

Chapter 9

**ON DIAGNOSTIC RATIONALITY:
BAD NEWS, GOOD NEWS, AND THE SYMPTOM RESIDUE**

in John Heritage and Douglas W. Maynard (eds.)

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“Consideration of the patient’s condition” or the fourth phase of the medical interview is, according to Byrne and Long (1976), the point at which the physician, having performed introductory matters, ascertained the reason for the patient’s visit, and conducted a history and exam, delivers diagnostic information. In the “three function model” of the medical interview (Cohen-Cole 1991; Lazare, Putnam, and Lipkin Jr. 1995), conveying diagnostic information fits within the third function of carrying out patient education and treatment plans. To date, research on this phase and function of the interview has been minimal, and has emphasized “bad” news and the communication problems surrounding it. And this literature, as Ptacek and Eberhardt (1996) concluded in a comprehensive review, is overwhelmingly anecdotal, based on clinical experience, written from the physician’s point of view, and rarely theoretically justified or accompanied by empirical investigation.¹ Moreover, the preoccupation with bad news has meant that other kinds of diagnoses, such as those that are good news or uncertain, have received virtually no study. For the medical profession, this neglect in research also means there is not much of a base on which to build curricula or standards of practice.

Recently, Frankel (1994), Heath (1992), Maynard (1991c; 2003), and Peräkylä (1998; 2002; this volume), approaching the delivery and receipt of diagnostic news as an interactional event, have employed video recordings of actual interviews as a basis for analysis. However, neither Heath’s (1992) nor Peräkylä’s (1998) investigations distinguish between bad or good news deliveries as such, while Frankel (1994) and Maynard (1991c) exclusively consider bad news. Our analysis in this chapter concentrates on episodes in which the delivery is produced and/or received as having a *valence* either way—as “good” or “bad.” Further, because of their prominence in our data, we also analyze cases involving uncertainty.² One purpose is to demonstrate that the valence of testing or diagnostic news—whether medical information is marked as good, bad, or uncertain—matters significantly for both delivery and receipt of diagnostic news.

Beyond investigating patterns of diagnostic delivery and receipt, we are interested in

applications of interaction-based research. Heath (1992:264) has argued that efforts to transform communication and other behavioral features of medical consultation need to be sensitive to interactional organizations through which participants accomplish matters such as the diagnostic presentation. Those interactional organizations are not readily transparent, in part because of the lack of empirical and theoretical grounding for the understanding of clinical discourse in general, not just diagnostic informing events (Frankel 1995b; West and Frankel 1991). With regard to these events, the little existing research suggests that doctors are generally poor at communicating diagnostic information, even when they have had video feedback training during medical school (Maguire, Fairbairn, and Fletcher 1986). But, argues Frankel (1995b), “As education and scholarship in this area continue to develop, important questions about how best to communicate not only bad news but ‘good news’ and ‘no news’ will be addressed.” Developing such a knowledge base is another aim of our chapter.

While many American and all Canadian medical schools now offer training in communication skills, only a few offer sessions specifically about the conveyance of diagnostic information.³ If there is no formal instruction about presentational strategies as part of medical training, the skills whereby participants deliver and receive good, bad, and other kinds of news are part of a tacit or commonsense knowledge base (Garfinkel 1967; Polanyi 1958; Schutz 1962), acquired without pedagogy or practice and through everyday communicative experiences. For example, by emerging and ongoing participation in society, and becoming competent at conversation, participants may learn a generic News Delivery Sequence or NDS (Maynard 1997; 2003) comprising four turns of talk—announcement, announcement response, elaboration, and assessment. We will explore how doctors and patients enact and configure this sequence in the context of medical diagnostic news.

Our analysis includes a discussion of the strong interactional asymmetries in the delivery and receipt of good as opposed to bad news. Good news, as might be expected, involves an easier path than does bad news, implicating both parties in relief and joint solidarity. Deliverers present good news in an *exposed* fashion—prefacing the news with a positive assessment, placing the news in the first turn of the NDS, avoiding disfluencies, and so on. By contrast, bad news often

approaches a breakdown in solidarity and a breach in rational discourse between physician and patient. Bad news is *shrouded* — deliverers preface the news with neutral terms (or even positive evaluations) rather than negative assessments, often delay the delivery until the third turn of the NDS, produce the news after hesitations and other disfluencies in a turn of talk, or otherwise position it last in the turn. Moreover, compared with their immediate, evaluative reactions to good news, recipients are restrained in how they treat bad news. They may delay their responses, and often do not use a semantic term when assessing the news, but do produce expletives like “Oh shit,” or “Oh god.” The pattern of asymmetry in the interpersonal handling of news works toward the sense of a “benign” social world (Maynard 2003). Nevertheless, good news can have its own edge, for a *symptom residue* often accompanies good news in the clinic—persistent medical complaints may go unexplained when a serious diagnostic possibility is excluded. This raises the specter of indeterminacy and uncertainty in clinical medicine and thereby a different but no less significant approach to the irrational than bad news presents.

