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Power and Discourse: Comparing the power of doctor talk in two contrasting interactive encounters.

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Introduction

This study will investigate the role of doctor talk in two contrasting encounters: institutional and domestic. According to Heritage & Clayman (2010), in institutional encounters participants 'are tied to their institutional-relevant identities' (34), whereas during domestic encounters, speakers rely on linguistic characteristics attributed to ordinary conversation such as vague or non-literal expressions (Wardhaugh, 2011: 271).

Transcript I is obtained from Channel 4's medical series *Embarrassing Bodies* where a general practitioner, Dr Bernadette 'Pixie' McKenna, is consulting an eighty-five year old female patient, who is diagnosed with the skin condition pruritus. In contrast, transcript II involves research participants and explores a conversation between a doctor and his eighty-one year old grandmother in a domestic setting.

This study aims to explore whether the power recognised in doctor talk is solely prevalent in institutional settings. By collecting data of a doctor interacting with a family member in a domestic situation, it enabled me to compare the power of doctor talk in two comparable settings and to explore whether the environment could affect a doctor's authority.

Since Henderson's (1935) ground-breaking research concerning doctor talk, I have been intrigued by this facet of healthcare communication. Silverman et al. (2005) have estimated that 'doctors perform 200,000 consultations in a professional lifetime' (7). These statistics reflect the professional and cultural authority associated with doctor talk, thereby reiterating the significance of this discipline. Moreover, research conducted by Heritage and Clayman (2010) also revealed the delicacy between the boundaries of ordinary and institutional conversation. The duo recognised the difficulties in defining these two variants of conversation, but did emphasise that the context of institutional conversation did impact the interactional techniques employed by the speakers, which influenced my decision to explore the prevalence of doctor talk in two comparable settings. As a result, I decided to probe further into this fascinating demesne of healthcare communication.

Background

Although there is a plethora of literature regarding doctor talk, the following literature has been selected due to their particular prominence within the field and their insightful analysis into structure and power.

Byrne and Long's (1976) research was influential in exploring the popularity of doctor-centred consultations during the late twentieth century. Byrne and Long were perceptive in recognising how general practitioners relied on language to assert their power, enabling them to control their consultations. This has resulted in the duo being heralded as among the first researchers to 'systematically interrogate the structure of the consultation'

(Harvey & Koteyko, 2013: 8) due to their establishment of a six phase consultation sequence that is outlined below.

> I Greeting and relating
> II Discovering the reasons for attendance
> III Conducting a verbal or physical examination or both
> IV A consideration of the condition
> V Detailing further treatment
> VI Terminating the interview.
> (Byrne and Long, 1976: 132)

Through their analysis of the six phases, Byrne and Long realised that doctors relied on their medical prestige and socio-cultural authority to verbally and non-verbally guide patients through the phases, concluding with a diagnosis and treatment plan. This was due to the consultation being 'a goal-seeking activity' (Byrne and Long, 1976: 31) with both the doctor and patient actively seeking to achieve their individual objectives.

By using specific verbal communication, Byrne and Long (1976) noted that general practitioners could linguistically probe into a patient's medical background, relying on questions, such as open or closed, to gather a detailed medical history. Similarly, non-verbal behaviour such as the use of silence or back channelling tokens like 'Uh-hu' were also relied upon to indicate understanding, or to provide encouragement during the interaction. This resulted in significant changes to the medical curriculum with medical students being taught how to utilise their clinical skills during the consultation in order to prevent dysfunctional communication (Tate, 2010: 12).

Miles (1991) noted that medical students must grasp 'a process of education and socialization during which they learn, not only the formal subjects of the curriculum but also the values' (135). These 'values' are frequently explored in medical handbooks by advising medical students how to include patient involvement whilst retaining their authority. Although medical academics like Athreya (2010) have recognised that the doctor-patient relationship has 'taken a dramatic and crucial turn in the past fifty years' (15) it is commonly accepted that in the consultation 'the physician has all the information' (Athreya, 2010: 15) and therefore all the power.

