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The interactional organisation of talk in naturopathic interviews

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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

[1] Cited in West (1984b: 17-18).

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),[2] 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

[2] Cited in West (1984b: 19-20).

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.

[3] Cited in West (1984b: 20).

[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

[5] Cited in Mishler (1984: 28) and Cicourel (1985: 194).

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.[6] 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

[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),[7] 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.[8]

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).[9] 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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[7] Cited in Silverman (1987: 198).

[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.[10] 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.).

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[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'me" 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,[2] 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".[3]

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.[4,5] The encounter analysed is an example of multi-party interaction, where a paediatrician

[2] Cited in Auer (1992: 21).
[3] For further details on contextualization cues, see Gumperz (1982, 1992a, 1992b) and Levinson (2003). For a definition of contextualization, see Auer (1992).
[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.[6] 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.[7] 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

[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".

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.[8] 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.[11] 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.[1] 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

[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).[2]

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

[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

[3] For a full description of repair, see Schegloff et al. (1977). For an extensive treatment of repair mechanisms and non-alignment in conversation, cf. also Fele (1991).

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").[4] *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.[5] As pointed out by Jefferson (1980), and as we will

[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 bu:rgled 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.[6] 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).[7]

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,

[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).

1981; Frankel, 1990; Maynard, 1991a, 1991b, 1992; West, 1993 [1983]), counselling 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] Vice versa, in the opening sequence of a medical interview 'how are you' is

[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).

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.[9] 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.[10] 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

[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).[11] Each of these phases is associated with particular types of contributions: 'small talk' (cf. Coupland, 2000a,b) is emplyed 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".

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.[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 *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. *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

[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).

[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).[14] 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

[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.[15]

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 erm (.) 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.[16] 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

[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

[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.[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

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reproduction of their terminology. Contrary to this use of "initiated", I would deem more suitable a term like "produced". In fact, if a topic, a sequence, or repair can be initiated, can a speaker initiate an interruption or, even worse, a question/utterance?

[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.).

[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.[20] Moreover, patients were found to answer 98 percent of doctors' questions,

[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 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);[21] *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.

[21] 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 sick." Pt: "A little bit. Ye:s" Dr: "Mmh hmh. 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.

(F. Roberts, 2000: 162-63).

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

[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).[25]

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).

[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))
```

```
07   PAT:    >Okay.< (0.2) about five weeks ago I went to Disneyland
08           an' I wore a pair = a sandals that weren't very
09           supportive.
```

(Robinson & Heritage, 2005: 487).

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),[26] 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.[27] 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.

[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.[28] Moreover, a turn at talk may legitimately perform more than one activity,

[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.
```
(Jefferson, 1972: 295).

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 re:al (0.3) painful you know I can turn
so far and then I just can't go that way anymore
→ 3 (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).[29,30] 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 think so:=They're really strung ou:t.
4         y[a know they're over uh long period uh time. but-
5    DOC:  [Mn hm,
6    PAT: .hh Yieah: (,)
```

(Stivers &Heritage, 2001: 157).

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 [si nus]
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,]
```

```
17 →P   =thing but anyway and i might try when i did the clarit- and i did
18      every
19   PR (slb slb [slb  slb)]
20   P           [.hhh  stu]pid thing
21   PR uh [huh.]
22 →P      [ in ] the in thee erm (.) store and not [nothing] helped.=
23   PR                                            [o  kay.]        =what
24      about hearing loss, erm (.) nose bleeds, tzt vertigo,
```

(UBNMC: INT13-11.21.03: 1651-74).[31]

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:

```
1 DOC: Tl=D'you have any breast lumps that=yer aware of?,
2      (0.8)
3 PAT: I don't check_
4      (4.0)
5 PAT: I should.
```

(Stivers & Heritage, 2001: 161).

[31]For ease of reference, lines have been renumbered from 1 to 24 (cf. Appendix B).

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[32] 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 *contingen*t or *follow-up* questions. These, however, are not *and*-prefaced, as in the following example:

```
7    HV: 1→ Your tail's alri:ght.
8           (0.7)
9    M:     Ye::s.
10          (.)
11   M:     Lot more comfortable no:w.
12          (0.7)
13   HV: 2→ Did you have stitches.
14   M:     I di:d Yeah.
15   HV:    °Mm:.°
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 → 1.  Dr. E: What do you see? As-as his difficulty.
2 → 2. Mrs. C: Mainly his uhm-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
3 → 8.  Dr. E: Okay I you know I think we BASICALLY in some ways agree with
  → 9.         with you insofar as we think that D's MAIN problem you know
 → 10.         DOES involve you know LANGuage,
   11. Mrs. C: Mm hmm
   12.  Dr. E: you know both you know his-being able to understand, and know
   13.         what is said to him, and also certainly also to be able to
   14.         express, you know his uh thoughts
   15.                                        (1.0)
   16.  Dr. E: Um, in general his development
```

(Maynard, 1991b: 468).

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".[33] 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

[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', prefaces 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…').[34] 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

[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.).[35] 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

[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?
```

(Meehan, 1981: 113).

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 (l. 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";

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,[1] 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

[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 participate. 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.[2]

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 organisational constraints affecting them (cf. Heath, 1997: 190).

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

[2] The term 'primaries' refers to fourth-year student clinicians (cf. 4.4).

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 immedialy 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.[3] 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.[4] 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

[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.[5,6] 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 then 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.[7]

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).[8] 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

[8] 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).

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.[9] 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.

[9] 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).[1] 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

[1] For a review of the most influential studies on interruptions see Zorzi (1990: 84ff.).

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.[2] 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    o↓ther
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.

[2] In conversations with at least four participants we sometimes observe a phenomenon known as 'schism' or 'schisming' (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.

Excerpt 2

```
1924   P      so er so now i'd be interest- [i don't ] know. i d- i don't know.
1925   PR                                   [uh  huh.]
1926          [uh huh.]
1927   P      [if i'm ] getting if i'm sensory, [erm obviou  sly  my]
1928   PR                                      [ uh losing your sen]siti↑vity
1929   P      ((lifting leg)) left [ ffff]f(hh)oot [is.]
1930   PR                          [okay.]         [ o ]kay.
```

(UBNMC, INT13-11.21.03).

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,
```

```
757    PR     [oh good!]
758    P      [ veggie ] a:nd
759    PR     good.
760    P      i bought erm
761           (0.7)
762    P      chinese dumplings?
763    PR     yeah,
764    P      with erm chicken and leek.
```

(UBNMC, INT7-11.14.03).

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

```
966    PR     is for the heart it's mostly  for like, cholesterol?
967    P      u:h [i   see.]
968    PR         [erm it's] a lowering agent, [for cholesterol ]
969    P                                       [lowering   agent] yeah.
```

(UBNMC, INT12-11.20.03).

[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.

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",[4] 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.[5]

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         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         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-°]
645   P                            [ i know   my  ] aunt, and my cousin and
646         my grandmother. my grandmother had a history of diabetes.
```

(UBNMC, INT6-11.12.03).

[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'

[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   ↑pa rent]
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).[7]

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- e:rm 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           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.

326 P [so] so you gotta kind of improvise with it so,

(UBNMC, INT6-11.12.03).

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

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

(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	ahhhh
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 ↓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.[9] 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

[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
62          director but that's news to me have you heard that? (.) at ↑all
```

(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
1795          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,
1899   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[gery 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.[10] 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.

```
684          (2.2)
685    PR2   so.
686          (1.2)
687    SD    ((pointing at scars)) the right.
688    PR2   i see yeah. i see these scars, okay [this is   ve   ry  very,]
689 → P                                        [you know there's another]
690          one on the other side too.
691    PR2   uh huh [i'll ask,]
692 → P             [in  case ] you want to get [a look.]
693    PR2                                      [o  kay ] wow! okay now now i
694          have the picture.
695    P     yeah.
696    PR2   okay.=
697    P     =i wanted you to get it doctor!
698    PR2   but i have the full picture okay .h and i was expecting this
699          scar to be continuous with these but i see we have one two three
700          four major scars .hh
701    P     [↑four]
702    PR2   [ we  ] also have, ((coughs))
703 → P     doctor patton said
704    PR2   [yeah.]
705    P     [what ] i complained that he didn't [match the]
706    PR2                                      [ hu.  tzt]
707    P     seams too well [you] see he=
708    PR2                  [hu.]
709    P     =had to cut around this:,
710    PR2   right.
711    P     belly.
712    PR2   we also have these three are distancing. now (.) that,
713 → P     oh there's an app- appendectomy scar there.
714    PR2   erm yes i i i appreciate that .hhh erm so we have these three
715          distancing and that too erm erm is: a significant scar. so in in
716          brief wha- what is the biological significance of of .hh of of
717          these scars, and the answer is that given that (.) more than
718          ninety percent of the autonomic neurofibers [of the]=
719    PR                                               [uh huh]=
720    PR2   body are located in the skin,
721    SD    ((to P)) °(slb slb slb)°
722    P     hu?
723    PR2   [ at thee ]
724    SD    [(slb slb ]slb)
725    P     hu
726    PR2   at the dermal epidermal junction just below that junction i
727          talked about this many times,
728    PR    uh huh,
```

729 PR2 .hh given that .hh erm (.) i could just say in shorthand they
730 cut this is disrupting the communication to acupuncture
731 meridians.
732 PR [uh huh,]
733 PR2 [whether] you wanna speak of acupuncture meridians or (.)
734 autonomic circuitry of the skin,
735 PR uh huh,
736 PR2 i think we're talking about practically the same thing. .hh so
737 erm it would: erm it would be of enormous benefit erm to to
738 lizabeth for us to treat these. esp-
739 SD libby.
740 PR2 er,
741 SD [hu hu]
742 PR2 [er lib]by? [libby?]
743 SD [hu hu]
744 → P oh no! go ahead.
745 PR2 [lizabeth.]
746 P [i'm used] [to it for the] [time] [here don't be bo]thered.=
747 SC [he he he he] [he]
748 PR2 [yeah] [es pe cially]
749 =especially since thee: erm especially since the, and the
750 treatment is is painless [al so.]
751 SD [uh huh.]

(UBNMC, INT1-11.04.03).

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,
```

```
353    PR     okay that one you will [have to get.]
354    P                             [and the tinc]ture i have just a little bit
355    PR     the tincture of,
356    P      erm smilex tincture.
357    PR     okay. right .hhh now
358    P      bromelin is almost gone,
359    PR     okay (.)[and]
360 →  P              [ i ] can't see any change in the veins (.)(during that)
361           that was to clear up the ↑veins
362           (0.3)
363    PR     the bromelin?
364    P      yes
365    PR     e::rm
366           (0.4)
367    P      if the: erm (0.5) [(slb of blood slb slb slb)]
368    PR                       [ and and  al  so  for the ] the cs- scar tissue
369           and everything but that's gonna take a while i mean,
370    P      [yeah.]
371    PR     [that ] doesn't happen,
372    P      okay.
373    PR     [.hhh erm ]
374 →  P      [nothing's] happened there.
375    PR     yeah .h how can i see your right [ leg?]
376    P                                       [sure!]
377    PR     coz and the horse chestnut was for the veins,
378    P      yeah.
379           ((P lifts trousers and PR looks at leg)) (0.7)
380    PR     that would be long term though that's something that .hh oh it
381           does look better. does look a lot better.
382           (0.5)
383    P      it's [ softer.]
384    PR          [and it's] much softer.
385    P      yeah.=
386    PR     =yeah.
387           ((PR examining P's leg)) (0.8)
388    PR     see your body is reabsorbing all that blood you had a
389           (.)
390    P      [yeah.]
391    PR     [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 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 erm .h last week you were
687          taking (.) erm a (triple_s) [↑herbal ]
688    P                                 [uh yeah.] yeah i was er er i'm on
689          [er]this=
690    PR    [er]
691    P     =thing yeah.
692    PR    you are [ tak ]ing that [still?]
693    P             [yeah.]         [ yeah.]
694    PR    [o   kay  do]
695 →  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                                   [.hhh 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
```

```
711          you know er °(what you think?)°
712    PR    erm actually the (triple_s) [should] be fine.=
713    P                                 [  uh! ]         =fine.
714    PR    [uh   yes    we had ]
715    P     [that should be fine]  uh [huh.]
716    PR                             [yeah] we double checked that [to  see ]
717    P                                                            [uh ↑yeah]
718    PR    if there was any contraindications [for ↓you]
719    P                                        [uh   huh] uh huh,
720    PR    and there were not.
721    P     uh huh [uh ] huh,=
722    PR           [erm]     =but just: you [know] if if you're: in ↑doubt=
723    P                                    [ uh,]
724          =yeah [yeah yeah yeah,]
725    PR          [you  know then ] i would probably just slowly decrease the
726          amount that you're taking.
727    P     probably yeah [yeah yeah yeah.]
728    PR                 [if    you find ] that it seems to be causing
729    P     yeah [yeah.]
730    PR         [more ] problems with the palpitations.
731    P     yeah absolutely [ if ] i,
732    PR                    [yes.]
```

(UBNMC, INT12-11.20.03).

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]
```

```
1168   SC     [ha ha  ha] ha
1169   PR     .hh hu
1170 →SC      we can show you that afterwards.
1171   P      okay.
```

(UBNMC, INT1-11.04.03).

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

```
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)
```

[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.

(UBNMC, INT1-11.04.03).

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.
```

```
1353   SD     uh huh,
1354   P      it's it still bleeding by the ↑way
1355   SD     ((to PR and SC)) did you see something?
1356   PR     in i-
1357   SC     it's still bright red so,=
1358   PR     =bright red.=
1359   SC     =I don't know again I didn't see it last [week ] so I [don't]
1360   SD                                              [right]      [right]
1361   SC     know what the=
1362   SD     =yeah erm
1363   P      [and you   di- you d- ]
1364 →SD     [ i  don't know the an]swer to that and i think it just it all
1365           depends on the different factors that is all,
1366   P      uh huh uh huh ye- you didn't have your, (.)
1367   PR     okay so,
1368   P      with your pulse and blood thee: erm
1369   SD     diagnose. hhhh
1370   P      [ophthalmoscope.]
1371   SD     [ he he  he he  ] [actually] there's somebody who told me was
1372   PR                      [okay i, ]
1373   SD     gonna teach me how to [ use  ] that one ha
1374   PR                           [check,]
1375   SD     ((looking at SC)) and that was you i [thought] [ it was ]
1376   P                                           [  ha   ] [ ha  ha ]
1377   SC                                                    [ he  he ]
1378   P      [ha ha ]
1379   SC     [he .hh]
1380   SD     she's gonna teach me and,
1381   P      [ha ha ]
1382   SC     [hh hh ]
1383   SD     right (slb slb)
1384   P                              [ but that ]
1385   PR     ((talking to himself)) [°check the] blood pressure again°,
```

(UBNMC, INT1-11.04.03).

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).[12] 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

[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.[13] 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 "ri:ght," 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).

[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").[14] 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.

[14] 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 irri↑tation
310    P      yea:h [it's:: ]
311    PR           [uh like] a crusty? [you ↑said]
312    P                                [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. Schegloff 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           nothing [with that.]
453 →  P              [(slb  slb)] don't take maybe once in (0.4) three weeks
454           (0.8)
455    P      thee: erm (0.9) erm that thing that help you your bowel movement
456           be regular,
457           (0.4)
458    P      (is this)?
459    PR     the fi↑ber
460    P      yeah.
461    PR     psy↑llium
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 of↓ten
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
```

```
1142          [like week or something,]
1143    P     [ oh   no!   i  ne  ver ] do that.
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),[15] 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

[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).[16] 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).

[16]A 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
969			past charts.
970			(0.6)
971	→	PR	i'm wondering if you:,
972			(1.3)
973			you know,
974			(1.9)
975		PR	before the whole colonoscopy,
976			(1.4)
977		PR	thing. mandy were you feeling,
978			(0.8)
979		PR	you know extra stress about any particular event?
980		P	we:ll,
981			(0.9)
982	→	P	you know with my son and all that stuff [uh,]
983		PR	((looking at P and nodding)) [o]kay, okay,
984		P	and, i don't know i think: you know it's getting closer now to:
985			(.) gonna be a year of my husband's death and i don't know, i
986			think about that more often now.
987		PR	((shaking head)) that is,
988			(0.6)
989		PR	[tha-]
990		P	[in] fact i was in church saturday. and this lady got sick in
991			church and: oh i just felt like crying. and i j- just hoped that
992			she wasn't gonna, (.) collapse.
993		PR	yes:,
994		P	so they just took her out of church but,
995			(0.8)
996		P	[i] was so upset.=
997		PR	[yeah,]
998		P	=you [know?]
999		PR	[yeah,] yeah,
1000		P	and those things bother you every once in a while.
1001		PR	sure!
1002		P	[uh huh.]
1003	→	PR	[and you] know the anniversary especially the first anniversary,
1004		P	u:h,
1005		PR	[is]
1006		P	[i] ↓know
1007		PR	known to be very tough.
1008		P	uh,
1009	→	PR	you know but this is, (1.0) i mean the whole year you've been
1010			working on,
1011			(.)

```
1012   PR     getting on, with days and [you] know,=
1013   P                                [uh,]
1014   PR     =just functioning and getting out and,
1015   P      right,
1016   PR     but i mean that that anniversary, you know,
1017          (.)
1018   PR     it sends things ↑flooding ↓ba:ck and it's,
1019   P      right,=
1020  →PR     =i think it's inevitable! so i [ i ]
1021   P                                    [uh,]
1022  →PR     i think you're absolutely right that,=
1023   P      =uh,
1024          (.)
1025   PR     you know? that could in fact,
1026   P      yeah.
1027   PR     be (slb slb) just being upset over your son, having all these
1028          feelings come back, you know, [  a   ]bout your husband,
1029   P                                   [right,]
1030          ((7 seconds missing from tape))
1031  →PR     a tough time.
1032   P      uh,
1033   PR     defini[tely.]
1034   P            [ but ] today is my son's birthday the one that died.
1035   PR     o::h,
1036   P      [he would have been for  ty   four.]
1037   PR     [oh it's  this the  son you're ↑tal]king a↓bout
1038   P      well but this is my other son.
1039   PR     oh o[kay.]
1040   P          [ i  ] mean,
1041   PR     because [you have ]
1042   P              [you know,]
1043   PR     a living that's going through some,
1044   P      yeah he had the, (.) he broke his back.
1045   PR     ri:ght.
1046   P      and,
1047  →PR     right oh boy![ so, ]
1048   P                   [yeah,]
1049   PR     right now [is,]
1050   P               [so,]
1051  →PR     there's a [ lot ] of stuff.
1052   P               [yeah,]
```

(UBNMC, INT8-11.18.03).

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.[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 "okays" (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
1055          (.) one catastrophe after another. [hhh hhh]
1056   SC                                        [uh huh,] uh huh,=
1057   P      =(hh)and he just, (0.5) he finally moved in there last month but:
1058          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          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
1071          in the process of fixing the house .hh and what happened was the
1072          roof wet and a leak right in the bedroom and ruined the
1073          furni[ture,]
```

```
1074   PR          [ tzt ]
1075   P      and [the] rugs and,=
1076   SC         [oh!]
1077  →PR     =oh god [man]dy that's,
1078   P              [hu ]
1079           (.)
1080   P       [  hu  ]
1081  →PR     [that's] ↓terrible
1082   P       i know. isn't ↑it
1083   PR      [yeah,]
1084   P       [  i  ] think it [ was ] just,
1085   PR                       [yeah,]
1086           (0.7)
1087   P       (part) of the things that were happening and i, s- oh my ↓go:sh
1088   PR      ye:ah, [yeah,]
1089   P             [ you ] know?
1090           (1.0)
1091   PR      [(slb)]
1092   P       [  i  ] mean there's nothing i can do about it, [  but  ]
1093   PR                                                      [ri:ght.]
1094   P       i mean it just,
1095           (0.7)
1096   P       you know really upsets you. [you know?]
1097   PR                                  [of  cour ]se! of course yeah. now do
1098           you have someone that you can? i remember you said that you and i
1099           think  your sister and a friend met,
1100           (0.8)
1101   PR      to pray.
1102   P       yeah,
```

(UBNMC, INT8-11.18.03).

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*.[18] 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

[18] On the various uses of laughter see Jefferson (1979; 1985), Jefferson et al. (1987), and Glenn (1995).

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
1118          can share with [ you ] know?=
1119 →PR                    [good.]
1120   PR     =good.=
1121   P      =so,=
1122 →PR      =that's so important. i'm glad [you] have that. [yeah.]
1123   P                                    [uh,]            [ uh, ]
1124          (.)
1125   PR     o[kay.]
1126   P       [pat ] my friend called me from arizona, ha ha she hasn't called
1127          me in a while and i [unloa]ded on her.=
1128   PR                         [o::h,]          =oh oh!
1129   P                 [ha  ha ha ha ha   ha    ha .hhh]
1130   PR     ((smiling)) [you unloaded i thought you were] gonna say she[gave]=
1131   P                                                                [ ha ]=
1132   PR     =me bad news.
1133   SC     hhha
1134   P      no:!
1135   SC     hh
1136   P      no she had good news. she's been having a house built she's gonna
1137          be moving in a few weeks [but,]
1138   PR                             [ oh,]
1139   P      ha ha ha ha [ha .hhh]
1140   PR                 [o  kay.]
1141   P      but i unloaded on her. .hhh ha [ ha   ha]
```

```
1142   PR                                      [well you] know ↑what
1143   P       [.hhh]
1144   PR      [  i ] mean,
1145   P       ha
1146 →PR       that's what good friends [are are ] [there] [for.]
1147   P                                [ ha  ha ] [ ha  ]
1148   SC                                          [ uh  ] [huh.]
1149   PR      they [ un   der    stand,]
1150   P            [well we're friends ] from grammar school [days.]
1151   PR                                                     [ oh! ]
1152   SC                                                     [ oh! ]
1153   PR      so that's [(given) ha ha ha] [ha .hhh] [  ha  ]
1154   SC                [uh huh  ha ha ha] [ha .hhh] [  ha  ] [ha ]
1155   P                 [ha  ha  ha ha ha]           [that's] [how] long we
1156           know each other. ha [  ha  ]
1157   PR                         [right,] right, it's good [to ]
1158   P                                                    [er,]
1159 →PR       have i know friends from childhood. i mean who knows you
1160           better? [right?]
1161   P               [  uh, ]
```

(UBNMC, INT8-11.18.03).

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 *time-out* leaving aside troubles-talk proper for a moment and engaging in 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]
```

1203 P [uh,]
1204 PR so you aware that i, [that]
1205 P [uh,]
1206 PR you know it's probably important
1207 (.)
1208 →PR now really [im]portant now=
1209 P [yeah,]
1210 PR =because, (0.4)
1211 P uh, yeah well, i have .hhh lot of different things coming up
1212 especially with christmas [now.]
1213 SC [uh] huh,
1214 PR right, right,
1215 P you know?
1216 →PR okay [good. that's good]
1217 P [coz i be]long to the auxiliary there [and now,]
1218 SC [uh huh.]
1219 P and they're gonna have a christmas party, and then the
1220 organization's gonna have a christmas party, .hhh which,
1221 (1.1)
1222 P kind of be kind of funny, because it's (0.4) .hhh actually the
1223 twentieth (0.8) it will be on the twentieth and my husband died on
1224 the twenty first and that's where he died but,
1225 →PR o:h! [o:h!]
1226 P [ha] ha ha [but,]
1227 →PR [so] that may be a little,
1228 P u:h,=
1229 PR =emotional? [for you.]
1230 P [↑ye↓ah] but,
1231 SC [(just think)]
1232 P [i think:] i'll get through it.
1233 SC yeah.
1234 P ha ha
1235 PR yeah.
1236 →SC and you will get through it.
1237 P uh,
1238 →SC you're doing very well.
1239 P [uh,]
1240 →SC [and] just continue surrounding yourself [with peo]ple=
1241 PR [uh huh,]
1242 SC =who love and support you.
1243 P yeah.
1244 →SC that is the best thing you can do.
1245 and knowing [that] you're gonna get through all of this.
1246 P [uh,]
1247 PR [uh huh.]

1248 P   [uh huh,]
1249 PR   yes.
1250 →SC   life goes on.

(UBNMC, INT8-11.18.03).

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!]
```

1283 →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 [°ohhh°!]
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 →P [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 [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 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?

1328 P [o kay.]
1329 PR [to see] how you're doing,
(UBNMC, INT8-11.18.03).

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 tat 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 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 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 weel 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           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.]
```

```
322    P                    [ha]                 [ ha  ] ha ha ha ha ha ha
323    PR     [tzt] well no you have [this er] you know,=
324    P      [ha ]                  [.hhh ha]
325    PR     =array [of  of com]plaints and different things .hhh=
326    P             [.hhh ha hh]
327    PR     =normally what we try to do: (well) sometimes we do is start with
328           the most pressing to you that will improve your quality of life .h
329    P      [hhh]
330    PR     [and] then start to address some of these deeper issues here
331 →         (.) tzt what's erm? (.) what do you think is the most pressing
332           right now?
333    P      well probab- i think i'd pull both now i don't know if there is
334           (.) if it is the mercury [fillings] we can fix=
335    PR                              [uh  huh,]
336    P      the neuropathy if the neuropathy is due to a back thing=
337    PR     =uh huh,=
338    P      =then i- we you can't.
339    PR     okay. o[kay.]
340    P             [.hh ] erm it's the depression [i can't] take the=
341    PR                                           [o  kay.]
342    P      =depression. [you know,]
343    PR                  [o    kay.]
344    P      erm [this is   not ] fun.
345    PR         [when when did,]
346           (.)
347    PR     when did most of the symptoms (.) begin? let's start with the
348           depression a:nd thee: low back.
349    P      .hhh
350    PR     no let's start [with] the low back.[°the  neuropathy°.]
351    P                     [well]              [well low low back,]
352           erm at twenty one when i was (nurse) four months and i did erm
353           rupture a disc.
```

(UBNMC, INT13-11.21.03).

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)
```

```
664    PR     okay. how old is she.
665    P      she's thirteen.
666           (0.8)
667    PR     okay where did you grow up by the way around here,
668           [o:r,]
669    P      [yeah] hartford connecticut.
670    PR     okay.
671           (1.0)
672 → PR      tzt .hh right, erm okay. i'm gonna ask you a little bit
673           about your diet,
674    P      uh huh.
675 → PR      so:, which erm if am i wrong to think that's probably what you
676           want advice with? to[day? ]
677    P              ((nodding)) [yeah.]
678    PR     [yeah.]
679    P      [ pre ]tty much.
680    PR     yeah.=
681    P      =yeah.=
682    PR     =i mean i want to get some information on your asthma and eczema,
683           coz we can help you with ↑that
684    P      [ o kay.]
685    PR     [but the] diet is the first thing that we'll start so that's
686           [where you] wanna start?=
687    P      [  o kay. ] ((nodding)) =okay.
688    PR     that's a good idea. .hh erm so what do you eat for breakfast
689           usually?
690    P      he hee depend like erm i did, i did have some cereal cereal this
691           morning.
692    PR     [okay,]
693    P      [but i] know me. i'm just like i'm i'm just traditional, you know
694           pancakes and sausage, and all that other stuff. [and that,]
695    PR                                                    [ o  kay. ]
696    P      but i eat cereal. but ever since they told me that i try to eat
697           some other thing, i eat some erm what they call it oatmeal bread
698           cereal?
699    PR     uh huh.
700    P      it's not sweet but a little little sweet. [with]
701    PR                                              [ uh.]
702    P      raisins in it.
703    PR     uh huh.
704 → P      i don't know in so i tried that but you know?
705    PR     uh,
706    P      i don't know much [about]
707    PR                       [okay.]
708 → P      dieting and i'm not an expert on dieting.=
```

```
709    PR     =okay okay. well we are. [ so  ]
710    P                               [yeah.]
711    PR     we're gonna help you. erm okay so pancakes and sausage,
```

(UBNMC, INT6-11.12.03).

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").[2]

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:

[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	[e:rm] 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

```
614          responsibility. that's, you know we really encourage people to be
615          in charge of their own health.
616    P     yeah.
617    PR    you know that's part of the whole, difference in philosophy in
618          alternative [versus ] conventional medi↑cine=
619    P                 [uh huh,]
620    PR    =you know they, they erm in conventional medicine they don't
621          really encourage people to be very active about their own health.
622          but we do.
623    P     yeah.
624 → PR     so, that's great. that you already are. .hh but i'm not gonna i'm
625          gonna kind of change topics coz i don't wanna, tzt spend too much
626          time on this. coz erm what we probably will focus on today in this
627          visit is talking about your diet.
628    P     uh huh.
629 → PR     erm and your lifestyle factors. and especially it sounds like you
630          wanted some advice. with diet.
631    P     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".

naturopathic approach and its allopathic counterpart (ll. 614-22).[5] 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 monday.
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)°]
```

```
261 → PR            [  and what do  ] you think about that? do you think you
262          can never get rid of it? do you believe ↑it
263    P     oh! i don't know.
264    PR    [yeah,]
265    P     [ er  ] if it stays like this it's fine!
266    PR    yeah.
267    P     [you know?]
268    PR    [ .hh  so ] he wanted you to continue the (slb slb slb),
269          (1.2)
270    PR    [right?]
271    P     [  he  ] he he (0.3) he did (i got enough) probably fo:r end of
272          december.
273    PR    uh hu.
274    P     erm (0.9) and then we're gonna let it go, coz i think it's (0.5)
275          february fourth. (0.3) i go back for colonoscopy.
276          (0.7)
277    PR    okay.
278          (0.5)
279    P     he said that he wants to check because ts-(.) colitis is the
280          closest thing to cancer,
281    PR    uh huh,
282    P     (definitely) you can get.
283    PR    ok(h)ay.
284    P     erm he wants to see how it has been, it'll be two years,
285          (0.8)
286    PR    okay,=
287    P     =erm
288          ((PR looking at P's chart)) (2.4)
289    P     the only reason it went to february they wanna er er (0.4) right
290          after the holidays,
291          (0.7)
292    P     it i insisted on the first appointment in the morning.
```

(UBNMC, INT10-11.19.03).

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

another medical encounter.[6] 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).[7] 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.[8] 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

[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 <u>you</u> to check it when you get home, a:nd erm
1872		actually i'd like you to give me a <u>call</u>. and let me know. (.)
1873	P	[here?]
1874	SD	[if] it's gone down. uh huh. tzt you can call erm, let me find
1875		out what extension this i- cause i don't have my extension any
1876		more. so erm actually i'm gonna call you tonight. that'll work
1877		out, that'll be easier.
1878	P	okay.
1879	SD	okay?. h and then we'll decide how to proceed.
1880	P	yeah.
1881	SD	okay?
1882	→P	yeah well it's erm that i- erm we've had erm a couple of very
1883		bad days with of course you know, two those yesterdays affect me
1884		today.=
1885	SD	=right, exactly .hh but er i don't wanna you know we talked
1886		[a bout this,]
1887	P	[you're getting] nervous.
1888	SD	well i don't want there to be something catastrophic to happen,
1889	P	yeah.
1890	SD	and you know we,
1891	P	yeah.
1892	SD	and: i it would just make everything worse.
1893	P	yeah.
1894	SD	okay?
1895	→P	well i b- i: but i it's so is she? and i wanted to talk to you
1896		about that ↑any↓way because she wakes up,
1897		(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)) .hhhhhhhh
1933   P      erm i know. okay i will.
1934   SD     ((breathing out)) pfhhhhhhh
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 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),[9] 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),[10] 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).[11] 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,

[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.

1987: 79-80) "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).[13] 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.[14] 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).[15]

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.[16] 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

[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 excercises).
[15] Note the instance of baby talk in line 1940 ("alrighty"). Cf. Snow and Ferguson (1977).
[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    P     ((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, 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

```
109   P     i was working on, looking at myself.
110         (1.1)
111   P     and (look) just,
112         (0.9)
113   P     straight at me and trying to: (.) visualize that,
114         (2.5)
115   P     erm impression of myself to be,
116         (0.4)
117   P     better.
118   PR    uh huh.
119   P     erm
120         (0.8)
121   P     and i think i: got there. °almost there°.
122   PR    good.
```

```
123          (0.7)
124    PR    good.
125          (0.4)
126    PR    good.
127          (1.3)
128    PR    that's (0.5) er if you especially if you've never done it
129          be↑fore takes (slb slb than) anything else.
130    P     uh,
131    PR    but incredibly powerful. so powerful.
132          (0.7)
133    PR    i mean you need to get where you wanna be with your body.
134          where your body can actually have [some ]thing=
135    P                                       [yeah,]
136    PR    =to (slb ) for.
137          (0.5)
138    PR    it it it's really that simple.
139    P     uh,
140    PR    the mind is the most powerful thing. coz it will (slb slb)
141          like fifty percent when you get body er er anybody any
142          medication.
143          (0.8)
144    PR    so,
145          (1.2)
146 →  PR    keep working an an and you know! you don't need to spend (slb slb
147          at it) you just spend some time at it. (.) and getting exactly
148          where  you wanna be. how you wanna look. and play that movie!
149          press play.
150 →        (0.8)
151    PR    how you wanna stand.
152 →        (0.7)
153    PR    and finally how you wanna present yourself.
154 →        (1.0)
155    PR    all that if you want is all connected.
156    P     °uh°,
157    PR    so keep keep definitely keep working on that.
158 →        (0.9)
159    PR    erm have you bee able to:: do any kind of exercise?
```

(UBNMC, INT7-11.14.03).

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.

246 P [i'm not] having problems with any of the positions
247 except for:,
248 (0.5)
249 P tzt something called the tripod? not tripod, .h it's where
250 it's a hand balance you're basically,
251 (0.6)
252 P [ba]lancing on the hands with=
253 PR [yeah,]
254 P =your knees on the back of your elbows?
255 PR gotcha.
256 P and we've only tried that once a long time ago. and i don't
257 know you know at this point if i can try again. but she
258 suggested not [↓to hu]
259 PR [do you?] do you do is it something that you
260 would like to do?
261 P yoga?
262 PR that pos- that particular,
263 P tzt position.
264 PR position.
265 P .hh i think at this point because i was unable to do it
266 susses- successfully in my eyes the first time,
267 PR uh huh,
268 P that it's i'm i'm eager to try it again.
269 PR [great!]
270 P [to] see if i can get there.
271 (0.9)
272 P a:nd,
273 (1.1)
274 P mentally ((PR nods)) i know what i have to do and how i
275 (0.7)
276 P can do ↓it and i see myself in the position? .h er even if
277 it's for a couple of seconds,
278 PR [uh huh.]
279 P [(slb slb] slb) out there? but erm,
280 (1.0)
281 P and i don't wanna hurt myself either. so i'm not trying any
282 of the,
283 PR yeah,
284 P very difficult positions
285 PR [uh huh.]
286 P [outside] of class.
287 → (2.0)
288 PR good.
289 (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
319         slb slb slb) and decided i wanted to run a marathon.
320         (0.8)
321   PR    that meant nothing to other people.
322         (0.5)
323   PR    for me it meant the world.
324   P     °right°.
325         (0.8)
326   PR    and i kept >running running running running< and i (slb slb
327         slb slb slb slb slb slb).
328         (0.6)
329   PR    and this summer i i (thought get out of here i won i won a
330 →       cool marathon) the point in being is that things like that
331         (1.0)
332   PR    fill your spirit so much, this is a spiritual exercise.
333   P     uh,
334         (0.6)
335   PR    and physical obviously but mostly spiri- spiritual. coz
336         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)
```

342 PR and you don't get that feeling every day.
343 (1.0)
344 PR you know? you don't get that feeling every day you only get
345 those feelings like every now and then.
346 P right.
347 → PR you know that feeling of accomplishment i had a friend who
348 just ran the new york city marathon. she did it in four
349 hours and about twenty minutes.
350 (1.0)
351 PR she she was high. [she]
352 P [uh,]
353 PR was she was high.
354 P °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

355 PR because she did something that really not everybody in the

```
356          world could do or everybody could do but er they don't.
357          (1.4)
358    PR    so you know,
359          (0.3)
360    PR    if that's one of the things that you personally wanna do,
361          (0.4)
362    PR    and you can't,
363          (0.4)
364    PR    and along with with with your weight loss program, probably
365          when you start with losing just a few pounds, you're
366          [go ]nna=
367    P     [uh,]
368    PR    =be able to do that
369    P     =uh,
370    PR    position. coz,
371    P     uh huh.
372    PR    you know, [pro-]
373    P                [ e  ]xactly.
374    PR    right?=
375 → P      =well that's the thing! she said that my mental block of
376          course was there's no way i'm getting this,
377          (0.5)
378    P     hhh .hhh myself into that position,
379    PR    right.
380    P     w- with as heavy as i am.
381    PR    right.
382    P     erm
383          (0.4)
384    P     but,
385          (0.4)
386    P     she dismissed the, er she i didn't even vo- ver- vocalize it
387          but she said,
388          (0.6)
389    P     erm
390          (1.8)
391    P     i don't know. (.) maybe felt that i was thinking it, or
392    PR    [uh huh,]
393    P     [because] i may have seen str- pressure that i couldn't get
394          into this (slb tion),
395    PR    uh huh,
396    P     erm
397          (0.5)
398    P     just stated that it wasn't,
399          (1.6)
400    P     you know, there is no reason you can't get into it
```

```
401          regardless of your size regardless of your,
402          (0.7)
403    P     stature height whatever. .hh you should be able to get into
404          it if you want to. and you know just working on the lower
405          belly, and the muscles are a little weak down there, i'm not
406          doing any push up chair or sit ups right now. but erm,
407          (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)
```

```
420    PR     that erm a hot feeling like (slb slb slb). and a hot feeling!
421    P      uh huh.
422    PR     like i can that feeling is an amazing feeling,
423           (1.5)
424    PR     and you know er er and you're gonna definitely feel that
425           when you get to your erm the point where you wanna be as
426           far as er your body composition.
427           (1.0)
428 → PR     (slb slb) amazing. so certainly you got some things you
429           gotta you gotta keep working on it mentally. and certainly
430           physically but more so mentally.
431    P      uh huh,
```

(UBNMC, INT7-11.14.03).

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.").[18] 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

[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.

4.5),[2] 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).[3] 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

[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",[4] 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.

[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).[5]

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 heathcare delivery of a patient-centred approach that places communication at the heart of the medical practice.

[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

Ainsworth-Vaughn, N., 2001. "The Discourse of Medical Encounters". Schiffrin et al. 2001. 453-69.

Aldrich, C., 1999. *The Medical Interview: Gateway to the Doctor-Patient Relationship.* New York: Pantheon.

Armstrong, D., 1984. "The Patient's View". *Social Science and Medicine* 18(9): 737-44.

Aston, G., 1988. *Learning Comity*. Bologna: CLUEB.

Atkinson, J.M., 1999. "Medical Discourse, Evidentiality and the Construction of Professional Responsibility". Sarangi & Roberts 1999a. 75-107.

Atkinson, J.M., 2004. "The Discursive Construction of Competence and Responsibility in Medical Collegial Talk". *Communication & Medicine* 1(1): 13-23.

Atkinson, J.M. and Drew, P. (eds.), 1979. *Order in Court: The Organisation of Verbal Interaction in Judicial Settings.* London: Macmillian.

Atkinson, J. M. and Heath, C. (eds.), 1981. *Medical Work: Realities and Routines*. Aldershot: Gower.

Atkinson, J. M. and Heritage, J.C. (eds.), 1984. *Structures of Social Action. Studies in Conversation Analysis.* Cambridge: Cambridge University Press.

Auer, P., 1992. "Introduction: John Gumperz' Approach to Contextualization". Auer & di Luzio 1992. 1-37.

Auer, P. and di Luzio, A. (eds.), 1992. *The Contextualization of Language*. Amsterdam and Philadelphia (PA): John Benjamins.

Austin, J.L., 1962. *How To Do Things With Words.* Oxford: Clarendon Press.

Balint, M., 1964. *The Doctor, his Patient and the Illness.* London: Pitman.

Beach, W.A., 1995. "Preserving and Constraining Options: 'Okays' and 'Official' Priorities in Medical Interviews". Morris & Chenail 1995. 259-89.

Beach, W.A., 2001. "Introduction: Diagnosing 'Lay Diagnosis'". Sarangi & Wilson 2001. 13-18.

Beach, W.A. and Metzger, T.R., 1997. "Claiming Insufficient Knowledge". *Human Communication Research* 23(4): 562-88.

Beckman, H. B. and Frankel, R.M., 1984. "The Effect of Physician Behavior on the Collection of Data". *Annals of Internal Medicine* 101: 692-96.

Bercelli, F., Leonardi, P. and Viaro, M., 1999. *Cornici Terapeutiche. Applicazioni Cliniche di Analisi dell'Interazione Verbale*. Milano: Raffaello Cortina Editore.

Bercelli, F., Rossano, F. and Viaro, M., 2005. "Patients' Storytellings as Responses to Therapists' Elaborations". Paper presented at the ninth International Pragmatics Conference, Riva del Garda, 10-15 July 2005.

Boden, D. and Zimmerman, D.H. (eds.), 1991. *Talk and Social Structure*. Cambridge: Polity Press.

Bowman, M.A., Herndon, A, Sharp, P.C. and Dignan, M.B., 1992. "Assessment of the Patient-Doctor Interaction Scale for Measuring Patient Satisfaction". *Patient Education Counseling* 19: 75-80.

Button, G., 1992. "Answers as Interactional Products: Two Sequential Practices Used in Interviews" Drew & Heritage 1992a. 212-34.

Button, G. and Casey, N., 1984. "Generating Topic: The Use of Topic Initial Elicitors". Atkinson & Heritage 1984. 167-90.

Button, G. and Lee, J.R.E. (eds.), 1987. *Talk and Social Organisation.* Clevedon: Multilingual Matters.

Byrne, P. and Long, B., 1976. *Doctors Talking to Patients.* London: DHSS.

Caffi, C., 1999. "On Mitigation". *Journal of Pragmatics* 31 (7): 881-909.

Caffi, C., 2001. *La Mitigazione. Un Approccio Pragmatico alla Comunicazione nei Contesti Terapeutici.* Münster, Hamburg and London: LIT Verlag.

Caffi, C. and Janney, R.W., 1994. "Toward a Pragmatics of Emotive Communication". *Journal of Pragmatics* 22 (3/4): 325-73.

Candlin, C.N., 2003. "Complex Ethical Challenges to Reflexive Accounts in Discourse Analysis". Lecture given at the first COMET Conference, Cardiff, 26-28 June 2003.

Candlin, C.N., 2004. "Constructing Concordance – Discursive and Ethical Aspects of Compliance in Medical Settings". Lecture given at the second COMET Conference, Linköping, 3-5 June 2004.

Cicourel, A.V., 1973. *Cognitive Sociology.* Harmondsworth: Penguin.

Cicourel, A.V., 1985. "Doctor-Patient Discourse". In *Handbook of Discourse Analysis. Vol. 4: Discourse Analysis in Society*, T.A. van Dijk (ed.), 193-202. London: Academic Press.

Cicourel, A.V., 1992. "The Interpenetration of Communicative Contexts: Examples from Medical Encounters". Duranti & Goodwin 1992. 291-310.

Cicourel, A.V., 1993 [1983]. "Hearing is Not Believing: Language and the Structure of Belief in Medical Communication". Todd & Fisher 1993 [1983]. 49-66.

Cicourel, A.V., 1999. "The Interaction of Cognitive and Cultural Models in Health Care Delivery". Sarangi & Roberts 1999a. 183-224.

Cicourel, A.V., 2004. “Cognitive Overload and Communication in Two Healthcare Settings”. *Communication & Medicine* 1(1): 35-43.

Clayman, S.E., 1992. “Footing in the Achievement of Neutrality: The Case of News-Interview Discourse”. Drew & Heritage 1992a. 163-98.

Clayman, S.E. and Maynard, D.W., 1995. “Ethnomethodology and Conversation Analysis”. ten Have & Psathas 1995. 1-30.

Coulehan, J.L. and Block, M.R., 2001. *The Medical Interview. Mastering Skills for Clinical Practice.* Philadelphia (PA): F.A. Davis Company.

Coulthard, M. and Brazil, D., 1982. “The Place of Intonation in the Description of Interaction”. Tannen 1982. 94-112.

Coupland, J. (ed.), 2000a. *Small Talk*. Harlow: Pearson Education.

Coupland, J., 2000b. “Introduction: Sociolinguistic Perspectives on Small Talk”. Coupland 2000a. 1-25.

Dascal, M. (ed.), 1999. *Misunderstanding*. *Journal of Pragmatics* 31 (Special Issue).

Davidson, J., 1984. “Subsequent Versions of Invitations, Offers, Requests, and Proposals Dealing with Potential or Actual Rejection”. Atkinson & Heritage 1984. 102-28.

Davis, K., 1993 [1983]. “Nice Doctors and Invisible Patients: The Problem of Power in Feminist Common Sense”. Todd & Fisher 1993 [1983]. 243-65.

Davis, M.S., 1968. “Variations in Patients’ Compliance with Doctors’ Advice: An Empirical Analysis of Patterns of Communication”. *American Journal of Public Health* 58: 274-88.

Davis Wills, D., 1977. “Participant Deixis in English and Baby Talk”. Snow & Ferguson 977. 271-95.

Dijk, T.A. van, 1985. *Handbook of Discourse Analysis. Volume 3: Discourse and Dialogue*. London: Academic Press.

Drew, P., 1991. “Asymmetries of Knowledge in Conversational Interactions”. In *Asymmetries in Dialogue*, I. Markova & K. Foppa (eds.), 21-48. Hemel Hempstead: Harvester Wheatsheaf.

Drew, P., 2001. “Spotlight on the Patient”. Sarangi & Wilson 2001. 261-68.

Drew, P. and Heritage, J.C. (eds.), 1992a. *Talk at Work. Interaction in Institutional Settings*. Cambridge: Cambridge University Press.

Drew, P. and Heritage, J.C., 1992b. “Analyzing Talk at Work: An Introduction”. Drew & Heritage 1992a. 3-65.

Drew, P. and Sorjonen, M.-L., 1997. “Institutional Dialogue”. In *Discourse as Social Interaction.* Discourse Studies 2, T. A. Van Dijk (ed.), 92-118. London, Thousand Oaks and New Delhi: Sage.

Duranti, A. and Goodwin, C. (eds.), 1992. *Rethinking Context.* Cambridge: Cambridge University Press.

Egbert, M.M., 1997. "Schisming: The Collaborative Transformation from a Single Conversation to Multiple Conversations". *Research on Language and Social Interaction* 30(1):1-51.

Engel, G.E., 1977. "The Need for a New Medical Model: A Challenge for Biomedicine". *Science* 196: 129-36.

Erickson, F., 1999. "Appropriation of Voice and Presentation of Self as a Fellow Physician: Aspects of a Discourse of Apprenticeship in Medicine". Sarangi & Roberts 1999a. 109-43.

Fairclough, N., 2001. "Critical Discourse Analysis". McHoul & Rapley 2001. 25-38.

Fasulo, A. and Zucchermaglio, C., 2005. "Working Narratives: Time Frame, Activity and Participation". Paper presented at the ninth International Pragmatics Conference, Riva del Garda, 10-15 July 2005.

Fele, G., 1991. *L'Insorgere del Conflitto: Uno Studio sull'Organizzazione Sociale del Disaccordo nella Conversazione.* Milano: Franco Angeli.

Ferguson, C.A., 1977. "Baby Talk as a Simplified Register". Snow & Ferguson, 1977. 209-35.

Fisher, S., 1984. "Institutional Authority and the Structure of Discourse". Frankel 1984a. 201-24.

Fisher, S. 1993 [1983]a. "Doctor Talk/Patient Talk: How Treatment Decisions are Negotiated in Doctor-Patient Communication". Todd & Fisher 1993 [1983]. 161-82.

Fisher, S. 1993 [1983]b. "Reflections on Gender, Power, and Discourse". Todd & Fisher 1993 [1983]. 287-99.

Fleischman, S., 2001. "Language and Medicine". Schiffrin et al., 2001. 470-502.

Foucault, M., 1973. *The Birth of the Clinic.* London: Tavistock.

Frankel, R.M. (ed.), 1984a. *Physicians and Patients in Social Interaction: Medical Encounters as a Discourse Process*. *Discourse Processes* 7 (Special Issue).

Frankel, R.M., 1984b. "Editor's Introduction". Frankel 1984a. 103-5.

Frankel, R.M., 1984c. "From Sentence to Sequence: Understanding the Medical Encounter through Micro-Interactional Analysis". Frankel 1984a. 135-70.

Frankel, R.M., 1990. "Talking in Interviews: A Dispreference for Patient-Initiated Questions in Physicians-Patient Encounters". Psathas 1990a. 231-62.

Frankel, R.M., 1993 [1983]. "The Laying on of Hands: Aspects of the Organization of Gaze, Touch, and Talk in a Medical encounter". Todd & Fisher 1993 [1983]. 71-105.

Frankel, R.M., 1995. "Some Answers about Questions in Clinical Interviews". Morris & Chenail 1995. 233-57.

Frankel, R.M., 2001. "Clinical Care and Conversational Contingencies: The Role of Patients' Self-Diagnosis in Medical Encounters". Sarangi & Wilson 2001. 83-111.

Gardner, R., 1997. “The Conversation Object *Mm*: A Weak and Variable Acknowledging Token”. *Research on Language and Social Interaction* 30(2): 131-56.

Garfinkel, H., 1967. *Studies in Ethnomethodology.* Englewood Cliffs (NJ): Prentice-Hall.

Gavioli, L. and Mansfield, G., 1990. *The PIXI Corpora: Bookshop Encounters in English and Italian*. Bologna: CLUEB.

Giarelli, G., Good, B.J., Del Vecchio Good, M.-J., Martini, M. and Ruozi, C. (eds.), 2005. *Storie di Cura. Medicina Narrativa e Medicina delle Evidenze: L’Integrazione Possibile*. Milano: Franco Angeli.

Gill, V.T., 1998. “Doing Attributions in Medical Interaction: Patients’ Explanations for Illness and Doctors’ Responses”. *Social Psychology Quarterly* 61: 322-60.

Gill, V.T. and Maynard, D.W., forthcoming. “Explaining Illness: Patients’ Proposals and Physicians’ Responses”. Heritage & Maynard forthcoming.

Gill, V.T., Halkowski, T. and Roberts, F., 2001. “Accomplishing a Request without Making One: A Single Case Analysis of a Primary Care Visit”. Sarangi & Wilson 2001. 55-81.

Glenn, P.J., 1995. “Laughing *at* and laughing *with*: Negotiation of Participant Alignments through Conversational Laughter”. ten Have & Psathas 1995. 43-56.

Goffman, E., 1967. *Interaction Ritual. Essays on Face-to-face Behavior*. New York: Pantheon Books.

Goffman, E., 1974. *Frame Analysis.* New York: Harper and Row.

Goffman, E., 1981. *Forms of Talk*. Oxford: Blackwell.

Goldman-Eisler, F., 1958. “Speech Production and the Predictability of Words in Context”. *Quarterly Journal of Experimental Psychology* 10: 96-104.

Goodwin, C., 1980. “Restarts, Pauses, and the Achievement of a State of Mutual Gaze at Turn-Beginning”. *Sociological Inquiry* 50: 272-302.

Goodwin, C., 1992. “Assessments and the Construction of Context”. Duranti & Goodwin 1992. 151-89.

Goodwin, C. and Goodwin, M.H., 1992. “Assessments and the Construction of Context”. Duranti & Goodwin 1992. 147-89.

Grice, H.P., 1975. “Logic and Conversation”. In *Syntax and Semantics. Vol. 3: Speech Acts*, P. Cole & J. Morgan (eds.), 41-58. New York: Academic Press.

Gumperz, J.J., 1982. *Discourse Strategies.* Cambridge: Cambridge University Press.

Gumperz, J.J., 1992a. “Contextualization and Understanding”. Duranti & Goodwin 1992. 229-52.

Gumperz, J.J., 1992b. “Contextualization Revisited”. Auer & di Luzio 1992. 39-53.

Gumperz, J.J. and Hymes, D. (eds.), 1972. *Directions in Sociolinguistics: The Ethnography of Communication.* New York: Holt, Rinehart and Winston.

Haakana, M., 2001. "Laughter as a Patient's Resource: Dealing with Delicate Aspects of Medical Interaction". Sarangi & Wilson 2001. 187-219.

Haberland, H. and Mey, J.L., 1981. "Wording and Warding: The Pragmatics of Therapeutical Conversation". In *Wording and Warding*, H. Haberland and J.L. Mey (eds.), 103-11. *Journal of Pragmatics* 5 (Special Issue).

Hahn, S.R. and Kroenke, K., 1996. "The Difficult Patient: Prevalence Psychopathology and Functional Impairment". *Journal of General Internal Medicine* 11: 1-8.

Halkowski, T., forthcoming. "Realizing the Illness: Patients' Narratives of Symptom Discovery". Heritage & Maynard forthcoming.

Have, P. ten, 1989. "The Consultation as a Genre". In *Text and Talk as Social Practice*, B. Torode (ed.), 115-35. Dordrecht & Providence (RI): Foris Publications.

Have, P. ten, 1991. "Talk and Institution: A Reconsideration of the 'Asymmetry' of Doctor-Patient Interaction". Boden & Zimmerman 1991. 138-63.

Have, P. ten, 1995. "Medical Ethnomethodology: An Overview". *Human Studies* 18: 245-61.

Have, P. ten, 1999. *Doing Conversation Analysis*. London, Thousand Oaks (CA) and New Delhi: Sage.

Have, P. ten, 2001a. "Applied Conversation Analysis". McHoul & Rapley 2001. 3-11.

Have, P. ten, 2001b. "Lay Diagnosis in Interaction". Sarangi & Wilson 2001. 251-60.

Have, P. ten and Psathas, G. (eds.), 1995. *Situated Order: Studies in the Social Organization of Talk and Embodied Activities.* Washington (DC): University Press of America.

Heath, C., 1981. "The Opening Sequence in Doctor-Patient Interaction". Atkinson & Heath 1981. 71-90.

Heath, C., 1984. "Talk and Recipiency: Sequential Organization in Speech and Body Movement". Atkinson & Heritage 1984. 247-65.

Heath, C., 1992a. "The Delivery and Reception of Diagnosis in the General-Practice Consultation". Drew & Heritage 1992a. 235-67.

Heath, C., 1992b. "Gesture's Discreet Tasks: Multiple Relevancies in Visual Conduct and in the Contextualisation of Language". Auer & di Luzio 1992. 101-27.

Heath, C., 1997. "The Analysis of Activities in Face to Face Interaction Using Video". Silverman 1997. 183-200.

Heritage, J.C., 1984. "A Change-of-State Token and Aspects of its Sequential Placement. Atkinson & Heritage 1984. 299-345.

Heritage, J.C., 1985a. “Analyzing News Interviews: Aspects of the Production of Talk for an Overhearing Audience”. van Dijk 1985. 95-117.

Heritage, J.C., 1985b. “Recent Developments in Conversation Analysis”. *Sociolinguistics* 15: 1-18.

Heritage, J.C., 1997. “Conversation Analysis and Institutional Talk: Analysing Data. Silverman 1997. 161-82.

Heritage, J.C. and Atkinson, J.M., 1984. “Introduction”. Atkinson & Heritage 1984. 1-15.

Heritage, J.C. and Greatbatch, D., 1991. “On the Institutional Character of Institutional Talk: The Case of News Interviews”. Boden & Zimmerman 1991. 93-137.

Heritage, J.C. and Sefi, S., 1992. “Dilemmas of Advice: Aspects of the Delivery and Reception of Advice in Interactions between Health Visitors and First-time Mothers”. Drew & Heritage 1992a. 359-417.

Heritage, J.C. and Sorjonen, M.-L., 1994. “Constituting and Maintaining Activities across Sequences: *And*-prefacing as a Feature of question Design”. *Language in Society* 23: 1-29.

Heritage, J.C. and Watson, D.R., 1979. “Formulations as Conversational Objects”. Psathas 1979. 123-61.

Hopper, R., 1995. “Episode Trajectory in Conversational Play”. ten Have & Psathas 1995. 57-71.

Hurwitz, B. and Greenhalgh, T., 2004. *Narrative Research in Health and Illness*. Oxford: Blackwell.

Hutchby, I. and Wooffitt, R., 1998. *Conversation Analysis*. Cambridge: Polity Press.

Hymes, D., 1962. “The Ethnography of Speaking”. In *Anthropology and Human Behavior*, T. Gladwin & W. C. Sturtevant (eds.), 13-53. Washington (DC): Anthropological Society of Washington.

Hymes, D., 1972a. “On Communicative Competence”. In *Sociolinguistics*, J.B. Pride & J. Holmes (eds.), 269-93. Harmondsworth: Penguin.

Hymes, D., 1972b. “Models of the Interaction of Language and Social Life”. Gumperz & Hymes 1972. 35-71.

Jefferson, G., 1972. ”Side Sequences”. Sudnow 1972. 294-338.

Jefferson, G., 1978. “Sequential Aspects of Storytelling in Conversation”. Schenkein 1978. 219-248.

Jefferson, G., 1979. “A Technique for Inviting Laughter and its Subsequent Acceptance Declination”. Psathas 1979: 79-96.

Jefferson, G., 1980. “On ‘Trouble-Premonitory’ Response to Inquiry”. *Sociological Inquiry* 50: 153-85.

Jefferson, G., 1984a. “On Stepwise Transition from Talk about a Trouble to Inappropriately Next-Positioned Matters”. Atkinson & Heritage 1984. 191-222.

Jefferson, G., 1984b. “On the Organization of Laughter in Talk about Troubles”. Atkinson & Heritage 1984. 346-69.

Jefferson, G., 1984c. “Notes on a Systematic Deployment of the Acknowledgement Tokens ‘Yeah’ and ‘Mm hm’”. *Papers in Linguistics* 17: 197-216.

Jefferson, G., 1985. “An Exercise in the Transcription and Analysis of Laughter”. van Dijk 1985. 25-34.

Jefferson, G., 1988. “On the Sequential Organization of Troubles-Talk in Ordinary Conversation”. *Social Problems* 35(4): 418-41.

Jefferson, G. and Lee, J.R.E., 1992. “The Rejection of Advice: Managing the Problematic Convergence of a ‘Troubles-telling’ and a ‘Service Encounter’”. Drew & Heritage 1992a. 521-48.

Jefferson, G., Sacks, H. and Schegloff, E.A., 1987. “Notes on Laughter in the Pursuit of Intimacy”. Button & Lee 1987. 152-216.

Jones, C.M., 2001. “Missing Assessments: Lay and Professional Orientations in Medical Interviews”. Sarangi & Wilson 2001. 113-50.

Kendon, A., 1992. “The Negotiation of Context in Face-to-Face Interaction”. Duranti & Goodwin 1992. 323-34.

Kjaerbeck, S., 2005. “Narratives in Institutional Interaction”. Paper presented at the ninth International Pragmatics Conference, Riva del Garda, 10-15 July 2005.

Korsch, B.M. and Negrete, V.F., 1972. “Doctor-Patient Communication”. *Scientific American* 227: 66-74.

Labov, W. and Fanshel, D., 1977. *Therapeutic Discourse: Psychotherapy as Conversation*. New York: Academic Press.

Labov, W. and Waletzky, J., 1997. “Narrative Analysis: Oral Versions of Personal Experience”. *Journal of Narrative and Life History* 7: 3-38.

Leech, G., 1983. *Principles of Pragmatics.* London and New York: Longman.

Leonardi, P. and Viaro, M., 1990. *Conversazione e Terapia: L’Intervista Circolare*. Milano: Raffaello Cortina Editore.

Levinson, S.C., 1983. *Pragmatics.* Cambridge: Cambridge University Press.

Levinson, S.C., 1992. “Activity Types and Language”. Drew & Heritage 1992a. 66-100.

Levinson, S.C., 2003. “Contextualizing ‘Contextualization Cues’”. In *Language and Interaction: Discussions with John J. Gumperz*, S. L. Eerdmans, C. L. Prevignano and P. J. Thibault (eds.), 31-39. Amsterdam and Philadelphia (PA): John Benjamins.

Linder-Pelz, S. and Struening, E.L., 1985. “The Multidimensionality of Patient Satisfaction with a Clinic Visit”. *Journal of Community Health* 10: 42-54.

Lobley, J., 2001. “Whose Personality is it anyway? The Production of ‘Personality’ in a Diagnostic Interview”. McHoul & Rapley 2001. 113-23.

Maynard, D.W., 1991a. “The Perspective-Display Series and the Delivery and Receipt of Diagnostic News”. Boden & Zimmerman 1991. 164-92.

Maynard, D.W., 1991b. “Interaction and Asymmetry in Clinical Discourse”. *American Journal of Sociology* 97: 448-95.

Maynard, D.W., 1992. “On Clinicians Co-Implicating Recipients’ Perspective in the Delivery of Diagnostic News”. Drew & Heritage 1992a: 331-58.

Maynard, D.W., 1997. “The News Delivery Sequence: Bad News and Good News in Conversational Interaction”. *Research on Language and Social Interaction* 30(2): 93-130.

Maynard, D. W. and Heritage, J.C. (eds.), 2005. “Conversation Analysis, Doctor-Patient Interaction and Medical Communication”. *Medical Education* 39: 428-35.

Maynard, D. W. and Heritage, J.C. (eds.), forthcoming. *Communication in Medical Care: Interactions between Primary Care Physicians and Patients.* Cambridge: Cambridge University Press.

McHoul, A., 1978. “The Organisation of Turns at Formal Talk in the Classroom”. *Language in Society* 7: 183-213.

McHoul, A. and Rapley, M. (eds.), 2001. *How to Analyse Talk in Institutional Settings*. London and New York: Continuum.

Meehan, A.J., 1981. “Some Conversational Features of the Use of Medical terms by Doctors and Patients”. Atkinson & Heath 1981. 107-27.

Mehan, H., 1979. *Learning Lessons: Social Organization in the Classroom.* Cambridge (MA): Harvard University Press.

Mehan, H., 1985. “The Structure of Classroom Discourse”. van Dijk 1985. 120-32.

Mishler, E., 1984. *The Discourse of Medicine: Dialectics of Medical Interviews*. Norwood (NJ): Ablex.

Mishler, E., 2004. “The Unjust World Problem: Towards an Ethics of Advocacy for Healthcare Providers and Researchers”. *Communication & Medicine* 1(1): 97-104.

Mitchum, P.A., 1990. “Verbal and Nonverbal Communication in a Family Practice Consultation: A Focus on the Physician-Patient Relationship”. von Raffler-Engel 1990a. 109-57.

Morris, G.H. and Chenail, R.J. (eds.), 1995. *The Talk of the Clinic: Explorations in the Analysis of Medical and Therapeutic Discourse*. Hillsdale (NJ): Lawrence Erlbaum.

Murray, M. and Pizzorno, J. (eds.), 1998. *Encyclopedia of Natural Medicine*. Rocklin (CA): Prima Health.

Ochs, E. and Capps, L., 2001. *Living Narrative. Creating Lives in Everyday Storytelling.* Cambridge (MA) and London: Harvard University Press.

Paget, 1993 [1983]. "On the Work of Talk: Studies in Misunderstandings". Todd & Fisher 1993 [1983]. 107-26.

Parsons, T., 1951. *The Social System.* New York: The Free Press.

Peräkylä, A., 1995. *AIDS Counselling: Institutional Interaction and Clinical Practice.* Cambridge: Cambridge University Press.

Peräkylä, A., 1997. "Reliability and Validity in Research Based on Transcripts". Silverman 1997. 201-20.

Polanyi, L., 1985. "Conversational Storytelling". van Dijk 1985. 183-201.

Pomerantz, A.M., 1980. "Telling my Side: 'Limited Access' as a 'Fishing' Device". *Sociological Inquiry* 50: 186-98.

Pomerantz, A.M., 1984a. "Giving a Source or Basis: The Practice in Conversation of Telling 'How I Know'". *Journal of Pragmatics* 8: 607-25.

Pomerantz, A.M., 1984b. "Agreeing and Disagreeing with Assessments: Some Features of Preferred/Dispreferred Turn Shapes". Atkinson & Heritage 1984. 57-101.

Pomerantz, A.M., 1984c. "Pursuing a Response". Atkinson & Heritage 1984. 152- 63.

Pomerantz, A.M., 1988. "Offering a Candidate Answer: An Information Seeking Strategy". *Communication Monographs* 55: 360-73.

Pomerantz, A.M., Ende, J. and Erickson, F., 1995. "Precepting Conversations in a General Medicine Clinic". Morris & Chenail 1995. 151-69.

Pomerantz, A.M., Fehr, B.J. and Ende, J., 1997. "When Supervising Physicians See Patients: Strategies Used in Difficult Situations". *Human Communication Research* 23(4): 589-615.

Psathas, G. (ed.), 1979. *Everyday Language: Studies in ethnomethodology*. New York: Erlbaum.

Psathas, G. (ed.), 1990a. *Interaction Competence*. Lanham (MD): University Press of America.

Psathas, G., 1990b. "The Organization of Talk, Gaze, and Activity in a Medical Interview". Psathas 1990a. 205-30.

Quirk, R., Greenbaum, S., Leech, G. and Svartvik, J., 1985. *A Comprehensive Grammar of the English Language.* London and New York: Longman.

Raffler-Engel, W. von (ed.), 1990a. *Doctor-Patient Interaction*. Amsterdam and Philadelphia (PA): John Benjamins.

Raffler-Engel, W. von, 1990b. "Introduction". von Raffler-Engel 1990a. xxvii-xxxviii.

Ragan, S.L., Beck, C.S. and White, M.D., 1995. "Educating the Patient: Interactive Learning in an OB-GYN Context". Morris & Chenail 1995. 185-207.

