0.4) have a meal in the morning 

(2.1) 

rather than the Atkins shake 

[okay. ] well I can't eat cereals, 

(0.5) 

I'm not talking about what you would normally have for a normal dinner. 

(1.5) 

so [i] 

[(slb)] 

sauerkrauts [in the morning.] 

[no. I mean I ] 

[for breakfast.] 

[wanna yeah. ] I wanna I'm talking a nice healthy dinner you know, chicken with some vegetables or whatever. .hhh but if we could or if we could switch your calories, (.) to the front end of the day, rather than the back end you're gonna have to have some benefits 

[okay.] 

[from (slb)] there. 

[i had to (0.6) train myself to eat breakfast in the morning because it used to be if I ate in the morning I would eat all day long. but if I started around noon, (0.5) I didn't eat 

[okay.] 

[all day] long. 

well you will start your metabolism up by eating in the morning. 

[a:nd] 

[i'm ] aware of this. 

and it's not necessarily bad for a person to be eating all day long depending on what you're eating all day long. 

no it was more like a seafood diet. 

okay well, I mean you [go ]tta 

[hhh] 

make sure what you're seeing as a[ppro]priate
not eat carbs,
right.

[nor ma lly.] [which is good] which is fine. which is you know?

otherwise you know i would love to sit down and have (0.5)
chips with salsa sometimes.

yeah well, sometimes do it!

(2.1)

okay.

sometimes do it. because if you th- that's one of those
things if you don't do this then if you don't cheat once
in a while, you're gonna go (slb slb).

(0.4)

you know i mean who want you know er you live life you(he)
know,

uh huh.

enjo(h)y what you enjoy.

yeah well, no.

(slb slb) do it at at a normal pace so if you can get you
up in the morning, if you can get you to eat more in the
morning kind of (taper) off in the evening maybe, have
your atkins shake in the evening instead,

(1.1)

before you go to bed you know in that range,
what is a time that i should not eat after?

.hh well i can't eat myself (slb slb) it depend on the
person if i eat anything after eight o'clock, i have a
crappy night sleep. so i kinda [(slb slb slb)]

[ i've been known] to eat

at eleven.

well so have i. and then i i j- i sleep like hell. then i

[oh,]

[you] know, .hh so erm i i so that's up to you you gotta
decide that. now but: i won't put much solid type food. i
won't have a big dinner after seven. (.) seven or eight.

okay.

you know and [not much]
P: it work i can

PR: (clears throat)

P: probably eat by eight o'clock.

PR: yeah.

PR: and then erm that's why i say if you eat more during the day it kind of, and kind of say let's have an atkins and maybe some erm apple and a salad, or or whatever in the evening you know or soup and salad in the evening. hh instead of you know a bigger meal, then i think you'll be much better off too.

PR: so just those er just this is kinda make those th- little changes, try to get that exercise in there and then switch the calories to the front end.

PR: (and they've done) specific studies calories in the morning get burned off you lose weight, .hh calories in the afternoon kind of stay with you .h and maintain your weight, calories in the evening go up. (. ) the weight goes up.

PR: okay.

PR: okay?

PR: well let's just make those little couple of changes.

PR: erm it's not (slb let's see) how we can make an effort to to fit it in the schedule.

PR: otherwise we're just gonna do this every time.

PR: (bangs his head against the closet) (1.3)

PR: ((smiling voice)) no that's that's you!

PR: hu hu hu hu [hu hu hu hu ]

P: [ha ha .hhh .hhh]

PR: .hhh so,

P: okay.

PR: okay.

P: did you want to check the underarms?

P: [ e:rm ]

P: [or not,]

PR: not today. let's come=

P: =not today,

PR: yeah. er i- it's a quarter of now i'm out of time. .hhh
erm are you putting anything on 'em?

i am using regular deodorant and i've been using (slb slb)
and then .hh i went (slb slb) at the trader joe's which so
i'm not using aluminum.

okay. .hhh erm=

=erm i had been using (1.4) t- something with aluminum but
since i don't shave my pits it's not as bad.

you can try (slb slb) i think we (still) it in in the
clinic that i've there's a c_c_c cream in the clinic and
then there's a (slb slb) cream .hhh in the clinic. .hhh
erm downstairs erm i've i've had i've had a little rash
problem under my armpits (slb slb) just got over (slb)
using the (slb slb) cream. erm

[ is that] something i need to have a script for?

[that kind] erm no you're a student so you can go down and
get it. and then there's a c_c_c cream which erm vitamin c
calendula and tzt maybe c- erm there's another c in there,
i forgot what it is. but that's that's a good topical
product too.

i do have calendula erm crea:m.

[i ] have some

erm (tre ᵁmel)at home [(slb)]

[(slb ] tre ᵁmil)

[(tre mil. tre mil.)]

[yeah that's good for ](inflammation.) .hh you could use

it

(0.5)

erm with=

okay.

put some on tonight and see what happens. .h even if even
if you you put some stuff >(er there and if it is useful
we can make it we can just slb stuff that get it out)<

(0.7)

and then we can probably we'll probably well let's work
some erm next time we talk would you do any probiotics
or anything like that?

(0.5)

.hhh not parti[cu]larly.=

[no] =okay so we'll try and get (slb slb

slb slb slb) type of supplementation routine.
but i-it's something i actually started looking at and i
called up: erm (nutriawestern) and: (maasen) and somebody
despite today, .huhh and asked for [ stuff to be sent to ]
[(the ca ta logues,)]
me.
okay great. .huhh then [erm when you]
[erm al so ]
get,
from also for my mum.
okay.
because she needs some stuff.
that's good.
a:nd]
[ so ] then will you have access to that so you get a
cheaper and
(slb slb slb),
but i you know i have been taking supplements,
uh [ huh ]
[(that's] just it) you know i mean i actually need to
go to trader's and buy some another multivitamin and and
erm more b complex today.
okay i'd rather you see [er]
[i ]
i'd [ra]ther you= 
ok[ is]
=ut.
.hh i'd rather you see you to get it from other new
companies. a good multi,
i don't have any multi right now.
okay well i'd rather you wait a couple of days,
(0.6)
get your catalogues,
(0.7)
and then order something from one or the other companies.
erm vital nutrients is a, did you get their catalo\gue yet
(1.1)
i'll give you one when we, vital nutrients offers erm
postal price plus twenty percent off the whole sale to to
students.
[uh!]
(and] they don't charge you for shipment.
oh that sounds [intere]sting,=
[ okay.] =so you'll actually get a
much much greater greater quality.
(slb slb [slb slb] vital nutrients is awesome!)=
PR [product] =and: ye
it'll be cheaper than what you get at trader joe's so i'll
give you that catalogue (make the thing [that slb])
P [ o kay. ]
PR (slb slb [you know])
P (coz i ) i do buy erm
P (1.1)
i said i take a hundred and fifty (co_q ten) a day, i take
er eight hundred er er i_u_c_v. >i started taking c i
hadn't been taking c because i had (slb slb slb slb)< (.)
but now i understand i need ;it for (solid) [ re pair! ]
PR [(don't know)]
if there was any correlation that they found between
vitamin [ c and your stones.]
P [well i was told ]
PR there there [ was.]
PR [yeah.]
PR and all the studies have come that that (slb slb) [right]
SC [[ yes]
PR (slb slb) recently the hugest study that there've been
PR (slb) people with the highest gluucose
SC (0.6)
PR (slb slb slb)
PR (the slb slb kidneys) so,=
SC =(slb slb out of their genetics)
SC yeah.=
SC =(slb slb slb) some people have a genetic tendency (but
it's like quite o o two percent.)
SC (0.5)
P oh [ i had, i had (slb) o ]peration=
SC [(slb slb slb slb slb slb) ]
SC =for (slb) stone but [it was huge]
SC [(slb slb slb] slb slb slb slb]
PR so i would not erm
P okay.=
PR =worry about the vitamin c you're getting.
PR (slb [slb slb] slb)=
P [ o kay] =and and i take (slb slb slb slb slb)
PR [sure.]
P [ and ] i think i told you (slb slb slb slb)
P e:rm
P but i buy some of that stuff at trader's.
PR okay. next time okay?
P oh sure. my little go a ^rounds
PR hu,
i'll relabel them up.

[(slb slb slb slb)]

when you gonna make some changes.

(1.0)

well i think it's a case of when can you fit me in at all!

for here because i can go [( a head (slb slb slb))]

[they want to you they ] want

you to do that .hhh i mean i can fit i mean i'm usually

you know i'm here on tuesday wednesday thursday.

okay.=

=so however that fits into your schedule,

erm

=next=

=i think you're pretty booked.

i'm i may be. i don't know i have to see the schedule but

so you have to look at the schedule see how it looks but

.hhh there's no point in coming back unless we've,

no.

made an effort in er actually doing something a little

different than we have been.

so we we probably need to look at well it's it's you

you're not here thanksgiving week don't?

no so [probably after]

[i'm looking at ]

=thanksgiving there's hope there's er er plenty of (hope).

is this off yet?(.) have you turned this off yet?

(i don't know).

P

Hu hu hu hu ha ha
SC: (slb slb slb)
PR: okay alright I think it's for: start talking again.
P: [huh.]
PR: [erm] so you mentioned that at the clinic downstairs they had told you that your blood pressure was one thirty what was it? [one thirty two was it?]
P: [.hh like it was one]thirty eight [coz,]
PR: [ o ]kay.
P: it it went up and down pretty much.
PR: okay.
P: when i went to the hospital the night before it we- it went up to one thirty eight.
PR: [huh.
P: it went up to one thirty eight.
PR: [huh.]
P: and then before that it only was one thirty two over something i don't remember.
(1.2)
PR: okay. (. ) so you had been in the hospital the night before?
P: yeah, erm asthma.
PR: okay. (. ) and do you wanna tell me about what happened?
P: oh no i just had a small breathing problem. [that]
PR: [ o ]kay.
P: it wasn't this major breath. it was quite that i had to react before it got to the point, [that]
PR: [huh,]
P: the (slb slb slb slb slb slb)
PR: okay so you went to the e_r [or get ] someth-=
P: [uh huh.]
PR: [kay. ]
P: [yeah.]
(2.8)
PR: now how often do you have attacks?
(P: (. )
PR: like that?
P: e:rm last time i had an attack like that was i could say more than six years ago.
PR: oh great! okay.( . ) oh that's perfect,=
P: =but they think, they must have the: you will get another inhaler.
PR: you had to get another inhaler?
P: yeah. [erm]
PR: [you] mean get it last night
P: e:rm they gave me a prescription for then they have and
they said i’ll go need it again.

oh okay, so you hadn’t been using it

no, a(hh)ha [no.]

[ o ]kay okay. .hh and so was it last night

that you went to the er, or [a month ago? ]

[oh no. it was] last week

sorry.

last week.

[last we- ]

[no that's] okay i misunderstand. =

yeah last week. =

=okay, (1.2) now i feel very conscious of what i'm saying

because of hhh this microphone >([slb] slb slb slb slb slb)

slb)<=

[huh]

=but .hh erm {(writing on file)) (8.5) okay so when erm

when did you stop using an inhaler, coz i guess you'd used

it in the past,

yeah and then i just stopped using that. i think,

uh huh.

i think bout four years ago.

okay. =

=if i’m right.

{(PR writing)}(5.5)

and how long had you been using it?

().

before you stopped.

o:h erm erm i 've had asthma since i was born so,=

=o:h okay. =

=so this is a lifetime [thing]

[huh?] okay (.) so do you know how

had you been i guess you'd been using the inhaler all

[all the ] (time then),

[yeah did]

yeah during all my [life.]

[ o ]kay okay. (.) so how often did

you use to use it before you stop[ped]

[de ]pend. it depends

e:rm (.) if because i'm bad at it [i could]

[uh huh.]

be using ↓it once a day twice a day three times a day[or ]

[oh!] 

if it was really bad [as ] often=

[uh,]

=as ne[cessa]ry so,=

[okay.]
but you were using it at least once a day it sounds like 90

[(slb slb)] 91

it dep- yeah. 92

((writing)) okay (12.4) okay now had you been taking any kind of erm medication to prevent asthma attacks? or doing anything else,

(.) 93

in the past?

(.) 94

or was was the inhaler the only thing you used for asthma? 95

the inhaler was the only thing i was i was using at the time. 96

((writing)) okay (7.2) so okay so you didn't take anything by mouth any kind of pills for it

no not that i can remember. 97

((writing)) okay (3.9) okay so you decide, ((knocks at the door)) okay (.) come in!

hi ya there. 98

how you doing,

how is it going?

how you doing.

nice to meet you.

you too.

(slb slb slb) and

huh,

[huh]

[pho]tograph and everything [ a bout] yourself,=

[huh huh]

[huh huh]

=uh,

but we must do that.

no problem.

what brings you in today?

uh curiosity i guess [i've]never=

[i've never done alternative medicine but i read i read something about it and so i wanted to give it a try.

okay ramona what: what's going on?

well i just got erm a couple of health issues. specific [ uh, ]

[health] concerns he wants to address, erm one of them is weight erm which we're gonna talk about when we're gonna get to weighing him and [ tak ]ing=

[great.] 99

=height and weight and [body ]=

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=mass. and [that]=
[sure.]=
=erm and he does work out three times a week but he was
you know he had [uh.]=  
=right an they said that his blood pressure was a little
bit high.
okay.
[uh huh,]
erm so we took it here. erm he also has asthma, lifelong
asthma.  
[we were]  
[uh huh.]
kind of talking about that and getting to the history of
he's been doing [ for it,]
[er sure.]  
erm so he had an attack last week of asthma which he
hadn't had attacks in six years,
[uh huh.]
which is great,
[uh,]
we were already talking about that you know [ and ]about=
[uh huh.]
=he hasn't used an inhaler in four years.
great!
=he used to use the inhalers, erm sorry to talk about
you like you're not [ and ]  
=this is something we do normally.
[uh [huh.]
[when] you know they tell me what they've asked
you and [(stuff)]
[yeah. ]
[this is our (.) yeah]
[(it's funda mental) ] (slb slb slb slb) now and again
yeah.
yeah it's kind for them to evaluate that we're learning,
[ oh good.]  
[.hh erm]
=[[] he had]an attack last ↑week
[uh huh.]
=right and he hadn't had an attack in six years erm had

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been using the inhaler until four years ago. hh er so
when he was told erm after he went to the emergency room
last week for the attack, he was told to (consider) using
the inhaler again so that maybe one thing we can help him
with is you know preventing,
what [drug, were]
[with as]thma=
you using it abutrol or=
=uh huh.
well they gave abuterol now.
right.=
=but when i was in this i was using the strong stuff. erm
proventalin.
proventil.=
=uh [huh,]
yeah] the the strong one.
okay.
so i was using that erm i was using that for a while.=
=okay.=
=and then i just stopped using it.
okay so you're never using anything other than that for
your asthma,
no.
okay.
°okay,° so erm (.) er we took his blood pressure here
[erm ]
[yes.]
and we took it erm with a regular size and a large size
[cuff.]
[ uh. ]
erm and it was one twenty over eighty six.=
=uh huh.=
=and one twenty six over ninety erm on the left side.
okay.
for thee:: regular versus large cuffs. so they're about
the same and the other arm the right arm is one twenty
eight over eighty six,
okay. (.) right.=
=so [i mean]
[and how]old are ya?
twenty six.
right. (.) that that's normal.
uh huh.
but you know we will [we'll erm] we'll see what else=
[°uh huh°]
=(slb slb) weight and everything else.
P  uh huh.
PR  and if they took your blood pressure at the emergency
room
P  uh,
PR  i'm sure you were very anxious
(.)
PR  at the time.
PR  yeah that's [what they] said.=
PR  [and that]  =right that raises your blood
pressure.=
P  =yeah.=
PR  =even the next morning you may still have been feeling
PR  anxious and nervous [ and,]
P  [yeah.]
PR  i mean we would have to take your blood pressure three
times. you know three independent different visits,
PR  yeah.
PR  erm to really make any kind of conclusion
P  uh huh.
PR  erm cause that's just part of the standard diagnosis
P  okay.
PR  erm but yeah i mean i don't i i guess they did explain
PR  that to you
P  though [that that was, ]
PR  [yeah that's what] that's what [they said.]
PR  [ uh huh.]
SD  [ uh, ]
P  [ an, ]
PR  [yeah.]
PR  (.)
PR  but you know it's always good to have good cardiovascular
help and we're thinking ahead,=
PR  [uh,]  =yeah exactly.[
SD  [you know] °yeah.°=
PR  =right so continue with your history,
PR  uh huh.=
SD  =erm erm (. ) get his weight and his height,
PR  uh huh.=
SD  =and come and talk to me it should take you probably about
another; (. ) well let's say twenty minutes to complete
your history and get=
PR  =uh huh.
SD  get that done. do a quick line and then come and grab me.
PR  okay?
PR  okay.
(.)

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nice to see ya.
okay.
((SD leaves))
okay so: erm (.) let's see so do you normally had, you
have you been having any breathing problems in the last
four years,
no:

[no?]
really.
great great. (3.6) now did something did you: move to a
new place four years ago, do you know what happened did
something change or did you,

(0.5)
you know?
(0.5)
what kind of gave you the courage to stop using the
inhaler?
or you [just]
(0.8)
deided that you were=
nothing really i just,=
=you didn't [need it,]
[stopped.]
any more,=
i just stopped. it i just stopped!=
uh huh. okay.
i mean i had prescription to fill up but i just left it
there.
okay now have you been using the inhaler after attacks
would start? or did you use them throughout the day, you
probably waited till attack started,=
yeah.
[okay.]
[i pretty much waited 'till (if) i had a [wheezing] o:r,=
[ øokay.ø]
[i just]
[o kay.]
you know some kind of sign.
okay [ so the ]
[you know,]
attacks stopped,
( .)
four years ago?

uh huh,
oh er really six years ago! [right?]
320 P the attacks [stopped] [↓yeah ]
321 PR [ ya ya. ] [a:nd ]
322 P [okay.] [okay.]
323 P i haven't had no gre- i haven't had we had no problem with it, after that.
324 PR okay.
325 P so [i am ] [okay.]
326 P i'm i'm pretty and i'm pretty much i'm pretty much active as far as [sports.]
327 PR [ u:h ]
328 P or something like that.
329 PR okay. what kind of workout do you do at the gym? [er]
330 P er depend it d- e:rm i just focus on the body part that i wanna workout as far as erm three weeks
331 PR okay so [do] you do any cardiovascular, [so ]
332 P [er]
333 P i'm sorry i interrupted you [but,]
334 P [yeah] tztt see that would this
335 PR this school damn they they don't have [any]
336 PR [uh,]
337 P cardiovascular machine!
338 PR yeah (. ) i [know.]
339 P [ so ] so you gotta kind of improvise with it so,
340 PR uh,
341 P if i if i i had the three weights for the chest and then some weights for the stomach and the arm, .hh then i'd do pretty much i'd do pretty much,
342 PR ="uh"= play basketball for like half an hour [that's it.]
343 PR [ o kay. ] okay.
344 P but [when ] i'm home yeah. [that's that's great work]out though!
345 P uh huh.
346 PR no i mean that's great. you don't need machines,
347 P (. )
348 PR you know to do cardiovascular [stuff.]
349 P [ no ] you don't do [pre]tty=
350 PR [so,]
351 P =much improvise. and sometime .hh like i i used to erm (. ) do
pushups and sit ups on my own about a few times
P a [week,]
PR [ uh ]
P fifty pushes and fifty sit ups.
PR uh huh.
P and stuff .hh but i haven't i haven't really been doing it
PR that much.
P uh huh.
P and stuff so isn' that you know for cardio it's hard to,
P it's hard to do it up here unless erm on the run or
PR something like that.
P [uh huh.]
P [but ] back home i know i (hit the treadmill) for like
PR er half an hour,
P and stuff so,
PR (1.1)
PR okay and you never have any trouble with breathing,
PR (.)
P no[ oh. ]
PR [>when] you exercise< that's ↑great okay.
PR (1.7)
PR now do you know what might have, erm (0.5) did were you
PR exposed to anything or do you know what might have caused
PR you to have an attack last week, that you [can,]
P think of in your life,
P i can't really i can't really (.i can't really see, the
PR only thing i've been doing new, is erm tzt this semester
PR is take a taekwondo
PR (.)
P class.
PR okay.
P and i think that's (all bother) you.
PR okay.
P you know we do it for two hours and for [that]first hour
PR he=
PR [uh, ]
P =really >he he he he< works you to the limit for that
PR first hour nonstop.
PR uh huh.
P so erm that's the only thing new i've been doing.
PR (2.1)
P okay. and how long have you been doing that since i guess
PR august?
since the first semester started.

[yeah.]

[this ] is my first time for the semester i've been doing this.

[yeah.]

okay see, coz the reason i'm asking i'll explain this to you since you're kind of here out of curiosity [^partly]

[uh huh.]

erm we we look for causes.

[uh huh.]

[you know] that's part of what's naturopathic medicine does to you. instead of just try and treat the symptoms and surprise might, did they ask you at the e_r if you know what you thought might have caused the attack?

(0.8)

.hh i don't

[yeah.  erm]

[know if they ] do that.

[uh huh.]

[or ] just don't remember them asking me that but:,

[or ] they they might not have coz they don't that's not always the approach — there

[uh huh.]

but so that's why you know if we can figure out what caused you to have that attack maybe it's you know some kind of isolated event,

[uh huh.]

or maybe it's something that you would have you're exposed to now, and you weren't before and it's something that we need to figure out so we can get that out of your life.

[uh huh.]

so that's why i'm asking you this.

[yeah okay.

[let's see are you erm tzt i guess have you used any kind of different erm like shampoo or soap, or anything different any kind of different chemical (.]

[thing that you may be exposed to, (.]

[er cologne, [ aftershave,]

[well as far ]as far as shampoo, sham- i mean shampoo is shampoo to me.

[uh huh.]

but as far as soap i always (slb slb slb) dermatology's
reason and
i would use that.
okay.
that jus- erm because it don't has them the chemicals and
stuff like that that react to my skin.
uh huh.
i don't use erm fragrance i don't erm i don't use
fragrance for erm allergic reasons,
okay.
it's the the e:rm tzt it's: i mean that's pre- that's
pretty much it.
okay you said for allergic reasons?
[yeah it turns on]
[something you get] reactions,
i think i get reactions to erm perfume give me perf- i
mean colognes give me erm reactions some type of reaction.
[o kay.] [as far] as skin and stuff so i don't use it.
ok what happens when you use cologne?
erm i think my skin breaks out,
okay. er do you know how like what happens to your skin
what it looks like
it's like coz i have eczema.
okay.=
=so,=
when when did that,
(.)
when that start?
cezema came with asthma lifetime thing.
okay so that's been since birth also.=
yeah. (.)[erm ]
[okay.]
and the the funny thing about that it comes and it goes is
like,
(. ) like for for years i won- i won- i won't have problem
and then
i will suddenly have this pop out of nowhere maybe,
[ uh huh. ]
[something]that i'm using don't know. and then just starts
to show up,
uh huh.
and then the itching will start again. and it stop and
then it goes away so it could be something that i'm using
that i'm not aware tof
uh huh.
.hh that cause it or i'm not doing so,
that's that's another thing,

okay coz i'm wondering since i'm asking about hygiene

products, that's one thing that we look at in alternative

medicines is environmental exposure

uh huh.

and a lot of problems you know that people have coz we're

exposed to a lot of chemicals.

yeah.

so and we're not really aware you know and there's it's

not really practical to try to get rid of all this

exposure that we have, .hh so that's that's why i'm asking

you about this.

yeah.

so the eczema erm did you take medication for it

oh yeah i used to take

uh huh.

everything from (.)(butane) cream to pill. pill they they

used to give me pills to stop the itching.

uh huh.

pills so: (.i) i could i could sleep at night. cream for

the skin screen [for] just for the arm,="

[uh,]

=>cream for just for the neck, cream for just for the

face,< (butane) cream to get rid of the dark spots,

uh.

i mean all this: just all bunch of stuff.

okay. do you know what kind of pills the were they

steroids? did they tell you?

well all like you could do with eczema is is steroids.

right. yeah. [i guess they were.]

[and then they had] different doses of

steroids.

uh huh.

so [depend.]

[o kay. ]you don't remember the names,

na::!

=that's not that important coz it was when was the last

time you

had an eczema attack?

erm pfhhh oh it's been just as long, (.i) just as long,

it's been about six years

probably longer than that coz erm,

[uh huh.]

[i mean ] the the the more problem i have with it like

recently is
you know like little (slb slb slb) ashy spots for the
eczema,
[it wou-]
[uh huh.]
P
it would just shows up.
[uh huh.]
P
[ but i ]
take i buy cor- i buy cortisone ten [from c ]_v_s= [uh huh.]
P
=for the erm
uh huh,
P
which erm which helps it.
PR
okay. so how often do you use that?
P
the cortisone ten i haven't used it like in a month or two
now.
PR
((writing)) okay (3.4) so how er how often have you were
you using it before,
P
erm before erm like (.') depends on what the prescription
said. twice a day,
PR
uh huh.
P
before you go to be:ed or you know it it depends on what
the doc- what the prescription [the pre]scription says.=
[ o kay.]=okay. now were you taking that erm to prevent the eczema
attacks, coz you mentioned you haven't been having them
lately.
P
[yeah.]
PR
[ so ] is that why are you taking that?
P
that's why i was taking it but erm prev- erm yeah.=
PR
=okay.
P
the skin breakout and stuff yeah.
PR
o[kay.]
P
[and ] the itching and then,
(1.8)
PR
((writing)) okay (2.4) so: gk you stopped a month ago is
that unusual that you stopped, or do you have you been
taking it constantly,
P
no [ not un us ual. ]
PR
[(slb slb slb slb) ]
P
i mean i think the prescription said to keep using it.
PR
[uh huh.]
P
[like si]multaneous to (slb) for me itches i just used it
off and on on and off.=
PR
=uh huh. okay.=
P
=and stuff so,
(2.8)
so maybe you're using it like half the time, like six
months out of twelve?
(0.5)
does that [sound right?]
[could be ] could be even longer than that!
okay.
that depend, it [could be]
[ o kay.]
sometimes could be like a year or two (to five) and takes
the stuff again.
oh wow!
[kay,]
little bit about that asthma and eczema,
[uh,]
and] do you know i don't know if you've heard or not.
i'll tell you a little bit more about this since you're
curious,
uh huh,
but normally i don't know if i would tell the patient too
much about this if they weren't really curious, erm but
have you heard anything about there being a link between
eczema and asthma?
[yeah,]
do you know about that?
[(slb)]?you do?
i think i know that yeah.
okay. okay.=
=coz erm (..) i i see i used to see dermatologists so
often,
[ uh huh. ]
[and stuff.] and there i can easily tell (slb slb) there's
a link bet[ween,]
[ uh, ]
yeah. i know the [link ] between the two.=
[yeah.]
okay. so it's something that we can kind of approach. you
know we can help you with. .hh erm so that's something
that if you wanna come back and keep going you know,
getting our help with that
uh huh.
it won't, it's not something we can address right away.
no.
i mean it's not it will take some time. we would have to
like try some things, and .hh you know it just er er it's
it will be a gradual kind of process. [slb slb]
yeah. i know coz i see,

[okay.]

yeah. i: er whatever it er for me whatever (pertain) i mean i'm not, i don't read everything that's medical [or,]
you know but anything pertaining to asthma, [or]

[uh huh.]
you know or eczema,=
yeah.=

=i read it coz erm i don't know coz it could be something that i make that give me a reaction or, [much]
of that very often it could be life treatment.
yeah.
so i wish so i could be a way for myself.
yeah. okay good! that's good. coz you know patient's responsibility. that's, you know we really encourage people to be in charge of their own health.
yeah.
you know that's part of the whole, difference in philosophy in alternative [versus ] conventional medicine=
you know they, they erm in conventional medicine they don't really encourage people to be very active about their own health. but we do.
yeah.

so, that's great. that you already are. .hh but i'm not gonna i'm gonna kind of change topics coz i don't wanna, tzt spend too much time on this. coz erm what we probably will focus on today in this visit is talking about your diet.

uh huh.

erm and your lifestyle factors. and especially it sounds like you wanted some advice. with diet.
yeah.

erm so i'm gonna just ask you erm about is there any: family history of of high blood pressure? like yer mother or father or,

no [ i know ] we got a=

["siblings"]
i know i have a family history of diabetes.

okay.
you know and I don't know if it skips a generation or not
but I know that a few people who have diabetes,
[P: o.kay]
[PR: er er] erm it's in our family so they can't really deal=
[PR: o.k a y, ]
=P: =with the sugar and the salt and all that stuff.
[PR: okay who has diabetes? in your fam-]
[P: i know my aunt, and my
cousin and my grandmother. My grandmother had a history of
diabetes.
[PR: o[kay]
P: [ so] the (last that she had to stay away from).
[PR: okay so either of your parents,
P: not no.
[PR: okay do either of your parents have any illnesses?
[P: u:h (0.7) i don't know i er not that i know
of.
(P: (writing)) okay. (3.1) okay so has anybody in your family
had a heart attack? or a stroke?=
[PR: ((nodding)) yeah.
P: i think my sister do. we di- erm we didn't find out until
sometime this year,
P: 1.2)
[PR: okay. how old is she.
P: she's thirteen.
(0.8)
[PR: okay where did you grow up by the way around here,
[PR:    (3.2)
[PR:  [yeah] hartford connecticut.
[P: okay.
(1.0)
[PR: txt .hh right, erm okay. i'm gonna ask you a little bit
about your diet,
P: uh huh.
[PR: so:, which erm if am i wrong to think that's probably what
you want advice with? to[day? ]
[P: ((nodding)) [yeah.]
[PR: [yeah.]
P: [ pre ]tty much.
[PR: yeah.=

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P =yeah.=
PR =i mean i want to get some information on your asthma and
eczema, coz we can help you with that
P [ o kay.]
PR [but the] diet is the first thing that we'll start so
that's [where you] wanna start?=
P [ o kay. ] ((nodding)) =okay
PR that's a good idea. hh erm so what do you eat for
breakfast usually?
P he hee depend like erm i did, i did have some cereal
PR [ o kay,]
P [but i ] know me. i'm just like i'm just traditional,
you know pancakes and sausage, and all that other stuff.
PR [and that,]
P [ o kay. ]
PR but i eat cereal. but ever since they told me that i try
to eat some other thing, i eat some erm what they call it
PR oatmeal bread cereal?
P uh huh.
PR it's not sweet but a little little sweet. [with]
PR [ uh.]
P raisins in it.
PR uh huh.
P i don't know in so i tried that but you know?
PR uh,
P i don't know much [about]
PR [okay.]
P dieting and i'm not an expert on dieting.=
PR =okay okay. well we are. [ so ]
P [yeah.]
PR we're gonna help you. erm okay so pancakes and sausage,
PR (.)
PR okay. and do you have a snack before lunch?
PR (1.7)
P yeah if i have the time [i'm]
PR [uh,]
P i'm a i'm a hot packet freak.
PR okay.
P yeah. hhe
PR °uh,°
P i'm (slb slb) full of hot packets.
PR okay erm how many do you eat,
PR (.)
PR like per per that snack before lunch,
P two.
er ↑two okay. (. ) i don't know i never eat them so i don't
really know.
[yeah.]
[i ] mean i've seen the commercials but i'm not sure
what's in [that.]
[yeah ] they're so addictive!
[yeah]

[ yeah]

[yeah. ]

[uh, ] hh okay erm what do you have for lunch?
(1.9)
tzt erm if i usually don't have i don't i usually don't
eat much. i don't really have time for lunch.
[o kay.]
[i usually do if i have break/fast, and that stuff er i
usually erm i usually did hold it up to later on until i
eat dinner.]

okay.

=okay well are you not hungry for lunch?
(0.4)
[ or, ]
[yeah] sometimes but i did i'm so used to it i did deal
the hunger pain till it's time to eat.
(. )
[uh!]
[till] the time to eat dinner.

okay. so is that that you feel you don't have time, to eat
lunch?
(.)
is that why?
oh is sometime i don't have time or sometimes i just don't
choose to eat lunch. p- pretty much.
uh! (1.2) okay so you choose not to eat i- if you're hun-
even though you're hungry and even though you have time?
yes someti- pretty much. yeah i just [don't]
[ kay.]
i just i just wait.
(.)
why is that though coz it sounds a little bit,
i don't know why i do it. he [he]
[i don't know why i do i just been doing it i just been
doing it as ong for like, i've been doing it since like
when i was since eighty ↑nine
okay. is it coz you is it is it it's some kind of like way
to lose weight is [that,]
P: [yeah.] pretty much.=
PR: =okay. [okay.]
P: [yeah.] pretty much.

(2.4)
P: is it is is a weight (. ) issue.
PR: weight loss[ kind of] thing?=
P: [body issue]

P: =yeah for me.
PR: okay coz you probably, (. ) coz it sounds like you're pretty informed about that so you probably have heard that erm skipping meals is erm that it's better to eat frequently throughout the day
P: yea and stuff but,
PR: yea.
P: all the food i eat is so high in salt and [grease,]
PR: [ uh, ]
P: coz [that]
PR: [coz ] that's what you've been eating,
P: yeah.=
PR: =[°yeah.°] I have to have (slb slb slb) like,
P: you feel like you can't eat stuff that's not high in that grease and [butter]
P: [yeah it] is like you got a waffle you gotta have taste pretty [much]
PR: [u:h,]
P: in it,=
PR: =okay.=
P: =and stuff.
PR: [ o kay. ]
P: [then all] my food i- is either fried baked o: r
PR: [°uh°]
P: [ it ] is so high in grease and stuff,
(2.9)
PR: okay. (1.9) okay so erm (. ) do you have a snack before dinner?
(0.5)
P: no. not really i just eat erm (0.9) maybe after dinner it depends.
PR: =[uh°]
P: [ li ke olives i 'll all other olives and chips like spicy, like spicy nuts or chips and stuff anything that's spicy i'm a bigs i like spice, [ ain't]
ai'n't nothing too hot for me. [uh]
okay so what do you have for dinner?
((sniffs and swallows)) ererm it depends it depends.
don't really have like erm a favorite, it it depends. and
stuff.
okay do you have some kind of meat with dinner
so yeah me i'm erm i like chicken i'm a big fan of
chicken.
okay.
[(slb slb)]
you have the chicken like fried or,
fried baked any anyway i can get it.
yeah okay.
and stuff.
okay. do you have any like vegetables or fruits at all
yeah erm well usually with fruits at dinner? it's
something big in a pie.
okay.
erm f- yeah vegetables not that, yeah i like i like
vegetable muffle.
[o kay.]
i like mixed vegetables and stuff [like that.]
[ uh huh. ]
okay.
well the thing is i i i might have like (. ) little salt or
butter [ just:,
[uh huh.]
just to make it you know tasteful.
okay. how often do you think you have mixed vegetables
with the meal?
i don't have it that often. [erm]
[ uh ]huh
not since i've been up here. if i go home for the weekend
[ i]
[uh]
usually do a lot of cooking so yeah. ho- if [it's home.]
[ uh huh.]
often but [i can't]
[o kay.]
do that often now).
okay so erm where do you eat here? like in the dorms or,
["uh"]
[well] i buy my own supply up here. [erm]
[uh,]
basically anything that can be dinner to microwave.
PR  uh huh. [okay.]

P  [pretty] much.

(1.2)

P  so that'll be pretty much maybe t_v dinners and stuff like that.

(2.5)

PR  okay but you cook for yourself on the weekends,

P  but,=

PR  =for yourself and your family i [guess,]

P  [ well ] when i'm home i

P  coo-

PR  okay.

P  i cook and i usually do a lot of baking and frying,

PR  uh huh.

P  and: tzt .hh a lot of thing that may you know and i might j- add ve- vegetables in it and put like a whole lot of seasoning

P  [on it,]

PR  [uh huh.]

P  and stuff like that you know i-

PR  ↓yeah

P  you know pretty much make it tasty.

PR  okay. erm so on the week days like do you do you feel like you don't have time to ↑cook ↓food is that why you're eating like microwave food so ↑much

P  no i just don't choose to. i just don't choose to.=

PR  =you choose to not cook?

P  not i choose not to cook when i'm up here.

PR  ok.

P  ↓

P  i need something fast to fast and on the go. pretty [much.]

PR  [ uh, ] well

P  do you think if if one of the things that we suggested to you was to start try and reduce some microwave food that you ↑eat

P  ↓uh

PR  [and] actually have some more like .hh real kind of food that you >you may have to spend some time cooking do you think that's something you could do<

( .)

P  ↓

P  ↓

PR  on week days?

P  i don't see, i don't see the problem.

PR  uh huh.=

P  ↓

PR  ↓
PR =yeah probably yeah.

P okay coz microwave food, i mean there's a lot of bad for you in it.

PR yeah i know. [ hu] [for] the most yeah you know for the most part it's not even real food.

P i know.

PR you know and the thing about junk food that a lot of people don't know .hh is that it's not only that it doesn't give you any nutrients

P [ºuhº] [ and] a lot of it doesn't give you any kind of nutrients.=

PR [ and] break it down and everything. [you're] using a lot= P [ºuhº]

PR =of nutrients but you're not gaining anything back from the food. so you're actually losing nutrients.

P okay.

PR and a lot of people don't know that.

P o[kay.]

PR [ so ] yeah. [ºnowº]

P [((clears throat))] that's just one thing i just kind of share with you right now.

P uh huh.

PR but: tzt okay. alright so do you snack after dinner usually?

P sometimes yeah is it usually is just something simple.

PR [uh. ] o[kay.]

P [like] (. ) chips and erm dooritos and stuff like that.

PR just about it.

P nothing major,

PR okay. so do you drink water? o[drink [(slb slb)º]]

P [ yeah i ] drink a whole lotta water. that's that's that's,

PR [ o kay.]

P [what can] i [ can ] say,=
PR

=good=

PR

good.

P

= i drink a whole lotta water.

PR

okay. do you know about how much?

P

on a daily ba sis

PR

uh.

P

i'm i'm talking about (1.1) maybe three to four bottles

twenty two ounces at a bottle.

PR

okay.

P

(1.6)

i'm not really erm i'm not really a big fan of juice or soda.

P

(0.8)

uh huh. [ o kay. ]

P

[ and stuff]

PR

so you don't drink juice or soda [ulse,]

P

[i do drink] it. but you

PR

know not as [m- not]

P

[ o kay]

PR

not that much of it.

P

do you drink coffee at all

PR

no i don't like coffee.

P

okay. (6.0) okay erm do you smoke?

PR

erm yeah that's it. not cigarettes though erm i'm i'm (slb slb) to (.) like erm exotic cigars, i go to different

cigar shops and i see what they have and you know, yes so

yeah.

P

[°uh huh°]

[ i'm a] big (slb slb) to cigars. i've been like that

since

P

[°uh°]

[erm ]since erm high senior in high school.

PR

okay. so how many do you smoke?

P

i smoke cigars on occasions.

PR

[ o[kay.]

P

[ it ]depends what the occasion is [and stuff,]

PR

[ o kay. ]

P

i don't smoke it every day. [and stuff.]

PR

[ uh huh. ] so maybe once a

week

maybe yeah. maybe depend if, like it could be a few times

a week or [sometimes]

P

[ uh huh,]

PR

may i can (barely) go a couple of weeks without it. but

PR

[ o kay.]