Diagnostic News Deliveries in Primary Care

In clinical environments, the “primary” consequential figure in a diagnostic news delivery is the patient. And, although family members may be attending as well, patients are the main recipient. In fact, this is one general way of differentiating information transfer in institutional settings from that in ordinary conversation. In conversation, participants regularly share news about others or about themselves. Most episodes, that is, are “third-party” deliveries (Maynard 2003) about relatives, friends, neighbors, acquaintances, and sometimes public persons whom the participants know in common. Or conversational episodes are “first-party” tidings in which the deliverer is the primary figure, reporting something about ego or self, as when party A tells party B, “Guess what, I haven’t had a drink for eight days now” (Terasaki (1976:7). Only rarely in conversation are there episodes in which one party tells a recipient “second party” news, or tidings about the recipient him- or herself as the primary figure. In that sense, the conversational experiences of participants are limited. However, in various organizations, professionals customarily have “second-party” news to deliver. It is our welfare workers, police, clergy, real estate agents, attorneys and of course physicians and nurses who are regularly involved in bearing news to a recipient who is the primary figure. This feature of medical routine—the frequency with which

practitioners are in the position of conveying news to the primary figure—may be at the root of arguments for medical schools needing to devote more time to training about the communication process and especially bad news (Lipkin Jr., Putnam, and Lazare 1995). We shall argue that conveying good news and uncertain diagnostic information need attention as well.

As a matter of everyday routine, physicians, in interaction with patients, deploy the News Delivery Sequence, but configure its four turns differently from the conversational sequence. Physicians regularly announce testing and diagnostic information by *citing or explicating the evidence* or making reference to the tests that warrant their diagnostic announcements (Maynard, 1991a; In press; Peräkylä 1998). This citing of the evidence often occurs in a first turn Announcement or may appear in an Elaboration turn. In either case, it represents a contrast with conversational deliveries of news. In ordinary conversation, deliverers and recipients display an orientation to the speaker's "firsthand knowledge" or at least closer-hand knowledge than the recipient. Consequently, news deliveries do not necessarily exhibit *how* speakers know about what they announce although they may exhibit *that* speakers are knowledgeable and recipients are not. For instance, when giving news about themselves, as in excerpt (1) deliverers draw on and have respected their entitlement to know their own experiences (Sacks 1992:243-48). When bearing news about third parties, as in excerpts (2) and (3), deliverers announce it by assertions or declarations that display "firsthand knowledge" also deriving from their own biographies (if only having heard the news previously from someone else). Recipients, in response and without asking for any kind of displays of "practical epistemology" (Whalen and Zimmerman 1990) from deliverers, produce various kinds of newsmarks, news receipts, and assessments that show an orientation to having a "changed state" (Heritage 1984a) or having received the news and understood its valence as bad or good (Maynard 1997). In short, conversational participants exhibit an orientation to deliverers' knowing *that* something is news and possibly good or bad. In the clinic, physicians exhibit not only that they are knowledgeable but *how* they are knowledgeable.⁴

Asymmetries between Good and Bad News: Minor Conditions

The delivery and receipt of good diagnostic news, then, can closely follow a generic News Delivery Sequence, which is configured in ways to show how physicians know the basis of their

diagnostic news. Additionally, while there may be generic ways for the delivery and receipt of diagnostic news, as we have seen in conversation, there are orderly asymmetries between bad and good news in the clinical setting. These asymmetries shed light on what each type of event means in relation to the *rationality* of discourse in medicine. Asymmetries between bad and good diagnostic news appear across the clinical spectrum from reports on minor procedures and conditions to more major ones.⁵

As a start, we examine instances of reporting blood pressure results. In the excerpt below, which has “good” results, the patient has been sitting on the examining table while the doctor takes his blood pressure. The doctor removes the blood pressure cuff and hangs it on the wall just before the utterance in line 1 below. At line 4, the patient’s reference to the “freshman at Cornell” refers to the physician’s daughter, whom they have discussed previously.

(4) CGN: 39 (3.3; p. 7:10)

1 Dr. G: Have a seat. ((Doctor sits down at desk in corner of
2 room; patient then sits down next to the desk, facing
3 the doctor.))
4 Mr. T: Fre:sh man at Cornell huh?
5 Dr. G: Ye:ah.
6 Mr. T: That’s great.
7 (2.0)
8 Mr. T: Doesn’t that time go fast (.) MAN[hh
9 Dr. G: [Sure does .hhh
10 1 ONE THIRTY SIX OVER EIGHTY FOUR with yer sittin, so=
11 Mr. T: 2 =Mkay=
12 Dr. G: 3 =those are in good shape. [Let’s get a white cell
13 Mr. T: 4 [((nods head))
14 Dr. G: taday,
15 Mr. T: Okay.

After the side sequence about how fast the time goes, Dr. F announces the blood pressure result at arrow 1 by citing the evidence. Then, following the patient’s “mkay” response (arrow 2), Dr. G elaborates the news at arrow 3 by providing a positive assessment. Mr. T receives this assessment by nodding (arrow 4). Because the physician is the one who first assesses the news (arrow 3), he can be heard in that turn to be *interpreting* the blood pressure reading for the patient, and the patient’s nodding aligns to the positive assessment rather than independently assessing the news (as often happens in the fourth turn). Notice that there is nothing hesitant in Dr. G’s manner for giving either the result or the assessment, and both are produced quickly in the sense that the news

represents an abrupt change from the previous topic of the physician's son, and is followed by a topic change, a proposal for a different ("white cell") test (line 12), which occurs in simultaneity with the patient's nodding.