Roberts, C., Moss, B., Wass, V., Jones, R. and Sarangi, S., 2003. "Charting Misunderstandings in GP Consultations with Linguistic Minority Patients". Paper presented at the first COMET Conference, Cardiff, 26-28 June 2003.

Roberts, C. and Sarangi, S., 1999a. "Introduction: Negotiating and Legitimating Roles and Identities". Sarangi & Roberts 1999a. 227-36.

Roberts, C. and Sarangi, S., 1999b. "Introduction: Revisiting Different Analytic Frameworks". Sarangi & Roberts 1999a. 389-400.

Roberts, F., 2000. "The Interactional Construction of Asymmetry: The Medical Agenda as a Resource for Delaying Response to Patient Questions". *Sociological Quarterly* 41: 151-70.

Robinson, J.D. and Heritage, J.C., 2005. "The Structure of Patients' Presenting Concerns: The Completion Relevance of Current Symptoms". *Social Science & Medicine* 61: 481-93.

Rossano, F., Bercelli F. and Viaro, M., 2003. "Second Stories in psychotherapy?". Poster presented at the first COMET Conference, Cardiff, 26-28 June 2003.

Ryave, A.L., 1978. "On the Achievement of a Series of Stories". Schenkein 1978. 113-32.

Sacks, H., 1972. "An Initial Investigation of the Usability of Conversational Data for Doing Sociology". Sudnow 1972. 31-74.

Sacks, H., 1975. "Everyone Has to Lie". In *Sociocultural Dimensions of Language Use*, M. Sanches and B.G. Blount (eds.), 57-79. New York: Academic Press.

Sacks, H., 1984. "Notes on Methodology". Atkinson & Heritage 1984. 21-27.

Sacks, H., 1987a. "On the Preference for Agreement and Contiguity in Sequences in Conversation". Button & Lee 1987. 54-69.

Sacks, H., 1987b. "You Want to find out if Anybody Really Does Care". Button & Lee 1987. 219-25.

Sacks, H., 1992a. *Lectures on Conversation*. Vol. 1. Oxford: Blackwell.

Sacks, H., 1992b. *Lectures on Conversation*. Vol. 2. Oxford: Blackwell.

Sacks, H., Schegloff, E.A., and Jefferson, G., 1974. "A Simplest Systematics for the Organization of Turn-Taking for Conversation". *Language* 50: 696-735.

Sarangi, S., 2001. "On Demarcating the Space between 'Lay Expertise' and 'Expert Laity'". Sarangi & Wilson 2001. 3-11.

Sarangi, S., 2004. "Towards a Communicative Mentality in Medical and Healthcare Practice". *Communication & Medicine* 1(1): 1-11.

Sarangi, S. and Candlin, C.N., 2003. "Introduction. Trading between Reflexivity and Relevance: New Challenges for Applied Linguistics". *Applied Linguistics* 24(3): 271-85.

Sarangi, S. and Roberts, C. (eds.), 1999a. *Talk, Work and Institutional Order*. Berlin and New York: Mouton De Gruyter.

Sarangi, S. and Roberts, C., 1999b. "The Dynamics of Interactional and Institutional Orders in Work-Related Settings". Sarangi & Roberts 1999a. 1-57.

Sarangi, S. and Wilson, J. (eds.), 2001. *Lay diagnosis*. *Text* 21(1/2) (Special Double Issue).

Schegloff, E.A., 1972a. "Sequencing in Conversational Openings". Gumperz & Hymes 1972. 346-80.

Schegloff, E.A., 1972b. "Notes on a Conversational Practice: Formulating Place. Sudnow 1972. 75-119.

Schegloff, E.A., 1980. "Preliminaries to Preliminaries: 'Can I Ask you a Question?'". *Sociological Inquiry* 50: 104-52.

Schegloff, E.A., 1982. "Discourse as an Interactional Achievement: Some Uses of 'Uh huh' and Other Things that Come between Sentences". In *Analyzing Discourse: Text and Talk*, D. Tannen (ed.), 71-93. Washington (DC): Georgetown University Press.

Schegloff, E.A., 1984. "On Some Questions and Ambiguities in Conversation". Atkinson & Heritage 1984. 28-52.

Schegloff, E.A., 1987. "Recycled Turn Beginnings: A Precise Repair Mechanism in Conversation's Turn-Taking Organisation". Button & Lee 1987. 70-85.

Schegloff, E.A., 1988. "Presequences and Indirection: Applying Speech Act Theory to Ordinary Conversation". *Journal of Pragmatics* 12: 55-62.

Schegloff, E.A., 1992. "On Talk and its Institutional Occasions". Drew & Heritage 1992a. 101-34.

Schegloff, E.A., Jefferson, G. and Sacks, H., 1977. "The Preference for Self-Correction in the Organization of Repair in Conversation". *Language* 53: 361-82.

Schegloff, E.A. and Sacks, H., 1973. "Opening up Closings". *Semiotica* 8(4): 289-327.

Schenkein, J.N. (ed.), 1978. *Studies in the Organization of Conversational Interaction*. New York. Academic Press.

Schiffrin, D., Tannen, D., Hamilton, H.E. (eds.), 2001. *The Handbook of Discourse Analysis*. Oxford: Blackwell.

Searle, J.R., 1969. *Speech Acts. An Essay in the Philosophy of Language*. Cambridge: Cambridge University Press.

Shuy, R.W., 1976. "The Medical Interview: Problems in Communication". *Medical care* 3(3): 365-86.

Shuy, 1993 [1983]. "Three Types of Interference to an Effective Exchange of Information in the Medical Interview". Todd & Fisher 1993 [1983]. 17-30.

Silverman, D., 1987. *Communication and Medical Practice*. London: Sage.

Silverman, 1993 [1983]. "Policing the Lying Patient: Surveillance and Self-Regulation in Consultations with Adolescent Diabetics". Todd & Fisher 1993 [1983]. 213-41.

Silverman, D., 1997. *Qualitative Research: Theory, Method and Practice.* London: Sage.

Snow, C.E. and Ferguson, C.A. (eds.), 1977. *Talking to Children. Language Input and Acquisition.* Cambridge: Cambridge University Press.

Sorjonen, M.-L., Raevaara, L., Haakana, M., Tammi, T. and Peräkylä, A., forthcoming. "Lifestyle Discussions in Medical Interviews". Heritage & Maynard forthcoming.

Stivers, T., forthcoming. "Treatment Decisions: Negotiations between Doctors and Patients in Acute Care Encounters". Heritage & Maynard forthcoming.

Stivers, T. and Heritage, J.C., 2001. "Breaking the Sequential Mold: Answering 'More than the Question' during Comprehensive History Taking". Sarangi & Wilson 2001. 151-85.

Strong, P., 1979. *The Ceremonial Order of the Clinic.* London: Routledge.

Sudnow, D. (ed.), 1972. *Studies in Social Interaction*. New York: Free Press.

Tannen, D., 1990. *You just Don't Understand: Women and Men in Conversation*. New York: Morrow.

Tannen, D. and Wallat, C., 1987. "Interaction Frames and Knowledge Schemas in Interaction: Examples from a Medical Examination/Interview". *Social Psychology Quarterly* 50: 205-217.

Tannen, D. and Wallat, C., 1993 [1983]. "Doctor/Mother/Child Communication: Linguistic Analysis of a Pediatric Interaction". Todd & Fisher 1993 [1983]. 31-47.

Todd 1993 [1983]a. "A Diagnosis of Doctor-Patient Discourse in the Prescription of Contraception". Todd & Fisher 1993 [1983]. 183-209.

Todd. 1993 [1983]b. "Exploring Women's Experiences: Power and resistance in Medical Discourse". Todd & Fisher 1993 [1983]. 267-85.

Todd, D. A. and Fisher, S. (eds.), 1993 [1983]. *The Social Organization of Doctor-Patient Communication*. Norwood (NJ): Ablex.

Towell, R., Hawkins, R. and Bazergui, N., 1996. "The Development of Fluency in Advanced Learners of French". *Applied Linguistics* 17: 84-115.

Transana Online Manual. Version 1.21. (1995-2002). http://www.transana.org (visited October, 15 2005).

Watson, D.R., 1981. "Conversational and Organisational Uses of Proper Names: An Aspect of Counsellor-Client Interaction". Atkinson & Heath 1981. 91-106.

Watzlawick, P., Beavin, J.and Jackson D., 1967. *Pragmatics of Human Communication*. New York: Norton.

West, C., 1978. “Communicating Gender: A Study of Dominance and Control in Conversation”. Unpublished doctoral dissertation. Department of Sociology, University of California, Santa Barbara.

West, C., 1984a. “Medical Misfires: Mishearings, Misgivings, and Misunderstandings in Physician-Patient Dialogues”. Frankel 1984a. 107-34.

West, C., 1984b. *Routine Complications: Troubles in Talk between Doctors and Patients*. Bloomington (IN): Indiana University Press.

West, C., 1993 [1983]. “ ‘Ask Me No Question…’ An Analysis of Queries and Replies in Physician-Patient Dialogues”. Todd & Fisher 1993 [1983]. 127-57.

West, C. and Frankel, R., 1991. “Miscommunication in Medicine” In *‘Miscommunication’ and Problematic Talk*, N. Coupland, H. Giles, and J.M. Wiemann (eds.), 166-94. 1991. Newbury Park (CA): Sage.

Widdowson, H.G., 1983. *Learning Purpose and Language Use*. Oxford: Oxford University Press.

Wilson, R.N., 1970. *The Sociology of Health: An Introduction.* New York: Random House.

Wolf, M.H., Putnam, S.M., James, S.A. and Stiles, W.B., 1978. “The Medical Interview Satisfaction Scale: Development of a Scale to Measure Patient Perceptions of Physician Behavior”. *Journal of Behavioral Medicine* 1: 391-401.

Zimmerman, D.H. and Boden, D., 1991. “Structure-in-Action: An Introduction”. Boden & Zimmerman 1991. 3-21.

Zorzi Calò, D., 1990. *Parlare Insieme. La Co-produzione dell’Ordine Conversazionale in Italiano e in Inglese.* Bologna: CLUEB.

APPENDIX A: TRANSCRIPTION CONVENTIONS

Transcription conventions [1]

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.
te(h)xt	One or more 'h's' in parentheses within words indicate breathiness within words, as in laughter, crying, etc.
<u>text</u>	Underlining indicates speaker emphasis.
t_e_x_t	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

UBNMC: INT1-11.04.03

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
P it came up this week.
PR 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!°
PR hu=
P =°okay.°=
SC =hha ((researcher comes back))
P °here she is.° .hhha
PR ((talking to himself)) (° slb slb slb°) 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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```
44          (1.9)
45   P      now? [no! ]
46   PR          [yeah] now okay,
47   P      no it it seems hhh (h)i d(h)on't know why it seems to hit me
48          when i'm cooking, (.) .hh i guess maybe i assume a certain
49          position.
50   SC     [uh huh.]
51   PR     [uh huh.] [  o   kay.   °okay.°]
52   P                [you  know    at the ] stove.
53   PR     huh,
54   P      and: (1.3) that's that maybe is it does seem that way you know
55          that most ( slb slb slb) is when i'm cooking.
56   PR     [uh huh.]
57   SC     [uh huh.]
58          (2.2)
59   P      huh,
60          ((PR writing)) (5.5)
61   PR     a:nd how's your eye, i remember the last time you told me,=
62   P      =the eye,
63   PR     [uh huh,]
64   P      [well it] i don't know how long, i- it it's still there.
65   PR     still there.=
66   P      =i can still see [it you ] know?=
67   PR                      [uh huh.]
68   P      =and: (1.3) ((knocks at the door)) somebody [knocked.]
69   SC                                                 [come ↑in]
70          ((SD enters)) (0.9)
71   P      here ↑she ↓is
72          (1.6)
73   P      [where is my bag?]
74   SD     [(was wondering) ] o:h (slb) ↓it
75   P      books?
76   SD     yeah.
77   P      yeah.
78   SD     could you (slb slb slb)?
79   P      no you can put it in.
80   SD     (slb slb)
81   P      she's quite erm a cr- erm quit- erm
82   PR     cure for [all (slb),]
83   SD              [huh  i    ] have heard that name before.
84   P      she's quite a history!
85   SD     (slb slb)
86          (1.3)
87   SD     okay.
88   P      her ↓tool
89          (2.8)
```


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```
 90   SD    you'll bring us okay?
 91   P     uh huh.
 92   SD    right,
 93   P     doctor halliburton agreed to translate the books for me.
 94   SD    ha ha ha ha ha ha .hah hha
 95   P     they're in english but i cannot [i can't] [sort of]
 96   SD                                    [ha  ha ] [ ha  ha]
 97   PR                                              [ hu  hu]
 98   SC                                              [ he  he] [he  he ]
 99   P                                                         [i don't] i
100         don't have the background.
101   SD    [that's it.]
102   P     [really to ] read them she's a real a little bit florid in her
103         write to to my,=
104   SD    =uh huh,=
105   P     =but you know a lot of florid people could be telling the truth
106         too! [yeah.]
107   SD         [sure!]
108   P     bec- she is a [ p_h_] d  in physiology.=
109   SD                  [sure.]                 =sure.
110   P     and she's not always southern as you are,
111   SD    ha ha ha more northern?
112   P     huh yeah.=
113   SD    =you don't see yourself as (slb slb slb slb)
114   P     yeah! well i mean attitude.
115   SD    huh that's it.=
116   P     =look when i say southern i mean genteel.
117   SD    oh, okay.
118   P     i've heard something this week and i said oh maybe if i tell
119         that story i'll tell doctor: .hh halliburton ((covering her ears
120         with her hands)) to cover her delicate ears.
121   PR    hhhu hhu
122   P     okay where were we?
123   SD    >wait wait wait< so what's the sto↓ry
124   P     i can't remember.
125   SD    ↓a:h [ ha ha ha ha ha ha ha]
126   PR         [ hu hu hu hu hu hu hu] [.hu]
127   SC         [ha ha ha ha ha ha ha ] [.he]
128   P                                  [but] it was colorful
129         [e  liza ]bethan.=
130   SD    [oh okay.]
131   P     =i asked my niece if if the nurse used old english or: (.)
132         elizabethan and she said it's been a while since i studied i
133         can't tell you.
134   SD    okay.
135   P     i was gonna further [define that question.]
```


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SD [but er er e li]zabethan in parts of north carolina,
P [yeah that's,]
SD [and that's] where in like (slb slb slb), on the coast and also in the (slb slb slb slb) you know,
[the the (slb slb slb) that's] it.=
P [yeah yeah (it's up there too).]
SD =so anyway to <u>you</u>. (.) how are you doing?
(.)
P okay i guess, well you know the hemorrhage is still there.
(1.0)
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 ↑look
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 ↓call=
SD =what if it does?
P know what it was i asked doctor z- oh i got to tell ((pointing at SD)) <u>you</u> what happened to <u>me</u> 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 day i can't go. so now i have to make another appointment.
SD okay.
P tzt 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: gillian he's trying gently 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 .hhh but anyway i i guess and that's when thee: er er the triple a surgery came up ((miming stitching up a cut)) OH MY ARGH! I WON'T KEEP MY SEE IT. what it is a bypass or something? down here the groin you know [coz they] went in,

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SD [uh huh,]
(.)
P he said we'll talk to doctor doctor sandler that's all he said.
SD uh huh.
(.)
P .hhh erm a few minutes later he comes in with four of your students,
(.)
P .hhh i said well, (.) i was a teaching tool again!
SD ↑ah↓ah
P good they were he was ta- showing them where they it's on! resectioning or what [e ver]
SD [right. right.]
P the term is you know that thee: it's perfectly okay even if it's no easy.
SD uh huh.
P you know it's i guess he's going through [(this way).]
SD [↑ah ↓ah] okay.=
P =yeah he wou- i was a ↑teaching ↓tool i'm lying there, [partially unco] vered,=
SD [pff ha ha ha ha]
P =almost flapped up and they were all putting their stethoscopes in my groin!
SD okay. well tha-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 permiss(h)ion.
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

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```
228         .hh spoke to me to call me by my name and i sai- do i know↓you
229         you know?
230   PR    ↓u:h
231   P     .hhh but then i'm a fixture down here on tuesdays. and er and i
232         said i i've seen her who is she? and i've seen her who is she?
233         you know and all that sort of (slb slb),=
234   SD    =also did he recommend an ultrasound?
235   P     oh yeah!
236   SD    okay.=
237   P     =and i'm scheduled for it when i can't go coz  [ er]
238   SD                                                  [huh]
239   P     they scheduled me for friday now and i have to change the
240         appointment because [friday's] my sister's er chemo.=
241   PR                        [ uh uh. ]
242   SD                                                    =o[kay just]=
243   P                                                       [and  i  ]=
244   PR                                                      [uh  uh. ]=
245   SD    =just keep trying.
246   P     yeah he figures three w(h)eeks ha .hh he said three, come back
247         in three weeks and he'll discuss it with me.
248   SD    yeah.
249   P     shall i carry a tape recorder for you?
250   SC    [((smiles))]
251   PR    [  hhhhh   ]
252   SD    [ ha   ha  ] ha .hhh ha .hh you can report back and i'll get
253         i'll get i'll get one version or another. [ha   ha  ha ]
254   P                                              [yeah. hh huh] okay.=
255   SC    =he he he .hh
256   SD    [but thank you i'm] glad that you're following up with that.=
257   PR    [oh  it's  o  kay.]
258         =uh huh
259         (.)
260   P     I DONT'T GET THIS! i don't get it the other day you thanked me
261         for talking pleasantly  [to doctor sandler,]
262   SD                            [ha ha  ha  ha  ha ]
263   P     [now you thank me for] [going] to have tests.=
264   SD    [ ha  ha   ha  ha  ha] [.hhh ]
265   PR    [ hu  hu   hu  hu  hu]
266   SC    [((s  m  i  l  e  s))]
267   PR    =[.hhh hu]
268   SD    =[why did] you ↑(slb) ↓it i know that it's it's not what you you
269         know that it's something that you're you're (0.3) trying to
270         balance the two different approaches.
271         ((knocks at the door)) (0.4)
272   SD    and so that's,
273   P     wh-two which two approaches?
```


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274 SD ((going to the door)) allopathic and the naturopathic ones.
275
276 P ((SD opens the door))i'm trying to ↑balance it
277 (1.4)
278 SD ((to someone who is outside)) ↑yes
279 (2.1)
280 PR tzt so you haven't had the ultrasound yet,
281 P huh?
282 SC you've not had the ultrasound yet.
283 P no no [no they] it was they scheduled it for friday.=
284 PR [alright.] =o[kay]
285 SC [this]
286 coming ↑fri↓day
287 P yeah.
288 SC and so you're gonna have to reschedule it.
289 P yeah i have to reschedule it.
290 SC [o kay.]
291 PR [uh huh] okay.
292 SD okay so [have] you done the vitals?=
293 P [yeah,] =huh?
294 SD have you done vitals yet.=
295 P no↓o [we've just been talking.]
296 SD [(slb slb slb slb slb)] you guys started. okay can i
297 give you time to do vitals and then i would like will graham to
298 take a look at your ↓scar do you remember i was telling you he
299 does the scar therapy?
300 P oh yes something to stress,
301 SD right. (.) right.
302 P [o(h) kay.]
303 SD [so (slb)] (slb slb slb slb) you must be
304 [tired (slb slb slb slb)]
305 P [i am a teaching tool] around here!
306 SC he [he he .hh]
307 SD [ha ha .hh] oh thank you for that and c(h)an i thank you for
308 ↑that ha
309 P ((nodding)) [tshh]
310 SD [ha] ha=
311 PR [smiles]
312 SC [smiles]
313 SD =.hhh okay. [so,]
314 P [so.]
315 SD so we will we'll i'll i'll come back after erm with will.
316 (.)
317 SD okay?
318 P okay.
319 SD thank you.

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P you go- you don't have any film or what, do you want fil- to film my incision too? we- you have letisha bring her over a:nd,
SD ha ha ha ha
(.)
PR °okay.°
P and on top of that it was such a bad day i think i'll chase a shower so he's taken his.
(1.7)
SC ssst
PR hu hu
SC ha ha
PR [.hh hu .hh hu]
SD [.hhhh hhhh]
SC okay
PR hh [hu .hh]
SC [ha ha]
P alright.=
PR =okay ah mel can you-
P is it a man?
(1.0)
SC will ↑graham
PR °will graham.°
P yeah.
SC yeah.
P i see,
SC yeah.
P is he a doctor?
SC yes.
PR uh huh.
P is he the he's an m_d right?
SC yes.
P huh good! i admire him.
SC ((to PR)) give me the watch,
P for anyone who is anyone who ha- you know any medical person is really flying in a (place of things),
(1.4)
P well you do (.) you we- you were what a a,
SC i i've been a medical assistant and a teacher.
P teacher of what?
SC bio↑logy °(anthropogenous) bio↑logy°
P i remember the medical assistant you worked in a hospital,
SC uh huh. uh huh.
P ((sniffs)) do you get fish eyes?
(0.6)
P from your friends?
(1.3)

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366 P like you're a little wacky?
367 SC yeah. he hh but i've always [done those.]
368 P [you get]used to it. believe me
369 [you get used to it.]
370 SC [i i've got those] since i was young [so, he] he he=
371 P [oh well] =oh
372 you're follow- you're not following my lead but you,=
373 SC =well i'd like to now try now that i know you.
374 P ha [ha ha]
375 SC [he he] [he]
376 P [no] you know what i mean [you] you're a beginner=
377 SC [.hhe] =he
378 he he
379 P when you choose to be.
380 SC yeah.
381 (3.4)
382 P ((to SC while PR is filling in P's file)) i was thinking about
383 you remember i was telling you about you i don't think you knew
384 that (salvator),=
385 PR =((to SC)) can you take the blood pressure?
386 SC ((to PR)) yeah.
387 PR ((SC turns round to get stethoscope)) yeah okay.
388 P ((SC still showing her back to P)) i didn't i think i surprised
389 you when i told you that (slb slb) salvator was mended on long
390 ↑island
391 (1.6)
392 P when i was talking to you one time?
393 SC yes.
394 P .hh and they had: there was a program on u_ boats in the second
395 world war,=
396 SC =uh huh.=
397 P =and they mentioned they mentioned that one too you know again
398 that they were mended by: more than they (.) who were mended on
399 on long island.
400 PR how's this erm lesion?
401 P oh i don't know where!
402 PR huh!
403 (.)
404 P i don't know it's been there a couple of weeks since i noticed
405 it. no::!
406 PR uh uh uh,
407 P no.
408 PR .hh okay let's [take this.]
409 P [i don't] see two things and twins.
410 PR uh huh [hhu hu] .hhh
411 SC [he he]

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412 P neither this here she only dislocates one shoulder at
413 [a time.]
414 SC [that's right.] [(slb slb slb)] [he]
415 PR [hhh hh hu] [.hhh]
416 P [how] did you ↓fall [hu]
417 SC [i:]
418 i slipped in the bathroom and i went to reach out,
419 P o:::h!=
420 SC =and i continued slipping so i went down and my arm was
421 PR uh [uh] uh [huh,]
422 P [oh:!]
423 SC [like]
424 (1.6)
425 SC so,
426 P that's a mean one you could have done [a lot more] damage!=
427 SC [i could have]
428 =yeah,
429 P boy!
430 (2.7)
431 SC °okay.° can i ask you to roll it on? great!
432 ((SC measuring blood pressure)) (23.6)
433 SC can i do that one more ↓time
434 (.)
435 P ((to PR)) uh huh. she (doesn't agree).
436 (18.8)
437 SC i'm gonna have you do it. hhhh
438 PR okay.
439 SC yeah.
440 P tight?
441 SC they're tighter than usual yeah.
442 (1.9)
443 P well the other day when the nurse took my blood pressure it was
444 up far a hundred and eighty.=
445 SC =okay.=
446 P =or something like that she (slb slb),
447 SC okay.
448 P she said not too bad.
449 (2.3)
450 P and i said what do you consider ↓bad she go two thirty hh ha
451 SC ah↓ah
452 (23.3)
453 PR huh? i don't hear anything.
454 (1.9)
455 SC you didn't hear any↑thing oops.
456 (3.0)
457 P ophthalmoscope! that's,

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458 SC yeah ophthalmoscope.
459 P yeah i started to (slb slb) whether it was an ophthalmoscope.
460 SC ((turning to PR who's checking if stethoscope works)) no it's
461 different.
462 PR uh,
463 (9.8)
464 P ((singing to herself)) °hu hu hu hu°
465 (.)
466 P i've been having fun here so maybe that's my blood pressure
467 (slb) problem how i feel,
468 (14.6)
469 P thhh °(slb slb) the camera (slb)
470 (.)
471 P i forgot about that!°
472 SC °and you have a microphone too!°
473 P yeah,
474 SC yeah can you not ↑hear ↓ginko
475 PR no i cannot hear.
476 P hear what?
477 PR the pulse.
478 SC is the stethoscope alright turn it around. (.) yeah there ye go.
479 PR oh there you go!
480 SC hhh one more time.
481 P ha okay. (.) couldn't hear the ↓pulse (.) [my] arm is dead?=
482 SC [(slb)]
483 =hhhh
484 P was it for ↓you:
485 SC he he he
486 (5.6)
487 P you see? the camera is bothering him.
488 SC °oh°
489 P huh!
490 (21.8) ((knocks at the door))
491 SC °come in!° ((SD and PR2 enter))
492 PR okay you have one eighty over ninety two.
493 SC okay.
494 PR yeah.
495 SC i i read it as higher,
496 SD yeah.
497 PR as higher?
498 SC yeah.
499 PR huh,
500 SC two eighteen.
501 PR two eighteen,
502 P can i pull [it down?]
503 SC [o ver] ninety six.

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504 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 ↓stern
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

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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 hu [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 hhhh 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

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596 (.)
597 SD yeah they used erm as far as the er [(slb slb slb)]
598 P [yeah in the] groin they
599 went into the groin.=
600 PR2 =o:h my goodness! okay alright so that,=
601 P ha-
602 PR2 [now that,]
603 P [have you] seen enough or you wanna see the rest?
604 PR2 er even even i can extrapolate from what i'm seeing, now i
605 under[stand]
606 P [jee-]
607 PR2 [what we're dealing with.]
608 P [i haven't heard that] since i was studying ↓maths=
609 PR2 =that's right.
610 SD hhh he
611 SC [he]
612 PR2 [that's] right. that's right. okay okay so that's a:
613 P oh g- goo- o↑kay i don't ↓mind
614 PR2 no if you if you erm .hh erm okay show me show me more of this
615 scar [please.]
616 P [ha]
617 SD [i]
618 P [i knew it!]
619 SD [think you could] lie down.
620 PR2 yeah.
621 P i knew this here.=
622 PR2 =yeah.=
623 SD =yeah why don't we have you, why don't you put your [head] here=
624 PR2 ((turns to PR)) [so.]
625 SD =so,

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625	PR2	what what we've been (slb)	SD	((P lies on exam table)) so we
626		here,		don't use the mike then so it
627	PR	uh huh.		would be here here lizabeth.
628	PR2	erm this is always something	P	you know i have to inform all
629		(slb) an opportunity.		of you of somethin, when i was
630	PR	uh huh,		a kid when i heard the name
631	PR2	this give us the opportunity		lizabeth called to me, i went
632		to discuss the rationale,		the other way.
633	PR	uh huh,	SD	oh so it's libby.
634	PR2	for a (.) german system of	P	yeah.
635		treatment called neural	SD	oh so,
636		therapy.		[sorry. he he he .hhh]
637	PR	uh huh,	P	[that was just to inform] you
638	PR2	which the closest thing in		of a historical fact. any time
639		the united states to that is		i heard that,
640		what's called trigger point	SC	[he he he he]
641		therapy as: as erm er as	P	[i went the op]posite way.
642		became well known through	SC	he he he he .hhh
643		the writings of doctor janet	SD	oh we don't want you to go the
644		trevell. who happened to be		opposite way. [hhh]
645		erm the personal physician	P	[ha]ha ha no!
646		to john_f_kennedy.		i don't.
647	PR	oh↓oh	SD	okay so feet this way. so we
648	PR2	((turning back to P))		don't lose your mike.
649		Interesting.	P	oh feet!
650		((P lies on exam table and	SD	yeah.
651		PR2 starts examining her	P	oh i see.
652		abdominal scars))	SD	and head that way.
653				[(head that way).]
654			P	[i was going] the other
655				Way.
656			SD	[alright.]

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657		P	[alright.]
658		SC	you needing a ↑hand
659		SD	((P hits SD's watch)) oops!
660			he he he
661		P	no i'm at.
662			(.)
663		P	alright.
664		SD	alrighty.
665			(.)
666		SD	where did you go? to a summer
667			fest?
668		P	uh?
669		SD	where did you go a summerfest
670		P	oh that's an old (slb slb slb
671			of keeping these d-) new
672			t_shirts,
673		SD	ah↓ah
674		P	(we have to wear) new t_shirts
675			with the weather because we
676			don't have a drier,

NOTE. The table above illustrates a case of schisming (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.

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677 SD oh damp!
678 SC would you be more comfortable if i could (slb slb) ↑this
679 P okay.
680 PR2 ((turns to P who is lying on the exam table)) a::h! okay so,=
681 P =i'm okay.=
682 SC =okay.=
683 PR2 =erm tzt okay so erm,
684 (2.2)
685 PR2 so.
686 (1.2)
687 SD ((pointing at scars)) the right.
688 PR2 i see yeah. i see these scars, okay [this is ve ry very,]
689 P [you know there's another]
690 one on the other side too.
691 PR2 uh huh [i'll ask,]
692 P [in case] you want to get [a look.]
693 PR2 [o kay] wow! okay now now i
694 have the picture.
695 P yeah.
696 PR2 okay.=
697 P =i wanted you to get it doctor!
698 PR2 but i have the full picture okay .h and i was expecting this
699 scar to be continuous with these but i see we have one two three
700 four major scars .hh
701 P [↑four]
702 PR2 [we] also have, ((coughs))
703 P doctor patton said
704 PR2 [yeah.]
705 P [what] i complained that he didn't [match the]
706 PR2 [hu. tzt]
707 P seams too well [you] see he=
708 PR2 [hu.]
709 P =had to cut around this:,
710 PR2 right.
711 P belly.
712 PR2 we also have these three are distancing. now (.) that,
713 P oh there's an app- appendectomy scar there.
714 PR2 erm yes i i i appreciate that .hhh erm so we have these three
715 distancing and that too erm erm is: a significant scar. so in in
716 brief wha- what is the biological significance of of .hh of of
717 these scars, and the answer is that given that (.) more than
718 ninety percent of the autonomic neurofibers [of the]=
719 PR [uh huh]=
720 PR2 body are located in the skin,
721 SD ((to P)) °(slb slb slb)°
722 P hu?

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PR2 [at thee]
SD [(slb slb]slb)
P hu
PR2 at the dermal epidermal junction just below that junction i talked about this many times,
PR uh huh,
PR2 .hh given that .hh erm (.) i could just say in shorthand they cut this is disrupting the communication to acupuncture meridians.
PR [uh huh,]
PR2 [whether] you wanna speak of acupuncture meridians or (.) autonomic circuitry of the skin,
PR uh huh,
PR2 i think we're talking about practically the same thing. .hh so erm it would: erm it would be of enormous benefit erm to to lizabeth for us to treat these. esp-
SD libby.
PR2 er,
SD [hu hu]
PR2 [er lib]by? [libby?]
SD [hu hu]
P oh no! go ahead.
PR2 [lizabeth.]
P [i'm used] [to it for the] [time] [here don't be bo]thered.=
SC [he he he he] [he]
PR2 [yeah] [es pe cially]
=especially since thee: erm especially since the, and the treatment is is painless [al so.]
SD [uh huh.]
PR2 so erm we will we will go over the thee: erm erm (slb slb) alpha stem unit that's used and how it's operated it's extrem- er very very simple and: and i think this would be a a wonderful help.
(1.9)
SD you can pull ↓up
(.)
PR2 tzt
SD [okay.]
PR2 [may i] make one observation?
P yeah.
PR2 you're spunky.
P [ha ha] [ha ha ha ha] [ha]
SD [he he] [he he hh hh] [hh]
PR [hu hu .hh hu]
P [why(h) did you] say ↓that=
SD [hhh .hh hh] =.hh he
PR2 because you are.

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SC [he he] he he he=
PR [.hh hu]
SD =we like that. [he he]
PR2 [thank you.]
P you're [welcome.]
PR2 [it was] very nice to meet you,
P and meet my ↑scar ↓too
PR2 [and met your scar!]
SD [ha ha ha ha] ha ha ha .hhh
PR o↑kay [nice meeting both of you!]
SD [(slb slb) you can sit up.]
P oka(h)y [he he] [right] [will,]
PR2 [okay.]
SC [ha ha] [ha]
SD [he he] [he] [.hh] .hh .hh
[(slb slb)] too sit up for that,
PR2 [thank you.]
(.)
SD alrighty.
P i (slb slb slb slb round) here but i'm spunky!
PR [hu hu hu]
SD [yeah ab so]lutely absolutely. so so today we're just we're
just assessing and i just wanted him coming in have him coming
in get hi- his opinion .hh and then next week we'll start
treatments, and [erm],
P [on] what?
SD .hh basically well erm erm it's it's essentially working with
your scar tissue, to help break down the scar tissue?
P yeah.
SD and it's using this erm alpha stem unit which is erm it's it's
just it's like this little erm .h battery operated erm (.) unit,
P what it gonna do massage ↑it
SD .hh erm [it wi-] actually it works to break down the scars.
PR [to:]
P yeah.
SD so [that's] yeah. [that's]
PR [uh,]
P [and] you're gonna have fun coz that's a
long one!
SD it is (.) it is no it's probably gonna take quite a few .hh
treatments but hopefully it'll affect your blood pressure and
bring it down.
P REALLY?
SD yeah that's what we're hoping.
P REALLY?
SD uh huh.

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```
P     you mean my scar may be creating my blood pressure or just
      contributing to↑it=
SD    =contributing uh huh.=
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
      know [that you were]
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,
      (.)
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,
      and sympathetic is your (slb slb slb) (.) (neurons) you know you
      [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
      Scar?
SD    it did alright.=
P     =↑yeah okay.=
SD    =ninety percent of erm er it's of the autonomic nervous system
      it's under the skin so that when you have a scar it interrupts
      the circuitry.
P     oh yeah!
SD    and so if you break down the scar tissue then you can have you
      know a a circuit that doesn't that isn't interrupted.
      (0.9)
SD    it's it's like acupuncture but it's,=
```


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861 P =huh,
862 SD it's more direct as far as your skin.
863 P i was just thinking remember i told you when i when i went back
864 to see doctor patton who did the surgery,
865 SD uh huh.
866 P and i told me he didn't match the seams too well,
867 (.)
868 P because it does say want me to (slb slb slb)
869 [you'll see it stay]
870 SD [he he he he]
871 P ↑erm
872 SD .hh .hh no i sa(h)w it [that's o] [k(h)ay]
873 PR [hu hu] [.hh] [hu]
874 SC [he::] [he] [he]
875 P [you] [can] see when i'm
876 ↑down
877 SD you showed me he he he [.hh]
878 PR [.hh] hh
879 SD so [that's it.]
880 P [o kay.] but it [does say!]
881 SD [but i] think i think he did a
882 pretty
883 (slb) good job though i have to say.
884 P oh yeah i guess so.
885 SD yeah.=
886 P =anyway erm (0.9) you know↓me
887 SD i know [you.]
888 P [you] know how [brash i am,]
889 PR [.hh hh .hh] hh [.hh hh .hh hh]
890 SD [i know. i know.]
891 P and it er he he's a big man you know doctor ↑kutcher
892 SD no.
893 P he's a <u>big</u> ma:n i mean he you know he could take m- medical
894 advice to lose (.) w- weight.
895 SD ha ha [.ha ha]
896 P [a ny]way. (h) he said(h) he said what are you
897 complaining a↓bout and then he said i had to go round your belly
898 button and i said these seams still don't match.
899 SD [he he] he that's it.
900 P [tss hh]
901 P he (slb slb) that i was you know just (slb slb)
902 SD spunky.
903 P yeah [that one.]
904 SD [he he] he
905 P (slb slb slb) had you told him about me before?
906 SD no:. no i said he that he would enjoy you.

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907 P oh yeah! hh (.) [good.]
908 SD [(slb]slb) so erm so i'm not gonna be here
909 next week.
910 P yeah i thought you were not gonna be here this week.
911 SD no next week next week so erm so (.) probably erm doctor
912 madi↑son
913 P that's good. [who] is he?=
914 SD [well] =she's the clinic director i don't know
915 if you've met her [before.]
916 P [no i] haven't.
917 SD erm she might be the person who's gonna be the supervising
918 doctor but you'll see the same people.
919 P °yeah° but is isn't today your reception?
920 SD today's ↑my rec- no tomorrow tomorrow is that. .hh but then i'm
921 going i'm going out to i'm going to to to portland and seattle
922 for a: erm
923 P beg[ging tour?]
924 SD [a board] meeting. he he .hh f(h)or a for: for our
925 national association (.) so,
926 P [did you] say board meeting?=
927 SD [i (slb)] =yeah.
928 P you're on the ↑board
929 SD yeah.
930 P wow!
931 SD yeah i'm a marketing (slb). i'll give you a report.
932 P [yeah sure.]
933 SD [he he]
934 PR [hu hu]
935 SC [he he]
936 SD so erm so so bu- we'll start they'll start it next week.
937 P okay.=
938 SD =you just you know ask any questions.
939 PR doctor graham is going to bring his ↑device
940 SD will.
941 PR will.
942 SD uh huh.
943 PR [is gonna bring his device,]
944 SD [tzt actually we have one.] [here.]
945 PR [oh] we have one,
946 SD yes we have one so you can you can erm this week play with: with
947 doctor madison get [get her to] show you more.=
948 PR [oh okay.] =i have
949 [no idea that's,]
950 P [now wh- this is] what is is like an acupun↓cture
951 SD oh yeah it's,=
952 P =a ma↓chine

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SD 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.
P and it stimulates it,
SD right.
(.)
P because i'm my sister is going to ask me and i have to be able to explain it to her.
SD okay.
P it stimulates in this in into -der the car scar tissue?
SD uh huh.
(.)
P huh,
(.)
P that's interesting.
SC but it doesn't penetrate the skin.
P no i- it's,=
PR =er right.
SC it doesn't like acupuncture needles it doesn't go into the skin it's gonna be on top.
P really?
PR uh [huh.]
SC [yeah.]
SD yeah exactly.
PR [uh huh.]
P [and it's] a stimulate the breakdown of the scar tissue,
SD uh [huh.]
SC [uh] huh.
P well you got a good one to work on here.
SC he [he he he]
SD [i that's wha-] oh that's exactly what i ↑thought
PR hu .hh
P yeah.
SD so erm so you're gonna go ahead you're gonna take a look [and,]
SC [yeah.]
SD erm [erm eyes and repeat the blood] pressure,=
PR [eyes and: blood pressure a gain.] =again,
SD alrighty?
PR yeah.
P yeah okay.
SD and so i'll see you in a couple of weeks.
P [alright.]
PR [and::,]
SD okay.
P big shot.
SD kh ha ha [ha ha] ha=
P [hh hh]

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```
 999   PR    =sh- she's running out the crataegus tin↑cture
1000   SD    tzt okay,
1001   PR    and: we are,
1002   SD    oh well!
1003   PR    discussing about changing to solid extract. [because that's,]
1004   SD                                                [i think that's ] a
1005         good idea.
1006   PR    doesn't [have ] alcohol.=
1007   P             [what?]
1008   SD    =to have <crataegus solid extract>
1009   P     right.=
1010   SD    =rather than the crataegus tincture. erm because i think that it
1011         erm it erm packs more the punch.
1012   P     uh huh,=
1013   SD    =as far as what we're trying to do with the crataegus.
1014   P     okay.
1015   SD    it's it's an unusual taste. it's a little tart.
1016         (0.9)
1017   P     oh well!
1018   SD    he he .hh he probably it tastes better.
1019   P     [well i  like    vinegar! ]
1020   SD    [ is that is?  that o kay,] is tha- i mean do you think are you
1021         okay? to go erm with the extract, rather than the tincture,
1022   P     am i okay, i'm not the one!
1023   SD    i'm s- i this is my recommendation.
1024   P     alright that's enough for me.
1025   SD    okay.
1026   PR    °huh,°
1027   SD    [thank you.]
1028   P     [ because, ][yeah sure!] i mean [i don't come down] here to tell
1029   PR                [  o  kay. ]        [hu  hu   hu   hu ]
1030   P     [you what]
1031   PR    [.hh  hu ]
1032   P     [what you should do!]
1033   SD    [ he   he   he   he ]
1034   PR    hu
1035   SD    that's it okay so erm so,
1036   P     are you gonna have fun out there too?
1037   SD    i hope [so.]
1038   P            [in ] portland?
1039   SD    yeah but i heard it was snowing there the other day.
1040   PR    snowing?
1041   SD    ↑uh↓uh even [(if  it  was)] seven[ty ]
1042   PR                [ so how  mu- ]      [how] much you gonna dispense?
1043         [erm]
1044   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 tzt
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.
(.)
SC and this is another one that you wanna: drink some water afterwards.
P okay.
SD yeah anything we can do to get you to drink water. that's it.
P hhh
SC he he he .hh
P ((coughs))
(1.9)
P ((croaky voice)) alright.
(1.4)
P okay. .hh
SD okay.
P alright.
SD alrighty. o:h i have to sign this,
P okay.
SD okay.
(1.0)
SD okay well tell your sister i said hi. how's she doing?
P she's nervous like all the time that's all. (.) you know because that's her nature anyway.
(0.8)
P and: (0.8) .hh she was pretty good when i left because everything got screwed up today, and thee the nurse called and and said new orders in the course. so both of us got <u>new</u> orders you know, but we don't like the way medicine operates today. .hh they talk above you.
SD [uh,]
P [i] mean and then you know they're all discussing you but they're not telling you about it.
(.)
P that isn't the way i grew up in medicine. the doctor would talk to you and that's what i love with naturopathic coz you do

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spontaneous with the patient and explain.
SD °well thank you.°
P hu?
SD i i like that part about it too.
P sure! you can form a relationship.
SD that's it.=
SC =right.=
PR =uh huh.
P you know with the patient and,
PR [huh,]
P [it] is!
SC it's important.
SD oh it's it's it's the only way it goes as far as i'm concerned.
P it is especially with someone like me.
SD .hh he he he he [he .hh]
P [o kay.] well have [a good] trip.=
SD [bye bye] =thank you.
[he he he]
P [are you go]nna be
begging too?
(.)
SD no i don't think so not this trip.
P okay.
SD there will be that's i'll let you know with the next protocol.
P ha ha ha o(h)kay ha ha ha
SD (slb slb slb)
P bye have a good trip. ((SP leaves))
SC okay.
PR okay. (slb slb)
P jee! she's on the national board uh?
SC she ↓is
P oh!
(0.8)
P she doesn't act it does↓she ((PR turns down the light))
SC oh.
PR too dark?
SC too dark erm perhaps can we p- yeah that's a good idea.
(1.3)
SC that's perfect.
(1.0)
SC okay.
P now you're gonna look into my eye.
SC i am going to,
P .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.

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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 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 pretty much exactly you have your optic disc right here. it's just about at around eleven ten eleven o'clock from your optic 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.
PR 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)
SC no that's mine.
PR it's not mine.

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SC so you're focused ↑on
(1.0)
PR okay.
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 i:n.
PR uh huh.
SC this way.
PR uh huh.
SC and just look for the red reflex.
(18.7)
SC no?
(1.0)
PR erm no.
SC you don't see it okay we'll work on that later. [hh he]
PR [uh o(h)]kay.
SC i'm gonna look in your other eye too.
(9.3)
P you're experienced in this ↑uh
SC i've been practicing.
P oh [is that what] it ↓is=
SC [he he he] =yeah okay so again just look,
P uh huh.
SC over my shoulder.
(4.4)
SC °sorry for the cold hands.°
(7.9)
SC okay just: your [right eye.]
P [yeah yeah.] ye- you know though i'd i th- i was thinking, because .hh hh my father lost his eye. (.) it was shot out when he was erm delivering something to,
SC [uh huh.]
P [the kid]
shot in the eye would (slb slb slb) so he lost his eye my mother my mother's eye, i don't know which one but anyway they: erm she she was doing something a photography and the eye pull (.) down in the eye.
SC oh,
P and i know my father us erm and occasionally would wear a patch.
SC uh huh.
P tzt and mother sometimes or maybe she had later erm later she had erm a hemorrhage or someth- coz she would she wore glasses and she put a a,
SC shade to cover her ↑eye
P shade to cover her eye. .hhh and i i it isn't bothering me today it doesn't pain.

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SC [uh huh.]
P [or a]nything like that you know? but it's uncomfortable.
SC right even when you lean forward no ↓pain
P no!
SC okay.
P no i 'll lean backward forward,
SC oka(h)y. he he he
P alright.
SC don't don't fall ↓back
P alright. [ha ha ha]
SC [he he he] .hh
P but no the- then you'd have to (slb) my bottom as well!
SC he he that's rights. .hh=
P =anyway erm so i was wondering the only part of it that seem to to bother me, to erm
SC okay,
P you know not terribly but irritatingly you know?
SC uh huh.
P and i tha- (slb slb) can't do that you know, so (slb) i w- i was wondering if if erm if if i should wear a pa- it does affect my sight you know because it does affect [it.]
SC [right.] so are you seeing double vision?
P no.
SC er- you're just or you're just havin- whether when you say that
it affects your sight how,
P oh well it we- it sometimes it blurs,
SC okay,
P alright. and then when i'm looking with both eyes it affects thee: the other part i mean if i cov- if i cover my eye my vision i'll my left eye is perfect.
SC right.
PR °uh huh.°
P you know but sometimes it will do that,
SC .hh erm
PR decrease the vision?
(.)
PR side?
P hu?
PR decrease the vision.
(1.1)
PR ((indicating right side of eye)) here.
SC let's try.
(.)
SC hold that for a moment. .hh okay well i'm gonna ask you to look

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straight at me.
P on your nose?
SC right at my nose.
P okay.
SC and tell me when you can see that my fingertips i'm gonna be moving them like this. [okay?]
P [i can] see you.
SC hh okay.
(2.0)
P now.
SC okay.
(2.1)
P now.
SC hh hh i can't do the other arm. hh ha
PR i'll do it.
P uh?=
SC =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.
P coming from back?
SC yeah.
(0.5)
P yep.
SC did you see em on both ↓sides=
P =yeah.
SC okay.
(2.2)
P yeah.
SC okay.
P both sides.
SC okay.
(2.0)
P yeah i did [yeah.]
SC [o-] okay you looked,
P i looked but i saw it [before i looked.]
SC [okay you saw it] okay. .hh th-
PR seems to be fine.
SC seems to be fine okay. just follow my erm the tip of my finger.
(.)
SC just with your eyes.
(6.6) ((knocks a the door))
SC come ↑in
SD (slb slb slb slb slb)
SC okay. .hh
SD i just wanted to get you going so you didn't miss [(slb slb slb slb)] the dispensary.=
SC [the dispensary,] =okay erm she's still i

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didn't see the hemorrhage last week in her right eye but it's definitely [still there.]

P [i told] her where it was!

SC she she knew exactly where it was too.

P i told doctor sandler.

(.)

P i said it's over here.

SD uh huh.

P i think you [know] that's all i could say.=

SC [yeah.]

P =i said i think it's over there.

SD uh huh. uh huh.

P so,

SD yeah well it just, to me it's just: er erm another indication that we have to hit your blood pressure.

P oh yeah. i know i know.

SC okay [(slb slb) to the dis]pensary [(slb slb)]

P [i'll i'll look it up]

SD [o kay]

P okay that's you've read enough i say.

SD [yeah.]

P [right] yeah yeah. you think you keep it on mind i know that so,

SD okay.

P right so,

SD th- the crataegus,

SC yeah.

SD that's good for that.

P really?

SD yeah it it helps with vascular integrity,

P do you have any idea of how long it will take because i can still see ye you know,

(.)

P red.

SD uh huh,

P it's it still bleeding by the ↑way

SD ((to PR and SC)) did you see something?

PR in i-

SC it's still bright red so,=

PR =bright red.=

SC =i don't know again i didn't see it last [week] so i [don't]

SD [right] [right]

SC know what the=

SD =yeah erm

P [and you di- you d-]

SD [i don't know the an]swer to that and i think it just it all depends on the different factors that is all,

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1367 P uh huh uh huh ye- you didn't have your, (.)
1368 PR okay so,
1369 P with your pulse and blood thee: erm
1370 SD diagnose. hhhh
1371 P [ophthalmoscope.]
1372 SD [he he he he] [actually] there's somebody who told me was
1373 PR [okay i,]
1374 SD gonna teach me how to [use] that one. ha
1375 PR [check]
1376 SD ((looking at SC)) and that was you. i [thought] [it was.]
1377 P [ha] [ha ha]
1378 SC [he he]
1379 P [ha ha]
1380 SC [he .hh]
1381 SD she's gonna teach me and,
1382 P [ha ha]
1383 SC [hh hh]
1384 SD right. (slb slb)
1385 P [but that]
1386 PR ((talking to himself)) [°check the] blood pressure again°,
1387 P that will is is a doctor is he ↓not
1388 SD he is but he:
1389 PR °he's a m-°
1390 SD he would [rather just be will.]
1391 PR [° me di cal doctor,°]
1392 P hu,
1393 SD he'd rather just be will here.
1394 P okay.
1395 SD so we don't usually call him [(slb).]
1396 P [i] just wanted to confirm.
1397 that's all.
1398 SD yes.
1399 P but he kept insisting the other way i got him,
1400 PR hu hu
1401 SD that was kind of winking. ((h)slb slb) going no i'm just will,
1402 SC he he he
1403 SD that's it. okay so,=
1404 P =what type of what type it's did he have a specialty as a,
1405 SD dermatology.
1406 PR dermatologist.
1407 P dermatology?
1408 SD yes but he's come over to this side.
1409 P huh!
1410 (0.8)
1411 SD way over to this side.
1412 P yeah.

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1413 SD okay so you guys are almost done.
1414 SC [yeah.]
1415 P [al]right.
1416 SD good.
1417 (.)
1418 SD bye bye.
1419 P bye.
1420 (1.1)
1421 P where is she gonna see you?
1422 (.)
1423 P because i wanna get some kali bichromium for my sister.
1424 SC oh (.) erm that you can just go down and,
1425 P i know that. [i] know that.=
1426 SC [yeah.]
1427 P =but she said she was gonna see you. is she gonna meet you down
1428 at the dispensary or what?
1429 SC no.
1430 P oh no,
1431 SC she's gonna see us later on check out. i'm gonna get this for
1432 you?
1433 P ye- could you pick up the kali bichromium i'll give you the
1434 money for it,
1435 (.)
1436 SC sure.
1437 P i get to pay for it.
1438 SC yeah you gonna have to pay for it first let me, (.) i i'll be
1439 back erm let me see the:
1440 P we- you know what i did last time i called doctor erm doctor
1441 pitt,
1442 SC uh huh,
1443 P .hh and i said (.) you know it's gonna be a flying trip.
1444 SC right.
1445 P and she said well i'll put the bill at the desk and:,
1446 SC yeah.
1447 P so she can do that and i'll pay for it.
1448 SC okay okay.
1449 P okay?
1450 SC yeah.
1451 PR ((measuring blood pressure)) yeah i have to do it again so,
1452 P erm i'm sorry.
1453 SC is it in[to] way you got it the right way yeah?=
1454 P [my]
1455 PR =yeah.
1456 P pfwuoi!
1457 SC hh .hh hh
1458 P pf(h)uf!

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SC this camera,
P hu! ((SC leaves))
((measuring blood pressure on left arm))(48.0)
PR .hh
P right she was a professional! (.) don't didn't she,
PR ((moving cuff from to P's right arm)) mel?
P mel.
PR yeah.
P yeah she's had a lot of experience!
PR uh huh she has experience.
P hu?
PR she↓has
(1.8)
P i mean you don't learn stethoscopes when you're an accountant.
PR i know ye(h)s.
P ha ha ha ha ha
PR ye(h)ah.
(1.2)
PR [ac count ant,]
P [what made you] cha- what made you co- co- come over? is i- is it really anything that happened that turned you towards (.) naturopathy?
PR you know i didn't have any clear goal in my ↓life
P even though you were an accountant,
PR yeah.
P no kidding.
PR yeah i was studying finance like stock market like: you know,
P oh yeah.
PR put option, [call] option,=
P [yeah] =yeah,
PR and: er you know thee:: dollar yen rate,
P uh huh
PR those type of [stu dy.]
P [yeah yeah]
PR i st- (started) i didn't,
(1.2)
P ye [ye just]
PR [i was] not impressed by you know doing that in the rest of my [↑life]
P [i] can imagine ↓that
PR uh huh [right]
P [i] was a posting clerk once [you] know,=
PR [right] =and every day,
P i got allergic!
PR right so i was looking for something and: .hh actually (.) i

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participated like a volunteer work?
P yeah
PR and: i went to ghana in africa.
P ↑really
PR yeah it was it was quite ex[pe rience]
P [what did] you say the ↑peace ↓corp
PR ghana in africa.
P no- do you went to ghana.
PR yeah
P how did you go to ghana? why did you go to ghana?
PR 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
P yeah
PR 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,
P wha- what (slb slb) group or just
PR erm i don't know exactly but i think so (.) erm=
P =↑really
PR yeah we worked at the hospital helped those patients.
P yeah,
PR and i really enjoyed it!
P that's great!
PR yeah
P yeah
PR so i began to realize you know maybe medicine will be,
P uh huh
PR you know a really excellent field.
P well did ye in well in ghana, erm did you er did you get into herbs and things like that?
PR erm no we didn't discussed about that but you know you know like people that i met,
P [yeah]
PR [it's] really beautiful.
P yeah,
PR and i really enjoyed it (.) [so]
P [huh!] (slb slb slb slb slb slb was he slb) he was in ghana wasn't ↑he
PR yeah [yeah yeah.] yeah right. right right.=
P [yeah yeah.] =but tha- that was before your time.
PR uh huh yeah.
P that's longer ago than,
PR yeah so let me [get the blood pressure.]
P [that's interesting. did] you get there from

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japan? or,
PR e::rm from japan yeah.
P ↑yeah
PR uh huh.
((PR puts on the stethoscope))(5.3)
P were you a hippie?
((PR is measuring blood pressure)) (30.8)
P how was that?
PR yeah it's high erm that's=
P =i wonder ↓why=
PR =that's your right arm,
(.)
PR right
P yeah that's my right arm.
PR yeah
P .hh erm were you a japa[nese] hippie?=
PR [erm] =erm no i was not hh
P okay
PR hu hu
((PR writing on P's chart))(5.3)
P that's interesting.
((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 slee:p,
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
(1.8)
PR .hh yeah seems to be fine,
(.)
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.]

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P [ca ro]tids.
PR right.
P so,
PR so:, ((SC comes back))
SC hi.
P hi.
PR okay.
SC okay i wanted to just check with you before they printed everything out.
P hu?
SC the crataegus solid extract,
P na-
SC is approximately twenty nine do↓llars
P pfui! i [brought a lot of money.]
SC [it it's o kay it's a] larger container.
P yeah.
SC so that's okay?
P yes yes.
SC and wha- erm the you want a kali↑bic
P yeah.
SC what potency do you know?
P thirty six [is what] she usually takes.=
SC [o kay.] =okay i will go ahead and (.) print up the bill for you then.
P okay.
SC °okay° are you all set?
PR tzt yeah erm i took the blood pressure on (pulse) and:,
SC okay.=
PR =i got two twenty over eighty one ten over ninety two.
SC okay.
PR so,=
SC =yeah that's,
(1.7)
PR that's really high and:,
P WHAT? TWO ↑TEN
PR [uh huh.]
SC [and two] twenty!
PR two twen[ty yeah.]
P [really?]
PR on this side so should [we just speak to] doctor,
P [why would that ↓be]
PR halli[burton before] we,
SC [yeah i think so.]
P what?
SC we're gonna talk to doctor halliburton before we send you out of here.

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1643 (2.1)
1644 P why?
1645 SC well w- just because that is that is a change in your blood
1646 pressure from the last time you were here.=
1647 P =yeah [i] [was] one sixty eight or something,=
1648 SC [s-]
1649 PR [uh] [huh.] =[right]
1650 SC =[yeah] so erm i
1651 just wanna erm check it with her befo:re,
1652 P sure!
1653 SC we send you on your way.
1654 P okay.
1655 SC okay.
1656 (3.5)
1657 PR okay i'll be back
1658 (.)
1659 PR shortly.
1660 (1.0)
1661 P uh huh. ((SC leaves))
1662 PR so you said your sister keep waking you ↑up
1663 P hu?
1664 PR your sister keep wake wake you up?
1665 P oh yeah.
1666 PR yeah?
1667 P yeah she wake up in the night like this morning i think it was i
1668 sat with her for a while she gets this this is something,
1669 PR right,
1670 P she wakes up,
1671 PR uh huh,
1672 P and then becomes frightened.
1673 PR uh huh,
1674 P and very nervous.
1675 PR okay.
1676 P so she won't calm.
1677 PR uh huh.
1678 P you know and: (0.8) yeah she does she does wake me up.
1679 PR uh huh.=
1680 P =maybe that's what's causing it you know,
1681 PR okay.
1682 P and: (1.8) .hh ye you know something ↑though
1683 ((PR writing on P's chart)) (2.0)
1684 P my cuff my cuff was higher than usual but it wa(s)nt like <u>that</u>.
1685 PR what do you mean ↑here
1686 P er erm yeah my cuff i have a cuff you know? e:r
1687 PR uh huh. was ↑higher
1688 P we- higher than,

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1689 PR at home?
1690 P w- yeah it u- not higher than that.
1691 PR uh huh.=
1692 P =not higher than that.
1693 PR okay.
1694 P but it it's it's consistently lower.
1695 PR constan[tly lower.]
1696 P [but it was] it went down after a while.
1697 PR huh okay.
1698 P so,
1699 PR .hh okay.
1700 P why should it be that high,
1701 PR uh huh.
1702 P i don't know.
1703 PR yea:h erm it's really high and,
1704 P [yeah i know.]
1705 PR [so you should] pay attention to that number.
1706 P that's erm two ↑twenty
1707 PR yeah two twenty over eighty .hh this number it will be same but
1708 this higher num↑ber
1709 P uh huh,
1710 PR it's a little high.
1711 P a little ↓high
1712 PR ((smiley voice)) yeah not little but it's really [high. high.]
1713 P [it's high.]
1714 yeah i know i know.
1715 PR so:,
1716 P especially coz i told doctor: gillian i remember that it was
1717 one fifty eight,
1718 PR [uh huh,]
1719 P [o ver] something last time.
1720 PR right right okay.
1721 P who knows,
1722 PR erm did you eat today?
1723 P yeah.
1724 PR yeah, breakfast and lunch?
1725 P hu?
1726 PR breakfast and lunch?
1727 P well er we- i had a meal [for breakfast and] then i had this=
1728 PR [o kay. uh huh.]
1729 P =peanut butter sandwich.
1730 PR okay.
1731 P and: (1.2) .hhh i really i'm very frustrated.
1732 (0.3)
1733 P and that is probably pushing my blood pressure up.
1734 PR uh [huh]

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P [may] because i: (1.8) everything is going↓wro:ng [you know?]
PR [uh huh,]
(0.5)
P and i wanna get things done and something is stopping me,
(0.2)
PR uh huh=
P =mh i'm very frustra- and then another thing that ↑really
frustrates me is we don' (0.2) we don't have transportation.
(0.3)
PR [uh huh]
P [you know] a car and if you live where i live,
(1.1)
P .hhh you are in the middle of a desert.
(0.3)
PR [right.]
P [becau]se it's very residential section and you just don't
walk down the street if you wanna bu- get something you know
what i mean? [someti]mes,=
PR [uh huh.]
P =i think i'd like to live over on east side Bridgeport.
PR right right. ((SC comes back))
P mh tha- that is erm, i remember i d- i was just telling erm
ginko(1.3) tzt that i'm very very frustrated.
SC uh huh,
(0.5)
P erm
(1.5)
P i'm falling behind at home you know, ((SC nods)) i mean seein'
you at a point where washer's needed when co(h)mes the dishes.
SC right.
P right and that frustrates me >another thing< .hhh and another
thing that's been frustratin' me i had a friend who used to:
(0.4) erm (0.5) take me out °you know° and: unfortunately he
died a year ago.=
SC =huh,=
P =and i i haven't got transportation so,
(0.8)
P 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. <u>that</u> may be contributing,
SC [i d- i think all of] those things do.=
P [to the high blood pressure.] = yeah,
SC and the fact that you're not sleeping, and: yeah.
P yeah, ((knocks at the door SD comes back))
SC we have to actually get you downstairs to ↑pay for the the con-
P you have to get me downstairs [to↓pay]

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1781 SD [he he]
1782 PR hu hu
1783 SC yeah and so tha- coz they're gonna be going home soon and
1784 P what time is↓it
1785 SC it's: five twenty five.
1786 P wow!
1787 SD yeah. (.) erm (.) i'm sorry.
1788 SC that's okay.
1789 SD yeah erm so your blood pressure is higher than its high normal
1790 to↑day
1791 P oh yeah.
1792 SD and: erm=
1793 P =i don't think i've ever hit two hundred here.
1794 SD u:h, you have before. (.) you [have before.]
1795 P [oh i have,]
1796 SD yeah erm=
1797 P =but it it's lower at home.
1798 SD .hh well that's what i want that's what i want you to do. i i
1799 have a feeling it's kind of th- it's a little bit because of the
1800 excitement we're doing kind of new things today and i'm
1801 [that what i'm] thinking,=
1802 P [that's possible!]
1803 SD =.hh but what i want you to do is when you get home, (.) i want
1804 you to check it because it's you know anything else going ↓on as
1805 far as i mean it's just regular stressful things that are
1806 happe↓ning
1807 P hh hh regular stress[ful] things for real are pretty=
1808 SD [yeah.]
1809 P stressful!=
1810 SD =yeah.
1811 P now my sister my sister will wake up maybe you know something
1812 like this,
1813 SC i'm gonna excuse myself and just maybe i'll take your the money=
1814 SD =order [yeah]
1815 P [sure]
1816 SC erm so [that] they can go home and we can make sure [you'll] get
1817 P [sure] [sure]
1818 SC your supplements.
1819 SD right.
1820 P anyway. erm (0.9) my sister is a nervous type anyway and she's a
1821 worry. well anyway she's she she wakes up in the middle of the
1822 night,
1823 SD you have erm for for↑mel i think she needs to,
1824 P hu?
1825 SD the- er everybody's leaving. (h)as far [as (slb]slb)
1826 P [o kay!]

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SC
[ha ha] [ha ha ha ha]
P [KEEZE!] [you be gin to] [sound like] my sister!=
PR [hu . hh hu .hh] [hu .hh] =[hu]
SC =[ha]
SD =[he]
PR [.hh hh]
SC [ha ha]
SD [he he]
P [c- RIGHT!]
SC [ha]
SD [he] he .hhh
SC we just wanna make sure you get you know,
[your supplements and,]
P [YEAH YEAH YEAH YEAH YEAH!]
SC [the ka li bic for your sister.]
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 i don't °where is it where,° ((drops some banknotes))
SD oops my goodness. okay well so erm basically,
P you see? i came prepared to pay.
SD [hh ha]
SC [he he] .hh
SD erm so you do want you to check, and your follow up were they rescheduling thee:, erm
P yeah and he,=
SD =ultrasound .hh and when do you have a follow up at park city,
P yeah in three weeks from last week.
(.)
SD okay.
(.)
P he wrote it down.
SD okay.
P in doctor's script.
SD okay. hhh
P °in [doctor's script think i told you°]
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
P yeah,
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.
P yeah. so?
SD so: i just want you to check it when you get home, a:nd erm

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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 [uh huh.]
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 [uh huh. uh huh.]
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
no! well we didn't tell the er doctor.