P

[yeah i] smoke only on occasion.

360
(3.6)
PR okay. do you drink alcohol
P yeah i do.
PR okay. how much do you drink?
P erm i make a habit just to drink on the weekends. i
[ okay. ]
P [ don't drink] during the week for erm for pr- erm just by
PR personal rea- i don't think [ it's right or,]
[ uh huh. uh ] huh.
P i don't erm like on like fridays saturdays and sundays
maybe, depend it but [yeah.]
PR [ uh ] huh=
P =i i drink erm i like to drink like (.) like very
expensive bottle
PR okay.=
P =and stuff so.
( .)
PR okay so how many drinks like on a friday or saturday night
P do you drink.
PR i know if i have time i could go through a whole i could
P do i could go through a whole big bottle myself.
[ uh= ]
P =straight.
PR okay.=
P =and if i don't have time i just take a few glasses. and
stuf so,
P okay. so like you usually drink at least one glass at
PR least three glasses,
P yeah three [three glass ]es and stuff.=
PR [three four,]
P =yeah it dep[end yeah.]
PR [ o kay. ] and then like a whole bottle
P that's like maybe ten
( .)
P glasses,
P yeah they call it the erm fifth. in what the (buck) i
P drink the [fifth.]
PR [ uh, ]
P erm tzt may may could be as high as my knee.
P the bottle
P yeah.
PR and you drink that whole thing
P and i can i i it's mo- it's been one or two times i go
through that myself.
PR wow!
P yeah.
so that's that's a lot of shots.
yeah. [yeah. ]

that's like twenty five
(0.7)

may[be?] [it ] could be more i don't know.=
yeah coz that's that's a lot.
[he yeah.]

[and is ] the bottle this thick?
(0.5)

.hhh the bottle is like (.).hh the bottle is like maybe
like (1.1) like this thick and then it goes up like (0.6)
from my from my foot, it can probably go up to: (1.0) one
size it can go up here, and then the bigger size which i
had one time it goes up to my knee.

(0.7)

[ o kay. ]

[and that] size took me [ on ]ly:=
[^wow,^]

=one week only took me like two days to go through that.
[^wow,^]

[ by ] myself.

okay alright. okay so and that you drink just friday
saturday do you drink sunday al↓so
.hhh depend, i don't make a [ ha bit ] to drink on
[^uh huh^]

sundays.=

=okay.

you know but friday and saturday, (.). sometime that could
just be my weekend sometimes.

okay do you drink alone som↓etimes

drink alone, or i [don't]

[ uh, ]

erm or socially but mostly alone.

okay.

(2.2)

do you get hang↓overs

(1.0)

no. not really. i'm i guess i'm so used to it it just the
only thing it [does ] just keeps me hungry i [don't]
[^uh^]

i don't get hangovers and i don't get sick.=

[^uh^]

[ it c-]

[but it] makes you hungrier [that's to ↑say]
it really gets me hungry. [erm]

maybe coz of the nasty taste in my mouth.

[uh!]

the the intoxication, but it just gets it just gets me very hungry.

okay. like hungrier while you're drinking or the next day,

no hungry after i've done drinking it.

okay. (1.6) \( \downarrow \) u:h (0.9) do you tend to eat a \( \uparrow \) lot then

after you drink,

u:h no just just enough to j-just to satisfy the hunger

and

[ o kay.]

don't get] myself sick in the morning.

okay.

so,

okay so erm have you ever like do you ever feel guilty

about drinking, that you drink too much,

(1.1)

u:h, hu hu. to be honest no i don't.

okay.=

a lot of people,

°o[kay.°]

like a lot of people do tease me coz the alcohol

erm they say the the alcohol (slb slb) i have i i guess

i'm not ashamed or i gotta [(slb) and]stuff like that.=

uh huh.]

=and i think about that too.

uh huh.=

=i think about that and just (detoxes) i just sit and

it'll be like, maybe i should cut down cut down on the

drinking,

(.)

a lot,

uh huh.

coz you know it's not (slb slb slb) but it's nothing (slb)
to show that that,=

=uh huh.=

it's best to be erm it's making me show physically.

ah hah.

and stuff. so a few times i think i've thought about it

but the proverb go easier said than done!

\( \uparrow \)uh\:uh so have you tried to stop drinking?

(.)

ever have you tried to quit,
me? erm tried to stop drinking?

to quit. but i've never tried to quit it. erm i thought

about it a couple of times erm er in the past you know, i

thought about you know maybe one day i might stop drinking

period.

[ uh huh. ]

[for health] reasons, erm=

=but (if i did i) mean in the long term,

[yeah.]  

[ as ] far as kidneys and other [health]issue,=

[ yeah,]

i [ have]

[(slb)]

(to have thought about that,

(.)

but erm and then you know it just i don't know it's just

like e:rm tzt i wanna call erm i wanna call it erm tzt

like: the erm

acquired ↑taste or

["uh"]

[some]thing like ↑that and if you see this, erm alcohol

that i do buy is .hh is like really elegant,

[uh hu.]

[and ex ]pensive and i call i like to call it acquired

taste so,=

=ah hah.

maybe just an excuse but that is me.

okay okay. have you ever like drunk alcohol in the

morning? during [like week or something,]

[ oh no! i ne ver ] do that.

okay.

alcohol,=

=okay=

it's just it's just somethin (that's easy to go by) it if

i know if i'm at the point that i'm drinking alcohol early

in the morning, [like for,]

[ uh huh]

breakfast and s- then i know i have a problem.

uh! [ o kay.]

[and stuff] so i'll [never,]

[ o kay]

no that's something i'll never do.=

=okay=

please do not reproduce or circulate without written permission
P =not even on the weekends.
PR okay. [ o kay.]
P [ i won't] do that i'll wait till like after five.
PR [ uh huh okay.]
P [and stuff i you] know and stuff so;
PR okay. that's good. that's good. .hh so have you ever
PR thought about just i mean coz you thought you said you
PR thought about quitting, have you thought about just kind
PR of reducing, like drinking every other weekend or drinking
PR just one night a week instead of two
PR [nights,]
P [.hhh ] when i thought about actually s- quitting i just
P don't know. i didn't say when i would [ do. ]=
PR [yeah.]=
P =it but i have thought about slowing down. but .hhh i just
PR haven't come to that that erm that conclusion yet.
PR okay.
PR and stuff so.
PR alright alright that's kind, it's there.
P [yea:h. ]
PR [in your] mind,
P but it's still on [my mind.]
PR [ o kay.]
P but i think [one day] i might stop maybe.=
PR [ o kay.] =uh huh.
PR [ o kay. ]
PR [(weekends)]
P and even before i mean even without stopping you can still
PR you know that you can reduce,
P yeah.
PR you know what i mean,
P [.hh er]
PR [ when ] you feel like you're ready i guess,
P yeah [ i mean,]
P [(slb slb)]
P I KNOW this is one thing i know if i wanna stop and stuff
PR i can do it.
P i've been[i've been]through so many other things,=
PR [ uh huh.]
P =and stuff.
PR uh huh. [ o kay.]
P [and if ] i wanna just slow down doing it i can do
PR it and don't (slb slb slb) so
PR uh huh.
P but i just haven't just got to the point that i wanna do
PR it yet.
PR [yeah.]

P [ you ] know so,

PR okay. what else have you? have you quit,

(.)

PR you say have you quit other things, like what else?

P yeah i quit erm tzt i quit other things just fo:r erm for

PR my personal like ( paraphernalia ),

PR [okay.]

P [e:rm ] i mean erm not i should say herbal ( paraphernalia )

PR coz i know i don't do the other stuff but,

PR [uh huh.]

P [ i have ] stopped that. [ i st-]

PR [okay.]

P i've been i stopped that almost five years ago now. [e:rm]

PR [okay]

P well the ( paraphernalia ) you mean coz i mean do you do you

PR smoke ^pot

P yeah.

PR [okay.]

P [ i i ] used to.

PR okay and the ( paraphernalia ) like you mean buying the

P ^stuff

PR [erm]

PR [the] ( paraphernalia ) stuff.

P yeah buying just buy[ing it.]

PR [o kay. ]

P and you know buying it and using it. i

PR uh huh.

P just one day i just stopped just out of the [blue.]

PR [ uh. ]

P i just said i'm just i'm just gonna stop and that's five

PR years ago. and i never walked back to that yet.

PR [ okay.]

P [and I ] i have a lot of pe- i've been with a lot of

PR people that still does ↓it

PR uh huh.

P and they think i might get tempted. [ and stuff ] like=

PR [ uh huh. ]

P =that.=

P =yeah.=

P =but no. i don' t i don' t i don' t miss it at all.

PR okay. so you don't smoke it at all any more?

P no i don' t. [ i don' t i don' t.]

PR [ o kay. coz if ] you do you can tell us coz

PR we're not

PR no. no i don't.
this is all confidential and [°you know?]°
[ i was ] i was a
regular=
=okay. okay.
for it,=
=yeah. [ uh huh.]
[and then]i just st- it just stopped. i just
stopped.=
=ah hah.=
=it just it just it wasn't it wasn't safe for me. i mean i
started doing it when i was in high school,
uh huh,
and (. ) the the fact how was for me then .hh and at that
time, it
just was a mistake in a way you [just get] tired,=
[uh huh.]
=yeah.
so i just stopped and [ you ] know?= [yeah.]
=[right.]
= [ i ]just never looked back to it!
okay. okay that's about five years ↑ago
that was yeah. that was five years ago proba[ bly.]
[uh.°]
i have to say five years ago.
okay.
so that,=
you have you haven't smoked recently have you?
no. [e:rm ]
[okay.]
as far as anything? No.
ok.
a:!
Alright. ( .) okay erm so do you drink soda like every day,
na.
[°okay.°]
i'm not] really a big soda drinker.
[i'm not] really a big fan of soda if i have like: like a
bad taste in my mouth from anything, it doesn't matter
((knocks at the door)) erm coz i drink i drink soda but,
↑done
e:rm [almost.]
[ ready ] to (step up)?
[ almost. ]
now and talk about it.

((leafing through file)) erm (. ) tzt alright.

(slb) down.=

=okay. hh

°uh huh.°

excuse us (slb slb) {(slb slb) slb slb}=

[uh huh.]

=°slb slb slb° i'll just (take) the (slb)
((reading P’s file)) alright. so let's see where we got.

(7.6)

yeah,

(1.5)

are we on?

(0.7)

yeah

uh,

(slb slb slb)

(1.1)

alright.

(2.2)

(what do you got anything for me),

.hhh er erm no i don't.

"okay."

=last week was pretty (slb slb),

(in what way)

(4.4)

in what way?

erm mid term, not mid terms exams we had,

u:h,

histology and anatomy on top of each other.

you did

(0.8)

you went from here to your anatomy project you also had a

a

[test]

[ the ] practical and then i had (0.4) a histology test.

(2.0)

and then this weekend i erm

(1.1)

relaxed and didn't do any work, and went out and

(1.1)

had a good time

drank a little, yeah.

right.

(slb slb slb)

(0.7)

where did you go

(slb slb and who did you go with),

erm

(1.8)
P Jenny. She's a (slb slb slb slb slb there),
PR o:h,
P And [a bunch of the girls,]
PR [you're makin' you're makin'] in friends with e-
P [everyone i]
PR [every body] but the naturopathic students!
P [he he he he]
PR [ha ha ha ha]
P [he he he he]
PR ha ha (((claps hands)))
P [ .hhh ]
PR [.hhh ]
P [well,] er no. (((slb slb)) to be [with 'em] other times,=
PR [ ha ha ] [.hhh ha]
P =[he he he]
PR =[ha ha ha] ha ha gk gk .hhh
P definitely (slb slb [ slb ] slb slb slb slb slb)=
PR [cool!]
PR =right everyb[ (h) o ] dy,=
P [yeah,]
PR =[but: ha ha]
P =[e ve ry] one except he he he he [ he ]
PR [.hhh] that's so
PR amazing,
P that's it's so amazing (((slb slb)),)
P [ the girls ] from my class were
PR there
P though,
PR [ oh they ] ↑were=
P [and some] =chiro guys too.
PR (2.4)
PR interesting people,=
PR =so you had a good time,
P i did. i did.
PR that's great that, that's incredibly important.
PR (1.7)
P (slb slb slb) sometimes.
PR alright. so erm w- w- (0.5) what ha- what have you done as
PR far as
PR your [your goal] and your program, (((which you))]
P [tztt .hhh] [ i've wor ked on my
PR (visuals slb slb), erm
PR what have you done,
PR (1.2)
P [well,]
PR [with ] that?
P just
(1.1)
P (probably) sitting down and trained the (real slb slb)
meditate on it
(1.0)
P if you wanna call that,
PR [are you,]
(1.0)
PR were you able to (0.4) see [some]thing?=
P [tzt ] =erm i realized
(1.8)
P i have a certain impression of myself when my when i'm
clothed
PR uh huh,
P and then when i'm not
PR uh huh, tzt and what is that?
P and when i'm clothed apparently the clothes help me, (.)
look
PR uh huh, tzt and what is that?
P smaller than i perceive myself without clothes on
(1.1)
P hence probably the baggy clothes, and
(0.5)
P things that are (slb slb) and
(0.5)
P i was working on, looking at myself.
(1.1)
P and (look) just,
(0.9)
P straight at me and trying to: (. ) visualize that,
(2.5)
P erm impression of myself to be,
(0.4)
P better.
PR uh huh.
P erm
(0.8)
P and i think i: got there. °almost there°.
PR good.
(0.7)
PR good.
(0.4)
PR good.
(1.3)
PR that's (0.5) er if you especially if you've never done it
be before takes (slb slb than) anything else.

uh,

but incredibly powerful. so powerful.

0.7

i mean you need to get where you wanna be with your body.

where your body can actually have [some ]thing=

[yeah,]

[to (slb ) for.

(it it it's really that simple.

uh, the mind is the most powerful thing. coz it will (slb slb)

like fifty percent when you get body er er anybody any

medication.

(0.8)

so,

(1.2)

keep working an and you know! you don't need to spend

(slб slб at it) you just spend some time at it. (.) and

getting exactly where you wanna be. how you wanna look.

and play that movie! press play.

(0.8)

how you wanna stand.

(0.7)

and finally how you wanna present yourself.

(1.0)

all that if you want is all connected.

"uh",

so keep keep definitely keep working on that.

(0.9)

erm have you bee able to:: do any kind of exercise?

tzt .hhh erm (as i slб slб) i did go walking tzt (slб)

walks even

when it was freezing cold outside on friday. [{i did}]

[uh huh,]

(1.4)

erm i didn't go swimming this week,=

=okay.=

=because (slб slб slб) because of the [test.] 

[ how ] was walking

on the cold?

[tzt]

[is ] that something that you li- you came back home, and

you go

i'm never wanna do [that a]gain?=

[ i:: ] =love it because
it's desert and
no one's around, and hhh
uh huh,
the cold, i love cold air. (.) erm
how long have you walked,
erm tcwho0 hours
two hour walk (.) wo:w!
PR
uh huh,
P
P
ERM
tcwho0 hours
two hour walk (.) wo:w!
PR
uh huh,
how long have you walked,
ERM
PR
uh huh,
P
tcwho0 hours
two hour walk (.) wo:w!
PR
uh huh,
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two hour walk (.) wo:w!
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tcwho0 hours
two hour walk (.) wo:w!
PR
uh huh,
it happens yeah.

[yeahh,]

[ and ] how what do you think of that? did it help with [(ºthis slb slbº)]

[i think it ] helps a great deal. [it's ]

[good!]

making me feel b- er more comfortable in my skin. [a:nd ]

[good!]

((sniffs))

(0.4)

erm

(0.6)

uh the: concept that it's you know,

(0.8)

mostly in your mind it's all mental. erm (.) she was:, a lot of other people are having problems with certain positions that, require like hand stand or balance.

uh huh.

and they see it as: er strength exercise but she was trying to teach us that it's more, ((miming two pans in a balance)) (1.2) a combination of flexibility and strength. not all strength.

[sure.]

[ but ] some.

yeah!

but if you alter your perception of what it is you're trying to do then it'll be easier to do. (.) a:nd

ex [ actly.]

[i'm not] having problems with any of the positions except for:,

(0.5)

txt something called the tripod? not tripod, .h it's where it's a hand balance you're basically,

(0.6)

[ ba ]lancing on the hands with=

[yeah,]

=your knees on the back of your elbows?

gotcha.

and we've only tried that once a long time ago. and i don't know you know at this point if i can try again. but she suggested not [↓to hu ]

[do you?] do you do is it something that you would like to do?

yoga?

that pos- that particular,
i think at this point because i was unable to do it successfully in my eyes the first time,

uh huh,

that it's i'm i'm eager to try it again.

[great!]

[ to ] see if i can get there.

(0.9)

and, 

(0.1)

mentally ((PR nods)) i know what i have to do and how i can do it and i see myself in the position? .h er even if it's for a couple of seconds,

[uh huh.]

[(slb slb] slb) out there? but erm, 

(1.0)

and i don't wanna hurt myself either. so i'm not trying any of the,

yeah,

very difficult positions

[uh huh.] 

[outside ] of class.

(2.0)

good.

(0.6)

erm you know life life is very, 

(0.5)

life forcing goals. and people who really accomplish anything (. they constantly have goals and if you read any motivational book or er any er self er (. personal coaching book or any personal coach will tell you that, (. - we need we function on goals. so if it's something that you know again that you wanna accomplish, 

(1.3)

coz coz life is also about achieving things. 

(0.8)

and for whatever we achieve this is is important to us. or whatever i achieve is very important to [ me. ]

[yeah.]

whatever you achieve is very important to you is very individualized very subjective. so, 

(1.6)

c- certainly if
if something as important or less important to other people but important to you as making you know doing that position in yoga, and if that's truly important to you that's you should have that as one of your goal.

i i'll tell you long ago i had you know i had never (slb slb slb) and decided i wanted to run a marathon. that meant nothing to other people. for me it meant the world. °right°.

and i kept >running running running running< and i (slb slb slb slb slb). and this summer i i (thought get out of here i won i won a cool marathon) the point in being is that things like that fill your spirit so much, this is a spiritual exercise. uh, and physical obviously but mostly spiri- spiritual. coz you're like i did it.

is that feeling like i did it you know?= =uh huh, nothing er er is it's a powerful feeling. and you don't get that feeling every day. you know? you don't get that feeling every day you only get those feelings like every now and then.

you know that feeling of accomplishment i had a friend who just ran the new york city marathon. she did it in four hours and about twenty minutes. she she was high. [she]

was she was high.
“exactly.”

because she did something that really not everybody in the
world could do or everybody could do but er they don't.
(1.4)

so you know,
(0.3)

if that's one of the things that you personally wanna do,
(0.4)

and you can't,
(0.4)

and along with with with your weight loss program,

probably when you start with losing just a few pounds,

you're gonna= [uh,]
=be able to do that
=uh,

position. coz,

uh huh.

you know, [pro-]
[ e ]xactly.

right?=
=well that's the thing! she said that my mental block of
course was there's no way i'm getting this,
(0.5)

myself into that position,

right.

w- with as heavy as i am.

right.

erm

but,

(0.4)

she dismissed the, er she i didn't even vo- ver- vocalize

it but she said,

(0.6)

erm

i don't know. (. ) maybe felt that i was thinking it, or
[uh huh,]

[because] i may have seen str- pressure that i couldn't
get into this (slb tion),

uh huh,

erm

(0.5)

just stated that it wasn't,
(1.6)
you know, there is no reason you can't get into it regardless of your size regardless of your stature height whatever. hh you should be able to get into it if you want to. and you know just working on the lower belly, and the muscles are a little weak down there, i'm not doing any push up chair or sit ups right now. but erm,

it was encouraging to hear say that and,

put me back in my mind to make you know to know that, i can achieve anything that i put my mind to. absolutely! absolutely and th- er you get that feeling that i was just talking about. a feeling of i can.

it was encouraging to hear say that and, putting me back in my mind to make you know to know that, i can achieve anything that i put my mind to. absolutely! absolutely and th- er you get that feeling that i was just talking about. a feeling of i can.

uh, that erm a hot feeling like (slb slb slb). and a hot feeling! uh huh.

like i can that feeling is an amazing feeling,

and you know er er and you're gonna definitely feel that when you get to your erm the point where you wanna be as far as er your body composition.

(slb slb) amazing. so certainly you got some things you gotta you gotta keep working on it mentally. and certainly physically but more so mentally.

uh huh,

and:

you know i:,

i'm i'm done in a few weeks from here. so what i'm hoping to do with you kind of like put you on your way. where you know exactly what to do how to do it, and lately you you'll be able to do it er pretty much on your own.

so that's where i i hope i hope you'll be. so talk talk to me about your nutritional life style this past week. erm hhh very poor actually. i,
what do you mean by that?

I made poor food choices in my eyes.

like what?

erm crispy cream donuts? hhh

okay.

erm [(slb slb)]

[ on what ] day, [at what time,] [it was just,]

(0.8)

°when was that then,°

(1.0)

°erm°

(3.0)

tuesday night.

okay.

and wednesday night. (. .) we:,

okay.

we meaning two oh my friends and i went to crispy cream and got a dozen.

okay.

and how many did you eat,

four. (we each had) four.

in one night

two in each night.

two in each night [ o ] kay.

[two.]

and what else,

(0.6)

erm {(rhythmic lip smack)} tzt tzt tzt tzt

(6.9)

potatoes,

okay,

and (slb slb slb) he he he=

=and (slb slb [↑slb])

[well ] just at the cafeteria basically.

[ yeah.]

white rice and potatoes. things you know,=

=so [what what was, ]

[erm kinds things.]

your typical breakfast.

tzt

let's start with that.

erm the same thing the,
three boiled eggs,

okay.

erm (.) this time i started putting

(2.2)

[uh,]

[hot] water in the toasted oates

(1.0)

and just making oatmeal without the sugar

[(slb that] they turned into,)=

=okay.

and then i put a little bit of maple syrup in it

(1.0)

for a sweetener.

uh huh,

and:

(0.6)

and what else,=

every once in a while c- a piece of (slb slb)

a little pear:

okay,

or banana.

okay.

that's (slb slb slb variable)

okay. what else?

(1.0)

erm

anything else with break fast

txt just two glasses of water.

(0.4)

okay.

(1.1)

how about for lunch or er snacks?

erm=

=between lunch er breakfast and lunch.

snacks last week was pretty i had a craving for bananas
all weeks. [i ]

[uh] huh. o[kay.]

[i: ]

uh huh.

ate bananas during my (slb) and

(0.8)

lunch

(0.7)
er lunch i had, gosh!
(1.9)
really anything the cafeteria was serving. but erm the
(slb slb)
not to be you know no fried food. er
uh huh.
stir fry sometimes.
uh [huh,]
[ so ] they have sweet sauces with that once in a
while.
(1.1)
okay.
(0.7)
.h and snacks between lunch and dinner this past week?
(3.6)
erm
(6.0)
txt i don’t think i really snacked then, i just gonna eat
dinner
early and (slb) in the night.
then what was your dinner?
(0.7)
more or less,
erm
(1.2)
we ate out a lot last week.
(0.4)
you and your new (.) [↑friends]
[ hu ]
(0.8)
txt [but they are still in my ]
[non na turo pa thic friends?]
class so they are naturopathic. he [he ] he he=
[ah!]
[ he ]
=pfui!]
.hhe .hhh erm (.) mediterranean, middle eastern food.
:o[ay.]
[like] er (slb) and
(laylas) o:r [(me di) ]terannean ↑food=
[ er er ]
=(leylas)?
er erm txt fala↑fel
yeah,
but (at leylas) yes [ e ]xactly.
[uh,]
we went there twice.

and what did you eat?
i had the chicken,

you know the thing wrapped in tortilla,

uh huh,

with the dip in sauce. garlic dip in sauce.

uh,

°(other than that)° and i had hummus,

°okay.°

(alright.)

=and next time i had (. ) schickh kebab.

uh,

°with falafel.°

what do you feel your relationship with food is right now?
txt

erm before, i was beginning to look at it as:

er er kind of mediocre something i needed to:

nurture myself. not nurture nourish myself with, erm

[uh huh.]

[as far ] as

er just eating a little bit here you know, just a little

(slb slb)

meal and,

if i became hungry it meant to me eat something for a

snack.

[ but, ]

[((sniffs))] uh huh.

you know (slb slb slb) eat

(last week.

(2.1)

i could blame it on

(0.4)
but then when I was actually consciously thinking about it while I made [certain] food choices, =
and I just thought well yeah, I can see this is stress right now.

I just (0.3) chose to do it regardless. (3.5)
even when I er hesitated this is probably not the best choice for me right now.
I did it anyway. (.hhh) alright. this is what we gonna do as t-
when you gonna be in those situations very often. you you you wanna stay focused where you wanna be,

you don't wanna focus on where you don't wanna be. (0.6)
or what you don't want. (0.7)
coz you're gonna track what your mind er what kind of information your your mind has, so if you're focusing on that's not what I want, the donut is not what I want I don't want the donut, it's not the best thing for me, you're still focusing on a donut, (0.7)

so you’re gonna want the donut more. [you're gonna= 
=track it more to eat. (0.7)

okay? okay.
and that goes for everything. (1.2)
tzt what you do is gonna ask yourself the question .h what would be what would be the most nourishing food for me at this time,

what is the food that's gonna best er help me attain my
goal?

(2.6)

and then you you you take action from there,

(0.8)

but you definitely you know, you the mind cannot really
take in erm erm erm a negative word like w- you know, w-
that's not what [ i ]

[can't,]

want [ or i can't. ]

don't shouldn't,]

right.

(0.7)

okay.

(1.1)

txt a- ask yourself that question every time you're in a
situation what is what is the most nourishing food that i
got right now,

(0.5)

and w- what is the food that erm that will that will help
me attain my goal,

(0.7)

erm

(0.8)

you know?

(0.4)

losing weight.

(1.6)

e[very] single time.=

P  [ uh,]

=okay?

P  uh huh,

and:

(1.0)

of course that (slb slb slb slb) with any guilt

erm (. ) or waste [you know,]

[i didn't,] once i put the donut in my
mouth i said this is so ↓ good ((claps hands))

[u:h,]

[i'm ] glad i had ↑it he he [ he ]

[great.]
there's definitely a list of foods that are er definitely most nutritious [for you,]

then there's a list of foods that are not. .hh and you

know the foods,

[so  ] we don't have to go in so much detail you know i
good but you still want for whatever reason,

i mean you could you gonna start tell yourself or ask

yourself that question what is the most nourishing to you
right now? .hh and and you know what is the food that er
could help me attain my goal, the best food >that can help
me attain my g- you're gonna ask yourself those questions
then sometimes you< still probably, you know y- you want
something from that donut or something. .hh you definitely
wanna eat less of of those foods that are not tho-
[the best food] for you at that moment.=

[ uh uh. uh,]

=just eat less of it,

right.

[ 0.4]

.h well the donuts, that's the crazy thing i, crispy cream

originated in north carolina and [i never ate that.]}

[ ahh i didn't know ]

that!

(greensburgh) north carolina.

.hhh [(slb slb slb)]

[and there was] one right across the street from my
dorm in college and (.) the most i went was like twice a

eyear.

uh huh.

twice a semester for midterms and finals.

(0.6)

.hh and it wasn't a big thing for me you know, donuts er

not something i craved all that often,

[uh,]

[but] when we found out that that was down the street you

know, it was

(0.7)

er i'm a social eater. i know that i'm definitely a social

eater.(so if i) have a plan to eat something you know soup

or whatever, erm

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and then my friends (slb slb) well let's go out to eat, [and i'd] [uh huh,] say okay. [uh huh.] [go out ] to eat and (. ) eat something else instead. erm (1.0)
tzt (0.3) i am (. ) making a ^soup for tonight chicken, [oh good!]
[ veggie ] a:nd
good. i bought erm (0.7)
chinese dumplings?
yeah,
with erm chicken and leek.
okay.
and i will just eat that with erm (slb slb slb) erm soya sauce?
ok ay.
so that’s you know? another option (for eating) this week.
[good.] [ so ] i'm trying to get very simple things that i can either prepare in advance and put in the refrigerator, and just you know warm it up for lunch. and erm good!
something really quick for dinner just to make it simple so
(0.9)
you know if i don't feel like going to the cafeteria which p-for me doesn't really have the best food choices, anyway erm i can just do something that isn't too laborious (1.0)
at home you know [here in] the dorm. (. ) erm [uh huh.] (0.9)
and there're things i've [done u sua lly,] [you said you do] drive, you have a car?
i do drive.
definitely did i give you a list of the health food stores (slb) [ (slb ^slb) ]
[ tzt no ] i've heard of misses greens, and haven't been able to
find it.  
but you definitely wanna go to these stores. they give you  
a lot of options that that you normally can't get in er  
regular stores.  
o.kay.  
erm because there're certain foods that for example s-  
speaking of the foods that are are not er the best foods  
for you, .hh  
certainly wheat,  
(0.6)  
and dairy fall in that category,  
(right,  
(t)hey fall) in that category big times. and then in fact  
i've seen people lose weight without doing any kind of  
exercise just  
[°eliminate all that,°]  
[ eliminat ing food. ]  
[eliminating food.]  
three things. corn,  
°yeah,°  
wheat, and dairy.  
so the thing is when i (. ) get away from wheat i turn to  
corn.  
(1.1)  
oh yeah, [(slb slb slb)]  
[me xi can, ] and  
sure!  
[just ]  
[yeah.] that's [that's what most]  
[just as bad. ]  
people do.  
uh huh.  
txt that's what most people do you definitely wanna  
consider the food, and and not the best food or less than  
great food for you at this time anyway.  
uh huh,  
put that in that category in your head because it is (. )  
(erm so that you eat a lot less of it,  
(0.6)  
the fact that you exercised so ↓much this ↑week is great.  
because usually with exercise you your body could m- m-  
m metabolize food a lot better.  
right,  
so that's a great thing and and you know your body  
for for for for,  
[ hu hu hu .hhh ]  

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[things that are less] than perfect for you.

but erm certainly you you definitely wanna understand that this this food including hydrogenated erm er oils and high fructose corn syrup,

uh the maple,

[i don't know where that (comes from)]

[i mean]

[high fructose corn syrup. which is is you what what happens is and this is high fructose corn syrup this is also fructose sugar.

anything that's anything co- corn syrup high fructose corn syrup fructose sugar, all this sugars.

that they use a lot in: in in diet bars and everything they're the worst. they're the worst because your body cannot metabolize it. you don't have the you don't have enough of a certain enzyme to break that food down so that your body can use it.

[i uh huh,]

[you just] don't have it.

so people who promote these sugars er because it doesn't promote such an insulin response (.) has nothing to do with that your body doesn't have the proper er or enough enzymes to, so your body only had a limited amount and used it up and whatever else is extra where is it going?

(into your adipose tissue. (probably) your liver gets (slb slb) some fatty,

uh huh,

high fructose corn syrup is one of the worst sugars that there is. .hh actually there's nothing that i will tell you not to ever t- take or not to ever eat, (.) but high fructose corn syrup may be one of them.

txt i'm gonna l- give you a list of all the foods that contain er high fructose corn syrup.

okay.

(slb slb slb slb [slb slb])

[ o kay. ]

 erm

(1.2)

that hydro-

[erm]

[ so] right. now this week i'll tell you what we gonna do,
you did a great battle in this past week.

and i really do mean that. because you exercised a lot more than what you've used to in a long time and that's a very big part of the program. so i definitely congratulate you on that. you did=

P =uh,=

PR =very very well.

PR tzt

PR have a firm understanding of the foods that are not or or that are less than perfect for you for you right now.

PR have a firm understanding on what they are, (. ) all the junk food that you know of, (. )

PR but erm you know highlight the the wheat, the corn, and:

PR that's one then of course the high fructose corn syrup and hydron- hydrogenated oils. . hh i'm gonna give you a list of of everything that contain grea- er wheat. er i'm gonna give you a list of all that.

PR (slb slb slb) because you gonna kinda like er you know be you not go [nna know ] everything, gonna read through

PR [ it,]=

P [yeah]=

PR =you have other things going on it's not just like you're focusing on just this. but certainly these are foods that once you reduce them, ( . ) to a large extent you're gonna really see some benefits as far as your body composition changing and all that.

PR you're gonna be in shock. i mean really (. ) it just happens.

PR what happens is you you know you first day you do it not a big change, second day er not a big change, third day it just kicks in. and once it ki- kicks in, it's just like there's no turning back.

P uh huh.
i mean it's that dramatic!

i've seen it happened many times.

((clears throat)) that's why a lot of people are onto the atkins diet and then they lose a lot of weight.

the a lot of people,

uh huh.

tzt are onto the er erm m-, the diet that i subscribe to the most is the blood type diet.

okay.

tzt and and you know i i'm i work with a doctor and i've seen a lot of great things with that diet help your diet,

and tzt you also exercise i think it's important as you know you're doing a great job doing that, you don't if you start getting on this kind of diet without exercising, then your muscle is reduced as well. you're not gonna look good or feel good but you're gonna lose weight. and that's never my purpose. i wanna help you you know lose a proper weight, change your body composition, and keep you healthy.

[it's a good thing.]

[and that's exactly what you want.]

.hhh so erm

(have slb slb slb) right now.

you have to you have a cross reference or you're all [mine,]

[ no:.]

[i scheduled]

[for the next ]

from now until the end of the semester at this time because i get out at [three.]

[cool! ]

so we are (slb slb slb),

°oh my my my my,"

°here you go."
P: yes.
PR: good.

P: [ didn't]
PR: [what did] with that,
P: follow very well last week.
PR: when [i]
P: [i] was doing very well,
PR: you [were]
P: [ i ] was getting up at six o'clock every morning to
do my yoga until six thirty,
PR: ((clears throat))
P: get ready erm to go to class, 'thank you.'
PR: that's a (slb slb) [a ny]thing that contains wheat and
substitutes, again su- many of these substitutes you could
only find in health food stores.
PR: that's what (slb slb) erm from the (slb slb) yourself with
health [food stores,]
P: [ soy sauce ] has wheat in it
PR: yes:::. yes it does
P: thank you.

PR: ((singing)) na na na na na na na
PR: here's one of dairy,  
PR: and possible
PR: dairy substitutes.
P: thank you.
I found a pasta made of wild rice. You have to look at the ingredients. They sometimes, e::rm you have to look at the ingredients sometimes they say buck wheat pasta. u:h, and it has wheat. You look at the ingredients it has some buck wheat but it h- also has wheat. okay. there's brown rice pasta it's a hundred percent brown rice. again er but you only see 'em in health food stores. and i believe there's quinoa, okay. pa[sta.] anything else but wheat it is great. okay. or spelt or any, look at that list and you'll see other things that are like wheat like spelt, °(well let me copy this for you let's see),° °okay.° alright. i have to make a copy of it. high fructose corn syrup, thank you. (1.1) that i- that's like you can put up (a few extras except for that) that's erm very very very important. to i you know what there's nothing, i eat everything. [well,] [ but ] if i know that something has that, i don't eat it. okay. that i don't eat er artificial sugars.
I don't eat.

So there're few things that I just don't eat. At all refined sugars and soda, uh?

I cannot all candy bars all candy. Good.

Don't eat things that are really (slb) and sweeties. Well except for the donuts.

Ugh huh.

Now and some ice cream every once in a while, that's okay.

All sugar and dairy but,

That's that's o-o- that's okay. Have it. Erm

If you need to have ice cream, if you wanna have ice cream, have it as early as possible,

Have it on an empty stomach,

And you know, have a decent portion don't have a big portion and enjoy it.

Enjoy it so much. Eat it slowly so that you can enjoy it, and not have to eat 'er a pint.

You wanna eat less

Uh huh.

Of it and enjoy it.

And it's okay as long as it's you know what, eat regular ice cream don't get these (slb slb slb) ice creams.

No. Just (slb slb that)] [or (slb) they add a ] lot of junk into those things that are not really good. Eat regular hagen daaz or regural ice cream any,

You know again as early as possible,

And and a small portion.

Hhh

Your goals as to why you wanna lose weight,
tzt you need to like,

be with (..) be one with these goals.

okay

so you certainly goals happen g- g- you succeed, (..) in pretty much everything but particularly in your situation when you write things down?

if

if you don't wa- wanna (slb slb) just mainly e:rm a a wish you wish to lose weight,

when you write it down it has more power.

when you write a goal down this is this is a good lesson for anything in life but particularly in your case if you write these things down is particularly that much more powerful.

.hhh the goals you asked me to write down,

[uh huh,]

[the ten] goals

uh huh.

[uh,]

you gotta dig.

[1.3]

everybo- i've never had anybody not giving me ten goals.

[twenty] reasons why.

(they wanna that they wanna lose weight) never .h not stuck, but i found myself

(1.8)

rewording things saying the same thing [(slb slb slb)]

[you're not the ]

first to do ↓that he he

oka(h)y.

(1.6)

[erm]
[you] gotta dig.

