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“Does it mean I’m gonna die?”: On meaning assessment in the delivery of diagnostic news

Douglas W. Maynard*

University of Wisconsin, Madison, WI, USA

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Abstract

This paper investigates how, in the delivery of diagnostic news, participants to the delivery may engage in *meaning assessment* or interpreting the news. It draws on data from 24 conversations in developmental disabilities clinics, internal medicine clinics and HIV counselling and testing clinics in the USA. The analysis shows that participants initiate meaning assessment *sequences* whereby one participant proposes what the news means and the other aligns or disaligns with the proposal. When meaning assessment occurs, the preferred way for this to happen is that the clinician initiates and proposes an interpretation. Following the interpretive proposal, a patient or family member aligns or disaligns with the interpretation, with alignment being sought over disalignment. Further practices of meaning assessment are “affirming the positive” and “disconfirming the negative,” which work to provide relatively benign interpretations of news. Analysis of a collection of meaning assessment sequences in clinical settings is brought to bear on a single case in which an internist tells a patient that he has stomach cancer. After delivering the diagnosis, this doctor neither affirms the positive nor disconfirms the negative, and the patient ends up asking, “Does it mean I’m gonna die?” At this point, the interview gets disrupted as the patient withdraws. Asking what the news means is a structurally dispreferred way of handling problems of meaning, and as such this patient’s exhibition of difficulty is an outcome of orderly social practices. A clinician’s withholding of auspicious meaning assessment may undermine the relationship with patients and/or family members and disrupt the encounter.

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Introduction

In the context of deliveries of diagnostic news, clinicians and their recipients—patients or family members—may address the issue of what the diagnosis means. That is, they may raise a question of how to *interpret* the news. There is now a considerable interaction-based literature on the delivery of diagnostic news (Frankel, 2001; Heath, 1992; Heritage & Stivers, 1999; Leppänen, 1998; Maynard, 1989, 2003; Peräkylä, 1998; Silverman, 1997; Stivers, 1998), which is consistent with Byrne and Long’s (1976) suggestion that such delivery is a distinct and orderly phase of the medical interview, following introductory matters, discovering the reason

*Tel.: +1 608 265 5583.

E-mail address: maynard@ssc.wisc.edu.

for the patient's visit, and conducting a history and exam. The diagnostic phase, in turn, is regularly followed by treatment recommendations (Heath, 1992; Stivers, *in press*) and termination of the visit (West, *in press*). However, there is very little systematic consideration of whether and how participants, during or after diagnostic presentation, work at interpreting it through what I call meaning-assessment sequences. The sequences can be initiated by either physician or patient, and consist of proposals or formulations of meaning, followed by an aligning or disaligning response. In this paper, one overall argument is that meaning assessments are structured to give auspicious or benign versions of news. However, there can be considerable jockeying between participants as to how benign the news can be taken to be. In addition, whether and in what manner participants in a news delivery interpret the diagnosis has consequences for the doctor–patient, or more generally, clinician–client relationship.

My inquiry into meaning-assessment sequences began with an interactionally problematic episode of cancer diagnosis. One Friday morning, “Clint Jones,” a 37-year-old African-American male, walked into a primary care clinic affiliated with a US medical school. He had complaints about stomach pain, weight loss, and an inability to tolerate solid foods. Dr. “Edward Hoffman,” a white third-year resident in the primary care internal medicine training program, became extremely concerned and referred him to a gastroenterologist, Dr. Smith, for further evaluation later that same day. When Mr. Jones, the patient, was able to see Dr. Smith, Dr. Hoffman accompanied his patient. Dr. Smith performed an endoscopy, putting a scope down into the patient's esophagus, and finding a suspicious-looking mass. A biopsy was performed over the weekend. The growth proved to be malignant, and on the Monday after the Friday procedure and the weekend biopsy, Dr. Hoffman arranged to see Mr. Jones back in the clinic to tell him that the growth they had seen was cancer.

The delivery of this news, including the lead-up to the pronouncement of the cancer diagnosis, has been examined in detail elsewhere (Maynard & Frankel, *in press*). Of main concern here is the aftermath. When told of the cancer, Mr. Jones says, “What does this mean?” Dr. Hoffman replies that he is “going to need to see a lot of doctors,” and then Mr. Jones asks, “Does it mean I'm gonna die?”, and “How long do I got?” We will later examine the actual talk and conduct of Dr. Hoffman and Mr. Jones, but here it can be noted that Mr. Jones' rather plaintive queries about what the news means obtain very circumspect or guarded replies answers from the physician, who ends up saying he does not “know” how long the patient has and that “there are a lot of questions,” while Mr. Jones remained agitated, got up from his chair, and appeared as if he were going to leave, although he finally sat down and completed the interview. Presently, I will draw upon an analysis of my entire collection of meaning assessment sequences to show the organization of practices whereby participants in the news delivery event raise and answer questions about meaning. This analysis will allow us to explore the social organization involved in the assembly of diagnostic-related meaning assessment sequences, and then to make sense of how Dr. Hoffman and Mr. Jones deal in the ways that they do with the meaning of the patient's cancer diagnosis in this particular episode.