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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

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1965 into the bridgeport paper yesterday, .hh and it says you: to
1966 overcome weight gain you take this drug,
1967 SD uh huh,
1968 P and then that affects your (slb slb slb). so you take a drug to
1969 (slb slb slb slb slb) and it comes right to the end and it says
1970 the last one they give you will increase weight. you know but i
1971 was (slb slb slb slb) but it it's so true.
1972 SD uh huh uh huh.
1973 P you know it is so true. you're taking so many drugs! [well]
1974 SD [uh:,]
1975 P you know me on drugs anyway but:,
1976 SD i know i know. but if we don't get your (.) blood pressure
1977 down, i mean that's i know doctor gillian talked to you about
1978 that [that' s:,]
1979 P [oh yeah!] he did. also didn't i say
1980 absolutely not!
1981 SD i ↓kno:w but let's let's ((tapping head with finger)) (0.7)
1982 [i don't wanna bore,]
1983 P [ab so lu te ly] look !
1984 SD i know,
1985 P i'm [the one that]
1986 SD [ha ha ha]
1987 P had this.
1988 (0.3)
1989 SD right. no but: i'm i'm concerned about combination. (0.3) of
1990 what's going [on.]
1991 P [oh,] i'm sorry doctor.
1992 SD i ↓know well so we're gonna get to: (0.4) do some
1993 [deep breathing, and all this,]
1994 P ((shaking head)) [erm erm mh and i went]
1995 through. when i did and i so told him.
1996 SD uh huh.
1997 P gave him the wrong figures.
1998 PR uh huh,
1999 P but i saved all of thee the strips that came in.
2000 (.)
2001 P i had three courses of norvasc.=
2002 SD =uh huh.
2003 P which has a side effect of muscle weakness.
2004 SD uh huh.
2005 P and then a- avopro.
2006 SD uh huh.
2007 P side effect [of mu]scle weakness.=
2008 SD [uh huh!] =(slb slb)
2009 P and i looked ta him and i said, (.) i told him that. i was wrong
2010 in my er in i'd said six b- anyway. and i w- and i said and what

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2011 is an aneurysm?
2012 SD ((nods))
2013 (1.9)
2014 P that's what i am thinking.
2015 SD uh huh,
2016 P .hhh and you will find that i am extremely stubborn.
2017 (0.6)
2018 SD i: ↑know↓that. well and also i think let's do the crataegus.
2019 (0.3)
2020 SD solid extract and see where we get.
2021 P okay!
2022 SD okay?=
2023 P =alright good.
2024 SD alrighty! i'm not i'm not here to do battle. ha [ha]
2025 P [hu?]
2026 SD i'm not here to do battle i'm just:,
2027 P i won't do you any good.
2028 SD i know it. ha ha ha ha ha .ha [okay.]
2029 P [so w-] [i'm ter]rified.=
2030 PR [uh huh.]
2031 P i am i mean taking that stuff would raise my blood pressure!
2032 SD uh huh. also i'll give you a call. coz erm i wanna check it and
2033 see what it is,=
2034 P =okay!=
2035 SD =and so when you get out of here and there's,
2036 P yeah.
2037 SD less excitement.
2038 P uh okay.
2039 SD i've seen this he he alright.=
2040 P =jee- this this this discuss the one on ↑tape hu
2041 PR hu hu.hh [so you wanna,]
2042 SD [(slb slb slb)] [he he] he=
2043 P [long time]
2044 PR =so lizabeth you wanna say something at last,
2045 P [no oh!]
2046 SD [he he] [he he]
2047 PR [to the] camera? hu hu
2048 SD actually i think le[tisha's got some]thing she wanted you to
2049 P [i'm the moon star,]
2050 SD fill[out something,]
2051 P [no tape star.]
2052 P hu?
2053 SD letisha will have something to (slb slb). hey here she is.
2054 (.)
2055 SD alright.
2056 PR okay.

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2057 SD okay so you're i think you're all done.
2058 PR [o] [kay eah.]
2059 P [hi] [le ti]sha!=
2060 R [hi!]
2061 SD =alrighty bye bye.
2062 PR ((to the camera)) thank you very much. [hu hu hu]
2063 SC [he he he]

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P that was that wasn't thee e_r. it was the: gk (.) erm
(slb slb slb) [chi ro] clinic.
PR [uh huh.]
(0.6)
P .hhh i erm hhh
PR °that's not my pen.°
(0.8)
P 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)
P before erm the medication (kept down)
(0.8)
P they put me on (seperol).
PR (seperol)?
((PR writes on P's file))(2.2)
P five hundred milligrams twice a day five days.
(((PR still writing)) (5.7)
P and carol: (1.6) cultured my urine
(1.3)
P o:n (0.5) monday.
(0.8)
P 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)
P .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 thir↓ty::
(0.9)
P two, two thirty four.
(0.7)
PR after two hours?
P after two hours.=
PR =yeah it's a bit high.
P but (0.5) .hh erm er normally i'm really careful about
what i eat,
(1.6)

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P erm i had a caribbean salad, (0.4) which they probably loaded with
sugar and i didn't (even) think about that.
(0.7)
P so i don't know what my sugar's been like,
(1.1)
P .hhh coz i <can't find my glucometer!>
(1.8)
P a:nd once upon a time i [was]
PR ((talking to SC)) [thanks.]
P told that you (here) would be able to help me get a free one.
PR i have no idea about ↓that
P oh that would that was [what a pre]vious=
PR [because erm,]
P =naturopath told me.
PR coz if we were able to get a free one, i think we would all be on
a a (bandwagon) to get a free one.
(1.0)
P oh sh- i was told that you ought to help me get a free one.=
PR =uh=
P =coz i don't even know where it is and i certainly .hhh do not
have an extra fifty dollars to go out and by a new
PR .hhh[hhhhh]
P [gluco]meter. [(fifty or hundred.)]
PR [well i'll ask the] i'll ask the clinic
director but that's news to me have you heard that? (.) at ↑all
SC well i know you can get (0.4) (slb slb slb refunds on)
(0.5)
(slb)[(slb slb slb)]
P [but you go]tta find it. i mean (0.4) i stopped using it (c)oz the battery died,
SC right,
P i went out to buy a new battery (slb slb) the battery (slb) now
[i can't]
SC [the strips?]
P find (slb slb) but (that's not) [the] strips.=
SC [no,]
P =i can't even find a glucometer!

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SC okay.
(1.3)
PR ((sniffs))
P i have no idea where it is.
PR i mean i picked one up at c_v_s for fifteen bucks.
P fif↑teen
PR [yeah.]
P [what] kind was it?
PR c_v_s brand.
P oh [o kay.]
PR [it's their] their model which was guaranteed to be as good as
any any other one. so they just .hhh ye know they just want you to
buy the things that (you use buying) these,
P [thee strips,]
PR [(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,]
P [oh!]
gary
PR yeah?
P had said that it was possible,
PR .hhh no. ((clears throat)) i'll ask that's all i can do and
P [uh huh.]
PR [find out] about that °o[kay?°]
P [are] you dressed up for this, did you
know this was happening?
PR erm no:. she says actually i'm underdressed and should be wearing
a tie °(slb slb slb)°
P oh this is a nice shirt!
PR oh thank you.
((PR is writing on P's file)) (4.5)
PR and of course we have a glucometer down in the lab. so
P yeah.
PR erm that can be used whenever we can check your glucose, erm when
you come in.
(1.3)
PR .hhh hhh a(hh)nyway hhh (0.8) tzt ((clears throat))
(0.5) so what
else is going on any ANY, erm

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```
133             (1.5)
134   PR        changes since you've had thee, erm
135   P         well let's say i noti- i noticed a couple of things one,
136             (1.3) i
137             got really angry and i liked bitched at jennifer and we we
138             talked
139             over some stuff and it was stuff that had been irritating
140             me for a
141             long time. .hhh a:nd i c- i cs- then i realized
142   PR        is jennifer the erm house (slb)?
143   P         that was yes. that was jennifer brando my roommate.
144   PR        okay.
145             (0.6)
146   P         tzt and: (0.5) then i went hey wow! you know i took this
147             stuff
148             maybe it had something to do with it, .hhh and:
149   PR        and that that anger was out of the ordinary? or it [just]
150   P                                                            [ oh ]
151             yeah. i
152             mean she held up something and i punched at it. i fe(h)lt
153             s(h)o
154             mu(h)ch be(h)tter!
155   PR        [uh,]
156   P         [ha ] ha .hhh i don't do that often.
157   PR        °u:h° okay.
158   P         erm=
159   PR        =so it's kind of unprovoked anger, more or less?
160             (0.3)
161   P         oh, it was like fed up.
162             (0.3)
163   P         the the,=
164   PR        =so,=
165   P         =straw that brought the [ cam ]els=
166   PR                                [(slb)]
167   P         =back and and: (1.2) you know? no. (1.7) i i figured her
168             husband's
169             a saint and i'll be up for my my medal when [when]
170   PR                                                    [ hh ]
171   P         she moves out in a year and a half.
172             (1.5)
173   PR        okay .hhh and=
174   P         =because she's daft!
175             (0.9)
176   P         .hh hh
177   PR        she's ↑what
```


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178 P da:ft.
179 PR what does that mean,
180 (1.2)
181 P hh ha ha ha .hhh well it's not stupid it's like no common
182 sense.
183 (0.6)
184 PR ha ok(h)a(h)y.
185 P °ha ha ha ha ha° .hh she just has a different way of doing
186 things.
187 PR right .hhh °uh so° other than that, what else has you
188 noticed?
189 (0.6)
190 P erm (1.2) .hh then er i went out and ate some stuff that i
191 wanted
192 to i didn't feel guilty about i,
193 (0.4)
194 P i din't, (0.5) referred to it as i've been bad,
195 (0.6)
196 P although a cou- er er later on i did but [but]
197 PR [was] it bad
198 food?
199 (0.6)
200 PR i mean was [it something that we nor ma]lly=
201 P [oh it was something it was,]
202 PR =say i(h)s bad,
203 P .hh no. it was: ins- it was something with carbohydrates
204 in it.
205 (0.7)
206 PR (chai,)
207 P which i don't normally eat.
208 (0.5)
209 PR what was the food what was it (slb slb)?
210 P oh i don't (.) remember [(slb)]
211 PR [don't] remember or don't want to
212 tell me,
213 (0.4)
214 P no it's okay. it's only i don't remember. [this is]
215 PR [okay.]
216 (0.4)
217 P just=
218 PR =so,=
219 P =about two weeks [ago.]
220 PR [okay.] so it just something that in the
221 past you
222 were saying maybe >i shouldn't have and kind of feel a

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```
223              little bad
224              about it and (this [time slb slb)?]<
225   P                             [ no   er  i   ] didn't feel
226   PR         [(slb slb]  [(slb slb)]
227   P          [gui  lty] a[ bout it.] i just went back and you know
228              tried to eat
229              normally i i had been badly (this desire) to go for
230              chinese fo(h)r
231              a fe(h)w da(h)ays, .hhh it does happen occasionally  he he
232              .hhh
233              like hhh ha i haven't had any food to go out in a
234              restaurant,
235              (1.1)
236   P          erm hh (1.1) tzt i haven't had coffee for two weeks now.
237   PR         really?=
238   P          =SINCE SINCE (1.1) the wee- the monday before i got the
239              pills.
240              (0.8)
241   P          well the monday that week.
242              (0.9)
243   P          okay? [i haven't]
244   PR               [uh  huh. ]
245   P          had any coffee i guess it's this is what week three now.
246   PR         uh huh.
247              (0.8)
248   P          and still i'm enjoying the taste.
249              (1.6)
250   P          i still have my diet coke on occasion but i'm not having
251              that
252              every day.
253              (0.4)
254   P          sometime. sometime.=
255   PR         =you you you were having it every ↓day
256   P          i generally i would have [ one ]
257   PR                                  [yeah,]
258   P          a day, skip a day,
259              (0.8)
260   P          but i haven't had one for, (0.9) few days.
261              (1.7)
262   P          and i still have a twelve pack in my house.
263              (0.5)
264   PR         °okay.°
265   P          ha ha ha ha .hhh but i've like been fixing yogi tea,
266              (0.7)
267   P          .hhh and having that.
```


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```
268              (1.0)
269   P          tzt .hhh a::nd erm hhh (2.7) oh! i do have (0.8) erm (0.6)
270              tzt
271              some form of (0.8) erm skin irritation under my armpits::,
272   PR         okay.
273   P          and carol doesn't know whether it's a s- strep or
274              (stapper), or
275              yeast or whatever, it's something i've been playin with
276              for month.
277              (1.2)
278   P          i honestly think it would be more towards (1.7) (slb slb
279              slb slb)
280              a yeast. because .h (0.7) i'm er heavier than i had been,
281   PR         [uh huh.]
282   P          [ a:nd  ] my arms aren't getting the air that they might
283              have
284              before. because i'd also had some at the size of the
285              [  aprons  ]
286   PR         [((sniffs))]
287              (0.5)
288   PR         ((clears throat)) [((clears throat))]
289   P                            [ (  slb   slb  ) ] (you're familiar
290              with the term),
291              (0.5)
292   PR         yeah.=
293   P          =er that yeah okay the fat pad and (slb slb) round okay so
294              i had
295              some ((touches waist and lower back)) here and here
296              earlier in the summer. .hhh
297   PR         okay.=
298   P          =and i i was dealing with thee acupunctures for that, and
299              they
300              were gettin me on some sort of (1.0) herbal, (0.7) and:
301              (1.0)
302              anyway i still have some [under]
303   PR                                  [okay.]
304   P          my arms.
305   PR         both arms?
306   P          both [yeah.]
307   PR              [ is  ] one worse than the other?
308              (0.7)
309   P          tzt i like to think so, or i don't like to think s(h)o
310              whatever.
311              .hhh erm but erm i haven't shaved my pits for a while
312              ei(h)ther.
```


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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.
PR but that's not new that's that's something you've been dealing with for a while,
P yeah several months.
(1.7)
P but it doesn't ↑itch
((PR writing)) (2.4)
P 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.
P 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

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(7.3)
PR .hhh tzt well you know erm of bowel movements, erm
(1.4)
PR how often are you going,
(0.9)
P ↑uh ↓uh two three times a day.
PR two three times a ↑day
P uh huh. which is the normal for me.
((PR writing))(5.2)
PR ((sniffs))
(0.6)
PR formed, loose, watery?
(1.4)
P e:rm (1.5) gk gk generally formed.
PR uh huh.
P 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 ne(h)w
toi(h)lets (and stuff), and the(h)re's not a poo(h)l water .hh
PR [°okay.°]
P [or lot] of a pool water in there any more. .hhh erm hh so
sometimes they are less formed than others.
PR okay.
P but they have not been watery.
PR okay. do you have to wipe a lot?
(1.8)
P e:rm
PR do you get it easy?
P yeah, w- d- depend. er
PR so at times is
P yeah,=
PR =multiple wi(h)pe,
P oh yeah. but er i would probably do a multiple wipe even if i
didn't have to because [i]
PR [(slb)]
P would want to be:,
PR right but er,
P (careful).
PR 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

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403 slb slb)
404 another way of .hhh figuring that out is if they have to
405 wipe more
406 than normal.
407 P no i i haven't [a l m o s t]
408 PR [((clears throat))]
409 P crapped my pants no.[it's not]
410 PR [°o kay.°]
411 P that bad. excuse my French.
412 PR .hhhh and erm other than the fact you've had the urinary
413 tract
414 Infection, how's y- your urination normally?
415 (0.7)
416 P well i've been trying to drink a little bit more water so
417 of course i'm drinking,
418 PR uh huh,
419 P er more and i'm peeing more.
420 (0.8)
421 PR so how many times a day roughly? on average,
422 (0.7)
423 P o:h,
424 (1.1)
425 P erm i i try to if i feel an urge to avoid go between
426 classes or at
427 the break. .hh even er don't even if it's just a little
428 bit i just
429 don't wanna (0.8) dance in my hhh s(h)ea(h)t. (slb slb)
430 PR uh huh.
431 P because if i'm in class i'm drinking fluids and,
432 PR uh,
433 P .hh like this is,
434 PR ((clears throat))
435 P it's like this is artif- artificially sweetened peach tea
436 that they they sell from (selby), .hhh it makes me
437 thirstier. you know
438 if i drink water i'm not as=
439 PR =so [you're drin]king,=
440 P [thir sty.]
441 PR =diet, that's a diet drink?
442 (0.6)
443 P the- this particular one yes.
444 PR sounds [like there's sa]ccharine,=
445 P [it's the (slb)]
446 PR =and (slb slb slb slb)or something
447 [(it's slb slb slb slb)]

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P [i think it's probab]ly sorbitol.
PR [uh,]
P [or] something.
PR °okay.°
(0.5)
P .hhh normally i'm if if i'm at home i use (slb slb).
(1.1)
P [i don't]
PR [uh huh.]
P i don't use any any kind of saccharine or anything like that at home.
((PR writes on file))(3.2)
P 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)
P and i had a full thing of water today.
(1.3)
P so,
PR (slb slb slb slb slb slb)?
(0.6)
P oh i had some water before i left. but .hhh
(0.9)
P erm we're talking i probably drank sixty ounces of water t- er fluids today.
(3.3)
P coz that's thirty two ounces.
(2.5)
P and with the ice it got filled completely and then i poured some more stuff in it.
PR °okay.°
P so it's over sixty ounces of fluids. so no wonder (slb slb) i'm going (slb slb).
(0.8)
P but i er i'm like every two hours probably. if if i'm not
(1.1)
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 mi ddle]
PR [did you stop that]
P of the night [(slb slb)]
PR [did you] stop drinking at night?
(1.2)
P e:rm no coz i'm up until eleven twelve o'clock,

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493 PR >but you still gonna have to go before you wake up in the
494 morn↑ing<
495 P oh yeah!
496 PR yeah,
497 (0.8)
498 P but
499 PR just er you know (then you don't) fall back asleep (slb
500 slb slb slb),
501 P hell no!
502 PR no.
503 (0.6)
504 P ah hah
505 (0.5)
506 P the only thing that keeps me awake is you know like these
507 gun shots going off and,=
508 PR hu hu hu hu=
509 P =no it's it's the trash man that (comes round).
510 PR okay.
511 P three o'clock in the morning (until) the trash comes
512 around.
513 (1.4)
514 PR (slb slb)so er so how often are you having diet products
515 as far as beverages?
516 (1.3)
517 P tzt well i had been having an atkins drink,
518 (0.9)
519 P in the morning probably for five times a week.
520 (1.7)
521 P and on occasion i was having an atkins bar and that was it
522 as far as diet products.
523 PR i mean diet sodas.
524 P diet sodas, [oh,]
525 PR [yeah.]
526 P i'm sorry.=
527 PR =diet sodas, diet drinks, that kind of thing.
528 (0.4)
529 it's arl- artificially sweetened (with other than sugar),
530 (1.2)
531 P maybe once a day.
532 PR yeah? okay.
533 (2.2)
534 P and and not even that often. .h i prefer er selt↑zer
535 PR uh huh.
536 P to erm (0.8) you know to a soda i like the the sodas
537 because i can

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538		normally burp by myself, an i like to be able to burp on
539		occasion,
540		((PR writing)) (1.3)
541	P	tzt and: (0.5) s- sodas and seltzer (what it'll) do ↑for
542		you
543		((PR still writing)) (5.7)
544	P	and:
545		((PR still writing))(3.0)
546	P	no i got i got this coke,
547		(1.0)
548		i bought it in the summertime it's still hanging around!
549		(0.6)
550	PR	okay.
551		(0.5)
552	PR	.hhhhhh okay e:rm hhh tzt now last time you told me when
553		you ate er, this was er basically breakfast you said was
554		like er (2.2) er soy paddies atkins type diet, erm lunch
555		with protein with the salad no carbs, fruit with veggies
556		(0.5)
557	PR	for di↑nner
558	P	uh huh.
559	PR	does it sound about right?
560	P	[yeah.]
561	PR	[still?]
562	P	erm i haven't had the soy paddies for a little bit coz we
563		ran out.
564		(0.8)
565	P	but like today i had an a- erm
566	PR	((sniffs and clears throat))
567	P	atkins drink.
568	PR	uh huh.
569		(1.5)
570	P	erm
571		(3.6)
572	P	.hhh i had a bowl of soup from the school,
573		(0.6)
574	P	full cream and broccoli.
575		(2.2)
576	P	i had one and a half (0.6) chicken erm breast,
577		(0.9)
578	P	that i had cooked up without skin and i got some (slb slb)
579		and some erm relish from the cup from (slb slb). and i
580		sort of cut it off and i ate that together.
581		(0.7)
582	P	did i have anything in class,

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583 (5.8)
584 P ((rhythmic lip smack)) tz-tz-tz-tz-tz-tz-tz- yesterday or
585 toda- today, i think it was yesterday i had an atkins bar.
586 it's last of my atkins bars.
587 PR okay.
588 P i don't think i had anything in in: (0.6) my class,
589 although i was
590 probably looking for something coz the atkins drinks (slb
591 slb slb two hundred) calories.
592 (1.8)
593 P erm
594 (1.6)
595 P and then i've had wa↑ter
596 (0.6)
597 P and that: (selby) diet tea, and
598 PR [o kay.]
599 P [that's all] i've eaten today.
600 PR ((writing on file)) ((sniffs))
601 (1.3)
602 PR hhhh what are you planning (slb) for dinner,
603 (0.4)
604 P .hh that's a good question, i don't know.
605 PR uh, what did you have last night,
606 (0.6)
607 P .hhh o:h,
608 (0.4)
609 P last night i sort of (1.2) i had: three s- eggs scrambled
610 in olive oil,
611 (0.5)
612 P .h and some leftover,
613 (0.7)
614 P erm (1.0) t-t-t- ((rhythmic lip smack)) bean thread that i
615 had er rehydrated and i put some brown butter on it
616 because i've been trying to experie- experiment with
617 cooking it, so i can take it down at my folks house and
618 see how i can make it up coz i won't eat noodles but only
619 the bean thread,
620 PR uh huh.
621 (0.5)
622 P instead of the noodle. and i'd love it like (step up step
623 down) between now and (0.5)
624 PR uh huh.
625 P (doomsday) tzt what else did i, ha- i had some olive oil
626 that i sipped on,
627 (0.4)

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628 PR sipped on olive ↑oil
629 P i'll yeah. i drink olive oil on occasion.
630 (0.6)
631 P even had the doctor tell me i should.
632 (1.7)
633 PR how (h)often do you d(h)rink olive oil?
634 P every day.
635 ((PR writing)) (1.8)
636 P i'm not saying i drink a quarter of a cup,
637 (0.4)
638 P i'm only saying i drink it.
639 (0.4)
640 P (slb slb) the cup i might have a tablespoon,
641 (1.4)
642 P maybe two tablespoons,
643 PR did you choose that over say fish oil? or flax oil or
644 something like that or,
645 (0.3)
646 P yeah.
647 PR uh,=
648 P =well first of all i'm (slb) not gonna go up and get fish
649 (.) oil
650 when you just can't drink it.
651 PR well they have flavored fish oils.
652 P yeah i know. er (slb alexanders)
653 PR yeah. [(slb slb slb slb)]
654 P [(slb slb slb slb] slb slb)
655 PR yeah right. and there's also some other norwegian er you
656 know,
657 P yeah but er no. erm no erm this is just a little bit to
658 sip and (slb) i have some, and then i give the rest to the
659 dog it's fair trade and,
660 PR °okay.°
661 P it's sort of a mother daughter type of thi(h)ng. ha ha
662 (0.4)
663 P ha ha .hhh
664 (0.7)
665 P .hh that look exactly like my rottweiler.
666 (1.3)
667 PR [(slb)]
668 P [my] rottweiler loo(h)ks exactly like me!
669 PR .hhh why do you know, why are you doing it?
670 (1.0)
671 PR taking drinking olive oil? other don't you like it,
672 (0.6)

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673 P .hhh erm (0.5) originally it w- was i started doing stuff
674 with olive oil w- to get rid of gallstones many many many
675 years ago.
676 PR uh huh.
677 (0.8)
678 P and i use olive oil instead of butter (.) now for the most
679 part.
680 (0.5)
681 P on occasion i do (.) use butter,
682 (0.8)
683 P a:nd: that's what i use for (↑slb slb)
684 (1.1)
685 P so (normally) i put it on the salad but (0.5) sometimes i
686 don't
687 have lettuce in the house i just have a little olive oil,
688 oh! and i had: (1.3) a small piece of goat cheese about
689 this big, (0.6) about that high (1.1) because i had the
690 other oh [that's it!]
691 PR [((cough))]
692 P i had the other half of that goat cheese today er in in
693 class.
694 (0.6)
695 P before ten o'clock.
696 (1.0)
697 P i knew it i came up with something.
698 (0.6)
699 P tzt a:nd: i think i had a piece of soy cheese,
700 (0.6)
701 P you know,
702 (0.7)
703 P wrapper.
704 ((PR writing)) (3.0)
705 PR wra↑pper
706 P yeah it's preformed you know like ch-=
707 PR =oh you mean like a mozzarellas thick type thing,
708 P well no this is it's flat like american ↑cheese
709 PR >oh oh oh oh!< er okay that crappy fake er(ghee),
710 P well this is [this is]
711 PR [he he] he he tasty! [he he]
712 P [this is] soy cheese
713 (slb slb)
714 i'm used to it.
715 PR °hu hu hu hu hu hu° .hhh ((clears throat))
716 (2.0)
717 PR that just that? i mean just snack on soy cheese,

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```
718              (0.6)
719   P          yeah!
720              (0.5)
721   PR         °uh° .hh now this is the second time i'm going over diet
722              with you
723              and i really don't see much erm (0.6) fruits or
724              vegetables,
725              (0.9)
726   P          .hh erm i did not have any apples today i had them
727              yesterday, i
728              had   them the day before,
729              (1.3)
730   P          e:rm (0.4) yesterday i had: a s- salad,
731   PR         ((clears throat))
732   P          er erm (1.1) i went to the dining hall,
733   PR         uh huh.
734   P          apple s- some salad vegetables mixed in with the chicken,
735              (0.8)
736   P          e:rm (slb slb slb slb slb slb slb) something rather
737              (0.7)
738   P          erm tzt i had a couple of pieces of sliced turkey without
739              cheese i used mustard and mayonnaise .h and i put it on my
740              lettuce leaves so i rolled it up,
741              (0.4)
742   P          to make a sandwich with the the long romaine or: (0.7)
743              green lettuce leaves,
744              (0.9)
745   P          so that's what i had yesterday.
746              (1.2)
747   PR         okay.
748              (0.7)
749   P          and:
750   PR         ((croaky voice)) (are you) are you living on dorm here or
751              are you off >(slb slb slb [  slb or slb)<]=
752   P                                    [ (slb slb slb)]=
753   PR         =>(slb slb plan for the dorm here on you< [or)]
754   P                                                    [ i ]
755              i have erm money i
756              put on i think i put a hundred and fif[ ty dollars.]
757   PR                                                 [(o  kay so,)] (just
758              to)
759              this. [(go  o ver there,)((clears throat))]
760   P                [term  i  go   o      ver    there  ] once a week
761              maybe and,
762   PR         okay.
```


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(0.6)
PR .hhh erm do you not have the time to prepare meals?
(1.6)
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)
erm tzt some nut butter yesterday too.
(0.7)
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?
(0.6)
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)

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808 P i put olive oil on it.
809 PR °hu hu°
810 (0.9)
811 PR °(slb slb slb slb slb)°
812 P it's good!
813 PR no. and there's no exercise really you're not walking or
814 anything,
815 i know ye[sterday you walk-]
816 P [on ly a round] only around here. [uh]
817 PR [erm]
818 had you start
819 started to walk with carol? or is that [erm]
820 P [we] we we did but
821 it
822 (went) way down the tubes.
823 PR yeah?
824 (0.7)
825 P yeah when the weather got bad.
826 (0.5)
827 P or cool.
828 PR is there any place you can g- [start to walk?]
829 P [not around] not around
830 my house
831 at night.
832 (0.7)
833 PR what [about day?]
834 P [or during] well i'm not home during the day.
835 PR (slb slb)=
836 P =i'm here from eight until ↑five
837 PR i realize that. but what about: you have no breaks when
838 you can
839 you can walk along the water, or something or
840 P [i have a]
841 PR [i just wa]nna get you mo[ving. °(slb slb slb slb)°]
842 P [<i have an hour off>]
843 (0.7)
844 P <five days a week two of them are spent in class.> because
845 the
846 professors have (looped) the class time.
847 (2.3)
848 P and then i have erm k_four_i,(.) doctor joey's leadership
849 program, s_g_a and (saka)
850 PR ((clears throat))=
851 P =that are going in my lunchtimes.
852 PR the you need all ↑those

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(0.5)
P 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
(0.6)
P e::rm i'm probably about twenty five minutes away.
PR °right. .hhh°
P and i will not walk around my neighborhood.
PR °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 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:
(0.9)
P i work friday saturday and sunday until eleven except this week i'm working saturday until one a_m on sunday.
SC do you have a tape recorder?
(0.5)
P no.
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,
(0.5)

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P well that sort of m- means that you got to go ahead and be looking at it to [tape record it.]
SC [(oh it'll just] be lectures you know (slb) lectures erm micro, (histology slb slb slb) erm
(2.2)
P uh huh.
(1.9)
P well, (.) doesn't always work.
SC doesn't always but it's (nice to be listening),
P no i had, i don't have a tape recorder.
SC (slb slb)
((PR turns towards SD who has come in))(5.3)
SD so er er are you thinking about exercise options, are the- (these are) exercise that you like to to do,
P i like to swim.
SD you like to swim,
PR [((clears throat))]
P [i actually] have a bathing suit in my (carry on).
SD yeah?
P as we speak.
SD okay.=
P =and a towel.
(0.4)
SD and you (slb) at a nice pool,
(0.7)
P 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 [yeah]
P semester since i've been there.
(0.7)
SD erm
(1.3)
SD can er can you: er i'll tell you what i do (slb slb slb)
P erm i'm sorry i missed your name.
SD i'm i'm i'm franc sheridan.
PR it's the supervising doc[tor.]
SD [i'm] the doctor.
(0.6)

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P i assumed as much.
SD erm hhhh ha ha ha .hhh i was i actually a competitive swimmer at college,
(0.6)
SD so (slb slb slb slb for you) and (0.5) when i we- when i went (slb slb slb) school,
(1.0)
SD 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)
SD we (slb slb) up and we just decided (slb slb slb we'll swim) every day at lunch.
(0.6)
SD so we did. we went to pool we had you know dried from the pool (slb was outside)
PR ((clears throat))
SD (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,
P uh huh.
SD right? so we never ate lunch at lunchtime we always were eating lunch in class.
(0.5)
SD 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))
SD 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)
SD 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)
SD y- you know you you could you could you know (slb slb slb slb),
(0.7)
P uh huh.
SD i i would urge you to do that at least three times a week.
(0.9)
SD so you can come in,
(1.0)

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SD you know come in earlier and start your day with a swim.
P hhhh
SD see,
P [hu hu hu hu hu .hhh]
SD [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, (.)=
P [hu]
SD =[you jump in the water,]
P =[hu hu hu hu hu hu] hu
SD and you shower after you get out of the pool, do your hair,
(0.8)
SD (and run off) to class.
P uh huh
SD right. that way y- (0.5) you're not you're not doing the shower thing twice.
P uh huh.
SD right. and get more efficient.
(0.7)
SD 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)
SD you'll be (feeling) pretty good.
(0.7)
P it's it's hard for me to get up in the morning.
SD yeah.
P it's it's a good idea.
SD yeah i would [i]
P [i] mean i i did make it with carol,=
SD =(slb slb slb slb) that [at least]
P [pro ba]bly for a week.=
SD =here's the thing!
(2.5)
SD 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)
SD 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 slb normal).
P uh huh.

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(0.5)
SD you're waking up sluggish in the morning. it's a
[(slb slb)]
P [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,=
PR =((clears throat))=
P =i'm fixing my lunch in the morning! jennifer and i are
pushing each other with the elbows, try(h)ing to ge(h)t
the sa(h)me ki(h)nd of space .hh erm
SD yeah. so, [(slb slb slb)]
P [(slb slb) i'm] reading [reading something]
SD [(the question is)] can
can you get creative enough, to carve out the time for
yourself to get moving,
(1.0)
SD right?
P uh huh.
SD (go take) carve out some time to go for a swim,
(0.7)
SD and can you get? (.) 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)
SD and er thee and this is important for you coz you're a
student now and when you when you're done being a student,
guess what?
(1.9)
SD it doesn't get any easier. you
PR [hh hh]
SD [just get] busier.
(1.4)
SD 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)
SD and that's gonna take some creativity and use of your own
imagination.
(0.6)
SD and then (slb slb slb) you have practice to get it on the
way.
(1.7)
P uh huh.

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SD we can help with suggestions (slb slb slb slb)
(0.5)
SD 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)
SD i'm gonna be (slb slb) make it happen,
(1.1)
SD insist.
(0.6)
P uh huh.
(0.9)
SD it has to become a part of you (.) part of your life part of your routine.
(1.5)
SD otherwise you're not gonna be successful.
(3.5)
SD right if you go oh i (slb slb slb) i guess i need it i need the exercise,
(0.5)
SD 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)
P uh huh.
(0.5)
SD right?
(0.6)
SD see the difference?
P yes.=
SD =you have to really incorporate that into who you are.
(3.2)
SD when you do that, (2.7) you will have you'll be happy.
(0.7)
SD 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).
P uh huh.
(0.4)
P (it's all way) up to go.
SD right [and]
P [ha]
SD [and i]
PR [hu hu]

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SD and i i expect that,
P and i did exercise last two days i was racking the yard,
(1.0)
SD that's good.
(0.7)
PR [(slb slb slb)]
SD [(slb slb slb] that's good work okay).
P 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)
P but erm tzt i did the racking.
(2.8)
SD any other s- stuff,
PR .hhh ouch yeah it's it's it's a time this is (slb) a time
issue.
SD [yeah.]
PR [erm] a[ny] suggestion=
SD [yeah]
=that's it it's
[(just a time i ssue)]
PR [a ny su ggestion] seems to be erm
SD yes,
PR seems to be countered with erm a time issue. erm
SD 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)
SD we were talking about resistance.
(0.4)
SD 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 slb) but when he when he was
trying to extrapolate that out to to to erm to what's
happening (to him) emotiona↑lly here's resistance. what
you're what you're describing is your (slb slb slb slb)
resistance (to making suggestion).
(0.8)
SD and there's erm there's an excuse for everything (.)right?
that's in that's for resistance.
(0.8)
SD 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

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1168 against it.
1169 (0.9)
1170 SD and and
1171 (0.5)
1172 SD and so part of working with the system is, you know you're
1173 working, as okay this is a pattern.
1174 (0.5)
1175 SD right? now can we change the pattern. how do we change the
1176 pattern,(.) and the opposite of resistance is (1.0)
1177 sensitivity. right and if we're talkin about (.) about
1178 increase in sensitivity, that means when when you're in a
1179 er in a conversation with somebody, (0.6) (you also do
1180 that) you increase your sensitivity you listen.
1181 (1.5)
1182 SD and not just hearing you're listening.
1183 (0.9)
1184 SD right. and you're listening with an open mind. that's
1185 increase in sensitivity.
1186 (0.6)
1187 SD okay many of us also has have high levels of sensitivity
1188 for erm certain things. other things can you know our
1189 sensitivity's gonna be (0.5) oh that's bad. oh oh that's
1190 good. i'm gonna do that. (.)
1191 right? and so so and sometimes all the waters get crossed.
1192 PR [((clears throat)]
1193 SD [(slb slb slb)] as waters get crossed so there'll be
1194 questioning times. you have to you have to be again open
1195 minded to evaluate where this sensitivity (slb slb hot
1196 spots are to go) does that make any sense?
1197 (0.9)
1198 SD in (0.3) today's ↑world
1199 (0.3)
1200 SD there's a lot of (other) patterns,
1201 (0.3)
1202 SD (slb slb slb) a long long time ago.
1203 (1.2)
1204 SD and have to do with with resistance.
1205 (0.9)
1206 SD [right?]
1207 P [i] have to tell you part of your discussion with me
1208 was like listening to my mother. and there was resistance
1209 in that part of the discussion.
1210 SD sure! so this,=
1211 P =coz this was like,
1212 PR hu hu [hu hu hu]

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P [ha ha ha]
PR hu
P i don't wanna hear this at ↓all [hhh]
PR [hu] hu
P .hhh
SD 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 o↑kay 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,
P oh yeah!
SD okay? and so that's that's the first step you go. (0.4)
now now
(slb slb slb) who(h) who(h) wa(h)nts the resistance?
(0.9)
SD right, what what is that and is that still a useful you
know,
(0.5)
SD er tool for you?
(2.1)
P 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.
hhh
(0.4)
SD yeah [so is it?]
P [ha ha .hhh]
SD is it useful for you in this situation,=
P =no it's not.
SD right.
(0.4)
SD and that's it. open (slb slb) conversation (slb slb)
communication
so you see this again and again and again and [a gain.]
PR [uh huh.]
(0.4)
SD and
(0.9)
SD 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)
SD what i (slb slb slb slb slb but you may wanna) consider as
well is when you come into this environment,

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1258 (0.6)
1259 PR ((sniffs))
1260 SD you're coming with an open mind.
1261 (0.4)
1262 SD which means you're prepared to listen to suggestions er
1263 and and instead of being resistant right away, you're
1264 you're which is which is which we recognize as as
1265 essentially a defense mechanism.
1266 P °uh huh.°=
1267 SD =okay,
1268 (0.5)
1269 SD and the whole i guarantee you. (0.6) you come in with an
1270 open mind and you go (0.5) hu well that works. (coz i slb
1271 slb slb slb with)
1272 you ↑know and you go through that that that (slb) pattern
1273 whatever that is which is sensitivity. okay you go yeah,
1274 oh okay (he has interesting suggestions). maybe maybe i'll
1275 listen to what he has to say right?
1276 (0.6)
1277 SD and
1278 (0.8)
1279 SD w- will that work in my life (or that) can i do that,
1280 that's sensitivity okay?
1281 (0.4)
1282 SD and then (0.4) it may ultimately be like well (0.7) you
1283 know erm it may ultimately (slb slb slb slb) well that's
1284 that's not gonna work but a piece of that (will work).
1285 P °uh huh.°
1286 (0.7)
1287 SD right?
1288 (0.7)
1289 SD and as you develop that sensitivity and keep that open
1290 mind, (.) that's when you open yourself to change.
1291 (0.6)
1292 SD when you resist it and you're not entertaining opp-
1293 opportunities,
1294 (0.7) there will be no change.
1295 (0.5)
1296 SD and i will guarantee if you don't make any changes with
1297 with with this stuff,(.) your way is not gonna change (slb
1298 slb). ((knocks))
1299 (0.6)
1300 SD because (0.5) (slb slb slb slb slb slb slb slb slb slb slb
1301 slb)
1302 (0.6)

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P u:h .hhh erm one of the er er you need to have a a vacuum
for something to come in. you 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 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)

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SD okay?
P okay.
SD 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)
SD that you're here, (0.6) that's a good sign.
P uh.
(0.6)
SD (slb slb) say how committed are you to make these changes in your life?
(3.4)
P tzt fairly.
PR okay.=
P =not a hundred percent.
SD okay.
(1.7)
P (o[kay).]
SD [you] can think about that between now and our next meeting as well.
PR .hh hu hu
(1.2)
SD okay?
P okay.
SD coz when you when you're when you're absolutely committed to changes that will happen. (and it will happen slb).
(2.1)
SD (°okay,°)
(4.4)
SD is that feasible?
P yes.
(0.8)
SD so erm (0.6) so you're on your way to start a new course in your life.
P okay.
(1.5)
SD that
(1.5)
SD erm
P okay.
SD (ready to wrap up),
PR okay.
(1.3)
P uh huh.
PR okey dokey.
SD (slb slb slb slb)

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1393 (1.5)
1394 PR ((clears throat)) tzt
1395 ((P looks at watch while SD signs files))(5.8)
1396 PR ((smiling at P)) (it's late).
1397 (1.9)
1398 PR okay.
1399 SD that's it.
1400 PR alright.((SD leaves))
1401 (6.4)
1402 P ((waving with right hand)) hello! (.) ((waving with left
1403 hand)) good bye! .hhhhh hhh hh
1404 PR well i mean er er (.) i mean he said it more elegantly
1405 than i i could, oh as far as the whole situation and and
1406 as he says when i (0.4) have been making suggestions i've
1407 been (0.5) the wall's gone up. you know .hh it seems like
1408 it's it's it's hard to you know,
1409 (0.7)
1410 PR er to say let's try to get a little er walking or exercise
1411 or something into it. and you know then the whole the
1412 whole the whole of this comes down as far as as
1413 P you know i er i hadn't thought of it that way.
1414 PR and it ye know it's it's frustrating on this side, because
1415 it's the k- i wanna help you.
1416 P [uh,]
1417 PR [i] know i can help you but if we're not going to work
1418 together, then,
1419 (0.7)
1420 PR you know things are gonna you're gonna come in here, .hhh
1421 you're gonna hhhe he he he he he he .hhh no nothing's
1422 happened. i'm gonna get frustrated and the whole you know
1423 the whole thing is gonna just you know,
1424 P okay.
1425 PR just kind of move like that. .h i mean we're all students
1426 i know it's a pain in the ass. erm but er
1427 P no. i- [i- i- i-]
1428 PR [i- it is] not easy.[i know.]
1429 P [i- in] the fourth semester
1430 i'm in class thirty eight hours a week.
1431 PR i understand that. i i [mean]
1432 P [yeah.]
1433 PR we i mean i m- you know we're all on the same boat. and
1434 .hh you you'll get through it. but you know some of the
1435 things you know i mean you (know) the kay one seminar this
1436 seminar (another thing), and if you wanna do it fine. but
1437 .hhh you know you gotta get to consider what what what's

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1438              what's a better (0.3) balance for you as
1439              far as, (i know) i don't know what time thee the the the
1440              gym opens i don't know what time the pool opens. .hh
1441   P          [yeah i have to   go over]
1442   PR         [ i   i know it's   o pen]
1443   P          there and find out.=
1444   PR         =i know it's open after (0.4) after class for you. and
1445              you're probably getting out like at fourish most ↑days
1446              four,=
1447   P          =five thirty,
1448   PR         okay whatever.=
1449   P          =six o' clock.=
1450   PR         =whatever day it might be but even if it's like you say if
1451              you could get over there for half an hour,
1452   P          [uh,]
1453   PR         [be ]fore you go home you know make a part of it your day.
1454              (0.5)
1455   PR         you gonna go over there you gonna get moving you gonna
1456              feel better because you did that. and it's also gonna take
1457              some stress out.
1458   P          uh huh.
1459   PR         and you'll be more set up for the evening.
1460              (0.8)
1461   PR         you know .hhh and then if we can somehow (0.6) pr- you
1462              know i i mean to say you know it it's a (time consuming)>i
1463              mean who wants to go over to the gym, and then who wants
1464              to go home and make supper, and then who wants to go home
1465              and sit and study,< (0.3) you know >it's it's it's it's it's
1466              it's< it sucks you know?
1467   P          uh huh.=
1468   PR         =it's: and then you know and then you know if you have to
1469              catch up on the weekend and you're working, .hh you know
1470              and and th- and and that's that's not easy. it's ↑not
1471              easy. by any means. .hhh so,
1472   P          uh huh.
1473   PR         you just take it,=
1474   P          =say there's no money either!
1475   PR         and there's no money. and there's no money. [which is]
1476   P                                                     [  hh hh ]
1477   PR         also another complicating issue in the whole (slb slb),
1478              but you don't need money to do the exercise.
1479   P          ha ha ha .hhh=
1480   PR         =that's something you don't need money for. so,
1481              (0.6)
1482   PR         run over and find out what the schedule is (that),
```


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1483 [(slb slb that you like) i mean i mean (how much)]
1484 P [i will run o ver and find out the schedule.]
1485 PR you want you like to swim, you said you have a (0.4)
1486 P a suit and a towel.
1487 PR a suit and a towel in your carry on you're ready to go!
1488 you [know?]
1489 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
1500 some days it's higher than others and (not so good. i mean
1501 it it)
1502 (0.5)
1503 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↓o 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,

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1528 (0.5)
1529 P i will [do so.]
1530 PR [if if] it works in the morning (ask) i think that
1531 will work great for you just because you could just just
1532 set that damn alarm for five thirty and get up you know,
1533 .hh you can get up do you think and get out er before er
1534 before (slb slb slb you were mention↑ing)
1535 SC (slb slb [slb slb)]
1536 P [i have] jennifer and i have teddy.
1537 PR well i mean you you can get out it's hopefully before they
1538 get get going or whatever. at least that won't be that
1539 much of a battle in the morning. .hh and i mean you know
1540 and then if not, [(slb slb slb slb)]
1541 P [oh if i t- if] i take a shower over
1542 there then i don't need i don't
1543 [have to fight for the b-]
1544 PR [yeah so that, right so that's]
1545 so there's [(slb slb slb)]
1546 P [te ddy and] i take showers in the morning.
1547 and [(slb slb)]
1548 PR [so there's] you know there's a little window it
1549 sounds like (this) depending on what time they're open.
1550 (.) i don't know if they open at at at the right time for
1551 you that's that's the thing.
1552 so just run [o ver and get the schedule,]
1553 SC [(slb slb slb slb slb slb slb)](seven)
1554 PR oh they open that ↑early
1555 SC er er er
1556 P er
1557 SC sometimes i've heard (someone) say five but,
1558 P i don't think [they o pen at five.]
1559 PR [five would be (slb slb)] [(slb slb)]
1560 SC [(slb slb)] (slb
1561 slb)=
1562 P =maybe [six.]
1563 PR [se]ven or six.
1564 P six thirty maybe.
1565 PR but you know six thirty would be great you know and that
1566 six to seven range would be great for you. you can get up
1567 (0.5) you know .hhh i mean if you're making a meal the
1568 night before make an extra and just throw it in a
1569 container and bring it for lunch.
1570 P uh huh.
1571 PR you know,
1572 P .h did you want me? (0.6) hell i don't wanna ask this. did

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you want me to stop eat- having my atkins shakes in the morning?

PR .hhh erm what i would like you to do, (1.4) is (0.4) have a meal in the morning

(2.1)

PR rather than the at[kins shake]

P [o kay.] well i c- i don't eat c- cereals,

(0.5)

PR i'm not talking a[bout what you would nor]mally=

P [that sort of leaves me]

PR =think.

P eggs.

PR no i'm thinking of what you would gonna normally have for a normal dinner.

(1.5)

P so [i]

PR [(slb)]

P i i've been known to have (slb slb slb) sauerkrauts [in the morning.]

PR [no. i mean i]

P [for breakfast.]

PR [wa nna yeah.] i wanna i'm talking a nice healthy dinner you know, chicken with some vegetables er er or or whatever. .hhh but if we could er er 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

P [o kay.]

PR [from (slb)] there.

P 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

PR [o kay.]

P [all day] long.

PR well you will start your metabolism up by eating in the morning.

[a:nd]

P [i'm] aware of this.

PR and it's not necessarily bad for a person to be eating all day long depending on what you're eating all day long.

P no it was more like a seafood diet.

PR okay well, i mean you [go]tta

P [hhh]

PR make sure what you're seeing as a[ppro]priate

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P [hu.]
PR .hhh so .h erm the reason probably why because you were setting your metabolism and you wanted more food, and basically you gotta feed the furnace in order to lose the weight. .hh and erm er it sounds to me you have very er subca- subcaloric diet here. .hhh erm for the most part i mean and if we can [just]
P [no.] i d- i yeah i don't eat carbs,
PR right.
P [nor ma lly.]
PR [which is <u>good</u>] which is fine. which is you know?
P otherwise you know i would love to sit down and have (0.5) chips with salsa sometimes.
PR yeah well, sometimes do it!
(2.1)
P okay.
PR 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)
PR you know i mean who want you know er you live life you(he) know,
P uh huh.
PR enjo(h)y what you enjoy.
P yeah well, no.
PR (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 <u>instead</u>,
(1.1)
PR before you go to bed you know in that range,
P what is a time that i should not eat after?
PR .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 <u>crap</u>py night sleep. so i kinda [(slb slb slb)]
P [i've been known] to eat at eleven.
PR well so have i. and then i i j- i sleep like hell. then i
P [oh,]
PR [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.
P okay.
PR you know and [not much]

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1663 P [i- it] work [i can]
1664 PR [((clears throat))]
1665 P probably eat by eight o'clock.
1666 PR yeah.
1667 (0.4)
1668 PR and then erm that's why i say if you eat more during the
1669 day it kind of, and kind of say say let's have an atkins
1670 and maybe some erm apple and a salad, or or whatever in
1671 the evening you know or soup and salad in the evening .hh
1672 instead of you know a bigger meal, then i think you'll be
1673 much better off too.
1674 (0.7)
1675 P okay.
1676 PR so just those er just this is kinda make those th- little
1677 changes, try to get that exercise in there and then switch
1678 the calories to the front end.
1679 (0.5)
1680 PR (and they've done) specific studies calories in the
1681 morning get burned off you lose weight, .hh calories in
1682 the afternoon kind of stay with you .h and maintain your
1683 weight, calories in the evening
1684 (0.7)
1685 PR go up. (.) the weight goes up.
1686 P okay.
1687 PR okay?
1688 (0.9)
1689 PR well let's just make those little couple of changes.
1690 P okay.
1691 PR erm it's not (slb let's see) how we can make an effort to
1692 to fit it in the schedule.
1693 (1.4)
1694 PR otherwise we're just gonna do this every time.
1695 ((bangs his head against the closet))(1.3)
1696 P ((smiling voice)) no that's that's you!
1697 PR hu hu hu hu [hu hu hu hu]
1698 P [ha ha .hhh .hhh]
1699 PR .hhh so,
1700 P okay.
1701 PR okay.
1702 P did you want to check the underarms?
1703 PR [e:rm]
1704 P [or not,]
1705 PR not today. let's come=
1706 P =not today,
1707 PR yeah. er i- it's a quarter of now i'm out of time. .hhh

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1708 erm
1709 (0.8)
1710 PR .hhh are you putting anything on 'em?
1711 P i am using regular deodorant and i've been using (slb slb)
1712 and then .hh i went (slb slb) at the trader joe's which so
1713 i'm not using aluminum.
1714 PR okay. .hhh erm=
1715 P =erm i had been using (1.4) t- something with aluminum but
1716 since i don't shave my pits it's not as bad.
1717 PR you can try (slb slb) i think we (still) it in in the
1718 clinic that i've there's a c_c_c cream in the clinic and
1719 then there's a (slb slb) cream .hhh in the clinic. .hhh
1720 erm downstairs erm i've i've had i've had a little rash
1721 problem under my armpits (slb slb) just got over (slb)
1722 using the (slb slb) cream. erm
1723 P [is that] something i need to have a script for?
1724 PR [that kind] erm no you're a student so you can go down and
1725 get it. and then there's a c_c_c cream which erm vitamin c
1726 calendula and tzt maybe c- erm there's another c in there,
1727 i forgot what it is. but that's that's a good topical
1728 product too.
1729 (0.4)
1730 P i do have calendula erm crea:m.
1731 PR [uh]
1732 P [i] have some
1733 (0.9)
1734 P erm (tre ↑mel)at home [(slb)]
1735 PR [(slb] tre ↑mil)
1736 P [(tre mil. tre mil.)]
1737 PR [yeah that's good for](inflammation.) .hh you could use
1738 it
1739 (0.5)
1740 PR erm with=
1741 P =okay.
1742 PR put some on tonight and see what happens. .h even if even
1743 if you you put some stuff >(er there and if it is useful
1744 we can make it we can just slb stuff that get it out)<
1745 (0.7)
1746 PR and then we can probably we'll probably well let's work
1747 some erm erm next time we talk would you do any probiotics
1748 or anything like that?
1749 (0.5)
1750 P .hhh not parti[cu]larly.=
1751 PR [no] =okay so we'll try and get (slb slb
1752 slb slb slb) type of supplementation routine.

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P but i-it's something i actually started looking at and i called up: e:rm (nutriawestern) and: (maasen) and somebody else today, .hhh and asked for [stuff to be sent to]
PR [(the ca ta logues,)]
P me.
PR okay great. .hhh then [erm when you]
P [erm al so]
PR get,
P from also for my mum.
PR okay.
P because she needs some stuff.
PR that's good.
P [a:nd]
PR [so] then will you have access to that so you get a cheaper and
(slb slb slb),
P but i you know i have been taking supplements,
PR uh [huh]
P [(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.
PR okay i'd rather you see [er]
P [i]
PR i'd [ra]ther you=
P [is]
=out
PR .hh i'd rather you see you you to get it from other new companies. a good multi,
P i don't have any multi right now.
PR okay well i'd rather you wait a couple of days,
(0.6)
PR get your catalogues,
(0.7)
PR and then order something from one or the other companies. erm vital nutrients is a, did you get their catalo↑gue yet
(1.1)
PR i'll give you one when we, vital nutrients offers erm postal price plus twenty percent off the whole sale to to to students.
P [uh!]
PR [and] they don't charge you for shipment.
P oh that sounds [intere]sting,=
PR [okay.] =so you'll actually get a much much greater greater quality.
SC (slb slb [slb slb] vital nutrients is awesome!)=

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1798 PR [product] =and: ye
1799 it'll be cheaper than what you get at trader joe's so i'll
1800 give you that catalogue (make the thing [that slb)]
1801 P [o kay.]
1802 PR (slb slb [you know)]
1803 P [coz i] i do buy erm
1804 (1.1)
1805 P i said i take a hundred and fifty (co_q ten) a day, i take
1806 er eight hundred er er i_u_c_v. >i started taking c i
1807 hadn't been taking c because i had (slb slb slb slb)< (.)
1808 but now i understand i need ↓it for (solid) [re pair!]
1809 PR [(don’t know)]
1810 if there was any correlation that they found between
1811 vitamin [c and your stones.]
1812 P [well i was told]
1813 there there [was.]
1814 PR [yeah.]
1815 and all the studies have come that that (slb slb) [right]
1816 SC [(yes]
1817 (slb slb) recently the hugest study that there've been
1818 (slb) people with the highest glu↑cose
1819 (0.6)
1820 SC (slb slb slb)
1821 PR (the slb slb kidneys) so,=
1822 SC =(slb slb out of their genetics)
1823 PR yeah.=
1824 SC =(slb slb slb) some people have a genetic tendency (but
1825 it's like quite o o two percent.)
1826 (0.5)
1827 P oh [i had, i had (slb) o]peration=
1828 SC [(slb slb slb slb slb slb)]
1829 P =for (slb) stone but [it was huge]
1830 SC [(slb slb slb] slb slb slb slb)
1831 PR so i would not erm
1832 P okay.=
1833 PR =worry about the vitamin c you're getting.
1834 (slb [slb slb] slb)=
1835 P [o kay] =and and i take (slb slb slb slb slb)
1836 PR [sure.]
1837 P [and] i think i told you (slb slb slb slb)
1838 PR e:rm
1839 P but i buy some of that stuff at trader's.
1840 PR okay. next time okay?
1841 P oh sure. my little go a↑rounds
1842 PR hu,

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1843 P i'll relabel them up.
1844 PR [(slb slb slb slb)]
1845 P [when do you wa]nna see me again?
1846 PR erm
1847 (1.0)
1848 PR when you gonna make some changes.
1849 (0.8)
1850 P well i think it's a case of when can you fit me in at all!
1851 PR well er er i mean
1852 P for here because i can go [a head (slb slb slb)]
1853 PR [they want to you they] want
1854 you to do that .hhh i mean i can fit i mean i'm usually
1855 you know i'm here on tuesday wednesday thursday.
1856 P okay.=
1857 PR =so however that fits into your schedule,
1858 P erm
1859 PR erm
1860 P tuesday i'm off from class at four thirty.
1861 PR so if you wanna come back,
1862 P erm=
1863 PR =next=
1864 P =i think you're pretty booked.
1865 PR i'm i may be. i don't know i have to see the schedule but
1866 so you have to look at the schedule see how it looks but
1867 .hhh there's no point in coming back unless we've,
1868 P no.
1869 PR made an effort in er actually doing something a little
1870 different than we have been.
1871 P so we we probably need to look at well it's it's you
1872 you're not here thanksgiving week don't?
1873 PR no so [pro bably af]ter=
1874 P [i'm looking at]
1875 PR =thanksgiving there's hope there's er er plenty of (hope).
1876 is this off yet?(.) have you turned this off yet?
1877 SC (i don't know).
1878 PR hu hu hu hu ha ha

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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 uh 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 =o[kay.]
P [yeah.]
(2.8)
PR now how often do you have attacks?
(.)
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

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44              they said i'll go need it again.
45   PR         oh okay. so you hadn't been using ↑it
46   P          no, a(hh)ha [no.]
47   PR                     [ o ]kay okay. .hh and so was it last night
48              that you went to the er, or [a month ago? ]
49   P                                      [oh no. it was] last week
50              sorry.
51   PR         last week.
52   P          [last we- ]
53   PR         [no that's] okay i misunderstand.=
54   P          =yeah last week.=
55   PR         =okay, (1.2) now i feel very conscious of what i'm saying
56              because of hhh this microphone >([slb] slb slb slb slb
57              slb)<=
58   P                                             [huh]
59   PR         =but .hh erm ((writing on file)) (8.5) okay so when erm
60              when did you stop using an inhaler, coz i guess you'd used
61              it in the past,
62   P          yeah and then i just stopped using that. i think,
63   PR         uh huh.
64   P          i think bout four years ago.
65   PR         okay.=
66   P          =if i'm right.
67              ((PR writing))(5.5)
68   PR         and how long had you been using it?
69              (.)
70   PR         before you stopped.
71   P          o:h erm erm i've had asthma since i was born so,=
72   PR         =o:h okay.=
73   P          =so this is a lifetime [thing]
74   PR                                [huh? ]okay (.) so do you know how
75              had you been i guess you'd been using the inhaler all
76              [all the ] (time then),
77   P          [yeah did]
78   P          yeah during all my [life.]
79   PR                            [ o   ]kay okay. (.) so how often did
80              you use to use it before you stop[ped]
81   P                                           [de ]pend. it depends
82              e:rm (.) if because i'm bad at it [i could]
83   PR                                           [uh huh.]
84   P          be using ↓it once a day twice a day three times a day[or ]
85   PR                                                               [oh!]
86   P          if it was really bad [as ] often=
87   PR                              [uh,]
88   P          =as ne[cessa]ry so,=
89   PR                [okay.]
```


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```
 90   PR          =but you were using it at least once a day it sounds ↑like
 91   P           [yeah.]
 92   PR          [(slb ] slb)
 93   P           it dep- yeah.
 94   PR          ((writing)) °okay° (12.4) okay now had you been taking any
 95               kind of erm medication to prevent asthma attacks? or doing
 96               anything else,
 97               (.)
 98   PR          in the past?
 99               (.)
100   PR          or was was the inhaler the only thing you used for asthma?
101   P           the inhaler was the only thing i was i was using at the
102               time.
103   PR          ((writing)) okay (7.2) so okay so you didn't take anything
104               by mouth any kind of pills for ↑it
105   P           no not that i can remember.
106   PR          ((writing)) okay (3.9) okay so you decide, ((knocks at the
107               door)) °okay° (.) come in!
108   SD          hi ya there.
109   P           how you doing,
110   SD          how is it going?
111   P           how you doing.
112   SD          nice to meet you.
113   P           you too.
114   SD          (slb slb slb) and
115   P           huh,
116   PR          [huh]
117   SD          [pho]tograph and everything [ a bout] yourself,=
118   P                                       [huh huh]
119   PR                                      [huh huh]
120   P           =uh,
121   SD          but we must do that.
122   P           no problem.
123   SD          what brings you in today?
124   P           uh curiosity i guess [i've]never=
125   PR                               [ erm]
126   P           =i've never done alternative medicine but i read i read
127               something about it and so i wanted to give it a try.
128   SD          okay ramona what: what's going on?
129   PR          well i just got erm a couple of health issues. specific
130   SD          [  uh, ]
131   PR          [health] concerns he wants to address, erm one of them is
132               weight erm which we're gonna talk about when we're gonna
133               get to weighing him and [ tak  ]ing=
134   SD                                  [great.]
135   PR          =height and weight and [body ]=
```


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136 SD [sure.]=
137 PR =mass. and [that]=
138 SD [uh.]=
139 PR =erm and he does work out three times a week but he was
140 you know he had erm he had his blood pressure checked at
141 the u_b clinic
142 downstairs [e:rm] about a week ago,=
143 SD [uh huh,]
144 P =uh huh.=
145 PR =right an they said that his blood pressure was a little
146 bit high.
147 SD okay.
148 PR erm so we took it here. erm he also has asthma, lifelong
149 asthma.
150 [we were]
151 SD [uh huh.]
152 PR kind of talking about that and getting to the history of
153 he's been doing [for it,]
154 SD [er sure.]
155 PR erm so he had an attack last week of asthma which he
156 hadn't had attacks in six years,
157 SD uh huh.
158 PR which is great,
159 P uh,
160 PR we were already talking about that you know [and a]bout=
161 P [uh huh.]
162 PR =he hasn't used an inhaler in four years.
163 SD great!
164 PR but he used to use the inhalers, erm sorry to talk about
165 you like you're not he(h)re. but(h)erm=
166 SD =this is something we do normally.
167 P uh [huh.]
168 SD [when] you know they they tell me what they've asked
169 you and [(stuff)]
170 P [yeah.]
171 PR [this is our (.) yeah]
172 SD [(it's funda mental)] (slb slb slb slb) now and again
173 yeah.
174 PR yeah it's kind for them to evaluate that we're learning,
175 P uh huh.=
176 PR =so that's why [we're talk]ing about you(h) so(h)rry.=
177 P [oh good.]
178 PR =[.hh erm]
179 SD =[he had]an attack last ↑week
180 P uh huh.=
181 PR =right and he hadn't had an attack in six years erm had

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182 been using the inhaler until four years ago. .hh er so
183 when he was told erm after he went to the emergency room
184 last week for the attack, he was told to (consider) using
185 the inhaler again so that maybe one thing we can help him
186 with is you know preventing,
187 SD what [drug, were]
188 PR [with as]thma=
189 SD =you using it abute↑rol or=
190 PR =uh huh.
191 P well they gave abuterol now.
192 SD right.=
193 P =but when i was in this i was using the strong stuff. erm
194 proventalin.
195 SD proventil.=
196 PR =uh [huh,]
197 P [yeah] the the strong one.
198 SD okay.
199 P so i was using that erm i was using that for a while.=
200 SD =okay.=
201 P =and then i just stopped using it.
202 SD okay so you're never using anything other than that for
203 your asthma,
204 P no.
205 SD okay.
206 PR °okay.° so erm (.) er we took his blood pressure here
207 [erm]
208 SD [yes.]
209 PR and we took it erm with a regular size and a large size
210 [cuff.]
211 SD [uh.]
212 PR erm and it was one twenty over eighty six.=
213 SD =uh huh.=
214 PR =and one twenty six over ninety erm on the left side.
215 SD okay.
216 PR for thee:: regular versus large cuffs. so they're about
217 the same and the other arm the right arm is one twenty
218 eight over eighty six,
219 SD okay. (.) right.=
220 PR =so [i mean]
221 SD [and how]old are ya?
222 P twenty six.
223 SD right. (.) that that that's normal.
224 P uh huh.
225 SD but you know we will [we'll erm] we'll see what else=
226 PR [°uh huh°]
227 SD =(slb slb) weight and everything else.

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228 P uh huh.
229 PR and if they took your blood pressure at the emergency
230 ↑room
231 P uh,
232 PR i'm sure you were very anxious
233 (.)
234 PR at the time.
235 P yeah that's [what they] said.=
236 PR [and that] =right that raises your blood
237 pressure.=
238 P =yeah.=
239 PR =even the next morning you may still have been feeling
240 anxious and nervous [and,]
241 P [yeah.]
242 PR i mean we would have to take your blood pressure three
243 times. you know three independent different visits,
244 P yeah.
245 PR erm to really make any kind of con↑clusion
246 P uh huh.
247 PR erm cause that's just part of the standard diag↑nosis
248 P okay.
249 PR erm but yeah i mean i don't i i guess they did explain
250 that to you
251 though [that that was,]
252 P [yeah that's what] that's what [they said.]
253 PR [uh huh.]
254 SD [uh,]
255 P [an,]
256 PR [yeah.]
257 (.)
258 PR but you know it's always good to have good cardiovascular
259 help and we're think[ing]ahead,=
260 P [uh,] =yeah e[xactly.]
261 PR [you know] °yeah.°=
262 SD =right so continue with your history,
263 PR uh huh.=
264 SD =e:rm erm (.) get his weight and his height,
265 PR uh huh.=
266 SD =and come and talk to me it should take you probably about
267 another:, (.) well let's say twenty minutes to complete
268 your history and get=
269 PR =uh huh.
270 SD get that done. do a quick line and then come and grab me.
271 okay?
272 PR okay.
273 (.)

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```
SD          nice to see ya.
P           okay.
            ((SD leaves)) (2.4)
PR          okay so: erm (.) let's see so do you normally had, you
            have you been having any breathing problems in the last
            four years,
P           no:.
PR          [no?]
P           [not] really.
PR          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)
PR          you know?
            (0.5)
PR          what kind of gave you the courage to stop using the
            inhaler?
            (0.8)
PR          or you [just]
P                  [ no.]
PR          decided that you were=
P           =nothing really i just,=
PR          =you didn't [need it,]
P                       [stopped.]
PR          °any more,°=
P           =i just stopped. it i just stopped!=
PR          =uh huh. okay.
P           i mean i had prescription to fill up but i just left it
            there.
PR          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,=
P           =yeah.
PR          [okay.]
P           [i pre]tty much waited 'till (if) i had a [wheezing] o:r,=
PR                                                    [ °okay.°]
P           =[i just]
PR           [o kay.]
P           you know some kind of sign.
PR          okay [ so the  ]
P                [you know,]
PR          attacks stopped,
            (.)
PR          four years ago?
P           uh huh,
PR          oh er really six years ago! [right?]
```


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320 P [↓yeah]
321 PR the attacks [↑stopped]
322 P [ya ya.] [a:nd]
323 PR [okay.]
324 P i haven't had no gre- i haven't had we had no problem with
325 it, after that.
326 PR okay.
327 P so [i am]
328 PR [okay.]
329 P i'm i'm pretty and i'm pretty much i'm pretty much active
330 as far
331 as [sports.]
332 PR [u:h]
333 P or something like that.
334 PR okay. what kind of workout do you do at the gym?
335 P er depend it d- e:rm i just focus on the body part that i
336 wanna workout as far as erm three ↑weeks
337 PR okay so [do] you do any cardiovascular,
338 P [er]
339 (.)
340 PR i'm sorry i interrupted you [but,]
341 P [yeah] tzt see that would this
342 this school damn they they don't have [any]
343 PR [uh,]
344 P cardiovascular machine!
345 PR yeah (.) i [know.]
346 P [so] so you gotta kind of improvise with it
347 so,
348 PR uh,
349 P if i if i if i had the three weights for the chest and
350 then some weights for the stomach and the arm, .hh then
351 i'd do pretty much i'd do pretty much,=
352 PR =°uh°
353 P play basketball for like half an hour [that's it.]
354 PR [o kay.] okay.
355 P but [when i'm home yeah.]
356 PR [that's that's great work]out though!
357 P uh huh.
358 PR no i mean that's great. you don't need machines,
359 (.)
360 PR you know to do cardiovascular [stuff.]
361 P [no] you don't you do
362 [pre]tty=
363 PR [so,]
364 P =much improvise. and sometime .hh like i i used to erm (.)
365 do

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366 pushups and sit ups on my own about a few times
367 (0.5)
368 P a [week,]
369 PR [uh]
370 P fifty pushes and fifty sit ups.
371 PR uh huh.
372 P and stuff .hh but i haven't i haven't really been doing it
373 that much.
374 PR uh huh.
375 P and stuff so isn' that you know for cardio it's hard to,
376 it's hard to do it up here unless erm on the run or
377 something like that.
378 PR uh [huh.]
379 P [but] back home i know i (hit the treadmill) for like
380 er half an hour,
381 PR okay.
382 P and stuff so,
383 (1.1)
384 PR okay and you never have any trouble with breathing,
385 (.)
386 P no[oh.]
387 PR [>when] you exercise< that's ↑great okay.
388 (1.7)
389 PR now do you know what might have, erm (0.5) did were you
390 exposed to anything or do you know what might have caused
391 you to have an attack last week, that you [can,]
392 P [i]
393 PR think of in your life,
394 P i can't really i can't really (.) i can't really see, the
395 only thing i've been doing new, is erm tzt this semester
396 is take a taekwondo
397 (.)
398 P class.
399 PR okay.
400 P and i think that's (all bother) you.
401 PR okay.
402 P you know we do it for two hours and for [that]first hour
403 he=
404 PR [uh,]
405 P =really >he he he he< works you to the limit for that
406 first hour nonstop.
407 PR uh huh.
408 P so erm that's the only thing new i've been doing.
409 (2.1)
410 PR okay. and how long have you been doing that since i guess
411 august?