(it takes this is gonna take a little bit of time.

right,

erm it's it's worth it.

it's one of those things that it's worth it.

erm

dig.

dig dig think deeply as to why.

you know, make sure

make sure that nobody in your family friends or any relationships will be,

erm

unhappy

if you start losing weight.

make sure that nobody friends family

uh huh.

or er or other,

that they will that they will be unhappy if you start to lose weight. and be

[(slb slb)]

[there are] some times, what i'm trying to say is there are times when

tzt kind of subconsciously loved ones, quote unquote. kind of are happy that you are

overweight.

and not up to (slb) where you wanna be.

so erm

i'm not saying that's your situation. but i'm saying
that's (slb slb) ti- erm a few times that kind of er so
what i'm saying is you don't go, y- er if you haven't gone
through that already with your
(0.5)
PR
t R personal erm awareness erm weekends, that you that you've
done erm just make sure that this, that's
(1.1)
PR
you know that th- there there's people that really truly
love you,
PR
uh huh,
PR
and coz you know you gotta ma- you're we've been around a
little bit of time, there's always family members friends
that are your friends but some\times
(0.5)
PR
tzt you gotta love them from f.a.r.
PR
right. .hhh that's interesting that you say that. i have:,
(0.7)
P
tzt my family
(1.9)
P
is very very (nuclear).
(0.9)
P
and traveling our entire li- you know, er my whole life
anyway,
(0.9)
P
.hh erm we
(0.5)
P
were all we've had.
(0.4)
P
for a very l- for our whole (we), as long as i can
remember
(0.4)
P
.hh and my mother and my father (0.4) erm my sister all of
them especially my mother are extremely supportive in
anything i wanna do.
(0.6)
P
and
(2.6)
P
thee:: leadership conference i attended,
(0.4)
P
they were some: some way apprehensive
(0.6)
P
and this past weekend when i went to visit my sister, she
not this past weekend the weekend before.
(0.8)
P
tzt gave me ha ha ha .hhh erm a paper on (.). how to
recognize a (coz)
and supposedly she did it you know as a joke. but then she also erm (pulled) (slb slb slb slb slb) and did some research on support groups.

in the area for weight loss or whatever, erm she has this impression, she's going to you know psychology training. she ↓ is yes ha [she's be coming]

[how old is your] sister, she's twenty, (0.4) three. okay.

and she's going through the program for (1.5) counseling psychology at n\_y\_u. okay n\_y\_u. °okay.°

and erm she's dorming over there she's dorming over there. uh,

d that's where i stay when i go to new york. cool alright.

and apparently she has the feeling that i seem to have the need to belong to a group. (0.9)

okay, (1.7) and the thing with my sister throughout our lives we've always had a very (1.8) big (0.5) misunderstanding of one another, (0.5)

great relationship. very close, very loving, very caring toward one another,

uh huh.

erm we had our share of fights growing up,

uh huh.

it happens when you're so close in age i guess.=
PR =sure.
1333  
1334 P and
1335 (2.5)
1336 P all the while (.). i don't think we've really ever (1.0) got to know each other,
1337 PR really
1338 (1.7)
1339 P that well.
1340 (1.5)
1341 P erm there've been (0.6) tzt moments throughout the past few years where i've realized (0.9) that she has impressions of me, (1.2) that i don't even,
1344 (0.7)
1345 P well basically attributes feelings that i may have about myself to me, that completely don't exist. that i have
1347 (0.4)
1348 P no clue where she might have got 'em.
1349 PR okay.
1350 P certain ideas from,
1351 PR okay.
1352 P erm
1353 (0.6)
1354 P [the big one was that i w-]
1355 PR [((slb slb slb slb slb slb)) first to be dis[cussing this]
1356 P [ he he he ]
1357 he
1358 PR is god tryin to talk through me?
1359 P .he
1360 PR is that happening right now?
1361 (0.4)
1362 PR or someone
1363 P .hh well,
1364 (0.6)
1365 P i don't know my whole life i you know,
1366 PR [((clears throat))]
1367 P [ spent pro ]tecting her basically.
1368 PR uh huh,
1369 P erm
1370 (1.9)
1371 P i see her as: fortunate and somewhat selfish and self (1.3) erm (0.8) concerned. er
1372 (1.8)
1373 P a:nd (1.4) i don't know even as teenagers er you know what she wanted to do, w- where she wanted to go travel and
1376 trips, florida,
1377 PR uh huh,
you know,

and see west whatever, she did it she went.

uh huh,

erm and it's also the older younger sibling dynamic where the you- older daughter has or (0.5) child has more problems because they're pushing the limits er you know trying [ to, ]

get the barriers first with the parents,

right,

and the second child just goes through because by that time the par[ents (slb:)]

[.hhh would ] like to [retire,]

know,

definitely coz erm some friction [there be]tween us.=

e=and (2.1) er after graduation graduating college i went straight to work. erm

uh huh,

trying to save money for school.

she went to Germany and studied for a semester there,

uh huh,

and then came back and went to school, got a new school (slb slb)

and (0.6) i suppose i was i was extremely happy for her but somewhat, jealous? that she had that opportunity,

thee: er (0.3) you know chance to live in germany for six months, eight months actually.

and (1.1) you know it was great for her and she had a really good time and you know told us all about it, it was really wonderful. but erm

i don't know, it often happens actually when we're in germany,
staying alone by ourselves together and show this,

come out and say things like,

immediately after: hh high school i believe it was for
her, er we went to germany for a while and she said that
she always saw me as im- (1.5) immovable,
(0.6)
impenetrable,

P robot like individual.

P [whose] feelings can't be hurt.

(0.7)
ands (0.6) you know i just (slb slb slb slb) not allowing
anything to bother me, anyone to hurt me anything like
that.

and hhh [that was the first]

[were you try ing,] you were holding things in?

[ tzt no. ba ]sically she saw me as being so strong,=
[your feelings,]

= [uh huh.]

= [and so ] and so (0.5) invincible,

that (0.7) i didn't have feelings in a sense.

uh huh,

(0.5)

erm

and she genuinely meant that. and that really really hurt
me.

(1.3)

because i thought we were close (to one another),

right,

(2.4)

and tha- that was really the first epiphany of

wow she has no clue. who i am ha ha ha .hhh you know? all
of this time we spent together growing up, me protecting
her as being you know best of friends in a sense,

(0.4)

yet so having our own friends because of the age
difference,
P you know that was (0.4) pretty difficult to deal with. and it happens (1.0) every once in a while again with the leadership conference situation, erm
PR ((clears throat))
P she came to the so called *graduation* which was actually (slb slb) to (slb) other people into the seminar, hh erm (1.1)
PR er er of the of the organization,
P of the organization yeah. he he he hh erm
PR uh, that's interesting.
P yeah,
PR (1.6)
P basically we brought friends and family,
PR well it’s in the bottom line is that they can help other people.
P exactly.
PR they [can help other people.]
P [and that's the way i loo]ked at it. as
PR right.
P i know it's a money making thing for them as well, of course you know,
PR you're gonna do a lot of things that are money making at the same time.
PR (0.6)
PR you're gonna [help (slb) a better]
P [help for poor people]
PR (slb slb) a lot of peo-[peo]ple=
P [yes.]
PR =and (1.2) and we definitely erm (1.6) er t- to come up with the time, th- just a little bit you you definitely wanna have, you don't wanna have a poverty conscious mentality,
PR right,
PR and as a profession we do have a poverty conscious mentality.
PR (0.9)
PR erm and you don’t wanna have that [er]
P [o kay.]
PR as a profession,
P okay,
PR so you know,
If life is about win win, not yeah. win win and give and receive,

Okay.

And (slb slb slb slb) money so, (0.4)

Er keep that in mind as you go along because some people you gonna have people right around you, they're gonna 'heal the world and (slb slb slb slb) making money'

Uh huh.

An you're gonna be a very better doctor you know making the money.

Uh uh,

So you know (0.7)

Is it a (slb) for them, of course it is. it's a way for them to know so people see how valuable their staff is. and when you wanna join, sure!

Right.

But there's nothing wrong with that.=

As long as they're helping people. and they're certainly helping you.

Right.

Hhh and it's not for everyone and that's,

[It is not for everyone that's sure.]

You know, doesn't feel it's for her. she's definitely not going to do it,

Erm yet she've still tried to be supportive,

For me.

((clears throat))

Erm but i think her reaction as far as (2.3)

She discussed it with my mother and my grandmother, and my mum discussed it with my grandmother, my grandmother is a very well learned you know,

(1.1)

Counseling kind of (slb) work body work erm therapist. and

Erm (0.4) i always go to her for very valuable advice.

Uh huh,
and i hadn't spoken to her about it but apparently he had
you know my paren- my mum and my sister had concerns. so
[they did.]
[uh huh, ]
.h and she assured them that you know, i was intelligent
enough and strong enough to know what i was getting myself
into, and only take that from which i was given what i
could use.
(0.8)
and that was valuable to me and could help me (.) forward
myself.
(0.6)
and (.) they were happy with that explanation so it er you
know er made them more comfortable with=
=uh huh,
what i was doing.
PR
uh huh.
and (1.4) at that time what i had gone to so (1.6) w- w-
why my sister insisted on giving that to me, still you
know i was again somewhat insulted, but they were just
kind of like naa! (slb slb slb slb) this (0.9) her i
guess,
(0.6)
[think] she does,=
[ so ] =so (0.3) er (0.4) er basically what
you're
telling me is that, what i'm saying is making some sense
and there might be
(0.5)
[.hhh]
[some] some.
er not with my immediate family.
yeah,
erm the people that you love from a distance i don't have
those people i just,
(0.6)
that,
o[ kay.]
[yeah.] family's family but:. okay. [ o kay.]
(you know,) that doesn't mean i have to
\"great,\" [okay.]
[ erm ]
txtt make my s- my situation more difficult by trying to do
for them,
PR: yeah.=

P: =erm constantly bec~ just because they are family. you

PR: right.

P: erm that's pretty much my dad's family.

PR: °yeah.°

P: hhh [ and ]

PR: [°right.°]

P: my mum's family nothing but supportive, loving caring

PR: giving,

P: right,

P: give and take [ com ]pletely.

PR: [good.]

P: [ so i do have that si ]tuition,=

PR: [that that's that's won der ful.]

P: =.h but where that would come into play is erm

relationships. male relationship.

PR: (1.1)

P: erm and that's something i've always had a problem with.

PR: oh you spoke a†bout ↓that

P: right.

PR: you spoke about that last time and,

PR: (1.8)

P: so you think so you (are trapped). (. ) it's how you're

feeling you (are trapped),

PR: (1.8)

PR: so, (0.3) you know, you're you you you you got to you

PR: know

PR: (0.4)

PR: you have a result. (. ) your past experience.

PR: (1.2)

PR: until very recently.

P: (0.4)

P: right,=

PR: =and i'm sure (slb slb slb slb) something that you just

heal from

PR: that in one weekend course, that be may be very helpful

but everybody's different you may [ or ] may not have,=

P: [look.]

PR: =[i mean,]

P: =[ ro ]berto i've been doing loads of work for [most]

PR: [ oh,]

P: do you have?

P: since i was thirteen.

PR: okay.

P: so,
(0.7) i- it's not just this you know one weekend course.

[so that was the climax.]

[(slb slb) a beautiful ] course that for me was thee:

(0.6) last hurdle. [ it was the]

[(slb slb slb)]

beginning to the peak of the mountain i was trying to climb.

(0.6)

erm but=

=so your your your results are the, [s- so that]

[i f- i ] feel

(various) results.

yeah so so that's the point. that's exactly my point. that

erm

(0.8)

you (didn't) you (didn't) result is with the issues, emotional

issues until very recently.

right.

(0.7)

but those [(slb slb) from my ]

[ as a result.]

past are still in my life. and [ that i ]

[(slb slb)]

do see as a problem.

(0.3)

they are still in your your yours boyfriends that you used
to got

ex boyfriends.

they're still in your life in w- [what way?]

[and one ] my first

boyfriend's

trying to: tzt make moves to come uh,

okay,

[to come ] back, [to c- be with you?]

[to come back in to ] my life.

so,

(1.0)

so what's the deal with that?

(tzt he: (0.4) erm (1.2)

do you have [ any in ]terest,=

[it's always]

=i- i- i- into returning with any of these guys,

absolutely not.
so w- what is the problem?
what is the issue,
(slbl slbl)
((looking into each other's eyes))(slb slb)
basically they're calling to tell me about the (slb slb)
that they themselves [have ] had,=
[their]  = (slb slb)=
=they
=they
[agr-]
[they]
[yeah] they bog me. see i'm i'm underappreciated, right?
peoples begin dating me, er they
misuse me or
underappreciate me. and it ends for one reason or another
one of their they cheated, or i got tired of them, or
[what e ]ver=
[uh huh,]
=happen. .hh erm
three people in particular continue to call back.
over the past, erm one i have known as long as nine years
now.
and (0.8) erm ups and downs you know,
other relationships,
friends not friends type of situations.
(0.5)
. hh and
now they're you know telling me
(1.5)
they don't wanna let me ↓go
[is there,]
[they rea ]lized how valuable i am,
[and what are the chances though]
[and they've grown up finally,]

of, what are the chances though of them making you feel
good right now?

txt erm i don't need them to make me feel good.

you don't [need them,]

[ i don't] see,

=they are not giving you anything right now.

[ not at all.]

[(slb slb slb) ] your ego,

conversation tss [pretty much it.]

[are they (slb slb)] your ego a little

bit, mak[ing,]

[ no.]

you feel important?

no.

okay.

no i'm i'm ha- more or less what they're telling me makes

me happy for them. that they're finally growing up and

becoming [somewhat]

[o kay. ]

so i don't [th- ]

[men.]

what i'm trying to sa- what i'm trying to ask is so then

er what is, (0.4) the problem.

(0.8)

.hh erm

(0.4)

txt really i,

[what's that?]

my whole life has been, (0.7) make friends quick, pick up, go.

make friends quick, [pick up,] go.=

[ uh huh.] =(that's it).

leave behind leave behind. hhh and recently i've come to:

i'm starting to feel, (0.9) one i don't have a place to
call home.

(0.8)

er yet i can call anywhere home.

(0.6)

as long as my family's with me and now my family's not

with me because we're growing up, we're starting to

[ven ture=]

[uh,h,]

=off on our own.

uh huh.

so i'm somewhat lacking that
(2.3) feeling of home as stability that has always been there with my family.

(0.7) and i like any other,

(0.7) you know healthy whatever woman, .hhh erm

(0.8) do:

(0.8) hope that i eventually find a loving caring relationship

(0.8) and i am i'm feeling no rush. no hurry,

(0.8) to do so, i feel that i'm so very young and [i have]

lutely.

a lot of goals to accomplish in the work tour right now,

(0.4) and not that i see a relationship as a burden or hindrance
to that but i realized since i can't get that much,

(1.0) and i have these other priorities right now,

(0.4) a relationship may not be

(0.5) you know in the near [future,]

[you may] be right. sure.

(0.6) or it could be well, who know if the right person comes

along,

(slb) [(slb slb slb)]

[i think that] it will happen once you get to erm

where you wanna be in every sense with [you know,]

[ o kay, ]

in every sense with that.

okay.

(0.6) coz you're just gonna attract it.

right,

it's gonna be so easy,

(1.3)

you gonna it's gonna be the most easy thing you've ever

thought i wish i would have noticed before i woul[dn't, ]
... before. 1839
PR right.
1840 PR again you you've just reached results in certain issues,
1841 P [uh huh,]
1842 PR [im por ]tant issues that have affected your whole entire
1843 life.
1844 (1.3)
1845 PR that's big!
1846 (0.7)
1847 PR that's big!
1848 (0.9)
1849 PR (now you're taking) care of your physical (. aspect,
1850 (1.4)
1851 PR that again probably to some extent has had an effect on
1852 your own entire life.
1853 P [uh,]
1854 PR [or ] for the most of your life.
1855 (1.0)
1856 PR tzt so you're gonna be a new woman. you go- you're working
1857 on being a totally new individual.
1858 P right.
1859 PR like a born again christian. like they're born ^again you
1860 P [right,]
1861 PR [ work ]ing on being born again totally new individual.
1862 with a different identity.
1863 (0.7)
1864 P well it's hilarious because most of the, well one (. of
1865 my friends (sib) in particular erm had this epiphany after
1866 thinking
1867 over something i said erm a week before,
1868 (0.7)
1869 P basically that
1870 (0.9)
1871 P erm
1872 (1.9)
1873 P tzt i've been l- lied to by many people my entire ↓life
1874 a:nd i don't need that in my life[ a ny ]↑more=
1875 P [uh huh]
1876 P =so: don't make promises you can't keep. don't you know,
1877 don't even tell me. ((clears throat))
1878 (0.4)
1879 P you're going to do something and not do it, just don't say
1880 that at ↑all if you can't guarantee that it's gonna happen
1881 don't say it. .hhh erm
basically that i'm you know, 
(0.8) 
comfortable with who i am, content for the first time in 
my life with who i am, and happy and proud and, .hh 
that's excellent. [(slb)] that's wonderful. =
(0.6) 
just ] =i don't need 
drama 
[well,] 
[i ] don't need people bringing me down. and if that's 
you know, what i view them as doing then, (( miming 
cutting throat)) zack! you know, 
(slb slb slb) [you know,] 
[ please,] 
when move and move (ahead) 
(slb slb) ha [ha ha ] 
(gonna have those people, people are (slb slb slb )slb) 
right, crave [men tal]ity. =
((slb slb)) =crab mentality ?
(1.2) 
it's what i call, 
"yeah." tha- that's that that has to be right, did i tell 
you the story about the lecturer, (were you [here) 
(0.9) 
((clears throat)) old guy (eighty) two years old 
chiropractor came to give a lecture on on business aspects 
[ of of me =]dical= 
[right, right right.] 
=practice. 
right and he told that the crab mentality story, 
(0.5) 
a crab's everywhere. 
yeah. 
(0.4) 
crabs are everywhere and and and and that's the 
unfortunate truth. 
(0.8) 
uhahh, where the where else (slb slb) i feel sorry for 
them. 
right, 
they're not like that coz they wanna be. they're not 
happy. 
right, 
they're like that be[cause they've got too si mi ]lar= 
(e xa ctly. e xactly.]
PR = issues.
1931 P exactly.
1932 PR how (.) how easy could it be, could have could have been for you to be a crab?
1933 P uh,
1934 PR and and and and feel sorry for yourself because this happens to me, because this happens to me,
1935 (1.1)
1936 PR y- you could have been one easily.
1937 P uh,
1938 (1.1)
1939 PR you made [(slb slb)]
1940 P           [ i was ] for a very long time.
1941 PR look at that!
1942 (2.0)
1943 PR so,
1944 (0.6)
1945 PR you know somebody else, you know you squeeze an orange, (0.4)
1946 PR what comes out is orange juice.
1947 P right.
1948 (1.0)
1949 PR so life pressure is like squeezing the person and what comes out the crab like mentality the the attitude to this. and that is what's inside just like an orange you can al- what's inside is what comes out.
1950 P uh huh.
1951 PR so, (1.6)
1952 PR so, so you know, they they're gonna be there. they're gonna always be there. and how to deal with them is this the the true work. and
1953 P right,
1954 PR and again you you s- seems like to me from what you tell me, you you're working on that as well, and
1955 PR well [my first instance]
1956 PR [i thought you were] working on on on er you gonna be a totally new individual and i really hope i got to see that.
1957 (1.0)
1958 PR you could you're definitely working on it. and:
1959 (1.0)
1960 PR i certainly by the time you graduate from ↓here
1961 P uh huh.
1962 PR er you should be a totally new individual. you you have a
doctor's degree, you are a different person, you think differently.

you're thinking of matters conducive to your health. you make decisions that are conducive to your health.

you're gonna try great things.

and i congratulate you in advance because i'm certainly sure this is gonna happen.

certainly sure it's gonna happen.

let's go and weight you (out there).

okay.
414

UBNMC: INT8-11.18.03

1  P    fixed?
2 SC    they they just put it up on top of the [ bill row. ]
3 PR    ((to researcher leaving the room))  [°(slb slb)°]
4    [°all set?°]
5 P    [ oh yeah, ]
6 SC    a couple of weeks [ a go. ]
7 PR    [°okay.°]
8 SC    [so,]
9 P    [oh!]
10 PR    okay so i guess we can start now,
11 P    [ uh huh. ]
12 PR    [let's hope] we haven't stressed [ you] [out.]
13 P    [ ha ] [ ha ]
14 SC    [°okay.°]
15 hu hu hu hu .hhh
16 P    hey! no more than u{usual,}
17 PR    [ ha ] [ha ha]
18 SC    [ ha ] [ha ha]
19 PR    thanks jen! [hhh]
20 SD    [hu ] [hu]
21 P    [ha ] [ha] ha ha
22 PR    okay.
23 P    [((cough))]
24 PR    [ so, ]
25 P    [((cough))]
26 PR    yeah i{ was just }]
27 P    [ .hhh [((cough))]
28 PR    [ reading ]
29 P    [((cough))]
30 PR    here, that you were in on october twenty eight and you saw
31 P    ramona that day.
32 P    [uh huh.]
33 PR    [ i must] have been at the women shift on that day.
34 P    yeah,
35 PR    .hh so erm
36 P    and then i had to come another time and they said you
37 P    weren't here or something,
38 PR    ↓oh ↑oh
39 (.)
40 P    yeah,
41 PR    w- it must have be, was it on a tues↑day
42 P    yeah.
43 PR    okay, so yeah. it's every other week so,
uh,
i'll t- so next week for instance, i'll be (.) at the
women
shelter and then it just goes back and forth.
[uh,]
[you] know every other week i'm here.
oh,=
=on tuesdays only.
uh.
((clears throat)) i mean tuesdays is the only day i,
[yeah.]
[ go ] to the women [ shel ]ter.=
[right.]
=okay. so so i'm just looking at the notes from last
visit, (.) and er i see that you (.) we- were still having
some intermittent dia†rrhea
yeah,
and you had blood one time on the [tissue
right.
[i was.]
( .)
or,
[ o ]kay.
(.)
okay so, erm (.) how is that doing now?
well i went for a colonoscopy,
you did, [ so,]
[last] tuesday.
ok.
but i didn't get the result yet. i called the office
before coz i work today i'm i'm working three days now.
so,
↓oh↑oh
i'm work[ing monday tues-]
do do you get ] some (slb slb) ↑too
yeah on monday tuesday and thursday morning. so er .hh by
the time i got home and called, .hh they said well we have
to look up your charts and then we'll have to call you
back with the results. .hhh
[uh,]
[but] what they told me i went to see these to get the
procedure done.
uh huh,
and after the procedure the nurse told me that .hh the
doctor did remove two polyps and that they were going to
be biopsied,

okay so they removed two polyps, and i've been feeling lousy ever since.

[i mean] i don't know why. i mean the last time i had a colonoscopy,

[i mean] i don't know why. i mean the last time i had

((knocks at the door)) a colonoscopy,

[i mean] i don't know why. i mean the last time i had

[come in]

[i mean] i don't know why. i mean the last time i had

[hey]

[i mean] i don't know why. i mean the last time i had

[hey]

[i mean] i don't know why. i mean the last time i had

[just telling them]

[i went for that colonoscopy last week,]

[i've been feeling lousy ever since.]

[(er but that was) (slb slb slb slb)]

[(er but that was) (slb slb slb slb)]

[no. no] because er they tell you to call a week later er erm to get the results, and when i called before they said they would have to get my charts etcetera etcetera, and=

=(gotcha).

[i had to leave so,]

[i'm telling you i just er i mean the last time i had a a]
colonoscopy five years ago then it didn't bother me at all

but this time i mean i've just been feeling terrible.

i (slb slb slb) [.hhh ha]

[ do you] mean that it physically drained you?

P [er ]

PR [the] fact

P physically and everything. and i just felt lousy you know i had this like nauseous feel[ing, and]

PR [ u::h, ] uh huh.

P [ e:rm ]

SD [(were you)] (having) any ↑gas ↓bloating

P and gas yeah.

SD yes.=

P =i mean they tell you th- you know you because they pump air in you i guess,

PR tzt ah, okay.

SD [the] problem with (slb slb slb slb)=

P [but:]

SD =was er probiotics,

P [yeah.]

SD [ be ]cause when you that purge,

P (.)

SD [yeah,]

P [which] i'm [sure ]

SD [yeah,]

P you en[joyed] the night before.

PR [ uh, ]

P oh jee- [ please! ]

SD [( i know] this is qui(h)te slb slb)

P [ ho ho that is the worse, i mean]

SD [(slb slb slb slb worse i think it's ] the worse).

P oh it ↓is

SD [erm] but [erm]

P [ i ] mean all i did was run to the bathroom every minute. uh,

P yeah,=

SD =so i think [if we give]

P [he he he ]

SD some h_m_f (it would be [slb slb slb so])

PR [yeah o- o- o ]kay. so the

SD [yeah.]
[slb slb] okay. [i] think that that would be that would be good. and hopefully that would give you the relief, uh, as far as all these different symptoms. right okay. (.i) does that sound good [mandy (.i) okay. anything will sou(h)nd go [ho ho ho] [ha ha ha]

[ha ha ha]

[sd] .hhh hhh hhh hhh

[i and:] [.hhh ] hu

[i was just gonna [fol]ow up with her, about the er=

[hu,]

[i know that you had wanted to go off with the last

[course

[course

[course

[course

[course

[course

[course

[course

oh yeah. i did: get thee: er (.i) and i got the bone density handy. the last: lab thing was the one from, (1.7)
i don't know from may i guess it was.

((searching in her bag))(5.1)
oh that's the bone density, this is thee: (1.4) er this is from march. this was the last er (.i) cholesterol thing i have,

(1.2)

and this is before,

[yeah.]

[con ]siderably before you went off,

[yeah!]

[ the ]

[yeah.][ yeah.]

[me ][agination.]

[i didn't ] go off until july.

so er so the bone density, (.i) erm (.i) it looks like they're they're erm finding osteoporosis (.i) in your erm in your femur,

[(i see)]

[and what] what is that, w- er

it's in your er they do measurements, they'll do it in your hip.

(.i)

[uh huh,]

[essen ]ially. [ and ] in your spine.=

[yeah.]

=uh huh.=

=and erm they found erm basically when they w- it there're
different categories, but osteoporosis is (one) it's it's
when you have actual holes in [ in ] your bone.
[yeah,]
=that you know, [it's ] at that stage=
[yeah.]
=yeah.=
=but in your spine, it is erm it's less,
[uh huh,]
[so it's] osteopoenia. that is considered detecting bone
loss but it hasn't gone to osteoporosis.

P  [uh huh,]
SD  [yeah.
P  well he wants me to go on with that (actimol),
SD  okay.
P  which i don't know if i want to. in fact i ,hhh i brought
this er magazine, i don't know if you've ever seen it by
doctor williams .hh and they have some articles in here,
.h lowering your cholesterol won't prevent a heart attack
coz they say y- your cholesterol don't doesn't have
anything to do with it, .hh and then an aspirin a day can
give you a stroke,

PR  [hh ha]
P  [inste](h)a instead of: [you know?]
SD  [slb slb slb [slb ] slb]=
P  [sso,]
SD  and then why calcium can't stop osteoporosis, [ but ] i
P  [yeah,]
SD  mean:=
P  =ºhu huº
SD  yeah. well erm
P  this says that a lot er i i read the whole thing, i mean
SD  [yeah.]
P  [that ] you know a lot of this stuff he came out with
SD  years ago, and now the medical profession is just
P  (0.5)
PR  [catching up]
P  [ getting on] line with it. but they're still not,
SD  (0.3)
P  [yeah,]
SD  [re ]commending:
SD  yeah. the thing er er w- let's take one one thing at a
time.
P  [yeah.]
SD  [now ] the thing wi[th: os te]oporosis that a lot of
P  [hu hu hu]
SD  people don't realize is just how serious it can be?
uh [huh,]
[erm ] it can actually not just like an alarm but you
can actually be a be a favorable condition, in the sense
this that it's it's it's not that itself but if you (were
to take) a fall, and you already had weakened,
(.)
hips. essentially you would (slb slb) break your hip,
that's it's it's sort of it's a very slippery slope.
[uh,]=
=and it's erm it's one of the things that and you're
already on calcium supplementation y- you know, you're
you're doing all the good things for yourself and then
still coming up with osteoporosis.
[uh,]
[and] so that erm i think that we really need to talk
about conventional approaches because erm it's it's just
one of the things where it- as far as rebuilding bone erm
you know the things that we can recoimmend
(.)
but hhh they can they can take time. and if you know i
would just hate to see you,
[uh,]
er fall. and and break your \ hip [ es ]sentially.=
[yeah,]
=which erm you're predisposed to do if it's if it's
osteoarthritis at this point.
[uh,]
[and] erm (. ) so i thi- it's something to to really look
at carefully. it's erm in a certain sense it's it concerns
me more than your cholesterol \ does [ at ] this point,=
[uh,]
=just because i think that it's erm it's something that
could set up a chain of events,
[ uh huh. ]
[that would] really erm injure your mobility. [so,]
[uh ] huh.
erm (. ) so i erm i think that you know just for (revisit)
while you're taking notes and to see, do you have an
earlier bone density scan? coz it's very often it's
helpful to compare them.
(1.0)
[ huh]}
[erm]
do you [have (slb)]
[ yeah i ] had one a few years ago i [guess,]
[ and ] do
you remember what they erm said,
well he just said it was borderline at that point.
yeah. so now if you're if you're you passed that point
and probably if he said it was borderline, either that
means w- erm borderline osteopaenic paenic or er
osteoporosis. so this is hard
(.
(2.0)
okay. now next next thing,
[ ha ha ha ha .hhh]
[(slb slb slb slb slb)] who this person is.
(0.9)
and what is he selling. hhh [he he he]
[hu hu hu] [hu hu]=
[ha ha ha] [ha ha]=
=[well he's]
=[that's al]ways my question.=
=he's you know,
(0.6)
he (slb slb) a letter every month or whatever,=
yeah,=
=so he's selling that. but it's supposed to give you you
know non
(0.9)
erm prescription stuff, to use. [ you ] know,=
[right.]
=uh,
i mean he's not selling you
right.=
=erm necessarily, but and some things are
(.
you know,=
=well actually what he's if you go to the article about
lowering your choleslowerol (it say) he's talking about
eating cholesterol
(.
won't (.). lower your cholesterol. and erm that is true
actually. i mean it's it's very important like ten percent
of people who're eating cholesterol (how would they eat)
their cholesterol but it's different that erm if you
already have elevated cholesterol that we know,
[uh,]
[for] in- you know blood test said something that that'll
that changes the picture.
uh huh.
erm of it (1.3) erm
.h so in a way it's erm (2.6) kind of like it makes it sensationalist, the way he does the headlines

and then i don't know that his facts are wrong i (don't think) that erm you know, some- it maybe is to get your bias ha sort of,

[hu,]

[on ] different things. so i think that erm that's something as far as erm because you haven't got any (back on to) cholesterol

no.=

=and when when is the retest for that?

er december eighth i guess.

oh good! okay it's around the corner.

yeah.

so we'll just keep, let's keep going

[yeah.]

[ and ] see where you get.

uh huh.

okay. so [she's off] thee: medication now and you're [(slb slb)]

gonna get retested december eight, [ is ]

[yeah.]

that [right?]

[right.]

i mean [she (mea-)]

[ o kay ]

i- i- it's one of those things [that I ]

[uh huh,]

i feel comfortable trying to figure out something else that works, as long as we test and figure out is it working,

[uh huh.]

[uh huh.]

if it's not working and that's,

[yeah,]

[ you ] know we will need to have the discussion as far as you know, [ this] is the only th- you know unfortunately [right]

the drugs are what have you know been proven to lower cholesterol.

uh [huh.]

[erm ] that's why the bone density tends to concern me more.

[uh huh,]
cause basically it's saying you know?

you are doing this but it's not really, it's not working.

uh

erm so we just: why don't we just keep going and we'll talk about it [(slb slb] slb slb]=

[( o kay.]

=([(okay).]

=[ [ okay. ]

[(↑slb)]

[ [ yeah.] yeah.

(.)

and then you where gonna tell me this postcolonoscopy

isn't [getting (slb slb slb] [slb slb)]

[ ha ha ha ha ha ] [ ha ha ] [ha ha]

[ hu hu ] [hu hu]

[ hhh [ha ha] ha=

[o kay]

=so erm but definitely there are things we can do there to

help settle your tummy and then=

=yeah,=

=erm and we'd love to get you know erm information about

what the results,

(.)

are of this from the from the biopsy of the polyps.

uh huh.

and di- did you have a history of ↑polyps (slb slb slb slb slb)

i can't remember if i had polyps the last time or not.=

==[kay.]

[ [ i ] w-

uh huh,

i really don't that was five years ago. [no.]

[ o ]kay. okay erm

i think have you certain forms for me to ↓sign

(.8)

thanks.

(5.1)

so how did my cholesterol seem ↓there

your cholesterol here is very good.

yeah?

the total is is good, it's hundred two hundred and the and

thee: most important (maybe) the h_d_l ratio the cho- the
total cholesterol to h_d_l ratio is erm two point seven

which is,

(.)

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excellent. ((SD leaves))

yeah.

so,=

=coz i was on the pills then thee:

you were on the pill so it'd [ be ] interesting to see

[yeah,]

[ how,]

[yeah,]

now what you know what we see (. ) with you er having been

off the medication [for] a while.=

[uh,]

=so we'll just do what we need to you know we'll get the

results erm i see that erm last visit you were in, they

recommended flax oil,

(.)

two ta[ble] spoons a day.=

[uh,]

=are you doing that at ↑all

flax ↑oil

[yeah.]

[ uh,] (. ) i thought it was flax seeds ↑no

.hhh erm

[ uh ]

[the] thing about the flax seeds is (1.0) y- you're

getting (1.5) you're getting erm it would you would have

to take a lot of seeds,

oh!

to get the concentration that's in a table spoon of oil.

oh,

you'd have to take a lot more than a table spoon of the

[flax]

[ oh,]

seeds.

oh!

erm er did (. ) okay so are you doing the flax ↑seeds

well i was doing some fla- well i haven't been doing

anything since er thi(h)s we(h)ek you know, because

o:h, [o kay. ]

[i just ] felt so lou[sy, you know i did]

[yes right. that's under]

standable. okay what i'm thinking is maybe, maybe erm (. )

maybe fish oils i think fish oils have been proven to be

probably the most [successful]

[i i don't ] er

what was the other thing i was taking, i er it didn't

agree with me, i you know what i mean er
PR: yeah,

P: what else am i taking: the the fish oil caps or something,

PR: erm [ i (slb slb)]

P: [and they just] kept repeating on me. Oh,

PR: now,

P: hu

PR: one thing you have to know about fish oils is you really need to take 'em first of all with a meal that contains fat because that would help to break them down and digest them. .hh you must take them with a sizeable meal. if you're just having a light snack t's not the time to take them.

P: uh huh.

PR: take them with the dinner or you know lunch or some meal that's [uh,]

PR: [ba ]relly heavy.

P: (.)

PR: erm do you now just (fearing) that, do you think that you were doing those 4things or (1.2)

P: i can't remember. i usually i think i was taking it,

P: well i (0.7)

P: .h i don't know if those where the ones that you have to take twice a day so i would take it w- with breakfast and then with supper.

PR: right. right.

P: (.)

PR: i don't remember if we had you on fish oils. erm wh- ["uh uh"]

PR: [ i mean] we could we could do the flax but i i i i i have to say that i i think that fish oils would be more effective

P: uh,

PR: erm so:

P: we can [we ] can you know?

P: [uh,]

P: (0.7)

P: that should be down there. or er [ er ]

PR: [.hhh]

P: i don't remember [you (slb slb slb)]

PR: [we had you on ] flax, erm (.) fish oil caps,
okay.

P  yeah.

PR  so we had you on a thousand milligrams one ca- one cap three times a day,

P  uh.

PR  and we could easily switch that to (1.5)

PR  you know?

PR  maybe two caps with (0.6) dinner and one cap with lunch, or something like that. .hhh and also i think it matters where you take it in the meal don't wait 'till the end.

PR  don't take it in the very beginning. get started eating then take it while you still have ((clears throat)) good amount of food left,

P  uh.

PR  to eat. (.) and so it's sort of mixed in with all your food erm

PR  i'm wondering mandy if you have any of these left,

P  no.

PR  okay.

P  i [used them] all up.

PR  [ o kay. ]

PR  erm well we can we can decide that before the end of the visit. why don't [we]

P  [uh] huh.

PR  why don't we talk about some other things, coz i don't wanna run out of time. and

P  (0.9)

PR  erm

SD  ((handing back paper)) i'm giving this back to you.

P  [oh! o kay.] [hh hh hh]

PR  [hh hh hh ]

PR  erm okay. so we'll think about some kind of supplementation that would help to:

PR  (1.1)

PR  erm that would help in in keeping your cholesterol adequate you know, at a manageable level. and then leave

P  [a ] bit of fish oils possibly flax oil erm but er er=

P  [uh]

PR  =when mel and i step out we can talk to doctor halliburton a[bout you,]
[uh huh] okay.

[see] if you know what she what what her opinion is. hhh erm (.).

okay. so erm so then er have you had any more bleeding with er going you know,

[uh,]

[with] having bowel movement, [no?] [no.]

just that one time,

[yeah.]

[ o ]kay.

(.)

and you do know polyps can be totally benign,

right.

i mean you know of course they can they can be more dangerous but they can be benign too.

[ uh huh.]

[(almost)] erm so (.). we'll just: you'll be getting those results this week, is that right?

well i i presume so. she said she was gonna get back to me [ to ]day,=

[yeah.]

=so,

yeah okay.

i mean i don't know now she's gonna tell me i have to come in the office, or she's just gonna [give] me the [results]

[okay, ] i see.

[right.]

[ o ]ver the phone, or what.

right it's a little nerve wrecking.

yeah.

right, yeah.=

=uh so [well,]

[ o ] kay. okay.

(.)

erm so would probably be a good idea for you to schedule another appointment fairly soon after this one. just so we can follow up with that.

uh huh.

erm (.). or if you wanna wait to reschedule depending on those results,

(1.1)

you can do that and then call in and make [ a ]nother= [uh,]
appointment. [if ] you wanna do that one,=
[uh,]

=°okay."°
(0.9)
erm (1.4) so: let’s see,
(0.7)

and how about the diarrhea,
(0.6)

diagnosis is probably hard to tell right. be[cause]=

=you're having so many problems,

yeah. well i i had it very loose this morning, it was you
know,

(.)

but i mean before then it was seen t- to be alright.
(1.0)

it wasn’t like that but this morning oh dea- i thought it
was never gonna stop! hu hu .hhh

oh okay,

[but:]  

[okay] yeah. but before this week then

yeah well.

diagnosis had it [gone ] ↑better

[yeah.]

er]

well it was you know, like just i went once or twice
(0.8)

a day but it wasn’t: you know that really loose.

[uh huh,]

[or a ]nything.

uh huh. okay so [it's more normal.]

[it's more normal.]

(.)

okay. erm

(1.7)

maybe we'll er i you know i'm not sure yet what to think

of that i think after we get the results of [ the ]

[yeah.]

colonoscopy,then we'll have more information.

right.=

=so erm

((filling in P’s file))(0.8)

°okay."°

(12.6)

°okay.  erm°
688 (2.0) .hnh and as far as i don't, i was looking back in the
689 chart and i don't think that we've ever put you on a
690 calcium supplement?
691 (0.9)
692 P [well,]
693 PR [ are ] you taking calcium
694 P yeah i'm i was i'm getting it from misses greens [well,]
695 PR [ o ]
696 P kay. now
697 PR what kind of calcium do [you know,]
698 P [oh jeez!]
699 PR ha ha ha ha .hhh ha [ha ha]
700 PR [ha ha] it's called the liquid
701 P calcium.
702 PR okay.
703 P [this]
704 PR [if ] i said the [form]
705 P [this]
706 PR would it (1.0) er would it be er th- there are different
707 kinds of calciums,
708 P uh huh.=
709 PR =and some are absorbed a lot more easily than others. and
710 PR so we wanna be very choosy now a[bout ]
711 P [yeah,]
712 PR what calcium supplement we give you. so erm one of the
713 PR most easily absorbed forms is (slb slb) or
714 P [ uh huh]
715 PR [(slb slb] slb slb) (. ) erm
716 P (1.7)
717 PR but i [a gain i ]
718 P [i'm not sure]
719 PR what [it is ] right now,=
720 PR [o kay.]
721 PR =okay. erm ((clears throat)) there's another called
722 PR (hydroxyl appetite) but i think that that one is hard to
723 PR absorb so if there's any digestive issue,
724 PR uh,
725 PR it might not be the best
726 P yeah,
727 PR to give you.
728 P right.
729 PR erm so we might want to i don't i you know we'll check
730 PR with doctor halliburton. see what she thinks erm but we
731 PR wanna definitely
732 (0.9)
you know, we wanna make that a conscious choice as to which calcium supplement you're on. [hhh]
and we can also erm talk about foods, (.)
that would be rich in calcium. coz now is the time to really concentrate on that.
uh huh.
erm doctor halliburton as she explained you know you're just a little more vulnerable pro-. a lot more vulnerable right now to a break if you would happen to fall,
and we don't want that to happen.
yeah,
at all .hh so erm (0.9) erm i'm gonna get to diet in a little while.
[yeah.]
[ coz ] i have your diet diary that you gave me and i appreciate that so much. giving me [ such a] detailed account.= [ºhu huº]
=erm so we'll get to that next i just wanna see if there's any other issues,
((to SC)) erm do you, did you want to (say something)?
how was your body then since erm the colonoscopy and that you've been feeling lousy,
well i mean (0.8) i wasn't hardly eating anything all week last week. so erm=
=okay.
[i m-]
[last] week,
yeah.=
=now you had the colonoscopy this week,
well i had it last tuesday.
oh oh! o[kay. okay. ]
[so i mean,] so (0.7) i wasn't (probably) eatin that much you know, soup then noodles and things like that. [and rice.]
[kay o ]kay.
(0.6)
yeah,
because my stomach has not been feeling (. ) too good.
[right.]
[ hu ] hu.
right.
SC have you been eating \textsuperscript{more} since (0.6) \\
SC (slb slb) \\
P er yeah saturday erm \textsuperscript{0.4} well i had gone out to dinner, (1.3) \\
P  erm to the catholic \textsuperscript{ward} that's in (slb slb) had a (pub) \\
P  roast dinner, \\
PR  okay. \\
SC  and how did you feel \textsuperscript{after} that \textsuperscript{that} \\
P  er okay! \\
SC  okay. \\
P  yeah. (0.9) \\
P  well it was mainly meat potato and : carrots. \\
SC  uh huh. = \\
PR  =uh huh. (.) \\
PR  uh huh, (1.0) \\
SC  and how do you what doctor halliburton just explained? to you \textsuperscript{erm how do you feel about that, has anyone} \\
SC  talked to you or \textsuperscript{slb slb slb slb slb the test done when} \\
SC  they got the results back) \textsuperscript{hhh did anyone talk to you about the implications for} \\
SC  \textsuperscript{those} \textsuperscript{results} \textsuperscript{(1.1)} \\
P  not really. \\
SC  okay. and how are you feeling now that you heard that information, (1.1) \\
P  hu hu hu not too good. [ha ha] \\
SC  [okay,] \\
P  ha [ha ,hhh ] [yeah it's] a little,= \\
P  =i mean,= =it's alarming. er er \\
P  this test was what taken in may wasn't \textsuperscript{it} \\
PR  erm let's see this bone scan, (1.0) \\
PR  was t- \textsuperscript{er yes may nineteen.} \\
P  yeah my doctor never called me or anything, and: \\
PR  oh, you mean you didn't get this in the mail did \textsuperscript{you} \\
P  \textsuperscript{0.9} \\
P  well i just picked that up! \\
P  [i called the office and asked'em for it.] [oh i see. okay o kay. but you were,]
but

yes,

this was in my and i never heard from them

(.)

about

[right,]

[ so ] i figured hey! it can't be that bad right

=so: (1.0) i went when i went to him fo- in september for

well your bone density wasn't too good he says so you'd

better go on this (actimol).

this is when [he told] me that.