Thus, a doctor's mastery of interaction is essential in eliciting information, but also as a tool for controlling the progression of the consultation. Through a combination of broad and closed questions, 'the clinician's eyes have to be open for new clues' (Athreya, 2010: 67) to establish a diagnosis. Whilst doctors have substantial diagnostic power, they also possess a responsibility to provide a conclusive and accurate diagnosis. Hence, medical textbooks have been vital in altering and influencing doctor talk; teaching medical students how to perform responsibly whilst retaining their power.

Furthermore, Lupton's (2003) research concerning the socio-cultural authority of medicine in western societies has been pertinent in this study. Lupton (2003) refers to medicine as 'a beneficent institution that performs a needed service, and whose members are justly rewarded by high prestige, status and *power*' (113, emphasis added). Although patient involvement has become included in consultations (through shared decision making), Lupton's research revealed that the cultural ethos towards medicine has enabled doctors to retain their power. Subsequently, there is an asymmetrical relationship between the doctor and the patient, which Lupton (2003) compares to that of a parent and child (113). This reiterates the paternalism that encompasses medicine, which Lupton (2003) argues is inherent within western societies.

Finally, Mishler's (1984) research was also insightful in exploring how doctors use the 'voice of medicine' to assert their authority. Mishler (1984) ascertained that occasionally a struggle for control can occur between doctors and patients, which is emulated by conflict between the 'voice of medicine' and the 'voice of the lifeworld'. The 'voice of medicine' is representative of the technical jargon associated with medicine. It is critical and theoretical whereas the 'voice of the lifeworld' considers the patient's personal experiences of events and problems. (Mishler, 1984: 14) Usually, the 'voice of medicine' is able to dominate, due to the paternalism and power associated with medicine, but occasionally, patients attempt to exert the 'voice of the lifeworld' to facilitate their perspective or opinion. This results in a deviation from the medical agenda, as the patient is eager to provide a detailed explanation of their problem, (which may include extraneous information) but also is acutely aware that they must cooperate and defer to the 'voice of medicine'. Such tension, according to Mishler, is an excellent example of how doctors react if their status is threatened, but also exhibits how doctors and patients have different perspectives towards illness.

Methodology

In order to explore the power and authority associated with doctor talk I considered how doctor talk could impact the turn-taking structure of medical interviews, which has implications on the allocation of footings. These approaches allowed this study to examine how doctors align themselves within institutional and domestic settings and whether this had repercussions on their status.

A turn has been defined as 'one or more streams of speech bounded by another, usually an interlocutor' (Crookes, 1990: 82) which indicates that a speaker's authority can be revealed through their turns. Markee (2000) also recognised that power can be revealed through analysis of the turn-taking structure as the system 'is not designed to ensure an equal distribution of turns' (87) suggesting that during interactions, there is always a dominant and submissive speaker. Each speaker recognises their position due to a 'finite set of turn-taking rules' (97), however, the submissive speaker refuses to accept their position, a struggle for the turn can ensue causing a breakdown in conversation. This is also relevant to research conducted by Sacks, Schegloff and Jefferson (1974), who recognised that formal institutional interactions are based on the preallocation of turns, whilst ordinary conversation allocates one turn at a time (729). Thus, it appears that during institutional encounters, (such as medical consultations) the turn-taking system is biased towards the speaker who possesses the institutional footing.

Furthermore, I was also keen to explore how changes in footings could alter a speaker's interactional stance or alignment. A footing is 'the stance or status of an individual in a specific interaction with another or others' (Goffman, 1981: 128). Hence, depending on the nature of the interaction, a speaker's stance can alter, thereby affecting their authority. Changes in footings have been recognised as 'linguistically centred' (ibid) and have been distinguished as 'another way of talking about a change in our frame of events' (ibid) Thus, I was eager to draw upon Goffman's (1981) research to explore how a change in footing could impact a speaker's interactional status.