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412 P since the first semester started.
413 PR [yeah.]
414 P [this] is my first time for the semester i've been doing
415 this.
416 PR okay see, coz the reason i'm asking i'll explain this to
417 you since
418 you're kind of here out of curiosity [↑partly]
419 P [uh huh.]
420 PR erm we we look for causes.
421 P [uh huh.]
422 PR [you know] that's part of what's naturopathic medicine
423 does to
424 you. instead of just try and treat the symptoms and
425 surprise might, did they ask you at the e_r if you know
426 what you thought might have caused the attack?
427 (0.8)
428 PR .hh i don't
429 P [yea:h. e:rm]
430 PR [know if they] do that.
431 P erm (.) if i think if they did i might have missed it,=
432 PR =uh [huh.]
433 P [o:r] just don't remember them asking me that but:,
434 PR they they might not have coz they don't that's not always
435 the approach ↑there
436 P uh huh.
437 PR but so that's why you know if we can figure out what
438 caused you to have that attack maybe it's you know some
439 kind of isolated event,
440 P uh huh.
441 PR or maybe it's something that you would have you're exposed
442 to now. and you weren't before and it's something that we
443 need to figure out so we can get that out of your life.
444 P uh huh.
445 PR so that's why i'm asking you this.
446 P yeah okay.
447 PR so(.) let's see are you erm tzt i guess have you used any
448 kind of different erm like shampoo or soap, or anything
449 different any kind of different chemical
450 (.)
451 PR thing that you may be exposed to,
452 (.)
453 PR er cologne, [aftershave,]
454 P [well as far]as as far as shampoo, sham- i
455 mean shampoo is shampoo to me.
456 PR uh huh.
457 P but as far as soap i always (slb slb slb) dermatology's

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458 reason and
459 i would use that.
460 PR okay.
461 P that jus- erm because it don't has them the chemicals and
462 stuff like that that react to my skin.
463 PR uh huh.
464 P i don't use erm fragrance i don't erm i don't use
465 fragrance for erm allergic reasons,
466 PR okay.
467 P it's the the e:rm tzt it's: i mean that's pre- that's
468 pretty much it.
469 PR okay you said for allergic reasons?
470 P [yeah it turns on]
471 PR [something you get] reactions,
472 P i think i get reactions to erm perfume give me perf- i
473 mean colognes give me erm reactions some type of reaction.
474 PR [o kay.]
475 P [as far] as skin and stuff so i don't use it.
476 PR okay what happens when you use cologne?
477 P erm i think my skin breaks out,
478 PR okay. er do you know how like what happens to your skin
479 what what it looks ↑like
480 P it's like coz i have eczema.
481 PR okay.=
482 P =so,=
483 PR =when when did that,
484 (.)
485 PR when did that start?
486 P eczema came with asthma lifetime thing.
487 PR okay so that's been since birth also.=
488 P =yeah. (.) [e:rm]
489 PR [okay.]
490 P and the the funny thing about that it comes and it goes is
491 like,
492 (.) like for for years i won- i won- i won't have problem
493 and then
494 i will suddenly have this pop out of nowhere maybe,
495 PR [uh huh.]
496 P [something]that i'm using don't know. and then just starts
497 to show up,
498 PR uh huh.
499 P and then the itching will start again. and it stop and
500 then it goes away so it could be something that i'm using
501 that i'm not aware ↑of
502 PR uh huh.
503 P .hh that cause it or i'm not doing so,

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PR u:h,
P that's that's another thing,
PR 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 expo↑sure
P uh huh.
PR and a lot of problems you know that people have coz we're exposed to a lot of chemicals.
P yeah.
PR 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.
P yeah.
PR so the eczema erm did you take medication for ↑it
P oh yeah i used to take
PR uh huh.
P everything from (.)(butane) cream to pill. pill they they used to give me pills to stop the itching.
PR uh huh.
P pills so: (.) i could i could sleep at night. cream for the skin screen [for] just for the arm,=
PR [uh,]
P =>cream for just for the neck, cream for just for the face,< (butane) cream to get rid of the dark spots,
PR u:h.
P i mean all this: just all bunch of stuff.
PR okay. do you know what kind of pills the were they steroids? did they tell you?
P well all like you could do with eczema is is steroids.
PR right. yeah. [i guess they were.]
P [and then they had] different doses of steroids.
PR uh huh.
P so [depend.]
PR [o kay.]you don't remember the names,
P na::!=
PR =that's not that important coz it was when was the last time you had an eczema attack?
P e:rm pfhhh oh it's been just as long, (.) just as long,
PR it's been about six ↑years
P probably longer than that coz erm,
PR [uh huh.]
P [i mean] the the the more problem i have with it like recently is

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```
550             you know like little (slb slb slb) ashy spots for the
551             eczema,
552             [it wou-]
553   PR        [uh huh.]
554   P         it would just shows up.
555   PR        [uh huh.]
556   P         [ but i ]
557             take i buy cor- i buy cortisone ten [from c ]_v_s,=
558   PR                                           [uh huh.]
559   P         =for the erm
560   PR        uh huh,
561   P         which erm which helps it.
562   PR        okay. so how often do you use that?
563   P         the cortisone ten i haven't used it like in a month or two
564             now.
565   PR        ((writing)) okay (3.4) so how er how often have you were
566             you using it before,
567   P         erm before erm like (.) depends on what the prescription
568             said. twice a day,
569   PR        uh huh.
570   P         before you go to be:d or you know it it depends on what
571             the doc- what the prescription [the pre]scription says.=
572   PR                                       [ o kay.]
573   PR        =okay. now were you taking that erm to prevent the eczema
574             attacks, coz you mentioned you haven't been having them
575             lately.
576   P         [yeah.]
577   PR        [ so  ] is that why are you taking that?
578   P         that's why i was taking it but erm prev- erm yeah.=
579   PR        =okay.
580   P         the skin breakout and stuff yeah.
581   PR        o[kay.]
582   P          [and ] the itching and then,
583             (1.8)
584   PR        ((writing)) okay (2.4) so: gk you stopped a month ago is
585             that unusual that you stopped, or do you have you been
586             taking it constantly,
587   P         no [ not un  us  ual. ]
588   PR           [(slb slb slb slb) ]
589   P         i mean i think the prescription said to keep using it.
590   PR        [uh huh.]
591   P         [like si]multaneous to (slb) for me itches i just used it
592             off and on on and off.=
593   PR        =uh huh. okay.=
594   P         =and stuff so,
595             (2.8)
```


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PR so maybe you're using it like half the time, like six months out of twelve?
(0.5)
PR does that [sound right?]
P [could be] could be even longer than that!
PR okay.
P that depend, it [could be]
PR [o kay.]
P sometimes could be like a year or two (to five) and takes the stuff again.
PR oh wow!
P [yeah,]
PR [kay] okay. (4.8) okay so i just want to ask you a little bit about that asthma and eczema,
P [uh,]
PR [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,
P uh huh,
PR but normally i don't know if i would tell the patient too much a↑bout ↓this if they weren't really curious, erm but have you heard anything about there being a link between eczema and asthma?
(1.0)
PR do you know about that?
P [yeah.]
PR [(slb)?]you do?
P i think i know that yeah.
PR o:kay. okay.=
P =coz erm (.) i i see i used to see dermatologists so often,
PR [uh huh.]
P [and stuff.] and there i can easily tell (slb slb) there's a link bet[ween,]
PR [uh,]
P yeah. i know the [link] between the two.=
PR [yeah.] =yeah. okay.
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
P uh huh.
PR it won't, it's not something we can address right away.
P no.
PR 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

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642 it will be a
643 gradual kind of process. [(°slb slb°)]
644 P [yeah. i] know coz i see,
645 PR [okay.]
646 P [e:rm]i: er whatever it er for me whatever (pertain) i
647 mean i'm
648 not, i don't read everything that's medical [o::r,]
649 PR [uh huh.]
650 P you know but anything pertaining to asthma,[o:r]
651 PR [uh]huh.
652 P you know or eczema,=
653 PR =yeah.=
654 P =i read it coz erm i don't know coz it could be something
655 that i make that give me a reaction or, [much]
656 PR [uh,]
657 P of that very often it could be life treatment.
658 PR yeah.
659 P so i i wish so i could be a way for myself.
660 PR yeah. okay good! that's good. coz you know patient's
661 responsibility. that's, you know we really encourage
662 people to be in charge of their own health.
663 P yeah.
664 PR you know that's part of the whole, difference in
665 philosophy in
666 alternative [versus] conventional medi↑cine=
667 P [uh huh,]
668 PR =you know they, they erm in conventional medicine they
669 don't really encourage people to be very active about
670 their own health. but we do.
671 P yeah.
672 PR so, that's great. that you already are. .hh but i'm not
673 gonna i'm gonna kind of change topics coz i don't wanna,
674 tzt spend too much time on this. coz erm what we probably
675 will focus on <u>today</u> in this visit is talking about your
676 diet.
677 P uh huh.
678 PR erm and your lifestyle factors. and especially it sounds
679 like you wanted some advice. with diet.
680 P yeah.
681 PR erm so i'm gonna just ask you erm about is there any:
682 family history of of high blood pressure? like yer mother
683 or father or,
684 P no [i know] we got a=
685 PR [°siblings°]
686 P =i know i have a family history of diabetes.
687 PR okay.

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688 P you know and i don't know if it skips a generation or not
689 but i know that a few people who have diabetes,
690 PR [o kay]
691 P [er er] erm it's in our family so [they can't]really deal=
692 PR [o k a y,]
693 P =with the sugar and the salt and all that stuff.
694 PR okay who has diabetes? [°in your fam-°]
695 P [i know my] aunt, and my
696 cousin and my grandmother. my grandmother had a history of
697 diabetes.
698 PR o[kay]
699 P [so] the (last that she had to stay away from).
700 PR okay so either of your parents,
701 P not no.
702 PR okay do either of your parents have any illnesses?
703 P e::rm (1.1) u:h (0.7) i don't know i er not that i know
704 of.
705 PR ((writing)) okay. (3.1) okay so has anybody in your family
706 had a heart attack? [or] a stroke?=
707 P [no.]
708 P =na::!
709 PR okay.
710 (3.2)
711 PR okay, erm does anyone else have asthma in your family?
712 (1.7)
713 P i think my sister do. we di- erm we didn't find out until
714 late.
715 (.) sometime this year,
716 (1.2)
717 PR okay. how old is she.
718 P she's thirteen.
719 (0.8)
720 PR okay where did you grow up by the way around here,
721 [o:r,]
722 P [yeah] hartford connecticut.
723 PR okay.
724 (1.0)
725 PR tzt .hh right, erm okay. i'm gonna ask you a little bit
726 about your diet,
727 P uh huh.
728 PR so:, which erm if am i wrong to think that's probably what
729 you want advice with? to[day?]
730 P ((nodding)) [yeah.]
731 PR [yeah.]
732 P [pre]tty much.
733 PR yeah.=

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734 P =yeah.=
735 PR =i mean i want to get some information on your asthma and
736 eczema, coz we can help you with ↑that
737 P [o kay.]
738 PR [but the] diet is the first thing that we'll start so
739 that's [where you] wanna start?=
740 P [o kay.] ((nodding)) =okay
741 PR that's a good idea. .hh erm so what do you eat for
742 breakfast usually?
743 P he hee depend like erm i did, i did have some cereal
744 cereal this morning.
745 PR [o kay,]
746 P [but i] know me. i'm just like i'm i'm just traditional,
747 you know pancakes and sausage, and all that other stuff.
748 [and that,]
749 PR [o kay.]
750 P but i eat cereal. but ever since they told me that i try
751 to eat some other thing, i eat some erm what they call it
752 oatmeal bread cereal?
753 PR uh huh.
754 P it's not sweet but a little little sweet. [with]
755 PR [uh.]
756 P raisins in it.
757 PR uh huh.
758 P i don't know in so i tried that but you know?
759 PR uh,
760 P i don't know much [about]
761 PR [okay.]
762 P dieting and i'm not an expert on dieting.=
763 PR =okay okay. well we are. [so]
764 P [yeah.]
765 PR we're gonna help you. erm okay so pancakes and sausage,
766 (.)
767 PR okay. and do you have a snack before lunch?
768 (1.7)
769 P yeah if i have the time [i'm]
770 PR [uh,]
771 P i'm a i'm a hot packet freak.
772 PR okay.
773 P yeah. hhe
774 PR °uh,°
775 P i'm (slb slb) full of hot packets.
776 PR okay erm how many do you eat,
777 (.)
778 PR like per per that snack before lunch,
779 P two.

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PR er ↑two okay. (.) i don't know i never eat them so i don't really know.
P [yeah.]
PR [i] mean i've seen the commercials but i'm not sure what's in [that.]
P [yeah] they're so addictive!
PR ↓yeah
P ha [yeah.]
PR [uh,].hh okay erm what do you have for lunch?
(1.9)
P 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.
PR [o kay.]
P [i usua]lly 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.
PR okay.
P so,=
PR =okay well are you not hungry for lunch?
(0.4)
PR [or,]
P [yeah] sometimes but i did i'm so used to it i did deal the hunger pain till it's time to eat.
(.)
PR [uh!]
P [till] the time to eat dinner.
PR okay. so is that that you feel you don't have time, to eat lunch?
(.)
PR is that why?
P oh is sometime i don't have time or sometimes i just don't choose to eat lunch. p- pretty much.
PR 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?
P yes someti- pretty much. yeah i just [don't]
PR [kay.]
P i just i just wait.
(.)
PR why is that though coz it sounds a little bit,
P i don't know why i do it. he [he]
PR [o]kay.
PR 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
PR okay. is it coz you is it is it it's some kind of like way to lose weight is [that,]

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826 P [yeah.] pretty much.=
827 PR =okay. [okay.]
828 P [yeah.]pretty much.
829 (2.4)
830 P is it is is a weight (.) issue.
831 PR weight loss[kind of] thing?=
832 P [body issue]
833 =yeah for me.
834 PR okay coz you probably, (.) coz it sounds like you're
835 pretty informed about that so you probably have heard that
836 erm skipping meals is erm that it's better to eat
837 frequently throughout the day
838 P yeah and stuff but,
839 PR yeah.
840 P all the food i eat is so high in salt and [grease,]
841 PR [uh,]
842 P coz [that]
843 PR [coz] that's what you've been eating,
844 P yeah.=
845 PR =[°yeah.°]
846 P [i] i have to have (slb slb slb) like,
847 PR you feel like you can't eat stuff that's not high in that
848 grease and [↑butter]
849 P [yeah it] is like you got a waffle you gotta
850 have taste pretty [much]
851 PR [u:h,]
852 P in it,=
853 PR =okay.=
854 P =and stuff.
855 PR [o kay.]
856 P [then all] my food i- is either fried baked o:r
857 PR [°uh°]
858 P [it] is so high in grease and stuff,
859 (2.9)
860 PR okay. (1.9) okay so erm (.) do you have a snack before
861 dinner?
862 (0.5)
863 P no. not really i just eat erm (0.9) maybe after dinner it
864 depends.
865 sometimes i'll be late and i i have i'll be hungry and
866 then just grab something like i eat something like chips
867 o:r
868 PR [°uh°]
869 P [li]ke olives i i'll all other olives and chips like
870 spicy, like spicy nuts or chips and stuff anything that's
871 spicy i'm a bigs i like spice, [ain't]

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872 PR [°uh°]
873 P ain't nothing too hot for me.
874 PR ↓u:h (.) okay so what do you have for dinner?
875 P ((sniffs and swallows)) er erm it depen- it depends i
876 don't really have like erm a favorite, it it depends. and
877 stuff.
878 PR okay do you have some kind of meat with ↑dinner
879 P so yeah me i'm erm i like chicken i'm a big fan of
880 chicken.
881 PR okay.
882 P [(slb slb)]
883 PR [and ha-]you have the chicken like fried or,
884 P fried baked any anyway i can get it.
885 PR yeah okay.
886 P and stuff.
887 PR okay. do you have any like vegetables or fruits at ↑all
888 P yeah erm well usually with fruits at dinner? it's
889 something big in a pie.
890 PR okay.
891 P erm f- yeah vegetables not that, yeah i like i like
892 vegetable muffle.
893 PR [o kay.]
894 P [i li-] i like mixed vegetables and stuff [like that.]
895 PR [uh huh.]
896 okay.
897 P well the thing is i i i might have like (.) little salt or
898 butter [just:,]
899 PR [uh huh.]
900 P just to make it you know tasteful.
901 PR okay. how often do you think you have mixed vegetables
902 with the meal?
903 P i don't have it that often. [e:rm]
904 PR [uh]huh
905 P not since i've been up here. if i go home for the weekend
906 [i]
907 PR [uh]
908 P usually do a lot of cooking so yeah. ho- if [it's home.]
909 PR [uh huh.]
910 P often but [i can't]
911 PR [o kay.]
912 P (do that often now).
913 PR okay so erm where do you eat here? like in the dorms or,
914 [°uh°]
915 P [well] i buy my own supply up here. [erm]
916 PR [uh,]
917 P basically anything that can be dinner to microwave.

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PR uh huh. [o kay.]
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 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
[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 okay.
(.)
P i need something fast to fast and on the go. pretty [much.]
PR [uh,] well 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<
(.)
PR on week days?
P i don't see, i don't see the problem.
PR uh huh.=
P =i might have to invest in some pots and pans but,
PR uh huh.=

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964 P =yeah probably yeah.
965 PR okay coz microwave food, i mean there's there's a lot of
966 bad for you in it.
967 P yeah i know. [hu]
968 PR [for] the most yeah you know for the most
969 part it's not even real food.
970 P i know.
971 PR you ↑know and the thing about junk food that a lot of
972 people don't know .hh is that it's not only that it
973 doesn't give you any ↑nutrients
974 P [°uh°]
975 PR [and] a lot of it doesn't give you any kind of
976 nutrients.=
977 P =uh huh.
978 PR but it actually depletes your body of nutrients.
979 P (oh good),
980 PR because it takes your your digestive system has to spend a
981 lot of energy to digest this food.
982 P [°uh°]
983 PR [and] break it down and everything. [you're]using a lot=
984 P [°uh°]
985 PR =of nutrients but you're not gaining anything back from
986 the food. so you're actually losing nutrients.
987 P okay.
988 PR and a lot of people don't know that.
989 P o[kay.]
990 PR [so] yeah. [°now°]
991 P [((clears throat))]
992 PR that's just one thing i just kind of share with you right
993 now.
994 P uh huh.
995 PR but: tzt okay. alright so do you snack after dinner
996 usually?
997 P sometimes yeah is it usually is just something simple.
998 [chips.]
999 PR [uh.] o[kay.]
1000 P [like] (.) chips and erm dooritos and
1001 stuff like that.
1002 just about it.
1003 PR okay.
1004 P nothing major,
1005 PR okay. so do you drink water? °drink [(slb slb)°]
1006 P [yeah i] drink a
1007 whole lotta water. that's that's that's,
1008 PR [o kay.]
1009 P [what can] i [can] say,=

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1010 PR [good!]
1011 =good=
1012 P =i drink a whole lotta water.
1013 PR okay. do you know about how much?
1014 P on a daily ba↑sis
1015 PR uh.
1016 P i'm i'm talking about (1.1) maybe three to four bottles
1017 twenty two ounces at a bottle.
1018 PR okay.
1019 (1.6)
1020 P i'm not really erm i'm not really a big fan of juice or
1021 soda.
1022 (0.8)
1023 PR uh huh. [o kay.]
1024 P [and stuff]
1025 PR so you don't drink juice or soda [u sual ly,]
1026 P [i do drink] it. but you
1027 know not as [m- not]
1028 PR [o kay]
1029 P not that much of it.
1030 PR okay. (.) do you drink coffee at ↑all
1031 P no i don't like coffee.
1032 PR okay. (6.0) okay erm do you smoke?
1033 P erm yeah that's it. not cigarettes though erm i'm i'm (slb
1034 slb) to (.) like erm exotic cigars, i go to different
1035 cigar shops and i see what they have and you know, yes so
1036 yeah.
1037 PR [°uh huh°]
1038 P [i'm a] big (slb slb) to cigars. i've been like that
1039 since
1040 PR [°uh°]
1041 P [erm]since erm high senior in high school.
1042 PR okay. so how many do you smoke?
1043 P i smoke cigars on occasions.
1044 PR o[kay.]
1045 P [it]depends what the occasion is [and stuff,]
1046 PR [o kay.]
1047 P i don't smoke it every day. [and stuff.]
1048 PR [uh huh.] so maybe once a
1049 ↑week
1050 P maybe yeah. maybe depend if, like it could be a few times
1051 a week or [sometimes]
1052 PR [uh huh,]
1053 P may i can (barely) go a couple of weeks without it. but
1054 PR [o kay.]
1055 P [yeah I]smoke only on occasion.

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1056 (3.6)
1057 PR okay. do you drink alco↑hol
1058 P yeah i do.
1059 PR okay. how much do you drink?
1060 P erm i make a habit just to drink on the weekends. i
1061 PR [o k a y.]
1062 P [don't drink]during the week for erm for pr- erm just by
1063 personal rea- i don't think [it's right or,]
1064 PR [uh huh. uh]huh.
1065 P i don't erm like on like fridays saturdays and sundays
1066 maybe, depend it but [yeah.]
1067 PR [uh]huh=
1068 P =i i drink erm i like to drink like (.) like very
1069 expensive bo↑ttle
1070 PR okay.=
1071 P =and stuff so.
1072 (.)
1073 PR okay so how many drinks like on a friday or saturday night
1074 do you drink.
1075 P i know if i have time i could go through a whole i could
1076 do i could go through a whole big bottle myself.
1077 PR ↓uh=
1078 P =straight.
1079 PR okay.=
1080 P =and if i don't have time i just take a few glasses. and
1081 stuff so,
1082 PR okay. so like you usually drink at least one glass at
1083 least three glasses,
1084 P yeah three [three glass]es and stuff.=
1085 PR [three four,]
1086 P =yeah it dep[end yeah.]
1087 PR [o kay.] and then like a whole bottle
1088 that's like maybe ↑ten
1089 (.)
1090 PR glasses,
1091 P yeah they call it the erm fifth. in what the (buck) i
1092 drink the [fifth.]
1093 PR [uh,]
1094 P erm tzt may may could be as high as my knee.
1095 PR the ↑bottle
1096 P yeah.
1097 PR and you drink that whole ↑thing
1098 P and i can i i it's mo- it's been one or two times i go
1099 through that myself.
1100 PR wow!
1101 P yeah.

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1102 PR so that's that's a lot of shots.
1103 P yeah. [yeah.]
1104 PR [right,]
1105 that's like twenty ↑five
1106 (0.7)
1107 PR may[be?]
1108 P [it] could be more i don't know.=
1109 PR =yeah coz that's that's a lot.
1110 P [he yeah.]
1111 PR [and is] the bottle this thick?
1112 (0.5)
1113 P .hhh the bottle is like (.).hh the bottle is like maybe
1114 like (1.1) like this thick and then it goes up like (0.6)
1115 from my from my foot, it can probably go up to: (1.0) one
1116 size it can go up here, and then the bigger size which i
1117 had one time it goes up to my knee.
1118 (0.7)
1119 PR [o kay.]
1120 P [and that] size took me [on]ly:=
1121 PR [°wow,°]
1122 P =one week only took me like two days to go through that.
1123 PR [°wow,°]
1124 P [by] myself.
1125 PR okay alright. okay so and that you drink just friday
1126 saturday do you drink sunday al↓so
1127 P .hhh depend, i don't make a [ha bit] to drink on
1128 PR [°uh huh°]
1129 P sundays.=
1130 PR =okay.
1131 P you know but friday and saturday, (.) sometime that could
1132 just be my weekend sometimes.
1133 PR okay do you drink alone some↑times
1134 P drink alone, or i [don't]
1135 PR [uh,]
1136 P erm or socially but mostly alone.
1137 PR okay.
1138 (2.2)
1139 PR do you get hang↑overs
1140 (1.0)
1141 P no. not really. i'm i guess i'm so used to it it just the
1142 only thing it [does] just keeps me hungry i [don't]
1143 PR [° uh °] [°uh?°]
1144 P i don't get hangovers and i don't get sick.=
1145 PR =↓u:h
1146 P [it c-]
1147 PR [but it] makes you hungrier [that's to ↑say]

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1148 P [really get]really gets me
1149 it really gets me hungry. [erm]
1150 PR [uh!]
1151 P maybe coz of the nasty taste in my mouth.
1152 PR [↓uh]
1153 P [o:r] the the intoxication, but it just gets it just gets
1154 me very hungry.
1155 PR okay. like hungrier while you're drinking or the next day,
1156 P no hungry after i've done drinking it.
1157 PR okay. (1.6) ↓u:h (0.9) do you tend to eat a ↑lot then
1158 after you drink,
1159 P u::h no just just enough to j-just to satisfy the hunger
1160 and
1161 PR [o kay.]
1162 P [don't get] myself sick in the morning.
1163 PR okay.
1164 P so,
1165 PR okay so erm have you ever like do you ever feel guilty
1166 about drinking, that you drink too much,
1167 (1.1)
1168 P u::h, hu hu. to be honest no i don't.
1169 PR okay.=
1170 P =a lot of people,
1171 PR °o[kay.°]
1172 P [erm] like a lot of people do tease me coz the alcohol
1173 erm they say the the alcohol (slb slb) i have i i guess
1174 i'm not ashamed or i gotta [(slb) and]stuff like that.=
1175 PR [uh huh.]
1176 P =and i think about that too.
1177 PR uh huh.=
1178 P =i think about that and just (detoxes) i just sit and
1179 it'll be like, maybe i should cut down cut down on the
1180 drinking,
1181 (.)
1182 P a lot,
1183 PR uh huh.
1184 P coz you know it's not (slb slb slb) but it's nothing (slb)
1185 to show that that,=
1186 PR =uh huh.=
1187 P it's best to be erm it's making me show physically.
1188 PR ah hah.
1189 P and stuff. so a few times i think i've thought about it
1190 but the proverb go easier said than done!
1191 PR ↑uh↓uh so have you tried to stop drinking?
1192 (.)
1193 PR ever have you tried to quit,

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1194 P me? erm tried to stop drinking?
1195 PR uh huh.
1196 P no i can't. i can't i'd be lying if i said that i've tried
1197 to quit. but i've never tried to quit it. erm i thought
1198 about it a couple of times erm er in the past you know, i
1199 thought about you know maybe one day i might stop drinking
1200 period.
1201 PR [uh huh.]
1202 P [for health] reasons, erm=
1203 PR =yeah.=
1204 P =but (if i did i) mean in the long term,
1205 PR [yeah.]
1206 P [as] far as kidneys and other [health]issue,=
1207 PR [yeah,]
1208 P i [have]
1209 PR [(slb)]
1210 P to have thought about that,
1211 (.)
1212 P but erm and then you know it just i don't know it's just
1213 like e:rm tzt i wanna call erm i wanna call it erm tzt
1214 like: the erm
1215 acquired ↑taste or
1216 PR [°uh°]
1217 P [some]thing like ↑that and if you see this, erm alcohol
1218 that i do buy is .hh is like really elegant,
1219 PR [uh hu.]
1220 P [and ex]pensive and i call i like to call it acquired
1221 taste so,=
1222 PR =ah hah.
1223 P maybe just an excuse but that is me.
1224 PR okay okay. have you ever like drunk alcohol in the
1225 morning? during [like week or something,]
1226 P [oh no! i ne ver] do that.
1227 PR okay.
1228 P alcohol,=
1229 PR =okay=
1230 P it's just it's just somethin (that's easy to go by) it if
1231 i know if i'm at the point that i'm drinking alcohol early
1232 in the morning, [like for,]
1233 PR [uh huh]
1234 P breakfast and s- then i know i have a problem.
1235 PR uh! [o kay.]
1236 P [and stuff] so i'll [never,]
1237 PR [o kay]
1238 P no that's something i'll never do.=
1239 PR =okay=

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1240 P =not even on the weekends.
1241 PR okay. [o kay.]
1242 P [i won't] do that i'll wait till like after five.
1243 PR [uh huh okay.]
1244 P [and stuff i you] know and stuff so:,
1245 PR okay. that's good. that's good. .hh so have you ever
1246 thought about just i mean coz you thought you said you
1247 thought about quitting, have you thought about just kind
1248 of reducing, like drinking every other weekend or drinking
1249 just one night a week instead of two
1250 [nights,]
1251 P [.hhh] when i thought about actually s- quitting i just
1252 don't know. i didn't say when i would [do.]=
1253 PR [yeah.]=
1254 P =it but i have thought about slowing down. but .hhh i just
1255 haven't come to that that erm that conclusion yet.
1256 PR okay.
1257 P and stuff so.
1258 PR alright alright that's kind, it's there.
1259 P [yea:h.]
1260 PR [in your] mind,
1261 P but it's still on [my mind.]
1262 PR [o kay.]
1263 P but i think [one day] i might stop maybe.=
1264 PR [o kay.] =uh huh.
1265 [o kay.]
1266 P [(weekends)]
1267 PR and even before i mean even without stopping you can still
1268 you know that you can reduce,
1269 P yeah.
1270 PR you know what i mean,
1271 P [.hh er]
1272 PR [when] you feel like you're ready i guess,
1273 P yeah [i mean,]
1274 PR [(slb slb)]
1275 P I KNOW this is one thing i know if i wanna stop and stuff
1276 i can do it.
1277 i've been[i've been]through so many other things,=
1278 PR [uh huh.]
1279 P =and stuff.
1280 PR uh huh. [o kay.]
1281 P [and if] i wanna just slow down doing it i can do
1282 it and don't (slb slb slb) so
1283 PR uh huh.
1284 P but i just haven't just got to the point that i wanna do
1285 it yet.

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1286 PR [yeah.]
1287 P [you] know so,
1288 PR okay. what else have you? have you quit,
1289 (.)
1290 PR you say have you quit other things, like what else?
1291 P yeah i quit erm tzt i quit other things just fo:r erm for
1292 my personal like (paraphernalia),
1293 PR [okay.]
1294 P [e:rm] i mean erm not i should say herbal (paraphernalia)
1295 coz i know i don't do the other stuff but,
1296 PR [uh huh.]
1297 P [i have] stopped that. [i st-]
1298 PR [okay.]
1299 P i've been i stopped that almost five years ago now. [e:rm]
1300 PR [okay]
1301 well the (paraphernalia) you mean coz i mean do you do you
1302 smoke ↑pot
1303 P yeah.
1304 PR [okay.]
1305 P [i i] used to.
1306 PR okay and the (paraphernalia) like you mean buying the
1307 ↑stuff
1308 P [erm]
1309 PR [the] (paraphernalia) stuff.
1310 P yeah buying just buy[ing it.]
1311 PR [o kay.]
1312 P and you know buying it and using it. i
1313 PR uh huh.
1314 P just one day i just stopped just out of the [blue.]
1315 PR [uh.]
1316 P i just said i'm just i'm just gonna stop and that's five
1317 years ago. and i never walked back to that yet.
1318 PR okay. [okay.]
1319 P [and I] i have a lot of pe- i've been with a lot of
1320 people that still does ↓it
1321 PR uh huh.
1322 P and they think i might get tempted. [and stuff] like=
1323 PR [uh huh.]
1324 P =that.=
1325 =yeah.=
1326 P =but no. i don't i don't i don't miss it at all.
1327 PR okay. so you don't smoke it at all any more?
1328 P no i don't. [i don't i don't.]
1329 PR [o kay. coz if] you do you can tell us coz
1330 we're not
1331 P no. no i don't.

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1332 PR this is all confidential and [°you know?°]
1333 P [i was] i was a
1334 regular=
1335 PR =okay. okay.
1336 P for it,=
1337 PR =yeah. [uh huh.]
1338 P [and then]i just st- it just stopped. i just
1339 stopped.=
1340 PR =ah hah.=
1341 P =it just it just it wasn't it wasn't safe for me. i mean i
1342 started doing it when i was in high school,
1343 PR uh huh,
1344 P a:nd (.) the the fact how was for me then .hh and at that
1345 time, it
1346 just was a mistake in a way you [just get] tired,=
1347 PR [uh huh.]
1348 PR =yeah.
1349 P so i just stopped and [you] know?=
1350 PR [yeah.]
1351 =[right.]
1352 P =[i]just never looked back to it!
1353 PR okay. okay that's about five years ↑ago
1354 P that was yeah. that was five years ago proba[bly.]
1355 PR [°uh.°]
1356 P i have to say five years ago.
1357 PR okay.
1358 P so that,=
1359 PR =you have you haven't smoked recently have you?
1360 P no. [e:rm]
1361 PR [okay.]
1362 P as far as anything? No.
1363 PR okay.
1364 P na:!
1365 PR alright. (.) okay erm so do you drink soda like every day,
1366 P na.
1367 PR [°okay.°]
1368 P [i'm not] really a big soda drinker.
1369 PR kay so you don't get much caffeine you don't drink much
1370 caffeine,=
1371 P =i'm not really a big fan of soda if i have like: like a
1372 bad taste in my mouth from anything, it doesn't matter
1373 ((knocks at the door)) erm coz i drink i drink soda but,
1374 SD all ↑done
1375 PR e:rm [almost.]
1376 SD [ready] to (step up)?
1377 PR [almost.]

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```
1378   SD          [(slb slb)] (slb slb) now and talk about it.
1379   PR          ((leafing through file)) erm (.) tzt alright.
1380   SD          (slb) down.=
1381   PR          =okay. hh
1382   P           °uh huh.°
1383   SD          excuse us (slb slb)[(slb slb] slb slb)=
1384   P                              [uh  huh.]
1385   PR          =°slb slb slb° i'll just (take) the (slb)
```


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PR ((reading P's file)) alright. so let's see where we got.
(7.6)
PR yeah,
(1.5)
PR are we on?
(0.7)
P ye↓ah
PR uh,
P (slb slb slb)
(1.1)
PR alright.
(2.2)
PR (what do you got anything for me),
P .hhh er erm no i don't.
PR °okay.°=
P =last week was pretty (slb slb),
PR (in what ↓way)
(4.4)
PR in what way?
P e:rm mid term, not mid terms exams we had,
PR u:h,
P histology and anatomy on top of each other.
PR you ↓did
(0.8)
PR you went from here to your anatomy project you also had a
a
[↑test]
P [the] practical and then i had (0.4) a histology test.
(2.0)
P and then this weekend i erm
(1.1)
P relaxed and didn't do any work, and went out and
(1.1)
PR had a good ↑time
P drank a little, yeah.
PR right.
P (slb slb slb)
(0.7)
PR whe- where did you go
P new haven to: (slb ↑slb)
PR pfff (slb slb and who did you go with),
P erm
(1.8)

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```
44  P     jenny. she's a (slb slb slb slb slb there),
45  PR    o::h,
46  P     a:nd  [ a   bunch of the   girls,]
47  PR          [you're makin   you're mak ]in friends with e-
48  P     [everyone i]
49  PR    [every body] but the naturopa[thic students!]
50  P                                  [ he  he  he   ]
51  PR    [ha ha ha ha ha]
52  P     [he he he he he]
53  PR    ha ha [((claps hands))]
54  P           [     .hhh      ]
55  PR    [.hhh ]
56  P     [well,] er no. [(slb slb)] to be [with 'em] other times,=
57  PR                   [  ha  ha ]       [.hhh  ha]
58  P     =[he he he]
59  PR    =[ha ha ha] ha ha gk gk .hhhh
60  P     definitely (slb slb [ slb ] slb slb slb slb slb)=
61  PR                        [cool!]
62  PR    =right everyb[(h)o ]dy,=
63  P                  [yeah,]
64  PR    =[but: ha ha]
65  P     =[ e   ve ry] one except he he he he [ he ]
66  PR                                         [.hhh] that's so
67        amazing,
68        that's it's so amazing [(slb  slb),]
69  P                            [ the girls ] from my class were
70        there
71        though,
72  PR    [oh  they] ↑were=
73  P     [and some]      =chiro guys too.
74        (2.4)
75  P     interesting people,=
76  PR    =so you had a good time,
77  P     i did. i did.
78  PR    that's great that, that's incredibly important.
79        (1.7)
80  P     (slb slb slb) sometimes.
81  PR    alright. so erm w- w- (0.5) what ha- what have you done as
82        far as
83        your [your goal] and your program, [(which you)]
84  P          [tzt  .hhh]                  [ i've   wor]ked on my
85        (visuals slb slb), erm
86  PR    what have you done,
87        (1.2)
88  P     [well,]
89  PR    [with ] that?
```


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```
 90   P           just
 91               (1.1)
 92   P           (probably) sitting down a:nd trained the (real slb slb)
 93               meditate on ↑it
 94               (1.0)
 95   P           if you wan[na call] that,
 96   PR                     [are you,]
 97               (1.0)
 98   PR          were you able to (0.4) see [some]thing?=
 99   P                                      [tzt ]      =erm i realized
100               that,
101               (1.8)
102   P           i have a certain impression of myself when my when i'm
103               ↑clothed
104   PR          uh huh,
105   P           and then when i'm ↑not
106   PR          uh huh, tzt and what is that?
107   P           and when i'm clothed apparently the clothes help me, (.)
108               look
109               (1.6)
110   P           smaller than i perceive myself without clothes ↑on
111               (1.1)
112   P           hence probably the baggy clothes, and
113               (0.5)
114   P           things that are (slb    slb) and
115               (0.5)
116   P           i was working on, looking at myself.
117               (1.1)
118   P           and (look) just,
119               (0.9)
120   P           straight at me and trying to: (.) visualize that,
121               (2.5)
122   P           erm impression of myself to be,
123               (0.4)
124   P           better.
125   PR          uh huh.
126   P           erm
127               (0.8)
128   P           and i think i: got there. °almost there°.
129   PR          good.
130               (0.7)
131   PR          good.
132               (0.4)
133   PR          good.
134               (1.3)
135   PR          that's (0.5) er if you especially if you've never done it
```


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be↑fore takes (slb slb than) anything else.
P uh,
PR but incredibly powerful. so powerful.
(0.7)
PR i mean you need to get where you wanna be with your body.
where your body can actually have [some]thing=
P [yeah,]
PR =to (slb) for.
(0.5)
PR it it it's really that simple.
P uh,
PR 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)
PR so,
(1.2)
PR keep working an an and you know! you don't need to spend
(slb slb 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)
PR how you wanna stand.
(0.7)
PR and finally how you wanna present yourself.
(1.0)
PR all that if you want is all connected.
P °uh°,
PR so keep keep definitely keep working on that.
(0.9)
PR erm have you bee able to:: do any kind of exercise?
P tzt .hhh erm (as i slb slb) i did go walking tzt (slb)
walks even
when it was freezing cold outside on friday. [(i did)]
PR [uh huh,]
(1.4)
P erm i didn't go swimming this week,=
PR =okay.=
P =because (slb slb slb) because of the [test.]
PR [how] was walking
on the cold?
P [tzt]
PR [is] that something that you li- you came back home, and
you go
i'm never wanna do [that a]gain?=
P [i::] =love it because

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```
182             it's desert and
183             no one's around, and hhh
184   PR        uh huh,
185   P         the cold, i love cold air. (.) erm
186   PR        how long have you walked,
187   P         erm tcwhoo ↑hours
188   PR        two hour ↑walk (.) wo:w!
189   P         on friday usually i take about forty minutes or so.
190             (5.1)
191   P         erm
192   PR        so you walked once this week, you walked once.
193   P         i walked for two hours once,
194   PR        [uh  huh,]
195   P         [and then] on two other occasions i walked for forty
196             minutes.
197             (1.1)
198   P         and i did the yoga on [wednes day.]
199   PR                              [so you wal ]ked three times,
200   P         yes [three times all   to   ge  ]ther.
201   PR            [ to   tal  of  three times.]
202   P         ((sniffs))
203             (2.5)
204   P         yoga,
205             (0.6)
206   P         three times last week.
207   PR        so you did six ↑things
208   P         uh,
209   PR        six things of er erm (slb slb slb) of exercise yeah. so
210             yoga you did three times,
211             (1.4)
212   PR        how do you feel after? after that after yoga how do you
213             [(slb)  after walking.]
214   P         [  d-   after yo ga   ] i feel, hhh gosh! there's no drug
215             that it can be the way yoga it is.
216   PR        uh huh.
217   P         not that i have experienced any drugs like ↑that [but  he]
218   PR                                                         [uh  hhh]
219   P         ((PR smiles while writing on chart)) he .hhh erm
220             (0.8)
221   P         it's very relaxing very,
222             (1.1)
223   P         i didn't go for the spiritual or meditative,
224   PR        uh huh.
225   P         purposes.
226   PR        [uh!]
227   P         [but] it happens anyway.
```


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228 PR it happens yeah.
229 (0.4)
230 P [yeahh,]
231 PR [and] how what do you think of that? did it help
232 with [(°this slb slb°)]
233 P [i think it] helps a great deal. [it's]
234 PR [good!]
235 P making me feel b- er more comfortable in my skin. [a:nd]
236 PR [good!]
237 P ((sniffs))
238 (0.4)
239 P erm
240 (0.6)
241 P uh the: concept that it's you know,
242 (0.8)
243 P mostly in your mind it's all mental. erm (.) she was:, a
244 lot of other people are having problems with certain
245 positions that, require like hand stand or balance.
246 PR uh huh.
247 P and they see it as: er strength exercise but she was
248 trying to teach us that it's more, ((miming two pans in a
249 balance)) (1.2) a combination of flexibility and strength.
250 not all strength.
251 PR [sure.]
252 P [but] some.
253 PR yeah!
254 P but if you alter your perception of what it is you're
255 trying to do then it'll be easier to do. (.) a:nd
256 PR ex [actly.]
257 P [i'm not] having problems with any of the positions
258 except for:,
259 (0.5)
260 P tzt something called the tripod? not tripod, .h it's where
261 it's a hand balance you're basically,
262 (0.6)
263 P [ba]lancing on the hands with=
264 PR [yeah,]
265 P =your knees on the back of your elbows?
266 PR gotcha.
267 P and we've only tried that once a long time ago. and i
268 don't know you know at this point if i can try again. but
269 she suggested <u>not</u> [↓to hu]
270 PR [do you?] do you do is it something
271 that you would like to do?
272 P yoga?
273 PR that pos- that particular,

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274 P tzt position.
275 PR position.
276 P .hh i think at this point because i was unable to do it
277 susses- successfully in my eyes the first time,
278 PR uh huh,
279 P that it's i'm i'm eager to try it again.
280 PR [great!]
281 P [to] see if i can get there.
282 (0.9)
283 P a:nd,
284 (1.1)
285 P mentally ((PR nods)) i know what i have to do and how i
286 (0.7)
287 P can do ↓it and i see myself in the position? .h er even if
288 it's for a couple of seconds,
289 PR [uh huh.]
290 P [(slb slb] slb) out there? but erm,
291 (1.0)
292 P and i don't wanna hurt myself either. so i'm not trying
293 any of the,
294 PR yeah,
295 P very difficult positions
296 PR [uh huh.]
297 P [outside] of class.
298 (2.0)
299 PR good.
300 (0.6)
301 PR erm you know life life is very,
302 (0.5)
303 PR life forcing goals. and people who really accomplish
304 anything (.) they constantly have goals and if you read
305 any motivational book or er any er self er (.) personal
306 coaching book or any personal coach will tell you that,
307 (.) - we need we function on goals. so if it's something
308 that you know again that you wanna accomplish,
309 (1.3)
310 PR coz coz life is also about achieving things.
311 (0.8)
312 PR and for whatever we achieve this is is important to us. or
313 whatever i achieve is very important to [me.]
314 P [yeah.]
315 PR whatever you achieve is very important to you is very
316
317 individualized very subjective. so,
318 (1.6)
319 PR c- certainly if

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320 (0.9)
321 PR if something as
322 (0.7)
323 PR as important or mo- or as minor to other people but
324 important to you as making making you know doing that
325 position in yoga,
326 (0.4)
327 PR and if that's truly important to you that's you should
328 have that as one of your goal.
329 (0.4)
330 PR i i i'll tell you long ago i had you know i had never (slb
331 slb slb slb slb) and decided i wanted to run a marathon.
332 (0.8)
333 PR that meant nothing to other people.
334 (0.5)
335 PR for me it meant the world.
336 P °right°.
337 (0.8)
338 PR and i kept >running running running running< and i (slb
339 slb slb slb slb slb slb slb).
340 (0.6)
341 PR and this summer i i (thought get out of here i won i won a
342 cool marathon) the point in being is that things like that
343 (1.0)
344 PR fill your spirit so much, this is a spiritual exercise.
345 P uh,
346 (0.6)
347 PR and physical obviously but mostly spiri- spiritual. coz
348 you're like i did it.
349 (0.5)
350 PR is that feeling like i did it you know?=
351 P =uh huh,
352 PR nothing er er is it's a powerful feeling.
353 (0.3)
354 PR and you don't get that feeling every day.
355 (1.0)
356 PR you know? you don't get that feeling every day you only
357 get those feelings like every now and then.
358 P right.
359 PR you know that feeling of accomplishment i had a friend who
360 just ran the new york city marathon. she did it in four
361 hours and about twenty minutes.
362 (1.0)
363 PR she she was high. [she]
364 P [uh,]
365 PR was she was high.

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366 P °exactly.°
367 PR because she did something that really not everybody in the
368 world could do or everybody could do but er they don't.
369 (1.4)
370 PR so you know,
371 (0.3)
372 PR if that's one of the things that you personally wanna do,
373 (0.4)
374 PR and you can't,
375 (0.4)
376 PR and along with with with your weight loss program,
377 probably when you start with losing just a few pounds,
378 you're [go]nna=
379 P [uh,]
380 PR =be able to do that
381 P =uh,
382 PR position. coz,
383 P uh huh.
384 PR you know, [pro-]
385 P [e]xactly.
386 PR right?=
387 P =well that's the thing! she said that my mental block of
388 course was there's no way i'm getting this,
389 (0.5)
390 P hhh .hhh myself into that position,
391 PR right.
392 P w- with as heavy as i am.
393 PR right.
394 P erm
395 (0.4)
396 P but,
397 (0.4)
398 P she dismissed the, er she i didn't even vo- ver- vocalize
399 it but she said,
400 (0.6)
401 P erm
402 (1.8)
403 P i don't know. (.) maybe felt that i was thinking it, or
404 PR [uh huh,]
405 P [because] i may have seen str- pressure that i couldn't
406 get into this (slb tion),
407 PR uh huh,
408 P erm
409 (0.5)
410 P just stated that it wasn't,
411 (1.6)

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P 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)
P it was encouraging to hear say that and,
PR good.
(0.7)
P put me back in my mind to make you know to know that,
(1.4)
P i can achieve anything that i put my mind to.
PR absolutely! absolutely and th- er you get that feeling that i was just talking about. a feeling of i can.
P deter[mi na tion?]
PR [the feeling] of i can.
P uh,
(0.8)
PR that erm a hot feeling like (slb slb slb). and a hot feeling!
P uh huh.
PR like i can that feeling is an amazing feeling,
(1.5)
PR 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.
(1.0)
PR (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.
P uh huh,
PR and:
(0.6)
PR you know i:,
(0.8)
PR 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 you'll be able to do it er pretty much on your own.
(0.7)
PR 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.
P erm hhh very poor actually. i,

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458 PR what do you mean by that?
459 (3.0)
460 P i made poor food choices in my eyes.
461 PR like what?
462 P erm crispy cream donuts? hhh
463 PR okay.
464 P erm [(slb slb)]
465 PR [on what] day, [at what time,]
466 P [it was just,]
467 (0.8)
468 P °when was that then,°
469 (1.0)
470 P °erm°
471 (3.0)
472 P tuesday night.
473 PR okay.
474 P a:nd wednesday night. (.) we:,
475 PR okay.
476 P we meaning two oh my friends and i went to crispy cream
477 and got a dozen.
478 PR okay.
479 P a:nd
480 PR how many did you eat,
481 P four. (we each had) four.
482 PR in one ↑night
483 P two in each night.
484 PR two in each night [o]kay.
485 P [two.]
486 (1.4)
487 PR and what else,
488 (0.6)
489 P erm ((rhythmic lip smack)) tzt tzt tzt tzt
490 (6.9)
491 P potatoes,
492 PR okay,
493 P and (slb slb slb) he he he=
494 PR =and (slb slb [↑slb)]
495 P [well] just at the cafeteria basi[cally.]
496 PR [yeah.]
497 P white rice and potatoes. things you know,=
498 PR =so [what what was,]
499 P [erm kinds things.]
500 PR your typical breakfast.
501 P tzt
502 PR let's start with that.
503 P erm the same thing the,

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504 (0.6)
505 P three boiled eggs,
506 PR okay.
507 (0.9)
508 P erm (.) this time i started putting
509 (2.2)
510 PR [uh,]
511 P [hot] water in the toasted ↑oates
512 (1.0)
513 P and just making (slb slb) oatmeal without the sugar
514 [(slb that] they turned into,)=
515 PR [o kay.] =okay.
516 P and then i put a little bit of maple syrup in ↑it
517 (1.0)
518 P for a sweetener.
519 PR uh huh,
520 (1.0)
521 P and:
522 (0.6)
523 PR and what else,=
524 P =every once in a while c- a piece of (slb slb)
525 a little pear:.
526 PR okay,
527 P or banana.
528 PR okay.
529 P that's (slb slb slb variable)
530 PR okay. what else?
531 (1.0)
532 P erm
533 PR anything else with break↑fast
534 P tzt just two glasses of water.
535 (0.4)
536 PR okay.
537 (1.1)
538 PR how about for lunch or er snacks?
539 P erm=
540 PR =between lunch er breakfast and lunch.
541 P snacks last week was pretty i had a craving for bananas
542 all weeks. [i]
543 PR [uh] huh. o[kay.]
544 P [i:]
545 PR uh huh.
546 P ate bananas during my (slb) and
547 (0.8)
548 PR ↑lunch
549 (0.7)

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```
P           er lunch i had, gosh!
            (1.9)
P           really anything the cafeteria was serving. but erm the
            (slb slb)
            not   to be you know no fried food. er
PR          uh huh.
P           stir fry sometimes.
PR          uh [huh,]
P              [ so ] they have sweet sauces with that once in a
            while.
            (1.1)
PR          okay.
            (0.7)
PR          .h and snacks between lunch and dinner this past week?
            (3.6)
P           erm
            (6.0)
P           tzt i don't think i really snacked then, i just gonna eat
            dinner
            early and (slb) in the night.
PR          then what was your dinner?
            (0.7)
PR          more or less,
P           erm
            (1.2)
P           we ate out a lot last week.
            (0.4)
PR          you and your new (.) [↑friends]
P                                [  hu    ]
            (0.8)
P           tzt [but they are still  in    my  ]
PR              [non  na turo pa  thic friends?]
P           class so they are naturopathic. he [he ] he he=
PR                                             [ah!]
P           =[ he  ]
PR          =[pfui!]
P           .hhe .hhh erm (.) mediterranean, middle eastern food.
PR          o[kay.]
P            [like] er (slb) and
PR          (laylas) o:r [(me  di) ]terannean ↑food=
P                        [ er  er  ]
PR          =(leylas)?
P           er erm tzt fala↑fel
PR          yeah,
P           but (at leylas) yes [ e ]xactly.
PR                              [uh,]
```


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596 (1.3)
597 P we went there twice.
598 (1.3)
599 PR and what did you eat?
600 P i had the chicken,
601 (1.6)
602 P you know the thing wrapped in tortilla,
603 PR uh huh,
604 P with the dip in sauce. garlic dip in sauce.
605 PR uh,
606 (1.1)
607 P °(other than that)° and i had hummus,
608 (0.6)
609 PR okay.
610 P and yellow rice.
611 PR °okay.°
612 (0.9)
613 PR alright.=
614 P =and next time i had (.) erm (la:mb) schickh kebab.
615 PR uh,
616 P °with falafel.°
617 PR what do you feel your relationship with food is right now?
618 P tzt
619 (0.7)
620 P erm before, i was beginning to look at it as:
621 (2.9)
622 P er er kind of medi↑cine something i needed to:,
623 (1.7)
624 P nurture myself. not nurture nourish myself with, erm
625 PR [uh huh.]
626 P [as far] as
627 (1.6)
628 P er just eating a little bit here you know, just a little
629 (slb slb)
630 meal and,
631 (1.2)
632 P if i became hungry it meant to me eat something for a
633 snack.
634 [but,]
635 PR [((sniffs))] uh huh.
636 P you know (slb slb slb) eat
637 (1.0)
638 P last week.
639 (2.1)
640 P i could blame it on
641 (0.4)

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642 P the ↑stress
643 PR uh huh,
644 P but then when i i was actually consciously thinking about
645 it while
646 i made [certain] food choices,=
647 PR [uh huh.] =uh huh.
648 P and i just thought well yeah, i can see this is stress
649 right now.
650 PR uh huh,
651 P bu:t
652 (3.5)
653 P i just (0.3) chose to do it re[gardless.]
654 PR [uh huh,]
655 P even when i er hesitated this is probably not the best
656 choice for
657 me right ↓now
658 PR uh huh,
659 P i did it anyway. [a:nd]
660 PR [.hhh] alright. this is what we gonna do
661 as t-
662 when you gonna be in those situations very often. you you
663 you you wanna stay focused where you wanna be,
664 P okay.
665 PR you don't wanna focus on where you don't wanna be.
666 (0.6)
667 PR or what you don't want.
668 (0.7)
669 PR coz you you're gonna track what your mind er what kind of
670 information your your mind has, so if you're focusing on
671 that's not what i want, the donut is not what i want i
672 don't want the donut, it's not the best thing for me,
673 you're still focusing on a donut,
674 (0.7)
675 PR so you're gonna want the donut more. [you're go]nna=
676 P [uh huh.]
677 PR =track it more to eat.
678 (0.7)
679 PR okay?
680 P okay.
681 PR and that goes for everything.
682 (1.2)
683 PR tzt what you do is gonna ask yourself the question .h what
684 would be what would be the most nourishing food for me at
685 this time,
686 P uh huh.
687 PR what is the food that's gonna best erm help me attain my

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goal?
(2.6)
PR and then you you you take action from there,
(0.8)
PR 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]
P [can't,]
PR want [or i can't.]
P [don't shouldn't,]
PR right.
(0.7)
P okay.
PR because you gonna it's this c- you you has you gonna attract what you don't want.
exactly [where you wa]nna what you gonna attract
P [(slb slb slb)]
(0.7)
PR .hh so,
(1.1)
PR tzt 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)
PR and w- what is the food that erm that will that will help me attain my goal,
(0.7)
PR erm
(0.8)
PR you know?
(0.4)
PR losing weight.
(1.6)
PR e[very] single time.=
P [uh,]
PR =okay?
P uh huh,
PR and:
(1.0)
PR of course that (slb slb slb slb) with any guilt erm (.) or waste [you know,]
P [i didn't,] once i put the donut in my mouth i said this is so ↓good ((claps hands))
PR [u:h,]
P [i'm] glad i had ↑it he he [he]
PR [great.]