[uh huh,] =yes.

but he didn't explain anything.

right right yeah.

(1.2)

does erm does it make sense to you what doctor halliburton had said,

[oh yeah!]

[a bout ] the the implications for osteoporosis an and

the femur,

[uh huh.]

[o kay.]

(.)

okay. .hhh will you right now well we're also telling you (is)that there's some very (0.7) it it's a good thing that you had this done.

[u h u h.]

[because ] right [now ]

((cer)tainly),

you are vulnerable, you're doing very well.

[u h u h.]

[and the ] thing that we can do preventively, part of that may be going one of the traditional the (actinol). but it we we can also help supplement you.

[uh,]

[and] and make you very strong.

[uh u h.]

[so it's ] this is a good thing that you found out that you brought this information to us. [and]

[uh ] huh,

you're in a good situation right now because you have a lot of choices.=

=yeah.

so we're gonna work with you on that, and the [next ]
time that you're coming to a visit, erm probably the
important thing to do is bringin that calcium supplement
that you're taking.

[yeah.]

[ be ]cause denise said all supplements are not created
equal and we wa[ nna ] make sure that you are =

[right,] =thee best,=

=uh,=

=most viable valuable supplement there is.

P   uh [ huh.]

PR   [right] so,

P   uh,

SC   okay.

PR   and there's different foods that you can concentrate on
you know, that would help to boost your calcium. and

(0.5)

P   [uh huh.]

PR   [and help] you know, erm

(1.4)

PR   er to add more density.

P   uh huh,

PR   to your bones. so we'll talk about that.

P   yeah.

PR   and also doing some erm (0.9) light weight bearing

exercises,

P   [uh huh,]

PR   [that al]so helps with

P   yeah. maybe that well i haven't even been out for a walk

lately.

PR   [right,]

P   [ last ] week and this wea\ther ohh!

PR   yeah,

SC   [ hu  hu  ]

PR   [and it's ] gonna be [tough,]

P   [ tsss ]

PR   in the winter.

P   [i \know]

PR   [so may ]be we can talk about some alternatives.

P   uh huh.

PR   erm (1.6) .hhh yeah i guess you know short of (0.7)

joining a gym, it's it's it's [it's tough.]

P   [ hu  hu.  ]

PR   it's tough, .hhh walking in the ma:ll,

(0.5)
do you, let's see you live in stratford right
do fairfield.
oh fairfield okay.
no we don't have any malls. hu hu
trumble.=
=trumble mall.
trumble.
yeah i [know that's:]
[it's ve ]ry close.
[erm ]
[that's] what you know that that (caught) on a number of
years ago, (.) people just started walking in the malls
[u:h]
you know for exercise,
and they have groups that meet too. the mall [(wal-)]
[uh, ]
walkers. [that meet in the mor ]ning too.
[right. o kay that's right.]
yeah.
[well ] thay meet early in the morning. i'm not a morning
person.=
=okay. [ ha ha ha]
[ ha ha ha]
[beside to] which i go [ to ]
[well,]
work three mornings a week now. [ so, ]
[they ] actually meet
around nine
o'clock in the morning so it's not too bad.
yeah, but i'm saying i go to work that [from,]
[ oh, ]
yeah.
[nine ] o'clock.
yeah but i mean you don't have [to ]
[uh,]
join [this ] group you know,=
yeah.
[i know.]
=it would ] be nice [ coz ]
[yeah.]
it gives that
(0.5)
that extra motivation [to ]
[uh,]
go if you have someone to meet there.
P yeah,
PR but erm [you can (slb)]
P [well my friend] goes to (curves).
SC uh,=
PR =Toh ↓oh=
P =she thinks that's a good place but,
PR (0.8)
P she goes early in the morning too. [and:]  
PR [ o:h] okay. ha ha ha
P .hhh
PR i mean that just doesn't work out [for me.]  
SC [ ha ha ] ha
PR yeah,
P and especially now with you know working three mornings  
PR a week. [ so, ]
PR [right] right. yeah even if you had to go by  
PR yourself,
P [u:h,]
PR [you ] know there's still it's still crowded and there's  
PR uh there'll be a lot going [on,]
PR [uh,]
PR you know with the christmas season, it'll be an  
PR interesting place to wa(ha)lk.
P uh,
PR .hhhh so er it's just an idea you [know,]
PR [yeah.]
PR it's an idea but i think y- maybe we should start thinking  
PR about how you could get around the latter coz [once ]
PR [yeah,]
PR it [starts snow]ing,
PR [ i know.]
PR (0.6)
PR it's gonna be hard [to: ]
P [u:h,]
PR stay a little active you know?
PR and then if i fall, [ha ]
PR [oh!]
PR right.
P [(slb slb) well (slb)]
SC [ha ha ha ha ] [ ha ha ha ha ] [ ha ]
P [(slb) breaking my ] [HIP!]
PR [right. no no no!]
SC [ha]
PR [can't,]
PR [ ha ][ha ha ][ha ha .hhh ]
PR [have that.][we won't have][that.]
pr: okay.

p: ern.

pr: alright, ern.

p: hhh hhh

pr: so: let's see mandy. how did you bring any blood pressure?,

p: yeah.

pr: er chart for us

p: er let's see,

pr: (1.1)

p: yeah.

pr: ((checking chart)) okay.

pr: (20.9)

pr: so these numbers look like they, they're a little bit higher than past charts.

pr: (0.6)

pr: i'm wondering if you:

pr: (1.3)

pr: you know,

pr: (1.9)

pr: before the whole colonoscopy,

pr: (1.4)

pr: thing. mandy were you feeling,

pr: (0.8)

pr: you know extra stress about any particular event?

p: we:ll,

p: (0.9)

p: you know with my son and all that stuff [uh,]

pr: (looking at and p nodding)) [ o ]kay, okay,

p: and, i don't know i think: you know it's getting closer now to: (.) gonna be a year of my husband's death and i don't know, i think about that more often now.

pr: ((shaking head)) that is,

pr: (0.6)

pr: [tha-]

p: [ in ] fact i was in church saturday. and this lady got sick in church and: oh i just felt like crying. and i j-

pr: just hoped that she wasn't gonna, (.) collapse.

p: yes:

p: so they just took her out of church but,
[0.8]

1056 [i] was so upset. =
1057 [yeah,]
1058 [you [know?]
1059 [yeah,] yeah,
1060 [yeah,] yeah,
1061 and those things bother you every once in a while.
1062 PR [yeah,]
1063 P [uh huh.]
1064 PR [and you] know the anniversary especially the first
1065 anniversary,
1066 P uh,
1067 PR [is]
1068 P [i] know
1069 PR known to be very tough.
1070 P uh,
1071 PR you know but this is, (1.0) i mean the whole year you've
1072 been working on,
1073 (.)
1074 PR getting on, with days and [you] know,=
1075 P [uh,]
1076 PR =just functioning and getting out and,
1077 P right,
1078 PR but i mean that that anniversary, you know,
1079 (.)
1080 PR it sends things flooding back and it's,
1081 P right,=
1082 PR =i think it's inevitable! so i [ i ]
1083 P [uh,]
1084 PR i think you're absolutely right that,=
1085 P =uh,
1086 (.)
1087 PR you know? that could in fact,
1088 P yeah.
1089 PR be (slb slb) just being upset over your son, having all
1090 these feelings come back, you know, [ a ]bout=
1091 P [right,]
1092 PR =your husband,
1093 ((7 seconds missing from tape))
1094 PR a tough time.
1095 P uh,
1096 PR definit(ely.)
1097 P [ but ] today is my son's birthday the one that
1098 died.
1099 PR o:h,
1100 P [he would have been for ty four.]}
1101 PR [oh it's this the son you're tal(king ab)out

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well but this is my other son.

oh o[kay.]

[i ] mean,

because [you have ]

[you know,]

a living that's going through some,

yeah he had the, (. ) he broke his back.

right.

and,

right oh boy![ so, ]

[yeah,]

right now [is,]

[so,]

there's a [ lot ] of stuff.

[yeah,]

[yeah.]

[yeah,] and he was in the process of moving and it was

just like (. ) one catastrophe after another. [hhh hhh]

[uh huh,] uh

huh,=

and he just, (0.5) he finally moved in there last

month but: he's still doing stuff he's just: (. ) their

place has been ha

((PR writing)) (1.3)

uh ↓u:h

sometimes i would say to him drew don't even tell me about

it i don't wanna hear it today.

i, hhh [yeah!]

[ ha ] [ ha ha ha ha .hhh]

[you reach a point where] you just can't

[take]

[ hu ]

any more, upsetting [↓news]

[i ] know! [ uh, ]

[yeah,] yeah,

i mean you couldn't believe it but hhh i mean they we-

they were in the process of fixing the house .hh and what

happened was the roof wet and a leak right in the bedroom

and ruined the furni[ture,]

[ tzt ]

and [the] rugs and,=

[oh!]

=oh god [man]dy that's,

[hu ]

(. )

[ hu ]
PR [that's] terrible
1149 P i know. isn't it
1150 PR [yeah,]
1151 P [ i ] think it [ was ] just,
1152 PR [yeah,]
1153 (0.7)
1154 P (part) of the things that were happening and i, s- oh my
1155 go:sh
1156 PR ye:ah, [yeah,]
1157 P [ you ] know?
1158 (1.0)
1159 PR [(slb)]
1160 P [ i ] mean there's nothing i can do about it, [ but ]
1161 PR [ri:ght.]
1162 P i mean it just,
1163 (0.7)
1164 P you know really upsets you. [you know?]
1165 PR [ of cour ]se! of course yeah.
1166 now do you have someone that you can? i remember you said
1167 that you and i think your sister and a friend met,
1168 (0.8)
1169 PR to pray.
1170 P yeah,
1171 PR do do is that that pfff help?
1172 P yeah! yeah.
1173 PR okay. okay coz,
1174 P yeah. that's where i'm going tonight.
1175 PR oh [ go (h)od. ] [ go (h)od. ]
1176 SC [ (you (h)u ) [ go (h)od).]
1177 P [ ha ha ] ha ha [ha ha .hhh]
1178 PR [o kay. ha] ha ha
1179 PR .hhh
1180 P ha
1181 PR yeah,
1182 P [ ha ha ]
1183 PR [yeah. coz ] right now it seems like these things,
1184 (.)
1185 PR [(slb slb) different issues.]
1186 P [and then i have you know ] a couple of close friends
1187 PR that i can share with [ you ] know?=
1188 PR [good.]
1189 PR =good.=
1190 P =so,=
1191 PR =that's so important. i'm glad [you] have that. [yeah.]
1192 P [uh,] [ uh, ]
1193 (.)
o[kay.]

[pat ] my friend called me from arizona, ha ha she hasn't
called me in a while and i [unloa]ded on her.=

[o::h,] =oh oh!

[ha ha ha ha ha ha ha .hhh]

((smiling)) [you unloaded i thought you were] gonna say
she[gave]=

[ ha ]=

=me bad news.

haha

no she had good news. she's been having a house built
she's gonna be moving in a few weeks [but,]

[ oh,]

ha ha ha ha [ha .hhh]

[ o kay.]

but i unloaded on her. .hhh ha [ ha ha]

[well you] know ^what

[.hhh]

[ i ] mean,

ha

that's what good friends [are are ] [there] [for.]

[ ha ha ] [ ha ]

[ uh ] [huh.]

they [ un der stand,]

[well we're friends ] from grammar school [days.]

[ oh! ]

[ oh! ]

so that's [((given) ha ha ha] [ha .hhh] [ ha ]

[uh huh ha ha ha] [ha .hhh] [ ha ] [ha ]

[ha ha ha ha ha] [that's] [how] long

we

know each other. ha [ ha ]

[right,] right, it's good [to ]

[er,]

have i know friends from childhood. i mean who knows you

better? [right?]

[ uh, ]

than someone that's been with [you]

[uh,]

since [you know?]

[oh a ]nother thing. and then my other best

friend from (. ) grammar school, her son died.

((PR nodding)) (0.8)
just.;
o::h!
like a month and [ a half a go. ]
((slb slb ↓slb) uh ) huh,
tzt so i went to the wake and funeral and all that?
yeah,
so:,
yeah,
uh.
uhhff it would be a good idea to erm you know?
just gi- subject yourself to some public thi- things.
like funny movies,
[yeah,]
[ or, ] you know just going out with friends.
[oh yeah.]
[i know ] d- that you make an effort to do that.
yeah,
right know i think it would be a really good thing for you
coz you need to balance all the [hea]vy-
[uh,]
=emotions [with,]
[some]thing=
=[uh ,]
a little bit lighter for yourself.
[uh, ]
[yeah] [and i think,]
[yeah i tried ] to get out you know, like i went to
dinner,
(y.?)
[yeah.]
[ on ] a saturday night [you know?]
[yeah. no] i think you do a good
job of
that. [just]
[uh, ]
so you aware that i, [that]
[uh, ]
you know it's probably important (.)
now really [ im ]portant now=
[yeah,]
because, (0.4)
uh, yeah well, i have .hhh lot of different things coming
especially with Christmas [now.]
[uh huh,
right, right,
you know?
okay [good. that's good]
[coz i be long to the auxiliary there
[and now,]
[uh huh.]
and they're gonna have a Christmas party, and then the
organization's gonna have a Christmas party, .hhh which,
kind of be kind of funny, because it's (0.4) .hhh actually
the twentieth (0.8) it will be on the twentieth and my
husband died on the twenty first and that's where he died
but,
o:h! [o:h!]
[ ha ] ha ha [but,]
[ so ] that may be a little,
[ ha h=]
=emotional? [ for you.]
[ ↑ye↓ah ] but,
((just think))
[ i think:] i'll get through it.
yeah.
ha ha
yeah.
and you will get through it.
uh,
you're doing very well.
[uh,]
(and) just continue surrounding yourself [with peo]ple=
=who love and support you.
yeah.
that is the best thing you can do.
and knowing [that] you're gonna get through all of this.
[uh, ]
[uh huh.]
[uh huh,]
yes.
life goes on.
[↓know ]
[it will.][yours]
[ oh ] [ri(h)ght do(h)n't] i know [that!]
[ ha ha ha ha] [yeah.]
i'm [sure you do.]
[ ha ha ha ] ha [ha]
you've [learned] that.=
[ ha ha ]
=[oh yeah]
=[in the ] past few year right?

uh,
[ and and through,]
[through all these] years [ oh yes. ]

mandy's lost a number of siblings. right mandy?
well lot of relatives and things like that.
yeah,=
in one year i lost, (. ) in five years in the five year
time that i think it was like eight.
oh no!=
eight you know, ((PR nodding)) like nephews, e:rm my
brothers, my sister in law my brother in law, .hh
(0.7)
((PR nodding)) two brother in laws, ye:ah and then my
husband was killed at that time too. my first husband.
[oh!]
[i ] already went through two husbands! hhha
yeah, yeah,
so,
so you know
[i know]
[that ] you're capable [of getting] through,=
[oh i ca- ]
yeah. it's just=
=anything.
=a matter [of time.]
[you know,]
you know? and
yes.
i think as you get older it's a little bit harder.
uh huh.
you know i really feel sorry for people that have been
married for
[°ohhh°!]
[fifty ] sixty years, [ and ]
[right]
then all of a sudden, for the first time they lose
somebody.
uh [ huh, ]
[that's] really tough.  

that that is. yeah. i i can [imagine that.] [i started at] a younger age.  

ha ha  

[ha ha] ha ha [ha so i can] [ha] [i could] [ha] [uh huh] [but you know not] not [to] [mi ni ] [mi] [ha] [ ha ha ]  

ze [ i could ha-]  

[that. at all!]  

well no! but i mean er i think i was able to handle it better. ha  

right,  

than if it start happening now you know, that whole process.  

right after [you'd been] together for,  

[ i mean,]  

(.)  

yeah,  

sixteen years or so. yeah, [fifty ] [right.]  

yeah,  

(.)  

okay. well i think you, [you know?] [uh huh. ] ((P nodding)) i think you know what to do to keep yourself like mel said [ sur ]rounded= [yeah,]  

=with people who love and support you.  

uh,  

that that is the best thing i agree.  

((P lowers head and looks at chart)) (1.1)  

okay erm, why don't we check your blood pressure now?  

oh [these are the things i:]  

[ mel will you do that?]  

[need ] er  

[yeah!]  

okay.  

that you'll sign me.  

e:rm  

(4.2)  

and then we'll do your vitals and then i just quickly want to go over a little bit about diet.  

uh [ huh.]  

[just ] have a couple of suggestions to make.
well actually (0.5) maybe we'll step out first, (.)
talk to doctor halliburton, then we'll come back and will
talk about that.

uh huh. (PR compiles file while SC takes out thermometer)
place this under your tongue.
this is you need to [hold it.]
[ hu  hu.]
it's a little heavy. ha
(slb slb slb slb slb slb slb slb)
°i'm just going (to go ahead to slb) pulse,°
okay.º
can't ask you anything [now!]
[ssst]
[i'll wait.]
[ ha  ha ] ha ha ha .hhh

(slb slb slb slb)
yeah blood pressure is (one sixty) over (eighty nine).
(alright okay.)
(slb slb slb)
yeah. yeah.
and the pulse is (slb slb slb slb slb slb slb)
okay.
()
okay.

(slb slb slb slb) thermometer.
[ h u  h ]
[ .hhh] i don't i don't know (maybe that [one's])
[  i  ]
[pa(h)asse(h)d]
[ know ha ] ha
.hhh any of the digital, .hhh
((thermometer rings))
ah thank goodness!
hu hu hu

the one in the ear that's the one that works fast,

[ yeah.]

[that's] what they [have at] the hospital.

[ it is,]

(1.1)

just [takes a second.]

[.hhh the one yeah] the ear thermometer a second. =

=yeah a second. ha

okay.

(ready).

okay.

(2.7)

.h okay so, (0.8) what we'll do is er just step out,

(0.7)

talk to the doctor and i will be back in,

uh huh.

and it's,

(slb slb) disconnect yourself before you stand up,

.hhh right.

[oh!]

[ha ] [ha ha ha]

[it might be] better just to sit there.

[ha]

[ha] [ ha]

[if] [you] [can] tolerate it,

[ ha]

ha ha

oh, oh yeah. (it was [for]) me,

[yeah.]

[ ha ] [ha ha] [ha ha]

[ha ha] [ha ha]

[okay.]

[.hhhh]

[ ha ]

okay. erm let's see i guess i can maybe (slb slb slb ↑slb)
PR: coz it's (1.0) un(slb)bly hot. (4.0) oops! ha (0.3) did i just move the camera?
(0.6)
SC: no.
PR: hu,
(0.8)
PR: right.
(0.8)
PR: tzt .hh okay. so hhh
(1.0)
PR: how are you doing?
(0.5)
P: reasonably well.
PR: okay.
P: but
PR: [ but ]
P: [( i )] (have a big problem),
(0.5)
PR: alright.
P: communication service (slb slb).
(0.9)
P: i never got this (slb) from doctor sheridan.
(0.6)
P: i called his office no answer (slb slb slb slb slb),
(0.5)
P: i don't know if there is something wrong with answer machine or person, er er or [the]
(uh )
P: number they gave me, but i didn't receive in a week or so.
(0.6)
P: i called here few times
(0.4)
P: and got no reply coz i ran out of almost everything.
(0.5)
PR: oh, my god okay.
P: so,
PR: °i'll get a piece of paper.°
P: everything you've done [with this point is erm ]
(°slb slb slb slb slb] slb°)
P: (0.6)
P: (slb slb) good but,
(0.5)
PR: alright so,
(1.0)  
PR  hhh[ hhh]  
(0.5)  
P  [(slb slb slb) fine.  
(0.5)  
PR  i took the (sulfur slb slb)  
(looking straight at P)) yes,=  
P  =so,  
PR  did you,=  
P  =there is some confusion now.  
(0.5)  
P  you er (0.4) it said on the paper one dose.  
(0.9)  
P  and i didn't know if that meant one or the little  
container with a magnifying glass,  
PR  ahhhh  
P  says take five.  
(2.4)  
PR  okay one dose er you mean five pills?  
P  yeah.  
PR  okay. er the the whether we gave you, i think  
three pills .hh whether you took three or f- the little  
pills  
P  it didn't say on the [pill (slb slb slb)]  
PR  ((glancing at chart))[ o kay er would] er  
SC  (little,)  
P  little blue.= ((PR turns to SC))  
SC  =(slb slb)  
PR  yeah.  
P  if i got [{slb slb slb slb}]  
PR  ((to P)) [ and i showed you] how to do that and i [showed]  
P  [yeah. ]  
PR  you thee:,  
P  yeah,  
PR  twist it three times,  
P  yeah.  
PR  so you get the three pills out and that okay that would be  
one dose.  
P  okay.  
PR  right here i i here i said [er one dose.]  
P  [o kay good.]  
PR  every day for two weeks.  
P  yeah,  
PR  so one [dose was the]  
P  [ so i took] one.  
PR  ↑pill  
P  every day.
one pill or,

[yeah.]

[it] doesn't matter really.

uh,

whether you take one [or five,]

[uh, o] kay.

it doesn't [mat t er.]

[now i've] had some of the eczema come back,

(. it's

one little spot,

o[kay.]

[ on] my elbow

(1.3)

right there.

but [it's still,]

[it's, right.]

much better [yes.]

[ oh] yeah. much better, [now,]

[but] it itches.

(0.6)

yeah,

er that's come back.

(0.4)

so that [was complete]ly,

[(slb slb) here]

=that was that was p- completely gone

(0.5)

last time it was still, [it]=

[ya.]=

=was a little bit [red yeah.]

[almost gone.] almost gone but it's come

back

and then i,=

=okay.

(0.9)

[(slb slb slb slb slb slb now)=

[ and on the o ther arm] =he he he he he .hhh

sa- same thing on er this arm. er er

did you have it on the other arm last time?==

=no.=

=no. so, .hhh

[ uh, ]

[(yeah] slb slb) a little [bit of (i no culation)]

[but (the slb slb) about it] it

it does

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you can feel it (slb slb slb slb) i think.

yeah [i can] feel it.=

[o kay?] =and there's one spot like that, that came back on my leg.

okay.

and then the ankle.

(it appears better but it's still there.

alright. .hhh

one, when did that come back?

after you took the sulfur

[i: (.) would say (slb slb slb slb better) it's about a month ago. that,

[yeah th- so, ]

[it came back.] erm

so it came back pretty much after [your visit he-]

[er no. no it] kept going with the sulfur like you said.

yeah,

for a few weeks and [ this (was )n't]=

[that's fine.]

=any worse or any better.

(2.4)

okay?

okay.

(0.6)

.hhh okay what i'm [hearing,]

[this one] is this spot right there the same size as this one. [almost. ]

[alright.]

(slb slb)=

=so when we when you came here last time you didn't have it on

that arm, you had it on that arm. [just]

[ a ] little bit,=

=little bit.

yeah.

.hhh you weren't complaining about [the] (fire).=

[no.]

=and ye your ankles were pretty much the same as they have always been,

yes.

pretty much.

yeah,=
PR =okay. so you took the sulfur and within that time that
you were taking the sulfur,
P it seemed to itch more [coz i had a little ]=
PR [it seemed to itch more.]=
P =tendency, it didn't show you know, how the skin is
discolored?
PR yes.
P (0.4)
PR (slb slb [slb slb])
PR [alright ] and that's when this arm showed up.
P yeah.
PR and the (fire) showed up.
P yeah.
PR okay .hhh so actually that may be a good thing.
PR (0.6)
P okay.
PR okay? .hhh what's not good, or which is less than optimal
i should say °that is to say not good° .hh i:s the fact
that we: you're running out of stuff and we need to get it
to you.
P yeah.
PR .hhh coz what happens was erm they did get the (slb slb
slb).
PR (1.1)
PR coz i remember them.
P that was left here you told me that they were gonna s-
PR [ er er]
P [mail it] out,
PR (0.5)
P uh [huh.]
PR [.hhh] the first t- the last time [they ]
P [yeah.]
PR were gonna mail it out,
P yeah.
PR and [then when you]
P [(slb slb slb)]
PR came they said they still hadn't gotten it,
P yeah.
PR well since, and then you were supposed to get it from
doctor sheridan and we gave you his information.
P yeah.
PR and he had your information too.
P and he was (phoned too).
P yes.=

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(slb:) [or (slb) slb [slb)]

PR [and yes] [yes] .hhh so i don't know whether

that makes the peace we'll talk to him today about it.

uh,

P but erm hopefully they still have the (slb slb slb) there.

because i do know that it came in. now whether they've

[sold it]

P [ o kay.]

PR [ since,]

PR yeah,

PR but (0.7) i think today we have to (0.7) have you (1.1)

get you can't leave here without it.

P coz this, alright. .hhh (0.3) erm

P what about? hhh (0.3) anything else any other symptoms,

P no. everything else 's fine.

PR okay. [ and your]

P [(slb slb)]

PR colitis is fine, you saw the doctor didn't [you,]

PR [ i ] saw the

doctor the day before;,

(0.5)

P er monday.

(0.5)

P and: he said (slb) he did tell me you'll never get rid of

P colitis,

P it's something that's in your system. that's there

P forever.

P even to the point that it's:: (1.0) erm (0.6) i don't know

P for instance colitis that my brother had a section

P removed.=

PR =uh huh.

P erm (0.3) he says you still have it. coz it’s in your

P whole system.

P (0.7)

P erm (0.5) but i've had no (0.6) problem,

P (0.5)

P at all.

PR okay.

P erm (0.9) none,

P (0.6)

P at all. [º(slb slb slb)º]
[ and what do ] you think about that? do you think you can never get rid of it? do you believe it?
oh! i don't know.
[yeah,]
[ er ] if it stays like this it's fine!
yeah.
[you know?]
[ .hh so ] he wanted you to continue the (slb slb slb),
(1.2)
[right?]
[ he ] he he (0.3) he did (i got enough) probably for:
end of december.
uh huh.
(0.9) and then we're gonna let it go, coz i think it's
two years. (0.3) i go back for colonoscopy.
(0.7)
okay.
(0.5)
he said that he wants to check because ts-(.) colitis is
the closest thing to cancer,
uh huh,
(0.5)
(definitely) you can get.
ok(h)ay.
(0.8)
okay,= =erm
((PR looking at P’s chart)) (2.4)
the only reason it went to february they wanna er er (0.4)
right after the holidays,
(0.7)
it i insisted on the first appointment in the morning.
hhh
for a reason.
yeah [ coz you can't eat.]
[(slb slb slb slb)]
yeah you c- that's right.
(0.6)
coz you can't eat.
(1.0)
.h alright. so basically let's go over what you're taking.
.hh
(0.5)
are you eating your berries every day?
(0.4)
trying to.
okay.

i do miss a few when i forget to get it but:

okay.

yes.

(1.1)

so we have you on, i know he has his: he's a great patient. he has a little s- ha ha ha ha

[ ha ha ha ha .hha he ha ha ]

[i've always had this (slb slb slb slb)]

.hhh okay.=

=erm

so,

now this was dropped,

(1.3)

i ran out of the h_m_s forty about:

(1.0)

o[kay,]

[ a ] week ago.

right.

the forty .hhh so that we have to give. [we ]

[no.]

have to give (slb) number forty.

i don't take the acidophilus (slb slb slb slb slb).

the h_m_s forty is the acidophilus.

yeah but then this is one that (slb slb slb slb).

yeah but the this the forty is a s- a strong version of

[fit]

[ o ]kay.

erm we can talk to doctor sheridan to see if if erm he

thinks that the er [er]

[o ]kay.

which one he thinks is best or if you have to take both. i

don't think you do.

this is

(1.2)

gone

the lacto(bu↓nin)

er [ er ]

[yes.]

terrible.

.hhh hhh .hhh

erm

that was for your gut to, to re[build your gut.]

[(i won der)](slb slb

might have gone slb)

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PR: .hhh that er the hydro-
P: the licorice is gone end of last week,
PR: okay that one you will [have to get.]
P: little bit
PR: that licorice is gone end of last week,
PR: okay that one you will [have to get.]
P: the tincture of,
PR: erm smilex tincture.
PR: okay. right. .hhh now,
P: bromelin is almost gone,
PR: okay. (.)[and]
P: [i ] can't see any change in the veins
PR: (.)(during that) that was to clear up the veins
PR: the bromelin?
P: yes
PR: e::rm
P: if the: erm (0.5) [(slb of blood slb slb slb)]
PR: [ and and al so for the ] the cs-
P:scar tissue and everything but that's gonna take a while i
PR: mean,
P: [yeah.]
PR: [that ] doesn't happen,
P: okay.
PR: [hhh erm ]
P: [nothing's] happened there.
PR: yeah .h how can i see your right [ leg?]
P: [sure!]
PR: coz and the horse chestnut was for the veins,
P: yeah.
((P lifts trousers and PR looks at leg)) (0.7)
PR: that would be long term though that's something that .hh
PR: oh it does look better. does look a lot better.
PR: it's [ softer.]
PR: [and it's] much softer.
P: yeah.=
P: =yeah.
((PR examining P’s leg)) (0.8)
PR: see your body is reabsorbing all that blood you had a
PR: (.)
PR: [yeah.]
PR: [huge ] amount of blood that is in there.
PR: (0.8)
PR: [and it]
P  [it's al]ways warm.
(0.5)
P  yeah but you know it's,
(0.3)
PR  it's er can i see the other leg?
(2.1)
PR  and you know even you're it's not as red there,
P  [no.]
PR  [as ] it [usually is.]
P  [no the red] redness is gone.
PR  [yeah.]
P  [(slb ] slb slb slb)
PR  yeah. that's true it is still warm.
P  yeah,
PR  but much less.
(0.8)
PR  much less than it was.
P  i've never had trouble,
(1.1)
P  with being cold.
(0.7)
P  for years.
(0.8)
P  and: the only thing that i've had trouble with recently
since i lost all the weight,
(0.7)
P  erm my hands get cold.
(0.6)
P  my fingers (slb slb) ice [cold.]
PR  [when ] when did you lose all the
P  weight?
(0.7)
PR  it was back some time.
P  yeah,
(0.4)
P  two years ago about eighteen pounds.
(0.9)
P  purposely.
PR  you lost your insulation i guess.
P  yeah.
PR  ha ha
P  yeah but that was always, (slb slb) in montana with my son
and tzt
(1.0)
P  (slb slb)
PR  okay. so [ we ]
PR ((talking to SC)) do you wanna see if doctor sheridan's here?
SC yes.
PR and: yeah i'll take this, and i'll write erm (1.4) i'll write this (slb slb slb)
(5.6)
PR hhh [a ny]thing else?
P no i’ve been feelin really good sleep good,
(0.5)
PR great.
P bowel movements fine. (slb slb [ slb slb slb] no blood)
PR [good no blood, no (slb),]
nothing [with that.]
P ((slb slb)) don't take maybe once in (0.4) three weeks
(0.8)
P thee: erm (0.9) erm that thing that help you your bowel movement be regular,
(0.4)
P (is this)?:
PR the fi†ber
P yeah.
PR psyllium
P psyllium.
PR yeah.
P [yeah.]
PR [ uh ] huh.
(0.6)
P i've ta[ken it, ]
PR [.hhh that's]
P once in,
PR [that's great!]
P [ three weeks.]
PR that's great!
P yeah.
PR coz when you first came here you were ta[king it,]
P [ oh er]
PR more of†ten
P i was taking it every day.
PR yeah=
P =or sometimes twice.
PR that's fabulous!
P yeah (. ) have no problem.
PR .hhh coz the hydrogenised lactobumin that is i- we got
cytro erm h you could easily digest, instead of that
cytro remember the cytro?
P yeah.=
PR =the awful fish stuff, i mean not this is mu- i mean this
is a little better than th- the fish stuff ↑right .hhh
P yeah [it's close,]
PR [g(h)a ha ] ha ha=
P =[close to that.]
PR =[ha ha ha ] ha ha ha (0.4) .hhh but that is
definitely to build up your erm mucus membranes meaning,
uh huh.=
P =your gut lining. [ and ]
P [yeah.]
PR stuff like that. .hhh i think that's important. we'll talk
to him about the h_m_s forty.
P [ o kay. ]
PR [my guess] is that he's gonna think that's a better
acidophilus,than the one that you're taking. we still
P [had]
P [uh,]
PR you on the catalytic formula,
(2.0)
P °i don't know ca[ ta li tic for mu la, ]°
PR [that was the four caps with] ↓meals are
you still
taking that?
P yeah. that's what i ran out,
PR okay.
P end of [last week.]
PR [let's talk ] to him about that to see if he still
wants you on that. (. ) .h the (glycerized and the nitro
slb slb slb the
slb slb slb slb the solid ex↑tracts)
(1.5)
PR those are definitely for they re[ du] ces=
P [yeah,]
PR =[ the ] pso[ rya ]sis in formation.=
P =[yeah. ] [yeah.]
P =e_e↑tes [ e e]
PR [(aes- aes]chylus)[which is,]
P [aes chy ]lus,
PR erm horse chestnut.
P oh, that's the horse chestnut okay.
PR that helps build the collagen in your
(0.4)
e:rm veins and arteries.

so it keeps the integrity of the the vein and artery walls intact.

[okay.]

[or or] it improves it. .hhh so because of the varicose veins that you have on your leg,

yeah,

that i think we'll probably will have you on for a while.

erm

and i think the bromelin he was having you on because of your leg,

that was for: thee: (. ) the blood,

yeah.

(slb [slb you ] know slb)=

[uh huh. ] =yeah but it's (0.4) i mean how long has it been since your surgery two ↑month$

august fourth. august september october november

[al most.]

[so three] months,

[three months yeah.]

[three months yeah.]

and we put, but you didn't go on it right away, y- we we [saw]

[no.]

you about a month or and a half after your (. ) your surgeries. *(do you remember ↑that)*

(1.3)

i:

or probably,

i think it was [(two) six] weeks ago.=

so pro[ba bly,]

[uh huh.]

two almost two months ago.

(1.5)

yeah,

(0.4)

[i think so yeah.]

[yeah coz this was] only two weeks away.
you came up two weeks ago.

it was nine seventeen actually so it was a month ago.

uh huh.

(pr) you came up two weeks ago. (pr) it was nine seventeen actually so it was a month ago. (pr) okay.

uh huh.

(slb slb slb slb slb slb slb) you came up two weeks ago. (slb) two weeks ago.

it was nine seventeen actually so it was a month ago. (pr) okay.

uh huh.

(slb slb slb slb slb slb slb) you came up two weeks ago. (slb) two weeks ago.

it was nine seventeen actually so it was a month ago.

(pr) okay.

(slb slb slb slb slb slb) you came up two weeks ago. (slb) two weeks ago.

it was nine seventeen actually so it was a month ago.

(pr) okay.

{(sd enters the room)}

[hello,]

[hey,]

how are you?

i'm doing reasonably well.

w- [(well).]

[i apologize for the supplements they're on the way.]

.hhh yeah. hhh ha ha ha ha [ha ha ha]

[i have i] have one (that had been sitting on) for a couple of weeks now. the other is has been ( slb slb slb slb slb slb slb ) yet. so,

okay.

(slb slb slb slb worth slb slb slb it's:)

(1.1)

(slb slb slb slb slb)

okay.

(1.4)

they got in the (slb slb) a couple of weeks ago [(slb)]

[ oh, ]

did

.yeah.=

=but they never sent it.

but they di[dn't send,]

[ oh they,]

it coz they pro- they thought that ye-[ he ]

[ yeah,]

was getting it [from you.]

[they pick ]ed it up (slb slb [slb slb])

[ o kay.]

coz that's the one i'm waiting,

[ o kay. ]

[(slb slb)] i get the other one,

[al[right.]}
SD: [that] (slb)

PR: okay.

SD: (slb slb slb slb)

PR: alright.

P: and what's the other one?

SD: (proberry slb [slb].)

PR: [(proberry).]

SD: it's,

P: [oh that's right. yeah.]

SD: [it's a li quid, ] it's a liquid berry extract.

PR: and was to help your your hydrolyzed lactobumin taste better.

ha [ ha ha ha ha]

SD: [(slb slb slb the)] (results [from this])

PR: [.hhh ha ]

SD: (slb slb slb [slb slb slb slb slb slb slb slb])

P: [er that's alright i go- i got ] six

months {slb slb [ slb slb slb slb]}

PR: [.hhh ghhh hhh hhh] [ha ha ha ha ]

SD: [ha ha ha .hhh]

PR: ha .hhh and that's the one he can't stand. hu

P: yeah,

PR: hu

SD: well, the the problem er er you're much more vulnerable,

PR: yeah defin[ely.]

P: [ now ] it is that replacing taking the blueberry

PR: uh huh.=

SD: =yeah.

P: yeah o[ kay.]

SD: [yeah.]

(0.5)

PR: big concentration of it. .hhh

SD: yeah.