In order for my study to compare an institutional encounter with a domestic interaction, I relied on obtaining a transcript from a television episode. This was due to ten Have's (2007) affirmation that the mass media can provide a multitude of accessible and professionally recorded resources (81). Ten Have (2007) also advised that 'making one's own recordings, or having them made at one's request is quite often the only way to get precisely the kind of data one wants' (82) which influenced my decision to collect and transcribe my own data. I audio recorded the domestic encounter as it would ensure consistency within my research, as both transcripts would then include a third person audience. In transcript I the

third person audience would be the television viewers, who are engaging with the consultation between the doctor and patient, whereas in transcript II, my position as the audio recorder meant that my presence during the interaction enabled me to become the third person audience.

All transcriptions in my research have adhered to the Jefferson transcription model (as outlined in Atkinson and Heritage, 1984) due to its capacity in recounting both phonological and verbal exchanges, which was invaluable when analysing the power concealed within doctor talk. Furthermore, as researchers of conversational analysis typically rely on Jefferson's model I was ardent (ten Have, 2007: 106) that my study adhered to the conventional presentation criteria associated with conversational analysis.

However, it must be appreciated that the transcriptions should not be taken as exact replicates of each encounter, as it is technically impossible to achieve a perfect transcription (ten Have, 2007: 89). It should also be recognised that the interaction in transcript I had been previously broadcasted and so may have been previously edited, which could have significantly altered the televised interaction.

Also due to resource and time constraints, I was unable to use computer software such as SoundEdit to authenticate the transcriptions, as this software can amplify sounds via a visual digital projection. Nevertheless, manually transcribed transcriptions are 'a convenient way to capture and present the phenomena of interest in written form' (ten Have, 95) hence reiterating the credibility of my transcripts.

In order to ensure my data adhered to research requirements all participants were provided with ethical consent forms, which clearly outlined the aims of my research and how participant anonymity would be protected. To ensure my data was accurate and authentic, transcript II was recorded on a small dictaphone with an excellent acoustic quality that could be discreetly used. The difficulty in collecting reliable data (with participant consent) has been recognised by Labov (1972) under the term 'observer's paradox' (61). This considers the predicament encountered by sociologists in their attempt to collect authentic, natural speech data. Labov (1972) claimed that if a speaker was aware they were being recorded, it could result in unnatural speech and thus unreliable information. Hence, by relying on a small and discreetly placed dictaphone, I hoped my data would replicate a natural exchange.

Analysis

As this study is solely exploring the verbal exchange of doctor talk rather than the behavioural interface, this analysis will only consider the verbal interaction during both encounters.

As mentioned beforehand by Crookes (1990), speaker power is inherently related to the turn-taking structure of an exchange. Tate (2010) recognised that the medical profession has 'adopted a well-meaning paternal role' (9) which further enhances a doctor's authority within the turn-taking structure. This can be seen in transcript I, as the doctor controlled sixty-three percent of the turns, whilst the patient possessed a mere thirty-seven percent. Ostensibly, the doctor is adhering to his institutional footing, which reiterates to the patient that due to the institutional setting, the doctor is the dominant speaker and is expected to possess the turns. Conversely, the start of the turn-taking structure in transcript II is characteristic of ordinary conversation, and it appears that speaker A prefers to adhere to his footing of a grandson rather than a physician. As a result, the grandmother possesses fifty percent of the turns, whilst the grandson maintains forty-four percent. This insightful data suggests that when speaker A aligns his footing to a grandson, his power is weakened and instead, he appears to exhibit 'linguistic respect' (Sŏng, 2009: 206) and adheres to socio-cultural conventions regarding discourse and the elderly. Fairclough (2001) has also

recognised this relationship between social conditions and language, by arguing that the relationship between discourse and power is deeply affected by the social environment (20).

Nonetheless, whilst speaker B does dominate the turns in transcript II, it should also be noted that despite this, speaker A in transcript II does revert to his institutional footing as the encounter progresses. This is particularly evident in speaker A's use of questions, which enable speaker A to exert the 'voice of medicine' and limit the 'voice of the lifeworld'. By relying on such questions, speaker A is asserting his institutional footing and trying to control the direction of the conversation, perhaps in an attempt to gather a medical history. This was fascinating as it revealed that despite Sacks, Schegloff and Jefferson's (1974) research into the turn-taking structure of ordinary conversation, it appears that speaker A disregards their conclusions, and instead alters his status and power through his shifts in footings.