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734 P he [.hhh]
735 PR [see] this there (.) there's definitely a list of
736 foods that are er definitely most nutritious [for you,]
737 P [uh huh,]
738 PR then there's a list of foods that are not. .hh and you
739 know the foods,
740 P [right.]
741 PR [so] we don't have to go in so much detail you know i
742 would suggest, is the foods that are that are not that
743 good but you still want for whatever reason,
744 (0.9)
745 PR i mean you could you gonna start tell yourself or ask
746 yourself that question what is the most nourishing to you
747 right now? .hh and and you know what is the food that er
748 could help me attain my goal, the best food >that can help
749 me attain my g- you're gonna ask yourself those questions
750 then sometimes you< still probably, you know y- you want
751 something from that donut or something. .hh you definitely
752 wanna eat less of of those foods that are not tho-
753 tho- [the best food] for you at that moment.=
754 P [uh uh. uh,]
755 PR =just eat less of it,
756 P right.
757 (0.4)
758 P .h well the donuts, that's the crazy thing i, crispy cream
759
760 originated in north carolina and [i never ate that.]
761 PR [ahh i didn't know]
762 that!
763 P (greensburgh) north carolina.
764 PR .hhh [(slb slb slb)]
765 P [and there was] one right across the street from my
766 dorm in college and (.) the most i went was like twice a
767 year.
768 PR uh huh.
769 P twice a semester for midterms and finals.
770 (0.6)
771 P .hh and it wasn't a big thing for me you know, donuts er
772 not something i craved all that often,
773 PR [uh,]
774 P [but] when we found out that that was down the street you
775 know, it was
776 (0.7)
777 P er i'm a social eater. i know that i'm definitely a social
778 eater.(so if i) have a plan to eat something you know soup
779 or whatever, erm

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780 (0.5)
781 P and then my friends (slb slb) well let's go out to eat,
782 [and i'd]
783 PR [uh huh,]
784 P say okay.
785 PR [uh huh.]
786 P [go out] to eat and (.) eat something else instead. erm
787 (1.0)
788 P tzt (0.3) i am (.) making a ↑soup for tonight chicken,
789 PR [oh good!]
790 P [veggie] a:nd
791 PR good.
792 P i bought erm
793 (0.7)
794 P chinese dumplings?
795 PR yeah,
796 P with erm chicken and leek.
797 PR okay.
798 P and i will just eat that with erm (slb slb slb) erm soya
799 sauce?
800 PR okay.
801 P so that's you know? another option (for eating) this week.
802 PR [good.]
803 P [so] i'm trying to get very simple things that i can
804 either prepare in advance and put in the refrigerator, and
805 just you know warm it up for lunch. and erm
806 PR good!
807 P something really quick for dinner just to make it simple
808 so
809 (0.9)
810 P you know if i don't feel like going to the cafeteria which
811 p-for me doesn't really have the best food choices, anyway
812 erm i can just do something that isn't too laborious
813 (1.0)
814 P at home you know [here in] the dorm. (.) erm
815 PR [uh huh.]
816 (0.9)
817 P and there're things i've [done u sua lly,]
818 PR [you said you do] drive, you have
819 a car?
820 P i do drive.
821 PR definitely did i give you a list of the health food stores
822 (slb)
823 [(slb ↑slb)]
824 P [tzt no] i've heard of misses greens, and haven't been
825 able to

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826 find it.
827 PR but you definitely wanna go to these stores. they give you
828 a lot of options that that you normally can't get in er
829 regular stores.
830 P okay.
831 PR erm because there're certain foods that for example s-
832 speaking of the foods that are are not er the best foods
833 for you, .hh
834 certainly wheat,
835 (0.6)
836 PR and dairy fall in that category,
837 P right,
838 PR (they fall) in that category big times. and then in fact
839 i've seen people lose weight without doing any kind of
840 exercise just
841 P [°eliminate all that,°]
842 PR [eliminat ing food.] erm
843 (0.5)
844 PR three things. corn,
845 P °yeah,°
846 PR wheat, and dairy.
847 P so the thing is when i (.) get away from wheat i turn to
848 corn.
849 (1.1)
850 PR oh yeah, [(slb slb slb)]
851 P [me xi can,] and
852 PR sure!
853 P [just]
854 PR [yeah.] that's [that's what most]
855 P [just as bad.]
856 PR people do.
857 P uh huh.
858 PR tzt that's what most people do you definitely wanna
859 consider the food, and and not the best food or less than
860 great food for you at this time anyway.
861 P uh huh,
862 PR put that in that category in your head because it is (.)
863 erm so that you eat a lot less of it,
864 (0.6)
865 PR the fact that you exercised so ↓much this ↑week is great.
866 because usually with exercise you your body could m- m-
867 metabolize food a lot better.
868 P right,
869 PR so that's a great thing and and and you know your body
870 forgives you for for for,
871 P [hu hu hu .hhh]

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PR [things that are less] than perfect for you.
(1.3)
PR but erm certainly you you you definitely wanna understand that this this food including hydrogenated erm er oils and high fructose corn syrup,
P uh the maple,
[and i] don't know where that [(comes from)]
PR [(i mean)] [high fru]ctose 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.
(1.5)
PR 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.
P [uh huh,]
PR [you just] don't have it.
(0.9)
PR so people who promote these sugars er because it doesn't promote such an insulin re↓sponse (.) 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 ex↑tra where is it going?
(0.8)
PR into your adipose tissue. (probably) your liver gets (slb slb) some fatty,
P uh huh,
PR 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.
(1.4)
PR tzt i'm gonna l- give you a list of all the foods that contain er high fructose corn syrup.
P okay.
PR (slb slb slb slb [slb slb)]
P [o kay.]
(1.2)
PR erm
(1.2)
PR that hydro-
P [erm]
PR [so] right. now this week i'll tell you what we gonna do,

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```
                you did a great battle in this past week.
                (0.8)
PR              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 par- part of the program. so i definitely
                congratulate you on that. you did=
P               =uh,=
PR              =very very well.
                (0.8)
PR              tzt
                (0.6)
PR              have a firm understanding of the foods that are not or or
                or that are less than perfect for you for you right now.
                (0.6)
PR              have a firm understanding on what they are, (.) all the
                junk food that you know of,
                (0.7)
PR              but erm you know highlight the the wheat, the corn, and::
                (0.8)
P               [dai]ry.=
PR              [dai]   =wheat the corn and the dairy.
                (1.1)
PR              that's one then of course the high erm the f- 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.
                (0.5)
PR              (slb slb slb) because you gonna kinda like er you know be
                you not go  [nna   know  ] everything, gonna read through
P                           [°know ↑more°]
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 really really really see some benefits as far as
                your body composition changing and all that.
                (0.9)
PR              you're gonna be in shock. i mean really (.) i:t just
                happens.
                (0.8)
PR              what happens is you 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.
```


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964 PR i mean it's that dramatic!
965 (0.6)
966 PR i've ↑seen ↓it it happened many times.
967 (0.8)
968 PR ((clears throat)) that's why a lot of people are onto the
969 atkins diet and then they lose a lot of [weight.]
970 P [right,]
971 PR the a lot of people ,
972 P uh huh.
973 PR tzt are onto the er erm m-, the diet that i subscribe to
974 the most is the blood type diet.
975 P okay.
976 PR tzt and and you know i i'm i work with a doctor and i've
977 seen a lot of great things with that diet help your diet,
978 (1.6)
979 PR and tzt you also exercise i think it's important as you
980 know you're doing a great job doing that, you don't if you
981 start getting on this kind of diet without exercising,
982 then your muscle is reduced as well. you're not gonna look
983 good or feel good but you're gonna lose weight. and that's
984 never my purpose. i: wanna help you you know lose a proper
985 weight, change your body composition, and keep you
986 healthy.
987 (1.3)
988 P [it's a good thing.]
989 PR [and that's e xa]ctly what you want.
990 (0.8)
991 PR .hhh so erm
992 (1.3)
993 PR hhh (you have slb slb slb) right now.
994 (4.2)
995 PR you have to you have a cross refe↑rence or you're all
996 [mine,]
997 P [no:.]
998 [i scheduled]
999 PR [for the next]
1000 P from now until the end of the semester at this time
1001 because i get out at [three.]
1002 PR [cool!]
1003 P so we are (slb slb slb),
1004 (0.9)
1005 PR °oh my my my my,°
1006 (1.0)
1007 PR °here you go.°
1008 (1.4)
1009 PR did i give you a handout on sleep?

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1010 (0.5)
1011 P yes.
1012 PR good.
1013 (0.5)
1014 P erm which i:
1015 (0.4)
1016 P [didn't]
1017 PR [what did] with that,
1018 P follow very well last week.
1019 PR when [i]
1020 P [i] was doing very well,
1021 PR you [↑were]
1022 P [i] was getting up at six o'clock every morning to
1023 do my yoga until six thirty,
1024 PR ((clears throat))
1025 P get ready erm to go to class, °thank you.°
1026 PR that's a (slb slb) [a ny]thing that contains wheat and
1027 substitutes, again su- many of these substitutes you could
1028 only find in health food stores.
1029 (1.3)
1030 PR that's what (slb slb) erm from the (slb slb) yourself with
1031 health [food stores,]
1032 P [ssoy sauce] has wheat in ↑it
1033 PR yes:::. yes it ↑do↓es
1034 (1.0)
1035 PR that's why it's a good sheet. because there's a lot of
1036 wheat hidden in different places that you don't know of.
1037 but soy sauce does contain wheat.
1038 (4.6)
1039 PR here's erm a list of health food stores around this area.
1040 so misses greens [is one]
1041 P [°thank you.°]
1042 PR of them but there's also a few others around here.
1043 P trader joe's it's where, i shop (in there)
1044 (2.5)
1045 PR °okay.°
1046 (2.1)
1047 PR ((singing)) na na na na na na na
1048 (1.8)
1049 PR here's one of dairy,
1050 (0.8)
1051 PR and possible
1052 (1.4)
1053 PR dairy substitutes.
1054 (0.6)
1055 P thank you.

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1056 (2.0)
1057 P .h i found a pasta made of wild rice.
1058 (1.3)
1059 PR tzt you have to look at the ingredients.
1060 (0.7)
1061 PR they sometimes,
1062 (1.5)
1063 PR e::rm
1064 (0.6)
1065 PR >you have to look at the ingredients sometimes they say<
1066 buck wheat ↑pasta
1067 P u:h,
1068 PR and it has wheat. you look at the ingredients it has some
1069 buck wheat but it h- also has wheat.
1070 P okay.
1071 PR there's brown rice pasta it's a hundred percent brown
1072 rice. again er but you only see 'em in health food stores.
1073 (0.7)
1074 PR and i believe there's quinoa,
1075 P okay.
1076 PR pa[sta.]
1077 P [qui]noa,
1078 PR anything else but wheat it is great.
1079 P okay.
1080 PR or spelt or any, look at that list and you'll see other
1081 things that are like wheat like spelt,
1082 (1.7)
1083 PR °(well let me copy this for you let's see),°
1084 (2.5)
1085 PR °okay.°
1086 (2.0)
1087 PR alright. i have to make a copy of it.
1088 (2.7)
1089 PR high fructose corn syrup,
1090 (3.4)
1091 P thank you.
1092 (1.1)
1093 PR that i- that's like you can put up (a few extras except
1094 for that) that's erm very very very important.
1095 (0.7)
1096 PR to i you know ↑what there's nothing, i eat everything.
1097 P [well,]
1098 PR [but] if i know that something has that, i don't eat it.
1099 P okay.
1100 PR that i don't eat er artificial sugars.
1101 (0.3)

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1102 PR i don't eat.
1103 (0.4)
1104 PR so there're few things that i just don't eat.
1105 P (slb slb slb) at all refined sugars and soda,
1106 PR uh?
1107 P i cannot (slb) all candy bars all candy,
1108 PR good.
1109 P don't eat things that are really (slb) and sweeties. well
1110 except for the donuts.
1111 PR uh huh.
1112 P now and some ice cream every once in a while, that's
1113 PR okay.
1114 P all sugar and dairy but,
1115 (0.8)
1116 PR that's that's o- o- that's okay. have it. erm
1117 (0.4)
1118 PR if you need to have ice cream, if you wanna have ice
1119 cream, have it as early as possible,
1120 (0.5)
1121 PR have it on an empty stomach,
1122 (0.6)
1123 PR and you know, have a decent portion don't have a big
1124 portion and enjoy it.
1125 (0.3)
1126 PR enjoy it so much. eat it slowly so that you can enjoy it,
1127 and not have to eat er a pint.
1128 (0.5)
1129 PR you wanna eat less
1130 P uh huh.
1131 PR of it and enjoy it.
1132 (0.5)
1133 PR and it's okay as long as it's you know what, eat regular
1134 ice cream don't get these (slb slb slb) ice creams.
1135 P [no. just (slb slb that)]
1136 PR [or (slb) they add a] lot of junk into those things
1137 that are not really good. eat regural hagen daaz or
1138 regural ice cream any,
1139 (0.6)
1140 PR you know again as early as possible,
1141 (0.3)
1142 PR and and a small portion.
1143 (5.3)
1144 PR hhh
1145 (3.4)
1146 PR your goals as to why you wanna lose weight,
1147 (1.1)

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1148 PR tzt you need to like,
1149 (0.3)
1150 PR be with (.) be one with these goals.
1151 P okay
1152 (0.5)
1153 PR so you certainly goals happen g- g- you succeed, (.) in
1154 pretty much everything but particularly in your situation
1155 when you write things down?
1156 (0.5)
1157 PR if
1158 (1.0)
1159 PR if you don't wa- wanna (slb slb) just mainly e:rm a a wish
1160 you wish to lose weight,
1161 (0.8)
1162 PR when you write it down it has more power.
1163 (0.7)
1164 PR when you write a goal down this is this is a good lesson
1165 for anything in ↑life
1166 (0.7)
1167 PR but particularly in your case if you write these things
1168 down is particularly that much more powerful.
1169 P .hhh the goals you asked me to write down,
1170 PR [uh huh,]
1171 P [the ten] ↑goals
1172 PR uh huh.
1173 P erm
1174 (0.6)
1175 P i was pretty much stuck at three. he he .hhh
1176 PR you gotta dig.
1177 P erm
1178 (1.3)
1179 PR everybo- i've never had anybody
1180 (0.6)
1181 PR not giving me ten goals.
1182 P [uh,]
1183 PR [ten] reasons why.
1184 (0.6)
1185 PR (they wanna that they wanna lose weight) never
1186 P .h not stuck, but i found myself
1187 (1.8)
1188 P rewording things saying the same thing [(slb slb slb)]
1189 PR [you're not the]
1190 first to ↑do ↓that he he
1191 P oka(h)y.
1192 (1.6)
1193 P [erm]

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PR [you] gotta dig.
(0.5)
PR it takes this is gonna take a little bit of time.
P right,
(0.6)
PR erm it's it's worth it.
(0.5)
PR it's one of those things that it's worth it.
(0.7)
PR erm
(0.8)
PR dig.
(0.5)
PR dig dig think deeply as to why.
(2.8)
PR you know, make sure
(0.7)
PR make sure that nobody in your family friends or any relationships will be,
(0.7)
PR unha↑ppy
(0.6)
PR if you start losing weight.
(2.5)
P make ↑sure
PR make sure that nobody friends family
P uh huh.
PR or er or other,
(0.9)
PR that they will that they will be unhappy if you start to lose weight. and be
(0.7)
P [(slb slb)]
PR [there are] some times, what i'm trying to say is there are times when
(1.3)
PR tzt kind of subconsciously loved ones, quote unquote. kind of are happy that you are
(0.6)
PR overweight.
(0.4)
PR and not up to (slb) where you wanna be.
(1.1)
PR so erm
(1.2)
PR i'm not saying that's your situation. but i'm saying

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1240 that's (slb slb) ti- erm a few times that kind of er so
1241 what i'm saying is you don't go, y- er if you haven't gone
1242 through that already with your
1243 (0.5)
1244 PR personal erm awareness erm weekends, that you that you've
1245 done erm just make sure that this, that's
1246 (1.1)
1247 PR you know that th- there there's people that really truly
1248 love you,
1249 P uh huh,
1250 PR and coz you know you gotta ma- you're we've been around a
1251 little bit of time, there's always family members friends
1252 that are your friends but some↓times
1253 (0.5)
1254 PR tzt you gotta love them from fa:r.
1255 P right. .hhh that's interesting that you say that. i have:,
1256 (0.7)
1257 P tzt my family
1258 (1.9)
1259 P is very very (nuclear).
1260 (0.9)
1261 P and traveling our entire li- you know, er my whole life
1262 anyway,
1263 (0.9)
1264 P .hh erm we
1265 (0.5)
1266 P were all we've had.
1267 (0.4)
1268 P for a very l- for our whole (we), as long as i can
1269 remember
1270 (0.4)
1271 P .hh and my mother and my father (0.4) erm my sister all of
1272 them especially my mother are extremely supportive in
1273 anything i wanna do.
1274 (0.6)
1275 P a:nd
1276 (2.6)
1277 P thee:: leadership conference i attended,
1278 (0.4)
1279 P they were some: some way apprehen↓sive
1280 (0.6)
1281 P and this past weekend when i went to visit my sister, she
1282 not this past weekend the weekend before.
1283 (0.8)
1284 P tzt gave me ha ha ha .hhh erm a paper on (.) how to
1285 recognize a (coz)

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1286 (1.2)
1287 P a:nd
1288 (2.3)
1289 P supposedly she did it you know as a joke. but then she
1290 also erm (pulled) (slb slb slb slb slb) and did some
1291 research on support groups.
1292 (0.4)
1293 P in the area for weight loss or whatever,
1294 (1.2)
1295 P erm she
1296 (0.3)
1297 P has this impression, she's going to you know psychology
1298 training.
1299 PR she ↓is
1300 P yes ha [she's be com ing]
1301 PR [how old is your] sister,
1302 P she's twenty, (0.4) three.
1303 PR okay.
1304 P and she's going through the program for
1305 (1.5)
1306 P counseling psychology at n_y_u.
1307 PR okay n_y_u. °okay.°
1308 P and erm
1309 PR she's dorming over ↑there
1310 P she's dorming over there.
1311 PR uh,
1312 P that's where i stay when i go to new york.
1313 PR cool alright.
1314 P and apparently she has the feeling that i
1315 (1.4)
1316 P seem to have the need to belong to a group.
1317 (0.9)
1318 PR okay,
1319 (1.7)
1320 P and the thing with my sister throughout our lives we've
1321 always had a very (1.8) big (0.5) misunderstanding of one
1322 another,
1323 (0.5)
1324 P great relationship. very close, very loving, very caring
1325 toward one another,
1326 PR uh huh.
1327 P erm
1328 (1.1)
1329 P we had our share of fights growing up,
1330 PR uh huh.
1331 P it happens when you're so close in age i guess.=

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PR =sure.
P a:nd
(2.5)
P all the while (.) i don't think we've really ever (1.0)
got to know each other,
PR rea↓lly
(1.7)
P that well.
(1.5)
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,
(0.7)
P well basically attributes feelings that i may have about
myself to me, that completely don't exist. that i have
(0.4)
P no clue where she might have got 'em.
PR okay.
P certain ideas from,
PR okay.
P erm
(0.6)
P [the big one was that i w-]
PR [(slb slb slb slb slb slb)] first to be dis[cussing this]
P [he he he]
he
PR is god tryin to talk through me?
P .he
PR is that happening right now?
(0.4)
PR or some↑one
P .hh well,
(0.6)
P i don't know my whole life i you know,
PR [((clears throat))]
P [spent pro]tecting her basically.
PR uh huh,
P erm
(1.9)
P i see her as: fortunate and somewhat selfish and self
(1.3) erm (0.8) concerned. er
(1.8)
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
trips, florida,
PR uh huh,

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1378 P you know,
1379 (0.7)
1380 P and see west whatever, she did it she went.
1381 (0.7)
1382 PR uh huh,
1383 P erm and it's also the older younger sibling dynamic where
1384 the you- older daughter has or (0.5) child has more
1385 problems because they're pushing the limits er you know
1386 trying [to,]
1387 PR [right.]
1388 P get the barriers first with the parents,
1389 PR right,
1390 P and the second child just goes through because by that
1391 time the
1392 par[ents (slb:)]
1393 PR [.hhh would] like to [retire,]
1394 P [hu hu] hu hu .hhh so that you
1395 know,
1396 (0.8)
1397 P definitely coz erm some friction [there be]tween us.=
1398 PR [uh huh,]
1399 P =and (2.1) er after graduation graduating college i went
1400 straight
1401 to work. erm
1402 PR uh huh,
1403 P trying to save money for school.
1404 (0.3)
1405 P she went to ↑ger↓many and studied for a semester there,
1406 PR uh huh,
1407 (0.4)
1408 P a:nd then came back and went to school, got a new school
1409 (slb slb)
1410 (1.0)
1411 P and (0.6) i suppose i was i was extremely happy for her
1412 but
1413 somewhat, jealous? that she had that opportunity,
1414 (0.4)
1415 P thee: er (0.3) you know chance to live in germany for six
1416 months, eight months actually.
1417 (0.7)
1418 P a:nd (1.1) you know it was great for her and she had a
1419 really good time and you know told us all about it, it was
1420 really wonderful. but erm
1421 (1.6)
1422 P i don't know, it often happens actually when we're in
1423 germany,

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1424 (0.4)
1425 P staying alone by ourselves together and show this,
1426 (0.5)
1427 P come out and say things like,
1428 (1.4)
1429 P immediately after: hh high school i believe it was for
1430 her, er we went to germany for a while and she said that
1431 she always saw me as im- (1.5) immovable,
1432 (0.6)
1433 P impenetrable,
1434 (2.1)
1435 P robot like individual.
1436 PR rea[↓lly]
1437 P [whose] feelings can't be hurt.
1438 (0.7)
1439 P ands (0.6) you know i just (slb slb slb slb) not allowing
1440 anything to bother me, anyone to hurt me anything like
1441 that.
1442 (1.4)
1443 P and hhh [that was the first]
1444 PR [were you try ing,] you were holding things in?
1445 P [tzt no. ba]sically she saw me as being so strong,=
1446 PR [your feelings,]
1447 PR =[uh huh.]
1448 P =[and so] and so (0.5) invincible,
1449 (0.4)
1450 P that (0.7) i didn't have feelings in a sense.
1451 PR uh huh,
1452 (0.5)
1453 P erm
1454 (1.3)
1455 P and she genuinely meant that. and that really really hurt
1456 me.
1457 (1.3)
1458 P because i thought we were close (to one another),
1459 PR right,
1460 (2.4)
1461 P and tha- that was really the first epiphany of
1462 (0.6)
1463 P wow she has no clue. who i am ha ha ha .hhh you know? all
1464 of this time we spent together growing up, me protecting
1465 her as being you know best of friends in a sense,
1466 (0.4)
1467 P yet so having our own friends because of the age
1468 difference,
1469 (0.6)

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P erm
PR ((sniffs))
(0.8)
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 ↑gra↓duation 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,
(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.
(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,
P right,
PR and as a profession we do have a poverty conscious
mentality.
(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,
(0.4)

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PR if life is about win win, not yeah. win win and give and receive,
P okay.
PR and (slb slb slb slb) money so,
(0.4)
PR er keep that in mind as you go along because some peo- you gonna have people right around you, they're gonna °heal the world and (slb slb slb slb) making money°
P uh huh.
PR an you're gonna be a very better doctor you know making the money.
P uh uh,
PR so you ↓know
(0.7)
PR is it a (slb) for them, of course it is. it's a way for them to you know so people see how valuable their staff is. and when you wanna join, sure!
P right.
PR but there's nothing wrong with that.=
P =right,
PR as long as they're helping people. and they're certainly helping you.
P right.
(0.8)
P .hhh and it's not for everyone and that's,
PR [it is not for e very one that's sure.]
P [you know i respect that with my sis]ter that she:
(0.4)
P you know, doesn't feel it's for her. she's definitely not going to do it,
(0.5)
P erm yet she've still tried to be supportive,
(0.5)
P for me.
PR ((clears throat))
(0.6)
P erm but i think her reaction as far as
(2.3)
P 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)
P counseling kind of (slb) work body work erm therapist. and
(2.1)
P erm (0.4) i always go to her for very valuable advice.
PR uh huh,=

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P =and i hadn't spoken to her about it but apparently he he
you know my paren- my mum and my sister had concerns. so
[they did.]
PR [uh huh,]
P .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)
P and that was valuable to me and could help me (.) forward
myself.
(0.6)
P and (.) they were happy with that explanation so it er you
know er made them more comfortable with=
PR =uh huh,
P what i was doing.
PR uh huh.
P 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)
P [think] she does,=
PR [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)
P [.hhh]
PR [some] some.
P er not with my immediate family.
PR yeah,
P erm the people that you love from a distance i don't have
those people i just,
(0.6)
P that,
PR o[kay.]
P [yeah.] family's family but:,
PR okay. [o kay.]
P [you know,] that doesn't mean i have to
PR °great,° [okay.]
P [erm]
(1.2)
P tzt make my s- my situation more difficult by trying to do
for them,

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PR yeah.=
P =erm constantly bec- just because they are family. you know?
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 giving,
PR 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.
(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,
(1.8)
PR so you think so you (are trapped). (.) it's how you're feeling you (are trapped),
(1.8)
PR so, (0.3) you know, you're you you you you got to you ↓know
(0.4)
PR you have a result. (.) your past experience.
(1.2)
PR until very recently.
(0.4)
P right,=
PR =and i'm sure (slb slb slb slb) something that you just heal from
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,]
do you have?
P since i was thirteen.
PR okay.
P so,

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1654 (0.7)
1655 P i- it's not just this you know one weekend course.
1656 PR [so that was the climax.]
1657 P [(slb slb) a beautiful] course that for me was thee:
1658 (0.6) last hurdle. [it was the]
1659 PR [(slb slb slb)]
1660 P beginning to the peak of the mountain i was trying to
1661 climb.
1662 (0.6)
1663 P erm but=
1664 PR =so your your your results are the, [s- so that]
1665 P [i f- i] feel
1666 (various) results.
1667 PR yeah so so that's the point. that's exactly my point. that
1668 erm
1669 (0.8)
1670 PR you (didn't) you (didn't) result is with the issues,
1671 emotional
1672 issues until very recently.
1673 P right.
1674 (0.7)
1675 P but those [(slb slb) from my]
1676 PR [as a result.]
1677 P past are still in my life. and [that i]
1678 PR [(slb slb)]
1679 P do see as a problem.
1680 (0.3)
1681 PR they are still in your your yours boyfriends that you used
1682 to ↑got
1683 P ex boyfriends.
1684 PR they're still in your life in w- [what way?]
1685 P [and one] my first
1686 boyfriend's
1687 trying to: tzt make moves to come uh,
1688 PR okay,
1689 P [live here.]
1690 PR [to come] back, [to c- be with you?]
1691 P [to come back in to] my life.
1692 PR so,
1693 (1.0)
1694 PR so what's the deal with that?
1695 P tzt he: (0.4) erm (1.2)
1696 PR do you have [any in]terest,=
1697 P [it's always]
1698 PR =i- i- i- into returning with any of these guys,
1699 P absolutely not.

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```
1700   PR          so w- what is the problem?
1701               (0.9)
1702   P           e:rm
1703   PR          what is the issue,
1704               (0.6)
1705   PR          (slb slb)
1706               ((looking into each other's eyes))(16.4)
1707   P           basically they're calling to tell me about the (slb slb)
1708               that they themselves [have ] had,=
1709   PR                               [their]     =(slb slb)=
1710   P           =they
1711               (1.5)
1712   P           do you [agr-]
1713   PR                 [ er ] they [they]
1714   P                              [yeah] they bog me. see i'm i'm
1715               underappreciated, right?
1716               (0.8)
1717   P           peoples begin dating me, er they
1718               (0.5)
1719   P           misuse me or
1720               (1.1)
1721   P           underappreciate me. and it ends for one reason or another
1722               one of their they cheated, or i got tired of them, or
1723               [what e ]ver=
1724   PR          [uh huh,]
1725   P           =happen. .hh erm
1726               (2.3)
1727   P           three people in particular continue to call back.
1728               (0.7)
1729   P           over the past, erm one i have known as long as nine years
1730               now.
1731               (0.5)
1732   P           and (0.8) erm ups and downs you know,
1733               (.)
1734   P           other relationships,
1735               (0.5)
1736   P           friends not friends type of situations.
1737               (0.5)
1738   P           .hh and
1739               (4.1)
1740   P           now they're you know telling me
1741               (1.5)
1742   P           they don't wanna let me ↓go
1743   PR          [is there,]
1744   P           [they rea ]lized how valuable i am,
1745   PR          [and   what   are  the chances though]
```


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1746 P [and they've grown up fi na lly,]
1747 PR of, what are the chances though of them making you feel
1748 good right now?
1749 P tzt erm i don't need them to make me feel good.
1750 PR you don't [need them,]
1751 P [i don't] ssee,=
1752 PR =they are not giving you anything right now.
1753 P [not at all.]
1754 PR [(slb slb slb)] your ego,
1755 P conversation tsss [pretty much it.]
1756 PR [are they (slb slb)] your ego a little
1757 bit, mak[ing,]
1758 P [no.]
1759 PR you feel important?
1760 P no.
1761 PR okay.
1762 P no i'm i'm ha- more or less what they're telling me makes
1763 me happy for them. that they're finally growing up and
1764 becoming [somewhat]
1765 PR [o kay.]
1766 so i don't [th-]
1767 P [men.]
1768 PR what i'm trying to sa- what i'm trying to ask is so then
1769 er what is, (0.4) the problem.
1770 (0.8)
1771 P .hh erm
1772 (0.4)
1773 P tzt rea[lly i,]
1774 PR [what's that?]
1775 P my whole life has been, (0.7) make friends quick, pick up,
1776 go.
1777 make friends quick, [pick up,] go.=
1778 PR [uh huh.] =(that's it).
1779 P leave behind leave behind. .hhh and recently i've come to:
1780 i'm starting to feel, (0.9) one i don't have a place to
1781 call home.
1782 (0.8)
1783 P er yet i can call anywhere home.
1784 (0.6)
1785 P as long as my ↑family's with ↓me and now my family's not
1786 with me because we're growing up, we're starting to
1787 [ven]ture=
1788 PR [u:h,]
1789 P =off on our own.
1790 PR uh huh.
1791 P so i'm somewhat lacking that

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1792 (2.3)
1793 P feeling of home as stability that has always been there
1794 with my family.
1795 PR uh huh.
1796 (0.7)
1797 P and i like any other,
1798 (0.7)
1799 P you know healthy whatever woman, .hhh erm
1800 (0.8)
1801 P do:
1802 (0.8)
1803 P hope that i eventually find a loving caring re↑lationship
1804 PR uh huh.
1805 (0.8)
1806 P a:nd i am i'm feeling no rush. no hurry,
1807 PR uh huh.
1808 P to do so, i feel that i'm so very young and [i have]
1809 PR [ab so]
1810 lutely.
1811 P a lot of goals to accomplish in the work tour right now,
1812 (0.4)
1813 P and not that i see a relationship as a burden or hindrance
1814 to ↓that but i realized since i can't get that much,
1815 (1.0)
1816 P and i have these other priorities right now,
1817 (0.4)
1818 P a relationship may not be
1819 (0.5)
1820 P you know in the near [future,]
1821 PR [you may] be right. sure.
1822 (0.6)
1823 P or it ↑could ↓be well, who know if the right person comes
1824 along,
1825 (slb) [(slb slb slb)]
1826 PR [i think that] it will happen once you get to erm
1827 where you wanna be in every sense with [you know,]
1828 P [o kay,]
1829 PR in every sense with that.
1830 P okay.
1831 (0.6)
1832 PR coz you're just gonna attract it.
1833 P right,
1834 PR it's gonna be so easy,
1835 (1.3)
1836 PR you gonna it's gonna be the most easy thing you've ever
1837 thought i wish i would have noticed before i woul[dn't,]

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1838 P [right.]
1839 PR (slb slb) before.
1840 P right.
1841 PR again you you've just reached results in certain issues,
1842 P [uh huh,]
1843 PR [im por]tant issues that have affected your whole entire
1844 life.
1845 (1.3)
1846 PR that's big!
1847 (0.7)
1848 PR that's big!
1849 (0.9)
1850 PR (now you're taking) care of your physical (.) aspect,
1851 (1.4)
1852 PR that again probably to some extent has had an effect on
1853 your own entire life.
1854 P [uh,]
1855 PR [or] for the most of your life.
1856 (1.0)
1857 PR tzt so you're gonna be a new woman. you go- you're working
1858 on being a totally new individual.
1859 P right.
1860 PR like a born again christian. like they're born ↑again you
1861 you you're born again, you're
1862 P [right,]
1863 PR [work]ing on being born again totally new individual.
1864 with a different identity.
1865 (0.7)
1866 P well it's hilarious because most of the, well one (.) of
1867 my friends (slb) in particular erm had this epiphany after
1868 thinking
1869 over something i said erm a week before,
1870 (0.7)
1871 P basically that
1872 (0.9)
1873 P erm
1874 (1.9)
1875 P tzt i've been l- lied to by many people my entire ↓life
1876 a:nd i don't need that in my life[a ny]↑more=
1877 PR [uh huh]
1878 P =so: don't make promises you can't keep. don't you know,
1879 don't even tell me. ((clears throat))
1880 (0.4)
1881 P you're going to do something and not do it, just don't say
1882 that at ↑all if you can't guarantee that it's gonna happen
1883 don't say it. .hhh erm

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1884 (0.5)
1885 P basically that i'm you know,
1886 (0.8)
1887 P comfortable with who i am, content for the first time in
1888 my life with who i am, and happy and proud and, .hh
1889 PR that's excellent. [(slb)] that's wonderful.=
1890 P [just] =i don't need
1891 ↑drama
1892 PR [well,]
1893 P [i] don't need people bringing me down. and if that's
1894 you know, what i view them as doing then, ((miming
1895 cutting throat)) zack! you know,
1896 PR (slb slb slb) [you know,]
1897 P [plea:se,]
1898 PR when move and move (ahead)
1899 P (slb slb) ha [ha ha]
1900 PR [and the] the unfortunate truth is you are
1901 gonna have those people, people are (slb slb slb ↑slb)
1902 P right, cra:b [men ta]lity.=
1903 PR [(slb slb)] =crab mentality ?
1904 (1.2)
1905 P it's what i call,
1906 PR °yeah.° tha- that's that that has to be right, did i tell
1907 you the story about the lecturer, (were you ↑here)
1908 (0.9)
1909 PR ((clears throat)) old guy (eighty) two years old
1910 chiropractor came to give a lecture on on business aspects
1911 [of of me]dical=
1912 P [right, right right.]
1913 PR =practice.
1914 P right and he told that the crab mentality story,
1915 (0.5)
1916 PR a crab's everywhere.
1917 P yeah.
1918 (0.4)
1919 PR crabs are everywhere and and and and that's the
1920 unfortunate truth.
1921 (0.8)
1922 PR uhahh, where the where else (slb slb) i feel sorry for
1923 them.
1924 P right,
1925 PR they're not like that coz they wanna be. they're not
1926 happy.
1927 P right,
1928 PR they're like that be[cause they've got too si mi]lar=
1929 P [e xa ctly. e xactly.]

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PR =issues.
P exactly.
PR how how (.) how easy could it be, could have could have been for you to be a crab?
P uh,
PR and and and and feel sorry for yourself because this happens to me, because this happens to me, because this happens to me,
(1.1)
PR y- you could have been one easily.
P uh,
(1.1)
PR you made [(slb slb)]
P [i was] for a very long time.
PR look at that!
(2.0)
PR so,
(0.6)
PR you know somebody else, you know you squeeze an orange,
(0.4)
PR what comes out is orange juice.
P right.
(1.0)
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.
P uh huh.
PR so,
(1.6)
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
P right,
PR and and again you you s- seems like to me from what you tell me, you you're working on that as well, and
P well [my first instance]
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.
(1.0)
PR you could you're definitely working on it. and:
(1.0)
PR i certainly by the time you graduate from ↓here
P uh huh.
PR er you should be a totally new individual. you you have a

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1976		doctor's
1977		degree, you are a different person, you think differently
1978		(.) you you're thinking of matters conducive to your
1979		health. you make decisions that are conducive to your
1980		health.
1981		(0.7)
1982	PR	you're gonna try great things.
1983		(0.8)
1984	PR	a:nd er i congratulate you in advance because
1985		(0.9) i i'm certainly sure this is gonna happen.
1986		(0.9)
1987	PR	erm
1988		(1.0)
1989	PR	certainly sure it's gonna happen.
1990		(1.5)
1991	PR	°let's go and weight you (out there).°
1992	P	okay.

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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	[hhh]
15		hu hu hu hu .hhh
16	P	hey! no more than u[sual,]
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		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		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,

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P uh,
PR i'll t- so next week for instance, i'll be (.) at the women
shelter and then it just goes back and forth.
P [uh,]
PR [you] know every other week i'm here.
P oh,=
PR =on tuesdays only.
P uh.
PR ((clears throat)) i mean tuesdays is the only day I,
P [yeah.]
PR [go] to the women [shel]ter.=
P [right.]
PR =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
P yeah,
PR and you had blood one time on the ↑tissue
P right.
PR it was bright ↑red
(.)
PR or,
P yeah it[was.]
PR [o]kay.
(.)
PR okay so, erm (.) how is that doing now?
P well i went for a colonoscopy,
PR you did, [so,]
P [last] tuesday.
PR okay.
P 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,
PR ↓oh↑oh
P i'm work[ing monday tues-]
PR [do do you get] some (slb slb) ↑too
P 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
PR [uh,]
P [but] what they told me i went to see these to get the procedure done.
PR uh huh,
P and after the procedure the nurse told me that .hh the doctor did remove two polyps and that they were going to

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```
 90              be biopsied,
 91   PR         o:kay,
 92   P          so,
 93   PR         okay so they removed two polyps,
 94   P          and i've been feeling lousy eve(h)r si(h)nce.
 95   PR         [ ↓o::h  ]
 96   P          [i  mean ] i don't know why. i mean the last time i had
 97              ((knocks at the door)) a colonoscopy,
 98   PR         [come  ↑i↓in]
 99   P          [  i    had ] no problems at all!
100   PR         [↓yeah]
101   P          [ hi. ] how [ are ] you?=
102   PR                     [yeah,]
103   SC                     [ hi! ]
104   PR         =hi doctor halliburton.
105   SD         how are you doing today,
106   P          well. i [ was,]
107   PR                 [hhhh]
108   P          just [telling them]
109   SD                [ha  ha  ha  ]
110   P          i went for that colonoscopy .h last week,
111              [and i've been feel]ing lousy [  e ver since.]
112   SD         [(er but that  was)]          [(slb slb slb) ]
113              (slb slb slb slb [slb slb slb)]
114   P                           [ ha  ha  ha ] .hhh [↓u:h]
115   SD                                             [ any] any findings
116              [(from this,)]
117   P          [  no.  no  ] because er they tell you to call a week
118              later er erm
119              to get the results, and when i called before they said
120              they would have to get my charts etcetera etcetera, and=
121   SD         =(gotcha).
122   P          i had to leave so,
123   SD         okay. okay.=
124   P          =.hh but er i was telling them that: the nurse after the
125              procedure told me that i had two polyps .hh the doctor
126              removed, and that it they were gonna be biopsied.
127   SD         good. (.) [good.]
128   P                    [ so, ]
129   SD         so they did the the good thing to do.
130   P          right.
131   PR         yea:h,
132   SD         [(slb slb slb)]
133   PR         [ex cept that,]
134   SD         (slb slb slb slb)
135   P          i'm telling you i just er i mean the last time i had a a
```


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136
137 colonoscopy five years ago then it didn't bother me at
138 ↓all
139 SD uh huh.
140 P but this time i mean i've just been feeling terrible.
141 i (slb slb slb) [.hhh ha]
142 PR [do you] mean that it physically drained
143 you?
144 (.)
145 P [er]
146 PR [the] fact
147 P physically and everything. and i just felt lousy you know
148 i had this like nauseous feel[ing, and]
149 PR [u::h,] uh huh.
150 P [e:rm]
151 SD [(were you)] (having) any ↑gas ↓bloating
152 P and gas yeah.
153 SD yes.=
154 P =i mean they tell you th- you know you because they pump
155 air in you i guess,
156 PR tzt ah, okay.
157 SD well [the] problem with (slb slb slb slb)=
158 P [but:]
159 SD =was er probiotics,
160 P [yeah.]
161 SD [be]cause when you that purge,
162 (.)
163 P [yeah,]
164 SD [which] i'm [sure]
165 P [yeah,]
166 SD you en[joyed] the night before.
167 PR [uh,]
168 P oh jee- [plea:se!]
169 SD [(i know] this is qui(h)te slb slb)
170 P [ho ho that is the worse, i mean]
171 SD [(slb slb slb slb worse i think it's] the worse).
172 P oh it ↓is
173 SD but [erm]
174 P [i] mean all i did was run to the bathroom every
175 minute. uh,
176 PR yeah,=
177 SD =so i think [if we give]
178 P [he he he]
179 SD some h_m_f (it would be [slb slb slb so)]
180 PR [yeah o- o- o]kay. so the
181 SD [yeah.]

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PR [(slb] slb) o[kay.]
SD [i] think that that would be that would be
good. and hopefully that would give you the relief,
P uh,
SD as far as all these different symptoms.
PR right okay. (.) does that sound good ↑mandy (.) okay.
P anything will sou(h)nd go [ho ho ho]
SD [ha ha ha]
P .hhh hhh hhh hhh
PR [and:]
P [.hhh] hu
PR i was just gonna [fol]low up with her, about the er=
P [hu,]
PR =i know that you had wanted to go off with the last ↑course
P oh yeah. i did: get thee: er (.) 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)
P oh that's the bone density, this is thee: (1.4) er this is from march. this was the last er (.) cholesterol thing i have,
(1.2)
PR and this is before,
P [yeah.]
PR [con]siderably before you went off,
P oh yeah!
PR [the]
SD [yeah.][yeah.]
PR [me][dication.]
P [yeah.][i didn't] go off until july.
SD so er so the bone density, (.) erm (.) it looks like they're they're erm finding osteoporosis (.) in your erm in your femur,
and [(i see)]
P [and what] what is that, w- er
SD it's in your er they do measurements, they'll do it in your hip.
(.)
P [uh huh,]
SD [essen]tially. [and] in your spine.=
P [yeah.]
=uh huh.=
SD =and erm they found erm basically when they w- it there're

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different categories, but osteoporosis is (one) it's it's
when you have actual holes in [in] your bone.=
P [yeah,]
SD =that you know, [it's] at that ↑stage=
P [yeah.]
=yeah.=
SD =but in your spine, it is erm it's less,
P [uh huh,]
SD [so it's] osteopoenia. that is considered detecting bone
loss but it hasn't gone to osteoporosis.
P uh huh.
SD erm what did your m_d recommend?
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] slb)=
P [sso,]
=and then why calcium can't stop osteoporosis, [but] i
SD [yeah,]
P mean:=
PR =°hu hu°
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
years ago, and now the medical profession is just
(0.5)
PR [catching ↑up]
P [getting on] line with it. but they're still not,
(0.3)
SD [yeah,]
P [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?

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274 P uh [huh,]
275 SD [erm] it can actually not just like an alarm but you
276 can actually be a be a favorable condition, in the sense
277 this that it's it's it's not that itself but if you (were
278 to take) a fall, and you already had weakened,
279 (.)
280 SD hips. essentially you would (slb slb) break your hip,
281 that's it's it's sort of it's a very slippery slope.
282 P uh,=
283 SD =and it's erm it's one of the things that and you're
284 already on calcium supplementation y- you know, you're
285 you're doing all the good things for yourself and then
286 still coming up with osteoporosis.
287 P [uh,]
288 SD [and] so that erm i think that we really need to talk
289 about conventional approaches because erm it's it's just
290 one of the things where it- as far as rebuilding bone erm
291 you know the things that we can reco↑mmend
292 (.)
293 SD but hhh they can they can take time. and if you know i
294 would just hate to see you,
295 P uh,
296 SD er fall. and and break your ↓hip [es]sentially.=
297 P [yeah,]
298 SD =which erm you're predisposed to do if it's if it's
299 osteoporosis at this point.
300 P [uh,]
301 SD [and] erm (.) so i thi- it's something to to really look
302 at carefully. it's erm in a certain sense it's it concerns
303 me more than your cholesterole ↑does [at] this point,=
304 P [uh,]
305 SD =just because i think that it's erm it's something that
306 could set up a chain of events,
307 P [uh huh.]
308 SD [that would] really erm injure your mobility. [so,]
309 P [uh] huh.
310 SD erm (.) so i erm i think that you know just for (revisit)
311 while you're taking notes and to see, do you have an
312 earlier bone density scan? coz it's very often it's
313 helpful to compare them.
314 (1.0)
315 PR uh [↓uh]
316 P [erm]
317 SD do you [have (slb)]
318 P [yeah i] had one a few years ago i [guess,]
319 SD [and] do

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320 you remember what they erm said,
321 P well he just said it was borderline at that point.=
322 SD =yeah. so now if you're if you're you passed that point
323 and probably if he said it was borderline, either that
324 means w- erm borderline osteopaenic paeniac or er
325 osteoporosis. so this is hard
326 (.) erm
327 (2.0)
328 SD okay. now next next thing,
329 P [ha ha ha ha .hhh]
330 SD [(slb slb slb slb slb)] who this person is.
331 (0.9)
332 SD and what is he selling. hhh [he he he]
333 PR [hu hu hu] [hu hu]=
334 SC [ha ha ha] [ha ha]=
335 P =[well he's]
336 SD =[that's al]ways my question.=
337 P =he's you know,
338 (0.6)
339 P he (slb slb) a letter every month or whatever,=
340 SD =yeah,=
341 P =so he's selling that. but it's supposed to give you you
342 know non
343 (0.9)
344 P erm prescription stuff, to use. [you] know,=
345 SD [right.]
346 PR =uh,
347 P i mean he's not selling you
348 PR right.=
349 P =erm necessarily, but and some things are
350 (.)
351 P you know,=
352 SD =well actually what he's if you go to the article about
353 lowering your choleste↓rol (it say) he's talking about
354 eating cholesterol
355 (.)
356 SD won't (.) lower your cholesterol. and erm that is true
357 actually. i mean it's it's very important like ten percent
358 of people who're eating cholesterol (how would they eat)
359 their cholesterol but it's different that erm if you
360 already have elevated cholesterol that we know,
361 P [uh,]
362 SD [for] in- you know blood test said something that that'll
363 that changes the picture.
364 P uh huh.
365 SD erm of it (1.3) erm

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366 (1.8)
367 SD .h so in a way it's erm (2.6) kind of like it makes it
368 sensationalist, the way he does the head↑lines
369 P uh huh,
370 SD and then i don't know that his facts are wrong i (don't
371 think) that erm you know, some- it maybe is to get your
372 bias ha sort of,
373 P [hu,]
374 SD [on] different things. so i think that erm that's
375 something as far as erm because you haven't got any (back
376 on to) choleste↑rol
377 P no.=
378 SD =and when when is the retest for that?
379 P er december eighth i guess.
380 SD oh good! okay it's around the corner.
381 P yeah.
382 SD so we'll just keep, let's keep going
383 P [yeah.]
384 SD [and] see where you get.
385 P uh huh.
386 PR okay. so [she's off] thee: medication now and you're
387 SD [(slb slb)]
388 PR gonna get retested december eight, [is]
389 SD [yeah.]
390 PR that [right?]
391 P [right.]
392 SD i mean [she (mea-)]
393 PR [o kay]
394 SD i- i- it's one of those things [that I]
395 P [uh huh,]
396 SD i feel comfortable trying to figure out something else
397 that works, as long as we test and figure out is it
398 working,
399 P [uh huh.]
400 PR [uh huh.]
401 SD if it's not working and that's,
402 P [yeah,]
403 SD [you] know we will need to have the discussion as far as
404 you know, [this] is the only th- you know unfortunately
405 P [right]
406 SD the drugs are what have you know been proven to lower
407 cholesterol.
408 P uh [huh.]
409 SD [erm] that's why the bone density tends to concern me
410 more.
411 P [uh huh,]

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412 SD [tzt be]cause basically it's saying you know?
413 (.)
414 SD you are doing this but it's not really, it's not working.
415 P uh
416 SD erm so we just: why don't we just keep going and we'll
417 talk about it [(slb slb] slb slb)=
418 PR [o kay.]
419 SD =[(okay).]
420 PR =[okay.]
421 SD [(↑slb)]
422 P [yeah.] yeah.
423 (.)
424 SD and then you where gonna tell me this postcolonoscopy
425 isn't [getting (slb slb slb] [slb slb)]
426 P [ha ha ha ha ha] [ha ha] [ha ha]
427 PR [hu hu] [hu hu]
428 P .hhh [ha ha] ha=
429 SD [o kay]
430 =so erm but definitely there are things we can do there to
431 help settle your tummy and then=
432 P =yeah,=
433 SD =erm and we'd love to get you know erm information about
434 what the results,
435 (.)
436 SD are of this from the from the biopsy of the polyps.
437 P uh huh.
438 SD and di- did you have a history of ↑polyps (slb slb slb slb
439 slb)
440 P i can't remember if i had polyps the last time or not.=
441 SD =o[kay.]
442 P [i] w-
443 PR uh huh,
444 P i really don't that was five years ago. [no.]
445 SD [o]kay. okay erm
446 i think have you certain forms for me to ↓sign
447 (0.8)
448 SD thanks.
449 (5.1)
450 P so how did my cholesterol seem ↓there
451 PR your cholesterol here is very good.
452 P yeah?
453 PR the total is is good, it's hundred two hundred and the and
454 thee: most important (maybe) the h_d_l ratio the cho- the
455 total cholesterol to h_d_l ratio is erm two point seven
456 which is,
457 (.)

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PR excellent. ((SD leaves))
P yeah.
PR so,=
P =coz i was on the pills then thee:
PR you were on the pill so it'd [be] interesting to see
P [yeah,]
PR [how,]
P [yeah,]
PR now what you know what we see (.) with you er having been off the medication [for] a while.=
P [uh,]
PR =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,
(.)
PR two ta[ble] spoons a day.=
P [uh,]
PR =are you doing that at ↑all
P flax ↑oil
PR [yeah.]
P [uh,] (.) i thought it was flax seeds ↑no
PR .hhh erm
P [uh]
PR [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,
P oh!
PR to get the concentration that's in a table spoon of oil.
P oh,
PR you'd have to take a lot more than a table spoon of the [flax]
P [oh,]
PR seeds.
P oh!
PR erm er did (.) okay so are you doing the flax ↑seeds
P well i was doing some fla- well i haven't been doing anything since er thi(h)s we(h)ek you know, because
PR o:h, [o kay.]
P [i just] felt so lou[sy, you know i did]
PR [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]
P [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

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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
P [uh,]
PR [ba]rely heavy.
(.)
PR erm do you now just (fearing) that, do you think that you were doing those ↓things or
(1.2)
P i can't remember. i usually i think i was taking it,
(0.7)
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.
(.)
PR i don't remember if we had you on fish oils. erm
P 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 effe↑ctive
P uh,
PR erm so:
(1.3)
PR we can [we] can you know?
P [uh,]
(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,

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550 okay.
551 P yeah.
552 PR so we had you on a thousand milligrams one ca- one cap
553 three times a day,
554 P uh.
555 PR and we could easily switch that to
556 (1.5)
557 PR you know?
558 (0.7)
559 PR maybe two caps with (0.6) dinner and one cap with lunch,
560 or something like that. .hhh and also i think it matters
561 where you take it in the ↓meal don't wait 'till the end.
562 don't take it in the very beginning. get started eating
563 then take it while you still have ((clears throat)) good
564 amount of food left,
565 P uh.
566 PR to eat. (.) and so it's sort of mixed in with all your
567 food erm
568 (.)
569 PR i'm wondering mandy if you have any of these left,
570 P no.
571 PR okay.
572 P i [used them] all up.
573 PR [o kay.]
574 (.)
575 PR erm well we can we can decide that before the end of the
576 visit. why don't [we]
577 P [uh] huh.
578 PR why don't we talk about some other things, coz i don't
579 wanna run out of time. and
580 (0.9)
581 PR erm
582 SD ((handing back paper)) i'm giving this back to you.
583 P [oh! o kay.]
584 SC [hh hh hh]
585 PR [hh hh hh]
586 (2.1)
587 PR e:rm okay. so we'll think about some kind of
588 supplementation that would help to:
589 (1.1)
590 PR erm that would help in in keeping your cholesterol
591 adequate you know, at a manageable level. and then leave
592 [a] bit of fish oils possibly flax oil erm but er er=
593 P [uh]
594 PR =when mel and i step out we can talk to doctor halliburton
595 a[bout you,]

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596 P [uh huh] o[kay.]
597 PR [see] if you know what she what what her
598 opinion is. .hhh erm
599 (.)
600 PR okay. so erm so then er have you had any more bleeding
601 with er going you know,
602 P [uh,]
603 PR [with] having bowel movement, [no?]
604 P [no.]
605 PR just that one time,
606 P [yeah.]
607 PR [o]kay.
608 (.)
609 PR and you do know polyps can be totally benign,
610 P right.
611 PR i mean you know of course they can they can be more
612 dangerous but they can be benign too.
613 P [uh huh.]
614 PR [(almost)] erm so (.) we'll just: you'll be getting those
615 results this week, is that right?
616 P well i i presume so. she said she was gonna get back to me
617 [to]day,=
618 PR [yeah.]
619 P =so,
620 PR yeah okay.
621 P i mean i don't know now she's gonna tell me i have to come
622 in the office, or she's just gonna
623 [give] me the [results]
624 PR [.hhh] [okay,] i see.
625 [right.]
626 P [o]ver the phone, or what.
627 PR right it's a little nerve wrecking.
628 P yeah.
629 PR right, yeah.=
630 P =uh so [well,]
631 PR [o] kay. okay.
632 (.)
633 PR erm so would probably be a good idea for you to schedule
634 another appointment fairly soon after this one. just so we
635 can follow up with that.
636 P uh huh.
637 PR erm (.) or if you wanna wait to reschedule depending on
638 those results,
639 (1.1)
640 PR you can do that and then call in and make [a]nother=
641 P [uh,]

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642 PR =appointment. [if] you wanna do that one,=
643 P [uh,]
644 PR =°okay.°
645 (0.9)
646 PR erm (1.4) so: let's see,
647 (0.7)
648 PR and how about the diarrhea,
649 (0.6)
650 PR this week is probably hard to tell right. be[cause]=
651 P [erm]=
652 PR =you're having so many problems,
653 P yeah. well i i had it very loose this morning, it was you
654 know,
655 (.)
656 P but i mean before then it was seen t- to be alright.
657 (1.0)
658 P it wasn't like that but this morning oh dea- i thought it
659 was never gonna stop! hu hu .hhh
660 PR oh okay,
661 P [but:]
662 PR [okay] yeah. but before this week ↑then
663 P yeah well.
664 PR had it [gone] ↑better
665 P [yeah.]
666 P [er]
667 PR [o]kay.
668 P well it was you know, like just i went once or twice
669 (0.8)
670 P a day but it wasn't: you know that really loose.
671 PR [uh huh,]
672 P [or a]nything.
673 PR uh huh. okay so [it's more normal.]
674 P [it's more normal.]
675 (.)
676 PR okay. erm
677 (1.7)
678 PR maybe we'll er i you know i'm not sure yet what to think
679 of that i think after we get the results of [the]
680 P [yeah.]
681 PR colonoscopy,then we'll have more information.
682 P right.=
683 PR =so erm
684 ((filling in P's file))(0.8)
685 PR °okay.°
686 (12.6)
687 PR °okay. erm°

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688 (2.0)
689 PR .hhh and as far as i don't, i was looking back in the
690 chart and i don't think that we've ever put you on a
691 calcium supplement?
692 (0.9)
693 P [well,]
694 PR [are] you ↑taking ↓calcium
695 P yeah i'm i was i'm getting it from misses ↑greens [well,]
696 PR [o]
697 kay. now
698 what kind of calcium do [you know,]
699 P [oh jeez!]
700 PR ha ha ha ha .hhh ha [ha ha]
701 P [ha ha] it's called the liquid
702 calcium.
703 PR okay.
704 P [this]
705 PR [if] i said the [form]
706 P [this]
707 PR would it (1.0) er would it be er th- there are different
708 kinds of calciums,
709 P uh huh.=
710 PR =and some are absorbed a lot more easily than others. and
711 so we wanna be very choosy now a[bout]
712 P [yeah,]
713 PR what calcium supplement we give you. so erm one of the
714 most easily absorbed forms is (slb slb) or
715 P [uh huh]
716 PR [(slb slb] slb slb) (.) erm
717 (1.7)
718 PR but i [a gain i]
719 P [i'm not sure]
720 what [it is] right now,=
721 PR [o kay.]
722 PR =okay. erm ((clears throat)) there's another called
723 (hydroxyl appetite) but i think that that one is hard to
724 absorb so if there's any digestive issue,
725 P uh,
726 PR it might not be the best
727 P yeah,
728 PR to give you.
729 P right.
730 PR erm so we might want to i don't i you know we'll check
731 with doctor halliburton. see what she thinks erm but we
732 wanna definitely
733 (0.9)

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PR you know, we wanna make that a conscious choice as to which calcium supplement you're on. [.hhh]
P [uh] huh.
PR and we can also erm talk about foods,
(.)
PR that would be rich in calcium. coz now is the time to really concentrate on that.
P uh huh.
PR 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,
P u:h,
PR and we don't want that to happen.
P yeah,
PR at all .hh so erm (0.9) erm i'm gonna get to diet in a little while.
P [yeah.]
PR [coz] i have your diet diary that you gave me and i appreciate that so much. giving me [such a] detailed account.=
P [°hu hu°]
PR =erm so we'll get to that next i just wanna see if there's any other issues,
(.)
PR ((to SC)) erm do you, did you want to (say something)?
SC how was your body then since erm the colonoscopy and that you've been feeling lousy,
P well i mean (0.8) i wasn't hardly eating anything all week last week. so erm=
SC =okay.
P [i m-]
PR [last] week,
P yeah.=
PR =now you had the colonoscopy this week,
P well i had it last tuesday.
PR oh oh! o[kay. okay.]
P [so i mean,] so (0.7) i wasn't (probably) eatin that much you know, soup then noodles and things like that. [and rice.]
PR [kay o]kay.
(0.6)
PR yeah,
P because my stomach has not been feeling (.) too good.
PR [right.]
P [hu] hu.
PR right.

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780 SC have you been eating ↑more ↓since
781 (0.6)
782 SC (slb slb)
783 P er yeah saturday erm (0.4) well i had gone out to dinner,
784 (1.3)
785 P erm to the catholic (ward) that's in (slb slb) had a (pub)
786 roast dinner,
787 PR okay.
788 SC and how did you feel ↑after ↓that
789 P er okay!
790 SC okay.
791 P yeah.
792 (0.9)
793 P well it was mainly meat potato and: carrots.
794 SC uh huh.=
795 PR =uh huh.
796 (.)
797 PR uh huh,
798 (1.0)
799 SC and erm do you what doctor halliburton just explained? to
800 you erm how how do you feel about that, has has anyone
801 talked to you or (slb slb slb slb slb the test done when
802 they got the results back)
803 .hhh did anyone talk to you about the implications for
804 ↑those re↓sults
805 (1.1)
806 P not really.
807 SC okay. and how are you feeling now that you heard that
808 information,
809 (1.1)
810 P hu hu hu not too good. [ha ha]
811 SC [okay,]
812 P ha [ha .hhh]
813 PR [yeah it's] a little,=
814 P =i mean,=
815 PR =it's alarming. er er
816 P this test was what taken in may wasn't ↑it
817 PR erm let's see this bone scan,
818 (1.0)
819 PR was t- er yes may nineteen.
820 P yeah my doctor never called me or anything, and:
821 PR oh, you mean you didn't get this in the mail did ↑you
822 (0.9)
823 P well i just picked that up!
824 [i called the office and asked'em for it.]
825 PR [oh i see. okay o kay. but you were,]

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826 P but
827 PR ye:s,
828 P this was in ma↓y and i never heard from them
829 (.)
830 P ↑about ↓it
831 PR [right,]
832 P [so] i figured hey! it can't be that bad ↑right
833 PR right.=
834 P =so: (1.0) i went when i went to him fo- in september for
835 my yearly physical, the only thing he said to me was .hh
836 well your bone density wasn't too good he says so you'd
837 better go on this (actimol).
838 this is when [he told] me that.=
839 PR [uh huh,] =yes.
840 P but he didn't explain anything.
841 PR right right yeah.
842 (1.2)
843 SC does erm does it make sense to you what doctor halliburton
844 had said,
845 P [oh yeah!]
846 SC [a bout] the the implications for osteoporosis an and
847 the femur,
848 P [uh huh.]
849 SC [o kay.]
850 (.)
851 SC okay. .hhh will you right now well we're also telling you
852 (is)that there's some very (0.7) it it's a good thing that
853 you had this done.
854 P [uh huh.]
855 SC [because] right [now]
856 PR [(cer]tainly),
857 SC you are vulnerable, you're doing very well.
858 P [uh huh.]
859 SC [and the] thing that we can do preventively, part of that
860 may be going one of the traditional the (actinol). but it
861 we we can also help supplement you.
862 P [uh,]
863 SC [and] and make you very strong.
864 P [uh huh.]
865 SC [so it's] this is a good thing that you found out that
866 you brought this information to us. [and]
867 P [uh] huh,
868 SC you're in a good situation right now because you have a
869 lot of choices.=
870 P =yeah.
871 SC so we're gonna work with you on that, and the [next]

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872 PR [yeah,]
873 SC time that you're coming to a visit, erm probably the
874 important thing to do is bringin that calcium supplement
875 that you're taking.
876 P [yeah.]
877 SC [be]cause denise said all supplements are not created
878 equal and we wa[nna] make sure that you are =
879 PR [right,]
880 SC =thee best,=
881 P =uh,=
882 SC =most viable valuable supplement there is.
883 P uh [huh.]
884 PR [right] so,
885 P uh,
886 SC okay.
887 PR and there's different foods that you can concentrate on
888 you know, that would help to boost your calcium. and
889 (0.5)
890 P [uh huh.]
891 PR [and help] you know, erm
892 (1.4)
893 PR er to add more density.
894 P uh huh,
895 PR to your bones. so we'll talk about that.
896 P yeah.
897 PR and also doing some erm (0.9) light weight bearing
898 exercises,
899 P [uh huh,]
900 PR [that al]so helps with
901 P yeah. maybe that well i haven't even been out for a walk
902 lately.
903 PR [right,]
904 P [last] week and this wea↓ther ohh!
905 PR yeah,
906 SC [hu hu]
907 PR [and it's] gonna be [tough,]
908 P [tsss]
909 PR in the winter.
910 P [i ↓know]
911 PR [so may]be we can talk about some alternatives.
912 P uh huh.
913 PR erm (1.6) .hhh yeah i guess you know short of (0.7)
914 joining a gym, it's it's it's [it's tough.]
915 P [hu hu.]
916 PR it's tough, .hhh walking in the ma:ll,
917 (0.5)

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```
P          u:h,
PR         do you, let's see you live in stratford ↑right
P          no fairfield.
PR         oh fairfield okay.
P          no we don't have any malls. hu hu
PR         trumble.=
SC         =trumble mall.
PR         trumble.
P          yeah i [know that's:]
PR                [ it's  ve   ]ry close.
P          [ erm  ]
PR         [that's] what you know that that (caught) ↓on a number of
           years ago, (.) people just started walking in the ↓malls
P          [u:h]
PR         [you] know for exercise,
SC         and they have groups that meet too. the mall [(wal-)]
P                                                       [  uh, ]
SC         walkers. [that meet in   the    mor  ]ning too.
PR                  [ right. o kay that's right.]
PR         [yeah.]
P          [well ] thay meet early in the morning. i'm not a morning
           person.=
PR         =okay. [ ha ha ha]
SC                [ ha ha ha]
P                 [beside to] which i go [ to  ]
SC                                       [well,]
P          work three mornings a week now. [ so, ]
SC                                         [they ] actually meet
           around nine
           o'clock in the morning so it's not too bad.
P          yeah, but i'm saying i go to work that [from,]
SC                                                [ oh, ]
PR         [yeah.]
P          [nine ] o'clock.
PR         yeah but i mean you don't have [to ]
P                                         [uh,]
PR         join [this ] group you know,=
P               [yeah.]
P          =[i   know.]
PR         =[it would ] be nice [ coz ]
P                               [yeah.]
PR         it gives that
           (0.5)
PR         that extra motivation [to ]
P                        [uh,]
PR         go if you have someone to meet there.
```


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```
964   P     yeah,
965   PR    but erm [you can  (slb)]
966   P             [well my friend] goes to (curves).
967   SC    uh,=
968   PR    =↑oh ↓oh=
969   P     =she thinks that's a good place but,
970         (0.8)
971   P     she goes early in the morning too. [and:]
972   PR                                      [ o:h] okay. ha ha ha
973         .hhh
974   P     i mean that just doesn't work out [for me.]
975   SC                                      [ ha ha ] ha
976   PR    yeah,
977   P     and especially now with you know working three mornings
978         a week. [ so, ]
979   PR            [right] right. yeah even if you had to go by
980         yourself,
981   P     [u:h,]
982   PR    [you ] know there's still it's still crowded and there's
983         uh there'll be a lot going [on,]
984   P                                [uh,]
985   PR    you know with the christmas season, it'll be an
986         interesting place to wa(ha)lk.
987   P     uh,
988   PR    .hhhh so er it's just an idea you [know,]
989   P                                       [yeah.]
990   PR    it's an idea but i think y- maybe we should start thinking
991         about how you could get around the latter coz [once ]
992   P                                                   [yeah,]
993   PR    it [starts snow]ing,
994   P        [  i   know.]
995         (0.6)
996   PR    it's gonna be hard [to: ]
997   P                        [u:h,]
998   PR    stay a little active you know?
999   P     and then if i fall, [ha ]
1000  SC                        [oh!]
1001  PR    right.
1002  P     [(slb slb) well (slb)]
1003  SC    [ha   ha    ha    ha ] [  ha   ha   ha   ha ]  [ ha ]
1004  P                            [(slb) breaking   my ]  [HIP!]
1005  PR                           [right.  no  no   no!]
1006  SC    [ha]
1007  PR    [we] [can't,]
1008  P         [ ha   ][ha   ha   ][ha   ha .hhh ]
1009  PR                [have that.][we won't have][that.]
```


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1010 SC [ha ha ha][ha]
1011 [ha ha .hhh]
1012 P [ha ha ha]
1013 PR okay. [hhh]
1014 P [ha] [ha ha .hhh]
1015 SC [.hhh] [ha ha ha]
1016 P ha[:: hhh]
1017 PR [alright, erm]
1018 P hhh hhh
1019 PR so: let's see mandy. how did you bring any blood
1020 pressure?,
1021 P yeah.
1022 PR er chart for ↑us
1023 (0.8)
1024 P er let's see,
1025 (1.1)
1026 P yeah.
1027 PR ((checking chart)) okay.
1028 (20.9)
1029 PR so these numbers look like they, they're a little bit
1030 higher than past charts.
1031 (0.6)
1032 PR i'm wondering if you:,
1033 (1.3)
1034 PR you know,
1035 (1.9)
1036 PR before the whole colonoscopy,
1037 (1.4)
1038 PR thing. mandy were you feeling,
1039 (0.8)
1040 PR you know extra stress about any particular event?
1041 P we:ll,
1042 (0.9)
1043 P you know with my son and all that stuff [uh,]
1044 PR (looking at and P nodding)) [o]kay, okay,
1045 P and, i don't know i think: you know it's getting closer
1046 now to: (.) gonna be a year of my husband's death and i
1047 don't know, i think about that more often now.
1048 PR ((shaking head)) that is,
1049 (0.6)
1050 PR [tha-]
1051 P [in] fact i was in church saturday. and this lady got
1052 sick in church and: oh i just felt like crying. and i j-
1053 just hoped that she wasn't gonna, (.) collapse.
1054 PR yes:,
1055 P so they just took her out of church but,

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1056 (0.8)
1057 P [i] was so upset.=
1058 PR [yeah,]
1059 P =you [know?]
1060 PR [yeah,] yeah,
1061 P and those things bother you every once in a while.
1062 PR sure!
1063 P [uh huh.]
1064 PR [and you] know the anniversary especially the first
1065 anniversary,
1066 P u:h,
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 ↓ba:ck 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 defini[tely.]
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 a↓bout

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```
1102   P           well but this is my other son.
1103   PR          oh o[kay.]
1104   P               [ i  ] mean,
1105   PR          because [you have ]
1106   P                   [you know,]
1107   PR          a living that's going through some,
1108   P           yeah he had the, (.) he broke his back.
1109   PR          ri:ght.
1110   P           and,
1111   PR          right oh boy![ so, ]
1112   P                        [yeah,]
1113   PR          right now [is,]
1114   P                     [so,]
1115   PR          there's a [ lot ] of stuff.
1116   P                     [yeah,]
1117   PR          [yeah.]
1118   P           [yeah,] and he was in the process of moving and it was
1119               just like (.) one catastrophe after another. [hhh hhh]
1120   SC                                                      [uh huh,] uh
1121               huh,=
1122   P           =(hh)and he just, (0.5) he finally moved in there last
1123               month but: he's still doing stuff he's just: (.) their
1124               place has been ha
1125               ((PR writing)) (1.3)
1126   PR          uh ↓u:h
1127   P           sometimes i would say to him drew don't even tell me about
1128               it i don't wanna hear it today.
1129   PR          i, hhh [yeah!]
1130   P                  [ ha  ] [ha    ha ha  ha    .hhh]
1131   PR                         [you reach a point where] you just can't
1132               [take]
1133   P           [ hu ]
1134   PR          any more, upsetting [↓news]
1135   P                               [  i  ] know! [ uh, ]
1136   PR                                          [yeah,] yeah,
1137   P           i mean you couldn't believe it but hhh i mean they we-
1138               they were in the process of fixing the house .hh and what
1139               happened was the roof wet and a leak right in the bedroom
1140               and ruined the furni[ture,]
1141   PR                              [ tzt ]
1142   P           and [the] rugs and,=
1143   SC              [oh!]
1144   PR          =oh god [man]dy that's,
1145   P                   [hu ]
1146               (.)
1147   P           [  hu  ]
```


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```
1148   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 erm 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               .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               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               (.)
```


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```
1194   PR          o[kay.]
1195   P            [pat ] my friend called me from arizona, ha ha she hasn't
1196               called me in a while and i [unloa]ded on her.=
1197   PR                                    [o::h,]           =oh oh!
1198   P                        [ha  ha ha ha ha   ha    ha .hhh]
1199   PR          ((smiling)) [you unloaded i thought you were] gonna say
1200               she[gave]=
1201   P              [ ha ]=
1202   PR          =me bad news.
1203   SC          hhha
1204   P           no:!
1205   SC          hh
1206   P           no she had good news. she's been having a house built
1207               she's gonna be moving in a few weeks [but,]
1208   PR                                              [ oh,]
1209   P           ha ha ha ha [ha .hhh]
1210   PR                      [o  kay.]
1211   P           but i unloaded on her. .hhh ha [ ha   ha]
1212   PR                                         [well you] know ↑what
1213   P           [.hhh]
1214   PR          [  i ] mean,
1215   P           ha
1216   PR          that's what good friends [are are ] [there] [for.]
1217   P                                    [ ha  ha ] [ ha  ]
1218   SC                                          [ uh  ] [huh.]
1219   PR          they [ un   der    stand,]
1220   P                [well we're friends ] from grammar school [days.]
1221   PR                                                        [ oh! ]
1222   SC                                                        [ oh! ]
1223   PR          so that's [(given) ha ha ha] [ha .hhh] [  ha  ]
1224   SC                    [uh huh  ha ha ha] [ha .hhh] [  ha  ] [ha ]
1225   P                     [ha  ha  ha ha ha]           [that's] [how] long
1226   we
1227               know each other. ha [  ha  ]
1228   PR                             [right,] right, it's good [to ]
1229   P                                                        [er,]
1230   PR          have i know friends from childhood. i mean who knows you
1231
1232               better? [right?]
1233   P                  [  uh, ]
1234   PR          than someone that's been with [you]
1235   P                                        [uh,]
1236   PR          since [you know?]
1237   P                [oh    a  ]nother thing. and then my other best
1238               friend from (.) grammar school, her son died.
1239               ((PR nodding)) (0.8)
```


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1240 P just:,
1241 PR o::h!
1242 P like a month and [a half a go.]
1243 PR [(slb slb ↓slb) uh] huh,
1244 P tzt so i went to the wake and funeral and all that?
1245 PR yeah,
1246 P so:,
1247 PR yeah,
1248 P uh.
1249 PR uhhhff it would be a good idea to erm you know?
1250 (0.7)
1251 PR just gi- subject yourself to some public thi- things.
1252 (0.6)
1253 PR like funny movies,
1254 P [yeah,]
1255 PR [or,] you know just going out with friends.
1256 P [oh yeah.]
1257 PR [i know] d- that you make an effort to do that.
1258 P yeah,
1259 PR right know i think it would be a really good thing for you
1260 coz you need to balance all the [hea]vy=
1261 P [uh,]
1262 PR =emotions [with,]
1263 SC [uh] huh.
1264 PR [some]thing=
1265 P [uh]
1266 PR =a little bit lighter for yourself.
1267 P [uh,]
1268 PR [yeah] [and i think,]
1269 P [yeah i tried] to get out you know, like i went to
1270 dinner,
1271 (0.7)
1272 PR [yeah.]
1273 P [on] a saturday night [you know?]
1274 PR [yeah. no] i think you do a good
1275 job of
1276 that. [just]
1277 P [uh,]
1278 PR so you aware that i, [that]
1279 P [uh,]
1280 PR you know it's probably important
1281 (.)
1282 PR now really [im]portant now=
1283 P [yeah,]
1284 PR =because, (0.4)
1285 P uh, yeah well, i have .hhh lot of different things coming