PR: basically (slb slb slb slb slb) has erm

P: yeah. [*slb slb slb slb*]

PR: [ i- it looks a ] lot better he er we gave him

the sulfur [twelve_c,]

P: [(it has ] started) [ to ] dry.

SD: [yeah,]

(0.6)

P: it's very dry again.

(0.9)

SD: now,
P and it itches.

(0.3)

SD yeah.

(0.4)

SD that was [not like this.]

PR [but it's not ] red [like it was last time.]

SD 

P [yeah,]

SD [ how ] how about your legs,

P erm a little [ (slb) ]

PR [º(slb)º]

P but not much er different.

PR he's,

P they were tied together they [were,]

PR 

P good.

SD oh i see. i see º(slb slb [slb slb]º)

PR [but the ][redness has]

P [this one was] black

hasn't (changed) very much.

PR but the redness is much it's less than it was.

SD uh,=

PR =oh there we go.

P yeah.

PR but it's less angry it looks.

(1.0)

PR ºstill there (slb slb slb)º

PR º(slbd slb)º

P ((SD examines P's leg)) (10.0)

PR hu

PR the stockings really help you [ out ] with that.

PR [yeah.]

P well you know it's amazing how much they do help because

PR you can see there's one vein here,

SD [yeah.]

P [(you)] know it didn't ache or,

PR uh,

P (missed) or something there's three or four in here that

PR show up early in the morning, they are very visible when i

PR first get up,

PR (0.7)

P by this time erm

PR hu,

(0.5)

P right now until er,

SD yeah,
no i know it can't get them all (like that) at a time but:

but that's how small this leg is compared to: the other one. and the other thing i noticed, (0.5) originally, (0.3) some years ago (0.4) erm they measured this leg erm (0.3) but this one to the same (tension), (1.1)

P (slb)

SD [right.] P [ this ] leg was huge.

PR u:h,

SD [right.]

P [ when ] i first had: (slb slb). and probably by this time of the day,

SD [oh yeah. ya.] P [it got pre ]ssurized.

PR yeah.

P and: now (. ) like when i (slb slb slb slb) no problem get them on

P this pair of pants,

(0.9)

P would not er slip over my

(0.5)

P would not go [ o ]ver=

PR [wow,]

P =[(that) i got to]

SD =[yeah. yes if you] have (any) [ you really you reallly]=

P [grab and hold it er]

SD =need that compression stocking. [yeah,]

P [yeah,]

(0.5)

do you think that's fore†ver

(1.0)

SD yeah.

(0.4)

P yeah?

(1.9)

SD yeah there er how long have you been wearing this,

(0.7)

PR two years (slb).

P oh no!
PR no?

P it was before that. erm (0.9)

P (slb slb slb)

(1.2)

SD you know it

(1.5)

SD with with with with d_v-ts then you know

PR yeah,

SD with (slb slb slb slb) major veins which (slb slb slb) you know it can take a year (slb slb slb), two years before before you get really to see what what they want to (slb) back.

PR [ uh,]

SD [(af)]ter having the (slb slb slb yes)

P uh,

SD so same thing er you know (or similar to what you'll find here), you have to (really know what the slb slb slb slb slb how we slb slb slb slb slb you know to)

P okay.

SD (slb slb slb slb)

P yeah, oh a great problem.

SD and right now it's really a lot of (slb slb) er er er it's a great benefit for you.

P yeah,

SD i think without it you'd have you'd have you would have significantly more (slb slb slb slb).

P yeah?

SD yeah and (.) there's a there's a (slb slb slb slb slb we will put you in your leg slb slb) compression. you know to just

P [o kay yeah.]

SD [keep keep it ] down. so erm (0.9)

SD (there are slb slb to put a little a little bit slb slb slb slb slb er you know erm)

(0.9)

SD but i think they probably just keep you more comfortable.

(1.2)

SD okay. (.) i have a [great] problem,= [yeah.] =yeah,

(0.7)

SD what's that?

PR okay,

P my forty dollar pair of stockings.=

PR =hu got to use [that one .hhh ha ha ha ha ha ha .hhh]
but yeah ye ye you know the old the old (slb slb) has the
next you know over the next few years,
yeah,
(0.5)
okay.

.hhh so he had a little er a bit of, ((PR points at P’s
left arm and SD shifts gaze from PR to P))
((lifting arm)) [was o ver here a lot less]
((it er er) and some on the ] o ther

but er showed up the itch.
((SD looking at P)) (0.5)
((pointing at P’s right leg)) [and (slb)]
((pointing at his right leg)) [erm one ] spot right here.
are these new eruptions? [or] are these [(slb slb)]
[no] [these are] old
ones.
old ones,=
=on the side here especially,
(0.6)
it's discolored.
(0.9)
wherever i've had the eczema.
yeah.
it's (0.3) still discolored there're spots on my back (slb
slb)
(1.1)
but this one itches. and
(0.3)
and one spot
(0.3)
it's right above,
below.=
two inches below there.

hh
[and two] [inches behind there]
[ ha ha] [ha ha ha ha ha ] ha ha ha ha=
[ha ha ha ha ha ] =he he he
.[hhh]
[ erm] it's
right in between the [ the no scratch a rea.]
[º(slb slb slb slb slb slb slb)º

he he .hhh
erm but it's not bad but it did come back. (0.4) erm=

okay.

(0.6)

and as i told you it is there is a misunderstanding

(0.4)

on my part.

((SD goes to door as someone has knocked)) (11.3)

erm

(2.7)

and i know this has (to be) turned three times and i did.

(0.6)

and only one came out but (i turned it once) and only one

with sulfur (pills [that]) came out it says take five,

[ yeah.]

(0.9)

=\text{the paper says}

=\text{[(slb slb slb)]}

\text{take one dose and,}

\text{yeah.}

\text{he took one pill.}

\text{i [took] one.}

\text{[this]}

\text{that's okay.}

\text{yeah,}

\text{that's fine.}

\text{uh. yeah,}

\text{er er here's the thing with homeopathics that:}

(0.6)

\text{the the number of (slb slb) you take}

\text{yeah,}

\text{doesn't matter.}

\text{okay.}

\text{usually its its three or five we [(slb slb slb)]}

\text{[ uh oh kay.]}\text{ actually we say three its not the it's not the amount of slb}

\text{you take. it's the frequency of which you take them,}

\text{oh [yeah]}

\text{[(that] makes the difference).}

\text{oh, okay.}

\text{so erm}

(0.9)

\text{that's one of the the idiosyncrasies of=}

\text{yeah.}
homeopathy and: so if you got one, that's fine you got the dose.
okay.
uh huh.
(0.8)
now i stopped that for two weeks like you said.
okay.
(0.4)
(0.8) so no major exacerbations. it appears that things are actually clearing up a little bit.=
=er clearing up a little bit yeah.=
=okay. so (the thing we will have [ to do ])
[the only] thing that's come back are these two and this one [(slb slb)]
[ one way ] of reducing it is c- is continue with the sulfur. now,
okay [three [thr- ]]
[three] yeah. right.
okay.
and at the same frequency. and:
(1.1)
erm you know do that for for you know, (two to four months) and and we'll see where you're at at that point.
(4.6)
right.
(2.3)
and thee: (0.8) (slb slb) hydrolyzed,
yeah, (you go[ tta keep going ] with that)=
[º(slb slb slb)º] =keep going,
(6.7)
let's see,
three pills every day for: till we see him ↑next o:r,=
=uh huh.
okay.
(1.9)
erm the other thing is he's run- he's(.) running out of his h_m_f forty he's also on another aci[ do phi lus,]
[this is the ] one i was prescribed here and there's an acidophilus here,
(1.0)
oh you need to do one or the other. no you don't need both.
okay.
(0.4)
coz the one i'm running out of this you know i just make
sure [that,] [yeah.] but con- continue with, yeah [ one or ] [with this.]

the other. [(slb slb)] [ o kay.]

(slb slb slb slb) (slb slb issue slb slb slb slb)

yeah. .hh erm catalytic formula he was ↓on do we wanna keep him on that?

(2.7) that was er (..) digestive enzyme

yeah. yeah.

(1.8) erm yeah.

okay.

(2.5) yea

and then obviously the the glyceryzer,

(0.4) (slb slb tro slb cus) he was on he needs more of the (slb slb) and the bromelin he was taking,

let me see your tongue.

(3.1)

okay. (.) okay.

(0.9)

that's your (entry slb slb slb)

(1.4)

(slb slb slb slb) i haven't changed them in i start at five thirty and quit about, (0.9) six or seven.

(you)

[ i ]

yeah.

(0.6)

u:h,

you're sleeping o kay

well.

(0.6)

what time is bedtime for you?

ten o'clock (early).

uh,

(0.9)
470

SD  (slb slb slb slb pressure)
1011  (3.1)

SD  (let's take his blood pressure).
1012

PR  yeah.
1013

SD  (slb slb slb) down erm
1014

PR  okay.
1015

SD  thee:
1016  (1.4)

SD  do you get enough fluids?
1019

PR  yeah.
1020

SD  probably not.
1021

PR  okay.  
1022

SD  (you look like you're all) dry.
1023

P  yeah.
1024

SD  well today i haven't been home since,
1025  (1.1)

P  eight o'clock this morning. and
1026  (0.7)

SD  you know i stopped here to get er close (slb slb slb) a
1028  glassful.
1029

P  and then
1030

SD  so erm i would say just push [push (slb slb)]
1031

PR                                        [(slb slb slb)] slb slb
1032

P  yeah,=
1033

PR  =hhh=  
1034

SD  =that's gonna help your system you know [  erm ]
1035

PR                                          [(live)] hhh
1036

SD  erm clear up erm
1037

P  okay.
1038

SD  that you know (slb) it's not it's not coming out through
1039  your
1040

SD  skin. (slb slb slb)=
1041

P  oh sure!
1042

PR  do we still wanna keep him on bromelin?
1043

PR  he was on bromelin one cap twice a day,
1044

SD  erm i don't think he [(slb slb slb)].]
[it was two,]

if he just uses

two

the catalytic formula, that's probably enough coz it has

(slb slb)

okay.

so you can, you can can (clip) the bromelin in the

schedule,

[ o kay.]

[(slb slb)]

great. and aescle- aes[chylus

(0.3)

he was on the tincture,

(.)

e:rm

that was for,

(3.9)

yeah if i get the (redness slb),

that's true.

you won't [have to take] the tincture.=

[(slb slb slb] =yeah,

right.

but just keep it [ in case.]

[(slb slb)] i take er

(0.6)

one i just (slb slb) i guess so.

((SC measures P's blood pressure)) (1.6)

e:rm

(1.7)

the one i take was the: erm

(0.9)

you know the the [ aes ch]lus.=

[(slb slb)]

c- could have been an extract (with with the rest of)

these tinctures,

(0.8)

you know, w- the er the thing with aeschylus that in in in

a sense that (slb slb) you know, that

uh,

uh huh,

it's actually the the (slb slb slb part of it slb slb slb

slb slb slb slb slb slb slb slb slb slb slb slb slb slb slb slb slb spoiling you know in a in

a way. and that that's the ideal with that way and thee

erm)

(well he's the smilex well he's) the tincture now. but

(hydrossi slb slb llia) you sh- you're not on any more,
no.

older (slb slb slb slb) you're not on any more so the
(smile ex) are both solid
ex[tracts]

[ oh ] they're
just solid.
yeah.
so that's, that's the only liquid,
yeah.
this one,=
=uh huh.
oh great, o[ kay. ]
[there's] one [(slb slb slb)]
[yes (slb slb)]
yeah one drop drop of it in the water.
yeah.
yeah.
yeah exactly.
this one.
yes.
uh [huh. ]
[yeah.] yeah that's it. keep keep doing that
[okay.]
[okay ] i only need that ( slb slb).
okay.
(0.8)
that's like (vein sealer).
is that right
yeah er (i i slb have a good slb what you think of it),
(1.2)
it [seals (slb slb slb)]
[(slb slb) extract ] not the tincture.
(0.5)
well, keep the tincture in case you run out with:
preferably we
want you to have the solid extract.
(1.2)
which we're gonna get to you.
maybe it's one forty.
one twenty eight [over six-]
[uh]
[oh yeah,] it went back to where i was

that's good.

i was i was always one twenty over seventy. was it
seventy?

it was twenty eight over sixty.

(1.8)

okay.

yes.

o[ ver six ]

[that's good.] that's good. so so: make these little little modifications, get some more fluids,

[yeah.]

[(slb ] slb slb slb when you get home today),

yeah.

and: (1.2) erm (slb slb slb slb) you know,

when do you wanna see him [next?]

[(slb ] slb slb slb slb slb slb) in a ↑month

month?

okay.=

right. () i will not be here in a month.

(1.0)

okay.

erm hopefully hhh i'll be graduating. ha ha ha ha he .hhh

so
d this guy will be there.

yes [he ] will be.=

[uh,] =okay.=

=so we'll talk about that.

okay.

(2.6)

and this you ↓know

(1.8)

°right.°

(1.2)

great.

(1.5)

alright.

(0.9)

okay. bye doctor.

(3.0)

(slbl slb [slb slb])

[ o k-]

(slbl [slb slb])

[ o kay. ][(clears throat)=

=i'm taking thee:,

(0.4)

you gonna k- take this.

er er yeah,
that [you're not taking,]
[(slb slb slb is) ] two drop tubes.=
two drop tubes twice a day.
okay.
okay i'm gonna write that down. okay?
(0.6)
yeah i've been i haven't been taking that much coz i have
been stretching until i can [ ( slb slb slb). ]
[ yeah. that's fine.] that's
fine.
the catalytic formula (i have to) [continue,]
[continue ] the same.
yeah, and that's for (0.7) digestion.=
=digestion.
the (licorice should i) continue, (i'm out of).
yeah.
uh,
(1.2)
smilex extract hopefully not the tincture,
yes hhh [if not]
[ and i ] don't take this one any more then for,
(0.6)
(antinflammatory) no.
(1.9)
coz you're getting better.
(1.3)
the glycerizer (withdraw) that you can still take,
okay. (slb [slb])
[and ] the hy- the hydrolyzed lacto-
[hh ha ha ha ha]
[hh ha ha .hh .hh]
.hh no. see that's the only one he didn't check off! ha ha
ha he he he doesn't like that.
but:
the sulfur,
[hhhhhh]
ha with taking it,
he he he he .hhh so [one i-]
[er the] sulfur continue,
yes.=
=yeah. (slb slb slb [slb ] slb)=
[yeah.] =and you don't have to
take the
h_m_f forty coz you have,
the acidophilus yeah.
[that acidophilus]
now this is (slb slb),
yeah.
(this this)
(0.8)
which one?
(this here),
(slb [ slb slb ])
[(down there) ] because your eyes [are (slb slb) ]
[(neutro) yeah.]
ok.

(0.5)
.hhh so [cross this one] out.=
[(slb slb slb)] = (or [cross this])
[or er y- w- one of
those you can cross out.
coz it's the same thing. thank you.
(cross) this one (twice a day),
(slb this one slb slb slb)
(0.8)
i haven't had that for a while.
well this is thi- this is er the english name, this is the
latin name,
oh, (..) okay.
(0.7)
i i was taking that at one point, both.
uh huh.
(0.4)
oh really
yeah.
the solid extract and the,
it won't hurt you.
it's alright. e:rm
so i should only be taking (slb slb slb slb),
yeah. what i'm writing down for you is basically
everything that you're gonna take.
(1.4)
.hh okay. oops .hh now he's sending you the protoberry.
hh okay?
supposedly.

=very slow.

you can do i mean it's coming by horse. hhh erm
do one tablespoon a day. i mean take it with your
hydrolyzed (slb) lactobumin.

[uh,]

[okay so,]

(make it blue instead of)
yeah.

(white. [okay].]

[yeah hhh] hhh proberry one,

(it's good.

(oh ] really?

and it's it's just the berry they don't put any sugar in
it so it's a little [sweet,]

[yeah. ]

a little tart, it's just the [con centra ted be rry.]

[slb slb slb slb slb slb]

su[gar, ]

[yeah.]

(they) won't take it.

((writing on P's chart)) yeah,

(too many things you buy today a:re

(0.4)

yeah,

and (you are slb slb slb slb slb dia- diagnosed by er)

(0.7)

doctor griffin.

(1.0)

he's not a naturopath but he believes in supplements you

know, (slb slb slb)

uh [huh.]

[(slb] slb)

i've heard of doctor griffin,

he erm (0.9) found out that i was hypoglycemic erm and

(slb slb slb slb) he almost put me in a coma with that
(slb),
SC  oh, you did the test?=
PR  =rea[†ly ]
P  [[five] hour test] oh yeah. [(slb)]
PR  [ wow!]
P  i went down like forty seven.
SC  er (slb slb) [that's  pretty bad.]
P  [( slb slb slb slb) ] was [seven]ty=
SC  [sixty]
PR  =yeah.
P  they were er er all the time i had my s-
SC  (0.9)
P  i mean sugar test done,
SC  (0.6)
P  erm
SC  (0.4)
P  (slb slb [ slb slb])
SC  [that test] yeah but: it's always in the
P  midseventy.
SC  (1.1)
P  erm
SC  so (slb slb) to react to (hypoglyce[mia](.) to su[gar
SC  (0.8)
P  or [you (respond) to the su ↑gar]
SC  (0.8)
P  [er (slb slb slb the pancreas)] the=
SC  =yeah,=
P  =pancreas er er or
SC  (0.6)
P  that made me very nervous coz my mother died of pancrea-
P  pancreatic cancer.
SC  (0.5)
P  (so if) i was hypoglycemic and didn't know it.
SC  (0.9)
PR  ((lifts head and looks at P nodding)) yeah,
SC  (0.8)
P  uh then my brother is borderline hypogly[ce mic.]
SC  [uh huh.]
SC  (3.8)
P  (like) the doctor told me (slb slb slb they never) and i
PR  asked him what are the downside of having the operation
SC  (slb slb), one in a hundred or so er erm
SC  (0.4)
PR  get infected.
P  get infected.
PR  [hu,]
[i] said ((smiley voice)) i'm number 1

P  hu hu hu hu

PR  i got in[fec ]ted!

[.hhh]

P  oh you did

SC  yeah.

(0.4)

P  well i (0.5) he jokes about it he said it was my fault.

PR  why,

P  because i heal very fast.

PR  oh that's [right.]

P  [ (so ] they they take the blood slb slb slb slb

PR  by the time it it turns around doctor griffin then

P  comes back i'm healed i'm just sitting slb slb).

SC  uh huh.

(0.3)

P  but he (put slb slb slb to) an inch open (slb slb slb slb

PR  slb) drain.

(0.6)

P  by the time i got home,

(0.6)

P  my wife said you'd better check it.

(0.3)

P  (to see) ((smiles))

(1.8)

SC  hu!

(2.3)

PR  okay.

(1.1)

PR  .hhh alright so would you wanna just take this, let me

P  just see the sulfur he (slb slb) [he has]

P  [i have] yeah.

PR  the glycerizer we have here okay.

(0.4)

PR  °(slb slb)°=

P  =w- er erm i'm gonna continue that one and not the

PR  licorice

(0.7)

PR  it's the same thing sorry.

P  okay.

PR  al[right.]

P  [ this ] one or (the)

PR  i- i- [glyc- er er]

P  [cross this one]out

PR  yeah. just yeah. [ th- er er alright.]
so i'll [ say licorice yeah.]

[(slb slb slb slb) okay.=

=okay licorice. (slb slb slb slb)

(0.6)

er (slb slb slb) have that you the (aeschylus) which is

the horsechestnut,

(.)

[yeah i ] have.

[this one] two drop tubes twice a day okay. .hh catalytic

formula,

(1.1)

we have on there,

yeah.

yeah.

(0.7)

and the smilex.

(0.4)

smilex i have.

okay. we have you have the sulfur and the hydrolyzed

lactobumin. .hhh a::nd proberry i have written down here.

okay? (. ) see if they have the these things.

smilex solid,

extract they i hope [they do.]

[ o kay.] yeah. (slb slb slb)

okay.

they should buy twice as much then.

i know!

(slb slb)

(1.7)

they say oh we never use it but, (. ) we do use it a lot.

yeah,

(1.1)

"okay" .hhh so basically everything that i have

written down here is what you're gonna (. ) what you're

taking o[kay]

[ o ]kay.

so if you get confused,

(0.5)

erm

(2.2)

alright. .hhh now i'm gonna say let's see how much,

(1.3)

okay. (. ) do you have your calendar with you, four weeks

from now.

(3.9)

i have (slb slb) doctor (slb) in the morning.
PR  .hhh okay. [ so that]
P  [(slb slb)]
PR  would be what? december seven[teen,]
P  [ se ]venteen.
PR  okay that's that is e:rm .hhh er why don't we make three
weeks from now, this:
PR  okay.
P  There .hhh be[cause]
PR  [(slb slb)]
P  erm can you come on wednesday?
PR  yes.
P  .hhh right w- let's see if there's an appointment
PR  available but i would definitely suggest that. .hh because
PR  i may still be here.
P  okay.
PR  erm i may not that but matt will be here.
P  [yeah.]
PR  [ doc ]tor sheridan will be here be[cause we,]
P  [ i know ] he's here
PR  only on wednesdays,
P  erm only on wednesdays that's why i'd like you to come on
PR  wednesdays.
P  yeah.
PR  .hhh erm this is finals week then the week of christmas
PR  .hhh
PR  (slb let's get [ slb ] slb slb)=
PR  [yeah.] =yeah [ so,]
P  [(and) the following
PR  week
PR  [i],]
P  [is ]
PR  (know they'll be)
P  yeah [so,]
P  [clo]sed.
PR  and then [ i think]
P  [ (again) ]
P  PR  we start, (. again here there's an (slb slb slb slb) week
PR  somewhere in here. so i think it would be good if you
PR  could come on the tenth,
P  okay.=
PR  =they just gonna have to fit you in. .hhh if there's i'm
PR  sure you'll be able to get in because then we can do that,
PR  and then a month later would be january so maybe we can
PR  head you off to, .hhh is there anybody in particular? i
PR  mean er
PR  (0.3)

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that
er er
you would
i [(slb slb slb slb slb)]
[student clinician,]
matt.
matt? [.hhh]
[ or] doctor sheridan.
okay.
(slb slb one)
okay yeah. definitely doctor Sheridan.
(a- absolutely.
okay erm matt is is i don't know if he's a prima- he's
gonna be a [ pri ma ↓ry ]
(slb slb slb)]
(1.1)
(can slb ↑this)
yeah we can (slb).
(slb let's release this one)
u,
(2.5)
bye letizia, hhh hhh
((P is having his temperature measured))
°when your vitals are done° then we'll just put a: it's just a speaker (slb) ♪phone
°uh huh.º
okay?
((SC and PR sign forms and look at P's charts)) (50.0)
°okay.º
°yeah?º
°hu hu huº
.SC .hhh
((SC measures P's blood pressure)) (18.7)
°yeah?º
°uh huh.º
((SC measures P's blood pressure)) (18.7)
°yeah?º
°hu hu huº
.SC .hhh
((SC measures P's blood pressure)) (18.7)
°yeah?º
°uh huh.º
.S.C  reading upside down?=
PR  ninety eight point zero. (. ) okay good. (. ) good.
°uh, uh huh.º
SC  (uh huh.)
PR  ((thermometer rings))
SC  (uh huh.)
PR  thank you
SC  =ninety eighty four. got it. uh huh all set.
PR  (. )
PR  i'll [ put this over here for now.]
SC  (slb slb slb slb slb slb slb)
PR  =ninety eighty four. got it. uh huh all set.
SC  (slb slb slb slb slb)
PR  uh?
SC  (slb slb?)
P  the pressure is (higher then)
SC  it's higher than it was ] last time.=
PR  [it's °a little,º]
SC  (slb slb slb slb)
PR  =yeah a little bit higher than last time. (. ) uh=
P  =er how much is it?
PR  =er how much is it?
P  the pressure is (higher then)
PR  (slb slb slb)
SC  it's higher than it was ] last time.=
PR  [it's °a little,º]
SC  it was ] lower last time.,=
PR  =yeah.
SC  people's blood pressure's often [ high ] er when they're
PR  [(they)]
P  here. but i think that my blood pressure sometimes i get
it during the day on the morning i get a hundred and forty
(.) erm over: seventy eight,
(.)
oh okay.
yeah. uh?
that (slb) that's hundred and one ↑forty [over ] seventy=
=eight, yeah seventy eight,
okay.
this is [ low ] ↓uh=
[that's]
=erm (barely) low, er it's actually more moderate.
uh huh,
erm yeah it's a little bit more moderate. low would be
something
like one lower would be one ↓ten or one hun↓dred over like
(.)
[ sixty, ]
[oh yeah!] yeah yeah.
that would be low. (. ) er so one forty for you it would be
=yeah.
erm but it's still classified as (. ) a moderate
hypertension,
[yeah but,]
[ or mild ] hypertension.
(slb slb slb slb slb: slb slb slb slb: slb slb slb slb slb
slb slb) ha ha ha ha ha or,
ha ha .hhh ↓uh now (lo[ li ta] is she all set?)
[(she slb slb slb slb slb slb]
is she ready to roll?
[ i think we] need to find her,
[on us or,]
(.)
tzt o[kay.]
[ we ] (gotta) we (got[ta] go] which channel (slb),
[o kay,]
(.)
we oh no! no channels[ ha ha ha ha .hh maybe] maybe some=
[.hhh hh hh hh hh .hhh ]
=day. [ ha ] ha ha=
[↓u:h]
=(slb slb) call my mother,
ha ha [ha]
[o ]ka(h)y. [ha ]
[she] doesn't know (slb slb slb slb)
PR: ha ha ha ha . hhh

P: well i { ga ther that} she she does she { slb slb slb}=

PR: { uh so this}

P: ={slb} slb slb slb} { no

PR: ={erm}

PR: either { ei ther just sit here,}

P: { oh they will take the } picture from there,

PR: or they'll take the picture from there.

P: oh yeah then they'll { slb} slb slb} over here { right=

PR: ={erm}

P: =so: it will be here we can we'll just talk here.

PR: ya ya.

P: erm and she'll be taping,

PR: uh,

P: and she'll be listening to our conversation,

PR: uh ya.

P: and then afterwards what she does is she ( .) he rea- she

PR: listens to the conversation again,

P: { uh,}

PR: [and] she goes through,=

P: =uh.=

PR: =different portions of the examination,

P: { yeah yeah.}

PR: [erm that ] as a doctor what you have to ↓ do and how

PR: the patient responds to it. ( .) so it's just a it's a

PR: learning tool for ↓ her

P: uh,

PR: erm then she's writing up a project a a thesis project

PR: they call it.

P: i see.=

PR: =erm that may benefit people later ↑ on to benefit doctors

PR: erm in relation to patients,

P: uh huh.

PR: erm interactions?

P: uh i see.

(0.7)

PR: uh it's interesting it,

P: (and i wonder if) she's not gonna be bothered if they're

all: erm er talking and,

PR: "i i don't know i ho-°° most likely because it's up because

it's { (tapping on clip-on mike) } close { to ↑ us }

P: { oh yeah} thee:,=

PR: =erm [then]

P: {erm } it is very close you don't get the

background.=

PR: =then it shouldn't get the back[ground no.]
P                               [ oh o ] kay.
137 PR  so we just we'll [ just] clip that,=
138 P                               [yeah.]
139 PR  =this is the speaker
140 P  uh ya.
141 PR  and we could even just clip it right either on to your
142 P                               sweater
143 [ portion or on] the collar.=
144 P                               [(slb slb) or on]  =o- on the collar
145 [it will be easier on,]  [and that would be o kay.]
146 P                               the collar yeah.
147 PR  we'll just clip that i'll clip that right up over here.
148 P                               yeah.
149 PR  oops let me clip it so that it's (. ) face in the right
150 P                               way.
151 PR  [here we are.]
152 P                               [uh huh uh ] huh [uh huh.]
153 PR                              [o kay ] good.=
154 P                               ya ya.
155 PR                               okay.
156 P                               okay.
157 PR  now (slb) thank you.
158 (1.1)  [uh,]
159 PR  did you find her [no?]  [uh,]
160 SC                               (1.1)
161 PR                               okay.
162 SC                               (can't work it out)
163 PR                               erm the lights are on she said.
164 (.)
165 SC  and she started all ready
166 PR                               erm may (hh) be she did ha ha .hhh erm
167 (6.9)
168 PR   is it ready?
169 SC  (slb slb slb slb)
170 PR                               okay.
171 SC                               (then maybe this is all slb slb slb)
172 PR                               okay [ i think we're ready] [to,]
173 P                                [hhh]
174 SC  [(slb slb slb we need] [ a ] chance to slb slb)=
175 PR  =yeah let me erm
176 (.)
177 P                               [won't you slb)] ha ha=
178 PR  [ hhh ha ha ] =let me do this do you mind,
179 P                               erm
180 PR                               (slb slb slb)}
181
SC (adjusting cables) (slb slb)

PR [ that would be great.]

SC [(slb) was in a ] rock band [and he] said= i just

PR =negotiating the wires,

SC ha [ha .hhh]

PR [it was ] the hardest [part.]

SC [erm] [grab a sit,]=

PR [ha ha ha ]=

PR =here. okay [then,]

PR then we'll get both patient and

PR in. (slb slb slb) if you want,]

PR [erm it's a good thing you are, the good]

PR thi-it's a good thing you're on my right side because

PR i think on the (slb) i'm deaf ↓uh

PR okay [yes yes. it they work]ed out fine. [ha ha .hhh]

PR [ha ha ha ha ha ] [uh hu hu]

PR okay so we're just gonna go over some questions

PR [erm] [to ] day?=

PR [ o ]kay.

PR [Yeah ]

PR =uh.

PR erm this is a follow up visit to day=

PR =yeah.=

PR =mostly for your low back pain. .hh

PR {SC leaves})

PR [uh,]

PR [erm] and the questions i have today, i see [you']ve=

PR [ uh,]

PR =filled out your diet diary,

PR yeah.

PR so we can review that today.

PR "okay. (. ) uh huh."'

PR er and as far as the low back pain, can you tell me how

PR you're doing today, as far as how you're feeling,

PR oh, [erm]

PR [er ]

PR well erm it was tough this morning to: erm to get out of

PR the bed. (. )

PR ["uh huh,"']

PR [more than] erm like it used to be. (. ) used to be used to

PR be. erm no more than pfff maximum five to eight minutes

PR and i (. ) i was able to walk practically almost normal i

PR mean quite i mean you know, erm .hhh

PR [kay.]

PR [but:] this morning i gotta er grab the the the
consolle i
mean near the, what do you call it tzt kind of next to the [bed?]
[the ]
you know,
okay yes. like the b- erm the night ↑stand
well [night stand in ge ne ]ral means: where you (log)=
[wash the night st-?]
=the the mirror wh- which one is [that?]
[ oh! ] like the the
dresser
the dresser
[wash] it yes.
so i gotta grab the dresser turn the (roller) erm er (.)
it's a very long way. i mean going from here to (hh) here
.hh and:
[uh,]
i walked on that. and then i stopped a bit and i
moved erm i had to to (monitor) the place you know?
and i was getting better and better but: the very step is
is painful you know, uh
"okay."
[es pec ]ially this morning and you know the the that much
you know,=
=now [how] long how long today did it take you to get up
[uh?]
and around,
o [kay] erm=
[erm]  =you said the other day it[ was ] about five
[yeah.]
↑minutes
yeah yeah.
how long was[ it ] today?
[well,]
this time: e::rm hhhe .hh i was er holding the dresser,
you know chasing) the mirror and i walked back and forth
(and all of that), and then hh hhhe that was about: a good
five minutes like that "uh
"okay."
=but: i got a (slb slb slb slb) to do to do peeppee and so
i: jumped on the (slb slb slb) i mean the on the roller to
get to the (slb slb) and hold the door and there and: (.)
we(hh)ll that wa(h)s erm the whole thing you know maybe
ten ↑minute:: [eight,]
[ but ]
maybe ten minute bu(h) you know?

okay so [some ]thing longer than,

[yeah.]

(yeah.)

yeah.

[ be ] fore.=

[yeah.]  

(yeah. ((sniffs))

can you tell me a little bit more about your pain, (.)  

erm ooh yes it's:

as far as the the feeling of pain can [you de ]scribe it

[uh huh.]

(.)

it's:: (.p)ufhh (i don't say this is) like if somebody

stepped on your toe but is: something (annoying me). (.)

er hhhh i don't know (slb slb) e::rm (slb slb slb slb) and

twist that you know, uh hoo hoo! er you know?

[ o kay. o ]kay.

[what i mean,]

[yeah]

[ oh ] by the way: i was: to erm griffin hospital

(student) (.) so no more er boots.

oh they did [take it off, okay.]

[ ya ye ye yeah ] they took it off and the

[slb)]

[ and ]

is okay now [uh,]

[the] ulceration has it healed completely?=

=yeah yeah yeah.

or is it still in the healing stage,

uh uh er ts- according to the doctor and the nurse erm

yhey says this is healed but you know what's happened .hh

erm wearing the:se: boots for three weeks you know,

[i know it's been a long time] for you.=

[(slb slb slb slb slb slb)]

=.hhh and they started to irritate the (slb slb) over here

well i used to have the same kind of the problem you know,

.hh

okay.

and: er it's: something you know like a (slb slb slb slb)

and i asked him what (slb slb i said oh) give me some

pills he says (slb slb) i was well. i hope you know ha ha

o[kay.]

[bu- ] but i mean er er (tight) there it is thee the

whole place you know the [that] was (slb slb) i go i got

[uh, ]

this condition:, the same i got the other one you know
that was big much bigger
than *be[fore.*]

[ and ] i remember [ you were ] mentioning that
yeah yeah.
when you first came in to visit me.
oh i [did that] yeah. (slb slb) yeah=
yes so,
=so it's still in the
same place,
ºuh huh.º
but just a little irri†ation
yeah [it's:: ]
[uh like] a crusty? [you ↑said]
[er ] it’s something:,
(2.1)
well and i c- er this morning i was feeling something when
i walking but: now i don't feel nothing er when i touch it
no.
((P touching his leg)) (0.9)
it's not sensitive any more i guess ((looking at PR)) ↑no
[good. good.] [and i f- ] according to him he must do [ he ]
[good.] (probably doesn't say °you know he [just slbº])
[uh like] a crusty? [you ↑said]
[.hhh th- ] yes

uh=
=he may just he may want to just watch it
[to see if see if ]=
yeah yeah uh uh uh,]=
=[uh uh uh,]
=[there’s any ] changes.
yeah he said that yeah.
okay [good ] so that was removed yester†day
[yeah.]
[was it removed,]
yeah yesterday.]
from [griffın]
[i was ] i was: to, oh! wait a minute. .hhh e:rm
((singing)) da da da da
(7.0)
yeah this is: [the:] [uh ] this is [erm]
[so ] wh- what's the day
there i did i did th- i think i was there the
day before.]
[erm today ] is such the twentieth so that would have
been er oh the [eighteen,]
[eighteen] uh. Tuesday oh kay.
[yeah.] uh.
(and this is doctor, uh)
[yeah.]
[okay]
[0.9)
(°okay°)
(1.4)
i [think: er er (my leg healing)] because, i'll tell you what. (slb slb slb slb slb slb) the nurse. oh my!
(uh) she should be er in: hollywood!
[okay] thank you.
[hh hh] she's a beauty oh my gosh!
[ha ha]
[hh hh] she's a beauty oh my gosh!
[ha]
[yeah you know, yeah yeah.]
[now tell] me a little bit [a] bout, erm
[yeah.]
(.)
.hh the pain.
yeah?
today.
yeah.
erm
er the location=
=erm actually it's [it's] the lower region,=
[yeah.]
[like] you had [er]
[yeah.]
[yeah] yeah.
what on a scale of one to ten,
yeah,
how does the pain feel today?
oh today [right] there=
[erm] =yes.[er]
[oh] no that's very low
that's: (.i think i'm okay. er i'm feeling the pain no.
(.) only [(once:)]
[okay ]
see if i can get up get up everything, (slb slb slb)
(1.5)
.hhh hhh yeah well [i don't]
[o kay.]
feel the pain while i do that you know,
okay so you're doing okay [get]ting up. =
[yeah,] =yeah [oh yeah!]
[ o kay ]
uh huh huh huh
erm
oh [(slb slb slb) sit down,]
[sit ting ] down is diff-
= (slb slb slb slb) yeah. ((sniffs)) [uh]
[so] on a on a
scale of one to 10 [one] being (.)
[yeah.]
very low or no pain and ten (.a) high pain,
[where would you rate it?]
[oh o kay the the] high number is the high
pain?
er er [er]
[er] the high number would be a high pain.
okay [so:] it's maybe two:, er one two?=
[erm] =okay so very low
[today.]
[very] low yeah.
((writing)) okay.
(5.4)
.hhh now you've been using the: erm the pad that
[ in ]tered=
[yeah.]
=heating [pad ]
[in ]tered yeah.
er how are you doing with that?
(.)
uh [huh.]
[has ] has that been helping at all erm over the past
week, since we talked last
huh yeah i think:: it's dif- i think here the the
massage you gave me er was helping even more you know,
when
[o kay.]
[i get] up: oh yeah i feel nothing. you know?
o[ kay.]
[yeah.] i think it was right on the spot i guess you
know,=
=how long er after the massage [ that] we did last week,=
[yeah,]
=how long did you feel relief?
before the massage?
erm afterwards. [af ter,]
[oh yeah] the the (slb slb ↑slb)

[i think: by the time we was talking]

[together: and: walking outside i was right to my car,

[i don't know.

[i don't want to, uh]

[.hhh but then how did you feel when you got home?

[i was well] too! yeah yeah.=

[how were you,]

=actually,

[still still there yeah still the: (slb slb) feel the er

(.) .hh in french we say le bien d'etre. le bien d'etre.

[ le b- o kay. o kay. ha .hhh]

[( le bien d'etre) ↑uh yeah ha ha yeah.]

[but i feel that you know, the what do you say in english

le bien d'etre, erm [good] feeling,=

[e:rm]

[er good] you e:rm you feel maybe re::↑freshed or

[yeah yeah. okay [yeah.]

[uh ]

[perfect. yeah that's [perfect] uh huh.=

[o kay. ] =okay

[yeah.

((PR writes on file)) (10.6)

and when did you start to feel the pain again? (. ) after

that last massage,

[what's his name er e:rm i gue-]

[yesterday i saw, erm [what's his name er e:rm i gue-]

[practor]

[i'm] not familiar with his name [but,]

[uh,] yeah. ha ha
non plus. erm my me too. uh no no er but: ((sniffs))

(4.0)

okay.

(2.4)

so tell me a little bit more you had mentioned erm when i

spoke to you about the palpitations

yeah.

tell me a little bit more about the palpitations.

[ uh ] huh yeah.

when when they had started,

=yeah [ i ] was driving you know, (. ) and: it's funny

[and]

those palpitations can happen any place anywhere (. )

without to know, erm (. ) even (. ) anything er can

triggers these things you know? er maybe er i was (slb slb

it's maybe) something from the brain you know i'm i'm

thinking it was something (slb slb would be slb slb avec)

something: quick you know

okay.=

=while i look i (get) something, i say what's the color

what's means that t- très you know what i mean

it's quick. it's [quick.]