This good news episode can be compared with one also involving blood pressure and in which the news is at least ostensibly bad. Neither physician nor patient assesses the news as bad, instead producing other interactional indications that the news is disfavored. The interview from which excerpt (5) is taken began with the physician and patient reviewing the patient's medications (she had come to obtain a renewal of her blood pressure medicine), and the doctor next proposed an agenda-like organization for the rest of the interview. In so doing he raised a concern about her blood pressure test. Notice how, in lines 1-3 below, Dr. L introduces the "borderline" blood pressure result. He names the feature to be reported on ("blood pressure," line 1), then gives a source for the to-be-reported result, next hesitates with an "uh:" and brief pause, then offers a hedge ("was perhaps") and minimizer ("little") before stating the "borderline" result.

(5) Dr. L./Ms. B (2.1:125)

1 Dr. L: .hh Alright, well: let's see. An' your blood pressure
2 according to thuh clinic assistants:=uh: (0.2) was
3 perhaps (uh:) little borderline. So may- I- I think I
4 might like to: jus' double check that.
5 Ms. B: M[kay,
6 Dr. L: [An' then why don't I look at thuh sma:ll of your
7 back.

Shortly after this, Dr. L put the blood pressure cuff on Ms. B (see lines 3-6 below) and conducted the pressure check for which he had indicated his intention. In announcing the result (below, arrow 1), Dr. L cites the evidence (lines 10-11) in a very delayed fashion (a turn initial "well," a naming of the condition to be reported on, "your blood pressure," and a reference to the "reading," lines 7-8). Although preceding his report of the result Dr. L offers an assessment, it is mitigated ("a little higher...", line 8). Furthermore, he embeds this assessment within a subsequent, moderating position-statement ("than I'd like tuh see it").

(6) Dr. L./Ms. B (2.1:173)

1 Dr. L: And how old are you now?

2 Ms. B: Fifty (three,)
3 (26.0)/((Dr. L is standing and inflating and
4 deflating the blood pressure cuff as Ms. B sits on
5 the examining table. He is removing the cuff from her
6 arm as the following is spoken:))
7 Dr. L: 1 Well, your blood pressure hh by that reading would
8 be a little higher than I'd like tuh see it. (Itsa-)
9 ((helping remove the cuff)) have you put your arm
10 through- (.) right there °okay like that°. I got
11 about one forty over ninety ei:ght.
12 (0.2)
13 Ms. B: 2 Mm.
14 Dr. L: 3 Which is (.) ya know a little bit higher than what
15 tuh clinic assistants g[ot].
16 Ms. B: 4 [Mm hm.
17 (2.5)
18 Dr. L: °ah:° .hh Do you ever have thee opportunity tuh
19 moni[tor it at all?
20 Ms. B: [I do:: an' I have uh car:d...

Then, when Dr. L reports the result (lines 10-11), he forms it as an approximation (“about ...”, line 11). After Ms. B’s token response (arrow 2), he elaborates (arrow 3) by observing that the reading is higher than the other one, which had been suggested as “borderline” in excerpt (5) (line 3). Consequently, the news delivery is one in which the upshot that the patient’s blood pressure is too high is never stated outright, and the delivery is, in various ways, cautious and circumspect. Ms. B receives the elaboration with another token (arrow 4). She neither shows a strong “change of state” in her understanding nor assesses this news. Her response, in accord with conversational news deliveries wherein a recipient is the primary figure, is restrained.⁶ As in the organization of conversational tidings, diagnostic bad news is shrouded, while diagnostic good news is exposed.

Asymmetries between Good and Bad News: Major Conditions

Compared to the ubiquity with which primary care physicians deliver news about relatively minor conditions, bad and good news concerning major conditions are less frequent. However, such news can take on life and death significance, result in dramatic and emotion-filled experiences for both the patient and the physician, and have profound legal, ethical, and social consequences. For such reasons alone, informing episodes involving potentially serious conditions warrant scrutiny. Beyond this, diagnostic news regarding major illness permits us to explore further the asymmetric modes of delivery and receipt for the interactional work that they perform. Along lines Heritage (1984b:269) has suggested about how preference structure in conversation exhibits affiliation and

solidarity, diagnostic news events show the importance placed on rational interchange in the doctor-patient relationship. Bad news threatens such interchange in a way that good news does not. Accordingly, preferencing forms in good news (exposing the news and visibility of its valence), and dispreferencing forms in bad news (shrouding the news and valence), work to enhance solidarity by preserving not only intersubjectivity or mutual understanding, but also public rationality.

We first examine an episode of good news concerning a patient's cardiovascular system, and follow this, for comparative purposes, with an example of bad news wherein a patient is told that he has cancer. In addition to verbalized aspects of this event, we explore the bodily comportment and non-vocalized behaviors of doctors and patients, which demonstrate alignment in the good news encounter and nonalignment in the bad news event, and are part of the asymmetries in delivery and receipt of the news.