In the institutional encounter, the doctor uses an open questioning style as demonstrated in line one, which according to Silverman et al. (1998) is typically used in consultations to 'obtain a picture of the problem from the patient's perspective' (73). This contrasts to transcript II, as the discourse in line one is typical of ordinary conversation and the interaction is not as structured. Only at line four does speaker A initiate an open question with 'How are you all doing?' which is reflective of the informality of the encounter. Then, in line six speaker A instigates another open question of 'You ok?', which through the exclusion of 'are' highlights the intimate, familial relationship between the speakers. Also, this question is extremely vague as the personal pronoun 'you' does not specify which speaker is being considered. Rather, this question is indicative of the vagueness of ordinary conversation and the everyday nature of the encounter.

Furthermore, this study revealed how power could be intensified during encounters through terms of address. In line one of transcript I, the doctor begins the consultation with 'So Audrey what's the matter?', which from the onset projects a friendly and comforting atmosphere for the patient. By referring to the patient by her forename, the doctor is reiterating her institutional footing, which immediately demonstrates her power. This is a vivid example of the paternalism associated with the medical profession, where despite the vast age difference between the doctor and patient, the doctor is seen as the esteemed participant, which disregards typical linguistic and cultural conventions. By referring to the patient by their forename, the doctor also facilitates a personal environment (which placates the patient) and shows an awareness of the third person audience, the television viewers, which is crucial in retaining the popularity and success of the series.

On the other hand, in transcript II, there is a blatant absence of naming as speaker A does not refer to speaker B by their forename, or even their familial title of 'grandma'. Evidently, in this non-institutional encounter speaker A does not feel the need to project his professional authority and instead is pursuing his footing as a grandson. Interestingly, by relying on her footing as an elderly grandmother, speaker B has aligned herself as the more powerful speaker, as depicted by her willingness to address speaker A by their forename in line eleven, rather than using their honorific title of 'doctor'. This reiterates how language and the speakers' consideration of each other reflects the informal setting. Speaker A is willing to accept his submissive stance, whilst speaker B uses her footing to establish her authority as an elderly grandmother.

In transcript I after the initial sequence of open questions, the patient possesses control of the turn-taking structure. Between lines one to five, the patient possess three turns, which is typical of an institutional encounter (Harvey & Koteyko, 2013: 16). This preallocation of turns usually occurs during the preliminary stages of the consultation as the patient is encouraged to provide a detailed explanation of their symptoms. According to Tate (2010) this is essential as it provides the doctor with an opportunity to establish a coherent medical history and evaluate key symptoms (62). Similarly, in transcript II from lines 16 to

44 speaker B also appears to be behaving like a patient, as she documents her accident to speaker B, who permits her to dominate the turns. Hence, it appears that when discussing a medical topic, speaker A transitions his footing from a grandson to a medical professional, which impacts his status and that of speaker B.

After the patient in transcript I outlines her symptoms and speaker B in transcript II recollects her injury, there is a staggering shift in power, as the doctor and speaker A vehemently adhere to their institutional footing. This is evident in line 34 of transcript II, where speaker A clarifies speaker B's anecdote, a technique that according to Mishler (1984) is as a method used by doctors to stifle the 'voice of the lifeworld'. By changing his footing, speaker A is now in a position of power as he tries to apply speaker B's symptoms to his medical knowledge. The power associated with the 'voice of medicine' means the 'voice of the lifeworld' loses 'the content and direction of the talk and becomes more or less constrained by questioning that is physician directed'. (Heritage & Clayman, 2010: 105) Now, despite her earlier dominance, speaker B has readily accepted the authority of the 'voice of medicine' and speaker A's status, which reiterates Lupton's research regarding Western societies attitudes towards medicine.