Data

From a corpus of news delivery events in both ordinary conversations and clinical environments, I collected all in which, as part of the news delivery or its aftermath, the participants explicitly addressed what the news could “mean.” In this paper, I examine instances from clinical rather than ordinary settings, although the latter inform the analysis as well. All clinical data are from the USA. In approximately three-quarters of my clinical cases, participants do not raise the question of meaning; the diagnostic terminology is transparent enough not to require interpretation. In these cases, as medical interviews go, the next phase of talk regularly concerns therapeutic interventions, in the case of “bad” news or some concrete diagnosis (Heath, 1992; Peräkylä, 1998), and movement to a next problem or toward termination of the interview in the case of “good” news where a particular condition may be disconfirmed. In the other one-quarter of cases, which is a total of 24, the clinician or the patient or family member do propose that some interpretive activity is relevant. Fourteen of these 24 are from two clinics for developmental disabilities (DD); seven are from an internal medicine clinic, and three are from an HIV counseling and testing clinic.

Most extracts in this paper are from the DD clinics because of more data being collected in these clinics. In all cases, the clinician is proposing a diagnosis to the patient or family member for the first time; none involves pre-diagnostic commentary or confirmatory or second opinions. In addition, the phases of the medical

interview mentioned above and in [Byrne and Long \(1976\)](#), while pertaining directly to primary care internal medicine, also characterize the other clinics in this investigation. Although the substance of the medical concern is different in these clinics, they each have formal phases consisting of an introduction (whereby relationships are established), ascertaining the reason for the appointment, and verbal and/or physical exam as precedent to delivering diagnostic information. In both the DD and HIV clinics, the testing process may take more time than in internal medicine—a day or two of examinations in DD clinics, and 2 weeks for a client's blood to be tested in the HIV clinic. Most internal medicine encounters can complete the exam during a relatively short, minutes-long interview, although it can be noted that in the cancer case already adumbrated, there is a three-day period comprising the initial encounter, performance of an endoscopy, the taking of a biopsy, and the presentation of diagnosis. And in each clinic, the diagnostic phase is followed by treatment recommendations and systematic termination of the encounter. Given these formal similarities among distinct clinics, the analysis in this paper aims for the generic practices whereby participants address problems of meaning, the presumption being that across these clinics there are “context-free” ways of engaging in the social action of diagnostic interpretation. These ways are also “context-sensitive” and the actions they implement display the particularities of the environment in which they appear ([Sacks, Schegloff, & Jefferson, 1974](#)). This implies that when issues of meaning emerge, they can range from providing definitions of relatively technical terms to more global assessments concerning health and life implications of the diagnosis.

Meaning assessment sequences

Meaning assessment sequences are positioned relative to the delivery of news, and I will examine each of four basic positions, which are exhaustive within my collection of data.¹

1. A clinician delivers the news and proposes meaning assessment within an announcing turn.
2. A clinician delivers the news and proposes meaning assessment in an “expanded turn transition space” between the diagnostic announcement and its receipt.
3. A clinician delivers the news and proposes meaning after a problematic receipt.
4. After a delivery of news, the patient or recipient asks what it means.

An orderly variant to these positions occurs in cases where a clinician, instead of offering an interpretation or being asked for one in juxtaposition to the delivery of diagnosis, may ask the news recipient, “What does this mean to you?” This occasions a version of the “perspective display sequence” ([Maynard, 1992](#)) whereby the clinician can then offer interpretations fitted to what the recipient says. For reasons of space, this variant is not further explored here.

Proposal of meaning within an announcing turn

In clinics where somewhat technical jargon may be used, clinicians sometimes offer to interpret the jargon by putting it in lay terms. That is, clinicians may initiate an interpretation of diagnostic terminology as part of an announcing turn of talk. The proposal of meaning is in a turn-posterior position, which is the turn's transition space ([Schegloff, Jefferson, & Sacks, 1977, p. 366](#)), and thereby occurs just as the news is announced. Extract (1), from a clinic that tests for the HIV antibody, illustrates this positioning as well as two regular practices that appear in meaning assessment sequences.

At the start of the informing interview, just after the client (“CL”) has been identified by an anonymous code (not on transcript), the counselor (“CO”) produces a diagnostic announcement at line 1. He reports the

¹Readers familiar with conversation analysis will notice that these positions are like those that inhabit the organization of repair in conversation ([Schegloff, Jefferson, & Sacks, 1977](#)). Although I draw on the literature regarding repair, meaning assessment and repair are distinct phenomena. Repair, as an action, “replaces or defers” whatever else was due next in an ongoing activity to fix what was previously said, whether the trouble has to do with speaking, hearing, or understanding of that prior talk ([Schegloff, 1997, p.503–504](#)). Relative to a delivered diagnostic term, meaning assessment also has a retrospective character but is an action concerned with defining and projecting the consequences of a diagnosis, it can occasion relatively long stretches of interpretive talk.

assessment. That is, whether the assertion indicates an auspicious or inauspicious interpretation depends on the relation of the assertion to contextual understandings about the terms being used. Such contextual understandings are often exhibited in the sequencing of the talk, according to the placement of assessment terms next to one another in a diagnostic elaboration, for instance. In extract (1), whereas “you’re negative” in some contexts could be an inauspicious interpretation, the counselor delays that announcement until after he has repeated terms such as “non-reactive” and “not” finding antibodies. Thus, when the announcement arrives, he has provided for its understandability as an auspicious one by virtue of these predecessor terms.