[ très ] yeah [uh Tuh ]

[how how] long had the

calpitations lasted,

[ i ] don't know, [short] uh=

[ how ]

=[it was ]

=[toom uh] toom. [just: like a] twitch,=

[erm like a]

=([slb slb slb slb])

=[so may be a ] a couple of seconds

[yeah.]

[ o:r,]

a couple of seconds.

[ or ] minutes?

>no no [no no.<]

[no, o ]kay.

uh?

and when was the last palpitation when [did you,]

[to day ] i just:,

just today,

yes [to day. erm]

[at what time] erm [to day,]

[when i] came: it was erm it was
550 before two uh may[be,]
551 PR [oh,]
552 P five ten minutes before two [yeah.]
553 PR [ o ]kay.
554 P [(slb slb slb ] slb slb slb)=
555 PR [and it happened,]
556 PR =just as you were driving down [↑here]
557 P [yeah ] yeah.
558 PR okay.
559 (0.9)
560 P strange it happens something it can be any kind of the the
561 the s- something er roll to my brain, you know it's
562 something: (. ) er er er (slb slb ↑slb) or you know the
563 color on i read the the the something i see on the
564 street, or something i i see on the telly too just like
565 that you know?
566 PR so it's something that's upsetting to ↑you
567 P yes [it's erm]
568 PR [it seems] to come up erm or [is it] just anything
569 P [hhhhh]
570 PR that,
571 (. )
572 P er er er er it can be anything.
573 PR [it can be a ny, ]
574 P [you know like it's:] er anything yeah. .hhh i know maybe
575 P this is like a (slb slb) probably being closing my eye my
576 P eyes you know, .hh coz: you know i'm blind right? so,
577 PR on the one,
578 P [yeah you know and some time] when i focus on something
579 too near,=
580 PR [the one eye is blind yes.]
581 P =er er because i gotta: search for: establishing what i'm
582 P t- trying to find out you know,
583 PR yes.
584 P uh you know what i mean,=
585 PR =yes.=
586 P =it's (slb slb) you know?
587 PR erm have you had any headaches at all? when you get the
588 P palpita[tons or] any dizziness,=
589 P [ no no.] =no:(slb slb) [ what]
590 PR [(slb)]
591 P happens is i i get this st- er er sometime feeling, erm
592 (2.3)
593 P how to explain this feeling,
594 (2.3)
595 P erm
i've feeling like a tiredness or something like that.

=yeah [yeah] a tiredness you know,=

[that]

=how do you feel right now?

=oh [perfect!] perfect [perfect.]

[ do you] [ do you] feel [ er ] tired?=

[yeah.]

=[or ] do you,=

=[no.] =no. no no.

=okay.]

[i ] no. no no. .hhh well this it doesn't last long you know,

=okay,

[(slb slb)] there is another thing when i get this something something that trigger the thing. .hhh so i say er er i'm talking to myself and i say he =[huh but it it will stop.]=

[er trying to figure out, ]=

=that it it stop it you know so it's you what(i mean

[slb slb)]

[so you ] tell your body to stop.

[yeah yeah yeah.]

[and it it ] stops,

yeah yeah. .hhh

[ o kay. ]

[ but: e ] ven before the the doctor many doctor told me oh (slb slb slb slb) this is this (slb) palpitation. the the one the kind you got is not dangerous .hhh so what i (gotta avoid) you know so it's: (. ) before i used to have a lot i used to a- amplify it it was worse.

=uh [o kay. ]

[i couldn't] get er i couldn't get this vicious circle. circles

you know?

[uh huh.]

[it was ] gonna (slb) and build up you know and then i was er finish like: .hh you know er like i get (slb slb tion),

er finish like i told you fourth time to the: er the panic,

[yes. yes. it's (some) worse]

[it's it's something like ] the very beginning very beginning of the: er e:r tzt.hhh e:rm what they call it,

=the panic attack?

like a panic o[ kay.]
P [yeah.]

PR o [ kay.]

P [yeah.]

PR erm [and] so it only lasted a a second or ↑so to↓day=

P [uh?] =if i

if i: i got able to get a very er immediate grip

[and con]trol,=

PR [uh huh.]

P =myself and then it disappear.

PR and then it disappears.=

P =yeah.

PR how about the supplements that you were taking, are you

back on supplements i know you had stopped the hyper

[ba lance,]

P [yeah yeah ] yeah.

[e:rm]

PR [e:rm] are you you’re not taking that,=

P =but: [because:] the amount: er .h hh the what you call:,=

PR [but er ]

P =magnesium i was taking it was working good you ↑know

PR okay. [and:] 662

P [ and] magnesium (slb slb) is the one that goes

PR to the:: [.h hh]

P [ uh,]

PR i understand the: (.) on the brain, on the i- it control

PR the:: neutron the:: something like ↑that

PR the: erm [the mag]ne[sium

PR [uh huh.]

P [yes.]

PR [sup ]plement that you're taking [ is ]

P [yeah.]

PR probably also helping [ to ] relax the ↓heart=

PR [yes,] =yeah.

PR [the muscle erm of the heart so that may ]

P [ex actly. o kay yeah yeah. o kay yeah.]

PR be helping [with all of the muscles.]

PR [neu ro trans mit ter ]neurotrans[mit ter ]

PR [.h hh then]

P you know,=

PR =and neuro[ transmitters ] in the brain yes.=

P [yeah yeah yeah.]

P =[yeah (slb slb slb)]

PR =[yes that’s ve ry ] beneficial. [ erm ]

P [yeah?]

PR besides the magnesium,

P yeah,
what else are you taking?

[oh] i i didn't stop like: the e q_ten which is for the heart,

[erm]

you know,

okay so [you're still] taking the q_ten,

[and the::]

= yeah and the e: the e: what else oh i take l_carnitine.

(1.2)

you have the list of here →
o

[erm] [i do have i ]

[well may be (slb slb slb slb)]

i may have the list here [erm]

[yeah] the vita:min uh

in fact i think [these] are all your lab reports.=

[yes.] =uh uh

uh=

=yeah this is:,

(2.3)

.hhh and your release of records here's one of the lists i know this goes back a little ways.

uh huh. [uh huh.]

[i think ] this is the older list that we had.

oh yeah. this is is there is one:

(.)

and that's in your other chart.

[u:h oh yeah!]

[and yeah this] is an older list=

=oh yeah okay uh,

okay but what you can remember [that ] you're taking,

[yeah,]

(is the magne:sium )

[yeah o kay. er l_ ]carnitine and:=

=l_carnitine okay.=

=erm pfff let me see: er

(1.9)

and you said the co_q →ten

the co_q ten yeah.

okay.

and there is another one, (. ) erm (slb slb slb slb slb slb the other one slb)

(3.4)

huh,

.hhh now are you also taking the last erm .h last week you were taking (. ) erm a (triple_s) [↑herbal ]
er i'm on [er]this=
[er]
=thing yeah.
you are [ tak ]ing that [still?]
[yeah.] [ yeah.]
[o kay do]
[but i don't] (. ) think: so far i don't see er . hhh i
don't see this is disturbing something maybe you know er
[er]
[o kay do you notice any improvement (.)
tak[ing that or ] any ↑changes=
[. hhh er:m hhh]
=(slb slb) oh they says it takes almost: two weeks before
you can see er improvement you know,
tzt okay.
because apparently they [said]
[ i ] think it's been almost two
weeks
[yeah some thing like that.]
[that you've started that.]
yeah so er no i don't think much you see: but: apparently
erm they probably see something erm create some kind of
problem: er.hh probably they find out i believe the i
believe er this kind of things that they give probably
disturb the the the heart so that you know er °(what you
think?)°
erm actually the (triple_s) [should] be fine.=
[ uh! ] =fine.
[yeah] we double checked that
[to see ]
[uh ↑yeah]
if there was any contraindications [for ↓you]
[uh huh] uh huh,
and there were not.
uh huh [uh ] huh,=
=but just: you [know] if if you're: in
[ uh,]
↑doubt=
yeah [yeah yeah yeah,]
[you know then ] i would probably just slowly
decrease the amount that you're taking.
probably yeah [yeah yeah yeah.]
[if you find ] that it seems to be
causing

P yeah [yeah.]

PR [more ] problems with the palpitations.

P yeah absolutely [ if ] i,

PR [yes.]

P (.)

P i only see maybe in the next couple of days maybe if it

start causing that i got this thing .hkk er more often,

you know because

PR [uh huh.]

P [i got ] something very seldom. sometimes i don't have

anything and (slb slb slb slb slb) uh,

PR i [know] you were doing well for quite a [while with ]out=

P [uh? ] [yeah. yeah.]

PR =the palpitations,

P yeah i [don't] know maybe this:=

PR [it's ] =we'll s=

P =if the one stopped maybe they give us er give us

PR [give us,]

PR [that may]

P the (slb slb slb [slb slb] uh )

PR [we- well yeah] was we’ll have to .h

P [yeah.]

PR [keep ] track of it.

P [yeah yeah.]

PR [you know, ] just to write down [ the ] best thing would

P [(slb)]

PR be to just write down:[ a ] erm=

P [(slb)] =the fact [uh]

PR [a ] journal.

P [erm]

PR [erm] when you're getting [ the pal ]pitations,

P [yeah, uh,]

P (.)

P yeah. [uh,]

P [erm] the time that it [ oc ]curs,

P [yeah.]

P (.)

P erm and possibly what you [were ] doing

P [yeah.]

P (.)

P [at that point.]

P [uh uh uh. ] at that point uh [ huh. ] yeah.=

PR [yeah. ] =yeah if

P you can do that and then that when we can we can [ ta ]ke=

P [yes.]
=a look at it and maybe we can figure out, (.)
yeah. [(this is a) reason for it.]
[er er mh the reasoning ] for it.
yeah sure. yeah=
=yes.
(.
=eh [erm]
[ o ]kay.
[gar]lic. i'm taking it's also for the heart (right=
=erm which one you said
er er garlic?
garlic [yes. o kay.]
i've got a couple of other one. (.) e:rm
(4.1)
uh huh, well if you if one d- did you get the can dig up
[all ]
[i'll]
the the list ↓no=
i'll review the old yes [yes i'll]
[uh huh. ]
review the other list that you have.=
oh mais you you can get the the the the one is it
complete ↓no
i have, [erm]
[uh ] you get the the (slb slb)
i have: your diet diary here and (.) let me take a look
here. (.) this was an old chart too.
°hu hu [hu hu] hu:
okay.] = let's see: (.) was there anything
else here, erm the calcium with magnesium
oh yeah. (slb slb) [magnesium (slb slb) uh huh.=
o kay.]
=erm fish oil?
fish oil yeah okay. yeah fish oil.
[o kay.]
[i ca ]rry on with everything er [the calcium,]
[(slb slb slb)]
=i was looking for this one. [er er]
[the the] the ↑calcium
yeah yeah.
okay [you]'re still taking that,=
[uh?] =yeah yeah.
er thee l_carnitine you men[tioned,]
P nitine too yeah yeah.

[1_car]

PR erm (harporn)

P erm (harporn) too yeah.

PR [okay.]

P [okay.] yeah yeah.

PR and your co_q down

P yeah yeah.

PR erm the d_m_a_[e,

P [uh] yeah yeah i d- i take this one too

yeah.

PR you are still [taking that,]

P [yeah uh huh.]

PR okay. (.) erm magnesium (aspirate)

P yeah. (trés trés) [yeah (slb slb)]

PR [that uh huh.] (.) and your vitamin C

P uh huh yeah.

PR okay.

P oh is it that, here everything there?

PR your leg

P [yeah.]

PR [erm ] with o_p_c_ s

P oh yeah yeah. well er thee o_p_c thee o_p_c (.) er it's

it's the

P same thing like: the (capsida:

PR [erm]

P [so ] something similar to it you know,

PR thee:: o_p_c,=

P =yeah,=

PR =is actually it's almost more of like a: bioflavonoid.

P yeah exactly [yeah.]

PR [it's ] what it does,

P [yeah uh yeah.]

PR [ so ] it helps] support your vein [structure]

P slb) uh huh

PR erm (lootine)

P (lootine) [yeah yeah.]

PR [are you] tak- are you still taking that

P yeah this is for the eye right?

PR for the [eye yes.]

P [yeah yeah] yeah.

PR erm (tua_vine)

P (tua_vine) yeah yeah.

PR okay erm tri zinc citric,

P erm the zinc yeah. i take the zinc too yeah yeah.

PR okay and the gu_
go

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erm the what?
  =erm gu\(\uparrow\)go
  erm [gugo,]
  [gugo \(\uparrow\)tract
erm (.i didn't take for a long time i don't know erm er
what's this is [what for] actually the (.i gu\(\uparrow\)go,]
erm (.) i didn't take for a long time i don't know erm er
  [ o kay,]
  what's this is [what for] actually the (.i gu\(\uparrow\)go,]
erm (.) i didn't take for a long time i don't know erm er
  [o kay,]
  the gugo

is for the heart?
oh \(\uparrow\)yeah
yes.=
=uh i should take i think.
erm
oh yeah. [yeah.]
=uh i should take i think.
[we][this ] one you haven't been taking i'll just
mark
yeah,
this one as no.
uh huh.
(1.5)
yeah they got over \textit{here at the: dispensary}[uh?]
[erm] we do
have gugo [yes.]
[yeah] okay. yeah yeah. this is: for the heart
right,
erm gugo is for the heart.
yeah [ uh,]
[erm] it's also good for er any type of erm (.)
difficulty with fats erm cholesterol
oh [yeah. yeah oh yeah.] yeah yeah.=
things like that's for,]
because i i'm taking thee the flax oil,
oh that's very good [for you.]
[yay yeah] flax oil. oui .hhh [and:]
[erm]
well the flax oil yeah. what else, u:h (.i we'll er er
flavonoid you know i take [that,]
[erm]
er this is not well for the for the whole system,
[you know yeah.]
it's for the ]
whole body yes.=
=yeah.=
=yes.=
=yeah yeah.
and the hyperbalance you're not taking,
no.
okay.
super hu hu.
okay.
yeah.
er superflavonoids?
yeah we just [said that.]
[ coz it ]
uh,
okay.
uh.
erm digest ↑ease [you're still tak]ing that for=
[ .hhh no, hhh]
=diges[tion,]
[ no ] my digestion is good you know no.
(.)
[ o kay.]
[that's it] i think.
erm and let's see d_h_e_a
 d_h_e_a i stopped.
you stopped [o kay.]
yeah i] stopped a long time ago yeah.
okay. (. ) erm ↑arthro (. ) seven,
[ yeah.]
[ erm ]
it's:[it' s] a co- er for the:=
it's:]
=collagen for the ↑joints
yeah yeah for the joints. yeah.
okay you're still taking ↑that
[yeah.]
[ erm ] a:nd (oxispectrum)
e:[erm ]
[it's] an antioxidant.
yeah [o kay.]
[or spec]trum,
yeah yeah.
are you still taking that [one?]
[o:r ] no i [ re]placed it
["no?"]
with another one.
°o[kay.°]
[e:rm ] it's:: (. ) (septin) ↑pure (septin) pure
[ in: e:rm]
[sep tin]pure
okay.
erm for the joins you know,
(2.3)
P (septin)

P =er (sep†tra)=

P =so i don't know how's actually the the the spell with:=

P =pure okay.

P uh,

(3.1)

P and our last one is thee: (prosthata)

P yeah i ta- i'm still taking [that yeah yeah.]

P [you are still] taking that

P okay.

P [you have (slb slb slb) slb) with that ↑yeah=

P [o kay good. so then] =yeah i think

P we have

P everything down here.

P uh huh.

P okay good.

P uh.

P and: [so what]

P [and so] gugo is is it's is is the (↑slb)

P [ gugo,]

P [that i] could have ↑yeah=

P is for the heart it's mostly for like, cholesterol?

P u:h [i see.]

P [erm it's] a lowering agent, [for cholesterol]

P [lowering agent] yeah.

(.)

P i don't know if actually my cholesterol was checked

P looking on the gugo.

P erm it was [che]cked the last .hh=

P [ uh] =yeah,

P erm as of this file i think the last check [ we ] have

P [yeah]

P [here]

P [yeah]

P was actually blood work ↑done [and your] testosterone

P [oh yeah]

P level.=

P =oh

P yeah [this] was the last ↑one=

P [ erm] =erm

P no.

P two thousand and three.

P [oh two thousand three.]

P [erm in sep tem ber.]

P oh okay [then.]

P [ sep ]tember and that's all [ i] have in,
and on your last blood work,

erm that was just your red blood cells

[oh yeah] = oh

Yeah!=

= and your your erm testosterone

[oh yeah] = oh yeah,

le[vel]

[oh ] this: so it's the one [is good (slb) ↑ yeah]

[and that was all] within

range yeah.

oh yeah that was all in [range.]

[yes ] that was all within

range.=

= oh yeah. i see yeah.

erm a couple of questions [i had ] on your diet ↑ diary

[yes yes.]

(.).

yeah.

erm (.) the: last we have here let's just take a look on the

diet [uh]=

[ uh,]=

= diary.

(3.2)

okay. (. ) and this was the first day,

(4.5)

okay good.

(.)

well this one i repeat was practically all the same every day.

this,

this is my breakfast i don't change er except: i can change different: erm like: instead the blueberry i take some other:

another [( ↑ type )]

[(slb slb)] er er er (slb) to the berries you know grape you know? (slb slb slb) [.hhh so that ] it can be a= [ o kay that 's,]

= change mais er er autre- otherwise is exactly what i'm taking every morning you know?

okay.
uh,
(1.8)
okay yeah it looks it looks good.
[yeah]
[it ] looks as if you're [you're] getting enough
[ yeah.]
nutrients and=
=yeah.
erm i'll go over this with doctor duncan
[al so to day? ]
[oh yeah. yeah yeah.]
i see=
erm just to see if he might have another recommendation
that [he ]
[yeah.]
might able to add [ o:r,]
[sure!] yeah yeah yeah. [yeah.]
[erm] to your
diet.
yeah.
(.)
okay good.
uh,
okay so what we'll do for now, [erm ]
we've already taken your vitals so we'll [do a ]
[uh huh.]
massage,[for your] lower lombar [a rea [o][kay]
[uh huh.][uh,][uh o]kay.
and i think we'll
the the the lady did he show up? or what she get lost
or,
erm no actually she's will be finishing with the video.
o:h! [hu]
erm] and then we'll do a massage next.
oh i [see.]
[ o][kay so we can [take the speakers off,]
o:h you you al rea ]dy
turned the whole thing \down
we took everything [yes.]
oh! ] you don't tell me anything,
you [see hhh he he .hhh that wasn't bad was \down it see he]
[hhh ha ha ha ha ha ha .hhh ha noh ha]
he he
oh \up my \up gosh
[so what,]
The here was (slb) up er er
the camera running,]
[everything (slb slb)] (up) yes.
o [oh hhh hhh ha ha ha ha ha ha]
[camera's running and everything's going for] you.
[kay. he he]
[uh hu hu]
[so what] we'll do i'll [talk to doctor duncan
[.hhh uh]
[on the] diet diary [that you gave,]
[yeah yes] [you take me,] er you take er
[you're ha ha] ha .hhh=
[it's: he he] =that
[that's good. that's]
[will you are ] you sure [that] the thing,=
[but ]
=you know [oh ] it was al-
[erm] =it was already running.
[yeah.]
[yeah.]

maybe the the it went it [ went on] by the voice [no ]
i'll take
[ac]tually it was running throughout=
[no]
[so i] see=
[uh huh]
[yeah [something yeah. u:h!]
[o kay. so we'll] take the clips off o'kay=
[yeah [yeah.]
[uh, ]
many many many problems. [uh huh.]
[lly i was convinced i had mercury toxicity. [uh [huh. uh [ huh. o kay. o kay.]
[ha! ] [.hh seriou(h)sly i ] mean we're talking neuropathy, (slb slb)myalgia,
[uh huh.]
[chronic] fatigue syndrome, [de ]pression, erm every
[uh,]
classic syndrome i do have twenty six mercury fillings. [uh huh.]
[okay. [o kay. ]
[so (it's] slb slb i went) to the dentist,
[okay,]
and i happened to be(h) i never [go on ] the computer,
[uh huh.]
[uh kay.]
[i was ] the: maternity erm erm teacher.
[and now i'm a masters in nursing.] [rea lly, o kay. oh ve ry good. oh] very good. uh huh.
[uh huh.]
[a n d: ] well so much for walking,=
=uh huh.
[uh huh.]
[i was ] the: maternity erm erm teacher.
[and now i'm a masters in nursing.] [rea lly, o kay. oh ve ry good. oh] very good. uh huh.
[uh huh.]
[uh huh.]
[uh huh.
[.hhhh so i ] called here,(. so actually and and then my

508
chiropractor came to school here,

PR  okay. o[kay.]

P  [ so ] i called him.

PR  [uh huh.]

P  [and i ] happened to say hey do you [know any] n_ps,=

PR  [uh huh. ] =uh

P  huh.

PR  tzt (slb slb slb) about erm (colating) is that [ how you,]

PR  ing

P  say it [(coolating) the]rapy. right?=  

P  [uh huh. uh huh.]

P  =so i have to pull all my teeth hhhh[out!]

PR  [ o ]kay. okay.

PR  =<it might be worth a try!>

PR  [uh huh.]

P  really is isn't it, and i said well jeez, where do you

P  students [use]

PR  [uh,]

P  [your ] clinical ?=

PR  [huh !] =uh huh.

P  she says we have our own clinic [ i ]

P  [yeah.]

P  said a:::hh!

PR  uh huh.

P  three hours but the price sounds great!

P  [ca(h)n] i c(h)ome?=  

P  [ yeah.]

P  =ca(h)n i c(h)ome [to your] clinic, [she] said sure.=

PR  [uh huh.]

PR  =okay.

P  [.hhh and] i said hey well you know,=

PR  [ o kay.]

P  =<it might be worth a try!>

PR  [uh huh.]

P  [you know] i've done the medical thing and that jus

screwed me up.
PR [yeah,]
92 P [ i ] mean [ i ] have gotten nowhere literally.=
93 PR [°yeah,°]
94 PR =o[kay.] okay.
95 P [e:rm ] i have (>matter of fact slb slb<) psychiatrist
to add me er literally i i've lost some i quite a bi- i
96 was a hundred and sixteen pounds normally,
97 PR okay. [ o kay.]
98 P [.hh i ] was a dancer,
99 PR uh huh
100 P i met my husband in my wait room,
101 PR uh huh,
102 P in nineteen seventy nine,
103 PR [yeah,]
104 P [when ] no woman were left in
105 PR [yeah, uh huh. uh huh.]
106 P [(grace). i was a com]petitive swimmer.
107 PR uh huh,
108 P tzt erm (. ) that's with the neuropathy you know,
109 PR [°uh huh.°]
110 P [the de ]pression [ e ]verything i do i think that,
111 PR [°uh,°]
112 P i'm forty eight.
113 PR uh huh,
114 P so i may have p_m_d_d. and then we have a lot
115 [of situational]
116 PR [uh, okay okay.]
117 P depression going on,
118 PR [okay. ]
119 P [i mean] he's my fifth femi- family member [to have]
120 PR [uh huh,]
121 P cancer.=
122 PR =okay,
123 P .hhh i was actually we were actually gonna get to worst.
124 PR uh huh,
125 P hha [in nine]ty nine [and then] he get sick,=
126 PR [ o kay.] [ o kay.] =o[kay.]
127 P [ so ] i
128 thought i'll be nice,
129 PR uh [huh. uh ] huh.=
130 P [you know,] =an and of course (slb slb slb) he was
131 well he was a year and a half he was diagnosed with
132 tashm
133 PR uh huh,
134 P lupus (vasculitis).
135 PR [u:h,]
P [may ] of may was of two thousand, as erm it was
endocardia[tis month,]

PR [uh huh,]

P he ended up with kidney cancer. [hhh]

PR [wow!]

P [how bad] is that? [how how ] absurd,=

PR [o kay.]

P =and he's a p- he's got palsies of ↑kidney
uh huh,

P so of course he of course that's why he does not have the
good kidney you [know, he end ]ed up (slb slb slb slb)=

PR [yeah, uh huh.]

=okay.

P so anyway, tzt erm our life sucks.

PR [yeah,]

P [ so ] i mean we do have a lot of uh,

PR [{slb slb slb slb slb slb} ]

P [we've seen it really great.]

PR i pro(h)bably [ go tta(h) be on ca(h) me ra,]

PR [yeah. he he he he he yeah.]

PR [don't e ven worry a bout it. uh]

P [i mean we still do have a lot of] .hh you know i mean
no money.
i mean we were never wealthy,

PR uh huh. [uh huh.]

P [but i] mean we went on vacation,

PR uh huh,

P the kids went [to private schools,]

PR [uh huh, uh huh, ]

P i mean i was a college professor,

PR uh [huh. uh] huh.=

P [i mean] =you know,

PR okay.

P ((crying)) [life]

PR [ o ]okay,

P ((crying)) [was not] like this.=

PR [o kay,] =okay,=

P =but i did not have, hh i mean i’m i’m i’m in pai- oh i
flipped, i

PR [uh huh,]

P [took a ] wicked dive last week. i have i've had a couple
of broken toes [as we ] see here right now.=

PR [uh huh.] =okay,

P ((tapping foot on floor)) .h i mean .hhh because i cannot,

PR (. ) you know,

PR uh huh. [uh huh.]
[.hhh i ] am much worse off. i actually did get
the day °i shouldn't (slb slb slb) to the camera.°
uh huh.
PR
.hhh °the guy from mount general?°
PR
uh [huh.]
P
[°ag ]reed that[the] guy from [(slb slb slb slb slb)=
[uh,] [ uh,]
PR
=had screwed up my surgery.°
PR
okay,=
P
=you did not hear that. [ (slb slb slb) ]
PR
[>yeah yeah yeah<] yeah.
P
right.
PR
uh huh.
P
so anyway [that was my all that was my all summer. ]
PR
[yeah they use (it slb slb on one another),] he
he
P
from may.
PR
uh [huh.]
P
[and ] i was in: i ended up with three extra surgeries,
PR
okay. [all on your] foot=
P
[because of ] =yeah. (slb) infection and
PR
[yeah, o kay.]
P
[then we did ] thee: [pick line and the: ]
PR
[pick line, uh huh. ]
P
the back of(slb slb) [which i ] was with the red mouth,=
PR
[uh huh.] =uh
huh.=
P
that stimulated nasty feelings and [to ta ]lly
PR
[°uh huh,°]
P
destroyed my stomach. oh i had g_e_i_d as well yeah.
PR
[oh yeah.]
PR
[o kay.]
P
i_b_s .hh i mean every like[i said, ]
PR
[°uh huh,°]
P
so i [don't know,]
PR
[°uh huh,°]
P
if it's fat if it's,
PR
the depression [so what]ever nobody's treating me.=
PR
[uh huh,] =okay.=
P
=i'm i'm i mean i was a bundle,
PR
uh huh,
P
of e[nergy i mean ] when i got my masters.=
PR
[nergy uh huh.] =uh,
P
i traveled (slb slb slb slb velocity).
PR
uh huh.
P
i i graduated with a two year old, a three year old,
PR  uh huh, 228
P  an eight year old. 229
PR  uh huh. 230
P  i was gonna set the world on [fire!] 231
PR  [ uh, ] yeah. and 232
everything has changed,] 233
P  [as soon as i get ] my p_h_d, 234
PR  uh huh. 235
P  my life went to hell [ and i ] hand back.= 236
PR  [uh huh.] =okay. 237
P  i mean [you know] i can there had been life thing,= 238
PR  [o kay.] =uh huh, 239
P  but also i was gonna tell you, my i had at one point i had 240
my sister in law and my mum in the hospital in ninety 241
three, 242
PR  uh huh, 243
P  my sister in law was on my cancer victims, erm she was 244
thirty four and of course nobody wanted to deal with 245
you're the nurse 246
[ (slb slb ] slb slb)< [ now you're] thee:= 247
PR  [ uh huh. ] [ uh huh. ] =yeah. 248
P  position,= 249
PR  =yeah, 250
P  .hhh everybody [you kno(h)w] you're the o(h)ne= 251
PR  [ uh huh. ] =[uh huh.] 252
P  ya out, they suck you dry:! 253
PR  uh huh, the phone always rings, 254
P  right. 255
PR  uh huh,= 256
P  well i was the one that had to be there and i had her in 257
the hospital. (slb) broken (nose) >i was in the fourth 258
year and my mum (slb slb slb slb slb) god bless her (slb)< 259
she had a total (hiss), 260
seven years prior. .hh came out of an (slb slb slb) 261
cancer, 262
PR  ↑uh↓uh 263
P  so i had the two of them with cancer i had to leave, 264
PR  uh huh,= 265
P  =and go meet my students for their (slb) 266
PR  [uh huh,] 267
P  [you know,] you know my sai- once [a gain ] separate= 268
PR  [uh huh.] 269
P  =the head here mind, [you know my mums] had cancer, oh 270
PR  [uh huh. uh huh.] 271
P  that's, okay you know, just run up the door go meet my 272
students, hh but
two days after that i [started] with anxiety attacks=
[uh huh.]
tzt that's okay,
okay. [okay.]
[and I] (slb) under the care of this shrink.
okay. okay.=
i was on a list of meds.
(1.8)
i guess you know
uh huh.
this one,
uh huh.
do you any do you know (psyche meds)
some of them. uh huh. uh huh.
at one time,
uh huh,
i was on (. ) fifteen hundred of depacode, six hundred of
[really?]
[to ca]max, four hundred of [(sara slb)]
[of to ca] max
sixty of paxol, forty five of (veron veron)
uh huh,
it was bizarre!
uh huh. how did [you walk around?]
[i was up to,] exactly.=
=uh huh. [uh huh.]
[i went] to (slb)
uh huh. [uh,]
[I was] (slb slb)
yeah, [yeah,]
[ha ]
yeah, uh [huh.]
[i ] lost five years of my life!><
uh huh. [uh huh.]
[i weigh]ed eleven hundred and twenty pounds,
okay.
i was a model, [he hlo] oh
[i was a dancer,
uh huh.]
i lost my life.
[o kay. o kay.]
[a year ago may ] i got wicked sick. a really bad flu,
uh huh. uh huh.
(1.1)
o:h, hello [world!]
[ uh, ] uh huh.
i stopped taking the meds,
okay.
obviously!

uh huh,
dropped a hundred pound
uh huh,
but now i'm frustrated as i get out trying to get my life back.

uh huh.
tzt and er in the meantime all these other things
uh huh,
have [ appeared. ]
[cropped up.]
so and so i'm now i'm forty eight .hhh and wonder do i
really have p_m_d_d,

uh huh,
tzt or it is just a byproduct of
everything that ha ppended.
[everything uh huh.]
[you know?]
[o kay. ]
so .hhhh ((pointing at PR)) [you have qui]te,
[uh huh, uh,]
[hhh hhhh ha ]
[quite i know you're] the typi[cal pa- pa]tient=
[ha ha ha ]
=that comes in [to] see naturopaths [yeah.]
[ha]
[ ha ] ha ha ha ha ha

[tzt] we no you have [this er] you know,=
[ha ] [.hhh ha]
=array [of of com]plaints and different things .hhh=
[.hhh ha hh]
=normally what we try to do: (well) sometimes we do is
start with the most pressing to you that will improve your
quality of life .h

[hhh]
[and] then start to address some of these deeper issues
here () tzt what's erm? (.) what do you think is the most
pressing right now?
well probab- i think i'd pull both now i don't know if
there is () if it is the mercury [fillings] we can fix=
[uh huh,]
the neuropathy if the neuropathy is due to a back thing=

515
=uh huh,=
=then i- we you can't.
okay. o[kay.]
[.hh ] erm it's the depression [i can't] take the=
[o kay.]
=depression [you know,]
[o kay.]
erm [this is not] fun.
[when when did]
(.)
when did most of the symptoms (. ) begin? let's start with
the
depression a:nd thee: low back.
.hhh
no let's start [with] the low back. [°the neuropathy°.]
[well]
erm at twenty one when i was (nurse) four months and i did
erm rupture a disc.
(0.9)
but [would] not do surgery.=
[ uh, ]
and spent two years of bilateral (biotica), (. ) but with
exercise.
[uh huh.] [and dead] rest got better. [they wan]ted=
[uh huh,]
[to do surgery but i said
uh [huh,]
[ no ] we're not doing surgery i'm only twenty one.
when you were twenty one, were you still dancing at that
↑time
uh uh. huh [oh er i was ] still dancing.
[o kay. what ty-]
[i was still dance ing.]
[what type of dance were ] you doing?
oh! oh ballet, tap,
okay,
everything.
okay.
yes we're not dancing right ↓now
[o kay.]
[ha hhh] (slb slb slb slb ↓slb)
okay e:rm when the back pain began, was it radiating back
pain or
was it,=
=o:h yeah. bilateral.
bilateral.
oh yeah.=
=uh huh.=
=it was bad uh huh.
(1.7)
tzt had the (milogram),
uh huh.
and i was sick i was allergic to the dye.
uh huh.
developed a re(slb)dya\dis
okay.
oh it was a bad scene,
how far down did the: erm pain radiate,
in my feet.
on your feet,
[uh huh.]
[uh huh.]
((PR writing on P's file)) (2.4)
down in my buttocks [and in ] to my feet.=
[ o kay.]
[hh and at different times it would depend you know
[which: ]
[uh huh.]
which leg.
sharp shooting,
sharp shooting.
uh huh.
but that was then.
and over time i mean it it chan- you know,
[uh huh.]
[i- i- ] i got rid of it.=
[uh huh.]
[ a majazingly.
[o kay. o kay.]
[i mean through li]ke i said dead rest. [you know]
[uh huh.]
exercise,.hhh like as i sit here now, right now [now i've]
[uh huh,]
got this left thing going into my (. ) buttocks,
[oh kay.]
[th- ] that happens to me today. i [mean it] depends on
[uh huh,]
the day. it depends on what i've done. [you know]
[o kay.]
what i mean, [ .hhh but]
PR [o kay.]
459 P  erm (. ) tzt now again you know,
460 PR  [uh,]
461 P  [i ] may be stuck with this neuropathy now [fo re ]ver.=
462 PR  [uh huh.]
463  =uh huh.
464 P  maybe it is a mercury thing maybe it is a [back thing,]
465 PR  [ uh  huh,]
466  okay. [you] don't know,=
467 P  [ i ] =i don't know who to belie:ve=,
468 PR  =okay.
469 P  and in wha[hhhh ]hhh=
470 PR  [okay,]
471 P  =[you know,]
472 PR  =[what a ]bout the timing of it, erm how was it as far
473  as er tzt the time of the day th- th th- the weather, is
474  it weather induced?
475 P  [o:h,  well supposed ]ly i had hha hha i was gold, (.)
476 PR  [is it time  induced.]
477 P  tzt i was on gold shots. (. ) cortisone.
478 PR  uh huh,
479 P  and (thackonel),
480 PR  uh huh,
481 P  for four years.
482 PR  okay.
483 P  for rheumatoid arthritis [that i don t have.]
484 PR  [that you don't  really have,
485 P  [.hhh ha ha]
486 PR  [o kay. o]kay. [uh huh.]
487 P  [i do] have osteoarthritis,
488 PR  [o kay.]
489 P  [i have ] had two shoulder surg-[ i ] was i told you
490 PR  [yeah,]
491  [uh huh.]
492 P  [i was ] a competitive swimmer.
493 PR  uh huh.
494 P  so i do have wicked overuse,
495 PR  okay.
496 P  i mean we were that was back then i mean as i've been
497  losing, we- okay at nine years old,
498 PR  uh huh,
499 P  i was five six and a half.
500 PR  uh huh.
501 P  a hundred a:nd fifteen pounds.
502 PR  okay.
503 P  so i've been losing weight since i was nine.
PR  okay.

P  so i mean we do have serious overuse i- issues.

PR  [o kay.]

P  [i mean] and you you i don't know how old you are, but

we were [obvious]ly of the generation non pain no gain.=

PR  [uh huh.]

P  =yeah. [uh huh. ]

PR  [you know,]

P  uh huh. [*uh huh.*]

PR  [so i've ] been beating up my body for long time.

P  [uh huh. okay.]

PR  [uh huh.]

P  so i do have ] i definitely and when they i did have the

two shoulder, i mean we did fifteen like different things

PR  [o kay.]

P  and we did have arthritis in there i d- in in erm (.) two

ninety eight. and two thousand we went in we did

arthroscopic surgery, which was very very erm successful.

PR  uh huh,

P  and we did scrape away a lots of arthritis.

PR  okay.

P  so we did see it,

PR  okay.

P  in the flesh.

PR  okay.

P  at the time so i do have, (.) unfortunately,

PR  [uh huh,]

P  [os teo ] arthritis. [so the]

PR  [o kay.]

P  weather tortures me. and this [foot!]

PR  [ uh, ]

P  aches [e ven ] more,=

PR  [uh huh.] =uh huh.

P  now that i've had the [surgery.]

PR  [surgery ] uh huh.

P  yeah,

PR  and the purpose of the surgery [was,]

P  [ o ]kay. .hhh what this
toe when he was to (kidney),

PR  uh [huh,]

P  [ he ] literally was in surgery i had developed

cellulitis

PR  uh huh,

P  and i was on those (.) drugs,

PR  uh huh. uh [ huh.]

P  [.hhh ] and they said oh wow! he wou- literally
[in surgery,=  
[uh huh.]  
=[uh huh.]

PR  
[and the ] guy said oh well, we'll be doing  
an ex ray to see how far down we have to amputate.  
[and was] (slb slb)

PR  
o kay,]

P  
(1.2)

PR  
[o kay.]

P  
[oh, ] okay instead of going,

uh [huh.]

P  
[ no. ] ho ho well,

uh  [huh.]

P  
[i thought] it was (slb slb) the point  
uh huh. [uh huh.]

P  
[losing] the toe was a (drag).

PR  
yeah. [yeah. yeah.]

P  
[ .hhh but ] i didn't understand i m- i did

maternity,

P  
[ uh huh,]

P  
[when people when you're a nurse you know when you're a  
cardiologist

PR  
uh huh,

P  
they expect you that you just do cardiology.

PR  
uh huh.=

P  
=when you're nurse i've been doing maternity for [twenty ]

PR  
[uh huh,]

P  
five years i don't remember anything about (slb slb)!

PR  
[yeah. yeah.]

P  
[ i don't ] know [ that ] when you lose this toe,

PR  
[°yeah,°]

P  
then you [screw] [up the rest of your foot! some ]

PR  
[yeah yeah yeah. yeah yeah, your gait.]

PR  
=yeah, [your gait has [pro bably changed.]

P  
[this is go nna happen to you,

uh [huh,]

P  
[ so ] that's what has happened [the rest] of my toes,

PR  
[uh huh,]

((knocks at the door))

P  
[you know, er ]

PR  
[come in!]

P  
you know bent and collapsed and became (clotted).

PR  
[he llo. ]

SD  
[hi there!]

P  
[hi.]

PR  
[hi ] this is doctor kenneth.
SD: doctor kenneth.

P: hi, (. ) oh you want to join us

SD: no i'm just coming in to say [hi.]

PR: [uh,]

P: oh hi!

SD: i'm gonna be signing off the papers with the answer.=

PR: =yeah. [ha ha]

P: [oh, o]kay. oh [you're a real doctor!]