Cardiovascular Good News

In the good news interview, as doctor and patient work their way through a diagnostic News Delivery Sequence, they demonstrate alignment and convergence in their vocal and nonvocal interactive practices on the goodness of the news. Dr. "Donna Thomas," an internist in the primary care center of a Midwest university hospital, has been treating a patient, 50-year-old Ms. "Gayle Roberts," for various symptoms, including severe chest pain. Because of this pain, the patient was referred to a cardiology clinic for specialized testing, which is now complete. Dr. Thomas has seen the results and after entering and seating herself in the clinic room where Ms. R has been waiting, and while paging through the patient's record, asks a standardized how-are-you question (line 1 below) that marks this as a return visit (Robinson, this volume). In answering such queries, Frankel (1995b) has observed, patients display two orientations. One is to answer in a "sociable" mode as an extension of or substitute "greeting sequence" (Sacks 1975). The other is to answer the question in a "clinical" mode, according to the specific medical complaint the patient may be bringing.⁷ Here, the patient, Ms. R initially responds sociably that she is "pretty good" (line 2) and then, in a more clinical vein, reports tentatively ("I think") that her test results have come out "okay" (lines 2-3). Without hesitation, Dr. T confirms this (line 4) and then leaves to obtain the "paper". She is gone for over two minutes (line 7):

(7) Dr. T/Ms. R

1 Dr. T: How are ya doin?

2 Pt. I'm doin pretty good. I ha:d- da te: sts::, an I

3 think they all came out o kay.

4 Dr. T: They did. Lemme go get- I had that um (0.8) uh tch

5 paper on that, be right ba[ck.

6 Pt.: [°Mm°

7 ((physician leaves room and returns after 2:12))

8 Dr. T: Did they talk to you:: at the time of

9 th[e:: (.) te:st?]

10 Pt.: [No: they didn't]

11 Dr. T: >Okay.<

12 Dr. T: pa .hhh Um (.) it did come out very well.

13 Ms. R: ga G[ood

14 Dr. T: 1 [Thee: uh::m (0.4) >you know they do< two:: (.)

15 | parts of it, a::nd one part is: .hhh (.) that they,

16 | have the electrocardiogram, ((brings hands toward

17 chest))

18 Ms. R: Mm [hm]

19 Dr. T: | [on.] .hhh an::dt that uh they look uh:: for

20 | evidence of too little (0.4) blood and oxygen going

21 | to the heart muscle. .hhh ((leans toward Ms. R)) an

22 | that was fi:ne,=

23 Ms. R: = [°Mm hmm°] ((nodding))

24 Dr. T: | = [the elec]trocadiogram part of it, they said that

25 | .hhh ((reading report on desk, left hand on page))

26 | you: (.) um exercized very well::, with an excellent

27 | functional ((returns gaze to patient)) ay:robic

28 capacity.

29 Ms. R: 2 O[kay] ((smiles; nods during Dr's next turn:))

30 Dr. T: 3 [So that] ((continuing gaze at patient)) that means

31 | that for that fo:r: .h >you know they always say for

32 | somebody at this particular< a:ge and a female

33 | per:son .hh they have kind of an a:verage or a low or

34 | a a hi::gh amount of ac[tivity] (.) that they

35 Ms. R: [°Mm hmm°]

36 Dr. T: | were able to do and you were able to do a lo:t of

37 activity.

38 Ms. R: 4 That's grea:t [cause] I want to really start=

39 Dr. T: [Yeah]

40 Ms. R: =exercizing a:nd reduc:e wei:ght. I [gained] fifteen

41 Dr. T: [Yeah]

42 Ms. R: poun:ds an .hhh the red li(h)(h)ght [is on.]

43 Dr. T: [((nodding))] So

44 .hh ((returning gaze to report)) that was good they

45 said a excellent functional ayrobic capa:ci[ty .hh

46 Ms. R: [So I

47 could- coul:d uh si:gn up fer aerobic classes.

48 (0.2) ((Dr. T looking at report))

49 Dr. T: Mm hmm ((nodding))

When Dr. T returns to the room, she asks if “they” had talked to the patient “at the time” the test

had been performed (lines 8-9), to which Ms. A replies negatively (line 10). After acknowledging this (line 11), Dr. T produces a kind of preface to her announcement of the news (paraphrase, line 12), which re-confirms (using emphasis on the verb) the favorability of the results. Goodwin (1996), following Sacks (1974) on story prefaces, has referred to utterances such as this as “prospective indexicals.” That is, “It did come out very well” provides a kind of headline to the upcoming news, and an indication of how to respond to it. Ms. R treats this utterance with a positive assessment that suggests a “go-ahead” (gesture) and occasions the announcement of results (arrow 1 at line 14 and continuing).

In the first part of the News Delivery, Dr. T cites and explicates the electrocardiogram test results, and also summarizes the outcome of a thallium procedure. She prefaces her delivery by suggesting that there are “two parts” and referring to the “electrocardiogram” being “on” (lines 15-16, 19). Then, referring to the thallium, Dr. T adds that “they look uh:: for ...blood and oxxygen going to the heart muscle” (lines 19-21), and produces a general assessment (line 22) that it “was fine.” At this point, Ms. R produces a continuer and starts nodding (line 23). In overlap with the continuer, and looking at the file on her desk, Dr. T cites the evidence from the electrocardiogram by reading specific determinations (lines 24-8). On the words “excellent functional aerobic capacity,” she also shifts her gaze from the record to the patient. The patient responds here with “smile voice” and an “Okay” acknowledgement (arrow 2).