A second feature to be noted in the interplay between disconfirming negatives and affirming positives in clinical settings is that clinicians use generalized assessment terms and lay formulations. Rather than getting more technical, they define, in less specialized terminology, technical vocabularies already used for the delivery of a diagnosis. The practices of disconfirming and affirming, accordingly, are recipient-designed and show clinicians’ attempts to translate official terminology into lay language.

Proposal of meaning in an “expanded” turn–transition space

Conversational interaction involves participants in taking turns of talk. Each turn contains a unit type, which could be a word, phrase, clause, sentence, etc. After a unit type is completed, there is what Sacks et al. (1974, p. 704) call a transition-relevance place or a point at which another speaker can take a turn. If another speaker does not take a turn, the current speaker can continue, but if neither speaks, then silence develops. Extract (2) is an example where the clinician delivers diagnostic information and there is such a silence. This an *expanded* transition space (Schegloff et al., 1977) in that the silence provides the clinician with an extra opportunity to initiate an assessment of meaning. The example has two other important features: it shows what happens with indeterminate results, and how the patient may affect the proposal of meaning by a particular response. The patient here is getting her mammogram results. While testing showed the right breast to be normal, the report for the left breast is not so good. In lines 1–10 below, Dr. K is reading from the report:

(2) 1.4:311; video

- 1 Dr. K: Well:: circumscribed density, is identified in the
 2 central portion o' the breast, with the lo:ngest axis
 3 about one point three centimeters. This could
 4 represent a cys:t but was not clea:rly: identified
 5 .hhh on [a pr]ior mammogram.
 6 Ms. V: [mhhh]
 7 (0.4)
 8 Dr. K: It says either ultrasou:nd to determine if this mass
 9 is cystic or a single view: followup in six months is
 10 warranted. .hhh to assure stability
 11 (1.2) ((Dr. and patient gaze at report))
 12 Dr. K: So what they're say:ing is:: (0.6) they see something
 13 that they cannot (1.2) say:: is perfectly nor:mal.
 14 (0.4)
 15 Ms. V: Mm hm[: :]
 16 Dr. K: [But th]ey're not very worried about it either,
 17 because they suggest we can do another picture in six
 18 months ta tell if it's stable.
 19 Ms. V: .hhh >Okay-< but it wasn't on my las:t mammogram?
 20 Dr. K: That's what they said.
 21 (1.0)
 22 Ms. V: Sh:::- okay.

After he finishes reading the report, which contains both a formulation of indeterminacy (lines 3–4) and a suggestion about how to resolve it (lines 8–10), both parties are silent as they continue looking at the report (line 11). This represents an expanded transition space, after which Dr. K at lines 12–13 and 16–18 engages in

what Moore (2004) analyzes as a post-report formulation of upshot. The “so what they’re saying” phrase is a device for proposing interpretation without using the word “meaning” as such. In this case, the initial upshot is a disconfirming of the *positive*, in that “they see something that they cannot say is perfectly normal” (12–13). During the word “say::” (line 13), Dr. K turns his gaze to his patient; she continues to look at the report until she produces a “continuer” (Schegloff, 1981) at line 15, at which point Dr. K produces a contrast term (“But”) and a mitigated form of disconfirming the negative (“they’re not very worried about it,” quoting a proposal for a follow-up exam (lines 17–18). Such a proposal is particularly relevant in the context of indeterminate results, but Ms. V only hesitatingly accepts this proposal at line 19 with an “Okay” token and with further receipts that downgrade the meaning assessment. That is, she issues a question (line 19) resulting in Dr. K’s confirmation (20) that the mass was not on her last mammogram. Then, through delaying further response (line 21) and using what Jefferson (1974) has called an “error correction format” whereby “sh:::” can project “shit” but is replaced by “okay” (22), Ms. V also exhibits disaffiliation from the “not very worried” meaning assessment.

In short, the patient withholds affiliating to her doctor’s assessment proposal. During the interview, Dr. V eventually suggests an ultrasound examination of the breast, which was performed on the same day. Subsequent to the ultrasound, in a follow-up telephone call to Ms. V to report the results, Dr. V announced that he had “good news” because the ultrasound suggested that the lump was a cyst, although he added that the radiologists “weren’t entirely reassured” about this diagnosis. Ms. V challenged the doctor’s proposal of “good news” and persistently sought clarification of his view of the experts’ opinion, eventually obtaining a suggestion for a three-month checkup that cut in half the radiological recommendation of waiting 6 months and then performing another mammogram (Maynard & Frankel, 2003). Accordingly, while clinicians may propose particular meanings for diagnostic news, patients and other recipients also affect the emergent interpretation. Here, Ms. V did not fully accept the “not to worry” and “good news” evaluations, and obtained a lesser interval for the follow-up exam. Meaning assessments, rather than unilateral impositions, can be collaboratively developed with various kinds of practical consequences.

Collaborative production of meaning: how far can it go?