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```
1286              up
1287              especially with christmas [now.]
1288   SC                                    [ uh ] huh,
1289   PR         right, right,
1290   P          you know?
1291   PR         okay [good.  that's good]
1292   P                [coz      i    be  ]long to the auxiliary there
1293              [and now,]
1294   SC         [uh  huh.]
1295   P          and they're gonna have a christmas party, and then the
1296              organization's gonna have a christmas party, .hhh which,
1297              (1.1)
1298   P          kind of be kind of funny, because it's (0.4) .hhh actually
1299              the twentieth (0.8) it will be on the twentieth and my
1300              husband died on the twenty first and that's where he died
1301              but,
1302   PR         o:h! [o:h!]
1303   P                [ ha ] ha ha [but,]
1304   PR                            [ so ] that may be a little,
1305   P          u:h,=
1306   PR         =emotional? [ for you.]
1307   P                      [ ↑ye↓ah  ] but,
1308   SC         [(just think)]
1309   P          [  i   think:] i'll get through it.
1310   SC         yeah.
1311   P          ha ha
1312   PR         yeah.
1313   SC         and you will get through it.
1314   P          uh,
1315   SC         you're doing very well.
1316   P          [uh,]
1317   SC         [and] just continue surrounding yourself [with peo]ple=
1318   PR                                                  [uh  huh,]
1319   SC         =who love and support you.
1320   P          yeah.
1321   SC         that is the best thing you can do.
1322              and knowing [that] you're gonna get through all of this.
1323   P                      [uh, ]
1324   PR         [uh huh.]
1325   P          [uh huh,]
1326   PR         yes.
1327   SC         life goes on.
1328   P          oh [i  ↓know ]
1329   PR            [it  will.][yours]
1330   P                       [ oh  ] [ri(h)ght  do(h)n't] i  know [that!]
1331   SC                              [ ha  ha    ha   ha]         [yeah.]
```


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1332 i'm [sure you do.]
1333 P [ha ha ha] ha [ha]
1334 SC [ha]
1335 PR you've [learned] that.=
1336 SC [ha ha]
1337 P =[oh yeah]
1338 PR =[in the] past few year right?
1339 P uh,
1340 PR [and and through,]
1341 P [through all these] years [oh yes.]
1342 PR [yes. yeah] you, ((to SC))
1343 mandy's lost a number of siblings. right mandy?
1344 P well lot of relatives and things like that.
1345 PR yeah,=
1346 P =in one year i lost, (.) in five years in the five year
1347 time that i think it was like eight.
1348 SC oh no!=
1349 P =eight you know, ((PR nodding)) like nephews, e:rm my
1350 brothers, my sister in la(h)w my brother in law, .hh
1351 (0.7)
1352 P ((PR nodding)) two brother in laws, ye:ah and then my
1353 husband was killed at that time too. my first husband.
1354 PR [oh!]
1355 P [i] already went through two husbands! hhha
1356 PR yeah, yeah,
1357 P so,
1358 PR so you know
1359 P [yeah!]
1360 PR [that] you're capable [of getting] through,=
1361 P [oh i ca-]
1362 P =yeah. it's just=
1363 PR =anything.
1364 P =a matter [of time.]
1365 PR [you know,]
1366 P you know? and
1367 PR yes.
1368 P i think as you get older it's a little bit harder.
1369 PR uh huh.
1370 P you know i really feel sorry for people that have been
1371 married for
1372 PR [°ohhh°!]
1373 P [fifty] sixty years, [and]
1374 PR [right]
1375 P then all of a sudden, for the first time they lose
1376 somebody.
1377 PR uh [huh,]

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1378 P [that's] really tough.
1379 PR that that is. yeah. i i can [imagine that.]
1380 P [i started at] a younger age.
1381 ha ha
1382 [ha ha] ha ha [ha so i can] [ha] [i could] [ha]
1383 PR [uh huh] [but you know not] not [to] [mi ni] [mi]
1384 SC [ha] [ha ha]
1385 P ze [i could ha-]
1386 PR [that. at all!]
1387 P well no! but i mean er i think i was able to handle it
1388 better. ha
1389 PR right,
1390 P than if it start happening now you know, that whole
1391 process.
1392 PR right after [you'd been] together for,
1393 P [i mean,]
1394 (.)
1395 P yeah,
1396 PR sixteen years or so. yeah, [fifty]
1397 P [right.]
1398 PR yeah,
1399 (.)
1400 PR okay. well i think you, [you know?]
1401 SC [uh huh.]
1402 PR ((P nodding)) i think you know what to do to keep yourself
1403 like mel said [sur]rounded=
1404 P [yeah,]
1405 PR =with people who love and support you.
1406 P uh,
1407 PR that that is the best thing i agree.
1408 ((P lowers head and looks at chart)) (1.1)
1409 PR okay erm, why don't we check your blood pressure now?
1410 P [o kay.]
1411 PR [to see] how you're doing,
1412 P oh [these are the things i:]
1413 PR [mel will you do that?]
1414 P [need] er
1415 SC [yeah!]
1416 PR okay.
1417 P that you'll sign me.
1418 PR e:rm
1419 (4.2)
1420 PR and then we'll do your vitals and then i just quickly want
1421 to go over a little bit about diet.
1422 P uh [huh.]
1423 PR [just] have a couple of suggestions to make.

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1424 (3.7)
1425 PR well actually (0.5) maybe we'll step out first,
1426 (.)
1427 PR talk to doctor halliburton, then we'll come back and will
1428 talk about that.
1429 P uh huh.
1430 ((PR compiles file while SC takes out thermometer))
1431 (26.7)
1432 SC place this under your tongue.
1433 (0.8)
1434 SC this is you need to [hold it.]
1435 P [hu hu.]
1436 SC it's a little heavy. ha
1437 (5.3)
1438 SC (slb slb slb slb slb slb slb slb)
1439 (55.4)
1440 SC °i'm just going (to go ahead to slb) pulse,°
1441 (33.3)
1442 P uh,
1443 SC °okay.°
1444 (7.4)
1445 PR can't ask you anything [now!]
1446 P [ssst]
1447 PR [i'll wait.]
1448 SC [ha ha] ha ha ha ha .hhh
1449 (4.7)
1450 PR (slb slb slb slb)
1451 SC yeah blood pressure is (one sixty) over (eighty nine).
1452 PR alright okay.
1453 SC (slb slb slb ↑slb)
1454 PR yeah. yeah.
1455 SC and the pulse is (slb slb slb slb slb slb slb slb)
1456 PR okay.
1457 (.)
1458 PR okay.
1459 (3.7)
1460 SC (slb slb slb slb) thermometer.
1461 P hu hu [hu]
1462 PR [.hhh] i don't i don't know (maybe that [one's)]
1463 SC [i]
1464 PR [pa(h)asse(h)d]
1465 SC [know ha] ha
1466 PR .hhh any of the digital, .hhh
1467 (22.4)
1468 ((thermometer rings))
1469 SC ah thank goodness!

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```
1470   PR          hu hu hu
1471   SC          ha .hhh
1472   P           the one in the ear that's the one that works fast,
1473   PR          [ yeah.]
1474   P           [that's] what they [have at] the hospital.
1475   PR                              [ it is,]
1476               (1.1)
1477   P           just [takes a   second.]
1478   PR                [.hhh the one yeah] the ear thermometer a second.=
1479   P           =yeah a second. ha
1480   PR          okay.
1481   SC          (ready).
1482               (2.0)
1483   PR          okay.
1484               (2.7)
1485   PR          .h okay so, (0.8) what we'll do is er just step out,
1486               (0.7)
1487   PR          talk to the doctor and i will be back in,
1488   P           uh huh.
1489   PR          and it's,
1490   SC          (slb slb) disconnect yourself before you stand up,
1491   PR          .hhh right.
1492   P           [oh!]
1493   SC          [ha ] [ha   ha  ha]
1494   PR                [it might be] better just to sit there.
1495   P           [ha]
1496   SC          [ha] [ ha]
1497   PR          [if] [you] [can] tolerate it,
1498   P                      [ ha]
1499   SC          ha ha
1500   PR          oh, oh yeah. (it was [for)] me,
1501   P                               [you,]    [yeah.]
1502   SC                                        [ ha  ] [ha ha] [ha ha]
1503   P                                                 [ha ha] [ha ha]
1504   PR                                                        [okay.]
1505               [.hhhh]
1506   P           [ ha  ]
1507   PR          okay. erm let's see i guess i can maybe (slb slb slb ↑slb)
```


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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]
PR [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]
PR [(°slb slb slb slb slb] slb°)
(0.6)
P (slb slb) good but,
(0.5)
PR alright so,

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```
44              (1.0)
45   PR         hhh[ hhh]
46   P             [(slb] slb slb) fine.
47              (0.5)
48   P          i took the (sulfur slb slb)
49   PR         ((looking straight at P)) yes,=
50   P          =so,
51   PR         did you,=
52   P          =there is some confusion now.
53              (0.5)
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
57              container with a magnifying glass,
58   PR         ahhhh
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
64              three pills .hh   whether you took three or f- the little
65              ↓pills
66   P          it didn't say on the [pill (slb  slb slb)]
67   PR         ((glancing at chart))[ o    kay  er would] er
68   SC         (little,)
69   P          little blue.= ((PR turns to SC))
70   SC         =(slb slb)
71   PR         yeah.
72   P          if i got [(slb slb slb slb)]
73   PR         ((to P)) [ and i showed you] how to do that and i [showed]
74   P                                                          [yeah. ]
75   PR         you thee:,
76   P          yeah,
77   PR         twist it three times,
78   P          yeah.
79   PR         so you get the three pills out and that okay that would be
80              one dose.
81   P          okay.
82   PR         right here i i here i said [er one dose.]
83   P                                     [o  kay good.]
84   PR         every day for two weeks.
85   P          yeah,
86   PR         so one [dose was the]
87   P                 [ so   i took] one.
88   PR         ↑pill
89   P          every day.
```


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```
 90   PR          one pill or,
 91               (.)
 92   P           [yeah.]
 93   PR          [ it  ] doesn't matter really.
 94   P           uh,
 95   PR          whether you take one [or five,]
 96   P                                [uh,  o  ]kay.
 97   PR          it doesn't [ma  tter.]
 98   P                      [now i've ] had some of the eczema come back,
 99               (.) it's
100               one   little spot,
101   PR          o[kay.]
102   P            [ on ] my el↑bow
103               (1.3)
104   P           right there.
105   PR          but [it's  still,]
106   P               [it's, right.]
107   PR          much better [yes.]
108   P                       [ oh ] yeah. much better, [now,]
109   PR                                                [but ] it itches.
110               (0.6)
111   PR          yeah,
112   P           er that's come back.
113               (0.4)
114   PR          so that [ was   comple ]tely,=
115   P                   [(slb slb) here]
116   PR          =that was that was p- completely ↑gone
117               (0.5)
118   PR          last time it was still, [it ]=
119   P                                   [ya.]=
120   PR          =was a little bit [r- red yeah.]
121   P                             [almost gone.] almost gone but it's come
122               back
123               and then i,=
124   PR          =okay.
125               (0.9)
126   P           [(slb slb slb slb slb  slb] slb now)=
127   PR          [ and on  the  o  ther arm]         =he he he he he .hhh
128   P           sa- same thing on er this arm. er er
129   PR          did you have it on the other arm last time?=
130   P           =no.=
131   PR          =no. so, .hhh
132   P           [ uh, ]
133   PR          [(yeah] slb slb) a little [bit   of  (i no  culation)]
134   P                                     [but (the slb slb) about it] it
135               it does
```


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```
136              you you c- can feel it (.)(slb slb slb slb) i think.
137   PR         yeah [i  can] feel it.=
138   P               [o kay?]        =and there's one spot like that, that
139              came  back on my leg.
140   PR         okay.
141   P          and then the ankle.
142              (0.7)
143   P          it appears better but it's still there.
144   PR         alright. .hhh
145              (0.7)
146   PR         one, when did that come back?
147              (0.9)
148   PR         after you took the sul↑fur
149   P          i: (.) would say (slb slb slb slb better) it's about a
150              month ago. that,
151   PR         [yeah th- so, ]
152   P          [it came back.] erm
153   PR         so it came back pretty much after [your visit he-]
154   P                                            [ er  no. no it] kept
155              going with the sulfur like you said.
156   PR         yeah,
157   P          for a few weeks and [ this  (was )n't)=
158   PR                             [that's fine.]
159   P          =any worse or any better.
160              (2.4)
161   P          okay?
162   PR         okay.
163              (0.6)
164   PR         .hhh okay what i'm [hearing,]
165   P                            [this one] is this spot right there the
166              same size as this one. [almost. ]
167   PR                               [alright.]
168   P          (slb slb)=
169   PR         =so when we when you came here last time you didn't have
170   it on
171              that arm, you had it on that arm. [just]
172   P                                            [ a  ] little bit,=
173   PR         =little bit.
174   P          yeah.
175   PR         .hhh you weren't complaining about [the] (fire).=
176   P                                             [no.]
177   PR         =and ye your ankles were pretty much the same as they have
178              always been,
179   P          yes.
180   PR         pretty much.
181   P          yeah,=
```


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```
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 mo:re.]=
P           =tendency, it didn't show you know, how the skin is
            discolored?
PR          yes.
            (0.4)
P           erm (1.5) it didn't show any more but it itched.
PR          okay.
P           °(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.
            (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).
            (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,
            (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).
PR          yes.=
```


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228 P =(slb:) [or (slb] slb [slb)]
229 PR [and yes] [yes] .hhh so i don't know whether
230 that makes the peace we'll talk to him today about it.
231 P uh,
232 PR but erm hopefully they still have the (slb slb slb) there.
233 (.)
234 because i do know that it came in. now whether they've
235 [sold it]
236 P [o kay.]
237 PR since,
238 P yeah,
239 PR but (0.7) i think today we have to (0.7) have you (1.1)
240 get you can't leave here without it.
241 (1.2)
242 PR coz this, alright. .hhh (0.3) erm
243 (1.3)
244 PR what about? hhh (0.3) anything else any other symptoms,
245 P no. everything else 's fine.
246 PR okay. [and your]
247 P [(slb slb)]
248 PR colitis is fine, you saw the doctor didn't [you,]
249 P [i] saw the
250 doctor the day before:,
251 (0.5)
252 P er monday.
253 (0.5)
254 P and: he said (slb) he did tell me you'll never get rid of
255 colitis,
256 (0.5)
257 P it's something that's in your system. that's there
258 forever.
259 (0.6)
260 P even to the point that it's:: (1.0) erm (0.6) i don't know
261 for instance colitis that my brother had a section
262 removed.=
263 PR =uh huh.
264 P erm (0.3) he says you still have it. coz it’s in your
265 whole system.
266 (0.7)
267 P erm (0.5) but i've had no (0.6) problem,
268 (0.5)
269 P at all.
270 PR okay.
271 P erm (0.9) none,
272 (0.6)
273 P at all. [°(slb slb slb)°]

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PR [and what do] you think about that? do you think you can never get rid of it? do you believe ↑it

P oh! i don't know.

PR [yeah,]

P [er] if it stays like this it's fine!

PR yeah.

P [you know?]

PR [.hh so] he wanted you to continue the (slb slb slb), (1.2)

PR [right?]

P [he] he he (0.3) he did (i got enough) probably fo:r end of december.

PR uh huh.

P erm (0.9) and then we're gonna let it go, coz i think it's (0.5) february fourth. (0.3) i go back for colonoscopy. (0.7)

PR okay. (0.5)

P he said that he wants to check because ts-(.) colitis is the closest thing to cancer,

PR uh huh,

P (definitely) you can get.

PR ok(h)ay.

P erm he wants to see how it has been, it'll be two years, (0.8)

PR okay,=

P =erm ((PR looking at P's chart)) (2.4)

P the only reason it went to february they wanna er er (0.4) right after the holidays, (0.7)

P it i insisted on the first appointment in the morning.

PR hhh

P for a reason.

PR yeah [coz you can't eat.]

P [(slb slb slb slb)]

PR yeah you c- that's right. (0.6)

PR coz you can't eat. (1.0)

PR .h alright. so basically let's go over what you're taking. .hh (0.5)

PR are you eating your berries every day? (0.4)

P trying to.

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PR okay.
P i do miss a few when i forget to get it but:,
PR okay.
P yes.
(1.1)
PR 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 ha .hha he ha ha]
P [i've always had this (slb slb slb slb)]
PR .hhh okay.=
P =erm
PR so,
P now this was dropped,
(1.3)
P i ran out of the h_m_s forty about:,
(1.0)
PR o[kay,]
P [a] week ago.
PR alright so that's your acidophilus,
P right.
PR the forty .hhh so that we have to give. [we]
P [no.]
PR have to give (slb) number forty.
P i don't take the acidophilus (slb slb slb slb slb).
PR the h_m_s forty is the acidophilus.
P yeah but then this is one that (slb slb slb slb).
PR yeah but the this the forty is a s- a strong version of [↑it]
P [o]kay.
PR erm we can talk to doctor sheridan to see if if erm he thinks that the er [er]
P [o]kay.
PR which one he thinks is best or if you have to take both. i don't think you do.
P this is
(1.2)
P ↑gone
PR the lacto(bu↓nin)
P er [er]
PR [yes.]
P terrible.
PR hhh hhh .hhh
P erm
PR that was for your gut to, to re[build your gut.]
P [(i won der)](slb slb might have gone slb)

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366 (0.5)
367 PR .hhh that er the hydro-
368 P the licorice is gone end of last week,
369 PR okay that one you will [have to get.]
370 P [and the tinc]ture i have just a
371 little bit
372 PR the tincture of,
373 P erm smilex tincture.
374 PR okay. right. .hhh now,
375 P bromelin is almost gone,
376 PR okay. (.)[and]
377 P [i] can't see any change in the veins
378 (.)(during that) that was to clear up the ↑veins
379 (0.3)
380 PR the bromelin?
381 P yes
382 PR e::rm
383 (0.4)
384 P if the: erm (0.5) [(slb of blood slb slb slb)]
385 PR [and and al so for the] the cs-
386 scar tissue and everything but that's gonna take a while i
387 mean,
388 P [yeah.]
389 PR [that] doesn't happen,
390 P okay.
391 PR [.hhh erm]
392 P [nothing's] happened there.
393 PR yeah .h how can i see your right [leg?]
394 P [sure!]
395 PR coz and the horse chestnut was for the veins,
396 P yeah.
397 ((P lifts trousers and PR looks at leg)) (0.7)
398 PR that would be long term though that's something that .hh
399 oh it does look better. does look a lot better.
400 (0.5)
401 P it's [softer.]
402 PR [and it's] much softer.
403 P yeah.=
404 PR =yeah.
405 ((PR examining P's leg)) (0.8)
406 PR see your body is reabsorbing all that blood you had a
407 (.)
408 P [yeah.]
409 PR [huge] amount of blood that is in there.
410 (0.8)
411 PR [and it]

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412 P [it's al]ways warm.
413 (0.5)
414 PR yeah but you know it's,
415 (0.3)
416 PR it's er can i see the other leg?
417 (2.1)
418 PR and you know even you're it's not as red there,
419 P [no.]
420 PR [as] it [usually is.]
421 P [no the red] redness is gone.
422 PR [yeah.]
423 P [(slb] slb slb slb)
424 PR yeah. that's true it is still warm.
425 P yeah,
426 PR but much less.
427 (0.8)
428 PR much less than it was.
429 P i've never had trouble,
430 (1.1)
431 P with being cold.
432 (0.7)
433 P for years.
434 (0.8)
435 P and: the only thing that i've had trouble with recently
436 since i lost all the weight,
437 (0.7)
438 P erm my hands get cold.
439 (0.6)
440 P my fingers (slb slb) ice [cold.]
441 PR [when] when did you lose all the
442 weight?
443 (0.7)
444 P it was back some time.
445 PR yeah,
446 (0.4)
447 P two years ago about eighteen pounds.
448 (0.9)
449 P purposely.
450 PR you lost your insulation i guess.
451 P yeah.
452 PR ha ha
453 P yeah but that was always, (slb slb) in montana with my son
454 and tzt
455 (1.0)
456 P (slb slb)
457 PR okay. so [we]

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458 P [(slb] slb slb)
459 (1.2)
460 PR ((talking to SC)) do you wanna see if doctor sheridan's
461 here?
462 SC yes.
463 PR and: yeah i'll take this, and i'll write erm (1.4) i'll
464 write this (slb slb slb)
465 (5.6)
466 PR hhh [a ny]thing else?
467 (0.4)
468 P no i've been feelin really good sleep good,
469 (0.5)
470 PR great.
471 P bowel movements fine. (slb slb [slb slb slb) no blood]
472 PR [good no blood, no (slb),]
473 nothing [with that.]
474 P [(slb slb)] don't take maybe once in (0.4) three
475 weeks
476 (0.8)
477 P thee: erm (0.9) erm that thing that help you your bowel
478 movement be regular,
479 (0.4)
480 P (is this)?
481 PR the fi↑ber
482 P yeah.
483 PR psy↑llium
484 P psyllium.
485 PR yeah.
486 P [yeah.]
487 PR [uh] huh.
488 (0.6)
489 P i've ta[ken it,]
490 PR [.hhh that's]
491 P once in,
492 PR [that's great!]
493 P [three weeks.]
494 PR that's great!
495 P yeah.
496 PR coz when you first came here you were ta[king it,]
497 P [oh er]
498 PR more of↓ten
499 P i was taking it every day.
500 PR yeah=
501 P =or sometimes twice.
502 PR that's fabulous!
503 P yeah (.) have no problem.

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PR .hhh coz the hydrogenised lactobumin that is i- we got
that so 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,
P uh huh.=
PR =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
[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_↑es [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)

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PR e:rm veins and arteries.
(0.3)
PR so it keeps the integrity of the the vein and artery walls intact.
P [okay.]
PR [or or] it improves it. .hhh so because of the varicose veins that you have on your leg,
(0.4)
P yeah,
(0.4)
PR that i think we'll probably will have you on for a while.
(0.6)
PR erm
(1.0)
PR and i think the bromelin he was having you on because of your leg,
P that was for: thee: (.) the blood,
PR yeah.
P (slb [slb you] know slb)=
PR [uh huh.] =yeah but it's (0.4) i mean how long has it been since your surgery two ↑months
(0.8)
P august fourth. august september october november [al most.]
PR [so three] months,
P [three months yeah.]
PR [three months yeah.]
(0.8)
PR and we put, but you didn't go on it right away, y- we we [saw]
P [no.]
PR you about a month or and a half after your (.) your surgeries. °(do you remember ↑that)°
(1.3)
P i:
PR or probably,
P i think it was [(two) six] weeks ago.=
PR [two mon-] =yeah.
so pro[ba bly,]
P [uh huh.]
PR two almost two months ago.
(1.5)
PR yeah,
(0.4)
PR [i think so yeah.]
P [yeah coz this was] only two weeks away.

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596 (0.9)
597 PR you came up two weeks ago.
598 (0.7)
599 P °(slb) two weeks a↑go°
600 PR it was nine seventeen actually so it was a month ago.
601 P okay.
602 PR uh huh.
603 P (slb slb slb slb slb slb slb slb)
604 PR yeah.=
605 P =uh,
606 PR okay.
607 ((SD enters the room))(3.0)
608 P [hello,]
609 PR [he:y,]
610 SD how are you?
611 P i'm doing reasonably well.
612 PR w- [(well).]
613 SD [i] apologize for the supplements they're on the
614 way.
615 PR .hhh yeah. hhh ha ha ha ha [ha ha ha]
616 SD [i have i] have one (that had
617 been sitting on) for a couple of weeks now. the other is
618 has been (slb
619 slb slb slb slb slb slb) yet. so,
620 P okay.
621 SD (slb slb slb worth slb slb slb it's:)
622 (1.1)
623 SD (slb slb slb slb slb)
624 PR okay.
625 (1.4)
626 PR they got in the (slb slb) a couple of weeks ago [(slb)]
627 SD [oh,]
628 they ↓did
629 PR yeah.=
630 P =but they never sent it.
631 PR but they di[dn't send,]
632 SD [oh they,]
633 PR it coz they pro- they thought that ye-[he]
634 SD [yeah,]
635 PR was getting it [from you.]
636 SD [they pick]ed it up (slb slb [slb slb)]
637 P [o kay.]
638 SD coz that's the one i'm waiting,
639 PR [o kay.]
640 SD [(slb slb)] i get the other one,
641 PR al[right.]

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642 SD [that] (slb)
643 PR okay.
644 SD (slb slb slb slb)
645 PR alright.
646 P and what's the other one?
647 SD (proberry slb [slb).]
648 PR [(pro]berry).
649 SD it's,
650 P [oh that's right. yeah.]
651 SD [it's a li quid,] it's a liquid berry extract.
652 (0.6)
653 PR and was to help your your hydrolyzed lactobumin taste
654 better.
655 ha [ha ha ha ha]
656 SD [(slb slb slb the)] (results [from this)]
657 PR [.hhh ha]
658 SD (slb slb slb [slb slb slb slb slb slb slb)]
659 P [er that's alright i go- i got] six
660 months (slb
661 slb slb [slb slb slb slb)]
662 PR [.hhh ghhh hhh hhh] [ha ha ha ha]
663 SD [ha ha ha .hhh]
664 PR ha .hhh and that's the one he can't stand. hu
665 P yeah,
666 PR hu
667 SD well, the the problem er er you're much more vulnerable,
668 PR yeah defini[tely.]
669 P [now] it is that replacing taking the
670 blue↑berry
671 PR uh huh.=
672 SD =yeah.
673 P yeah o[kay.]
674 SD [yeah.]
675 (0.5)
676 PR big concentration of it. .hhh
677 SD yeah.
678 PR basically (slb slb slb slb slb) has erm
679 P yeah. [°(slb slb slb slb)°]
680 PR [i- it looks a] lot better he er we gave him
681 the sulfur [twelve_c,]
682 P [(it has] started) [to] dry.
683 SD [yeah,]
684 (0.6)
685 P it's very dry again.
686 (0.9)
687 SD now,

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688 P and it itches.
689 (0.3)
690 SD yeah.
691 (0.4)
692 SD that was [not like this.]
693 PR [but it's not] red [like it was last time.]
694 SD [(slb slb slb slb slb)]
695 P [yeah,]
696 SD [how] how about your legs,
697 P erm a little [(slb)]
698 PR [°(slb)°]
699 P but not much er different.
700 PR he's,
701 P they were tied together they [were,]
702 PR [yes.] hh ha ha
703 P good.
704 SD oh i see. i see °(slb slb [slb slb)°]
705 PR [but the][redness has]
706 P [this one was] black
707 hasn't (changed) very much.
708 PR but the redness is much it's less than it was.
709 SD uh,=
710 PR =oh there we go.
711 P yeah.
712 PR but it's less angry it looks.
713 (1.0)
714 PR °still there (slb slb slb)°
715 P °(slb slb slb)°
716 ((SD examines P's leg)) (10.0)
717 PR hu
718 SD the stockings really help you [out] with that.
719 PR [yeah.]
720 P well you know it's amazing how much they do help because
721 you can see there's one vein here,
722 SD [yeah.]
723 P [(you)] know it didn't ache or,
724 PR uh,
725 P (missed) or something there's three or four in here that
726 show up early in the morning, they are very visible when i
727 first get up,
728 (0.7)
729 P by this time erm
730 PR hu,
731 (0.5)
732 P right now until er,
733 SD yeah,

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```
734                (0.5)
735   P            no i know it can't get them all (like that) at a time
736                but:,
737   SD           uh,
738                (0.8)
739   P            but that's how small this leg is compared to: the other
740                one. and the other thing i noticed, (0.5) originally,
741                (0.3) some years ago
742                (0.4) erm they measured this leg erm (0.3) but this one to
743                the same (tension),
744                (1.1)
745   P            (slb)
746   SD           [right.]
747   P            [ this ] leg was huge.
748   PR           u:h,
749   SD           [right.]
750   P            [ when ] i first had: (slb slb). and probably by this time
751                of the day,
752   SD           [oh yeah. ya.]
753   P            [it  got pre ]ssurized.
754   PR           yeah.
755   P            and: now (.) like when i (slb slb slb slb) no problem get
756                them on
757                (0.4)
758   P            this pair of pants,
759                (0.9)
760   P            would not er slip over my
761                (0.5)
762   P            would not go [ o  ]ver=
763   PR                        [wow,]
764   P            =[(that) i got to]
765   SD           =[yeah. yes if you] have (any) [ you really you rea]lly=
766   P                                           [grab and hold it er]
767   SD           =need that compression stocking. [yeah,]
768   P                                             [yeah,]
769                (0.5)
770   P            do you think that's fore↑ver
771                (1.0)
772   SD           yeah.
773                (0.4)
774   P            yeah?
775                (1.9)
776   SD           yeah there er how long have you been wearing this,
777                (0.7)
778   PR           two years (slb).
779   P            oh no!
```


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780 PR no?
781 P it was before that. erm
782 (0.9)
783 P (slb slb slb)
784 (1.2)
785 SD you know it
786 (1.5)
787 SD with with with with d_v_ts then you ↓know
788 PR yeah,
789 SD with (slb slb slb slb) major veins which (slb slb slb) you
790 know it can take a year (slb slb slb), two years before
791 before you get really to see what what what they want to
792 (slb) back.
793 PR [uh,]
794 SD [(af)]ter having the (slb slb slb yes)
795 P uh,
796 SD so same thing er you know (or similar to what you'll find
797 here). you have to (really know what the slb slb slb slb
798 slb slb how we slb slb slb slb slb you know to)
799 P okay.
800 SD (slb slb slb slb)
801 P yeah, oh a great problem.
802 SD and right now it's really a lot of (slb slb) er er er it's
803 a great benefit for you.
804 P yeah,
805 SD i think without it you'd have you'd have you you would
806 have significantly more (slb slb slb slb).
807 P yeah?
808 SD yeah and (.) there's a there's a (slb slb slb slb slb we
809 will put you in your leg slb slb) compression. you know to
810 just
811 P [o kay yeah.]
812 SD [keep keep it] down. so erm
813 (0.9)
814 SD (there are slb slb to put a little a little bit slb slb
815 slb slb slb er you know erm)
816 (0.9)
817 SD but i think they probably just keep you more comfortable.
818 (1.2)
819 P okay. (.) i have a [great] problem,=
820 SD [yeah.] =yeah,
821 (0.7)
822 SD what's that?
823 PR okay,
824 P my forty dollar pair of stockings.=
825 PR =hu got to use [that one .hhh ha ha ha ha ha ha .hhh]

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826
827 SD [ha ha ha he he he .hhh he he .hhh]
828 PR ha ha .hhh
829 P erm
830 SD but yeah ye ye you know the old the old (slb slb) has the
831 next you know over the next few years,
832 P yeah,
833 (0.5)
834 P okay.
835 PR .hhh so he had a little er a bit of, ((PR points at P's
836 left arm and SD shifts gaze from PR to P))
837 P ((lifting arm)) [was o ver here a lot less]
838 PR [(it er er) and some on the] o↓ther
839 P but er showed up the itch.
840 ((SD looking at P)) (0.5)
841 PR ((pointing at P's right leg)) [and (slb)]
842 P ((pointing at his right leg)) [erm one] spot right here.
843 SD are these new eruptions? [or] are these [(slb slb)]
844 P [no] [these are] old
845 ones.
846 SD old ones,=
847 P =on the side here especially,
848 (0.6)
849 P it's discolored.
850 (0.9)
851 P wherever i've had the eczema.
852 SD yeah.
853 P it's (0.3) still discolored there're spots on my back (slb
854 slb)
855 (1.1)
856 P but this one itches. and
857 (0.3)
858 P and one spot
859 (0.3)
860 P it's right above,
861 PR below.=
862 P =two inches below there.
863 PR hhh
864 P [and two] [inches behind there]
865 PR [ha ha] [ha ha ha ha ha] ha ha ha ha=
866 SD [ha ha ha ha ha] =he he he
867 [.hhh]
868 P [erm] it's
869 right in between the [the no scratch a rea.]
870 PR [°(slb slb slb slb slb] slb slb)°
871 SD he he .hhh

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P erm but it's not bad but it did come back. (0.4) erm=
SD =okay.
(0.6)
P and as i told you it is there is erm probably a misunderstanding
(0.4)
P on my part.
((SD goes to door as someone has knocked)) (11.3)
P erm
(2.7)
P and i know this has (to be) turned three times and i i did.
(0.6)
P and only one came out but (i turned it once) and only one with sulfur (pills [that)] came out it says take five,=
SD [yeah.]
(0.9)
P =[the pa per says]
SD =[(slb slb slb slb)]
P take one dose a:nd:,
SD yeah.
PR he took one pill.
P i [took] one.
PR [this]
SD that's okay.
PR yeah,
SD that's fine.
P uh. yeah,
SD er er h- here's the thing with homeopathics that:
(0.6)
SD the the number of (slb slb) you ↓take
P yeah,
SD doesn't matter.
P okay.
SD usually it's it's three or five we [(slb slb slb)]
P [uh o kay.]
SD actually we say three it's not the it's not the amount of (slb)
you take. it's the frequency of which you take them,
P oh [↑yeah]
SD [(that] makes the difference).
P oh, okay.
SD so erm
(0.9)
SD that's one of the the idiosyncrasies of=
P =yeah.=

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```
SD   =homeopathy and: so if you got one, that's fine you got
     the dose.
P    okay.
PR   uh huh.
     (0.8)
P    now i stopped that for two weeks like you said.
SD   okay.
     (0.4)
SD   erm (0.8) so no major exacerbations. it appears that
     things are
     actually clearing up a little bit.=
P    =er clearing up a little bit yeah.=
SD   =okay. so (the thing we will have [ to do) ]
P                                       [the only] thing that's
     come back are these two and this one [(slb slb)]
SD                                        [ one way ] of
     reducing it is c- is continue with the sulfur. now,
P    okay ↑three [thr- ]
SD                [three] yeah. right.
P    okay.
SD   and at the same frequency. and:
     (1.1)
SD   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)
P    right.
     (2.3)
P    and thee: (0.8) (slb slb) hydrolyzed,
SD   yeah, (you go[ tta keep going ] with that)=
P                 [°(slb slb  slb)°]          =keep going,
     (6.7)
P    let's see,
PR   three pills every day for: till we see him ↑next o:r,=
SD   =uh huh.
PR   okay.
     (1.9)
PR   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,]
P                                            [this is the ] one
     i was prescribed here and there's an acidophilus here,
     (1.0)
SD   oh you need to do one or the other. no you don't need
     both.
P    okay.
     (0.4)
P    coz the one i'm running out of this you know i just make
```


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```
964                sure  [that,]
965   SD                 [yeah.] but con- continue with, yeah [ one  or  ]
966   P                                                      [with this.]
967   PR                                                     [ o    kay.]
968   SD           the other. [(slb slb)]
969   PR                      [  o  kay.]
970   SD           (slb slb slb slb)
971                (1.0)
972   SD           (slb slb issue slb slb slb slb)
973   PR           yeah. .hh erm catalytic formula he was ↓on do we wanna
974                keep him on
975                that?
976                (2.7)
977   SD           that was er (.) digestive en↑zyme
978   PR           yeah.
979   P            yeah.
980                (1.8)
981   SD           erm yeah.
982   PR           okay.
983   SD           yeah.
984                (2.5)
985   SD           yeah.
986   PR           and then obviously the the glyceryzer,
987                (0.4)
988   PR           (slb slb tro slb cus) he was on he needs more of the (slb
989                slb) and the bromelin he was taking,
990   SD           let me see your tongue.
991                (3.1)
992   SD           okay. (.) okay.
993                (0.9)
994   SD           that's your (entry slb slb slb)
995                (1.4)
996   P            (slb slb slb slb) i haven't changed them in i start at
997                five thirty and quit about, (0.9) six or seven.
998   SD           [you]
999   P            [ i ]
1000  SD           yeah.
1001               (0.6)
1002  P            u:h,
1003  SD           you're sleeping o↑kay
1004  P            well.
1005               (0.6)
1006  SD           what time is bedtime for you?
1007  P            ten o'clock (early).
1008  SD           uh,
1009               (0.9)
```


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```
1010   SD          (slb slb slb slb pressure)
1011               (3.1)
1012   SD          (let's take his blood pressure).
1013   PR          yeah.
1014   SD          (slb slb slb) down erm
1015   PR          okay.
1016               (1.4)
1017   SD          thee:
1018               (7.4)
1019   SD          do you get enough fluids?
1020   P           probably not.
1021   SD          (you look like you're all) dry.
1022   P           yeah.
1023               (1.0)
1024   P           well today i haven't been home since,
1025               (1.1)
1026   P           eight o'clock this morning. and
1027               (0.7)
1028   P           you know i stopped here to get er close (slb slb slb) a
1029               glassful.
1030   SD          right,
1031   P           erm
1032   SD          right.
1033   P           erm today i know i the way down,
1034   SD          yeah the way down you you're (slb slb slb slb slb slb slb
1035               to to to slb slb slb dry)
1036   P           yeah and then
1037               (0.8)
1038   SD          so erm i would say just pu- push [push (slb slb)]
1039   PR                                           [(slb  slb slb ] slb slb
1040               slb)
1041   P           yeah,=
1042   PR          =hhh=
1043   SD          =that's gonna help your system you know [  erm ]
1044   PR                                                 [(live)] hhh
1045   SD          erm clear up erm
1046               (0.7)
1047   P           okay.
1048   SD          that you know (slb) it's not it's not coming out through
1049               your
1050               skin. (slb slb slb)=
1051   P           oh sure!
1052   PR          do we still wanna keep him on bromelin?
1053               (0.8)
1054   PR          he was on bromelin one cap twice a day,
1055   SD          erm i don't think he [(slb slb slb).]
```


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1056 P [it was two,]
1057 SD if he just u[ses]
1058 PR [two]
1059 SD the catalytic formula, that's probably enough coz it has
1060 (slb slb)
1061 PR okay.
1062 SD so you can, you can you can (clip) the bromelin in the
1063 schedule,
1064 PR [o kay.]
1065 SD [(slb slb)]
1066 PR great. and aescle- aes↑chylus
1067 (0.3)
1068 PR he was on the tincture,
1069 (.)
1070 SD e:rm
1071 PR that was for,
1072 (3.9)
1073 P yeah if i get the (redness slb),
1074 SD that's true.
1075 PR you won't [have to take] the tincture.=
1076 P [(slb slb slb] =yeah,
1077 SD right.
1078 PR but just keep it [in case.]
1079 P [(slb slb)] i take er
1080 (0.6)
1081 P one i just (slb slb) i guess so.
1082 ((SC measures P's blood pressure)) (1.6)
1083 P e:rm
1084 (1.7)
1085 P the one i take was the: erm
1086 (0.9)
1087 SD you know the the [aes chi]lus.=
1088 P [(slb slb)]
1089 SD =c- could have been an extract (with with the rest of)
1090 these tinctures,
1091 (0.8)
1092 SD you know, w- the er the thing with aeschylus that in in in
1093 a sense that (slb slb) you know, that
1094 PR uh,
1095 P uh huh,
1096 SD it's actually the the (slb slb slb part of it slb slb slb
1097 slb slb slb slb slb slb slb slb spoiling you know in a in
1098 a way. and that that's the ideal with that way and thee
1099 erm)
1100 PR (well he's the smilex well he's) the tincture now. but
1101 (hydrossi slb slb llia) you sh- you're not on any more,

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1102 P no.
1103 PR .h a:nd (slb slb slb slb) you're not on any more so the
1104 (slb slb slb slb slb) and the (smile ex) are both solid
1105 ex[tracts]
1106 SD [oh] they're
1107 just solid.
1108 PR yeah.
1109 SD so that's, that's that's the only liquid,
1110 PR yeah.
1111 SD this one,=
1112 PR =uh huh.
1113 SD oh great, o[kay.]
1114 P [there's] one [(slb slb slb)]
1115 SD [yes (slb slb)]
1116 P yeah one drop drop of it in the water.
1117 SD yeah.
1118 P yeah.
1119 SD yeah exactly.
1120 PR this one.
1121 P yes.
1122 PR uh [huh.]
1123 SD [yeah.] yeah that's it. keep keep doing that
1124 PR [okay.]
1125 P [okay] i only need that (slb slb).
1126 PR okay.
1127 (0.8)
1128 SD that's like (vein sealer).
1129 P is that ↑right
1130 SD yeah er (i i slb have a good slb what you think of it),
1131 (1.2)
1132 SD it [seals (slb slb slb)]
1133 P [(slb slb) extract] not the tincture.
1134 (0.5)
1135 PR well, keep the tincture in case you run out with:
1136 preferably we
1137 want you to have the solid extract.
1138 (1.2)
1139 PR which we're gonna get to you.
1140 P maybe it's one forty.
1141 SC one twenty eight [over six-]
1142 P [o:h yeah,] it went back to where i was
1143 ↑uh
1144 (0.5)
1145 SD that's good.
1146 (0.3)
1147 P i was i was always one twenty over seventy. was it

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seventy?
SC it was twenty eight over sixty.
(1.8)
P okay.
SD yes.
P o[ver six]
SD [that's good.] that's good. so so: make these little
little modifications, get some more fluids,
P [yeah.]
SD [(slb] slb slb slb when you get home today),
P yeah.
SD and: (1.2) erm (slb slb slb slb) you know,
PR when do you wanna see him [next?]
SD [(slb] slb slb slb slb slb slb)
PR in a ↑month
SD month?
P okay.=
PR right. (.) i will not be here in a month.
(1.0)
P okay.
PR erm hopefully hhh i'll be graduating. ha ha ha ha he .hhh
so
SD this guy will be there.
PR yes [he] will be.=
P [uh,] =okay.=
PR =so we'll talk about that.
P okay.
(2.6)
PR and this you ↓know
(1.8)
PR °right.°
(1.2)
PR great.
(1.5)
PR alright.
(0.9)
P okay. bye doctor.
(3.0)
P (slb slb [slb slb)]
PR [o k-]
P (slb [slb slb)]
PR [o kay.]((clears throat))=
P =i'm taking thee:,
(0.4)
PR you gonna k- take this.
P er er yeah,

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1194 PR that [you're not taking,]
1195 P [(slb slb slb is)] two drop tubes.=
1196 PR two drop tubes twice a day.
1197 P okay.
1198 PR okay i'm gonna write that down. okay?
1199 (0.6)
1200 P yeah i've been i haven't been taking that much coz i have
1201 been stretching until i can [(slb slb slb).]
1202 PR [yeah. that's fine.] that's
1203 fine.
1204 P the catalytic formula (i have to) [continue,]
1205 PR [continue] the same.
1206 P yeah, and that's for (0.7) digestion.=
1207 PR =digestion.
1208 P the (licorice should i) continue, (i'm out of).
1209 PR yeah.
1210 P uh,
1211 (1.2)
1212 P smilex extract hopefully not the tincture,
1213 PR yes hhh [if not]
1214 P [and i] don't take this one any more then for,
1215 (0.6)
1216 PR (antinflamma↑tory) no.
1217 (1.9)
1218 PR coz you're getting better.
1219 (1.3)
1220 PR the glycerizer (withdraw) that you can still take,
1221 P okay. (slb [slb)]
1222 PR [and] the hy- the hydrolyzed lacto-
1223 [hh ha ha ha ha]
1224 P [hh ha ha .hh .hh]
1225 PR .hh no. see that's the only one he didn't check off! ha ha
1226 ha he he he doesn't like that.
1227 P but:
1228 PR the sulfur,
1229 P i can taste it without taking it. [hhh]
1230 PR [rea-]
1231 SC [ha][ha ha]
1232 PR [hhhhh]
1233 SC ha with taking it,
1234 PR he he he he .hhh so [one i-]
1235 P [er the] sulfur continue,
1236 PR yes.=
1237 P =yeah. (slb slb slb [slb] slb)=
1238 PR [yeah.] =and you don't have to
1239 take the

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```
1240              h_m_f forty coz you have,
1241   P          the aci[  dophilus yeah.]
1242   PR               [that ac- a  ci  ]dophilus.
1243   SC         now this is (slb slb),
1244   PR         yeah.
1245   SC         (this this)
1246              (0.8)
1247   P          which one?
1248   SC         (this here),
1249   P          (slb [  slb   slb) ]
1250   SC              [(down there) ] because your eyes [are (slb slb) ]
1251   PR                                                [(neutro) yeah.]
1252   P          okay.
1253              (0.5)
1254   PR         .hhh so [cross this one] out.=
1255   P                  [(slb  slb slb)]     =(or [cross this)]
1256   PR                                         [ or   er   ]y- w- one of
1257              those you can cross out.
1258              (0.6)
1259   PR         coz it's the same thing. thank you.
1260              (0.6)
1261   P          (cross) this one (twice a day),
1262              (0.8)
1263   P          (slb this one slb slb slb)
1264              (0.8)
1265   P          i haven't had that for a while.
1266   SC         well this is thi- this is er the english name, this is the
1267              latin name,
1268   P          oh, (.) okay.
1269              (0.7)
1270   P          i i was taking that at one point, both.
1271   SC         uh huh.
1272              (0.4)
1273   SC         oh rea↑lly
1274   P          yeah.
1275   SC         the solid extract and the,
1276   PR         it won't hurt you.
1277              (1.2)
1278   PR         it's alright. e:rm
1279              (1.3)
1280   P          so i should only be taking (slb slb slb slb),
1281   PR         yeah. what i'm writing down for you is basically
1282              everything that you're gonna take.
1283              (1.4)
1284   PR         .hh okay. oops .hh now he's sending you the proberry.
1285              okay?
```


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```
1286  P     supposedly.
1287  PR    supposedl(h)y, hhh=
1288  P     =very slow.
1289  PR    .ha .ha ha ha ha ha .hhh it's coming by horse. .hhh erm
1290        you can do i mean it's concentrated berries you could do i
1291        do one tablespoon a day. i mean take it with your
1292        hydrolyzed (slb)lactobumin.
1293  P     [uh,]
1294  PR    [ o ]kay so,
1295  P     (make it blue instead of)
1296  PR    yeah.
1297  P     (white. [ o kay).]
1298  PR            [yeah hhh] .hhh proberry one,
1299        (1.0)
1300  PR    it's good.
1301        (0.5)
1302  SC    what company makes it?
1303  PR    it's the (slb slb slb) complete. [erm]
1304  SC                                     [oh ] really?
1305  PR    yeah. .hhh
1306  SC    okay.
1307  PR    and it's it's just the berry they don't put any sugar in
1308        it so it's a little [sweet,]
1309  P                        [yeah. ]
1310  PR    a little tart, it's just the [con cen tra ted be rry.]
1311  P                                  [slb slb slb slb slb slb]
1312        su[gar, ]
1313  PR      [yeah.]
1314  P     (they) won't take it.
1315  PR    ((writing on P's chart)) yeah,
1316        (0.3)
1317  P     too many things you buy today a:re
1318        (0.4)
1319  PR    yeah,
1320  P     and (you are slb slb slb slb slb dia- diagnosed by er)
1321        (0.7)
1322  P     doctor griffin.
1323        (1.0)
1324  P     he's not a naturopath but he believes in supplements you
1325        know,(slb slb slb)
1326  SC    uh [huh.]
1327  P        [(slb] slb)
1328  SC    i've heard of doctor griffin,
1329  P     he erm (0.9) found out that i was hypoglycemic erm and
1330        (slb slb slb slb) he almost put me in a coma with that
1331        (slb),
```


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1332 SC oh, you did the test?=
1333 PR =rea[↑lly]
1334 P [(five] hour test) oh yeah. [(slb)]
1335 PR [wow!]
1336 P i went down like forty seven.
1337 (0.9)
1338 SC er (slb slb) [that's pretty bad.]
1339 P [(slb slb slb slb)] was [seven]ty=
1340 SC [sixty]
1341 PR =yeah.
1342 P they were er er all the time i had my s-
1343 (0.8)
1344 P i mean sugar test done,
1345 (0.6)
1346 P erm
1347 (0.4)
1348 SC (slb slb [slb slb)]
1349 P [that test] yeah but: it's always in the
1350 midseventy.
1351 (1.1)
1352 P erm
1353 SC so (slb slb) to react to (hypoglyce↑mia)(.) to su↑gar
1354 (0.8)
1355 SC or [you (respond) to the su ↑gar]
1356 P [er (slb slb slb the pancreas)] the=
1357 SC =yeah,=
1358 P =pancreas er er or
1359 (0.6)
1360 P that made me very nervous coz my mother died of pancrea-
1361
1362 pancreatic cancer.
1363 (0.5)
1364 P (so if) i was hypoglycemic and didn't know it.
1365 (0.9)
1366 PR ((lifts head and looks at P nodding)) yeah,
1367 (0.8)
1368 P uh then my brother is borderline hypogly[ce mic.]
1369 SC [uh huh.]
1370 (3.8)
1371 P (like) the doctor told me (slb slb slb they never) and i
1372 asked him what are the downside of having the operation
1373 (slb slb), one in a hundred or so er erm
1374 (0.4)
1375 PR get infected.
1376 P get infected.
1377 PR [hu,]

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1378 P [i] said ((smiley voice)) i'm number ↑o↓one
1379 PR hu hu hu hu
1380 P i got in[fec]ted!
1381 PR [.hhh]
1382 SC oh you ↑did
1383 P yeah.
1384 (0.4)
1385 P well i (0.5) he jokes about it he said it was my fault.
1386 PR why,
1387 P because i heal very fast.
1388 PR oh that's [right.]
1389 P [(so] they they take the blood slb slb slb
1390 slb, by the time it it turns around doctor griffin then
1391 comes back i'm healed i'm just sitting slb slb).
1392 SC uh huh.
1393 (0.3)
1394 P but he (put slb slb slb to) an inch open (slb slb slb slb
1395 slb) drain.
1396 (0.6)
1397 P by the time i got home,
1398 (0.6)
1399 P my wife said you'd better check it.
1400 (0.3)
1401 P (to see) ((smiles))
1402 (1.8)
1403 SC hu!
1404 (2.3)
1405 PR okay.
1406 (1.1)
1407 PR .hhh alright so would you wanna just take this, let me
1408 just see the sulfur he (slb slb) [he has]
1409 P [i have] yeah.
1410 PR the glycerizer we have here okay.
1411 (0.4)
1412 PR °(slb slb)°=
1413 P =w- er erm i'm gonna continue that one and not the
1414 lico↑rice
1415 (0.7)
1416 PR it's the same thing sorry.
1417 P okay.
1418 PR al[right.]
1419 P [this] one or (the)
1420 PR i- i- [glyc- er er]
1421 P [cross this one]↑out
1422 PR yeah. just yeah. [th- er er alright.]
1423 SC [(slb slb slb slb slb)]

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1424 PR so i'll [say licorice yeah.]
1425 P [(slb slb slb slb slb)] okay.=
1426 PR =okay licorice. (slb slb slb slb slb)
1427 (0.6)
1428 PR er (slb slb slb) have that you the (aeschylus) which is
1429 the horsechestnut,
1430 (.)
1431 P [yeah i] have.
1432 PR [this one] two drop tubes twice a day okay. .hh catalytic
1433 formula,
1434 (1.1)
1435 PR we have on there,
1436 P yeah.
1437 PR yeah.
1438 (0.7)
1439 PR and the smilex.
1440 (0.4)
1441 P smilex i have.
1442 PR okay. we have you have the sulfur and the hydrolyzed
1443 lactobumin. .hhh a::nd proberry i have written down here.
1444 okay? (.) see if they have the these things.
1445 P smilex solid,
1446 PR extract they i hope [they do.]
1447 SC [o kay.] yeah. (slb slb slb)
1448 PR okay.
1449 P they should buy twice as much then.
1450 PR i know!
1451 P (slb slb)
1452 (1.7)
1453 PR they say oh we never use it but, (.) we do use it a lot.
1454 P yeah,
1455 (1.1)
1456 PR .hhh °okay° .hhh so basically everything that i have
1457 written down here is what you're gonna (.) what you're
1458 taking o[↑kay]
1459 P [o]kay.
1460 PR so if you get confused,
1461 (0.5)
1462 PR erm
1463 (2.2)
1464 PR alright. .hhh now i'm gonna say let's see how much,
1465 (1.3)
1466 PR okay. (.) do you have your calendar with you, four weeks
1467 from now.
1468 (3.9)
1469 P i have (slb slb) doctor (slb) in the morning.

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1470 PR .hhh okay. [so that]
1471 P [(slb slb)]
1472 PR would be what? december seven[teen,]
1473 P [se]venteen.
1474 PR okay that's that is e:rm .hhh er why don't we make three
1475 weeks from now, this:
1476 P okay.
1477 PR ↑here .hhh be[cause]
1478 P [(slb] slb)
1479 PR erm can you come on wednesday?
1480 P yes.
1481 PR .hhh right w- let's see if there's an appointment
1482 available but i would definitely suggest that. .hh because
1483 i may still be here.
1484 P okay.
1485 PR erm i may not that but matt will be here.
1486 P [yeah.]
1487 PR [doc]tor sheridan will be here be[cause we,]
1488 P [i know] he's here
1489 only on wednesdays,
1490 PR erm only on wednesdays that's why i'd like you to come on
1491 wednesdays.
1492 P yeah.
1493 PR .hhh erm this is finals week then the week of christmas
1494 .hhh
1495 P (slb let's get [slb] slb slb)=
1496 PR [yeah.] =yeah [so,]
1497 P [(and] the following
1498 week
1499 [i),]
1500 PR [is]
1501 P (know they'll be)
1502 PR yeah [so,]
1503 P [clo]sed.
1504 PR and then [i think]
1505 P [(again)]
1506 PR we start, (.) again here there's an (slb slb slb slb) week
1507 somewhere in here. so i think it would be good if you
1508 could come on the tenth,
1509 P okay.=
1510 PR =they just gonna have to fit you in. .hhh if there's i'm
1511 sure you'll be able to get in because then we can do that,
1512 and then a month later would be january so maybe we can
1513 head you off to, .hhh is there anybody in particular? i
1514 mean er
1515 (0.3)

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1516 PR that
1517 P er er
1518 PR you would
1519 P i [(slb slb slb slb slb)]
1520 PR [student clinician,]
1521 P matt.
1522 PR matt? [.hhh]
1523 P [or] doctor sheridan.
1524 PR okay.
1525 P (slb slb one)
1526 PR okay yeah. definitely doctor Sheridan.
1527 P a- absolutely.
1528 PR okay erm matt is is i don't know if he's a prima- he's
1529 gonna be a [pri ma ↓ry]
1530 P [(slb slb slb)]
1531 (1.1)
1532 P (can slb ↑this)
1533 PR yeah we can (slb).
1534 P (slb let's release this one)
1535 PR hu,
1536 (2.5)
1537 PR bye letizia, hhh hhh

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((P is having his temperature measured))
PR °when your vitals are done° then we'll just put a: it's just a speaker (slb) ↑phone
P °uh huh.°
PR okay?
((SC and PR sign forms and look at P's charts)) (50.0)
SC °okay.°
((SC measures P's blood pressure)) (18.7)
SC °yeah?°
P °hu hu hu°
SC .hhh
(22.1)
PR ((turning around as if looking for something)) °uh:↓uh°
(3.1)
SC (uh huh.)
(29.9) ((thermometer rings))
PR thank ↑you
(1.7)
PR ninety eight point zero. (.) okay good. (.) good.
((PR writes on P's file)) (33.2)
PR °uh, uh huh.°
SC reading upside do(h)wn?=
PR =ninety eighty four. got it. uh huh all set.
(.)
PR i'll [put this o ver here for now.]
P [(slb slb slb slb slb slb slb)]
(slb slb slb slb slb ↑slb)
PR uh?
(1.8)
SC (slb slb?)
P the pressure is (higher ↑then)
SC it's high[er than it was] last time.=
PR [it's °a little,°]
PR =yeah a little bit higher than last time. (.) uh=
P =er how much is it?
PR erm one sixty over eighty four.
P o:h [yeah.]
PR [uh] a little higher a little higher than the last=
SC =(it was) lower last time,=
PR =yea:h.
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

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```
44              it during the day on the morning i get a hundred and forty
45              (.) erm over: seventy eight,
46              (.)
47   PR         oh okay.
48   P          yeah. uh?
49   PR         that (slb) that's hundred and one ↑forty [over ] seventy=
50   P                                                    [yeah.]
51              =eight, yeah seventy eight,
52   PR         okay.
53   P          this is [ low  ] ↓uh=
54   PR                 [that's]
55              =erm (barely) low, er it's actually more moderate.
56   P          uh huh,
57   PR         erm yeah it's a little bit more moderate. low would be
58              something
59              like one lower would be one ↓ten or one hun↓dred over like
60              (.)
61              [     sixty, ]
62   P          [oh yeah!] yeah yeah.
63   PR         that would be low. (.) er so one forty for you it would be
64              lo↓wer=
65   P          =yeah.
66   PR         erm but it's still classified as (.) a moderate
67              hypertension,
68   P          [yeah but,]
69   PR         [ or mild ] hypertension.
70   P          (slb slb slb slb slb: slb slb slb slb: slb slb slb slb slb
71              slb slb) ha ha ha ha ha or,
72   PR         ha ha .hhh ↓uh now (lo[ li  ta)  is  she all set?]
73   SC                              [(she slb slb slb  slb  slb]
74   PR         is she ready to roll?
75   SC         e:rm [i think we] need to find her,
76   PR              [on us  or,]
77              (.)
78   PR         tzt o[kay.]
79   P               [ we ] (gotta) we (got[ta) go] which channel (slb),
80   PR                                    [o kay,]
81              (.)
82   PR         we oh no! no channels[ ha  ha ha ha .hh maybe] maybe some=
83   P                               [.hhh hh hh hh  hh .hhh ]
84   PR         =day. [ ha ] ha ha=
85   P               [↓u:h]
86   SC         =(slb slb) call my mother,
87   P          ha ha [ha]
88   PR               [o ]ka(h)y. [ha ]
89   SC                           [she] doesn't know (slb slb slb slb)
```


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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 slb) over here ↑right=
PR [erm]
=so: it will be here we can we'll just talk here.
P ya ya.
PR erm and she'll be taping,
P uh,
PR and she'll be listening to our our conversation,
P uh ya.
PR and then afterwards what she does is she (.) he rea- she
listens to the conversation again,
P [uh,]
PR [and] she goes through,=
P =uh.=
PR =different portions of the examination,
P oh [yeah yeah.]
PR [erm that] as a doctor what you have to ↓do and how
the patient responds to it. (.) so it's just a it's a
learning tool for ↓her
P uh,
PR erm then she's writing up a project a a thesis project
they call it.
P i see.=
PR =erm that may benefit people later ↑on to benefit doctors
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.]

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136 P [oh o] kay.
137 PR so we just we'll [just] clip that,=
138 P [yeah.]
139 PR =this is the spea↑ker
140 P uh ya.
141 PR and we could even just clip it right either on to your
142 swea↑ther
143 [portion or on] the collar.=
144 P [(slb slb) or on] =o- on the collar
145 [it will be eas ier on,]
146 PR [and that would be o kay.]
147 P the collar yeah.
148 PR we'll just clip that i'll clip that right up over here.
149 P yeah.
150 PR oops let me clip it so that it's (.) face in the right
151 way.
152 [here we are.]
153 P [uh huh uh] huh [uh huh.]
154 PR [o kay] good.=
155 P =ya ya.
156 PR okay.
157 P okay.
158 PR now (slb) thank you.
159 (1.1)
160 PR did you find her [no?]
161 SC [uh,]
162 (1.1)
163 PR okay.
164 SC (can't work it out)
165 PR erm the lights are on she said.
166 (.)
167 SC and she started al↑ready
168 PR erm may(hh)be she di(h)d ha ha .hhh erm
169 (6.9)
170 PR is it ready?
171 SC (slb slb slb slb)
172 PR okay.
173 SC (then maybe this is all slb slb slb)
174 PR okay [i think we're rea dy] [to,]
175 P [hhh]
176 SC [(slb slb slb we need] [a] chance to slb slb)=
177 PR =yeah let me erm
178 (.)
179 P ha ha [(won't you slb)] ha ha=
180 PR [hhh ha ha] =let me do this do you mind,
181 erm

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```
182   SC          ((adjusting cables)) (slb slb)
183   PR          [ that would be great.]
184   SC          [(slb) was   in   a   ] rock band [and he] said=
185   PR                                            [i just]
186   SC          =negotiating the wires,
187   PR          ha [ha .hhh]
188   SC             [it was ] the hardest [part.]
189   PR                                [ erm ] [grab a    sit,]=
190   P                                         [ha   ha    ha ]=
191   PR          =here. okay [then,]
192   P                       [  o  ]kay.
193   PR          then we'll get both patient and
194               [doc tor  in. (slb slb slb)  if you want,]
195   P           [erm it's  a good thing you are, the good]
196               thi-it's a good thing you're on my right side because
197               i think on the (slb) i'm deaf ↓uh
198   PR          okay [yes yes. it they work]ed out fine. [ha ha .hhh]
199   P                [ha  ha   ha  ha  ha  ]             [uh hu   hu]
200   PR          okay so we're just gonna go over some questions
201   P           [yeah ]
202   PR          [ to  ] day?=
203   P           =uh.
204   PR          erm this is a follow up visit to↓day=
205   P           =yeah.=
206   PR          =mostly for your low back pain. .hh
207               ((SC leaves))
208   P           [uh,]
209   PR          [erm] and the questions i have today, i see [you']ve=
210   P                                                    [ uh,]
211   PR          =filled out your diet diary,
212   P           yeah.
213   PR          so we can review that today.
214   P           °okay. (.) uh huh.°
215   PR          er and as far as the low back pain, can you tell me how
216               you're doing today, as far as how you're feeling,
217   P           oh, [erm]
218   PR              [er ]
219   P           well erm it was tough this morning to: erm to get out of
220               the bed. (.)
221   PR          [°uh huh,°]
222   P           [more than] erm like it used to be. (.) used to be used to
223               be. erm no more than pfff maximum five to eight minutes
224               and i (.) i was   able to walk practically almost normal i
225               mean quite i mean you know, erm .hhh
226   PR          o[kay.]
227   P                  [but:] this morning i gotta er grab the the the the
```


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```
228             consolle i
229             mean near the, what do you call it tzt kind of next to the
230             [bed?]
231   PR        [the ]
232   P         you know,
233   PR        okay yes. like the b- erm the night ↑stand
234   P         well [night stand in  ge   ne ]ral means: where you (log)=
235   PR             [was   it  the night st-?]
236   P         =the the mirror wh- which one is [that?]
237   PR                                         [ oh! ] like the the
238             dre↑sser
239   P         the dress[er.]
240   PR                 [was] it yes.
241   P         so i gotta grab the dresser turn the (roller) erm er (.)
242             it's a very long way. i mean going from here to (hh) here
243             .hh and:
244   PR        [uh,]
245   P         [ i ] i i walked on that. and then i stopped a bit and i
246             moved erm i had to to (monitor) the place you know?
247   PR        hhh
248   P         and i was getting better and better but: the very step is
249             is painful you know, uh
250   PR        [°okay.°]
251   P         [es pec ]ially this morning and you know the the that much
252             you know,=
253   PR        =now [how] long how long today did it take you to get up
254   P              [uh?]
255   PR        and around,
256   P         o  [kay] erm=
257   PR           [erm]    =you said the other day it[ was ] about five
258   P                                               [yeah.]
259   PR        ↑minutes
260   P         yeah yeah.
261   PR        how long was[ it  ] today?
262   P                     [well,]
263   P         this time: e::rm hhhe .hh i was er holding the dresser,
264             you know chasing) the mirror and i walked back and forth
265             (and all of that), and then hh hhhe that was about: a good
266             five minutes like that ↓uh
267   PR        °okay.°=
268   P         =but: i got a (slb slb slb slb) to do to do peepee and so
269             i: jumped on the (slb slb slb) i mean the on the roller to
270             get to the (slb slb) and hold the door and there and: (.)
271             we(hh)ll that wa(h)s erm the whole thing you know maybe
272             ten ↑minute:: [eight,]
273   PR                      [ but  ]
```


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```
274  P     maybe ten minute bu(h) you know?
275  PR    okay so [some ]thing longer than,
276  P             [yeah.]
277        (.)
278  P     yeah.
279  PR    [ be  ] fore.=
280  P     [yeah.]     =yeah. ((sniffs))
281  PR    can you tell me a little bit more about your pain, (.) erm
282  P     ooh yes it's:,
283  PR    as far as the the feeling of pain can [you de ]scribe ↑it
284  P                                           [uh huh.]
285        (.)
286  P     it's:: (.) pfuhh (i don't say this is) like if somebody
287        stepped on your toe but is: something (annoying me). (.)
288        er hhhh i don't know (slb slb) e::rm (slb slb slb slb) and
289        twist that you know, uh hoo hoo! er you know?
290  PR    [ o  kay. o  ]kay.
291  P     [what i mean,]
292  PR    [yeah]
293  P     [ oh ] by the way: i was: to erm griffin hospital
294        (student) (.) so no more er boots.
295  PR    oh they did [take it off, okay.]
296  P                 [ ya   ye ye  yeah ] they took it off and the
297        [(slb)]
298  PR    [ and ]
299  P     is okay now [uh,]
300  PR                [the] ulceration has it healed completely?=
301  P     =yeah yeah yeah.
302  PR    or is it still in the healing stage,
303  P     uh uh er ts- according to the doctor and the nurse erm
304        they says this is healed but you know what's happened .hh
305        erm wearing the:se: boots for three weeks you know,
306  PR    [  i know it's been a long time] for you.=
307  P     [(slb slb slb slb slb  slb slb)]
308  P     =.hhh and they started to irritate the (slb slb) over here
309        well i used to have the same kind of the problem you know,
310        .hh
311  PR    okay.
312  P     and: er it's: something you know like a (slb slb slb slb)
313        and i asked him what (slb slb i said oh) give me some
314        pills he says (slb slb) i was well. i hope you know ha ha
315  PR    o[kay.]
316  P      [bu- ] but i mean er er (tight) there it is thee the
317        whole place you know the [that] was (slb slb) i go i got
318  PR                             [uh, ]
319  P     this condition:, the same i got the other one you know
```