Now Dr. T (arrow 3, line 30 and continuing) elaborates the electrocardiogram news, proposing what the test result “means” (lines 30-34) and reporting that the patient was “able to do a lot of activity” (lines 36-7). Immediately (arrow 4, line 38 and continuing), the patient assesses this news positively and then provides an account for her assessment (lines 38, 40, 42), which has to do with her “want” to exercise because of a weight gain. Dr. T, gazing at the patient, tracks this account (lines 39, 41) and nods (line 43) at its completion. Following this, she also produces a positive assessment as part of a summarizing repeat of the findings (lines 43-45), which appears to be a device for holding the floor while further reading the report on her desk. Ms. R, however, next exhibits that her previous expression of wanting to exercise because of having gained weight may have been a tacit request for *permission* to exercise because at lines 46-7 she explicitly asks whether she could sign up for aerobic classes. Dr. T gives her nodding assent while continuing to

look at the report (lines 48-9).

Subsequently (not on the transcript above), there are brief references to back pain (which we discuss later) and then breathing difficulties the patient experienced during the electrocardiogram test. There is also a second segment to this good news delivery, wherein Dr. T elaborates on the thallium procedure, which showed that oxygen was getting to all sections of the heart. Dr. T ended the news delivery by saying that “together” the two tests (electrocardiogram and thallium) suggested that there was no “part of the heart which looks like it’s in danger,” and Ms. responded with “Um that’s good.” For considerations of space, we are not further analyzing this second segment. The first segment (excerpt (7)) displays several characteristics that also feature in the second and permits comparison with an interview concerning a patient’s diagnosis of cancer. The interview between Dr. T and Ms. R is summarized in Figure 1, which we discuss later, for purposes of comparison with the cancer interview.

Cancer Bad News

Bad diagnostic news, we have suggested, may not be referenced or formulated as such in the course of its delivery, and that taboo-like effort itself is indicative of a disfavored status the news occupies. But doctor and patient have other ways of exhibiting how they disfavor such news, as is very apparent in our next excerpt. “Clint Jones” is a 37-year-old African-American male patient in a primary care clinic affiliated with a medical school in an Eastern state (Frankel 1994). On a Friday, he reported to the clinic with 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 referred him to a gastroenterologist, Dr. Smith, for evaluation. Dr. Smith’s endoscopy, for which Dr. Hoffman was also present, revealed a suspicious-looking mass in the esophagus, and a biopsy was performed. The growth proved to be malignant, and on the Monday after the procedure, Dr. H arranged to see Mr. J back in the clinic. The interview started with Dr. H coming into the office where Mr. J had been seated, apologizing for Mr. J’s having to wait, and explaining that he had had a discussion with the previous patient that “took longer” than he thought it would. As in the interview concerning Ms. R’s cardiology results, the physician then produces a how-are-you doing query (line 1) exhibiting an orientation to this as a follow-up visit:

(8) Dr. H/Mr. J

1 Dr. H: tch 'hhhhhhh (0.6) so howareya doing.
2 (1.1)
3 Mr. J: I'm doin' good, I'm losin' weight?
4 (0.5)
5 Mr. J: °Whatever.°
6 (0.9)
7 Mr. J: What was the problem. Wha' was [(decided on).]=
8 Dr. H: [Sh- sh'you]=
9 Dr. H: =lost- yuh- you lost weight. .hhh ((turns gaze away
10 from patient to desk and chart on right))
11 (0.5)
12 Dr. H: Uh:m.
13 (2.5) ((Dr. repositions note on his chart))
14 Dr. H: pa There is a pro:blem. ((returns gaze to patient and
15 nods))
16 ga (1.6)
17 Dr. H: Uh:m: hh (1.3) tch!
18 (1.4)
19 Dr. H: (a) Do you re member what we talked abou:t at the
20 end o' the procedure, [you had on Fri:day::.
21 Mr. J: [°no:° ((shaking head))
22 (0.5)
23 Dr. H: Okay well let's- (0.1) let's go over that too:.
24 .hhhhh uh:m (1.6) hhh (1.2) .hhhh (0.8) .hh ya know
25 we put the sco:pe (.) ((gestures with hand moving
26 down torso)) down into your stomach (0.1) to look
27 around and see what- (0.2) what it was that we could
28 s:ee:. .hhhhh a:nd uh: hhhhhh tch Doctor Smith an' I
29 were there and we looked (.) into your stomach. .hhhh
30 (b) Do you remember we said we saw something g:ro:wing
31 in your stomach?=
32 Mr. J: =Mm hm
33 (0.6)
34 Dr. H: (c) D'you remember that?
35 (0.6)
36 Mr. J: °Ye:ah i gue:ss.°= ((Mr. J shifts in chair, hunches
37 over, and looks downward.))
38 Dr. H: 1 =°Oh kay.° Well that's what we did see:. We- we
39 | looked into your sto:ma:ch and we sa::w::
40 | (0.6) right at the spo:t where you feel like
41 | (0.2) the food is getting stu:ck,
42 (0.1) ((DR puts right hand on stomach.))
43 Mr. J: Mm
44 (1.0)
45 Dr. H: .hhh uh::, there is something growing in your
46 stomach.
47 (4.0) ((Mr. J sits rigidly, looking downward.))
48 Mr. J: 2 You can't te:ll what it is?=
49 Dr. H: 3 =I can tell you what it is °Cli:nt.°
50 (0.1)

51 Mr. J: Mm hm.
52 (0.1)
53 Dr. H: Uh: (0.2) it's a cancer.
54 (0.4) ((Mr. J brings head up and to his right))
55 Mr. J: 4 °Jhheesuhhs:° ((whispered)) ((Mr. J swings right
56 | elbow up and rests it on edge of edge of counter,
57 | puts right hand over eyes, and left hand at crotch.))
58 | (1.2)
59 Mr. J: | Oh:: °my gohhd°
60 | (1.2)
61 Mr. J: | TCH!
62 | (0.5)
63 Mr. J: | `hhh
64 | (1.8)
65 Mr. J: | °Oh::no::hh°. ((Mr. J bends forward, resting both
66 | elbows on his knees and hanging his head low.)