Recipients of news may have a role in the local production of meaning, but they do not hold the reins fully, which is to say that not anything goes when recipients respond to an interpretive proposal. When their recipients’ veer too far from a path that the news adumbrates, clinicians themselves can disalign to formulations of meaning. Extract (3) has another meaning assessment in an expanded transition space, after the pediatrician at lines 4–12 delivers the diagnosis that the mother’s daughter is performing at a borderline level of retardation. Meeting with silence at line 13 (wherein there may be some non-vocal responsiveness of the mother), the doctor produces an “Uh:::m” token (line 14) that projects his continued talking. After a considerable pause, he goes on to explain the numbers that sustain this diagnosis, offering at line 18 the upshot of what borderline functioning means. It appears that he starts to affirm the positive, in the sense that he limits the applicability of the diagnosis (“only related to school performance”). After Mother’s “schoolwise” acknowledgement at line 20, which may propose to emphasize the limits of the diagnosis, he offers a further upshot (lines 21–22) that clarifies this affirmation. As the doctor continues with this clarification about the daughter’s competing with other children (25), the mother has already started a turn of talk (line 24) and there is competition for speakership. The mother succeeds in getting an extended turn of talk (lines 29–35) in which she provides an auspicious interpretation of the diagnosis, and does so by displaying a stance that departs from the doctor’s assessment of school performance.

(3) NYII #3; audio

- 1 Mo: ... For her learning ability, she is ↑slow.
 2 (0.4)
 3 SW: Mm hm
 4 Dr: That’s what we:: uh:: (0.4) also found on- (.) psychological

5 testing.
6 (0.8)
7 Dr: That she was per- not performing like a normal (1.0) uh::m
8 (0.8) six and a half year old uh (0.6) should.
9 (0.4)
10 Mo: Mm
11 Dr: And she was performing more uh:m (1.0) what we call as a
12 borderline (0.3) rate of retardation.
13 (0.8)
14 Dr: Uh::m (2.6) for a normal (0.6) kind of like use a number (0.6)
15 it's usually bout hundred (0.2) or more (1.2) and anywhere
16 betwee:n uh:: (0.4) eighty two 'n (1.4) uh:: (0.8) ninety's kind
17 of a (0.5) borderline (1.0) kind of uh (1.0) functioning. (0.4)
18 That means it dis- (0.2) >kind of a number is< only uh related
19 to school. (0.5) performance.=
20 Mo: =Schoolwise.
21 Dr: That means she will always (1.6) have difficulty to uh (.)
22 perform in ().
23 (1.0)
24 Mo: Well [I think she will progress]
25 Dr: [to comp- to compete with child]ren,
26 (0.5)
27 Mo: later.
28 (1.8)
29 Mo: You know I think 'at the further she'll go on, (0.3) she will
30 learn ↑more. .hh be see by h:er bein' in the first grade, and
31 she got to uh:: .hh responsibility of books and homework and
32 stuff, .hhh from first grade jus' (.) startin' out, I think in
33 second grade she would try and (.) keep up with the rest of the
34 children. (0.5) She would enjoy school better and she would ↑see
35 (1.0) she would ↑lear:n.
36 (0.4)
37 Dr: She will need lo::ts of help.
38 (1.0)
39 Mo: Sur[:e.]
40 Dr: [to] uh (0.3) do that. (.02) .hhhhh I think (0.5) ((clears
41 throat)) >one of the reasons< why we are:: uh: having this
42 conference is also to uh:: (0.4) .hhh (0.4) uh:: make you
43 aware:: of (0.8) her limitations.

That is, at lines 29–35, the mother gives a strongly affirmative, even exacerbated, interpretation of the child's functioning, after which the doctor, at line 37 disaligns to this interpretation by suggesting the daughter will need “lo::ts of help.” The mother, in delayed fashion agrees (lines 38–39), after which the doctor produces a version of the “conference” they are in so as to make the mother “aware::” of the child's “limitations.” Hence, while the doctor first proposes to affirm the positive, in this case the mother competes to launch an auspicious version of the assessment that is out of keeping with what the doctor's own line of talk projects, and her exacerbated positive version is not accepted by the doctor. And, as the news deliverer, the doctor also invokes the inclusive “we,” which can imply the clinic's authoritative assertion of a countervailing interpretation when used in contrast to “you,” the mother, whose is being made “aware” of her child's “limitations” (Maynard, 1991, p. 479).

Proposing meaning assessment after a problematic receipt

When deliverers offer interpretations of their news in the announcement or shortly thereafter, we have seen how the meanings they propose are something like clarifying upshots. When they occur in an expanded

transition space, they may be indicating that the silence is problematic, but officially there is only the lack of response at a point of turn transition (as in extract 3 above), and this is converted to an intraturn pause as the clinician continues (Sacks et al., 1974). Another set of meaning assessments occur after a receipt of the news when deliverers more clearly show that they regard the receipt as problematic. First, the receipt may be ill-fitted to the proposed nature of the news, or, second, it may exhibit affect such as crying.

Inadequate receipt of diagnostic news

In extract (4), the patient has recently had a mammogram and she asks her physician, Dr. L, for the results (lines 1–2). Dr. L acknowledges that he was going to tell her the results and suggests that the “report on that was good” (lines 3–4). This pre-assessment of the news can work to solicit a parallel alignment from the patient—that is, a “good news” receipt—once the news gets delivered (Maynard, 2003). Going on to read from the report on his desk, Dr. L announces the mammogram result at arrow 1. However, the patient only responds with a nodding “Mm hm” at arrow 2. This occasions Dr. L’s meaning assessment, a formulation of upshot, at arrow 3, which upgrades the preceding “good news” characterization with a kind of *best case* elaboration (Pomerantz, 1986) that exacerbates positive assessment of the “report.” In a sequential position (arrow 4) where Ms. S virtually has been invited to provide some kind of positive assessment, she initiates a question.