SD: [(slb slb slb slb slb slb slb slb slb slb slb )]

P: [yeah great! (slb)]

SD: [(slb slb slb slb slb slb)]

P: [ o kay well, we ne ver ] know,

PR: [ he he] [he he he he ] [he]

P: [ o kay.] [hhh ha ha hhh] [er]

SD: [ ha ha]

P: i've been to [the] (slb slb slb) and they tell you five

SD: [ ha]

P: times they're the real doctors.

SD: yeah.=

P: =and then when the (slb) have all screwed up [they've] all

PR: [ u:h, ]

P: lied.

SD: [yeah,]

P: [ uh, ]

PR: [ and then [at the end,]

SD: [and then the ] real doctor,

P: the real like that [like li(hh)ke like an]

PR: [he he he he he he]

SD: [ha ha ha ha ha]

P: [like an e_ ]m_g=

SD: [(slb slb slb slb)]

PR: =huh

SD: [right.]

P: [ be ]cause they've all screwed up [a ny ]thing and:=

PR: [uh huh,]

SD: =i get [it. i get it.]

P: [he ha ha ha ha ha ha ha ha ha ha ] [ ha ]

SD: [(slb) slb slb)

P: while taking

SD: care of [(our san tos here, or slb slb )]

P: [yes. he's ve ry, he's ve ry ] sym- not exac-

SD: can i ask you if

PR: [ uh huh.]

P: [you don't] mind, how (slb slb) a name like santos,
yeah my [fa- yeah] my [ fa ]ther is d-  erm is from the

Dominican republic.

(1.5)

but our family is a (unique) family. our family was one of

the group of exile african americans who left here. =

=coz i'm irish.

oh really? [yeah yeah stuyve]sand yeah.=

[stuy ve- yeah] =ha [ha ha]

[and who]

actually left here in you know, during the slave period

and then went to settle in a place called (slb slb) island

in the dominican republic. and started .hh with: a number

of other i guess you wanna call 'em exiles or escape

slaves, and went to the dominica republic and up until the
dictatorship still spoke english until they (slb slb slb).

hha!=

=so yeah,

[wow,]

[ so,] uh huh.

uh, now he's very, he's very nice thank you [ ve ry ]

[ºuh huh,º]

much.

[ºuh ] huh,º=

[yeah.] =[(slb slb slb)]

= [ i i i ] hope you gonna fix me.

ºuh huh.º

yeah we've been through a lot,

[yeah,]

[ u:h,][so so there's]

[at my ten ]der forty eight ye(h)a [ ha ]

[yeah,]

[ yes ]

[ha ha ha ha]

[there's a er]

[ha ha ha ha ha ha ha ha ha]

[mirage of all kind of different sym]ptoms here, so,

yeah [we ] don't know what's wrong with me, [but then]

[erm] [we were]

well as he said that i'm a typical patient [that shows]

[ uh huh.]

up here.=

=uh.=

=until the doctor who's been screwing this way show

[ up ]

[yeah.]
P [(h)ere,]
SD  [  this  ] is a high high
[yeah, a high] [com ple] [ xity. ] [more more]
SD  [  this  ] is a high high
P  [ ha ha ha ] [ ha ha ] [ ha ha ] [ ha ha ]
PR  [uh huh.] [ uh huh.]
SD  [ ha ha ha ha hhh ]
SD  [ me di cal problems,]
PR  uh huh. uh ^tuhh
P .hhh [yeah,]
SD  [ but ] still ^smi\ling
PR  yeah. [ ha ]
SD  [ha ha ha ha ha ha]
SD  [(slb slb) slb slb slb slb for it]
PR  [uh huh]
PR  [yeah by] i know i al- i always smile no matter what.
P  [you got]
SD  [o kay.]
P  a laugh or cry [\right ]
SD  [ that's] right, ha ha ha=
P  =i \know
SD  also the way it works is he's gonna just wri- do do your
history, which i guess is already
PR  [uh huh.]
SD  [obvious]ly in progress,[and then]
PR  [uh huh.]
SD  [uh huh.]
P  we he'll probably step out (. ) and we'll have a chat
SD  about,
SD  [ what the the you ]
SD  [ you're go nna talk] about me [ be hind my ] ^back=
SD  [ have found out,]
SD  =talk about you if i mean,
PR  yeah. he he [ he he he he he he] .hhh hu=
SD  [(slb slb slb slb slb slb slb)] ==(slb
SD  slb slb slb slb slb slb slb)
PR  [hu hu hu hu]
P  [ ha ha ha ha] [ ha]
SD  [uh?] maybe you you can do a problem focus.
PR  [yeah,]
PR  [ be ]fore a more general physical exam [depend ]ing on
PR  [uh huh,]
SD  what the you know the issues at play are
SD  [ (i don't know),]
PR  [yeah we haven't ] really
determined like where we're we're trying to come over with
the chief complaint here. [which]

523
SD [yeah,]
PR would be the low back and depression.
P [yeah, i think,] =yeah.
PR [yeah,] =yeah.
P [pro bahly.]
SD [it sounds to me like this is gonna be just from what i saw there, from the .hh er f- from your description there it's gonna be a question of sort of not what to do, but where to begin.
PR uh huh.
P  ah hah. [ ye.]
SD [that] sounds=
P  =yeah. [uh huh.]
PR [yeah.uh] [ huh.]
SD [right] okay.
P w- i think you're trying to figure that out,
PR [hhh ha ha ha ha ha ha]
PR [o kay he yeah. he he he]
SD then come and tell me.
PR [.hhh ha ha ha ha ha ha ha ha ha ha ]
PR [ o kay i'll tell you what i figure out.]
PR ha ha ha great [thanks!]
SD [ (slb) ] [(slb slb) ] [(slb) ]
PR [ o kay. ] [ uh ] [huh.]
PR [ o ] [kay. ]
PR so what i'll do it is so that you know erm i'll get a good history on both the complaints, erm before i get to the general medical history. .hhh so:, (.) tell me a little bit more about the low back in terms of things that make it better, things that make it worse, how much are you having erm that pain right now?
PR well i can't do absolutely nothing.
PR o[kay.]
PR [erm ] for example yesterday erm tzt i and my sonnie went to co(hh)ops,
PR uh huh.
PR so i ventured off to the mall for [one full]
PR [are you] cold?
PR erm no. [ er i'm ne ver i'm al ways i'm hot.=
PR [°(slb slb such a slb slb)°]
PR =always hot.
PR sorry letizia. (slb slb) tell you [he uh hu]
PR [ha ha ha] no. so please do go ahead. is is you're right on the ocean [(there:re)]
PR [ yeah. ] yeah
yeah.

[it's really nice here.]

[i pulled up the gulls i (goes) that i said (has got) the

i thought i'm in the right [spot.]

[i'm an ocean freak. if my mother was pregnant on the ocean

[or some]thing, i'm from [(the slb slb) lake actually.]

[ah ha,] [uh huh.]

=(slb slb)

=canada.

(canada [ oh ] okay. [ o ]kay.=

[yeah,] [yeah,] =i'm (slb slb slb) on

(l_a)

but [i mean i was] born i was born there.=

[o kay. okay.] =uh huh.

so i get this affinity to the water [and the]

=o kay.]

ocean which i have no idea why. so i can just only do it

from must be prena(h)atal,

[o kay.]

[(all of) our guys are lifeguards some instructor. i

mean you know real er i mean cross (slb slb slb) i mean so

this is killing me=

=uh huh. uh huh.=

=it's my er er ted's he [he's ] rather ohe's rather been

[ uh, ]

(half), % [ha ha he ] does not he does not [ under ]stand

[okay. huh.]

that. <this for me is like,>

(5.6)

a (slb slb slb)

uh huh. uh huh. uh huh uh huh. (.) okay. [okay.]

[never]mind my

looks.

uh huh. [uh huh.]

[ne veh ]mi(h)n(hh) [coz peo]ple treat you

[uh huh,]

horribly when you look bad.=

=tzt

[they they just, well i don't think you look bad but,]

[and that i don't really be n lieve (slb slb slb)]

yeah that's true.=

=very good.=

uh huh. uh [ huh.]

525
[.hhh] but that

i ca- i mean i had the surgery.

uh huh.

well i spent the last year really depressed while having

lost nine years of my life. [hhh ha ]

[uh huh,]

and okay how do we get it back together, so may i said

well one thing,

[i  can  do  is ] of course the collapse of the toes like

if you know,[well i did know.]

[uh huh. uh huh.] uh huh.

so i said well, we'll have my toes straighten[ed.]

[ o ]

kay.[okay.]

coz i]could

still i could still wear [a pair ] of shoes for an hour

[uh huh.]

and do an aerobics slot.

uh huh.

wearing up for aerobics i'm still tough [for ae ]robics.=

[uh huh.]

=uh huh.=

=like a still wear er this pair of shoes, i'd gained

(a lot of weight [by the way) ag ain i ]

[uh huh. uh huh. uh huh.]

lost a lot >i gained again over the summer i [was on ]

[uh huh.]

a wheelchair the whole but i told you,< .hhh so i could

still wear shoes. now i can't wear shoes at all. [again]

[okay.]

okay.=

=so he said he, they probably tore like i mean by m- er er
cut a (slb) by mistake,

uh huh,

on the toe [ by (slb slb slb) out.]

[(on slb slb) uh huh.]

this toe's obviously going that way, [not going] that

[uh huh.]

way, .hh it was yeah. this (decision) was bad.

[uh huh.]

[anyway ] but tzt he does not understand that for me this

is devastating and i know i’m tough. right,

uh huh.

so i'm supposed to go,
uh [huh.]
[tzt ] lucky me i still have a head!
uh huh. uh [huh. uh ]huh.=
[you know,] well i'm sorry hh i'm not happy
enough,
[i know. i know i know.]
[to say lucky me i ] have a head, i mean i h- i was
hoping to wear on a pair of shoes and((croaky voice))
[take a ] walk.=
[uh huh.] =uh huh.
take a hike, (. ) ((crying)) ride a bike with my kids
[you know]
uh huh, uh huh,
and erm
(0.9)
.hhh that's me more depressed.
okay, [ o kay.]
[you know] we've really turned out really bad
spending four months in a freaking wheelchair at my
parents' house,
uh huh.
and i was on all of the antibiotics all freaking summer,
uh huh,
beep beep beep beep, my mother had a stroke while i was
there, [hhh ha i mean]
[o kay. o kay.]
you know just keeps going more interesting [↑yeah]
[ o o ]kay.º
erm tzt i'm so depressed that i want to die.
[ o o kay,º]
[and that's] not me.
okay. o[kay.]
[i ] was a very big lover of life,
uh huh.
and
(1.4)
i feel so full like i really have a lot to give.
uh huh.
and it’s a very big piece of me that doesn't wanna live
like this.
yeah, well we're gonna see if we can help you then.
( .)
you know,
yeah,
and erm
(1.8) P
°(to live like this),° i'd rather be dead.
(1.4) PR
okay well, you have something to live for. coz
(1.0) PR
my patients need to live.
(1.8) PR
alright? don't worry. we will see what we can do for you.
(1.2) P
tzt so anyway and i was (slb) a heavy (slb) that's true.
(2.5) PR
okay. okay.
(1.2) PR
we'll keep going and then see what we can come up with,(.)
(1.0) PR
o[kay?] [.hhh]
(1.2) P
as far as the back you know like [i said,]
(1.0) PR
[uh huh,]
(2.5) P
yesterday[i went ]into the store and i wasn't even
(1.2) PR
[uh huh,]
(1.2) P
(slb slb) out.=
(1.2) PR
=uh huh,=
(1.0) P
=(pointing at flip flops) coz i'm wearing these.
(1.2) PR
uh huh.
(1.2) P
i mean these have no support.
(1.2) PR
uh huh. [uh huh. (slb slb slb slb slb)]
(2.5) P
[you know, so and i'm kind of ] shuffling along,
(1.0) PR
o[kay.]
(1.2) P
[and ] then,
(1.2) PR
are you using [or]thotics of of any type[ or,]
(1.2) P
[s-]
[but ]i can't wear shoes,=
(1.2) PR
you can't wear shoe at all,
(1.2) P
right. hhh ha and [so,]
(1.2) PR
[uh,] uh,
(1.0) P
right so, i'm like [i said,]
(1.0) PR
[o kay.]
(1.2) P
i'm more screwed than i was before because before
(1.2) PR
[at least]
(1.0) PR
[uh huh,]
(1.2) P
i could have gone to one of them [u gly hhh ha]
(1.2) PR
[uh huh uh huh]
(1.2) P
deep [shoes,]
(1.2) PR
[ uh ] huh.
(1.2) P
which i ch- which i was going to do, but i chose to have
surgery so i could wear a normal shoe which isn't
orthotic, okay.
you [know?]
[kay. [.hh ]
[like] i do have a like a lot of
different=
=uh huh. uh huh.
too [which of course isn't go nna] help you.=
[kay. o kay. uh huh.] =uh huh.
[uh huh.]
in the left leg, .hh but erm i was you know
hoping to wear er normal shoes and i (slb) two thousand
dollars to have a pair of custom made s(hhh)oe(hh)s which
i ca(h)an't a(h)fford, .hhh=
tell me,=
so,=
=w- what meds you're on right now?
=so,=
what you're on right now?

and how long you've been on them,
well i'm supposed to be on, i'm on what's that (protonix)
which doesn't work. i've real i used to be when we when my
husband (slb) we used to pay twelve hundred bucks a month
for our insurance. ((sniffs)) and i used to be on:, oh god
i'm sorry we don't (eat) seriously.

uh huh.=
=no glucose for the brain.
i know [i got it right now.]
[i can't think and that] that's really [bad.]
[ uh,]
no you're still thinking. [i can't.]
[hu hu ]
(what slb slb) is that really good i had g_r_d i only
think i have (slb slb slb) that down,
uh huh. [o kay.]
[i hhh ] ha ha ha [ ha ha ha ha]
[now when you want] you have
i_b_s fibromyalgia,
[uh huh,]
[arthri ]tis these are these all diag- diagnosed
condi[tions,]
[y- ]
[or you feel like,]
[oh i didn't make ] no. i
[didn't make them up. no these've]
[ or you feel like you're o kay,]
been diagnosed. these are all diagnosed.

like er [by (slb slb slb slb)]

[by gastroenterologists, or just g_

no. gastroenterolo-

[i've been] to the gastro- oh yeah! am i,

[uh huh.] =er gastroenterolog[ists.]

neurologist,

uh huh.

oh i've been tha- i've been to all of the [freaking]

specialists that gotta break (in [my wo]man)yeah. [so,]

kay. so here you you're on:,

pro(h)- ka(hh)y (protonix). hhh [ er:rm ]

(1.6)

(selexus)=

leverprox,

uh huh.

(slb slb slb slb selexus) i began prozac i think it

works better. i left [(se le]xus) and then i went back to

this prozac. erm hhh (slb slb slb slb slb) would've been a

lot [better ]

[uh huh.]

actually.=

=uh huh.

but erm

topomax are you still on that

on the what

topomac erm

yeah.

uh huh.

oh welbutrion.

uh huh.

(3.0)

tzt i was on neurontin.

okay.

and (slb slb slb slb) ha ha [ha ha] (slb slb slb) i (slb)

a lot
PR
[uh huh]

P
[every]thing now needs prior approval.

PR
[okay.]

P
(slbl slb slb slb [on the]

PR
[uh huh.]

P
(label prior slb slb slb) even neurontin. .hhh [neurontin,]

PR
[yeah, only]

P
give on- only give the ones that you're on [now.]

P
[why ]drugs

PR
[ get ] every, yeah.=

PR
[yeah,]

P
erm the:: topomax welbutrion,

P
(1.9)

P
selexus but going [back to]

PR
[uh huh.]

P
(0.8)

P
prozac,

P
(0.9)

P
erm

P
(2.8)

PR
what about supplements?

PR
(0.6)

P
.hhh i used to take tons and tons of supplements

P
[(slb slb).]

PR
[ uh huh.]

P
(slbl slb) any .hh for now i take just: (.) a multivitamin.

PR
uh huh.

P
vitamin e: erm a b complex.

P
(1.3)

PR
uh huh,

P
(1.8)

PR
okay.

PR
it's about it.

PR
.hhh erm

PR
(1.0)

PR
tell me what you're eating. (. again start with the

PR
morning. let's just do a like a twenty four hour recall.

P
°(slb slb slb slb my food and health) [that's bad]

P
°[°uh huh.°]

P
thing.°=

PR
=uh what do you start up the morning with, do you eat?= 

PR
=well i had i used to have a (slb slb) protein and (slb

PR
slb think)

PR
uh huh. [what a bout now,]

P
[ttt and they just] but i don't seem to

P
tolerate that
any more.

PR uh huh.

P tzt so:: i might have erm maybe cereal and milk, and juice.

(2.2)

PR what type of juice?

P tzt orange juice.

PR orange, okay. .hh but any snack between that and lunch?

(2.9)

P tzt maybe, maybe not. depending on what's in the house.

PR okay. °okay° what about lunch?

(1.6)

P erm

PR no matter how bad it is you can tell.

P hhh [ha]

PR [no] matter.

P ha [ ha ha ha ha ha ha ]

PR [ coz you know, people you] know they come back, .hhh

PR i give them a diet diary and they come back with you know salads, juice,

P oh no. [no ] no actually [ i can't] to- sa-i lost [ i ]

PR [uh,] [(slb slb)] [uh,]

P can't tolerate the i_b_s dep- i never know what i can and what i can't,

PR uh huh. uh huh.

P you know,

PR i assume you're not doing too well with dairy.

P oh no!

PR uh huh,

P no forget [dai ry.] i'm in the bathroom [in five]

PR [uh huh.] [uh huh.]

P minutes. no erm and with the: lact\^ase

PR [or la- ] whatever that is that=

PR [uh huh.]

P =you take, no forget dairy. erm

PR so just give me a typical lunch. u:h,

( .)

P again depends on how much time i'm [running,]

PR [uh huh.]

P if i'm a buck for a buck you can get a [double ]

PR [uh huh,]

P cheeseburger,=

PR =uh huh. uh huh.

P which is really good food.
P: oh yeah. (1.5) I think my (slb slb) had the time I'd have a salad.
PR: uh huh. [uh huh.]
P: with chicken [and eggs.]
PR: [uh huh.]
P: and I love eggs. I love eggs.
PR: [uh huh.]
P: which so if I'm home, I probably have a couple of fried eggs. I don't have enough fruits and vegetables.
PR: uh huh.
P: So though this morning I've had orange juice and [a pear.]
PR: [uh huh.]
P: I brought it with me. I do drink a lot of water,
PR: uh huh.
P: it's free. [uh huh.]
PR: (0.8)
P: it's called the city gin. [ha ha yeah.]
P: [er oh we] have a well,
PR: [uh huh.]
PR: [uh huh.]
P: had it tested [so, hhh] (h)I don't know [if] I (h)It's
PR: [uh huh.]
P: good or not. [hhh]
PR: [uh huh.]
P: [uh huh.]
P: [uh huh.]
P: [uh huh.]
P: (1.5) We might have my husband made me balls last night so I had two meat balls.
P: Any veggies in there?
P: (Shaking head) uh uh.
P: [No]
P: I didn't have we don't have any vegetables. We don't have any in the house. [hhh and I]
PR: [and any] starches
P: I didn't want any pasta. I hate pasta.
PR: uh huh,
P: I'm sick of it. It's all we ever had [I'm,]
sick of pasta. hh (.) >pasta pasta pasta pasta,< i'm so
sick of pasta. i'm sick of potatoes coz we have
[po ta ]toes also, er .hh
[uh huh.]
we we i mean we literally we have no freaking money.
[ o kay. uh huh,]
[it's it's it zzz ] sucks so ba[(h)a(h)d!]
[ o kay. ]
and it costs a lot of money to eat well,
it it can. but i can show you how.
[ i mean ] you can [freaking,]
[so yeah.]
[uh huh.]
you know macaroni cheese is three bucks a pack.=
[yeah,]
=yeah
i'll show you how.=
=you know,
[i'll show you how. what[ a ]bout tobacco use,=
[so,] =oh no. no
[smoke.=
[no]
.=.hhh
[once.]
[i ] uh [huh. uh huh.]
[once when i was sixteen my girlfriend and i
went up town,
[o kay.]
[and a]bout to smoke a cigarette, [and i] let's (feel)
[okay.]
free.=
=okay.
=no(h)o. [and]
[al]cohol,
no i don't drink. i should though.
caffeine,
erm er yes sometimes i drink coke.
°uh huh,°
(coco),
uh huh.
[and er i'm] not much of a coffee drinker but for
[and erm uh]
(slb slb slb slb) i will have coffee.
okay.=
=sometimes [so-]
[a ]ny recreation drugs? marijuana anything
like ↓that
no.

no?

never did. but i think i should.

hh hu hu hu hu

i thi(h)nk i'd be be(h)etter off.

what about exercise, are you getting ↑any ↓now

no. no i'm,

uh [huh.]

[e ]very day i exercised normally right, now i can't
even go in the pool. er especially with my broken toes
they hurt too much.

(1.6)

erm normally at least an hour and a half a day
[of ]ercise.=

[uh huh.]

=which i need badly [ for my, ]

[°uh huh,°]

mental health as well as my physical health i'm i'm
[ pro ]ably=

[°uh,°]

=in the poorest shape i've been [ in a ] long

[°okay.°]

[long time.]

[° o kay.° ] what about e:rm your sleep, how many hours
are you getting a night,

sssstt i se- o:h i just started to take (slb slb slb
sterol),

uh huh.

it makes me sleep (slb)[ other ]wise i i have a hard
[uh huh.]

[i i i had i have a rea lly]

[without the me di ca tion how would]you,

uh huh,

i have a really bad trauma history.

okay.

i had a gun pointed about a year and a half ago,

okay.

by some strange idiot hhh in the neighbourhood (slb slb)
blowing

heads off, i was: (.) i was sexually molested too,

okay,

txt few times anyway erm we just: we just don't,

(2.4)

and you're never normal after that you know, (.) hhh ha

[ha ha ]
[uh huh.]

well [i guess] if i ever tell with it, but (. ) tzt i had=

[uh huh,]

=never gotten to do with it.

(1.7)

(they're really) funny.

so you're not waking re- rested at all (. ) when you wake
up ei[ther,]

[ c- ] correct.

yeah. tzt okay.

yeah we're getting really [good bags under] hhhe(h)eyes,

[ u h ' uh. ok ay.]

=i'm starting to look forty eight i used to look younger
[than my]

[uh huh.]

age, not any more.

i'm gonna ask you some things about your family history,
tzt e:rm are your mother and father [de ceased,]

[crazy peo ]ple,

are they deceased?

no [they're a live.]

[ erm they're still ] living, .hh any history of

cancer, heart disease,

both thyroid cancer. [and (slb) slb slb) cancer

[uh huh.]

(0.8)

tzt thyroid dad and (slb slb slb) mum. (. ) mum had erm
heart attack two years ago. she's been an (slb slb) for
two years.

[ u h huh.]

[(but a ) stroke in the way) happened and sure enough
she's gonna see the cardiologist next day.[she had] a:

[uh huh,]

stroke the night=

=before, okay. okay. dia betes

tzt no grandmum died. t- grandmum had a dull (slb slb) and
died of a pancreatic cancer.

okay,

but

any history of any mental, disorders of any type,
( .)

diagnosed?

 hh mum has erm many anxiety break. dad that i would say
is an undiagnosed erm hhh ( .) major major depressed.

okay.

my mother, my grandmother i found out [just] recently,
P =had had had electroshock therapy [ i ]
P just knew she was always a very mean person.

P didn't know why.

P >i always knew she went around< with a (slb slb) on her face.

P [erm ] didn't know she was depressed. now i know [why]

P i have two, i have a cousin and an uncle who committed suicide,

P [uh huh,] didn't know she was depressed. now i know [why]

P uh huh.

P so it's not a big deal committing suicide in my house.

P okay. what about, do you have brothers and sisters?

P i have one brother.

P and: [what,]

P [yeah.] his life to grow up in my house you wouldn't think we grew up in the same house.

P i we had (slb slb slb slb slb slb slb) [he went]

P to the air force academy.

P uh huh. uh huh.

P and: i'm his big sister, ((starts crying))

P uh huh.

P (1.4)

P (3.8)

P °uh,°

P txt hhh it was (in australia) his wedding hu

P °uh,°

P his wife did(n't have room slb slb) hu

P °uh,°

P i was a hundred and sixteen pounds,

P uh huh.

P and beautiful but it was my (slb slb slb) lucky. but let me tell

P you i raised much attention than she did.

P [uh huh.]

P [ my ] hair was down to here and erm yeah anyway we
didn't even
go there. hhh
(0.6)
how was his [life?]
[ but ] i obviously erm (1.3) i shielded him,
uh,
from life.
[uh huh.]
[because] when i start to talk about our childhood (slb
slb ↑slb)
uh huh,
you wouldn't think we(h)e grew up in the same house.
uh [huh. okay.]
[ha ha ha] ha ha
okay.
he was he was totally amazing.
uh huh.
i grew him alri- so tzt i'm glad he had a good childhood.
[how was your relationship with him,]
i parented my parents.
[i was a parent since i] was eight years old.
(.)
.hh if wasn't told i was mature .hh five hundred thousand
times,
(.)
i wasn't told (slb) so mature i was, .hh when i was nine
[years old,]
[ uh ] uh huh. uh huh.
i was precautious puberty [i mean,]
[uh huh.]
i had breasts in the third grade. who wants breast in the
third grade? when you're in catholic school believe me you
don't want them. .hh you know,
(1.2)
so: responsible!
what is your relationship like erm with your (0.7)
brother is
he's still leaving or, [ uh ] huh.=
[yeah.] =he's in new jersey
he's[(sib)]
[ uh, ]
(slb slb) doing fabul[ously.]
[o kay. ][any]
[ro-] rolling in the ↓dough
any any diseases, any sicknesses, (harnesses),
tzt denial.

denial, hu hu hu hu hu .hhh

that's what [the (slb) slb slb]=

[okay. ] =okay. erm=

doesn't know what it'll imply to be a common man any

more. the guy, with (slb slb middle class) [he ]llo:!=

[uh,] =uh.

((sniffs)) takes we ha- [er w- ] takes take having a

[uh huh,]

one, ((cough)) having that to er takes two hundred and

twenty thousand dollars to erm hhh a year and to erm

retire on [is]

[uh] huh.

tzt mu- much money. hhhh

uh [tell me this]

[he llo ho]

when did you start to first feel that like that depression

was actually part of that was going on in your life? and

that you were feeling depressed,

(0.6)

at what point.

(0.8)

what age?

(3.7)

tzt

(1.1)

erm not really until i woke up a year (h) ago. ho ho ho ha

okay.

.hhh but if i look ↑back=

=uh huh. uh huh.

(3.0)

.hh probably i had post partum depression.

uh huh.

but i was such an up person!

uh huh.=

=that i never recognized ↑it [or i ] could overcome ↑it=

[uh huh.]

=uh huh.

you know,

uh huh. uh huh.

because i was always so stro:ng,

uh huh.

and so positive, (.) so it took a real lot to get me down.

uh huh.

(1.6)

okay.
and now i don't have the outside (stand),

[ u h huh. ] yeah.

you know the exercise, or the money [or]

[ o ] kay.

you know the massage,

uh [huh.]

[ or ] whatever to keep me up.

okay.

you know so erm

.hh what about erm (0.5) uh erm are you still? do you

still have

your period or [you know,]

[u h huh.]

uh huh, erm do you have p.m.s symptoms that are (0.4)
horrific,

((P takes off her glasses)) (1.7)

yeah. [yeah. yeah o kay.]

P        [ mh ha ha ha ] ha ha ha ha ha ha ha ha ha ha ha

PR  okay.

.hhh well it was erm [ o ver] about a year and [a half ]

[uh huh.]

ago. [and] erm barbara said what [what day ]

[ uh huh.]

are you on, .hhh and i did [go to ]

[uh huh,]

the psychiatrist and i said to him,

uh [huh.]

[ a ] year ago [in sep ]tember.=

[uh huh.]

=i said erm i think i have p.m.d.d.

uh huh,

and he did look at me rolling his eyes back, he's real

freudian fellow you know, he's got (slb slb) last guy

[had]

[ uh] huh. [uh huh.]

[but as ]

far i was stuck (slb) i met at a certain place right after

i got the care, .hhh a:nd (.) tzt but i would say the

expression on my face is different.=

=uh huh.=

=erm just everything is different and he thought [i -]

[uh huh.]

oh, (slb slb slb) they're pretty good on prozac.

okay.

erm and he really did believe i had p.m.d.d, coz he didn't
think i suffered from depression for that. but erm
txt well do you have erm (.) bloating during that time, do
you have,
((miming big breasts)) oh! pffht
okay.
if like day fifteen,
uh,
boom! i mean [ i ]d- [i didn't]
[uh,] [ uh huh.]
have p_m_s as a ↓kid
okay. okay.
or as a young adult woman.
when did it begin
erm like probably two years ago i'd say.
uh huh,
or we go well like i said when i was all drugged up,
[i didn't]
[uh huh,]
know the difference,
uh [huh. okay. o kay.]
[t's hhh ha ha .hhh] i'll show you before and after
pictures you aren't gonna b-, i could go to ṭ(slbl slb slb
slb with a big tour)º
ºuh huhº what's the duration of your cycle?
well it's just the last two months,
[ uh huh.]
[that it's] changed dramatically.
uh huh.
and i don't know that's how [(slb slb slb or worse),]
how was it be fore ] the
last two months,=
i used to have so heavy heavy heavy five (full) days of,
i mean i (slb)
[wearing] a pad [and change] it every [hour or (from)]
[uh huh.]
[wearing a tampon and change it every freaking half hour.
okay.
you know, i mean [un ]believable.=
[and] 
the last two months was really light. erm and it was every
twenty
eight days on the nose.
ºuh huh.º
and it was every twenty five every twenty six days the
last six months say.
(0.8)
and the last two months was was really like light so i
(slb) and said wow! is that a period
[that's] a lot of cramps.
okay.
(slb) and said wow! is that a period
(h) and right sided pain always lower right (quarter). oh i
had (slb slb slb) did i did i forget to mention i have
really bad endometri(h)us.
oka(h)y. hu hu
ha ha ha [ha]
[uh] hu hu
(hh) i know you must think i'm a hypochondriac,
why the lower quar[ter pain]
[i know] yeah.
okay.
and that they thought i had erm appendicitis last june or
we- a year ago [june.]
[uh,] what [ a bout ] your last menstrual
period? when was that=
=erm the thirty first.
uh huh.
ha- halloween.
thirty first [of, er]
[ha .hhh] of October.=
=of october,
yeah.=
=okay.
(1.9)
okay .hhh [erm uh, uh uh.]
[ so what's today] the twenty first
[yeah.]
[ o ]kay so i'm due in like, (1.3) like what four days
[or so. ]
[uh huh,]
yeah. [(slb slb)]
[ what a ]bout pregnancies, erm [you've had]
[ ni::ne. ]
three,=
=nine pregnan[cies.]
[ ni ]ne pregnancies okay.
so sad, i had a tubular that almost killed me,
(1.6)
uh huh.
&and five miscarriages.° .hh i had a miscarriage the day
of my graduation from b_u. ((sniffs))
PR okay. =

P =coz of my masters i didn't [care,]

[°uh°]

PR [of showing up anywhere if it killed me.]

P .hh b_u my the (arch rivals and wreckers) yeah. ha are ^they

PR yea:h.

P (we'll see how [the graduate school) why] [in foot ball yeah yeah.]

PR did you did you go there? [undergraduate]

PR [yeah i slb slb]the

undergraduate yeah.

P ah you ↓did

PR yeah.

P see what i c- fou- since i was a graduate student i [i didn't]

PR [uh yeah,]

P [(slb to get) into that ] stuff.=

PR [you don't get into that,]

P =yeah of course. [ i i] want to tell you,=

PR [uh huh.]

P =i wanted to cruise so bad,

PR uh huh,

P also they let me do cruise [ a ] graduate course at that

PR [uh,]

P point, my kids were two three [and eight.]

PR [ uh huh.]

P by the time i graduated i mean (slb [slb] energy) i had,=

PR [ uh]

PR =uh huh.

P i could you know travel and graduate with a two year old, a three year old, [an eight] year ↓old=

PR [uh huh.] =[yeah.]

PR [ you ] know, who

PR went to school full ↓time .hhh i mean this is=

PR =uh huh,=

PR =who i used to be.

PR uh [ huh.]

P [where] is, °where hhh [where is] that person?°=

PR [uh huh,] =yeah,

P you know [i mean,]

PR [tell me] this. did you did you go for any

PR counseling after the miscarriages?

PR (shakes head))

PR no? okay. .h tzt the pregnancy or the births that you did

PR have, were they vaginal, caesarean,
P  =traumatic ha!
PR  okay.
P  ha ha ha .hh i had a i ended up with all c sections but on
the first one, was one of those (slb slb i started labour
on a) (. ) thursday and it was born at [ten to ] twelve ha!
PR                                        [uh huh,]
P  [ha i ] kept pushing for four hours,=
PR  [okay.]                                      =okay.
PR  an emergency c section yeah.
PR  are you currently on any type of birth control now, {(P
shakes head)} no,
P  no.
PR  okay. .hhh erm
PR                                        (1.9)
PR  any missing your periods, (. ) [at all?]
P  [ne ver.]
PR  okay.
P  no. .hh no i got (three boys and i),
PR  any bleeding in between [days,]
P  [ i'd ] die to have my a girl, no.
PR  okay.
P  no never.
PR                                        (0.7)
PR  tzt [(slb slb slb)]
P  [ no but i ] suppose >{(if you] want me to be
PR                                        [uh huh,]
P  honest), i guess i suppose i'd be lu-< i guess i should
PR  consider myself [ lu cky. ]
PR                                        [°uh huh,°]
P  right than i hadn't any kids at all.
PR                                        °uh,° when was your last pap?
PR                                        oh like in may or something,
PR  may? o(kay.)
PR  [yeah] i once had one that i suppose was abnormal,
PR  but [that erm] years ago.=
P  [uh huh.]                                      =uh huh.
PR  just from probably having had sex.
PR  okay.
PR  csss
PR  any sexually transmitted diseases, syphilis, gonorrhea,
P  s_p_i_v {(P shakes head)} uh huh.
P  i mean i have have had the same sexual part[ner for]
PR                                        [ o kay.]
P  twenty six years, [that's] only [good thing] about (still)
PR                                        [ u h, ]     [ u h  huh. ]
P  me(h)e [ting with] a g(h)uy. [ha]
P: hh i don't know how would you go out today, =today it's very dangerous. very very dangerous.

PR: (.)

P: very very dangerous.

PR: "very yeah. i'll tell you,"

PR: let me ask you this. erm have you: er had a (0.8) tzt recent blood work?

P: well i had in may when i had to, in may? okay. okay any other screening that you've done for anything, whether be:

P: .hh well for example,

PR: uh huh,

P: when i had my (slb) infection, my temperature was ninety seven point five.

PR: uh huh.

P: how normal is that?

PR: okay,=

P: =no i'm on met- i t- when i did i did go to a holistic physician years and years ago,

PR: [uh huh.]

P: [when i ] had really good insurance,

PR: uh huh,

P: and they did pay for it.

PR: uh huh.

P: and i was on (slb) thyroid.

PR: uh [o kay.]

P: [because] i was (i'm slb slb slb slb)!

PR: uh huh.

P: to a normal physician.

PR: [uh huh.]

P: [but i'm] definitely hypothyroid.

PR: uh [huh,]

P: [and ] i when i was on (slb) thyroid,

PR: uh huh,

P: i felt fabulous.

PR: uh huh.

P: that was one thing i'm low [i'm de]finetely=

PR: [o kay.]

P: =l- low,

PR: (1.0)

P: i'm definitely hypothyroidic.

PR: okay.
I take my temperature, and I'm never more than ninety-seven. According to a normal physician, I'm really normal!

The point is, every morning, if I take my temperature, I know, they go by their little super god—

drugs, and like for example cortisol, I bet you I'm high at night and low in the morning,

which is why I'm wide awake at night, and plopped out in the morning.

That's all. No real headaches. No injuries to the head. Just once.

It's just the pool. [hh]

That's all. No. No real headaches. No. No real injuries to the head.

Just once.

That's all. Yeah. No. No.

What about eye pain? Pain behind your eyes, a.m.

Oh, my eyes really bugged me this fall because I couldn't have my allergy medication.
so i went i w- i was going (slb slb).

P: uh huh.

P: i was sick for six weeks this fall with like a wicked bad
1795 [sinus]

P: [uh uh.]

P: type junk you know [going on,]=

P: [uh huh.]=

P: =i did have like eye infection [(that have)] (slb) my

P: eyes that i had never had my whole life. [not of] a daily

P: type of thing but anyway and i might try when i did the

P: clarit- and i did every

P: (.hhh stupid thing

P: uh [huh.]

P: [ in ] the in thee erm (.) store and not [nothing]

P: [o kay,]

P: helped.=

P: =what about hearing loss, erm (.) nose bleeds, tzt vertigo,

P: no.

P: (.)

P: no nose bleeds,

PR: sinus problems?

P: erm ((sniffs)) yeah.

PR: yeah.

P: (with er that i was always hacking heavy drip).

PR: what about any change in voice tone,

P: ((sniffs)) n:o. i [think]

P: [ ↓no ] .hh tooth problems?

P: (1.7)

PR: dental problems,

PR: i have two (slb) now [but,]

PR: [ uh ] huh. okay. have you had

PR: in the past [two three years?]

PR: [ i have a ] lot of gum like i to-

PR: tortured my teeth? i'm a s-

PR: uh huh.

PR: i was a scrubber.

PR: okay.

P: ha

PR: [kay. o kay.]

P: [ha ha ha ] ha ha ha ha [.hh ]

PR: [what] about erm

PR: i (slb slb [slb] slb)=

PR: [gk-] =oh did ↑you
P: [yeah.]
PR: [oh] kay. what about chest pain, any chest pain difficulty in breathing, shortness of breath,
P: only when i have like the anxiety type,
PR: uh huh.
P: attacks
PR: uh huh.
P: and of course with the g_e_r_d but that's the a different kind of chest pain.
PR: [uh huh.]
P: [pretty ] much you know [the]
PR: [o ]kay.
P: acid reflux [kind of]
PR: [uh huh.]
P: burning yeah. (. ) oh yeah. [well i 've]
PR: [uh huh. ]
P: had a, well when i was hea_vier
PR: uh huh.
P: i had asthma like i mean like (exercise due type) of asthma,
PR: o[kay.]
P: [kind] of thing [which short]ness of breath [but]
PR: [uh huh. ] [ uh huh. ]
P: that was when i was trying to exercise too hard close to that that
PR: okay.
P: i couldn't do,
PR: [okay.]
P: [and i] was d(h)etermined [i would] t(h)rain [a(h)nywa]
PR: [o kay. ] [ o kay. ]
P: he he he he ha [.hhh]
PR: [what] about erm
P: i was on inhalers for a while,
PR: you're on inhalers? [o kay. ]
PR: [uh huh.]
P: sputum with ↑that do do you (excrete) sputum or flam,
P: at that point [ when i]
PR: [right now] yeah.
PR: (. )
P: .hh well when i had [to go ] back over [a month a go, ]
PR: [uh huh. uh huh.]
P: oh yeah. [i was] d- yeah i was [(sniffs twice)]
PR: [okay. ] [ o kay. ]
P: [(sniffs)] yeah i did.
PR: okay.
P: but now no. [°(i changed the] slb slb)°
tzt well let's talk about your gastrointestinal system.