When Dr. H produces the “return-visit” query (Robinson, this volume) about how the patient is doing (line 1), he and Mr. J, who leans his left elbow on the desk, are facing one another. The patient first responds sociably that he is “doin’ good” and then, in a more clinical vein, announces his continued weight loss (line 3). Following a softly spoken “whatever” tag (line 5), Mr. J then occasions a news delivery by asking Dr. H about “the problem” (line 7).

Dr. H acknowledges the “lost weight” (lines 8-9) and then, after looking at the diagnostic report on his desk (lines 9-11), a turn-holding “Uh::m” (line 12), and a large silence during which he moves a small “post-it” memo (line 13), he responds to his patient’s query by nodding and confirming that “there is a pro:blem” in a manner that also prefaces the announcement of findings and diagnosis to come (pa , line 14). As a prospective indexical, this utterance and term project specification and “filling in” (Goodwin 1996:285) but in contrast to Dr. T’s preface “it did come out very well” in excerpt (7), this preface does not contain an evaluation as such and is relatively restrained. There is, in other words, no lexical pre-indication of how “bad” the problem might be. Notice also the delays and hesitations (lines 11-13) while he moves a “post-it” note—preceding the confirmation at line 14. This confirmation meets with no response from Mr. J, who directs his gaze to the chart Dr. H was just perusing. Rather, this behavior can be said to display “reciency” (Heath 1982) and operates as a nonvocal “go ahead” (ga , line 16) for the delivery of diagnostic news.

Dr. H then, hesitatingly, produces a perspective display invitation (arrow a, line 19). This in

fact, turns out to be the first of three such invitations (arrows (a), (b), and (c)). As described by Maynard (1991d) such devices initiate a pre-sequence to the delivery of news that displays the recipient's view of a condition in advance of the news delivery. Subsequent to the display, clinicians work both to *confirm* the recipient's perspective as valid and to use it in *affirming* their own diagnostic announcement. Here, Dr. H formulates the invitation at line 19 by asking Mr. J if he remembers what they had "talked about:" at the end of the procedure the previous Friday, thereby asking not just for any view from Mr. J but one that reflects a previous discussion. Mr. J denies remembering (line 21), and this occasions Dr. H's suggestion for going "over that too:" (line 23); he then describes the procedure through a brief narrative (lines 23-28) and also invokes another medical observer, Dr. Smith, besides himself, as jointly witnessing the evidence (lines 28-9). Embedded in this narrative are a number of breathy hesitations and silences, which prolong a halting quality to Dr. H's presentation. Then at arrow (b) (line 30), Dr. H produces the second of his perspective display invitations, this one proposing a specification of what Mr. J should "remember." Mr. J, at line 32, responds with a minimal utterance. Subsequently, in a third invitation at arrow (c) (line 34), and showing an orientation to the minimalism of his recipient's previous utterance, Dr. H asks for a stronger display of recollection. Although Mr. J produces such a display, it is delayed (line 35), spoken quietly, and the affirmative "Ye:ah" is muted with "I gue:ss" (line 36).

When Mr. J acknowledges remembering, he also bends his torso forward in his chair and faces the floor (lines 36-7), retaining this position as Dr. H moves to deliver the news. Overall, this effort at gleaning a display of recollection proposes to "co-implicate" Mr. J's perspective (Maynard, 1992), along with Dr. Smith's and his own, in Dr. H's subsequent announcement of a growth in Mr. J's stomach (arrow 1, lines 38 and continuing). Dr. H—partly through the emphasis on the deictic term "that's" and the verb "did"—produces an agreeing proposal that they saw something growing (lines 38-9) and then locates the growth in relation to what is suggested as the patient's own account of a symptom (lines 40-41). In regular fashion, he thereby suggests confirmation of Mr. J's purported "seeing" and experience of symptoms, and (after Mr. J's token at line 43) uses that perspective to affirm the diagnostic formulation at lines 45-46, that "there is something growing in your stomach." Mr. J is still bent forward during this turn of talk and, after

it, is silent (line 47) until vocalizing a response (arrow 2 in the transcript) to the announcement, a query that prefers (Sacks, 1987) confirmation that Dr. H “can’t te:ll what it is.” Still, Mr. J’s negative or denying response implicates the diagnostic upshot or announcement. Dr. H (arrow 3, line 49 and continuing), by suggesting that he “can tell” what it is, contravenes the proposal of his patient. After Mr. J’s delayed continuer (lines 50-1), Dr. H hesitatingly declares “it’s uh cancer” (line 53). Mr. J immediately shifts his body posture from his leaning-forward position to a brief lean back, with his left hand over his eyes (lines 55-58). Vocally, he produces whispered expletives (line 55, 59), a tongue click (line 61), and, after an inbreath (line 63), a very soft denying utterance (line 65). Mr. J also bodily returns to a torso-forward position, more extreme than the one he had just left. This segment of the interview (excerpt (8)) is summarized along with the heart interview (excerpt (7)) in Figure 1.