(4) Dr. L w/Ms. S (2.3; video)

- 1 Ms. S: An’ then: you were going tuh tell me tuhday about thuh
2 mammiogram.
3 Dr. L: Tlk .hh That’s right. A:nd I think thuh report on that
4 was good. (‘t) did cross my desk.
5 (1.0) ((Dr. looking through file))
6 Dr. L: 1→ ((reading:)) .hh Uh: uncha::nged appearance. ((shifts
7 gaze to patient:)) No evidence for cancer.
8 Ms. S: 2→ Mm hm. ((nodding))
9 Dr. L: 3→ ((returns gaze to report:)) So: it’s- it’s thuh:: .hh
10 b:est uh: report you can find. [(You just uh-)
11 Ms. S: 4→ [.hh Now: wouldju
12 answer a question for me. [On thuh=m- thuh mammiogram.
13 Dr. L: [I’ll try.
14 (.)
15 Dr. L: [Mm hm,
16 Ms. S: [eh - thee: extent of what it examines is thee::=uh
17 .hhh tissue of thuh breast itself.
18 (0.5)
19 Dr. L: Corre[ct.
20 Ms. S: [Correct?
21 Dr. L: Right.
22 Ms. S: Does it reach beyo:nd it.
23 Dr. L: It doesn’t really reach up in thuh arm pits. if that’s
24 what you’re: [were thinking of.
25 Ms. S: [Well I’m concerned (.) that there is uh
26 lump, an’ it is growing.

It turns out that the patient has a concern about a “lump” in her armpit. The mammogram has not covered that area, which means that, although the mammogram was negative for cancer, its possibility must further be considered. Maynard and Frankel (2003), following Abbott’s (1988, pp. 42–4) discussion of how, within any professional classification system, there can be “areas of unclassified, residual problems,” call Mr. S’ lump in the armpit a “*symptom* residue.” The symptom residue occurs here because a diagnostic test is not designed to evaluate another bodily area of concern. And that symptom residue appears to interfere with the patient hearing “no evidence for cancer” as good news, such that the physician, in pursuit of a response, affirms the

positive in a stronger “best case” fashion. His interpretive proposal still is not successful in garnering the patient’s agreeing alignment.

Receipts with crying or related affective displays

Displays of “negative” affect on the part of recipients also can engender a clinician’s meaning assessment. For example, in one interview at a developmental disabilities clinic, the mother of a six-year-old boy, James, had shown emotional resistance to formulations about the slowness of her child, at one point nearly crying. When the pediatrician broached the diagnosis, saying that a psychologist had found that James was performing “as a younger child” and that this placed him “within the range of mild mental retardation,” there was a long silence (over 3 s). The pediatrician then began to characterize his diagnostic “statement,” first registering a facially-exhibited emotional reaction of the mother, saying that he could see “by your face Mrs. Wright” that this was a “frightening” term and that it might seem to “cut off all kinds of hopes.” The doctor went on to invite the mother and father to “listen a little bit” so that she could define what the “term” “*might mean*.” However, following another long silence, the father asked his wife if she wanted to “go outside,” and both of them left the room. When mother and father returned, the pediatrician delivered more findings, summarizing by saying that their child “has limited intellectual potential.” He then returned to the issue of what “*that means*,” stating that “there is a limit” to how much James would “be able to assimilate,” but that he would be able to use skills to “work independently, to marry, to vote, to have children, to lead the kind of life that everyone of us leads.”

After deliveries of diagnostic news meet displays of emotional reactivity, proposals of meaning that disconfirm the negative and affirm the positive are ubiquitous devices. Extract (5) has a psychologist telling a mother, by way of an “incomplete syllogism” (Gill & Maynard, 1995) that her five-year-old daughter is mentally retarded (lines 2–3). At lines 5–7 (arrowed), after the mothers long silence (line 4), he offers a definition (“slow learning”) that affirms the positive by rendering the diagnosis in less severe terms—at the end of his turn, he uses a phrase “that’s all that mental retardation means.”

(5) H.31; video

1 Psy: .hhhh when a kid is- (0.2) delayed (0.2) significantly an’ when
 2 there’s pretty good reason ta believe that the delays are gonna
 3 be permanent .hhh that’s what we call mental retardation.
 4 (2.6)
 5 Psy:--> Slo:w learning. (1.0) with (0.1) an indication that it’s going
 6 --> to be a long term kind of problem. That- that’s all that mental
 7 --> retardation means.
 8 (20.0) ((mother grimaces; holds head, gaze downward))
 9 Mo: ((sobs:)) .hhhhhhh hhhhhhhh .hhhhhh ((grabs tissue))
 10 (2.5) ((mothers dabs eyes))
 11 Psy: Let me uhin (1.2) not try to ah- I- I don’t wanta .hhh g::oft
 12 coat that because I mean that- that’s a serious (.) diagnosis and
 13 I don’t wanna make a jo:ke or make light of that. (0.2) Ih ih
 14 it’s serious and ya have right ta- (0.2) and good reason ta be
 15 real upset .hhhh uh: I think it’s also though- (0.1) uhin .hhhh
 16 --> mental retardation does n:ot mean .hhhh uh:: that the child
 17 --> won’t learn, (0.2) cause the child (0.2) will learn.
 18 (0.6)
 19 Psy:--> Uhh::m (1.2) it’ll:: be a struggle, it’ll take ti:me, it’ll be
 20 slo::w but the child will:: continue to learn 'n .hhhhh it also
 21 .hhh doesn’t mean that she can’t live a happy (0.4) uh::: and
 22 even productive life.
 23 (1.4)
 24 Psy: Whe[n:]
 25 Mo: [Tha]t’s all I’m looking for, I jus:::- I want her ta talk
 26 .hhhh
 27 Psy: Yeah