PR  erm constipation?

P  no. usually erm er er pretty much, again er well us- with many

PR                 [ uh huh, ]

P  i would run the c- the game of an incredible constipation,

PR  [ to ] total diarrhea.

P  [uh huh,]

P  [i would] say now, uh huh,

P  as a (slb),

P  i'm pretty much in the diarrhea,

P  o[ kay. o kay.]

P  [phase pretty] much all the time. .hh it's such a

nuisance that i would go to the bathroom, and i would had i would still have to go to the bathroom,

uh huh,

P  and it's totally new stool and i can't go out of the bathroom. which really doesn't make [much sense.]

P  (i mean) still sitting in my co[lon

uh huh. [uh huh. ]

P  [it's new ] stool.

P  okay.

and i er so i'd go to the bathroom >and then half an hour later i'm going to the bathroom again, and then half an hour later i'm going to the bathroom again,< and this is quite a (slb). but

uh [huh.]

P  [but ] apparently that irritable bowel,

uh [huh.]

P  [syn ]drome [supposedly] i guess. [this is] what they told me.that's what the g_e_i guy said.

P  you do have irr- bowel. what about erm gas and bloating,

P  [uh huh. o kay. uh huh.]

P  [bo wel ] syndrome [i rri tates ] the g_e_[ i_ ]d,

P  [uh huh.]

[uh huh yeah.] [yeah.] uh huh.
uh [ huh. ]
[right,]
[uh] huh. too good. uh [ huh.]
it [right] it's totally,
.hhh any gall bladder disease [ a n ything,]
[oh yes i ] got a (slb)
loaded gall bladder [full of] stones.=
[uh huh,] =uh [huh.]
[that] didn't
come out which i
do they don't wanna cause i'm not having surgery ha but,
[ o kay.]
[is that] a bad thing? [ to ]
[.hhh]
be going round with a full gall bladder.=
yeah it's not good [yeah]
[ oh ] seriously?=
yeah yeah [i think you will have to definitely.]
[con si de ring that it's surgery ] that
i've been waiting avoiding,
well we'll have to bring that up and you know kind of
look at what we can do on this and
[to avoid ] the sur[gery yeah.]
[i'm really,] [yeah i do.]
uh huh=yeah i got the ultrasound. they got (slb) away [do you ]
[uh huh.]
know your gall bladder is full of stone, and my (slb) i
know oh [i know ] coz i cannot touch a fat! [it's one]
[uh huh.]
of the things i cannot have like fat foods,
[okay.]
[i do ] not eat fat foods by the way.
okay.
i will tell you that.
okay.
because i cannot. [.hhh hha]
((croaky voice)) [alright.]
so i do not eat fried fat, anything because
if i do i get [sick as] a dog.=
[uh huh.] =uh huh. .hhh what what
about er (1.3) tzt any nausea with †that
(0.7)
oh if i eat fat †foods
any with any type,
oh yeah. er [like as] i'm sitting right †now=

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[uh huh.]

1976 PR =uh huh.

1977 P all i've had is a little bit of orange juice and a pear.

1978 PR [my stomach is killing me.]

1979 PR [alright. so you're a little hyp-] okay.=


1981 PR =okay.]

1982 PR [.hhh]

1983 P =what

1984 PR about any kidney problems in the past,

1985 P no but why (slb slb slb) me with that,

1986 PR okay. any bladder problems erm getting up at night in the

1987 P middle of the night, to urinate many times, or frequency

1988 PR of urge

1989 P i have had but i retrained my bladder.

1990 PR uh huh= i think it was just coz the:

1991 PR okay.

1992 PR this er er i don't think that was anything,

1993 PR any pain on urination?

1994 P tzt i've had a couple of u_t_is [but that] was pretty

1995 PR [uh huh.]

1996 P much= okay.

1997 P that i think,

1998 P okay. er .hh what about erm we talked about arthritis

1999 P right? erm

2000 P any leg cramp,s that you have like at night or, (slb slb)

2001 P well as a matter of fact,

2002 P uh huh.

2003 P i was supposed to come last Friday.

2004 P uh huh.

2005 P and thursday a (german from slb slb slb) [my my] son by

2006 P [uh huh,]

2007 P the way is going to harvard.

2008 PR oh good. right[good. uh huh. uh huh.]

2009 P [or if he doesn't or] or or wesley and

2010 P we've [just rea]lized it's up the street

2011 P [uh huh.]

2012 P [i c(h)ame (slb) fif]teen=

2013 P [uh huh. uh huh. ] =uh huh.

2014 P .hhh i couldn't i had to call and cancel so,

2015 P [this is a ve ry rare ]

2016 P [uh huh. uh huh. uh huh.]

2017 P thing for me. i was driving home i (slb he was slb slb slb

2018 P slb slb) (slb) [a bout ] three hundred miles and in the

2019 P [uh huh.]

2020 P middle of driving i was gettin such a bad cramp here in

551
2022 the front of tibia,

2023 PR uh huh,=

2024 P =cramp in the back of the (edema),

2025 PR [uh huh.]

2026 P [.hhh my]toes are like this driving, [i'd be] oh luckily

2027 PR [ o kay.]

2028 P use, >(losing them) at that point it was [at night,<]

2029 PR [ uh huh. ]

2030 P >i already picked him up,< .hhh oh my james we have to

2031 drive.

2032 PR uh huh.

2033 P i could [not move.]

2034 PR [uh huh.] uh huh.

2035 P but that w- is rare [for me.]

2036 PR [ o kay.]

2037 P [yes.]

2038 PR [ o ]kay. [ o kay. ]

2039 P [yeah that's] rare for me.

2040 PR [o kay.]

2041 P [and at] least(didn't happen) like that but erm

2042 P [(slb slb was)]

2043 PR [ wes ley now ]is,

2044 P is is wesley in (slb slb)now, or no? [erm]

2045 P [ y-] y y- yes.

2046 PR it is, okay [ o kay.]

2047 P [well was] it an old girl school {(slb).}

2048 P [ i ]

2049 P ↑thought it ↓was [i don't know yeah.]

2050 P [yeah no. it is. ] it is. (slb)

2051 P [yeah slb slb) now] yes.=

2052 PR [uh huh. uh huh.]

2053 P =so that's for free. {(slb slb] slb] and if [you wa ]nna=

2054 PR [ uh huh.] [uh huh.]

2055 P =(slb slb slb) you definitely be[(hh) be long ]

2056 PR [ yeah there're some]

2057 PR interesting [people who go yeah.]

2058 P [ha ha ha ]ha .hhh [(yeah slb slb) ]

2059 PR [let's see, what]

2060 PR about: tzt tingling numb- numbness in your hands fingers

2061 feet,

2062 P hhh well i'll tell you (0.9) [ i ] don't know.=

2063 PR [uh,]

2064 P =the other day i touched a pan, on last week [i touch]ed a

2065 PR [uh huh,]

2066 P pan on the stove,

2067 (.)
which i didn't think was hot.

uh huh.

and my husband went and grabbed it and said [ouh!]

[uh, ]

and i just grabbed it!

[°o kay.°]

[and did ] not (mean)

.hhh okay.

but [i don't]

[uh huh.]

so er so now i'd be interest- [i don't] know. i d- i don't

[uh huh.]

know.

[uh huh.]

[if i'm ] getting if i'm sensory, [erm obviou sly my]

[ uh losing your sen]

sitiüvity

((lifting leg)) left [ ffff]f(hh)oot [is.]

[okay.] [ o ]kay.

but erm (. ) i d- are you are [i'm are] you aware when

[uh huh,]

you're ➔not=

=erm

i [don't think,]

[you may ] not be aware [someone else] will be

[ exact ly. ]

yeah. [uh huh. ]

[so that's] why [i'm saying] i don't know. [i mean,]

[uh huh. ]

what about anemias, any history of anemia,

i was very anemic [from one]

[uh huh.]

time because of (. ) bleedings of freaking (month),

[okay.]

[i mean] i used to bleed every two weeks for a week there

for a long time. ((knocks)) but i think [at this ] very

[come in!]

moment i'm not=

=come in!

hi.=

=hi.

hi:!

(slb [slb])

[ he ]

(slb[ slb] get ] very smiling faces (a[round here slb])

[yeah. yeah.] [yeah, doc tor ]
kenneth already came in because we thought you were downstairs in the lab,

[okay.]

[so he] he has already come in er alright are you done with are you down there yet[ no, ]

[yeah.]

yeah there may be one more coming one of my patients from the out satellites so,

okay.

alright that's doctor toury [by the way. ha ha ]

[hi. nice to meet you.]

[hi. how are you, nice ]

[ ha ha ] .hhh
[to meet]you too.

°okay.°

(slb [ slb])

[yeah.] no do you believe that, that's awful isn't it okay i forgot that's there.

that's [good!]

[ and ] coz i wear no make up and look horrible
[so,]

[yeah.] no you don't.=
=°alright.°

[ha ha [ ha ha ha ha ha ha .hhh]

[.hhh hu hu hu hu hhh hu]

[next time] i'm coming well prepared let me tell you.=

[hhh hhh] =uh

hu hu

((SD2 leaves))

(slb slb slb slb slb slb slb [slb])

[yeah] he's our newest resident. actually just started erm=
=good.

.hhh what about er skin stuff like dermatitis, psoriasis [i mean]

[oh it ]

chy itchy [it chy.]

[uh huh.]

very, cannot wear wool. very very sensitive to: erm (slb slb slb) products.

[uh huh.]

[i have ] to be like really careful with what i [use for soap.]

[ uh uh uh, ]

i can't even use soap.

uh huh.

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after like, yeah i'm i'm,
okay.
the detergents: what's being washed [what i ] wear
[yeah. er]
[uh huh. ]
yeah [i got] (slb slb)=
[okay.]
[uh huh.]
always [been like] that.

[uh uh. ]
(1.4)
okay.
(1.3)
[o kay.]
[i love] the ↓sun
you like [the ↑sun]
[ but i ] know [it's bad] for you,
[uh huh.]
(0.5)

=not all the time [no.]
[ i ] know it too but i love it.
[u:h .hhh okay. [uh,]
[ i ] look better with a tan.

you look better with a ↑tan=
=ye hhh yeah. [.hhh i i know]
[well you know cer ]tainly the sun is

[do you know,]
[really ne ]cessary for you,
ho- do you know, my oh! was an article
about tano[rexics ]
[uh huh.] uh huh.
people really. i mean [i'm not that extreme.]
[uh huh. uh huh. uh] huh.
people would in the sun and tan for seven days a week.
[uh huh.]
[and make] a big deal of that when er just like er
[uh huh.]
[an a ]norexic [i don't] do that.=
[uh huh.]
[okay. o[kay.]
[but ] anyway,
oklary.

but they do i'd w- well i was like a summer instructor for
years,=
=ah o[kay.]
so i mean i was out there for ever. =
[ o kay.]

okay.

i i d- i feel energized by the sun.
goo- oh, [uh huh. uh huh.]

[and i got a ] beautiful day, i i do
feel frustrated when i can't get outside on a nice day.
(.)

((croaky voice)) [o kay.]

[i love] it. i love the ocean i love the
beach i belong down south (of the u_s).

.(.)

((croaky voice)) [o kay.]

[i love] it. i love the ocean i love the
beach i belong down south (of the u_s).

[uh?]

then again [ i ]

[uh?]

don't like the i hate the heat heat [ i ]can't [i do ]
[yeah,] [uh huh.]

not tolerate the heat. .hh yet i have a low temp you think
i would

[ uh huh. uh huh. ]

[would ]you it doesn't] make sense[ at all, ]

[that doesn't] make

[sense uh huh.]

[that's backwards] i know.

(3.1)

[.hhh]

[but ] the cold hurts my body.

(1.5)

tzt .hhh i have erm an idea about which way we're gonna
go.

okay.=

=yeah erm i'm gonna go talk a little bit with doctor
kenneth and probably gonna come in and then do some
physical exam, i'm not sure exactly which way i wanna go
(in line with that) but .hhh erm i'm thinking about,
actually are you familiar with homeopathy at all
a little bit.

okay. erm

i was very into er homeopathy, herbs, bach i mean,

uh huh.

and er actually i was asked to er and now i've quitted
that's four

years [ a go ] so either you use it or lose it. =

[uh huh.]

[°uh huh.°]

and my husband thought it was totally [ absurd!]

and didn't want me spending wasting my time and money and
[ener)gy=
[uh huh.]
=doing that. so erm it's kind of (slb money in) my life
[actual ly.=
[uh huh.]
=.huh so er tha(ht's why i w(h)ant [ to ] d(h)ump him.=
[yeah,]
=[ha ha ha]
=[yeah.] [because] erm i think you know,
(3.9)
i think you would benefit from it. you've given me a lot
actually to: i wouldn't actually have to go too much
further with, normally with homeopathy what we do is we
take an hour hour and a half and we really go in depth but
you've given me a lot already.
[(slb slb) yeah uh huh.]
[told you that that's quick] (coz),
yeah [the yeah.]
[you know] you don't need to dig [ from me baby.]
[uh huh. uh huh.]
=no. [ha no.]
[i may not] not know [i may not] know the remedy right
[no. ha ha]
own, erm
(0.5)
tzt you know i have to go and repertoirize the remedy, but
erm i think that may be somewhere we wanna start. and also
with your gastrointestinal health because .hh
gastrointestinal health for us is connected with
autoimmune, (.) arthritis,
it's true. i'm not [getting] the right,=
[ e:rm ] =irritable bowel,
o[kay.]
[ de ]pression, thyroi- everything.
right,
for us [you know ] for a naturopath liver and and and
[it's true.]
[ the gut.]
[it's true.]
are that's it. alright? so that's what i think i'm gonna
start and i'll see what he has to say and so i'll be back
in any couple of minutes and we'll
[talk (tomorrow)]
[ how about de ]pression,
hhh very much so.
really?
yeah it can [be very much]
[because of ] serotonin up[take is not]
the:re,you can't get it ↑no:
it may be sometimes.
[ pro tein ]
[ food food] sensitivities.
[uh huh.] [i na ]dequate nutrition.
uh huh.
so: and then i think i'd like to really
[(slb slb)]
[ know ex]actly what you're eating, .hhh a:nd tzt e:rm
well last i had (pulses) last friday,
okay. okay well i want you to be i want you to have proper
nutrition not to worry about weight right now.
[that yeah,]
[well no] that
was [from]
[ uh ] huh.
actually my irritable bowel being so bad.
uh huh.
and i haven't (slb slb slb)
okay. okay.
(0.6)
i'll take this off so i don't walk down the street with
this.
[ha ha]
[ hhhh ]
i will be back she may come in i guess to kind and
disconnect you.
and [turn this] (slb slb slb)=
[ o kay. ]
=i'll be right [back.]
When is the date of your last pap smear?

( )

Erm two years ago.

Okay do you remember what month about

August?

Okay.

It (slb slb) three years ago then. Won't it be,

("slb [slb slb]*)

[ no two ] and a half.

Okay. ((Writing on P's file))

(2.5)

Okay.

Okay. ((Writing on P's file))

(1.6)

Okay.

Okay.

Okay.

((PR writing))

Any gynecological surgeries in the past?

No.

Or ( ) conditions,

No.

No, okay.

((PR writing))

Tzt any pregnancies ever

One.

One pregnancy,

((PR writing))

By birth?

Uh huh. One.

One.

(2.8)

Any abortions at all

No.

Okay. ( ) any miscarriages,

U::h, not that I know

Okay.
any difficulty with conceiving,
currently.

°okay.°

any complications with the pregnancy (. ) that you had,
no.

°okay.°
do you have any any future plans for pregnancy or,
tryin er trying,
you do, okay.
do you do er self (slb slb slb) at home? (. ) ever,
no.

ever okay. have you ever noticed any nipple discharge,
[no.]

[or ] anything like that, okay.
ever noticed any (slb) or tenderness or anything=
=no.

like that,
well (. ) hh i get tenderness before my period.

[every] ti- [every] month.

[okay.]
((clears throat))
okay and how old were you when you got your: er your first
period,
i think, (. ) thirteen.
°(slb slb slb)°

and what was the date of your last monthly period
(e:rm (1.5) eleven eight.

(1.4)
°wait a moment,° (. ) yeah eleven eight.
okay. (. ) and how many days does your period usually last,
seven to ten.
((PR writing)) (9.7)
okay and: tzt do you usually have a heavy flow?
((clears throat))
or what is it like generally,
P = kinda heavy first couple of days [and then]

PR [ o kay.]

P then not.

(PR writing) (7.7)

PR how many pads do you go through on your on your heavy
days,
P pads or tampons,

PR [ or ] tampons,
P .hhh erm hhh (2.2) t- erm (1.5) i don't know like maybe
three,

PR okay.
P four five,

(PR writing) okay.

(9.0)

PR any clots with the period

P u:h, small ones.

PR small clots.

(4.8)

PR any erm (. ) pain cramping

(0.8)

PR °with the period°

P u:h, occasional.

(PR writing) okay.

(10.8)

PR bleeding between cycles ever,
P no.

(.)

(PR writing) °okay.°

(5.1)

PR erm what type of p_m_s symptoms do you do you get besides
the breast tenderness?

P (cracking) ↑nipple ((smiles turning towards friend))

(crinkly!)

(PR writing) (8.0)

PR anything else?

P ((shaking head)) uh huh.

PR no cravings?

(3.1)

P i get hungry!

(PR writing) °you do.°

P yeah! ((clears throat))

(4.1)

PR any vaginal discharge? (slb slb slb) itching, or burning?

P no but, i kind of wonder if i don't have like a (. )

chronic bacterial vaginitis.
okay.
and I want to buy a test for that.
PR (PR writing) (2.7)
just because of the smell?
okay.
i don't know if you can get, I think you can I'm not sure but it would be very long term chronic if it was.
PR (PR writing) (2.8)
and when do you notice the discharge.
it's not really even just like a normal, okay.
vaginal discharge, okay.
but just the smell of it?
PR (noddng) o[kay.]
just coz I know that.
PR (noddng) right, (. okay.
=coz of my background I know that smell [you know,]
[ o kay. ]
and just kinda wonder.
okay. (. any pain during sex?
((shakes head lightly)) uh huh.
no?
PR (3.7)
.hhh yeah (however) yeah during ovulation and my period.
during ovulation?
yeah=
du- okay.
PR and my period I cannot have fun today coz I'm just ovulating, ((smiling)) today I think.
((writing)) ahhh! okay.
PR (6.4)
but I'm not gonna have fun (one of us (hh)) I (hh) s not gonna have fun (hh)n ha ha ha .hhh he he .hh coz it gets (slb slb) tender then,
PR ((writing)) °okay.°
(4.3)
do you know how old erm your mum was when she got menopause?
PR forty fou(hh)r:
((PR writing)) (3.0)
do you have any sisters?
PR two.
well they're about or i don't know,
they're younger.
they're younger okay. (. ) erm (. ) what about your
grandmother and
your aunts, do you know how old they were?
no okay.
(2.4)
ºokay.º and are you sexually active now?
uh huh.
yes. (. ) okay any birth control?
no. trying to get pregnant.
º(writing)º okay.
º(slb slb)º
any birth control methods used in the past? ((clears
throat))
before you were trying to get pregnant,
mostly. (slb slb slb) mostly.
ok(h)ay.
ºok(h)ay.º
any history of (depressed slb ↑slb)
((shaking head)) uh huh.
ºokay,º i have to ask this. do you do you need any
information on
other birth control methods at ↓all
((shaking head lightly)) uh huh.
no okay.
ºok(h)ay.º
okay. (. ) so now we have to start (slb slb slb slb slb)
okey i need to run to the bathroom and,
oka(h)y great.
ºok(h)ay.º
APPENDIX C: FEEDBACK QUESTIONNAIRES
POST-ENCOUNTER QUESTIONNAIRE FOR THE (STUDENT) CLINICIAN* 1

Do you agree with the following statements? Please, tick one of the given options.

1) I felt at ease with this patient
   [ ] strongly disagree
   [ ] disagree
   [ ] unsure
   [ ] agree
   [ ] strongly agree

2) Communication with this patient was difficult
   [ ] strongly disagree
   [ ] disagree
   [ ] unsure
   [ ] agree
   [ ] strongly agree

3) The patient was challenging
   [ ] strongly disagree
   [ ] disagree
   [ ] unsure
   [ ] agree
   [ ] strongly agree

4) The patient’s style was focused and systematic
   [ ] strongly disagree
   [ ] disagree
   [ ] unsure
   [ ] agree
   [ ] strongly agree

5) The patient’s style was dramatic
   [ ] strongly disagree
   [ ] disagree
   [ ] unsure
   [ ] agree
   [ ] strongly agree

1 Adapted in part from Hahn and Kroenke (1996).
6) The patient seemed to feel hopeless about her/his state
☐ strongly disagree
☐ disagree
☐ unsure
☐ agree
☐ strongly agree

7) The patient seemed suspicious of healthcare and healthcare professionals
☐ strongly disagree
☐ disagree
☐ unsure
☐ agree
☐ strongly agree

8) The patient was very self-confident
☐ strongly disagree
☐ disagree
☐ unsure
☐ agree
☐ strongly agree

Is there anything else you would like to add?
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Thank you very much for your help!

* PLEASE NOTE. This questionnaire is entirely anonymous
POST-ENCOUNTER QUESTIONNAIRE FOR THE PATIENT

Do you agree with the following statements? Please, tick one of the given options.

1) The doctor** greeted me pleasantly before dealing with my medical problem
   - strongly disagree
   - disagree
   - unsure
   - agree
   - strongly agree

2) The doctor seemed to pay attention as I described my condition
   - strongly disagree
   - disagree
   - unsure
   - agree
   - strongly agree

3) The doctor made me feel as if I could talk about any type of problem
   - strongly disagree
   - disagree
   - unsure
   - agree
   - strongly agree

4) The doctor asked questions that were too personal
   - strongly disagree
   - disagree
   - unsure
   - agree
   - strongly agree

5) The doctor explained the reason why the treatment was recommended for me.
   - strongly disagree
   - disagree
   - unsure
   - agree
   - strongly agree

2 Adapted from Bowman et al. (1992), Linder-Pelz, and Struening (1985), and Wolf et al. (1978).
6) The doctor recommended a treatment that is unrealistic for me.
   □ strongly disagree
   □ disagree
   □ unsure
   □ agree
   □ strongly agree

7) The doctor considered my individual needs when treating my condition.
   □ strongly disagree
   □ disagree
   □ unsure
   □ agree
   □ strongly agree

8) The doctor seemed to be rushed.
   □ strongly disagree
   □ disagree
   □ unsure
   □ agree
   □ strongly agree

9) The doctor behaved in a professional and respectful manner toward me.
   □ strongly disagree
   □ disagree
   □ unsure
   □ agree
   □ strongly agree

10) The doctor seemed to brush off my questions.
    □ strongly disagree
    □ disagree
    □ unsure
    □ agree
    □ strongly agree
11) The doctor used words that I did not understand.
   □  strongly disagree
   □  disagree
   □  unsure
   □  agree
   □  strongly agree

12) The doctor gave me all the information I thought I should have been given.
   □  strongly disagree
   □  disagree
   □  unsure
   □  agree
   □  strongly agree

Is there anything else you would like to add?

_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

Thank you very much for your help!

* PLEASE NOTE. This questionnaire is entirely anonymous
** PLEASE NOTE. The word doctor refers to the (student) clinician
**Table 1. Participants involved in the study**

<table>
<thead>
<tr>
<th>Total no. of patients</th>
<th>First-time patients</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Return patients</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Total no. of doctors</td>
<td>Supervising doctors</td>
<td>6</td>
</tr>
<tr>
<td>Student clinicians</td>
<td>20</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Primaries</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Secondaries</td>
<td>8</td>
</tr>
</tbody>
</table>

**Key to tables 2 and 3**
- T data = transcribed data (results for transcribed data are highlighted in grey)
- N-T data = non-transcribed data
- INT = interview
- PR = primary
- SC = secondary
- SD = supervising doctor

---

112 For a total of 14 recorded interviews.
Table 2. Patients’ answers to the feedback questionnaire

<table>
<thead>
<tr>
<th>Post-encounter questionnaire for the patient</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T data (9 INTs)</td>
</tr>
<tr>
<td></td>
<td>Total: 9 patients</td>
</tr>
<tr>
<td>1) The doctor greeted me pleasantly before dealing with my medical problem</td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
<tr>
<td>Agree</td>
<td>-</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>8</td>
</tr>
<tr>
<td>2) The doctor seemed to pay attention as I described my condition</td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
<tr>
<td>Agree</td>
<td>1</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>7</td>
</tr>
<tr>
<td>3) The doctor made me feel as if I could talk about any type of problem</td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
<tr>
<td>Agree</td>
<td>1</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>7</td>
</tr>
<tr>
<td>4) The doctor asked questions that were too personal</td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>5</td>
</tr>
<tr>
<td>Disagree</td>
<td>4</td>
</tr>
<tr>
<td>Unsure</td>
<td>-</td>
</tr>
<tr>
<td>5) The doctor explained the reason why the treatment was recommended for me</td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
</tr>
<tr>
<td>Agree</td>
<td>2</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>4</td>
</tr>
<tr>
<td>Other (no reply)</td>
<td>1</td>
</tr>
</tbody>
</table>

---

113 Answers other than ticks or crosses in the appropriate boxes (e.g. additional comments) are not included in the table.
114 The total number of patients out of five interviews is three because two patients did not compile the questionnaire.
6) The doctor recommended a treatment that is unrealistic for me

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Other (no reply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

7) The doctor considered my individual needs when treating my condition

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>Other (no reply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

8) The doctor seemed to be rushed

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Other (no reply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

9) The doctor behaved in a professional and respectful manner toward me

<table>
<thead>
<tr>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

10) The doctor seemed to brush off my questions

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Other (no reply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

11) The doctor used words that I did not understand

<table>
<thead>
<tr>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Other (no reply)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

12) The doctor gave me all the information I thought I should have been given

<table>
<thead>
<tr>
<th>Disagree</th>
<th>Other (no reply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-</td>
</tr>
</tbody>
</table>

115 “No reply” options include cases where patients did not tick any of the answers provided but added specific comments on a single item of the questionnaire (e.g. “n.a.” or “who am I to make that judgement”).
<table>
<thead>
<tr>
<th></th>
<th>T data (9 INTs)</th>
<th>N-T data (5 INTs)</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total: 14 clinicians</td>
<td>Total: 12 clinicians</td>
<td></td>
</tr>
<tr>
<td>PRs</td>
<td>SCs</td>
<td>PRs</td>
<td>SCs</td>
</tr>
<tr>
<td>Tot: 10</td>
<td>Tot: 4</td>
<td>Tot: 4</td>
<td>Tot: 7</td>
</tr>
</tbody>
</table>

**Table 3. doctors’ answers to the feedback questionnaire**

*Post-encounter questionnaire for the (student) clinician*

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Unsure</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>PRs</th>
<th>SCs</th>
<th>SDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) I felt at ease with this patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Communication with this patient was difficult</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) The patient was challenging</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strongly disagree</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disagree</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Agree</td>
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</tbody>
</table>

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116 See note 1.
<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<tbody>
<tr>
<td>4) The patient’s style was focused and systematic</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Unsure</td>
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<td>1</td>
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<td>Agree</td>
<td>4</td>
<td>-</td>
<td>2</td>
<td>5</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>5) The patient’s style was dramatic</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Unsure</td>
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<td>-</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>6) The patient seemed to feel hopeless about her/his state</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disagree</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>7) The patient seemed suspicious of healthcare and healthcare professionals</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Disagree</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Unsure</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly agree</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>8) The patient was very self-confident</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Disagree</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Strongly agree</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
APPENDIX D: CONSENT FORMS
1. Doctor consent form for audio recording

Title: doctor-patient communication in complementary and alternative medicine

Investigators:

Letizia Cirillo
Ph.D. student, c/o University of Naples ‘Federico II’ (Department of Statistics, Via Leopoldo Rodinò 22, 80138 Naples, Italy)
Teacher of Interpreting from English into Italian, c/o SSLMIT (School of Modern Languages for Interpreters and Translators) University of Bologna – Corso della Repubblica 136 – 47100 Forlì (Italy).
Mobile no. 011.39.328.96.71.628

University of Bridgeport Internal Review Board

Source of Support:

University of Naples ‘Federico II’
‘Alma Mater Studiorum’ University of Bologna

Description:

This study is designed to improve communication between doctors and patients during interviews. To do that we first need to observe real doctor-patient encounters. This is why we need your help. We are going to make audio recordings of 30 interviews involving 30 patients (one for each interview) and senior and trainee naturopathic doctors. ¹¹⁷

Before the interview you will be asked to read and sign the consent form. You will then enter the interview room and you will be asked to wear a clip-on microphone. You will find a camcorder in the room but the lens will be covered, so that only your voice will be recorded. The researcher (or a member of the University staff) will switch on the camcorder and will then leave the room. Once the interview has finished and the camcorder has been switched off, you will be asked to answer a short anonymous questionnaire on how satisfied you are with the interview. This will take you no more than 10 minutes.

Initials ____________

¹¹⁷ Thirty was an initial rough indication of the number of interviews we were planning to record.
COSTS AND PAYMENTS:

You will not be charged for participating in the study. You will not receive any compensation for participating in the study.

NEW INFORMATION:

Any new information developed during the course of this research, which may relate to your willingness to participate, will be provided to you.

CONFIDENTIALITY:

All records pertaining to your involvement in this research study will be stored in a locked file cabinet in the SITLeC (Department of Interdisciplinary Studies on Translation, Languages and Cultures), Corso Diaz 64, 47100 Forlì (Italy). A case number will indicate your identity on these records. This information will be accessible to the investigators and their research study staff listed on the first page of this document. Individuals from the agencies funding this research may review your records as part of their ongoing audit of this project. You will not be specifically identified in any publication of research results. However, in unusual cases, your research records may be inspected by appropriate government agencies, such as the US Food and Drug Administration, or be released in response to an order from a court of law. All research records will be kept for a minimum of seven years following closure of this study.

RIGHT TO WITHDRAW:

You do not have to take part in this research study and, should you change your mind, you can withdraw from the study at any time. You may be removed from the research study by the investigators in the event of technical problems during recording or transcription procedures.

COMPENSATION FOR ILLNESS OR INJURY:

University of Bridgeport investigators and their associates recognize the importance of your voluntary participation to their research studies. These individuals and their staffs will make reasonable efforts to minimize, control, and treat any injuries that may arise as a result of this research. If you believe that you are injured as the result of the research procedures being performed, please contact immediately the principal investigator listed on the first page of this document or the U.B. Institutional Review Board. Emergency medical treatment for injuries solely and directly relating to your participation in this research will be provided to you by a local hospital. It is possible that the hospital may bill your insurance provider for the costs of this emergency treatment, but none of these costs will be charged directly to you. If your research-related injury requires medical care beyond this emergency treatment, you will be responsible for the costs of this follow-up care, unless otherwise specifically stated in this consent. You will not receive monetary payment for, or associated with, any injury that you suffer in relation to this research.

Initials ___________
VOLUNTARY CONSENT:

I certify that I have read the preceding or it has been read to me. All of the above has been explained to me and all of my questions have been answered. I understand that Letizia Cirillo, or a member of her study staff, will answer any future questions I have about this research. Any questions I have concerning research-related injuries or my rights as a research subject will be answered by the Chair of the Institutional Review Board of University of Bridgeport. A copy of this consent document will be given to me. My signature below means that I have freely agreed to participate in this research study.

____________________          __________________________________
Date                                        Signature

____________________          __________________________________
Date                                        Witness Signature

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study. I have answered any questions that have been raised, and have witnessed the above signature.

____________________          __________________________________
Date                                        Investigator's Signature

Initials ____________
2. Doctor consent form for video recording

**Title:** doctor-patient communication in complementary and alternative medicine

**Investigators:**

Letizia Cirillo

Ph D student c/o University of Naples ‘Federico II’ (Department of Statistics, Via Leopoldo Rodinò 22, 80138 Naples, Italy)

Teacher of Interpreting from English into Italian c/o SSLMIT (School of Modern Languages for Interpreters and Translators) University of Bologna – Corso della Repubblica 136 – 47100 Forlì (Italy).

Mobile no. 011.39.328.96.71.628

University of Bridgeport Internal Review Board

**Source of support:**

University of Naples ‘Federico II’,

‘Alma Mater Studiorum’ University of Bologna

**Description:**

This study is designed to improve communication between doctors and patients during interviews. To do that we first need to observe real doctor-patient encounters. This is why we need your help.

We are going to make video recordings of 30 interviews involving 30 patients (one for each interview) and senior and trainee naturopathic doctors.

Before the interview you will be asked to read and sign the consent form. You will then enter the interview room and you will be asked to wear a clip-on microphone. The researcher (or a member of the University staff) will switch on the camcorder and will then leave the room. Once the interview has finished and the camcorder has been switched off, you will be asked to answer a short anonymous questionnaire on how satisfied you are with the interview. This will take you no more than 10 minutes.

Initials ____________
COSTS AND PAYMENTS:

You will not be charged for participating in the study. You will not receive any compensation for participating in the study.

NEW INFORMATION:

Any new information developed during the course of this research, which may relate to your willingness to participate, will be provided to you.

CONFIDENTIALITY:

All records pertaining to your involvement in this research study will be stored in a locked file cabinet in the SITLeC (Department of Interdisciplinary Studies on Translation, Languages and Cultures), Corso Diaz 64, 47100 Forlì (Italy). A case number will indicate your identity on these records. This information will be accessible to the investigators and their research study staff listed on the first page of this document. Individuals from the agencies funding this research may review your records as part of their ongoing audit of this project. You will not be specifically identified in any publication of research results. However, in unusual cases, your research records may be inspected by appropriate government agencies, such as the US Food and Drug Administration, or be released in response to an order from a court of law. All research records will be kept for a minimum of seven years following closure of this study.

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******************************************************************************

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________________________________________
Date                                               Signature

________________________________________
Date                                               Witness Signature

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study. I have answered any questions that have been raised, and have witnessed the above signature.

________________________________________
Date                                               Investigator's Signature

Initials _____________
3. Patient consent form for audio recording

University of Naples ‘Federico II’ – Department of Statistics
Via Leopoldo Rodinò 22, 80138 Naples (Italy)
‘Alma Mater Studiorum’ University of Bologna
SSLMIT (School of Modern Languages for Interpreters and Translators)
Corso della Repubblica 136, 47100 Forlì (Italy)
SITLeC (Department of Interdisciplinary Studies on Translation, Languages and Cultures)
Corso Diaz 64, 47100 Forlì (Italy)

CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY

**TITLE:** doctor-patient communication in complementary and alternative medicine

**INVESTIGATORS:**

Letizia Cirillo
Ph D student c/o University of Naples ‘Federico II’ (Department of Statistics, Via Leopoldo Rodinò 22, 80138 Naples, Italy)
Teacher of Interpreting from English into Italian c/o SSLMIT (School of Modern Languages for Interpreters and Translators) University of Bologna – Corso della Repubblica 136 – 47100 Forlì (Italy).
Mobile no. 011.39.328.96.71.628

University of Bridgeport Internal Review Board

**SOURCE OF SUPPORT:**

University of Naples ‘Federico II’,
‘Alma Mater Studiorum’ University of Bologna

**DESCRIPTION:**

This study is designed to improve communication between doctors and patients during interviews. To do that we first need to observe real doctor-patient encounters. This is why we need your help. We are going to make audio recordings of 30 interviews involving other patients (one for each interview) and senior and trainee naturopathic doctors.

******************************************************************************

Before your interview with the doctor, you will be given all necessary instructions and information in the waiting room. You will also be asked to read and sign the consent form. You will then enter the interview room and you will be asked to wear a clip-on microphone. You will find a camcorder in the room but the lens will be covered, so that only your voice will be recorded. The researcher (or a member of the University staff) will switch on the camcorder and will then leave the room. Once the interview has finished and the camcorder has been switched off, you will be asked to answer a short anonymous questionnaire on how satisfied you are with the interview. This will take you no more than 10 minutes.

Initials ____________
COSTS AND PAYMENTS:

You will not be charged for participating in the study. You will not receive any compensation for participating in the study.

NEW INFORMATION:

Any new information developed during the course of this research, which may relate to your willingness to participate, will be provided to you.

CONFIDENTIALITY:

All records pertaining to your involvement in this research study will be stored in a locked file cabinet in the SITLeC (Department of Interdisciplinary Studies on Translation, Languages and Cultures), Corso Diaz 64, 47100 Forlì (Italy). A case number will indicate your identity on these records. This information will be accessible to the investigators and their research study staff listed on the first page of this document. Individuals from the agencies funding this research may review your records as part of their ongoing audit of this project. Any information about you or your hospital treatment will be handled in a confidential (private) manner consistent with other hospital medical records. You will not be specifically identified in any publication of research results. However, in unusual cases, your research records may be inspected by appropriate government agencies, such as the US Food and Drug Administration, or be released in response to an order from a court of law. All research records will be kept for a minimum of seven years following closure of this study.

RIGHT TO WITHDRAW:

You do not have to take part in this research study and, should you change your mind, you can withdraw from the study at any time. Your other care and benefits will be the same whether you participate in this research or not. You may be removed from the research study by the investigators in the event of technical problems during recording or transcription procedures.

CONFLICT OF INTEREST

Your doctor may be an investigator in this research study, and as an investigator, is interested both in your medical care and in the conduct of this research. Before entering this study or at any time during the research, you may discuss your care with another doctor who is in no way associated with this research project. You are not under any obligation to participate in any research study offered by your doctor.

COMPENSATION FOR ILLNESS OR INJURY:

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**********************************************************************************

VOLUNTARY CONSENT:

I certify that I have read the preceding or it has been read to me. All of the above has been explained to me and all of my questions have been answered. I understand that Letizia Cirillo, or a member of her study staff, will answer any future questions I have about this research. Any questions I have concerning research-related injuries or my rights as a research subject will be answered by the Chair of the Institutional Review Board of University of Bridgeport. A copy of this consent document will be given to me. My signature below means that I have freely agreed to participate in this research study.

____________________          __________________________________
Date                                        Signature

____________________          __________________________________
Date                                        Witness Signature

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study. I have answered any questions that have been raised, and have witnessed the above signature.

____________________          ________________
Date                                        Investigator's Signature

Initials ____________
CONSENT TO ACT AS A SUBJECT IN A RESEARCH STUDY

TITLE: doctor-patient communication in complementary and alternative medicine

INVESTIGATORS: Letizia Cirillo
Ph D student c/o University of Naples ‘Federico II’ (Department of Statistics, Via Leopoldo Rodinò 22, 80138 Naples, Italy)
Teacher of Interpreting from English into Italian c/o SSLMIT (School of Modern Languages for Interpreters and Translators) University of Bologna – Corso della Repubblica 136 – 47100 Forlì (Italy).
Mobile no. 011.39.328.96.71.628

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Date                                        Signature

____________________          __________________________________
Date                                        Witness Signature

I certify that I have explained to the above individual the nature and purpose, the potential benefits, and possible risks associated with participating in this research study. I have answered any questions that have been raised, and have witnessed the above signature.

____________________          __________________________________
Date                                        Investigator's Signature

Initials ______________

591