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```
320             that was big much bigger
321             than °be[fore.°]
322   PR                [ and  ] i remember [ you were ] mentioning that
323   P                                    [yeah yeah.]
324   PR        when you first came in to visit me.
325   P         oh i [did that] yeah. (slb slb) yeah=
326   PR             [yes  so,]                    =so it's still in the
327             same place,
328   P         °uh huh.°
329   PR        but just a little irri↑tation
330   P         yea:h [it's:: ]
331   PR              [uh like] a crusty? [you ↑said]
332   P                                   [er     er] it's something:,
333             (2.1)
334   P         well and i c- er this morning i was feeling something when
335             i walking but: now i don't feel nothing er when i touch it
336             no.
337             ((P touching his leg)) (0.9)
338   P         it's not sensitive any more i guess ((looking at PR)) ↑no
339   PR        [good. good.]
340   P         [ and  i f- ] according to him he must do [ he  ]
341   PR                                                  [good.]
342   P         (probably doesn't say °you know he [just slb°)]
343   PR                                           [.hhh  th- ] yes
344   P         uh=
345   PR        =he may just he may want to just watch it
346             [to    see  if see if ]=
347   P         [yeah yeah  uh uh  uh,]=
348             =[uh     uh uh,]
349   PR        =[there's any  ] changes.
350   P         yeah he said that yeah.
351   PR        okay [good ] so that was removed yester↑day
352   P              [yeah.]
353   PR        [was  it removed,]
354   P         [yeah  yesterday.]
355   PR        from [gri↑ffin]
356   P              [ i  was ] i was: to, oh! wait a minute. .hhh e:rm
357             ((singing)) da da da da
358             (7.0)
359   P         yeah this is: [the:]
360   PR                      [uh  ] this is [erm]
361   P                                      [so ] wh- what's the day
362             there i did i did th- i think i was there the
363             [day before.]
364   PR        [ erm today ] is such the twentieth so that would have
365             been er oh the [eighteen,]
```


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```
366  P                          [eighteen ] uh.
367  PR          tuesday o[ kay.]
368  P                    [yeah.]
369  PR          uh.
370              (0.9)
371  PR          °and this is doctor,° uh
372  P           yeah.
373  PR          (°okay°)
374              (1.4)
375  P           i [think: er er  (my leg  ] healing) because, i'll tell
376  PR            [uh     okay  thank you.]
377  P           you what.(slb slb slb slb slb slb slb) the nurse. o:h my!
378              (.) she should be er in: hollywood!
379  PR          oh [ha ha]
380  P              [hh hh] she's a beauty oh my gosh!
381  PR          ha
382  P           and: you she's being (très) cool (avec avec slb) you know,
383  PR          uh [i   mean  ve    ry good. ] very good.=
384  P              [yeah you know, yeah yeah.]
385  PR          =[ now  tell ] me a little bit [  a  ]bout, erm
386  P           =[(°slb slb°)]                 [yeah.]
387              (.)
388  PR          .hh the pain.
389  P           yeah?
390  PR          today.
391  P           yeah.
392  PR          erm
393  P           er the loca↑tion=
394  PR          =erm erm actually it's [it's ] the lower region,=
395  P                                  [yeah.]
396  PR          =[like ] you had [ er ]
397  P           =[yeah.]         [yeah] yeah.
398  PR          what on a scale of one to ten,
399  P           yeah,
400  PR          how does the pain feel today?
401  P           oh today [right] ↑there=
402  PR                   [ erm ]       =yes.[er]
403  P                                       [oh] no that's very low
404              that's: (.) i think i'm okay. er i'm feeling the pain no.
405              (.) only [(once:)]
406  PR                   [ okay  ]
407  P           see if i can get up get up everything, (slb slb slb)
408              (1.5)
409  P           .hhh hhh yeah well [i don't]
410  PR                             [o  kay.]
411  P           feel the pain while i do that you know,
```


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412 PR okay so you're doing okay [get]ting up.=
413 P [yeah,] =yeah [oh yeah!]
414 PR [o kay]
415 P uh huh huh huh
416 PR erm
417 P oh [(slb slb] slb) while i [sit down,]
418 PR [so wha-] [sit ting] down is diff-=
419 P =(slb slb slb slb slb) yeah. ((sniffs)) [uh]
420 PR [so] on a on a
421 scale of one to ↑ten [one] being (.)
422 P [yeah.]
423 PR very low or no pain and ten (.)a high pain,
424 [where would you rate it?]
425 P [oh o kay the the] high number is the high
426 pain?
427 er er [er]
428 PR [er] the high number would be a high pain.
429 P okay [so:] it's maybe two:, er one two?=
430 PR [erm] =okay so very low
431 [today.]
432 P [very] low yeah.
433 PR ((writing)) okay.
434 (5.4)
435 PR .hhh now you've been using thee: erm the pad that
436 [in]trared=
437 P [yeah.]
438 PR =heating [↑pad]
439 P [in]trared yeah.
440 PR er how are you doing with that?
441 (.)
442 P uh [huh.]
443 PR [has] has that been helping at ↑all erm over the past
444 week, since we talked ↑last
445 P e::r hhh yeah i think:: it's dif- i think here the the
446 massage you gave me er was helping even <u>more</u> you know,
447 when
448 PR [o kay.]
449 P [i get] up: oh yeah i feel nothing. you know?
450 PR o[kay.]
451 P [yeah.] i think it was right on the spot i guess you
452 know,=
453 PR =how long er after the massage [that] we did last week,=
454 P [yeah,]
455 PR =how long did you feel relief?
456 P before the massage?
457 PR erm afterwards. [af ter,]

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458 P [oh yeah] the the (slb slb ↑slb)
459 PR yes.
460 P uh (slb slb slb slb) i think: by the time we was talking
461 together: and: walking outside i was right to my car,
462 PR [o kay.]
463 P [that was] where pa(h)a- i don't know.
464 [i don't want to, uh]
465 PR [.hhh but then h how] did you feel when you got home?
466 P oh [i was well] too! yeah yeah.=
467 PR [how were you,] =actually,
468 P still still there yeah still the: (slb slb) feel the er
469 (.) .hh in french we say le bien d'etre. le bien d'etre.
470 PR [le b- o kay. o kay. ha .hhh]
471 P [(le bien d'etre) ↑uh yeah ha ha yeah.]
472 P but i feel that you know, the what do you say in english
473 le bien d'etre, erm [good] feeling,=
474 PR [e:rm]
475 P =[(slb slb)]
476 PR =[er good] you e:rm you feel maybe re::↑freshed or
477 P yeah yeah. okay [yeah.]
478 PR [uh]
479 P perfect. yeah that's [perfect] uh huh.=
480 PR [o kay.] =okay
481 P yeah.
482 ((PR writes on file)) (10.6)
483 PR and when did you start to feel the pain again? (.) after
484 that last massage,
485 P uh erm when when i came back: (.) let me see er s-
486 yesterday i saw, erm [what's his name er e:rm i gue-]
487 PR [when you saw the e:rm chi ro]
488 ↑practor
489 P yeah [yeah.]
490 PR [o]kay ae↑mon
491 P no [i erm i don't do] any more with aemon erm with=
492 PR [chi- or an o ther]
493 P =↑jeff °what's his name jeff?°
494 PR uh okay the other [erm]
495 P [uh] we just talk[ed to him.]
496 PR [stu dent that] we
497 were [talk]ing to today.=
498 P [yeah.]
499 PR =[o kay. o]kay.
500 P =[yeah yeah yeah.]
501 PR i d- [i'm] not familiar with his name [but,]
502 P [uh,] [uh] yeah. ha ha
503 ha ha moi

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```
504             non   plus. erm my me too. uh no no er but: ((sniffs))
505             (4.0)
506   PR        okay.
507             (2.4)
508   PR        so tell me a little bit more you had mentioned erm when i
509             spoke to you about the palpita↑tions
510   P         yeah.
511   PR        tell me a little bit more about the palpita[tions.]
512   P                                                    [  uh  ] huh
513             yeah.
514   PR        when when they had started,=
515   P         =yeah [ i ] was driving you know, (.) and: it's funny
516   PR              [and]
517   P         those palpitations can  happen any place anywhere (.)
518             without to kno:w, erm (.) even (.) anything er can
519             triggers these things you know? er maybe er i was (slb slb
520             it's maybe) something from the brain you know i'm i'm
521             thinking it was something (slb slb would be slb slb  avec)
522             something: quick you ↑know
523   PR        okay.=
524   P         =while i look i (get) something, i say what's the color
525             what's means that t- très you know what i ↑mean
526   PR        it's quick. it's [quick.]
527   P                          [ très ] yeah [uh ↑uh ]
528   PR                                       [how how] long had the
529             palpitations last[ed,]
530   P                          [ i ] don't know, [short] uh=
531   PR                                           [ how ]
532             =[it was ]
533   P         =[toom uh] toom. [just: like a] twitch,=
534   PR                         [erm   like a]
535   P         =[(slb slb slb slb)]
536   PR        =[ so  may  be  a  ] a couple of se↑conds
537   P         [yeah.]
538   PR        [ o:r,]
539   P         a couple of se[conds.]
540   PR                      [ or   ] minutes?
541   P         >no no [no no.<]
542   PR               [no, o  ]kay.
543   P         uh?
544   PR        and when was the last palpitation when [did you,]
545   P                                                [to  day ] i just:,
546   PR        just today,
547   P         yes  [to  day.   erm]
548   PR             [at  what  time] erm [to day,]
549   P                                  [when i] came: it was erm it was
```


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```
before            two ↓uh may[be,]
PR                      [oh,]
P           five ten minutes before two [yeah.]
PR                                      [  o  ]kay.
P           [(slb slb slb slb ] slb slb slb)=
PR          [and  it happened,]
PR          =just as you were driving down [↑here]
P                                          [yeah ] yeah.
PR          okay.
            (0.9)
P           strange it happens something it can be any kind of the the
            the s- something er roll to my brain, you know it's
            something:: (.) er er er (slb slb ↑slb) or you know the
            color on on i read the the the something i see on the
            street, or something i i see on the telly too just like
            that you know?
PR          so it's something that's upsetting to ↑you
P           yes [it's erm]
PR              [it seems] to come up erm or [is it] just anything
P                                            [hhhhh]
PR          that,
            (.)
P           er er er er it can be anything.
PR          [it  can  be  a ny, ]
P           [you know like it's:] er anything yeah. .hhh i know maybe
            this is like a (slb slb) probably being closing my eye my
            eyes you know, .hh coz: you know i'm blind right? so,
PR          on the one,
P           [yeah you know and some time] when i focus on something
            too near,=
PR          [the one eye  is  blind yes.]
P           =er er because i gotta: search for: establishing what i'm
            t- trying to find out you know,
PR          yes.
P           uh you know what i mean,=
PR          =yes.=
P           =it's (slb slb) you know?
PR          erm have you had any headaches at all? when you get the
            palpita[tions or] any dizziness,=
P                  [ no  no.]              =no:(slb slb) [ what]
PR                                                      [(slb)]
P           happens is i i get this st- er er sometime feeling, erm
            (2.3)
P           how to explain this feeling,
            (2.3)
P           erm
```


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596 (2.5)
597 P i've feeling like a tiredness or something like that.
598 PR tiredness?=
599 P =yeah [yeah] a tiredness you know,=
600 PR [that] =how do you feel right
601 now?
602 P oh [perfect!] perfect [perfect.]
603 PR [do you] [do you] feel [er] tired?=
604 P [yeah.]
605 PR =[or] do you,=
606 P =[no.] =no. no no.
607 PR o[kay.]
608 P [i] no. no no. .hh well this it doesn't last long you
609 know,
610 PR [o kay,]
611 P [(slb slb)] there is another thing when i get this
612 something something that trigger the thing. .hhh so i say
613 er er i'm talking to myself and i say he he
614 [.hhh but it it will stop.]=
615 PR [er trying to figure out,]=
616 P =that it it it stop it you know so it's you what(i mean
617 [slb slb)]
618 PR [so you] tell your body to stop.
619 P [yeah yeah yeah.]
620 PR [and it it] stops,
621 P yeah yeah. .hhh
622 PR [o kay.]
623 P [but: e] ven before the the doctor many doctor told me
624 oh (slb slb slb slb slb) this is this (slb) palpitation.
625 the the one the kind you got is not dangerous .hhh so what
626 i (gotta avoid) you know so it's: (.) before i used to
627 have a lot i used to a- amplify it was worse.
628 PR uh [o kay.]
629 P [i couldn't] get er i couldn't get this vicious circle.
630 circles
631 you know?
632 PR [uh huh.]
633 P [it was] gonna (slb) and build up you know and then i was
634 er finish like: .hh you know er like i get (slb slb tion),
635 er finish like i told you fourth time to the: er the
636 panic,
637 PR [yes. yes. it's (some) worse]
638 P [it's it's something like] the very beginning very
639 beginning of the: er e:r tzt.hhh e:rm what they call it,
640 the panic attack?
641 PR like a panic o[kay.]

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642 P [yeah.]
643 PR o [kay.]
644 P [yeah.]
645 PR erm [and] so it only lasted a a second or ↑so to↓day=
646 P [uh?] =if i
647 if i: i got able to get a very er immediate grip
648 [and con]trol,=
649 PR [uh huh.]
650 P =myself and then it disappear.
651 PR and then it disappears.=
652 P =yeah.
653 PR how about the supplements that you were taking, are you
654 back on supplements i know you had stopped the hyper
655 [ba lance,]
656 P [yeah yeah] yeah.
657 [e:rm]
658 PR [e:rm] are you you're not taking that,=
659 P =but: [because::] the amount: er .hhh the what you call:,=
660 PR [but er]
661 P =magnesium i was taking it was working good you ↑know
662 PR okay. [and:]
663 P [and] magnesium (slb slb) is the one that goes
664 to the:: [.hhh]
665 PR [uh,]
666 P i understand the: (.) on the brain, on the i- it control
667 the:: neutron the:: something like ↑that
668 PR the: erm [the mag]ne↑sium
669 P [uh huh.]
670 [yes.]
671 PR [sup]plement that you're taking [is]
672 P [yeah.]
673 PR probably also helping [to] relax the ↓heart=
674 P [yes,] =yeah.
675 PR [the muscle erm of the heart so that may]
676 P [ex actly. o kay yeah yeah. o kay yeah.]
677 PR be helping [with all of the muscles.]
678 P [neu ro trans mit ter]neurotrans[mit ter]
679 PR [.hhh then]
680 P you know,=
681 PR =and neuro[transmitters] in the brain yes.=
682 P [yeah yeah yeah.]
683 P =[yeah (slb slb slb)]
684 PR =[yes that's ve ry] beneficial. [erm]
685 P [yeah?]
686 PR besides the magnesium,
687 P yeah,

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PR what else are you taking?
P [o:h] i i didn't stop like: thee: q_ten which is for the heart,
PR [erm]
P you know,
PR okay so [you're still] taking the q_ten,=
P [and the::]
P = yeah and thee: thee thee what else oh i take l_carnitine.
(1.2)
P you have the list of here ↓no
PR erm [i do have i]
P [well may be (slb] slb slb slb)
PR i may have the list here [erm]
P [yeah] the vita↑min uh
PR in fact i think [these] are all your lab reports.=
P [yes.] =uh uh
uh=
PR =yeah this is:,
(2.3)
PR .hhh and your release of records here's one of the lists i know this goes back a little ways.
P uh huh. [uh huh.]
PR [i think] this is the older list that we had.
P oh yeah. this is is there is one:
(.)
PR and that's in your other chart.
P [u:h oh yeah!]
PR [a:nd yeah this] is an older list=
P =oh yeah okay uh,
PR okay but what you can remember [that] you're taking,
P [yeah,]
PR [is the magne↑sium]
P [yeah o kay. er l_]carnitine and:=
PR =l_carnitine okay.=
P =erm pfff let me see: er
(1.9)
PR and you said the co_q ↓ten
P the co_q ten yeah.
PR okay.
P and there is another one, (.) e:rm (slb slb slb slb slb slb slb the other one slb)
(3.4)
P huh,
PR .hhh now are you also taking the last erm .h last week you were taking (.) erm a (triple_s) [↑herbal]

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```
P                                                [uh yeah.]yeah i was er
            er i'm on [er]this=
PR                    [er]
P           =thing yeah.
PR          you are [ tak ]ing that [still?]
P                  [yeah.]         [ yeah.]
PR          [o   kay  do]
P           [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]
PR          [o ]kay do you notice any improvement (.)
            tak[ing   that or ] any ↑changes=
P              [.hhh er:m  hhh]
            =(slb slb) oh they says it takes almost: two weeks before
            you can see er improvement you know,
PR          tzt okay.
P           because apparently they [said]
PR                                  [ i  ] think it's been almost two
            weeks
P           [yeah some  thing like that.]
PR          [that you've  started  that.]
P           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?)°
PR          erm actually the (triple_s) [should] be fine.=
P                                       [  uh! ]         =fine.
PR          [uh   yes    we had ]
P           [that should be fine]  uh [huh.]
PR                                    [yeah] we double checked that
            [to  see ]
P           [uh ↑yeah]
PR          if there was any contraindications [for ↓you]
P                                              [uh   huh] uh huh,
PR          and there were not.
P           uh huh [uh ] huh,=
PR                 [erm]     =but just: you [know] if if you're: in
P                                           [ uh,]
PR          ↑doubt=
            =yeah [yeah yeah yeah,]
PR                [you  know then ] i would probably just slowly
            decrease the amount that you're taking.
P           probably yeah [yeah yeah yeah.]
PR                        [if    you find ] that it seems to be
```


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```
780              causing
781   P          yeah [yeah.]
782   PR              [more ] problems with the palpitations.
783   P          yeah absolutely [ if ] i,
784   PR                        [yes.]
785              (.)
786   P          i only see maybe in the next couple of days maybe if it
787              start causing that i got this thing .hhh er more often,
788              you know because
789   PR         [uh huh.]
790   P          [i  got ] something very seldom. sometimes i don't have
791              anything and (slb slb slb slb slb) uh,
792   PR         i [know] you were doing well for quite a [while with ]out=
793   P            [uh? ]                                 [yeah. yeah.]
794   PR         =the palpitations,
795   P          yeah i [don't] know maybe this:=
796   PR               [it's ]                =we'll s-=
797   P          =if the one stopped maybe they give us er give us
798              [give us,]
799   PR         [that may]
800   P          the (slb slb slb [slb slb) uh  ]
801   PR                        [we- well yeah] was we'll have to .h
802   P          [yeah.]
803   PR         [keep ] track of it.
804   P          [yeah yeah.]
805   PR         [you know, ] just to write down [ the ] best thing would
806   P                                        [(slb)]
807   PR         be to just write down:[  a  ] erm=
808   P                               [(slb)]    =the fact [↓uh]
809   PR                                                  [a  ] journal.
810   P          [erm]
811   PR         [erm] when you're getting [ the pal ]pitations,
812   P                                    [yeah, uh,]
813              (.)
814   P          yeah. [uh,]
815   PR               [erm] the time that it [ oc  ]curs,
816   P                                       [yeah.]
817              (.)
818   PR         erm and possibly what you [were ] doing
819   P                                    [yeah.]
820              (.)
821   PR         [at that point.]
822   P          [uh  uh   uh.  ] at that point uh [ huh.] yeah.=
823   PR                                          [yeah. ]     =yeah if
824              you can do that and then that when we can we can [ ta ]ke=
825   P                                                           [yes.]
```


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826 PR =a look at it and maybe we can figure out,
827 (.)
828 P yeah. [(this is a) rea son for it.]
829 PR [er er mh the reasoning] for it.
830 P yeah sure. yeah.=
831 PR =yes.
832 (.)
833 P e(h) [erm]
834 PR [o]kay.
835 P [gar]lic. i'm taking it's also for the heart ↑right=
836 PR [erm]
837 PR =erm which one you ↑said
838 P er er garlic?
839 PR garlic [yes. o kay.]
840 P [yeah (slb slb] slb slb) what else i'm taking, uh
841 i've got a couple of other one. (.) e:rm
842 (4.1)
843 P uh huh, well if you if one d- did you get the can dig up
844 [all]
845 PR [i'll]
846 P the the list ↓no=
847 PR =i'll review the old yes [yes i'll]
848 P [uh huh.]
849 PR review the other list that you have.=
850 P =oh mais you you can get the the the the one is it
851 complete ↓no
852 PR i have, [erm]
853 P [uh] you get the the (slb slb)
854 PR i have: your diet diary here and (.) let me take a look
855 here. (.) this was an old chart too.
856 P °hu hu [hu hu] hu:°=
857 PR [okay.] = let's see:: (.) was there anything
858 else here, erm the calcium with magne↑sium
859 P oh yeah. (slb slb) [magne]sium (slb slb) uh huh.=
860 PR [o kay.]
861 PR =erm fish oil?
862 P fish oil yeah okay. yeah fish oil.
863 PR [o kay.]
864 P [i ca]rry on with everything er [the calcium,]
865 PR [(slb slb slb)]
866 P =i was looking for this one. [er er]
867 PR [the the] the ↑calcium
868 P yeah yeah.
869 PR okay [you]'re still taking that,=
870 P [uh?] =yeah yeah.
871 PR er thee l_carnitine you men[tioned,]

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872 P [l_car]nitine too yeah yeah.
873 PR erm (har↑porn)
874 P erm (harporn) too yeah.
875 PR [okay.]
876 P [okay.] yeah yeah.
877 PR and your co_q ↓ten
878 P yeah yeah.
879 PR erm the d_m_a_[e,]
880 P [uh] yeah yeah i d- i take this one too
881 yeah.
882 PR you are still [taking that,]
883 P [yeah uh huh.]
884 PR okay. (.) erm magnesium (aspi↑rate)
885 P yeah. (très très) [yeah (slb slb)]
886 PR [that uh huh.] (.) and your vitamin ↑c
887 P uh huh yeah.
888 PR okay.
889 P oh is it that, here everything there?
890 PR your leg↓vice
891 P [yeah.]
892 PR [erm] with o_p_c_↑s
893 P oh yeah yeah. well er thee o_p_c thee o_p_c (.) er it's
894 it's the
895 same thing like: the (capsi↓da:)
896 PR [erm]
897 P [so] something similar to it you know,
898 PR thee:: o_p_c,=
899 P =yeah,=
900 PR =is actually it's almost more of like a: bioflavonoid.
901 P yeah exactly [yeah.]
902 PR [it's] what it does,
903 P [yeah uh yeah.]
904 PR [so it helps] support your vein [structure]
905 P [yeah (slb] slb slb
906 slb) uh huh
907 PR erm (loo↑tine)
908 P (lootine) [yeah yeah.]
909 PR [are you] tak- are you still taking ↑that
910 P yeah this is for the eye right?
911 PR for the [eye yes.]
912 P [yeah yeah] yeah.
913 PR erm (tua↑vine)
914 P (tuavine) yeah yeah.
915 PR okay erm tri zinc citric,
916 P erm the zinc yeah. i take the zinc too yeah yeah.
917 PR okay and the gu↑go

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```
P     erm the what?=
PR    =erm gu↑go
P     erm [gugo,]
PR        [gugo ] ex↑tract
P     erm (.) i didn't take for a long time i don't know erm er
      what's this is [what for] actually the (.) gu[go,]
PR                   [ o  kay,]                    [er ]the gugo
      is for the heart?
P     oh ↑yeah
PR    yes.=
P     =uh i should take i think.
PR    erm
P     oh yeah. [yeah.]
PR             [this ] one you haven't been taking i'll just
      mark
P     yeah,
PR    this one as no.
P     uh huh.
      (1.5)
P     yeah they got over ↑here at the: dispensary [uh?]
PR                                                [erm] we do
      have gugo [yes.]
P               [yeah] okay. yeah yeah. this is: for the heart
      right,
PR    erm gugo is for the heart.
P     yeah [ uh,]
PR         [e:rm] it's also good for er any type of erm (.)
      difficulty with fats erm choleste↑rol
P     oh [yeah.  yeah  oh   yeah.] yeah yeah.=
PR       [things like that's for,]
P     =because i i'm taking thee the flax oil,
PR    oh that's very good [for  you.]
P                         [yeah yeah] flax oil. oui .hhh [and:]
PR                                                       [ erm]
P     well the flax oil yeah. what else, u:h (.) we:ll er er
      flavonoid you know i take [that,]
PR                              [ erm ]
P     er this is not well for the for the whole system,
      [you know yeah.]
PR    [it's for the  ]
      whole body yes.=
P     =yeah.=
PR    =yes.=
P     =yeah yeah.
PR    and the hyperbalance you're not taking,
P     no.
```


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```
 964   PR          okay.
 965   P           super hu hu.
 966   PR          okay.
 967   P           yeah.
 968   PR          er superflavonoids?
 969   P           yeah we just [said that.]
 970   PR                       [ coz  it  ]
 971   P           uh,
 972   PR          okay.
 973   P           uh.
 974   PR          erm digest ↑ease [you're still tak]ing that for=
 975   P                            [.hhh   no,   hhh]
 976   PR          =diges[tion,]
 977   P                 [ no  ] my digestion is good you know no.
 978               (.)
 979   PR          [  o  kay.]
 980   P           [that's it] i think.
 981   PR          erm and let's see d_h_e_↑a
 982   P           d_h_e_a i stopped.
 983   PR          you stopped [o kay.]
 984   P                       [yeah i] stopped a long time ago yeah.
 985   PR          okay. (.) erm ↑arthro (.) seven,
 986   P           erm [yeah.]
 987   PR              [ erm ]
 988   P           it's:[it' s] a co- er for the:=
 989   PR               [it's:]                  =collagen for the ↑joints
 990   P           yeah yeah for the joints. yeah.
 991   PR          okay you're still taking ↓that
 992   P           [yeah.]
 993   PR          [ erm ] a:nd (oxispectrum)
 994   P           e:[erm ]
 995   PR            [it's] an antioxidant.
 996   P           yeah [o  kay.]
 997   PR               [or spec]trum,
 998   P           yeah yeah.
 999   PR          are you still taking that [one?]
1000   P                                     [o:r ] no i [   re]placed it
1001   PR                                                [°no?°]
1002   P           with another one.
1003   PR          °o[kay.°]
1004   P             [e:rm ] it's:: (.) (septin) ↑pure (septin) pure
1005               [in: e:rm]
1006   PR          [sep  tin]pure
1007               okay.
1008   P           erm for the joins you know,
1009               (2.3)
```


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1010 P (septin)
1011 PR °er (sep↑tra)°=
1012 P =so i don't know how's actually the the the spell with::=
1013 PR =pure okay.
1014 P uh,
1015 (3.1)
1016 PR and our last one is thee: (prosthata)
1017 P yeah i ta- i'm still taking [that yeah yeah.]
1018 PR [you are still] taking that
1019 okay.
1020 P [you have (slb slb slb] slb) with that ↑yeah=
1021 PR [o kay good. so then] =yeah i think
1022 we have
1023 everything down here.
1024 P uh huh.
1025 PR okay good.
1026 P uh.
1027 PR and: [so what]
1028 P [and so] gugo is is it's is is the (↑slb)
1029 PR [gugo,]
1030 P [that i] could have ↑yeah=
1031 PR is for the heart it's mostly for like, cholesterol?
1032 P u:h [i see.]
1033 PR [erm it's] a lowering agent, [for cholesterol]
1034 P [lowering agent] yeah.
1035 (.)
1036 P i don't know if actually my cholesterol was checked
1037 looking on the gugo.
1038 PR erm it was [che]cked the last .hh=
1039 P [uh] =yeah,
1040 PR erm as of this file i think the last check [we] have
1041 P [yeah]
1042 PR [here]
1043 P [yeah]
1044 PR was actually blood work ↑done [and your] testosterone
1045 P [oh yeah]
1046 PR level.=
1047 P =oh
1048 yeah [this] was the last ↑one=
1049 PR [erm] =erm
1050 P no.
1051 PR two thousand and three.
1052 P [oh two thousand three.]
1053 PR [erm in sep tem ber.]
1054 P oh okay [then.]
1055 PR [sep]tember and that's all [i] have in,

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P [uh]
(.)
P ah,
PR and o:n your last blood work,
P oh yeah,
PR erm that was just your your red blood ↑cells
[your he]moglobin=
P [oh yeah] =oh
yeah!=
PR =and your your erm testosterone
P oh yeah,
PR le[vel]
P [oh] this: so it's the one [is good (slb) ↑yeah]
PR [and that was all] within
range yeah.
P oh yeah that was all in [range.]
PR [yes] that was all within
range.=
P =oh yeah. i see yeah.
PR erm a couple of questions [i had] on your diet ↑diary
P [yes yes.]
(.)
P yeah.
PR erm (.) thee: last we have here let's just take a look on
the
[diet]=
P [uh,]=
PR =diary.
(3.2)
PR okay. (.) and this was the first day,
(4.5)
PR okay good.
(.)
P well this one i repeat was practically all the same every
day.
PR this,
P this is my breakfast i don't change er except: i can
change different: erm like: instead the blueberry i take
some other:
PR another [(↑type)]
P [(slb slb)] er er er (slb) to the berries you know
grape you know? (slb slb slb) [.hhh so that]it can be a=
PR [o kay that's,]
P =change mais er er autre- otherwise is exactly what i'm
taking every morning you know?
PR okay.

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1102 P uh,
1103 (1.8)
1104 PR okay yeah it looks it looks good.
1105 P [yeah]
1106 PR [it] looks as if you're [you're] getting enough
1107 P [yeah.]
1108 PR nutrients and=
1109 P =yeah.
1110 PR erm i'll go over this with doctor duncan
1111 [al so to day?]
1112 P [oh yeah. yeah yeah.]
1113 i see=
1114 PR =erm just to see if he might have another recommendation
1115 that [he]
1116 P [yeah.]
1117 PR might able to add [o:r,]
1118 P [sure!] yeah yeah yeah. [yeah.]
1119 PR [erm] to your
1120 diet.
1121 P yeah.
1122 (.)
1123 PR okay good.
1124 P uh,
1125 PR okay so what we'll do for now, [erm]
1126 P [yeah,]
1127 PR we've already taken your vitals so we'll erm [do a]
1128 P [uh huh.]
1129 PR massage,[for your] lower lombar [a]rea [o↑kay]
1130 P [uh huh.] [uh,] [uh o]kay.
1131 PR and i think we'll
1132 P the the the the lady did he show up? or what she get lost
1133 or,
1134 PR erm no actually she's will be finishing with the video.
1135 P o:h! [hu]
1136 PR [erm] and then we'll do a massage next.
1137 P oh i [see.]
1138 PR [o]↑kay so we can [take the speakers off,]
1139 P [o:h you you al rea]dy
1140 turned the whole thing ↓on
1141 PR we took everything [yes.]
1142 P [oh!] you don't tell me anything,
1143 PR you [↑see hhh he he .hhh that wasn't bad was ↓it see he]
1144 P [hhh ha ha ha ha ha ha ha .hhh ha noh ha]
1145 PR he he
1146 P oh ↓my ↑gosh
1147 PR [so what,]

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```
1148   P            [er the  ] the here was (slb) up er er
1149               [the camera    running, ]
1150   PR          [e   verything (slb slb)] (up) yes.
1151   P           oh [oh   hhh   hhh     ha  ha ha  ha      ha    ha]
1152   PR             [ca  mera's running and every thing's going for] you.
1153               o[kay. he he]
1154   P            [ uh  hu hu]
1155   PR          [so what] we'll do i'll [talk  to  doc]tor duncan
1156   P           [.hhh uh]               [(slb slb slb)]
1157   PR          [on   the] diet diary [that you gave,]
1158   P           [yeah yes]            [you  take  me,] er you take er
1159               [you're ha ha] ha .hhh=
1160   PR          [it's:  he he]        =that
1161               [that's good. that's]
1162   P           [will   you    are  ] you sure [that] the thing,=
1163   PR                                      [but ]
1164   P           =you know [oh ] it was al-=
1165   PR                     [erm]          =it was already running.
1166   P           oh [yeah.]
1167   PR             [yeah.]
1168   P           maybe the the it went it [ went  on] by the voice [↑no ]
1169   PR                                   [i'll take]             [.hhh]
1170               erm no [ ac]tually it was running throughout=
1171   P                  [↑no]                                  =oh yeah
1172               [so  i ] see=
1173   PR          [uh huh]
1174   P           =yeah [something yeah. u:h!]
1175   PR                [o   kay.  so   we'll] take the clips off o↑kay=
1176   P           =yeah [yeah.]
1177   PR                [ uh, ]
```


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P many many many problems.
PR [uh huh.]
P [actua]lly i was convinced i had mercury toxicity.
PR uh [huh.] uh [huh. o kay. o kay.]
P [ha!] [.hh seriuo(h)sly i] mean we're talking neuropathy, (slb slb)myalgia,
PR [uh huh.]
P [chronic] fatigue syndrome, [de]pression, erm every
PR [uh,]
P classic syndrome i do have twenty six mercury fillings.
PR okay. [o kay.]
P [so (it's] slb slb i went) to the dentist,
PR okay,
P and i happened to be(h) i never [go on] the computer,
PR [uh huh.]
PR [o kay.]
P [and i] was on online,
PR uh huh,=
P =and someone said have you considered going to a ↑naturo↓path
PR uh huh,
P so i called up this guy in erm new jersey who wanted a million dollar, [my] (husband's selling the houses)=
PR [uh,] =uh huh.
PR [uh huh.]
P [i was] the: maternity erm erm teacher.
[and now i'm a masters in nursing.]
PR [rea lly, o kay. oh ve ry good. oh] very good. uh huh.
[uh huh.]
P [a n d:] well so much for walking,=
PR =uh huh.
P and so much for life.
PR uh huh.
P .hh erm i'm i'm not teaching right now. and (we might call) about eighteen hundred dollars a month. [gkkhhh]
PR [uh huh.] uh huh.
P in massachusett (slb slb) mortgages are thirteen fifty. so anyway.
PR [ha ha. uh huh.]
P [.hhhh so i] called here,(.) so actually and and then my

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```
44              chiropractor came to school here,
45   PR         okay. o[kay.]
46   P                 [ so ] i called him.
47   PR         [uh huh.]
48   P          [and i  ] happened to say hey do you [know any] n_ps,=
49   PR                                              [uh  huh. ]     =uh
50              huh.
51   P          tzt (slb slb slb) about erm (colating) is that [ how you,]
52   PR                                                        [ coolat  ]
53              ing
54   P          say it [(coolating) the]rapy. right?=
55   PR                [uh huh. uh huh.]
56   P          =so i have to pull all my teeth hhhh[out!]
57   PR                                            [ o  ]kay. okay.
58   P          so i thought wow, alright i called so i talked to
59              ↑bar↓bara
60   PR         uh [huh,]
61   P             [for ] quite a long [hhh was  ve ry ] sweet,=
62   PR                               [uh huh. uh huh.]
63   P          =(slb slb) i have to go and ↑meet her=
64   PR         =yeah. [yes she's a wonderful person. uh, ]
65   P                 [and (per sonal) after  our leaving] we had this
66              really great chat. .hhh and then she said but you know
67              it's something really expensive and i went [ohhhh yeah!]
68   PR                                                    [°uh   huh.°]
69   P          really is isn't it, and i said well jeez, where do you
70              students [use]
71   PR                  [uh,]
72   P          [your ] clinical ?=
73   PR         [huh !]           =uh huh.
74   P          she says we have our own clinic [  i  ]
75   PR                                         [yeah.]
76   P          said a:::hh!
77   PR         uh huh.
78   P          three hours but the price sounds great!
79              [ca(h)n] i c(h)ome?=
80   PR         [ yeah.]
81   P          =ca(h)n i c(h)ome [to your] clinic, [she] said sure.=
82   PR                           [uh huh.]         [uh,]
83              =okay.
84   P          [.hhh and] i said hey well you know,=
85   PR         [ o  kay.]
86   P          =<it might be worth a try!>
87   PR         [uh  huh.]
88   P          [you know] i've done the medical thing and that jus
89              screwed me up.
```


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```
 90   PR          [yeah,]
 91   P           [ i   ] mean [  i    ] have gotten nowhere literally.=
 92   PR                     [°yeah,°]
 93   PR          =o[ kay.] okay.
 94   P             [e:rm ] i have (>matter of fact slb slb<) psychiatrist
 95                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                ↑asthma
133   PR          uh huh,
134   P           lupus (vasculitis).
135   PR          [u:h,]
```


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```
136   P           [may ] of may was of two thousand, as erm it was
137               endocardia[tis month,]
138   PR                    [uh    huh,]
139   P           he ended up with kidney cancer. [hhhh]
140   PR                                        [wow!]
141   P           [how bad] is that? [how how ] absurd,=
142   PR          [o  kay.]          [wow  uh,]
143   P           =and he's a p- he's got palsies of ↑kidney
144   PR          uh huh,
145   P           so of course he of course that's why he does not have the
146               good kidney you [know, he end ]ed up (slb slb slb slb)=
147   PR                          [yeah, uh huh.]
148               =okay.
149   P           so anyway, tzt erm our life sucks.
150   PR          [yeah,]
151   P           [ so  ] i mean we do have a lot of uh,
152   PR          [(slb  slb slb slb slb slb) ]
153   P           [we've seen it really great.]
154   P           i pro(h)bably [ go  tta(h) be on ca(h) me  ra,]
155   PR                        [yeah.   he  he he  he  he yeah.]
156   PR          [don't e  ven  worry  a bout it. uh]
157   P           [i  mean we still do have a  lot of] .hh you know i mean
158               no money.
159               i mean we were never wealthy,
160   PR          uh huh. [uh huh.]
161   P                   [but  i] mean we went on vacation,
162   PR          uh huh,
163   P           the kids went [to private schools,]
164   PR                        [uh  huh, uh   huh, ]
165   P           i mean i was a college professor,
166   PR          uh [huh. uh] huh.=
167   P              [i mean]     =you know,
168   PR          okay.
169   P           ((crying)) [life]
170   PR             [ o  ]kay,
171   P           ((crying)) [was not] like this.=
172   PR                     [o  kay,]          =okay,=
173   P           =but i did not have, hh i mean i'm i'm i'm in pai- oh i
174               flipped, i
175   PR          [uh huh,]
176   P           [took a ] wicked dive last week. i have i've had a couple
177               of broken toes [as  we ] see here right now.=
178   PR                         [uh huh.]                    =okay,
179   P           ((tapping foot on floor)) .h i mean .hhh because i cannot,
180               (.) you know,
181   PR          uh huh. [uh huh.]
```


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182 P [.hhh i] am much worse off. i actually did get
183 the day °i shouldn't (slb slb slb) to the camera.°
184 PR uh huh.
185 P .hhh °the guy from mount general?°
186 PR uh [huh.]
187 P [°ag]reed that[the] guy from [(slb] slb slb slb slb)=
188 PR [uh,] [uh,]
189 P =had screwed up the my surgery.°
190 PR okay,=
191 P =you did not hear that. [(slb slb slb)]
192 PR [>yeah yeah yeah<] yeah.
193 P right.
194 PR uh huh.
195 P so anyway [that was my all that was my all summer.]
196 PR [yeah they use (it slb slb on one another),] he
197 he he
198 P from may.
199 PR uh [huh.]
200 P [and] i was in: i ended up with three extra surgeries,
201 PR okay. [all on your] ↑foot=
202 P [because of] =yeah. (slb) infection and
203 PR [yeah, o kay.]
204 P [then we did] thee: [pick line and the:]
205 PR [pick line, uh huh.]
206 P the back of(slb slb) [which i] was with the red mouth,=
207 PR [uh huh.] =uh
208 huh.=
209 P that stimulated nasty feelings and [to ta]lly
210 PR [°uh huh,°]
211 P destroyed my stomach. oh i had g_e_i_d as well yeah.
212 [oh yeah.]
213 PR [o kay.]
214 P i_b_s .hh i mean <u>every</u> like[i said,]
215 PR [°uh huh,°]
216 P so i [don't know,]
217 PR [°uh huh,°]
218 P if it's fat if it's,
219 P the depression [so what]ever nobody's treating me.=
220 PR [uh huh,] =okay.=
221 P =i'm i'm i mean i was a <u>bundle</u>,
222 PR uh huh,
223 P of e[nergy i mean] when i got my masters.=
224 PR [nergy uh huh.] =uh,
225 P i traveled (slb slb slb slb velocity).
226 PR uh huh.
227 P i i graduated with a two year old, a three year old,

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228 PR uh huh,
229 P an eight year old.
230 PR uh huh.
231 P i was gonna set the world on [fire!]
232 PR [uh,] yeah. and
233 eve[rything has changed,]
234 P [as soon as i get] my p_h_d,
235 PR uh huh.
236 P my life went to hell [and i] hand back.=
237 PR [uh huh.] =okay.
238 P i mean [you know] i can there had been life thing,=
239 PR [o kay.] =uh huh,
240 P but also i was gonna tell you, my i had at one point i had
241 my sister in law and my mum in the hospital in ninety
242 three,
243 PR uh huh,
244 P my sister in law was on my cancer victims, erm she was
245 thirty four and of course nobody wanted to deal with
246 >you're the nurse
247 [(slb slb] slb slb)< [now you're] thee:=
248 PR [uh huh.] [uh huh.] =yeah.
249 P position,=
250 PR =yeah,
251 P .hhh everybody [you kno(h)w] you're the o(h)ne=
252 PR [uh huh.] =[uh huh.]
253 P =[they suck]
254 ya out, they suck you dry:!
255 PR uh huh, the phone always rings,
256 P right.
257 PR uh huh,=
258 P =well i was the one that had to be there and i had her in
259 the hospital. (slb) broken (nose) >i was in the fourth
260 year and my mum (slb slb slb slb slb) god bless her (slb)<
261 she had a total (hiss),
262 seven years prior. .hh came out of an (slb slb slb)
263 cancer,
264 PR ↑uh↓uh
265 P so i had the two of them with cancer i had to lea:ve,
266 PR uh huh,=
267 P =and go meet my students for their (slb)
268 PR [uh huh,]
269 P [you know,] you know my sai- once [a gain] separate=
270 PR [uh huh.]
271 P =the head here mind, [you know my mums] had cancer, oh
272 PR [uh huh. uh huh.]
273 P that's, okay you know, just run up the door go meet my

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```
274             students, .hh but
275             two days after that i [started] with anxiety a↑ttacks=
276   PR                              [uh huh.]
277   P         =tzt that's okay,
278   PR        okay. [o kay.]
279   P               [and I ] (slb) under the care °of this shrink.°
280   PR        okay. okay.=
281   P         =i was on a list of meds.
282             (1.8)
283   P         i guess you know
284   PR        uh huh.
285   P         this one,
286   PR        uh huh.
287   P         do you any do you know (psyche↑meds)
288   PR        some of them. uh huh. uh huh.
289   P         at one time,
290   PR        uh huh,
291   P         i was on (.) fifteen hundred of depacode, six hundred of
292   PR        [really?]
293   P         [ to  ca]max, four hundred of [(sara slb)]
294   PR                                      [ of to ca ] ↑max
295   P         sixty of paxol, forty five of (veron veron)
296   PR        uh huh,
297   P         it was bizarre!
298   PR        uh huh. how did [you walk around?]
299   P                         [i  was   up  to,] exactly.=
300   PR        =uh huh. [uh huh.]
301   P                  [i went] to (slb)
302   PR        uh huh. [uh,]
303   P                 [°I ] was (slb slb)°
304   PR        yeah, [yeah,]
305   P               [ ha  ]
306   PR        yeah, uh [huh.]
307   P                  [<i  ] lost five °years of my life!°>
308   PR        uh huh. [uh  huh.]
309   P                 [i weigh]ed eleven hundred and twenty pounds,
310   PR        okay.
311   P         i was a model, [he ↓llo] ↑oh
312   PR                       [uh huh. ] uh huh.
313   P         i was a dancer,
314   PR        uh huh.=
315   P         =i lost my life.
316   PR        [o  kay. °o kay.°]
317   P         [a  year ago may ] i got wicked sick. a really bad flu,
318   PR        uh huh. uh huh.
319             (1.1)
```


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320 P o:h, hello [world!]
321 PR [uh,] uh huh.
322 P i stopped taking the meds,
323 PR okay.
324 P obviously!
325 PR uh huh,
326 P dropped a ↑hundred ↓pound
327 PR uh huh,
328 P but <u>now</u> i'm frustrated as i get out trying to get my life
329 back.
330 PR uh huh.
331 P tzt a:nd er in the meantime all these other things
332 PR uh huh,
333 P have [appeared.]
334 PR [cropped up.]
335 P so and so i'm now i'm forty eight .hhh and wonder do i
336 really have p_m_d_d,
337 PR uh huh,
338 P tzt o:r it is just a byproduct of
339 [everything that ha] ppened.
340 PR [everything uh huh.]
341 P [you know?]
342 PR [o kay.]
343 P so .hhhh ((pointing at PR)) [<u>you</u> have qui]te,
344 PR [uh huh, uh,]
345 P [hhh hhhh ha]
346 PR [quite i know you're] the typi[cal pa- pa]tient=
347 P [ha ha ha]
348 PR =that comes in [to] see naturopaths [yeah.]
349 P [ha] [ha] ha ha ha ha ha
350 ha
351 PR [tzt] we no you have [this er] you know,=
352 P [ha] [.hhh ha]
353 PR =array [of of com]plaints and different things .hhh=
354 P [.hhh ha hh]
355 PR =normally what we try to do: (well) sometimes we do is
356 start with the most pressing to <u>you</u> that will improve your
357 quality of life .h
358 P [hhh]
359 PR [and] then start to address some of these deeper issues
360 here (.) tzt what's erm? (.) what do you think is the most
361 pressing right now?
362 P well probab- i think i'd pull both now i don't know if
363 there is (.) if it is the mercury [fillings] we can fix=
364 PR [uh huh,]
365 P the neuropathy if the neuropathy is due to a back thing=

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```
366   PR          =uh huh,=
367   P           =then i- we you can't.
368   PR          okay. o[kay.]
369   P                  [.hh ] erm it's the depression [i can't] take the=
370   PR                                                [o  kay.]
371   P           =depression [you know,]
372   PR                      [o   kay. ]
373   P           erm [this is   not] fun.
374   PR              [when when did]
375               (.)
376   PR          when did most of the symptoms (.) begin? let's start with
377   the
378               depression a:nd thee: low back.
379   P           .hhh
380   PR          no let's start [with] the low back. [°the  neuropathy°.]
381   P                          [well]               [well low low back,]
382               erm at twenty one when i was (nurse) four months and i did
383               erm rupture a disc.
384               (0.9)
385   P           but [would] not do surgery.=
386   PR              [ uh, ]                =uh huh.
387   P           and spent two years of bilateral (biotica), (.) but with
388               exercise.
389   PR          [uh  huh.]
390   P           [and dead] rest got better. [they wan]ted=
391   PR                                      [uh  huh,]
392   P           =to do surgery but i said
393   PR          uh [huh,]
394   P              [ no ] we're not doing surgery i'm only twenty one.
395   PR          when you were twenty one, were you still dancing at that
396               ↑time
397   P           uh uh. huh [oh er  i   was ] still dancing.
398   PR                     [o kay. what ty-]
399   P           [i    was still danc   ing.]
400   PR          [what type of   dance were ] you doing?
401   P           oh! oh ballet, tap,
402   PR          okay,
403   P           everything.
404   PR          okay.
405   P           yes we're not dancing right ↓now
406   PR          [o kay.]
407   P           [ha hhh] (slb slb slb slb ↓slb)
408   PR          okay e:rm when the back pain began, was it radiating back
409               pain or
410               was it,=
411   P           =o:h yeah. bilateral.
```


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412 PR bilateral.
413 P oh yeah.=
414 PR =uh huh.=
415 P =it was bad uh huh.
416 (1.7)
417 P tzt had the (milogram),
418 PR uh huh.
419 P and i was sick i was allergic to the dye.
420 PR uh huh.
421 P developed a re(slb)dya↑dis
422 PR okay.
423 P oh it was a bad scene,
424 PR how fa- how far down did the: erm pain radiate,
425 P in my feet.
426 PR on your feet,
427 P [uh huh.]
428 PR [uh huh.]
429 ((PR writing on P's file)) (2.4)
430 P down in my buttocks [and in] to my feet.=
431 PR [o kay.]
432 P =.hh and at different times it would depend you know
433 [which:]
434 PR [uh huh.]
435 P which leg.
436 PR sharp shooting,
437 P sharp shooting.
438 PR uh huh.
439 P but that was <u>then</u>.
440 PR uh huh.=
441 P =and over time i mean it it chan- you know,
442 PR [uh huh.]
443 P [i- i-] i got rid of it.=
444 PR =uh huh. [uh huh.]
445 P [a ma]zingly.
446 PR [o kay. o kay.]
447 P [i mean through li]ke i said dead rest. [you know]
448 PR [uh huh.]
449 P exercise,.hhh like as i sit here now, right now [now i've]
450 PR [uh huh,]
451 P got this left thing going into my (.) buttocks,
452 PR o[kay.]
453 P [th-] that happens to me today. i [mean it] depends on
454 PR [uh huh,]
455 P the day. it depends on what i've done. [you know]
456 PR [o kay.]
457 P what i mean, [.hhh but]

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458 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 rea]lly 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.

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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.]
=yeah. [uh huh.]
P [you know,]
PR uh huh. [°uh huh.°]
P [so i've] been beating up my body for long time.
PR [uh huh. okay.]
P [so i do have] i definitely and when they i did have the two shoulder, i mean we did fifteen like different things [you know,]
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 <u>see</u> 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 celluli↑tis
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