In this case, the mother is extremely upset, although she is initially stoic and contained in her response (Maynard, 2003, Chapter 5). Silent for 20 s (line 8), she then lets out a sob and grabs a kleenex from the table in front of her to wipe her eyes (line 9). After this, the psychologist goes on (lines 11–15) to deny soft-coating the diagnosis by acknowledging its seriousness and the right of the mother to be upset. Then (arrowed lines 16–17, 19), he offers a further assessment of meaning—in two different ways, disconfirming the negative by saying what mental retardation does not mean. Subsequent to a silence (line 23) and the psychologist's start of another turn (24), the Mother then aligns to these formulations in her own affirmative terms (25–26), and the psychologist agrees (27).

After a delivery of news, recipient asks what it means

Overall, when recipients of news are silent or produce problematic receipts, these are like tacit requests for meaning assessment, because clinicians follow them with interpretive proposals. A fourth kind of placement for meaning assessment sequences arises when a clinician does not offer an interpretation in the course of presenting the news, in the transition space after the delivery, or after a problematic receipt. Then, the recipient may overtly ask what the news means. In extract (6), from internal medicine, the physician reads from the patient's file, giving a number from the cholesterol report at line 4. The patient is silent at line 5, which could operate as a tacit request for an interpretation of the figure, and following which the patient *asks* what it means (line 6). The doctor replies with a positive but qualified assessment (Jefferson, 1980; Schegloff, 1986), “that's pretty good” (line 7), after which she shows the chart to the patient and then draws a figure to interpret the “two hundred 'n seven” figure (lines 7–16).

(6) 3.6:432; video

1 Pt.: And: how did my cholesterol test come out. (0.2) blood
 2 test, I'm curious about that.
 3 (11.0) ((Dr. is reading file))
 4 Dr.: Tlk=.hh It was two hundred 'n seven,
 5 (0.4)
 6 Pt.: So what does that mean.
 7 Dr.: Tlk=.hhh uhm that's pretty goo:d. Usually >lemme just show
 8 you thuh numbers here,< thee uh:: (1.0) phhh (2.8) tlk=.hhh
 9 Less than two hundred, fer a cholesterol:, (.) is:
 10 considered desirable.
 11 Pt.: Mm hm?
 12 (3.6)
 13 Dr.: Tlk=.hh Two hundred tuh two forty, (.) is borderline?,
 14 (1.7) And (.) more than two forty?, is hi::gh. (1.4) .hhh
 15 So at two hundred an' seven you're:- just in this ballpark
 16 here, .hh What we usually do: is: if you're able at some
 17 point to come back for uh fasting?,
 18 (.)
 19 Pt.: Mm [hm,
 20 Dr.: [test, we do uh fasting breakdown of thuh cholesterol.
 21 .hh Usually at these kinds of levels we fin:d when we do
 22 thuh breakdown that there aren't any changes that need to
 23 be made in your diet but .hh then we can: s- break it down
 24 intuh thuh good an' thuh bad cholesterol an' just get a
 25 better idea [about (it.)
 26 Pt.: [Mm hm,

Because of the ambiguity involved in “pretty good,” the interpretation at line 7 may be an ambiguous instance of affirming the positive. Still, after a recommendation for further testing (lines 16–17, 20)—generically a *more-testing* proposal—the physician produces a further auspicious interpretation by suggesting that no changes in diet are usually needed and that they “just get a better idea . . .” (lines 21–25).

The necessity for a recipient to ask what some diagnostic news means is rare in my data. The overwhelming tendency is for physicians, in the context of diagnostic news that has any interpretive difficulty, to propose what the news means in the immediacy of the delivery or certainly after a problematic receipt. When there is interpretive difficulty and they do not do this, it may be an abrogation of the usual order, as it falls upon the patient to *ask* for interpretation. And, if a patient does pose a question about meaning, it still appears incumbent upon the physician to offer auspicious interpretations.

Discussion

The organization of meaning assessment in deliveries of diagnostic news

In clinics, meaning assessment sequences regularly involve one party—the physician or other professional—proposing an interpretation of news and the other party—the patient or family member as recipient—aligning or disaligning to the proposal. There are successive positions during a delivery of diagnostic news for meaning assessment to be initiated: (1) A clinician delivers the news and proposes its meaning as a clarifying upshot within an announcing utterance; (2) a clinician delivers the news and proposes its meaning in an “expanded” turn–transition space; (3) a clinician delivers the news and proposes its meaning after a problematic receipt; and (4) after the delivery of news, a recipient *asks* the clinician what it means. Accordingly, opportunities for clinician-initiations of meaning assessment precede those for recipient-initiation, as patients or family members allow their clinicians to initiate and perform interpretive proposals. When recipients initiate meaning proposals, it still allows the deliverer to make the interpretation. Indeed, if recipients themselves both initiate and propose meaning assessment for a clinician to confirm or disconfirm, that can represent abjuration on the part of the clinician, who is noticeably refraining from interpretation.