Both physician and patient remain silent for over 7 seconds. Mr. J is still bent forward, while Dr. H sits upright with his eyes on his patient’s head and back. Mr. J breaks the silence with a question at line 1 below:

(9) Dr. H/Mr. J

1 Mr. J: >What does that mean.<
2 (0.4)
3 Dr. H: TCH `hhhh (0.4) We:ll? (5.0) It mea::ns you’re going
4 to needta see a lo:t o’ do:ctors °Clint°.
5 (2.0)
6 Dr. H: °Uhhm° (1.0) You’re gonna need a lo:t of medical
7 help.
8 (0.4)
9 Mr. J: Phh (0.6) °>Does it mean I’m gonna die::.<°
10 (1.5)
11 Dr. H: hhh
12 (3.7)
13 Mr. J: (Oo: :::::)hhh .hh ((whimper))
14 (2.6) ((Mr. J shifts feet back and starts to stand.
15 Dr. H reaches hands out touching Mr. J’s left elbow.
16 Mr. J stands and swings body so that he is facing the
17 counter with his back to Dr. H))
18 Dr. H: Stay with me Clint.
19 (1.1)
20 Mr. J: How long I got.
21 (0.2)
22 Dr. H: Come on stay with me now.
23 ((Dr. H gestures toward empty chair with hand.))
24 (1.2)

25 Mr. J: How long do I got.
 26 (2.4)
 27 Dr. H: I don't know.
 28 (1.6)
 29 Dr. H: I don't know yet, there are a lo:t of questions yet
 30 we haven't answered.

Dr. H answers Mr. J (lines 3-4; 6-7) that he going to need “a lo:t” of further medical attention. Subsequently, and remaining in his forward bend, Mr. J queries (with downward intonation), “does it mean I’m gonna die:.” (line 9). As Dr. H hesitates in answering (lines 10-12), Mr. J emits a kind of whimpering sound (line 13) and starts to leave his chair (lines 14-17). As he does this, Dr. H reaches out with both hands as if to grab Mr. J’s elbow, but withdraws his hands quickly when Mr. J stands up fully and steps to the counter at his right (lines 14-17). Then, Dr. H asks him to “stay with me” (line 18), but Mr. J remains standing while asking “how long” he has (line 20). Next, Dr. H intensifies his request for Mr. J to “stay” with him, both verbally (line 22) and by gesturing to the chair (line 23), and Mr. J stays standing as he re-asks his question (line 25), which Dr. H answers by his claim to a lack of knowledge (lines 27, 29-30).

Eventually, after Mr. J returns to his seat, the physician discusses treatment options, emphasizes an immediate need for surgery, and suggests that Mr. J needs to see another doctor. It is clearly an agonizing interview for both patient and physician, in which they discuss a variety of topics, including “how long” the patient has, how to manage pain, how to handle feelings of despair, and other matters. Relevant to the shrouding of bad news, it is only at a juncture near the close of the interview, after proposing the need to “get things lined up and move quickly,” that Dr. H evaluates the tidings. He says, “it’s horrible news,” and adds, “I’m sorry I had to give ya such upsetting news,” reporting that he had “thought a lot about it this weekend, about how I would do it, and it didn’t come out at all the way I thought ...”.

Comparing Good and Bad News in Primary Care

Structurally, the interviews concerning cardiovascular good news and cancer bad news are parallel (see Figure 1). Both interviews proceed from the physician’s “how are you doing” inquiries. The patients produce socially appropriate responses first, following them with clinical responses, and then with utterances that initiate discussion of the diagnostic news. The heart patient,

Ms. R, tentatively *offers* an assessment that her tests “all came out okay,” which works to elicit a fuller report from the physician, while the cancer patient, Mr. J, with his question about what the “problem” is, *asks for* further information regarding his tests. Then, confirming what the patient has already suggested—that the testing came out very well (heart patient), or that there is a problem (cancer patient), each physician begins a preface to an upcoming announcement. In turn, each patient produces a go-ahead signal that occasions a delivery of diagnostic news.

FIGURE 1 ABOUT HERE

From this point, the interviews diverge, however, in that Dr. T indeed proceeds with a News Delivery Sequence—by almost immediately (1) announcing the thallium and electrocardiogram results—whereas Dr. H initiates a Perspective Display Series. Only after obtaining his patient’s exhibit of remembering what they jointly observed does he firmly (1) announce finding a growth in Mr. J’s stomach. Then, in each interview, after these announcements, the patients produce (2) responses—Ms. R produces a smiling “okay” and Mr. J asks a question—that elicit (3) elaboration. In her elaboration, Dr. T explains what the electrocardiogram results “mean;” Dr. H elaborates by asserting that his patient’s “growth” is a “cancer.” Subsequently, the patients produce (4) assessment-type receipts, or broad displays of understanding of the kind of news they have received. Ms. R verbalizes a “that’s great” assessment, while Mr. J produces response cries of various sorts.