After providing speaker A with her symptoms, speaker B is now subject to a barrage of closed questions during lines 53 to 61. This transition from open questions to closed questions is referred to by Silverman et al. (1998) as the 'open-to-closed cone' (73): an approach used by doctors in primary care consultations to establish a diagnosis and recommend treatment. Closed questions are 'direct questions but are characterised by complete specificity and a preference for yes or no answers' (Byrne & Long, 1976: 39). Similarly, in transcript I the doctor also relies on a sequence of closed questions during lines seventeen and eighteen to establish a hypothesis-testing procedure, which concludes with a prognosis in line 32. Closed questions are pertinent feature of institutional doctor talk, with the medical curriculum emphasising the importance of such questions 'to elicit symptoms and signs from which the clinician can make a diagnosis' (Steinberg, 2005: 1).

By relying on closed questions, it is clear that speaker A is drawing upon his clinical skills, which reiterates his medical footing. During lines 53 and 54 two closed questions are used within a space of 3.45 seconds, which exemplifies speaker A's ability to dominate the turns by asserting his professional authority. After a further 3 minutes 14 seconds a diagnosis of a 'drop attack' is established in line 114. Thus, similar to the doctor in transcript I, speaker A follows the 'open to closed cone' format, concluding with a diagnosis. It appears that as soon as there is a topic shift to a medical subject speaker A immediately changes his footing to a physician despite the domestic setting. Therefore, it would appear that institutional footings are indeed not solely confined to institutional settings.

Furthermore, analysis of transcript II also revealed that speaker A, like the doctor in transcript I, also uses empathetic statements. Washer (2009) defines empathy as the ability to project one's feelings and thoughts in order to identify with another (14) and are a common mannerism during consultations. During line 49 in transcript II, speaker A uses the exclamative 'gosh' which is similar to the doctor's interjection of 'oh deary me!' in line 25 of transcript I. Thus, prevalence of empathy in both transcripts reveals that as part of their institutional footing, physicians are conscious that they are expected to provide emotional support.

Moreover, aside from emphatic exclamations, medical professionals have been recognised to rely on non-verbal communication to express compassion during medical interviews. Hugman (2009) claims that non-verbal communication such as 'uh huh' or 'mhmm' are 'minuscule, microscopic, fleeting and vestigial' (60), yet are essential in providing a patient with encouragement during their narrative. Hence, the doctor's use in transcript I of non-verbal communication such as 'mhmm' during line 15 would be expected

due to the environment of the encounter. However, data from transcript II also revealed that speaker A also used non-verbal structures 'mhmm' in line 27, which reveals that by also using these structures, speaker A is adhering his institutional footing. According to medical research, doctors have also demonstrated a reliance on back channelling tokens such as 'yeah' and 'right' to exhibit active listening, but Barry et al. (2001) also attribute back channelling as a means of 'vetting information in order to dismiss the lifeworld and seek the voice of medicine'(495). In transcript II, during line 28 speaker A employs back channelling tokens such as 'yeah' to emphasize to speaker B their attention, but also as Barry et al. (2001) stated, it could be seen as a means of stifling the 'voice of the lifeworld'. Evidently, medical professionals rely on non-verbal communication to authenticate their authority, particularly if they feel it is threatened by the 'voice of the lifeworld'. Perhaps speaker A is particularly concerned with emphasising his authority as he recognises the challenge of asserting his professional status during a domestic encounter.

Another characteristic used by medical professionals to assert their power is through 'medspeak'. Washer identifies 'medspeak' as medical jargon specifically used amongst medical professionals, although doctors are advised to 'translate every term and concept from 'medspeak'' into a more appropriate definition for patients (Washer, 2009: 89). In transcript II, speaker A explains a 'blackout' during line 81 and uses this opportunity to later provide an explanation between 'lay' and professional knowledge in line 82. It is also an opportunity for speaker A to reiterate his authority because as a medical professional he can accurately 'use that term'.

'Medspeak' also occurs in transcript I which would be expected considering the encounter. In line 30 the doctor refers to the 'white marks' but interestingly, she then appears to abandon her institutional footing, by momentarily using 'lay' terminology such as 'stuff' to explain the condition to the patient. Then, in line 32 the doctor reverts back to her institutional footing, as highlighted through her choice of language. By using the personal pronoun 'we' in 'we call it pruritus' the doctor is able to highlight her exclusive position as a physician, which distinguishes her status and power.