Certainly in clinical settings, this asymmetry of meaning assessment, whereby clinicians have initial opportunities to engage in interpretation, can reflect an imbalance of knowledge. That is, clinicians have access to authorized or expert interpretations while patients and family members mainly have their own “lay” experience to draw upon. However, in interactional and sequential terms, lay participants’ deference to clinicians’ interpretive stances draws upon the more generic organization of news delivery sequences. Given the practical ways in which meaning assessment operates in the delivery of news, that is, the asymmetries between clinicians and patients for interpreting news has strong organizational dimensions at the internal interactional as well as external structural level. In these terms, familiar in conversation analytic work (Heritage, 1984; Pomerantz, 1984; Sacks, 1987; Schegloff et al., 1977), when participants to the clinical encounter initiate meaning assessment, there is something like an endogenous *interactional* preference for clinicians as deliverers of diagnostic news to produce interpretive proposals and a dispreference for their recipients to do so. This preference is what clinicians build upon for their authoritative version of disease and disability represented in diagnostic pronouncements.

Auspicious interpretation

When clinicians produce proposals of meaning, it most often is to offer auspicious interpretations of the news through the practices of disconfirming negative and affirming its positive aspects. In replying to proposals, recipients regularly display agreement, only rarely withholding it, as in extract (4). The usual agreement with auspicious interpretation occurs whether the news is good, bad, or even indeterminate, and it seems to reflect an orientation to the benign order of everyday life (Maynard, 2003, Chapter 6). That is, meaning assessment follows a pattern intrinsic to the delivery of news whereby participants shroud the bad or negative aspects and expose the good or positive aspects. To put the matter in vernacular or less technical terms, auspicious meaning assessment is a way for deliverers of news to offer reassurance to recipients, while recipients usually welcome such reassurance, along the lines that they may be free from disease, or that they have a less severe diagnosis than might have been expected, or that a condition is not to worry about, or that a disability is limited rather than all-pervasive, or that there are therapeutic things to be done in the face of a severe disablement.

How meaning assessment matters in the clinic

We can now bring this analysis to bear on the interview described at the beginning of this paper, and represented in excerpt (7). Two features regarding meaning assessment in this interview are worth emphasizing. First, the doctor does not initiate the assessment of meaning. In fact he bypasses several opportunities for doing so. He does not offer any interpretation of the diagnosis when it is delivered (arrow 1). After that delivery is a silence that extends the turn transition space (arrow 2). Next, at arrow 3, Mr. Jones produces a series of response cries, including “Jesus,” “Oh my god,” and so forth, which are clear exhibits of problematic receipt and offer further opportunities for Dr. H to engage in auspicious meaning assessment. And then after Mr. Jones bends over in his chair, there is a huge 7-plus s silence at line 12, after which he *asks* what the news means (arrow 4, line 13). This is the fourth, and dispreferred position for meaning assessment to be initiated. To this, Dr. H hesitates and suggests that he is going to “need tuh see alo:tta doctors” (lines 15–16).

(7) Dr. H/Mr. J:78; video

1 Dr. H: Uh::, there is something growing in your stomach.
 2 (4.0)
 3 Mr. J: You can't te:ll what it is?=
 4 Dr. H: =I can tell you what it is Cli:nt.
 5 (0.1)
 6 Mr. J: Mm hm.
 7 (0.1)
 8 Dr. H: 1→ Uh: (0.2) it's a cancer.
 9 2→ (0.4)
 10 Mr. J: 3→ Jhheesuhhs: (1.2) Oh:: my gohhd (1.2) tch! (0.5) hh (1.8)
 11 Oh::no::hh . ((Mr. Jones bends forward))
 12 (7.1)
 13 Mr. J: 4→ >What does that mean?<
 14 (0.4)
 15 Dr. H: tch hhhh (0.4) we:ll? (5.0) It mea:ns you're going tuh need
 16 tuh see a lo:tta do:ctors Clint (2.0) Ahhm (1.0) You're
 17 gunna need a lo:t of medical help.
 18 (0.4)
 19 Mr. J: phh (0.6) >Does (it) mean I'm gonna die::<
 20 (1.5)
 21 Dr. H: hhh
 22 (3.7) ((Mr. Jones is bent over looking at floor))
 23 Mr. J: (Oo:↑:::))hhh ((whimpering; stands up))
 24 (2.6) ((Mr. Jones turns away from physician))
 25 Dr. H: Stay with me Clint
 26 (1.1)
 27 Mr. J: How long I got.
 28 (0.2)
 29 Dr. H: Come on stay with me now.
 30 (1.2)
 31 Mr. J: How long do I got.
 32 (2.4)
 33 Dr. H: I don't know::.
 34 (1.6)
 35 Dr. H: I don't ↑know yet. (.) there are a lo:t of questions yet we
 36 haven't answered.
 37 (1.9)
 38 Mr. J: hhhhohh gohhd

This is like the device that I referred to earlier as a more-testing proposal, which usually appears in the context of indeterminate news, as in extracts (2) and (6). Dr. H follows this proposal with the assessment that he will “need a lo:t of medical help,” so that Dr. H’s only meaning assessment here is a rather “extreme” formulation (Pomerantz, 1986) and thus portentous and inauspicious way of putting that there is medical help to be had for cancer. Next, there is further silence on the part of Mr. Jones (lines 18). And now, after further hesitation (line 19), he not only initiates meaning assessment but provides the penultimate candidate proposal, “Does it mean I’m gonna die:”. Still, Dr. H is hesitant, emitting an outbreath (line 21) and gazing down at the back of Mr. Jones, who is bent over in his chair looking at the floor (line 22). Mr. Jones subsequently issues a whimpering sound and begins to stand up (line 23).