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```
550              [in sur ]gery,=
551   PR         [uh huh.]     =[uh  huh.]
552   P                        =[and the ] guy said oh well, we'll be doing
553              an ex ray to see how far down we have to amputate.
554              [and was] (slb slb)
555   PR         [o  kay,]
556              (1.2)
557   PR         o[kay.]
558   P           [oh, ] okay instead of going,
559   PR         uh [huh.]
560   P             [ no. ] ho ho well,
561   PR         [uh   huh.]
562   P          [i thought] it was (slb slb) the point
563   PR         uh huh. [uh huh.]
564   P                  [losing] the toe was a (drag).
565   PR         yeah. [yeah. yeah.]
566   P                [.hhh  but  ] i didn't understand i m- i did
567              maternity,
568   PR         [ uh huh,]
569   P          [when peo]ple when you're a nurse you know when you're a
570              cardiolo↑gist
571   PR         uh huh,
572   P          they expect you that you just do cardiology.
573   PR         uh huh.=
574   P          =when you're nurse i've been doing maternity for [twenty ]
575   PR                                                          [uh huh,]
576   P          five years i don't remember anything about (slb slb)!
577   PR         [yeah. yeah.]
578   P          [ i   don't ] know [ that  ] when you lose this toe,
579   PR                            [°yeah,°]
580   P          then you screw [up   the  rest  of  your foot!  some ]
581   PR                        [yeah yeah yeah. yeah yeah, your gait.]
582   P          body should have said hello::!=
583   PR         =yeah, (your gait has [pro  bably  changed.]
584   P                                [this is go  nna  ha]ppen to you,
585   PR         uh [huh,]
586   P             [ so ] that's what has happened [the rest] of my toes,
587   PR                                            [uh  huh,]
588              ((knocks at the door))
589   P          you [know, er ]
590   PR             [come  in!]
591   P          you know bent and collapsed and became (clotted).
592   PR         [he  llo. ]
593   SD         [hi there!]
594   P          [hi.]
595   PR         [hi ] this is doctor kenneth.
```


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596 SD doctor kenneth.
597 P hi, (.) oh you want to join ↑us
598 SD no i'm just coming in to say [hi.]
599 PR [uh,]
600 P oh hi!
601 SD i'm gonna be signing off the papers with the answer.=
602 PR =yeah. [ha ha]
603 P [oh, o]kay. oh [you're a real doctor!]
604 SD [(slb slb slb slb slb]
605 [yeah great! (slb)]
606 PR [u:h uh huh]
607 SD [(slb slb slb slb slb slb)]
608 P [o kay well, we ne ver] know,
609 PR [he he] [he he he he] [he]
610 P [o kay.] [hhh ha ha hhh] [er]
611 SD [ha ha] [ha]
612 P i've been to [the] (slb slb slb) and they tell you five
613 PR [ha]
614 P times they're the real doctors.
615 SD yeah.=
616 P =and then when the (slb) have all screwed up [they've] all
617 PR [u:h,]
618 P lied.
619 SD [yeah,]
620 PR [uh,]
621 P and then [at the end,]
622 SD [and then the] real doctor,
623 P the real like that [like li(hh)ke like an]
624 PR [he he he he he]
625 SD [ha ha ha ha]
626 P [like an e_]m_g=
627 SD [(slb slb slb)]
628 PR =huh
629 P you do (slb slb slb)
630 SD [right.]
631 P [be]cause they've all screwed up [a ny]thing and:=
632 PR [uh huh,]
633 SD =i get [it. i get it.]
634 P [he ha ha ha] ha ha ha ha ha [ha]
635 SD [(slb] slb slb)
636 while taking
637 care of [(our san tos here, or slb slb)]
638 P [yes. he's ve ry, he's ve ry] sym- not exac-
639 can i ask you if
640 PR [uh huh.]
641 P [you don't] mind, how (slb slb) a name like santos,

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642 PR yeah my [fa- yeah] my [fa]ther is d- erm is from the
643 P [stuy ve] [↓sand]
644 PR Dominican republic.
645 (1.5)
646 PR but our family is a (unique) family. our family was one of
647 the group of exile african americans who left here.=
648 P =coz i'm irish.
649 PR oh really? [yeah yeah stuyve]sand yeah.=
650 P [stuy ve- yeah] =ha [ha ha]
651 PR [and who]
652 actually left here in you know, during the slave period
653 and then went to settle in a place called (slb slb) island
654 in the dominican republic. and started .hh with: a number
655 of other i guess you wanna call 'em exiles or escape
656 slaves, and went to the dominica republic and up until the
657 dictatorship still spoke english until they (slb slb slb).
658 P hha!=
659 PR =so yeah,
660 P [wow,]
661 PR [so,] uh huh.
662 P uh, now he's very, he's very nice thank you [ve ry]
663 PR [°uh huh,°]
664 P much.
665 [°uh] huh,°=
666 SD [yeah.] =[(slb slb slb)]
667 P =[i i i] hope you gonna fix me.
668 PR °uh huh.°
669 P yeah we've been through a lot,
670 SD [yeah,]
671 PR [u:h,][so so there's]
672 P [at my ten]der forty eight ye(h)a [ha]
673 SD [yeah,]
674 PR [yes]
675 P [ha ha ha]
676 PR [there's a er]
677 P [ha ha ha ha ha ha ha ha ha]
678 PR [mirage of all kind of different sym]ptoms here, so,
679 P yeah [we] don't know what's wrong with me, [but then]
680 PR [erm] [we were]
681 P well as he said that i'm a typical patient [that shows]
682 PR [uh huh.]
683 P up here.=
684 PR =uh.=
685 P =until the doctor who's been screwing this way show
686 [up]
687 SD [yeah.]

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688 P [(h)here,]
689 SD [this] is a high high
690 [yeah. a high] [com ple] [xity.] [more more]
691 P [ha ha ha] [ha ha] [ha ha] [ha ha]
692 PR [uh huh.] [uh huh.]
693 P [ha ha ha ha hhh]
694 SD [me di cal problems,]
695 PR uh huh. uh ↑huh
696 P .hhh [yeah,]
697 SD [but] still ↑smi↓ling
698 PR yeah. [ha]
699 P [yeah.]
700 PR ha [hu hu]
701 SD [(slb slb] slb slb slb slb for it)
702 PR [uh huh]
703 P [yeah by] i know i al- i always smile no matter what.
704 [you got]
705 SD [o kay.]
706 P a laugh or cry [↑right]
707 SD [that's] right, ha ha ha=
708 P =i ↓know
709 SD also the way it works is he's gonna just wri- do do your
710 history, which i guess is already
711 [obvious]ly in progress,[and then]
712 PR [uh huh.] [uh huh.]
713 P [uh huh.]
714 SD we he'll probably step out (.) and we'll have a chat
715 about,
716 [what the the you]
717 P [you're go nna talk] about me [be hind my] ↑back=
718 SD [have found out,]
719 =talk about you if i mean,
720 PR yeah. he he [he he he he he he he] .hhh hu=
721 SD [(slb slb slb slb slb slb slb)] =(slb
722 slb slb slb slb slb slb)
723 PR [hu hu hu hu]
724 P [ha ha ha ha] [ha]
725 SD [uh?] maybe you you can do a problem focus.
726 PR [yeah,]
727 SD [be]fore a more general physical exam [depend]ing on
728 PR [uh huh,]
729 SD what the you know the issues at play are
730 [(i don't know),]
731 PR [yeah we haven't] really
732 determined like where we're we're trying to come over with
733 the chief complaint here. [which]

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734 SD [yeah,]
735 PR would be the low back a:nd depression.
736 P [yeah] i think,=
737 PR [yeah,] =yeah.
738 P [pro ba bly.]
739 SD [it sounds to] me like this is gonna be just from what i
740 saw there, from the .hh er f- from your description there
741 it's gonna be a question of sort of not what to do, but
742 where to begin.
743 PR uh huh.
744 P ah hah. [ye.]
745 SD [that] sounds=
746 P =yeah. [uh huh.]
747 PR [yeah.uh] [huh.]
748 SD [right] okay.
749 w- i think you're trying to figure that out,
750 P [hhh ha ha ha ha ha ha]
751 PR [o kay he yeah. he he he]
752 SD then come and tell me.
753 P [.hhh ha ha ha ha ha ha ha ha ha]
754 PR [o kay i'll tell you what i figure out.]
755 P ha ha ha great [thanks!]
756 SD [(slb)] [(slb slb)] [(slb)]
757 PR [o kay.] [uh] [huh.]
758 P [o] [kay.]
759 PR so what i'll do it is so that you know erm i'll get a good
760 history on both the complaints, erm before i get to the
761 general medical history. .hhh so:, (.) tell me a little
762 bit more about the low back in terms of things that make
763 it better, things that make it worse, how much are you
764 having erm that pain right now?
765 P well i can't do absolutely nothing.
766 PR o[kay.]
767 P [erm] for example yesterday erm tzt i and my sonnie went
768 to co(hh)ops,
769 PR uh huh.
770 P so i ventured off to the mall for [one full]
771 PR [are you] cold?
772 P erm no. [er i'm ne ver i'm al]ways i'm hot.=
773 PR [°(slb slb such a slb slb)°]
774 P =always hot.
775 PR sorry letizia. (slb slb) tell you [he uh hu]
776 P [ha ha ha] no. so please
777 do go
778 ahead. is is you're right on the ↑ocean [↓the:re]
779 PR [yeah.] yeah

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780 yeah.
781 [it's really nice here.]
782 P [i pulled up the] gulls i (goes) that i said (has
783 got) the
784 i thought i'm in the right [spot.]
785 PR [hu] hu hu
786 P i'm an ocean freak. if my mother was pregnant on the ocean
787 [or some]thing, i'm from [(the slb] slb) lake actually.=
788 PR [ah ha,] [uh huh.]
789 =(slb slb)
790 lake:,=
791 P =canada.
792 PR canada [oh] okay. [o]kay.=
793 P [yeah,] [yeah,] =i'm (slb slb slb) on
794 (l_a)
795 but [i mean i was] born i was born there.=
796 PR [o kay. okay.] =uh huh.
797 P so i get this affinity to the water [and the]
798 PR [o kay.]
799 P ocean which i have no idea why. so i can just only do it
800 from must be prena(h)atal,
801 PR [o kay.]
802 P [(all of)] our guys are lifeguards some instructor. i
803 mean you know real er i mean cross (slb slb slb) i mean so
804 this is killing ↓me=
805 PR =uh huh. uh huh.=
806 P =it's my er er ted's he [he's] rather °he's rather been
807 PR [uh,]
808 P (half),° [ha ha he] does not he does not [under]stand
809 PR [okay. huh.] [uh huh.]
810 P that. <this for me is like,>
811 (5.6)
812 P a (slb slb slb)
813 PR uh huh. uh huh. uh huh uh huh. (.) okay. [okay.]
814 P [never]mind my
815 looks.
816 PR uh huh. [uh huh.]
817 P [ne veh]mi(h)n(hh) [coz peo]ple treat you
818 PR [uh huh,]
819 P horribly when you look bad.=
820 PR =tzt
821 [they they just, well i don't think you look bad but,]
822 P [and that i don't really be n lieve (slb slb slb)]
823 PR yeah that's true.=
824 P =very good.=
825 PR uh huh. uh [huh.]

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826 P [.hhh] but that
827 (1.6)
828 P i ca- i mean i had the surgery.
829 PR uh huh.
830 P well i spent the last year really depressed while having
831 lost nine years of my life. [hhh ha]
832 PR [uh huh,]
833 P and okay how do we get it back together, so may i said
834 well one thing,
835 PR [uh huh. uh huh.]
836 P [i can do is] of course the collapse of the toes like
837 if you know,[well i did know.]
838 PR [uh huh. uh huh.] uh huh.
839 P so i said well, we'll have my toes straighten[ed.]
840 PR [o]
841 kay.[okay.]
842 P [coz i]could
843 still i could still wear [a pair] of shoes for an hour
844 PR [uh huh.]
845 P and do an aerobics slot.
846 PR uh huh.
847 P wearing up for aerobics i'm still tough [for ae]robics.=
848 PR [uh huh.]
849 =uh huh.=
850 P =like a still wear er this pair of shoes, i'd gained
851 (a lot of weight [by the way) ag ain i]
852 PR [uh huh. uh huh. uh huh.]
853 P lost a lot >i gained again over the summer i [was on]
854 PR [uh huh.]
855 P a wheelchair the whole but i told you,< .hhh so i could
856 still wear shoes. now i can't wear shoes at all. [again]
857 PR [okay.]
858 okay.=
859 P =so he said he, they probably tore like i mean by m- er er
860 cut a (slb) by mistake,
861 PR uh huh,
862 P on the toe [by (slb slb slb) out.]
863 PR [(on slb slb) uh huh.]
864 P this toe's obviously going that way, [not going] that
865 PR [uh huh.]
866 P way, .hh it was yeah. this (decision) was bad.
867 PR [uh huh.]
868 P [anyway] but tzt he does not understand that for me this
869 is devastating and i know i'm tough. right,
870 PR uh huh.
871 P so i'm supposed to go,

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872 PR uh [huh.]
873 P [tzt] lucky me i still have a head!
874 PR uh huh. uh [huh. uh]huh.=
875 P [you know,] =well i'm sorry hh i'm not happy
876 enough,
877 PR [i know. i know i know.]
878 P [to say lucky me i] have a head, i mean i h- i was
879 hoping to wear on a pair of shoes and((croaky voice))
880 [take a] walk.=
881 PR [uh huh.] =uh huh.
882 P take a hike, (.) ((crying)) ride a bike with my kids
883 [you ↑know]
884 PR [uh huh,]
885 uh huh, uh huh,
886 P and erm
887 (0.9)
888 P .hhh that's me more depressed.
889 PR okay, [o kay.]
890 P [you know] we've really turned out really bad
891 spending four months in a freaking wheelchair at my
892 parents' house,
893 PR uh huh.
894 P and i was on all of the antibiotics all freaking summer,
895 PR uh huh,
896 P beep beep beep beep, my mother had a stroke while i was
897 there, [hhh ha i mean]
898 PR [o kay. o kay.]
899 P you know just keeps going more interesting [↑yeah]
900 PR [°o]kay.°
901 P erm tzt i'm so depressed that i want to die.
902 PR [°o kay,°]
903 P [and that's] not me.
904 PR okay. o[kay.]
905 P [i] was a very big lover of life,
906 PR uh huh.
907 P a:nd
908 (1.4)
909 P i feel so full like i really have a lot to give.
910 PR uh huh.
911 P and it’s a very big piece of me that doesn't wanna live
912 like this.
913 PR yeah, well we're gonna see if we can help you then.
914 (.)
915 P you know,
916 PR yeah,
917 P a:nd erm

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(1.8)
P °(to live like this),° i'd rather be dead.
PR okay well, you have something to live for. coz
(1.4)
PR my patients need to live.
(1.0)
PR alright? don't worry. we will see what we can do for you.
P tzt so anyway and i was (slb) a heavy (slb) that's true.
PR okay. okay.
(2.5)
PR tzt ↓well
(1.2)
PR we'll keep going and then see what we can come up with,(.)
o[kay?]
P [.hhh]
as far as the back you know like like [i said,]
PR [uh huh,]
P yesterday[i went]into the store and i wasn't even
PR [uh huh,]
P (slb slb) out.=
PR =uh huh,=
P =((pointing at flip flops)) coz i'm wearing these.
PR uh huh.
P i mean these have no support.
PR uh huh. [uh huh. (slb slb slb slb slb)]
P [you know, so and i'm kind of] shuffling
alo:ng,
PR o[kay.]
P [and] then,
PR are you using [or]thotics of of any type[or,]
P [s-] [but]i can't wear
shoes,=
PR you can't wear shoe at all,
P right. hhh ha and [so,]
PR [uh,] uh,
P right so, i'm like [i said,]
PR [o kay.]
P i'm more screwed than i was before because before
[at least]
PR [uh huh,]
P i could have gone to one of them [u gly hhh ha]
PR [uh huh uh huh]
P deep [shoes,]
PR [uh] huh.
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

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964 orthotic,
965 PR okay.
966 P you [know?]
967 PR [o]kay. [.hh]
968 P [like] i do have a like a lot of
969 diffe↑rent=
970 PR =uh huh. uh huh.
971 P too [which of course isn't go nna] help you.=
972 PR [o kay. o kay. uh huh.] =uh huh.
973 [uh huh.]
974 P [you know] in the left leg, .hh but erm i was you know
975 hoping to wear er normal shoes and i (slb) two thousand
976 dollars to have a pair of custom made s(hhh)oe(hh)s which
977 i ca(h)an't a(h)fford, .hhh=
978 PR =tell me,=
979 P =so,=
980 PR =w- what meds you're on right now?
981 P erm
982 (.)
983 PR and how long you've been on them,
984 P well i'm supposed to be on, i'm on what's that (protonix)
985 which doesn't work. i've real i used to be when we when my
986 husband (slb) we used to pay twelve hundred bucks a month
987 for our insurance. ((sniffs)) and i used to be on:, oh god
988 i'm sorry we don't (eat) seriously.
989 PR uh huh.=
990 P =no glucose for the brain.
991 PR i know [i got it right now.]
992 P [i can't think and that] that's really [bad.]
993 PR [uh,]
994 P no you're still thinking. [i can't.]
995 PR [hu hu]
996 P (what slb slb) is that really good i had g_r_d i only
997 think i have (slb slb slb) that down,
998 PR uh huh. [o kay.]
999 P [i hhh] ha ha ha [ha ha ha ha]
1000 PR [now when you want] you have
1001 i_b_s fibromyalgia,
1002 P [uh huh,]
1003 PR [arthri]tis these are these all diag- diagnosed
1004 condi[tions,]
1005 P [y-]
1006 PR [or you feel like,]
1007 P [oh i didn't make] no. i
1008 [didn't make them up. no these've]
1009 PR [or you feel like you're o kay,]

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1010 P been diagnosed. these are all diagnosed.
1011 PR okay.
1012 P like er [by (slb slb slb slb)]
1013 PR [by ga stro en te]rologists, or just g_[ps]
1014 P [b-]by
1015 no. gastroenterolo-
1016 [i've been] to the gastro- oh yeah! am i,=
1017 PR [uh huh.]
1018 P =er gastroenterolog[ists.]
1019 PR [uh] huh.
1020 P neurologist,
1021 PR uh huh.
1022 P oh i've been tha- i've been to all of the [freaking]
1023 PR [o kay.]
1024 P specialists that gotta break (in [my wo]man)yeah. [so,]
1025 PR [o kay.] [o]
1026 kay. so here you you're on:,
1027 P .hhh
1028 PR what else?
1029 P pro(h)- ka(hh)y (protonix). hhh [e:rm]
1030 PR [uh huh.]
1031 (1.6)
1032 PR (sele↑xus)=
1033 P =leverprox,
1034 PR uh huh.
1035 P (slb slb slb slb slb selexus) i began prozac i think it
1036 works better. i left [(se le]xus) and then i went back to
1037 PR [uh huh,]
1038 P this prozac. erm hhh (slb slb slb slb slb) would've been a
1039 lot [better]
1040 PR [uh huh.]
1041 P actually.=
1042 PR =uh huh.
1043 P but erm
1044 PR topomax are you still on ↑that
1045 P on the ↑what
1046 PR topomac erm
1047 P yeah.
1048 PR uh huh.
1049 P oh welbutrion.
1050 PR uh huh.
1051 (3.0)
1052 P tzt i was on neurontin.
1053 PR okay.
1054 P and (slb slb slb slb) ha ha [ha ha] (slb slb slb) i (slb)
1055 a lot

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1056 PR [uh huh]
1057 P [every]thing now needs prior approval.
1058 PR [okay.]
1059 P (slb slb slb slb [on the]
1060 PR [uh huh.]
1061 P label prior slb slb slb) even neurontin. .hhh [neurontin,]
1062 PR [yeah, only]
1063 give on- only give the ones that you're on [now.]
1064 P [why]drugs
1065 [get] every, yeah.=
1066 PR [yeah,] =uh huh,
1067 P erm the:: topomax welbutrion,
1068 (1.9)
1069 P selexus but going [back to]
1070 PR [uh huh.]
1071 (0.8)
1072 P prozac,
1073 (0.9)
1074 P erm
1075 (2.8)
1076 PR what about supplements?
1077 (0.6)
1078 P .hhh i used to take tons and tons of supplements
1079 [(slb slb).]
1080 PR [uh huh.]
1081 P (slb slb) any .hh for now i take just: (.) a multivitamin.
1082 PR uh huh.
1083 P vitamin e: erm a b complex.
1084 (1.3)
1085 PR uh huh,
1086 (1.8)
1087 PR okay.
1088 P it's about it.
1089 PR .hhh erm
1090 (1.0)
1091 PR tell me what you're eating. (.) again start with the
1092 morning. let's just do a like a twenty four hour recall.
1093 P °(slb slb slb slb my food and health) [that's bad]
1094 PR [°uh huh.°]
1095 P thing.°=
1096 PR =uh what do you start up the morning with, do you eat?=
1097 P =well i had i used to have a (slb slb) protein and (slb
1098 slb think)
1099 PR uh huh. [what a bout now,]
1100 P [tzt and they just] but i don't seem to
1101 tolerate that

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1102 any more.
1103 PR uh huh.
1104 P tzt so:: i might have erm maybe cereal and milk,
1105 PR uh huh.
1106 P and juice.
1107 (2.2)
1108 PR what type of juice?
1109 P tzt orange juice.
1110 PR orange, okay. .hh but any snack between that and lunch?
1111 (2.9)
1112 P tzt maybe, maybe not. depending on what's in the house.
1113 PR okay. °okay° what about lunch?
1114 (1.6)
1115 P erm
1116 PR no matter how bad it is you can tell.
1117 P hhh [ha]
1118 PR [no] matter.
1119 P ha [ha ha ha ha ha ha]
1120 PR [coz you know, people you] know they come back,
1121 P .hhh
1122 PR i give them a diet diary and they come back with you know
1123 salads, juice,
1124 P oh no. [no] no actually [i can't] to- sa-i lost [i]
1125 PR [uh,] [(slb slb)] [uh,]
1126 P can't tolerate the i_b_s dep- i never know what i can and
1127 what i can't,
1128 PR uh huh. uh huh.
1129 P you know,
1130 PR i assume you're not doing too well with dairy.
1131 P oh no!
1132 PR uh huh,
1133 P no forget [dai ry.] i'm in the bathroom [in five]
1134 PR [uh huh.] [uh huh.]
1135 P minutes. no erm and with the: lact↑ase
1136 [or la-] whatever that is that=
1137 PR [uh huh.]
1138 P =you take, no forget dairy. erm
1139 PR so just give me a typical lunch. u:h,
1140 (.)
1141 P again depends on how much time i'm [running,]
1142 PR [uh huh.]
1143 P if i'm a buck for a buck you can get a [double]
1144 PR [uh huh,]
1145 P cheeseburger,=
1146 PR =uh huh. uh huh.
1147 P which is <u>really</u> good food.

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1148 PR uh huh. [uh huh.]
1149 P [e:rm]
1150 (1.5)
1151 P if (slb) my (slb slb) had the time i'd have [a sa]lad.
1152 PR [uh huh.]
1153 P with chicken [and eggs.]
1154 PR [uh huh.]
1155 P and i lo- i love eggs. [love e]ggs.=
1156 PR [o kay.]
1157 P =which so if [i'm home,] i pro-=
1158 PR [uh huh,]
1159 P =i might have a couple of fried eggs .h erm which i just
1160 (for a tap one pound a bags) for you and then everything
1161 but anyway erm (.) i don't i don't eat well. we don't have
1162 enough fruits and vegetables in the house. i do not get my
1163 fiber fruits and vegetables.
1164 PR uh huh.
1165 P er though this morning i've had orange juice and [a pear.]
1166 PR [uh huh.]
1167 uh huh.=
1168 P =i brought it with me. i do drink a lot of water,
1169 PR uh huh.
1170 P it's free. [uh hhh]
1171 PR [uh huh.]
1172 (0.8)
1173 PR it's called the city gin. [ha ha yeah.]
1174 P [er oh we] have a well,
1175 PR yeah, yeah. good good. good.[very] good.=
1176 P [.hhh] =but then again
1177 [i haven't]
1178 PR [uh huh.]
1179 P had it tested [so, hhh] (h)i do(h)n't know [if] i(h)t's
1180 PR [uh huh.] [hu.]
1181 P good [or]not. .hhh=
1182 PR [hu,] =what about dinner?
1183 P erm (1.5) we might have my husband made me balls last
1184 night so i had two meat balls.
1185 PR any veggies in ↑there
1186 P ((shaking head)) uh uh.
1187 PR ↓no
1188 P i didn't have we don't have any vegetables. we don't have
1189 any in the house. .hhh [and i]
1190 PR [and a]ny ↑starches
1191 P i didn't want any pasta. i hate pasta.
1192 PR uh huh,
1193 P i'm sick of it. it's all we ever had [i'm,]

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1194 PR [uh,]
1195 P sick of pasta. .hh (.) >pasta pasta pasta pasta,< i'm so
1196 sick of pasta. i'm sick of potatoes coz we have
1197 [po ta]toes also, er .hh
1198 PR [uh huh.]
1199 P we we i mean we literally we have no freaking money.
1200 PR okay, [o kay. uh huh,]
1201 P [it's it's it zzz] sucks so ba[(h)a(h)d!]
1202 PR [o kay.]
1203 P and it costs a lot of money to eat well,
1204 PR it it can. but i can show you how.
1205 P [i mean] you can [freaking,]
1206 PR [so yeah.] [uh huh.]
1207 P you know maca[ro]ni cheese is three bucks a pack.=
1208 PR [yeah,] =yeah
1209 i'll show you how.=
1210 P =you know,
1211 PR i'll show you how. what[a]bout tobacco use,=
1212 P [so,] =oh no. no
1213 [smo]ke.=
1214 PR =[↑no]
1215 =.hhh
1216 P [once.]
1217 PR [i] uh [huh. uh huh.]
1218 P [once when i]was sixteen my girlfriend and i
1219 went up town,
1220 PR [o kay.]
1221 P [and a]bout to smoke a cigarette, [and i] let's (feel)
1222 PR [okay.]
1223 P free.=
1224 PR =okay.
1225 P no(h)o. [and]
1226 PR [al]cohol,
1227 P no i don't drink. i should though.
1228 PR caffeine,
1229 P erm er yes sometimes i drink coke.
1230 PR °uh huh,°
1231 P (coco),
1232 PR uh huh.
1233 P [and er i'm] not much of a coffee drinker but for
1234 PR [and erm uh]
1235 P (slb slb slb slb) i will have coffee.
1236 PR okay.=
1237 P =sometimes [so-]
1238 PR [a]ny recreation drugs? marijuana anything
1239 like ↓that

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1240 P no.
1241 PR no?
1242 P never did. but i think i should.
1243 PR hh hu hu hu hu
1244 P i thi(h)nk i'd be be(h)etter off.
1245 PR what about exercise, are you getting ↑any ↓now
1246 P no. no i'm,
1247 PR uh [huh.]
1248 P [e]very day i exercised normally right, now i can't
1249 even go in the pool. er especially with my broken toes
1250 they hurt too much.
1251 (1.6)
1252 P erm normally at least an hour and a half a day
1253 [of ex]ercise.=
1254 PR [uh huh.]
1255 P =which i need badly [for my,]
1256 PR [°uh huh,°]
1257 P mental health as well as my physical health i'm i'm
1258 [pro]bably=
1259 PR [°uh,°]
1260 P =in the poorest shape i've been [in a] long
1261 PR [°okay.°]
1262 P [long time.]
1263 PR [° o kay.°] what about e:rm your sleep, how many hours
1264 are you getting a night,
1265 P ssstt i se- o:h i just started to take (slb slb slb
1266 sterol),
1267 PR uh huh.
1268 P it makes me sleep (slb)[other]wise i i have a hard
1269 PR [uh huh.]
1270 P [i i i had i have a rea lly]
1271 PR [without the me di ca tion how would]you,
1272 P oh i won't sleep ever.
1273 PR uh huh,
1274 P i have a really bad trauma history.
1275 PR okay.
1276 P i had a gun pointed about a year and a half ago,
1277 PR okay.
1278 P by some strange idiot hhh in the neighbourhood (slb slb)
1279 blowing
1280 heads off, i was: (.) i was sexually molested too,
1281 PR okay,
1282 P tzt few times anyway erm we just: we just don't,
1283 (2.4)
1284 P and you're never normal after that you know, (.) hhh ha
1285 [ha ha]

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1286 PR [uh huh.]
1287 P well [i guess] if i ever tell with it, but (.) tzt i had=
1288 PR [uh huh,]
1289 P =never gotten to do with it.
1290 (1.7)
1291 P (they're really) funny.
1292 PR so you're not waking re- rested at all (.) when you wake
1293 up ei[ther,]
1294 P [c-] correct.
1295 PR yeah. tzt okay.
1296 P yeah we're getting really [good bags under] hhhe(h)eyes,=
1297 PR [uh uh. okay.]
1298 P =i'm starting to look forty eight i used to look younger
1299 [than my]
1300 PR [uh huh.]
1301 P age, not any more.
1302 PR i'm gonna ask you some things about your family history,
1303 tzt e:rm are your mother and father [de ceased,]
1304 P [crazy peo]ple,
1305 PR are they deceased?
1306 P no [they're a live.]
1307 PR [erm they're still] living, .hh any history of
1308 cancer, heart disease,
1309 P both thyroid cancer. [and (slb] slb slb) cancer
1310 PR [uh huh.]
1311 (0.8)
1312 P tzt thyroid dad and (slb slb slb) mum. (.) mum had erm
1313 heart attack two years ago. she's been an (slb slb) for
1314 two years.
1315 PR [uh huh.]
1316 P [(but a] stroke in the way) happened and sure enough
1317 she's gonna see the cardiologist next day.[she had] a:
1318 PR [uh huh,]
1319 P stroke the night=
1320 PR =before, okay. okay. dia↑betes
1321 P tzt no grandmum died. t- grandmum had a dull (slb slb) and
1322 died of a pancreatic cancer.
1323 PR okay,
1324 P but
1325 PR any history of any mental, disorders of any type,
1326 (.)
1327 PR diagnosed?
1328 P .hh mum has erm many anxiety break. dad that i would say
1329 is an undiagnosed erm hhh (.) major major depressed.
1330 PR okay.
1331 P my mother, my grandmother i found out [just] recently,=

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1332 PR [uh.,]
1333 P =had had had electroshock therapy [i]
1334 PR [uh,]
1335 P just knew she was always a very mean person.
1336 PR uh huh.
1337 P didn't know why.
1338 PR uh huh.
1339 P >i always knew she went around< with a (slb slb) on her
1340 fa(h)ace.
1341 PR uh huh. uh [huh.]
1342 P [erm] didn't know she was depressed. now i
1343 know [why]
1344 PR [uh]
1345 huh. okay. okay.
1346 P i have two, i have a cousin and an uncle who committed
1347 suicide,
1348 PR uh huh,
1349 P so it's not a big deal committing suicide in my house.
1350 PR okay. what about, do you have brothers and sisters?
1351 P i have one brother.
1352 PR and: [what,]
1353 P [yeah.] his life to grow up in my house you wouldn't
1354 think we
1355 grew up in the same house.
1356 PR okay.
1357 P i we had (slb slb slb slb slb slb slb) [he went]
1358 PR [uh huh,]
1359 P to the air force academy.
1360 PR uh huh. uh huh.
1361 P and: i'm his big sister, ((starts crying))
1362 PR uh huh.
1363 (1.4)
1364 PR u:h,
1365 (3.8)
1366 PR °uh,°
1367 P tzt hhh it was (in australia) his wedding hu
1368 PR °uh.°
1369 P his wife did(n't have room slb slb) hu
1370 PR °uh,°
1371 P i was a hundred and sixteen pounds,
1372 PR uh huh.
1373 P and beautiful but it was my (slb slb slb) lucky. but let
1374 me tell
1375 you i raised much attention than she did.
1376 PR uh [huh.]
1377 P [my] hair was down to here and erm yeah anyway we

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1378              didn't even
1379              go there. hhh
1380              (0.6)
1381   PR         how was his [life?]
1382   P                      [ but ] i obviously erm (1.3) i shielded him,
1383   PR         uh,
1384   P          from life.
1385   PR         [uh huh.]
1386   P          [because] when i start to talk about our childhood (slb
1387              slb ↑slb)
1388   PR         uh huh,
1389   P          you wouldn't think we(h)e grew up in the same house.
1390   PR         uh [huh. okay.]
1391   P             [ha  ha ha ] ha ha
1392   PR         okay.
1393   P          he was he was totally amazing.
1394   PR         uh huh.
1395   P          i grew him alri- so tzt i'm glad he had a good childhood.
1396   PR         uh huh. [how was your relationship with him,]
1397   P                  [i   pa- i    parented my   parents.]
1398   PR         okay. [o kay you were  a   ↑pa rent]
1399   P               [i was  a   pa  rent  since i] was eight years old.
1400              (.)
1401   P          .hh if  wasn't told i was mature .hh five hundred thousand
1402              times,
1403              (.)
1404   P          i wasn't told (slb) so mature i was, .hh when i was nine
1405              [years old,]
1406   PR         [ uh   huh.] uh huh. uh huh.
1407   P          i was precautious puberty [i mean,]
1408   PR                                   [uh huh.]
1409   P          i had breasts in the third grade. who wants breast in the
1410              third grade? when you're in catholic school believe me you
1411              don't want them. .hh you know,
1412              (1.2)
1413   P          so: responsible!
1414   PR         what is your relationship like erm with your (0.7)
1415              ↓brother is
1416              he's still leaving or, [ uh  ] huh.=
1417   P                                [yeah.]     =he's in new jersey
1418              he's[(slb)]
1419   PR             [ uh, ]
1420   P          (slb slb) doing fabu[lously.]
1421   PR                             [o kay. ][any]
1422   P                                       [ro-] rolling in the ↓dough
1423   PR         any any diseases, any sicknesses, (harnesses),
```


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```
1424   P          tzt denial.
1425   PR         denial, hu hu hu hu hu .hhh
1426   P          that's what [the (slb] slb slb)=
1427   PR                        [o  kay. ]         =okay. erm=
1428   P          =doesn't know what it'll imply to be a common man any
1429              more. the guy, with (slb slb middle class) [he ]llo:!=
1430   PR                                                    [uh,]     =uh.
1431   P          ((sniffs)) takes we ha- [er  w- ] takes take having a
1432   PR                                 [uh huh,]
1433   P          one, ((cough)) having that to er takes two hundred and
1434              twenty thousand dollars to erm hhh a year and to erm
1435              retire on [is]
1436   PR                   [uh] huh.
1437   P          tzt mu- much money. hhhh
1438   PR         uh [tell me this]
1439   P             [he   llo ↓ho]
1440   PR         when did you start to first feel that like that depression
1441              was actually part of that was going on in your life? and
1442              that you were feeling depressed,
1443              (0.6)
1444   PR         at what point.
1445              (0.8)
1446   PR         what age?
1447              (3.7)
1448   P          tzt
1449              (1.1)
1450   P          erm not really until i woke up a year (h) ago. ho ho ho ha
1451   PR         okay.
1452   P          .hhh but if i look ↑back=
1453   PR         =uh huh. uh huh.
1454              (3.0)
1455   P          .hh probably i had post partum depression.
1456   PR         uh huh.
1457   P          but i was such an up person!
1458   PR         uh huh.=
1459   P          =that i never recognized ↑it [or   i ] could overcome ↑it=
1460   PR                                      [uh huh.]
1461              =uh huh.
1462   P          you know,
1463   PR         uh huh. uh huh.
1464   P          because i was always so stro:ng,
1465   PR         uh huh.
1466   P          and so positive, (.) so it took a real lot to get me down.
1467   PR         uh huh.
1468              (1.6)
1469   PR         okay.
```


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1470              (3.3)
1471   P          and now i don't have the out[side (stand),]
1472   PR                                    [ uh    huh.  ] yeah.
1473   P          you know the exercise, or the money [or]
1474   PR                                             [o ]kay.
1475   P          you know the massage,
1476   PR         uh [huh.]
1477   P             [ or ] whatever to keep me up.
1478   PR         okay.
1479   P          you know so erm
1480   PR         .hh what about erm (0.5) uh erm are you still? do you
1481              still have
1482              your period or [you know,]
1483   P                        [uh   huh.]
1484   PR         uh huh, erm do you have p_m_s symptoms that are (0.4)
1485              horrific,
1486              ((P takes off her glasses)) (1.7)
1487   PR         yeah. [yeah. yeah o kay.]
1488   P               [ mh   ha   ha ha ] ha ha ha ha ha ha ha ha ha
1489   PR         okay.
1490   P          .hhh well it was erm [ o  ver] about a year and [a half ]
1491   PR                              [uh huh.]                  [uh huh.]
1492   P          ago.[and] erm barbara said what [what day ]
1493   PR             [hhu]                       [ uh  huh.]
1494   P          are you on, .hhh and i did [go  to ]
1495   PR                                    [uh huh,]
1496   P          the psychiatrist and i said to him,
1497   PR         uh [huh.]
1498   P             [ a  ] year ago [in sep ]tember.=
1499   PR                            [uh huh.]
1500   P          =i said erm i think i have p_m_d_d.
1501   PR         uh huh,
1502   P          and he did look at me rolling his eyes back, he's real
1503              freudian fellow you know, he's got (slb slb) last guy
1504              [had]
1505   PR         [ uh] huh. [uh  huh.]
1506   P                     [but  as ]
1507              far i was stuck (slb) i met at a certain place right after
1508              i got the care, .hhh a:nd (.) tzt but i would say the
1509              expression on my face is different.=
1510   PR         =uh huh.=
1511   P          =erm just everything is different and he thought [i   j- ]
1512   PR                                                         [uh huh.]
1513   P          oh,(slb slb slb) they're pretty good on prozac.
1514   PR         okay.
1515   P          erm and he really did believe i had p_m_d_d, coz he didn't
```


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1516 think i suffered from depression for that. but erm
1517 PR tzt well do you have erm (.) bloating during that time, do
1518 you have,
1519 P ((miming big breasts)) oh! pffht
1520 PR okay.
1521 P if like day fifteen,
1522 PR uh,
1523 P boom! i mean [i]d- [i didn't]
1524 PR [uh,] [uh huh.]
1525 P have p_m_s as a ↓kid
1526 PR okay. okay.
1527 P or as a young adult woman.
1528 PR when did it be↓gin
1529 P erm like probably two years ago i'd say.
1530 PR uh huh,
1531 P or we go well like i said when i was all drugged up,
1532 [i didn't]
1533 PR [uh huh,]
1534 P know the difference,
1535 PR uh [huh. okay. o kay.]
1536 P [ts hhh ha ha .hhh] i'll show you before and after
1537 pictures you aren't gonna b-, i could go to °(slb slb slb
1538 slb with a big tour)°
1539 PR °uh huh,° what's the duration of your cycle?
1540 P well it's just the last two months,
1541 PR [uh huh.]
1542 P [that it's] changed dramatically.
1543 PR uh huh.
1544 P and i don't know that's how [(slb slb slb or worse),]
1545 PR [how was it be fore] the
1546 last two months,=
1547 P =i used to have so heavy heavy heavy five (full) days of,
1548 i mean i (slb)
1549 [wearing] a pad [and change] it every [hour or (from)]
1550 PR [uh huh.] [uh huh.] [hour uh huh.]
1551 P wearing a tampon and change it every freaking half hour.
1552 PR okay.
1553 P you know, i mean [un]believable.=
1554 PR [and] =now?
1555 P the last two months was really light. erm and it was every
1556 twenty
1557 eight days on the nose.
1558 PR °uh huh.°
1559 P and it was every twenty five every twenty six days the
1560 last six months say.
1561 (0.8)

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```
1562   P          and the last two months was was really like light so i
1563              (slb) and said wow! is that a ↑period
1564   PR         o[ kay. ]
1565   P           [that's] a lot of cramps.
1566   PR         okay.
1567   P          .h and right sided pain always lower right (quarter). oh i
1568              had (slb slb slb) did i did i forget to mention i have
1569              really bad endometri(h)us.
1570   PR         oka(h)y. hu hu
1571   P          ha ha ha [ha]
1572   PR                  [uh] hu hu
1573   P          .hh i know you must think i'm a hypochondriac,
1574   PR         why the lower quar[ter ↑pain]
1575   P                            [ i   know] yeah.
1576   PR         okay.
1577   P          and that they thought i had erm appendicitis last june or
1578              we- a year ago [june.]
1579   PR                        [ uh, ]what [ a  bout ] your last menstrual
1580   P                                     [(slb slb)]
1581   PR         period? when was ↓that=
1582   P          =erm the thirty first.
1583   PR         uh huh.
1584   P          ha- halloween.
1585   PR         thirty first [of,  er]
1586   P                       [ha .hhh] of October.=
1587   PR         =of october,
1588   P          yeah.=
1589   PR         =okay.
1590              (1.9)
1591   PR         okay .hhh [erm  uh,  uh uh.]
1592   P                    [ so what's today] the twenty ↑first
1593   PR         [yeah.]
1594   P          [  o  ]kay so i'm due in like, (1.3) like what four days
1595              [or so. ]
1596   PR         [uh huh,]
1597   P          yeah. [(slb slb)]
1598   PR               [ what  a ]bout pregnancies, erm [you've had]
1599   P                                                 [  ni::ne. ]
1600   PR         three,=
1601   P          =nine pregnan[cies.]
1602   PR                       [ ni  ]ne pregnancies okay.
1603   P          so sad, i had a tubular that almost killed me,
1604              (1.6)
1605   PR         uh huh.
1606   P          °and five miscarriages.° .hh i had a miscarriage the day
1607              of my graduation from b_u. ((sniffs))
```


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```
1608   PR          okay.=
1609   P           =coz of my masters i didn't [ care,]
1610   PR                                      [°uh?° ]
1611   P           of showing up anywhere if it killed me.
1612   PR          .hh b_u my the (arch rivals and wreckers) yeah. ha
1613   P           are ↑they
1614   PR          yea:h.
1615   P           (we'll see how [the  gra  duate  school) why]
1616   PR                         [ in  foot  ball  yeah  yeah.]
1617   P           did you did you go there? [un  der↑graduate]
1618   PR                                    [yeah i slb slb)]the
1619               undergraduate yeah.
1620   P           ah you ↓did
1621   PR          yeah.
1622   P           see what i c- fou- since i was a graduate student i
1623               [i didn't]
1624   PR          [uh yeah,]
1625   P           [(slb to  get) into that ] stuff.=
1626   PR          [you don't get into that,]
1627   P           =yeah of course. [ i   i ] want to tell you,=
1628   PR                           [uh huh.]
1629   P           =i wanted to cruise so bad,
1630   PR          uh huh,
1631   P           also they let me do cruise [ a ] graduate course at that
1632   PR                                     [uh,]
1633   P           point, my kids were two three [and eight.]
1634   PR                                        [ uh   huh.]
1635   P           by the time i graduated i mean (slb [slb] energy) i had,=
1636   PR                                             [ uh]
1637               =uh huh.
1638   P           i could you know travel and graduate with a two year old,
1639               a three year old, [an eight] year ↓old=
1640   PR                            [uh  huh.]          =[yeah.]
1641   P                                                 =[ you ] know, who
1642               went to school full ↓time .hhh i mean this is=
1643   PR          =uh huh,=
1644   P           =who i used to be.
1645   PR          uh [ huh.]
1646   P              [where] is, °where hhh [where is] that person?°=
1647   PR                                    [uh  huh,]             =yeah,
1648   P           you know [i mean,]
1649   PR                   [tell me] this. did you did you go for any
1650               counseling after the miscarriages?
1651   P           ((shakes head))
1652   PR          no? okay. .h tzt the pregnancy or the births that you did
1653               have, were they vaginal, caesarean,=
```


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```
1654  P     =traumatic ha!
1655  PR    okay.
1656  P     ha ha ha .hh i had a i ended up with all c sections but on
1657        the first one, was one of those (slb slb i started labour
1658        on a) (.) thursday and it was born at [ten to ] twelve ha!
1659  PR                                          [uh huh,]
1660  P     [ha i ] kept pushing for four hours,=
1661  PR    [okay.]                            =okay.
1662  P     an emergency c section yeah.
1663  PR    are you currently on any type of birth control now, ((P
1664        shakes head)) no,
1665  P     no.
1666  PR    okay. .hhh erm
1667        (1.9)
1668  PR    any missing your periods, (.) [at all?]
1669  P                                   [ne ver.]
1670  PR    okay.
1671  P     no. .hh no i got (three boys and i),
1672  PR    any bleeding in between [days,]
1673  P                            [ i'd ] die to have my a girl, no.
1674  PR    okay.
1675  P     no never.
1676        (0.7)
1677  PR    tzt [(slb slb slb)]
1678  P         [  no  but  i ] suppose >[(if you] want me to be
1679  PR                                [uh huh,]
1680  P     honest),i guess i suppose i'd be lu-< i guess i should
1681        consider myself [ lu cky. ]
1682  PR                    [°uh huh,°]
1683  P     right than i hadn't any kids at all.
1684  PR    °uh,° when was your last pap?
1685  P     oh like in may or something,
1686  PR    may? o[kay.]
1687  P           [yeah] i once had one that i suppose was abnormal,
1688        but [that erm] years ago.=
1689  PR        [uh  huh.]           =uh huh.
1690  P     just from probably having had sex.
1691  PR    okay.
1692  P     csss
1693  PR    any sexually transmitted diseases, syphilis, gonorrhea,
1694        s_p_↑v ((P shakes head)) uh huh.
1695  P     i mean i have have had the same sexual part[ner for]
1696  PR                                               [ o kay.]
1697  P     twenty six years, [that's] only [good thing] about (still)
1698  PR                      [  uh, ]      [ uh  huh. ]
1699  P     me(h)e [ting with] a g(h)uy. [ha]
```


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1700 PR [o kay.] [o]kay.
1701 P .hh i don't know how would you go out today,=
1702 PR =today it's very dangerous. very very dangerous.
1703 (.)
1704 PR very very dangerous.
1705 (0.5)
1706 PR very dangerous.
1707 P °very yeah. i'll tell you,°
1708 PR let me ask you this. erm have you: er had a (0.8) tzt
1709 recent blood work?
1710 (2.5)
1711 P well i had in may when i had to,
1712 PR in may? okay. okay any other screening that you've done
1713 for anything, whether be:
1714 P .hh well for example,
1715 PR uh huh,
1716 P when i had my (slb) infection, my temperature was ninety
1717 seven point five.
1718 PR uh huh.
1719 P how normal is that?
1720 PR okay,=
1721 P =no i'm on met- i t- when i did i did go to a holistic
1722 physician years and years ago,
1723 PR [uh huh.]
1724 P [when i] had really good insurance,
1725 PR uh huh,
1726 P and they did pay for it.
1727 PR uh huh.
1728 P and i was on (slb) thyroid.
1729 PR uh [o kay.]
1730 P [because] i was (i'm slb slb slb slb)!
1731 PR uh huh.
1732 P to a normal physician.
1733 PR [uh huh.]
1734 P [but i'm] definitely hypothyroid.
1735 PR uh [huh,]
1736 P [and] i when i was on (slb) thyroid,
1737 PR uh huh,
1738 P i felt fabulous.
1739 PR uh huh.
1740 P that was one thing i'm low [i'm de]finetely=
1741 PR [o kay.]
1742 P =l- low,
1743 (1.0)
1744 P i'm definitely hypothyroidic.
1745 PR okay.

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1746 P yeah i take my temp i'm never but ninety seven
1747 PR uh huh,
1748 P point two.
1749 PR [o kay.]
1750 P [you know] every morning [if i ta]ke it you know,=
1751 PR [uh huh. uh.]
1752 P =but according to a normal physician,
1753 PR uh huh.
1754 P i'm really normal!
1755 PR okay. [o kay.]
1756 P [you know,]so like that's that's another area like i
1757 said, they go by their little super god ↓eyes
1758 PR uh huh,
1759 P and like for example cortisol,
1760 PR uh huh.
1761 P i bet you i'm i bet you i'm (0.8) high at night [and low]
1762 PR [uh huh.]
1763 P in the morning.=
1764 PR =in the morning uh huh.
1765 P which is why i'm wide awake at night, hh
1766 PR uh huh,
1767 P and p(h)oopped out in the morn[ing.]
1768 PR [yeah.] we could actually do
1769 an a_m
1770 P [you know,]
1771 PR [and p_]m cortisol on you. .hh tell me this. any erm
1772 i'm just gonna start from head to toe and ask you some
1773 symptoms. e::rm any history of headaches migraines,
1774 (1.0)
1775 P no. no real headaches no.
1776 PR okay. any injuries to your head?
1777 (1.0)
1778 P it just once.
1779 PR uh huh.
1780 P just once.
1781 PR .hhh erm [what type?]
1782 P [(slb) to] the pool. [hhh]
1783 PR [uh,] okay.
1784 P that's all yeah. no. no.
1785 PR erm what about er well you do wear glasses. what about
1786 P yeah. [(slb slb)]
1787 PR [erm a]ny pain in your eyes, pain behind your
1788 eyes,
1789 P oh my eyes really bugged me this fall because i couldn't
1790 have my allergy medi[cation.]
1791 PR [uh huh.]

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```
1792   P          so i went i w- i was going (slb slb).
1793   PR         uh huh.
1794   P          i was sick for six weeks this fall with like a wicked bad
1795              [si nus]
1796   PR         [uh uh.]
1797   P          type junk you know [going on,]=
1798   PR                            [ uh  huh.]=
1799   P          =i did have like eye infection [(that have)] (slb) my
1800   PR                                        [ uh    huh!]
1801   P          eyes that i had never had my whole life. [not of] a daily
1802   PR                                                  [o kay,]
1803   P          type of thing but anyway and i might try when i did the
1804              clarit- and i did every
1805   PR         (slb slb [slb  slb)]
1806   P                   [.hhh  stu]pid thing
1807   PR         uh [huh.]
1808   P             [ in ] the in thee erm (.) store and not [nothing]
1809   PR                                                    [o  kay.]
1810   P          helped.=
1811   PR         =what about hearing loss, erm (.) nose bleeds, tzt vertigo,
1812   P          no.
1813              (.)
1814   P          no nose bleeds,
1815   PR         sinus problems?
1816   P          erm ((sniffs)) yeah.
1817   PR         yeah.
1818   P          (with er that i was always hacking heavy drip).
1819   PR         what about any change in voice tone,
1820   P          ((sniffs)) n:o. i [think]
1821   PR                           [ ↓no ] .hh tooth problems?
1822              (1.7)
1823   PR         dental problems,
1824   P          i have two (slb) now [but,]
1825   PR                              [ uh ] huh. okay. have you had
1826              in the past [two three years?]
1827   P                      [ i    have  a   ] lot of gum like i to-
1828              tortured my teeth? i'm a s-
1829   PR         uh huh.
1830   P          i was a scrubber.
1831   PR         okay.
1832   P          ha
1833   PR         o[kay. o kay.]
1834   P           [ha   ha ha ] ha ha ha ha [.hh ]
1835   PR                                   [what] about erm
1836   P          i (slb slb [slb] slb)=
1837   PR                    [gk-]     =oh did ↑you
```


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```
1838  P    [yeah.]
1839  PR   [ o   ]kay. what about chest pain, any chest pain
1840       difficulty in breathing, shortness of breath,
1841  P    only when i have like the anxiety type,
1842  PR   uh huh.
1843  P    att↓acks
1844  PR   uh huh.
1845  P    and of course with the g_e_r_d but that's the a different
1846       kind of chest pain.
1847  PR   [uh huh.]
1848  P    [pretty ] much you know [the]
1849  PR                           [ o ]kay.
1850  P    acid reflux [kind of]
1851  PR               [uh huh.]
1852  P    burning yeah. (.) oh yeah. [well i've]
1853  PR                              [ uh huh. ]
1854  P    had a, well when i was hea↓vier
1855  PR   uh huh.
1856  P    i had asthma like i mean like (exercise due type) of
1857       asthma,
1858  PR   o[kay.]
1859  P     [kind] of thing [which short]ness of breath [but]
1860  PR                   [ uh   huh. ]               [ uh] huh.
1861  P    that was when i was trying to exercise too hard close to
1862       that that
1863  PR   okay.
1864  P    i couldn't do,
1865  PR   [okay.]
1866  P    [and i] was d(h)etermined [i would] t(h)rain [a(h)nywa]
1867  PR                             [o kay. ]          [ o kay. ]
1868  P    he he he he he ha [.hhh]
1869  PR                     [what] about erm
1870  P    i was on inhalers for a while,
1871  PR   you're on inhalers? [o kay. ]
1872  P                      [uh huh.]
1873  PR   sputum with ↑that do do you (excrete) sputum or flam,
1874  P    at that point [ when   i]
1875  PR                 [right now] yeah.
1876       (.)
1877  P    .hh well when i had [to  go ] back over [a  month a go, ]
1878  PR                       [uh huh.]           [uh huh. uh huh.]
1879  P    oh yeah. [i was] d- yeah i was [(sniffs twice)]
1880  PR            [okay.]              [  o    kay.   ]
1881  P    ((sniffs)) yeah i did.
1882  PR   okay.
1883  P    but now no. [°(i changed the] slb slb)°
```


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1884 PR [what about erm]
1885 (0.7)
1886 PR tzt well let's talk about your gastrointestinal system.
1887 P oh pfff
1888 PR erm constipation?
1889 (0.7)
1890 P no. usually erm er er pretty much, again er well us- with
1891 many
1892 (slb slb) as i [was saying]
1893 PR [uh huh,]
1894 P i would run the c- the game of an incredible constipation,
1895 PR uh [huh.]
1896 P [to] total diarrhea.
1897 PR [uh huh,]
1898 P [i would] say now,
1899 PR uh huh,
1900 P as a (slb),
1901 PR uh huh.
1902 P i'm pretty much in the diarrhea,
1903 PR o[kay. o kay.]
1904 P [phase pretty] much all the time. .hh it's such a
1905 nuisance that i would go to the bathroom, and i would had
1906 i would still have to go to the bathroom,
1907 PR uh huh,
1908 P and it's totally new stool and i can't go out of the
1909 bathroom. which really doesn't make [much sense.]
1910 PR [o kay.]
1911 P (i mean) still sitting in my co↑lon
1912 PR uh huh. [uh huh.]
1913 P [it's new] stool.
1914 PR okay.
1915 P and i er so i'd go to the bathroom >and then half an hour
1916 later i'm going to the bathroom again, and then half an
1917 hour later i'm going to the bathroom again,< and this is
1918 quite a (slb). but
1919 PR uh [huh.]
1920 P [but] apparently that irritable bowel,
1921 PR uh [huh.]
1922 P [syn]drome [supposedly] i guess. [this is] what they
1923 PR [.hhh] [hhhhh]
1924 P told me.that's what the g_e_i guy said.
1925 PR you do have irr- bowel. what about erm gas and bloating,
1926 P oh [yeah. all that's (slb) but of] course the irritable
1927 PR [uh huh. o kay. uh huh.]
1928 P [bo wel] syndrome [i rri tates] the g_e_[i_]d,
1929 PR [uh huh.] [uh huh yeah.] [yeah.] uh huh.

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```
1930              uh [ huh. ]
1931   P             [right,]
1932   PR         [uh] huh. too good. uh [ huh.]
1933   P          [it]                   [right] it's totally,
1934   PR         .hhh any gall bladder disease [ a   nything,]
1935   P                                        [oh   yes i   ] got a (slb)
1936              loaded gall bladder [full of] stones.=
1937   PR                           [uh huh,]        =uh [huh.]
1938   P                                                [that] didn't
1939              come out which i
1940              they don't wanna cause i'm not having surgery ha but,
1941   PR         [ o kay.]
1942   P          [is that] a bad thing? [ to ]
1943   PR                                [.hhh]
1944   P          be going round with a full gall bladder.=
1945   PR         =yeah it's not good [yeah]
1946   P                              [ oh ] seriously?=
1947   PR         =yeah yeah [i think you will have to definitely.]
1948   P                     [con si  de  ring that it's  surgery ] that
1949              i've been waiting avoiding,
1950   PR         well we'll have to bring that up and you know kind of
1951              look  at what we can do on this and
1952              [to   avoid ] the sur[gery yeah.]
1953   P          [i'm really,]        [yeah i do.]
1954   PR         uh huh.=
1955   P          =yeah i got the ultrasound. they got (slb) away [do you ]
1956   PR                                                         [uh huh.]
1957   P          know your gall bladder is full of stone, and my (slb) i
1958              know oh [i know ] coz i cannot touch a fat! [it's one]
1959   PR                 [uh huh.]                          [ o  kay.]
1960   P          of the things i cannot have like fat foods,
1961   PR         [okay.]
1962   P          [i do ] not eat fat foods by the way.
1963   PR         okay.
1964   P          i will tell you that.
1965   PR         okay.
1966   P          because i cannot. [.hhh hha]
1967   PR         ((croaky voice))  [alright.]
1968   P          so i do not eat fried fat, anything because
1969              if i do i get [sick as] a dog.=
1970   PR                       [uh huh.]       =uh huh. .hhh what what
1971              about er (1.3) tzt any nausea with ↑that
1972              (0.7)
1973   P          oh if i eat fat ↑foods
1974   PR         any with any type,
1975   P          oh yeah. er [like as] i'm sitting right ↑now=
```


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```
1976   PR                      [uh huh.]                        =uh huh.
1977   P           all i've had is a little bit of orange juice and a pear.
1978               [my stomach  is    killing   me. ]
1979   PR          [alright. so you're a little hyp-] okay.=
1980   P           =wicked pains [in my ] stomach [abdo]minal cramping yeah.=
1981   PR                       [o kay.]         [.hhh]
1982               =what
1983               about any kidney problems in the past,
1984   P           no but why (slb slb slb) me with that,
1985   PR          okay. any bladder problems erm getting up at night in the
1986               middle of the night, to urinate many times, or frequency
1987               of urgence,
1988   P           i have had but i retrained my bladder.
1989   PR          uh huh,=
1990   P           =i think it was just coz the:
1991   PR          okay.
1992   P           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,=
1997   PR          =okay.
1998   P           that i think,
1999   PR          okay. er .hh what about erm we talked about arthritis
2000               right? erm
2001               any leg cramp,s that you have like at night or, (slb slb)
2002   P           well as a matter of fact,
2003   PR          uh huh.
2004   P           i was supposed to come last Friday.
2005   PR          uh huh.
2006   P           and thursday a (german from slb slb slb) [my  my ] son by
2007   PR                                                   [uh huh,]
2008   P           the way is going to harvard.
2009   PR          oh good. right[good. uh huh. uh  huh.]
2010   P                        [or  if  he doesn't or ] or or wesley and
2011               we've [just rea]lized it's up the street
2012   PR                 [uh  huh.]
2013   P           [i c(h)ame (slb) fif]teen=
2014   PR          [uh  huh.   uh huh. ]    =uh  huh.
2015   P           .hhh i couldn't i had to call and cancel so,
2016               [this is a  ve  ry rare ]
2017   PR          [uh huh. uh huh. uh huh.]
2018   P           thing for me. i was driving home i (slb he was slb slb slb
2019               slb slb)(slb) [a bout ] three hundred miles and in the
2020   PR                       [uh huh.]
2021   P           middle of driving i was gettin such a bad cramp here in
```


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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.] rare.
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 [(slb slb was)]
2043 PR [wes ley now]is,
2044 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 PR [i]
2049 ↑thought it ↓was [i don't know yeah.]
2050 P [yeah no. it is.] it is. (slb
2051 [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 interesting [people who go yeah.]
2058 P [ha ha ha ha ha]ha .hhh [(yeah slb slb)]
2059 PR [let's see, what]
2060 about: tzt tingling nunb- 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 (.)

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2068 P which i didn't think was hot.
2069 PR uh huh.
2070 P and my husband went and grabbed it and said [ouh!]
2071 PR [uh,]
2072 P and i just grabbed it!
2073 PR okay. [°o kay.°]
2074 P [and did] not (mean)
2075 PR .hhh okay.
2076 P but [i don't]
2077 PR [uh huh.]
2078 P so er so now i'd be interest- [i don't] know. i d- i don't
2079 PR [uh huh.]
2080 P know.
2081 PR [uh huh.]
2082 P [if i'm] getting if i'm sensory, [erm obviou sly my]
2083 PR [uh losing your sen]
2084 siti↑vity
2085 P ((lifting leg)) left [ffff]f(hh)oot [is.]
2086 PR [okay.] [o]kay.
2087 P but erm (.) i d- are you are [i'm are] you aware when
2088 PR [uh huh,]
2089 P you're ↑not=
2090 PR =erm
2091 P i [don't think,]
2092 PR [you may] not be aware [someone else] will be
2093 P [exact ly.]
2094 PR yeah. [uh huh.]
2095 P [so that's] why [i'm saying] i don't know. [i mean,]
2096 PR [uh huh.] [uh huh.]
2097 what about anemias, any history of anemia,
2098 P i was very anemic [from one]
2099 PR [uh huh.]
2100 P time because of (.) bleedings of freaking (month),
2101 PR [o kay.]
2102 P [i mean] i used to bleed every two weeks for a week there
2103 for a long time. ((knocks)) but i think [at this] very
2104 PR [come in!]
2105 P moment i'm not=
2106 PR =come in!
2107 SD2 hi.=
2108 PR =hi.
2109 P hi:!
2110 SD2 (slb [slb)]
2111 PR [he]
2112 P (slb[slb) get] very smiling faces (a[round here slb)]
2113 PR [yeah. yeah.] [yeah, doc tor]

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2114 kenneth already came in because we thought you were
2115 downstairs in the lab,
2116 SD2 [okay.]
2117 PR [so he] he has already come in er alright are you done
2118 with are you down there ↑yet[no,]
2119 SD2 [yeah.]
2120 PR yeah there may be one more coming one of my patients from
2121 the out satellites so,
2122 SD2 okay.
2123 PR alright that's doctor toury [by the way. ha ha]
2124 SD2 [hi. nice to meet you.]
2125 P [hi.how are you, nice]
2126 PR [ha ha] .hhh
2127 P [to meet]you too.
2128 PR °okay.°
2129 SD2 (slb [slb)]
2130 P [yeah.] no do you believe that, that's awful isn't it
2131 okay i forgot that's there.
2132 PR that's [good!]
2133 P [and] coz i wear no make up and look horrible
2134 [so,]
2135 SD2 [no] you don't.=
2136 PR =°alright.°
2137 P ha ha [ha ha ha ha ha ha .hhh]
2138 PR [.hhh hu hu hu hu .hhh hu]
2139 P [next time] i'm coming well prepared let me tell you.=
2140 PR [hhh hhh] =uh
2141 hu hu
2142 ((SD2 leaves))
2143 P (slb slb slb slb slb slb slb slb [slb)]
2144 PR [yeah] he's our newest
2145 resident. actually just started erm=
2146 P =good.
2147 PR .hhh what about er skin stuff like dermatitis, psoriasis
2148 [i mean]
2149 P [oh it]
2150 chy itchy [it chy.]
2151 PR [uh huh.]
2152 P very, cannot wear wool. very very sensitive to: erm (slb
2153 slb slb) products.
2154 PR [uh huh.]
2155 P [i have] to be like really careful with what i
2156 [use for soap.]
2157 PR [uh uh uh,]
2158 P i can't even use soap.
2159 PR uh huh,

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2160 P after like, yeah i'm i'm,
2161 PR okay.
2162 P the detergents:, what's being washed [what i] wear
2163 PR [uh huh.]
2164 P [yeah. er]
2165 PR [uh huh.]
2166 P yeah [i got] (slb slb)=
2167 PR [okay.] =okay.
2168 (0.7)
2169 P always [been like] that.
2170 PR [uh uh.]
2171 (1.4)
2172 PR okay.
2173 (1.3)
2174 PR [o kay.]
2175 P [i love] the ↓sun
2176 PR you like [the ↑sun]
2177 P [but i] know [it's bad] for you,
2178 PR [uh huh.]
2179 (0.5)
2180 P bu-hu=
2181 PR =not all the time [no.]
2182 P [i] know it too but i love it.
2183 PR u:h .hhh okay. [uh,]
2184 P [i]look better with a tan.
2185 PR you look better with a ↑tan=
2186 P =ye hhh yeah. [.hhh i i know]
2187 PR [well you know cer]tainly the sun is
2188 P [do you know,]
2189 PR [really ne]cessary for you,
2190 P ho- do you know, my oh! was an article
2191 about tano[rexics]
2192 PR [uh huh.] uh huh.
2193 P people really. i mean [i'm not that extreme.]
2194 PR [uh huh. uh huh. uh] huh.
2195 P people would in the sun and tan for seven days a week.
2196 PR [uh huh.]
2197 P [and make] a big deal of that when er just like er
2198 PR [uh huh.]
2199 P [an a]norexic [i don't] do that.=
2200 PR [uh huh.] =okay. o[kay.]
2201 P [but] anyway,
2202 PR okay.
2203 P but they do i'd w- well i was like a summer instructor for
2204 years,=
2205 PR =ah o[kay.]

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2206 P [so] i mean [you know] i was out there for ever.=
2207 PR [o kay.]
2208 =okay.
2209 P i i d- i feel energized by the sun.
2210 PR goo- oh, [uh huh. uh huh.]
2211 P [and i got a] beautiful day, i i do
2212 feel frustrated when i can't get outside on a nice day.
2213 (.)
2214 PR ((croaky voice)) [o kay.]
2215 P [i love]it. i love the ocean i love the
2216 beach i belong down south (of the u_s).
2217 PR .hhh
2218 P then again [i]
2219 PR [uh?]
2220 P don't like the i hate the heat heat [i]can't [i do]
2221 PR [yeah,] [uh huh.]
2222 P not tolerate the heat. .hh yet i have a low temp you think
2223 i would
2224 PR [uh huh. uh huh.]
2225 P [would ↑you it doesn't] make sense[at all,]
2226 PR [that doesn't] make
2227 [sense uh huh.]
2228 P [that's backwards] i know.
2229 (3.1)
2230 PR [.hhh]
2231 P [but] the cold hurts my body.
2232 (1.5)
2233 PR tzt .hhh i have erm an idea about which way we're gonna
2234 go.
2235 P okay.=
2236 PR =yeah erm i'm gonna go talk a little bit with doctor
2237 kenneth a:nd and probably gonna come in and then do some
2238 physical exam, i'm not sure exactly which way i wanna go
2239 (in line with that) but .hhh erm i'm thinking about,
2240 actually are you familiar with homeopathy at ↑all
2241 P a little bit.
2242 PR okay. erm
2243 P i was very into er homeopathy, herbs, bach i mean,
2244 PR uh huh.
2245 P and er actually i was asked to er and now i've quitted
2246 that's four
2247 years [a go] so either you use it or lose it.=
2248 PR [uh huh.] =uh huh.
2249 P and my husband thought it was totally [absu:rd!]
2250 PR [°uh huh.°]
2251 P and didn't want me spending wasting my time and money and

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2252 [e ner]gy=
2253 PR [uh huh.]
2254 P =doing that. so erm it's kind of (slb money in) my life
2255 [actual]ly.=
2256 PR [uh huh.]
2257 P =.hhh so er tha(h)t's why i w(h)ant [to] d(h)ump him.=
2258 PR [yeah,]
2259 P =[ha] ha [ha ha]
2260 PR =[yeah.] [because] erm i think you know,
2261 (3.9)
2262 PR i think you would benefit from it. you've given me a lot
2263 actually to: i wouldn't actually have to go too much
2264 further with, normally with homeopathy what we do is we
2265 take an hour hour and a half and we really go in depth but
2266 you've given me a lot already.
2267 [(slb slb) yeah uh huh.]
2268 P [told you that that's quick] (coz),
2269 PR yeah [the yeah.]
2270 P [you know] you don't need to dig [from me baby.]
2271 PR [uh huh. uh huh.]
2272 P no. [ha no.]
2273 PR [i may] not know [i may not] know the remedy right
2274 P [no. ha ha]
2275 PR now, erm
2276 (0.5)
2277 PR tzt you know i have to go and repertoirize the remedy, but
2278 erm i think that may be somewhere we wanna start. and also
2279 with your gastrointestinal health because .hh
2280 gastrointestinal health for us is connected with
2281 autoimmune, (.) arthritis,
2282 P it's true. i'm not [getting] the right,=
2283 PR [e:rm] =irritable bowel,
2284 P o[kay.]
2285 PR [de]pression, thyroi- everything.
2286 P right,
2287 PR for us [you know] for a naturopath liver and and and
2288 P [it's true.]
2289 PR [the gut.]
2290 P [it's true.]
2291 PR are that's it. alright? so that's what i think i'm gonna
2292 start and i'll see what he has to say and so i'll be back
2293 in any couple of minutes and we'll
2294 [talk (tomorrow)]
2295 P [how about de]pression,
2296 PR .hhh very much so.
2297 P really?

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2298 PR yeah it can [be very much]
2299 P [because of] serotonin up[take is not]
2300 PR [er we:ll]
2301 P the:re,you can't get it ↑no:
2302 PR it may be sometimes.
2303 P [pro tein]
2304 PR [food food] sensitivities.
2305 P [uh huh.]
2306 PR [i na]dequate nutrition.
2307 P uh huh.
2308 PR so: and then i think i'd like to really
2309 P [(slb slb)]
2310 PR [know ex]actly what you're eating, .hhh a:nd tzt e:rm
2311 (1.0)
2312 P well last i had (pulses) last friday,
2313 PR okay. okay well i want you to be i want you to have proper
2314 nutrition not to worry about weight right now.
2315 [that yeah,]
2316 P [well no] that
2317 was [from]
2318 PR [uh] huh.
2319 P actually my irritable bowel being so bad.
2320 PR uh huh.
2321 P and i haven't (slb slb slb)
2322 PR okay. okay.
2323 (0.6)
2324 PR i'll take this off so i don't walk down the street with
2325 this.
2326 [ha ha]
2327 P [hhhh]
2328 PR i will be back she may come in i guess to kind and
2329 disconnect you.
2330 and [turn this] (slb slb slb)=
2331 P [o kay.]
2332 PR =i'll be right [back.]
2333 P [al]righty. great,

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PR when is the date of your last pap smear?
(.)
P erm two years ago.
PR okay do you remember what month a↑bout
P august?
PR okay.
P it (slb slb) three years ago then. won't it be,
PR (°slb [slb slb°)]
P [no two] and a half.
PR okay. ((writing on P's file))
(2.5)
PR °okay.°
(1.6)
PR do you have a history of any atypical pap smear(slb slb slb) was all fine,
P they've ben normal for the past (1.5)ten years or,
(2.2)
P °i had a history of (slb slb slb slb) once.° .hh i didn't i've had no more pap just:: but they insisted they took a biopsy from, that
were that normal but all my paps have been fine.
PR okay.
((PR writing)) (3.6)
PR any erm gynecological erm surgeries in the past?
P no.
PR or (.) conditions,
P no.
PR no, okay.
((PR writing)) (3.8)
PR tzt erm any pregnancies ↑ever
P one.
PR one pregnancy,
((PR writing)) (2.3)
PR by birth?
P uh huh. one.=
PR =one.
(2.8)
PR erm any abortions at ↑all
P no.
PR okay. (.) any miscarriages,
P u::h, not that i ↓know
PR okay.

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(1.9)
PR any difficulty with conceiving,
P currently.
PR °okay.°
(4.7)
PR any complications with the pregnancy (.) that you had,
P no.
PR °okay.°
(6.3)
PR do you have any any future plans for pregnancy or,
P erm tryin er trying,
PR you do, okay.
(2.7)
PR do you do er self (slb slb slb) at home?(.) ever,
P no.
PR no okay.
(2.5)
PR ever okay. have you ever noticed any nipple discharge,
P [no.]
PR [or] anything like that, okay.
(2.1)
PR ever noticed any (slb) or tenderness or anything=
P =no.
PR like that,
P well (.) .hh i get tenderness before my period.
PR [okay.]
P [every] ti- [every] month.
PR [okay.]
(7.8)
P ((clears throat))
PR okay and how old were you when you got your: er your first
period,
P i think, (.) thirteen.
PR °(slb slb slb)°
(3.8)
PR and what was the date of your last monthly ↑period
P e:rm (1.5) eleven eight.
(1.4)
P °wait a moment,° (.) yeah eleven eight.
PR okay. (.) and how many days does your period usually last,
P seven to ten.
((PR writing)) (9.7)
PR okay and: tzt do you usually have a heavy flow?
P ((clears throat))
PR or what is it like generally,=

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```
 88   P          =kinda heavy first couple of days [and then]
 89   PR                                           [ o  kay.]
 90   P          then not.
 91              ((PR writing)) (7.7)
 92   PR         how many pads do you go through on your on your heavy
 93              days,
 94   P          pads or tam[pons.]
 95   PR                    [ or  ] tampons,
 96   P          .hhh erm hhh (2.2) t- erm (1.5) i don't know like maybe
 97              three,
 98   PR         okay.
 99   P          four five,
100   PR         ((writing)) okay.
101              (9.0)
102   PR         any clots with the ↑period
103   P          u:h, small ones.
104   PR         small clots.
105              (4.8)
106   PR         any erm (.) pain cramping
107              (0.8)
108   PR         °with the period?°
109   P          u:h, occasional.
110   PR         ((writing)) okay.
111              (10.8)
112   PR         bleeding between cycles ever,
113   P          no.
114              (.)
115   PR         °okay.°
116              (5.1)
117   PR         erm what type of p_m_s symptoms do you do you get besides
118              the breast tenderness?
119   P          (cracking) ↑nipple ((smiles turning towards friend))
120              (crinkly!)
121              ((PR writing)) (8.0)
122   PR         anything else?
123   P          ((shaking head)) uh huh.
124   PR         no cravings?
125              (3.1)
126   P          i get hungry!
127   PR         °you do.°
128   P          yeah! ((clears throat))
129              (4.1)
130   PR         any vaginal discharge? (slb slb slb) itching, or burning?
131   P          no but, i kind of wonder if i don't have like a (.)
132              chronic bacterial vaginitis.
```


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PR °okay.°
P and i want to buy a,
PR okay.
P test for that.
((PR writing)) (2.7)
P just because of the smell?
PR okay.
P 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 writing)) (2.8)
PR and when do you notice the discharge.
P it's not really even just like a normal,
PR okay.=
P =vaginal discharge,
PR okay.
P but just the smell of it?
PR ((nodding)) o[kay.]
P [just] coz i know that.
PR ((nodding)) ri:ght,(.) okay.=
P =coz of my background i know that smell [you know,]
PR [o kay.]
P and just kinda wonder.
PR okay. (.) any pain during sex?
P ((shakes head lightly)) uh huh.
PR no?
(3.7)
P .hhh yeah (however) yeah during ovulation and my period.
PR during ovulation?
P yeah=
PR =du- okay.
P and my period i cannot gonna have fun today coz i'm just ovulating, ((smiling)) today i think.
PR ((writing)) ahhh! okay.
(6.4)
P but i'm not gonna have fun (one of us(hh))i(hh)s not gonna have fu(hh)n ha ha ha .hhh he he .hh coz it gets (slb slb) tender then,
PR ((writing)) °okay.°
(4.3)
PR do you know how old erm your mum was when she got menopause?
P forty fou(hh)r:.
((PR writing)) (3.0)
PR do you have any sisters?
P two.

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178 PR well they're about or i don't know,
179 P they're younger.
180 PR they're younger okay. (.) erm (.) what about your
181 grandmother and
182 your aunts, do you know how old they were?
183 P uh huh.=
184 PR =no okay.
185 (2.4)
186 PR °okay.° and are you sexually active now?
187 P uh huh.
188 PR yes. (.) okay any birth control?
189 P no. trying to get pregnant.
190 PR ((writing)) okay.
191 (3.0)
192 P or i have abstinence, uh uh uhh
193 PR uhhh
194 P lately .hhh tryin to get pregnant that way!
195 PR °(slb slb)°
196 (6.4)
197 PR any birth control methods used in the past? ((clears
198 throat))
199 before you were trying to get pregnant,
200 P hhhh (slb slb slb) mostly.
201 PR okay.
202 (4.5)
203 PR any history of (depressed slb ↑slb)
204 P ((shaking head)) uh huh.
205 (7.2)
206 PR °okay,° i have to ask this. do you do you need any
207 information on
208 other birth control methods at ↓all
209 P ((shaking head lightly)) uh huh.
210 PR no okay.
211 (9.5)
212 PR okay. (.) so now we have to start (slb slb slb slb slb)
213 P okay i need to run to the bathroom and,
214 PR oka(hh)y great.
215 P °ok(h)ay.°

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APPENDIX C: FEEDBACK QUESTIONNAIRES

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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*[2]

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[112]

<table>
<tr><td rowspan="2">Total no. of patients</td><td rowspan="2">13</td><td>First-time patients</td><td colspan="3">3</td></tr>
<tr><td>Return patients</td><td colspan="3">10</td></tr>
<tr><td rowspan="3">Total no. of doctors</td><td rowspan="3">26</td><td>Supervising doctors</td><td colspan="3">6</td></tr>
<tr><td rowspan="2">Student clinicians</td><td rowspan="2">20</td><td>Primaries</td><td>12</td></tr>
<tr><td>Secondaries</td><td>8</td></tr>
</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

Post-encounter questionnaire for the patient[113]	*Results*	
	T data (9 INTs) Total: 9 patients	N-T data (5 INTs) Total: 3 patients[114]
1) The doctor greeted me pleasantly before dealing with my medical problem		
Unsure	1	-
Agree	-	2
Strongly agree	8	1
2) The doctor seemed to pay attention as I described my condition		
Unsure	1	-
Agree	1	-
Strongly agree	7	3
3) The doctor made me feel as if I could talk about any type of problem		
Unsure	1	-
Agree	1	2
Strongly agree	7	1
4) The doctor asked questions that were too personal		
Strongly disagree	5	1
Disagree	4	1
Unsure	-	1
5) The doctor explained the reason why the treatment was recommended for me		
Unsure	1	-
Agree	2	1
Strongly agree	4	-
Other (no reply)[115]	1	2

[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		
Strongly disagree	3	1
Disagree	3	-
Unsure	1	-
Other (no reply)	2	2
7) The doctor considered my individual needs when treating my condition		
Disagree	1	-
Unsure	1	-
Agree	3	-
Strongly agree	3	1
Other (no reply)	1	2
8) The doctor seemed to be rushed		
Strongly disagree	7	1
Disagree	2	2
9) The doctor behaved in a professional and respectful manner toward me		
Unsure	1	-
Agree	-	2
Strongly agree	8	1
10) The doctor seemed to brush off my questions		
Strongly disagree	4	1
Disagree	4	2
Other (no reply)	1	-
11) The doctor used words that I did not understand		
Strongly disagree	5	3
Disagree	3	-
Other (no reply)	1	-
12) The doctor gave me all the information I thought I should have been given		
Disagree	1	-

[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").

Unsure	-	1
Agree	5	-
Strongly agree	1	1
Other (no reply)	2	1

Table 3. doctors' answers to the feedback questionnaire

Post-encounter questionnaire for the (student) clinician[116]	*Results*				
	T data (9 INTs) Total: 14 clinicians		N-T data (5 INTs) Total: 12 clinicians		
	PRs Tot: 10	SCs Tot: 4	PRs Tot: 4	SCs Tot: 7	SDs Tot: 1
1) I felt at ease with this patient					
Strongly disagree	-	-	-	1	-
Disagree	1	-	-	-	-
Unsure	2	-	-	-	-
Agree	4	1	1	1	1
Strongly agree	3	3	3	5	-
2) Communication with this patient was difficult					
Strongly disagree	4	-	3	5	-
Disagree	4	3	1	2	1
Agree	2	-	-	-	-
Strongly agree	-	1	-	-	-
3) The patient was challenging					
Strongly disagree	1	1	1	3	-
Disagree	4	3	1	4	1
Unsure	-	-	1	-	-
Agree	4	-	-	-	-

[116] See note 1.

Strongly agree	1	-	1	-	-
4) The patient's style was focused and systematic					
Strongly disagree	1	1	-	-	-
Disagree	1	1	-	-	1
Unsure	2	-	-	1	-
Agree	4	-	2	5	-
Strongly agree	2	2	2	1	-
5) The patient's style was dramatic					
Strongly disagree	2	-	2	1	-
Disagree	4	2	1	5	1
Unsure	1	1	1	1	-
Agree	1	1	-	-	-
Strongly agree	2	-	-	-	-
6) The patient seemed to feel hopeless about her/his state					
Strongly disagree	3	2	2	2	1
Disagree	6	2	2	4	-
Unsure	-	-	-	-	-
Agree	1	-	-	1	-
Strongly agree	-	-	-	-	-
7) The patient seemed suspicious of healthcare and healthcare professionals					
Strongly disagree	4	2	2	3	1
Disagree	1	1	2	3	-
Unsure	3	1	-	1	-
Agree	-	-	-	-	-
Strongly agree	1	-	-	-	-
8) The patient was very self-confident					
Strongly disagree	1	-	-	-	-
Disagree	-	1	-	-	-
Unsure	5	1		1	1
Agree	2	1	3	4	-
Strongly agree	2	1	1	2	-

APPENDIX D: CONSENT FORMS

1. Doctor 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 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

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 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.

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 _____

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)
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We are going to make audio recordings of 30 interviews involving other patients (one for each interview) and senior and trainee naturopathic doctors.
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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.

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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 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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Date Signature

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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.

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Date Investigator's Signature

Initials _____

4. Patient consent form for video recording

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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)
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Date Witness Signature

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