Additionally, the use of interruptions also illustrates power and is prevalent in both transcripts. In line six of transcript I, the patient refers to the doctor with the endearment 'love' which causes a tension in the conversation as the patient is failing to orient to her participant status. So, in line seven the doctor quickly and abruptly interrupts the patient in order to reassert her authority. Research by Wynn (1999) has recognised interruptions as a means for enabling doctors to establish control (66). This is reflective in line seven when the doctor is clearly unwilling to have her status and power threatened by the patient and so relies on an interruption to orient the patient to her submissive status.

Likewise, speaker A also interrupts speaker B during transcript II, however my data revealed a startling occurrence in line 77 whereby speaker B successfully interrupts speaker A. According to Wynn 'patient interruptions are never successful' during institutional consultations (66) which suggests that due to the domestic setting, speaker A does not possess the same power as the doctor in transcript I. Unlike the patient, speaker B is unwilling to adhere to her submissive position and uses her social footing as a grandmother to assert her status.

Conclusion

Pendleton et al.'s (2003) affirmation that 'the environment in which a doctor works can make a great deal of difference' (93) has been aptly revealed in my research. It is evident that domestic encounters have the capacity to destabilize the institutional footing of a doctor and thus greatly reduce their conversational authority. In contrast, institutional encounters provide surroundings that reiterate the power of physicians, which enables doctors to use their footing

and socio-cultural symbolism to dominate the turn-taking structure. Even if a patient attempts to threaten their status, the doctor is quickly able to retain their power. Unlike speaker A in transcript II, the doctor in transcript I could quickly suppress any threats to her authority, whereas speaker A was forced to sometimes abandon their institutional footing and instead accept a relatively submissive role.

However, this study showed despite the contrasting settings, when presented with a medical matter, both speaker A and the doctor immediately adhered to their institutional footing, which was particularly remarkable considering the setting of transcript II. It appears that even when physicians are engaged in ordinary conversation, in a non-institutional environment, they can instantly revert to their professional footing, which increases their status as reflected by their use of language. Most interestingly, it is clear that the other participants are willing to accept this change in footing, which suggests that it is engrained within Western societies to defer to medical professionals and accept their authority through verbal and non-verbal communication.

Nevertheless, whilst my research has been insightful, due to my small sample of data it is not conclusive. Future research could examine a broader spectrum of doctor talk from different television shows, including those from other cultures. It would also be interesting to conduct research into whether medical professionals from other societies possess the same power as in the West.

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Appendix

Transcript I

This episode was accessed on 20/12/13 from http://www.youtube.com/user/embarrassingillness/videos

Key

D:Doctor
P:Patient

1. D: So Audrey what's the matter?
2. P: I itch
3. P: all over
4. D: You itch?
5. P: Legs, arms, (.) body, groin, but not, not there (.)you know what I mean don't you love
6. D: [okay]
7. D: Yep
8. D: Yeah I do
9. D: How long has that been going on for?
10. P:I've been under the hospital for three and a half years (.)
11. D:So you've got a very bad itch and when is it worse Audrey?
12. D:Is it worse at night-time?
13. P:Erhmm
14. P:It does wake me up some mornings at three o'clock
15. D: [Mmm kay]
16. P:and I go to the bathroom and put some more cream on
17. D:Do they get really hard?
18. D:Do you have to scratch really hard?
19. P:Oh, I use the brush
20. D:So you use a hairbrush?
21. P:No it's urhmm (.) it's a toilet brush!
22. P:((laughs))
23. D:Do you?
24. P:((laughs))
25. D:Oh deary me!
26. D:Right give them a good ole scrub.
27. P:It's got to be something strong that will take effect
28. D: [yeah]
29. D:Okay
30. D:And see these white marks here, (.) that's where the skin has become very inflamed and when you have scratched all the pigment, all the stuff that makes your skin brown (0.096)
31. D:disappears when it heals up
32. D:The problem that you have, we call it pruritus.
33. D:Where you have the desire to itch and itch and itch and scratch.
34. D:Now, (0.114) it is a very common problem in older people.
35. P:I just ((crying)) hoped there's something ((crying))
36. P:that is gonna help me hh ((crying))
37. D:I'm sorry for over emphasising this coz there is nothing worse than going to the doctor and, (.)
38. P:((crying))

39. D:and for them saying you know (0.120) that we're not sure what is wrong and we're not sure if we can treat it.
40. P:((crying))
41. D:But, the unfortunate thing about this condition is that it is very, very difficult to treat.
42. D:I think how we need to manage this is look at the itch-scratch cycle
43. D:and try and break it.