As Mr. Jones steps away toward a counter behind him (24), Dr. H beckons him back with “stay with me” (25). Still standing and facing away from Dr. H, Mr. Jones asks, “How long I got” (27), a query spoken very softly, and suggesting that he interprets Dr. Hoffman’s lack of an answer to his previous question as affirming the candidate proposal of meaning that he is going to die. After this, Dr. H again beckons him to the chair (29), and Mr. Jones repeats his question with different emphasis, “How long do I got?” (line 31). Dr. H responds by disclaiming knowledge (lines 33, 35), and then Mr. Jones walks further away and toward the door of the room (lines 37–38) in the corner opposite from where Dr. H is sitting. Mr. Jones remains there while Dr. H repeats a version of line 35’s “lo:t of questions yet we haven’t answered” (not on transcript). After 13 s of silence, Mr. Jones returns to the counter, where he stands in silence for another 12 s, and finally returns to his seat. Although Mr. Jones has stayed in the room, Dr. H regards him as interactionally unavailable for talk concerning the illness and treatment, all told, for over a half minute. After his patient returns to the chair he had left, Dr. H goes on to discuss treatment options, emphasizes an immediate need for surgery, and repeats his suggestion that Mr. J needs to see another doctor.

The upshot is that as he delivers the dire bad news of stomach cancer, Dr. Hoffman declines to provide any auspicious interpretations. He also allows for a dispreferred activity, wherein his patient both initiates the assessment of meaning and proposes and infers fully inauspicious interpretations. In answering the patient’s initial question, “What does that mean?”, moreover, Dr. Hoffman produced an assessment related to a device usually fitted to indeterminate results, but with the above-mentioned portentous aspects to it, telling him that he’s “gonna need to see a lotta doctors.”

This analysis would seem to suggest that Dr. Hoffman has performed badly, and perhaps he has. But I have consulted with a sociologically trained internal medicine physician about this,⁴ and what he sees is a doctor who is skilled at diagnosis, and who falters as the topic changes from diagnosis to prognosis. As projections are made as to what is going to happen, it is a topic that is out of the physician’s realm. And the metaphor my consulting physician/sociologist used is that Dr. Hoffman “punted,” a term suggesting that he is attempting to get rid of the football, trying to kick it away to the other team. This may give us some sense of the difficulties the doctor is up against, which involve his being a generalist and not a specialist, and, consequentially, lacking in knowledge about cancer and its treatment and wanting oncology experts to handle further questions about the meaning of the diagnosis. While involved in giving prognostic estimations are deep strains and dilemmas that can lead to avoidance or even pessimistic versions of disease outcomes, Christakis’ (1999) study shows that even in the context of indeterminacy and ambiguity, clinicians can and do achieve an appropriate balance between optimism and pessimism that encourages hope in their patients. There is, indeed, a moral obligation for the physician to do so (Christakis, 1999, p. 192).

Conclusion

When physicians and other clinicians deliver diagnostic news, it may be relevant to interpret the news to recipients. Although conversation analysts and others have examined news deliveries, they have not explored those episodes in which the participants raise and address interpretive issues. In my data, if it is in only a minority of cases where such issues come up, it is nevertheless a substantial minority (approximately 25%). Given the range of clinics in my research, it can be surmised that problems of diagnostic meaning are prominent aspects of many medical encounters.

⁴Dr. Brian Costello, Mayo Clinic, Rochester, Minnesota, personal communication, June 2003.

Proposals of meaning, whatever the kind of news, most regularly involve producing auspicious lay interpretations, to which recipients align by displaying agreement or acceptance. They can disalign and work to modify, not always successfully, what an auspicious interpretation implies in terms of therapy or treatment, but when the assessment of meaning is occasioned, auspicious interpretations and reassurance regarding the delivered news can be said to be interactionally required. The case study involving Dr. Hoffman and Mr. Jones is evidence for such a conclusion, and, because of the analysis of generic practices—“abstract, formal resources” involved in the collection of meaning assessment sequences—the analysis permits generalization beyond the case (Schegloff, 1987). When a physician does not offer auspicious interpretation, allows for a recipient to do the dispreferred activity of asking for a meaning assessment, and still refrains from affirming positive or disconfirming negative meanings, the patient or family member may make tormenting inferences that undermine the relationship between doctor and patient and the stability of the medical encounter. Put the other way around, when physicians and clinicians engage in meaning assessment in a preferred way, by defining disease and disability in ways that are affirmative and reassuring, it is beneficial to the interaction and to the encounter. Gropman (2004, p. 26), a physician, helps put these sociological matters in clinical terms: what I have called auspicious interpretation need not imply issuing unbridled hopeful remarks, but rather paving the way for proposing real options and genuine choices in the aftermath of diagnostic news. Finally, in this paper, episodes of news delivery include those that are bad, good, and indeterminate. The effective use of auspicious interpretation seems to transcend the type of news being delivered.

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