Transcript II
This conversation was recorded on the 6/12/13 at the grandparent's house.

Key
A: Grandson/doctor
B: Grandmother
C: Grandfather

1. A:You can get the uhmm
2. A:You can get the minibus to Libya
3. C:Good God keep away from there!
4. A:How are you all doing?
5. B:Mhmm
6. A:You ok? (0.224)
7. B:I fell down the other day
8. A:Did you?
9. A:When?
10. A:What did you, what happened?
11. B:I don't know what happened A I've tried to analyse it, tried to be sensible about it.
12. B:It's not like... (0.442)
13. B:This time I almost knew I was going to fall. You know
14. B:For a split second I thought [speaker B's name] you're going and I fell ( )
15. A:So what happened you fell?
16. B:Mhmm
17. A:You fell?
18. B:I just (0.270)
19. B:I just fell and hit my head and then my arm
20. A:Okay
21. A:Sounds pretty rough
22. A:Did you...
23. A:What do you mean you (.) said you kinda knew it was going to happen? Is that right?
24. B:I have fallen about four times
25. A:Really? Mhmm in how long? (0.333)
26. B:Well I fell the first time they just shoved me in hospital
27. A:Mhmm
28. A:Yeah (.)
29. B:And that when I fell
30. B:I'm trying to make sense of it to work it out
31. A:Mhmm
32. B:That when I fell there were colours
33. B:That's when there were colours
34. A:What do you mean by that?

35. B:Green and brown colours
36. A:Flashes or stripes or... ?
37. B:[Yeah] all colours
38. B:When I fell out of bed, I don't know what happened
39. B:I just (0.188)
40. B:I think I might have knocked myself out of it as I couldn't remember anything
41. B:This time (.) there was a funny feeling, like hh brown colour came on this side of my head
42. A:On your left eye?
43. B:Mhmm (0.378)
44. B:Brown with little marks in it
45. B:It was most peculiar
46. B:Anyway
47. B:I fell on the floor, wasn't hurt, C was in. So I was screaming and shouting ((laughs)) and he said
48. B:He said what are you shouting at me for and I said ((laughs)) shouting at you for you!
49. A:Gosh (0.251)
50. A:It was weird how you said you kinda of knew it was coming on
52. B:If I had a second more notice I'd cling onto something, you know I wouldn't actually go
53. A:Did you get dizzy at all?
54. B:No
55. A:Did you... feel faint? (0.158)
56. B:No it came so quick
57. B:If you feel faint its sort of .hh
58. A:It just came suddenly. Did your legs feel weak? (0.153)
59. B:No
60. A:Did you have problems with the chest, pains or any fluttering or?
61. B:No
62. A:Any weakness or anythi..? (0.220)
63. B:Weakness in what way?
64. A:Sorry as in like, leg weakness or any weakness on the face.
65. B:This time I recovered quite quickly
66. A:Oh okay
67. C:Only in terms of seconds
68. A:Really?
69. B:He got me up and I hh (.) sat on the chair in the kitchen in the afternoon by the afternoon I
70. A: [Did]
71. A:You think you blacked out again (.) this time
72. B:you see I must do something (0.230)
73. B:See I must do something
74. B:Either I have a blackout otherwise why would I fall?
75. B:When you are normally standing you don't fall for nothing (.)
76. A: [Well]
77. A:A lot of people have different interpretations of what blacking out d...
78. B: [Yeah]
79. A:So you don't really know (.) what that means
80. B: [No]
81. A:I think, I mean when doctors use that term it means to (.) lose consciousness

82. A:So you can fall but you don't have to blackout, like if you just tripped you don't blackout
83. A:But not blackout
84. B:This time wasn't so bad (.)
85. B:One time I banged myself I didn't tell C in the kitchen, when I came to
86. A: [So you don't]
87. A:A good question to ask is
88. A:Do you remember everything that happened from the moment you started going to when you woke up?
89. A:From what you just said you didn't?
90. B:Mhmm (.) yeah
91. A:So...
92. B:That was a little time
93. B:I got up with that time very quickly and uhm
94. B:Thing what I'm thinking A is that when she came I had fell out of bed because
95. A: [Mhmm]
96. B:I was really was not with it, you ask C
97. A:Yeah
98. B:It makes me think I hit my head somewhere
99. A:Mhmm that's probably a concern
100.B:Because when she took the blood, the ambulance people
101.B:I felt very bad ringing them up, but we couldn't get me up off the floor
102.A:Yeahh don't feel bad, you know (.) that's what they are there for
103.B:I uhmm The lower blood pressure was 99 on the lower number. When the doctor came, they said to me get the doctor
104. B:So the next day it had dropped to 49
105. A:Right... the lower number?
106. B:So she said just the heart had fell so I adjusted the Losartan, the lower number
107. A:What do you think...do you think there is anything that is causing this, like medicines or...?
108. B:((sniffs))
109. B:I honestly don't know
110. A: [I mean]
111. A:Do you think you could put it down to anything
112. B:Nothing, I think people say it is low blood pressure, people say like for a split second not enough blood goes to the brain
113. A:Mhmm
114. B:And it's something like that
115. A:Did they mention anything like a drop attack
116. B:Yes they used the word drop
117. A:Drop attack
118. B:I remember [family member's name] she had that cat Falldown, remember?
119. A:((laughs))
120. B:I thought I better get
121. A:Turned into one ((laughs))
122. B:A new name
123. B:I don't have any bruising or anything physical
124. A:Mhmm
125. B:Had no other effects that I could make out (.)
126. A:Do you remember you know falling or hitting yourself?

127. A:Or do you just
128. A:Do you remember falling and hitting yourself to find these bruises?
129. B:I don't feel the drop
130. A:Ahhh
131. B:I don't feel the drop
132. A:So you... suu so just... let me get this right
133. A:So you... you're walking along fine (.) and then you develop some symptoms of feeling a bit funny and seeing some funny colours hh and then (.) you feel yourself going (.) see yourself going but you don't remember falling then you find yourself on the floor.
134. A:Is that right?
135. B:hh let me analyse that carefully ermm
136. B:Do I feel myself falling?
137. B:When I fell out of the bed obviously I didn't I must have asleep
138. A: [been asleep] yeah
139. B:This time(.) did I feel myself...
140. B:Yes this time I did feel myself falling
141. B:This time I did feel myself falling
142. B:I called for C and he came in. I wasn't hurt
143. B:The next day there was a little bit of bruising but (.)
144. A:I'm sure you appreciate if you 're falling you risk hurting or breaking your bones and things so
145. B:Oh yes
146. B:Of course
147. A:And how many times do you think this has happened in the last six months?
148. A:Four?
149. B:In six months?
150. B:.hh (0.560)
151. B:Once they look me off to hospital didn't they?
152. A:Mhmm
153. B:I would say about five
154. A:So quite frequently then?
155. B:Mhmm
156. B:Anyway
157. C:No not five
158. C:You fell once here
159. B:That was the first time
160. C:That was carted...
161. B:And they took me to hospital
162. C:That was more than six months ago
163. A:Are you worried by them?
164. B:Mhmm?
165. A:Are you worried by the falls?
166. A:You're not worried?
167. A:You don't know?
168. B:What did he say?
169. A:I said does it worry you
170. B:No!
171. B: I'm nearly 82 I'm going to get something aren't I
172. B: I can't spend the rest of the time that I've got left thinking oh my God I can't do that or I will fall

173. B:You can’t live your life like that
174. A:That’s true
175. B:That’s not the way to live a life (.)
176. A:Mhmm
177. C:Very philosophical
178. A:As good as your book!
179. C:Ohh yeah
180. A:Do you like it?
181. C:The first thing that strikes me is
182. C:What’s the word...