However, while these generic how-are-you, prefaces to announcement, and News Delivery forms are similarly deployed in each interview, there are vocal and nonvocal patterns that exhibit strong asymmetries between good and bad news. Dr. T delivers her good news in more or less immediate response to the patient’s go-ahead signal and, in proceeding with few hesitations or pauses in her talk, is rather smooth in summarizing the thallium procedure and then citing the electrocardiogram evidence. She gives both the “that was fine” thallium upshot and “excellent functional aerobic capacity” upshot during the announcement, and subsequently, in what we call a *rational* elaboration of the news, she proposes to explain what these upshots mean medically. The patient, Ms. R, also produces continuers and news receipts in an unhesitating manner. Indeed, they are often spoken at the same time as Dr. T is talking, and Ms. R produces her fourth turn assessment, “that’s great...” immediately after the elaboration of the electrocardiogram results and

provides an account for this assessment. She virtually *embraces* Dr. T's announcement and rational elaboration. Nonvocally, these two parties maintain mutual gaze for long periods and their bodies frequently are aligned to one another, each participant sitting upright on her chair (the doctor moves forward and back) and squarely facing the other.

Things are much different with the cancer patient. Dr. H delivers the cancer bad news in a hesitating, delaying, halting fashion that is consonant with the manner in which conversational participants produce "dispreferred" utterances in response to various kinds of initiations.⁸ Moreover, Dr. H produces the citation of evidence concerning "something growing" in the patient's stomach through invoking, in a very deliberate manner, a Perspective Display Series, thereby aligning the patient's experience to this announcement (and vice versa) before producing the announcement. And the focal part of the news—the upshot that Mr. J has cancer—appears in turn 3 or elaboration of the NDS. This delays the attempt at rational explication of the news — explaining what it means medically — until after Mr. J's assessment turn.

Mr. J's responses to the diagnostic news, as well, involve delays, silence, and minimal utterances. In a word, they appear *resistive* to the trajectory of the news. He at first *denies* remembering, and then only reluctantly recalls the endoscopy and the discussion about it when a growth in his stomach was first witnessed. Subsequent to Dr. H's announcement that there is indeed this growth, Mr. J occasions the elaborating pronouncement about cancer with a *negatively formed* proposal that the doctor "can't tell what it is." Finally, after the "cancer" upshot, Mr. J appears agitated as he emits a series of expletives and a *disavowing* "oh no." In terms of body posture, throughout the interview the gaze of doctor and patient rarely meet, and they only face one another briefly. After the initial "how are you doing" sequence, the patient is mostly bending forward in his chair, looking at the floor, while the doctor glances back and forth between the report on his desk and the patient's head. After the cancer pronouncement, the patient is leaning back, bending over again, standing up, and walking about, while the doctor sits in his chair, making slight moves toward his desk or toward the patient and asking his patient to "stay with him."

Once again, these asymmetries point toward good news as something to be exposed—forthrightly, even boldly delivered and received. Bad news is shrouded—the participants

to the interview are extremely discreet in its treatment. Two facets of this contrast between good and bad news deserve further attention. One is related to how, in citing his evidence for Mr. J's stomach growth, Dr. H works to co-implicate *both* his patient-recipient and his colleague, Dr. Smith, in asserting the observability of the growth in Mr. J's stomach. Consequently, there is an effort to establish the diagnosis intersubjectively by publicly invoking a convergence or "reciprocity of perspectives" (Schutz 1962) within the medical interview itself. Dr. T's presentation, in contrast, only refers to an anonymous "they" as she describes what was looked for and what was found with Ms. R's electrocardiogram and thallium procedures. Neither she nor the patient is portrayed as having evidence related to the diagnostic upshots. Accordingly, the intersubjective status of these upshots—their truth for the physician and patient in the present situation—appears to derive from an authoritative perspective that is anchored outside of this situation but that can be permissively asserted within it.

Another facet of the contrast between bad and good news involves a semantically *positive* delivery and receipt of good news and a semantically *neutral* handling of the diagnostic bad news. That is, the announcement about Ms. R's heart is preceded with mildly positive assessments from both doctor and patient, including Ms. R's "good" by which she solicits delivery of the news. Dr. T interjects "fine" when announcing the thallium results, and "excellent" as she reads the electrocardiogram results. Ms. R marks her receipt of this report with "that's great" and goes on to offer an account for her assessment. Slightly later, after Dr. T further elaborates on the thallium results (transcript not shown), Ms. R claims being "happy" about the diagnostic news, because she had been nervous, there was a family history of stroke, and she "now" knows that she can ride the bike. Thus, positive assessments and this claim of happiness proliferate in the good news delivery and receipt about the patient's heart. In the cancer episode, however, doctor and patient appear to refrain from producing overt negative assessments and evaluations—neither formulates an assessment of the "badness" of the news, that is, in the context of its delivery—and at no point does Mr. J state or define how he is affected by the news. Rather, the "bad" valence is mostly exhibited in other practices, such as the withholding of reference to that valence, and the dispreferencing modes whereby the parties present and receive the news and the co-implicating manner of citing the evidence. It is only near the end of the interview that Dr. H acknowledges

verbally how “terrible” the news is.

We find caution, circumspection, or shrouding with regard to bad diagnostic news, then, and boldness, assertiveness, or exposure with good diagnostic news. Why the difference? What is the interactional work of these asymmetric modes of delivery? It seems apparent that, from the physician’s point of view, good news is something that needs relatively little build up, preparation or “forecasting” (Maynard 1996). Largely, physicians seem to depend on and often receive patient’s unmediated affiliation to the news and to its valence. This means that patients can and do follow what the news “means” in a discursively rational way, accepting the physician’s explanations and offering accounts of their own that build topically on those explanations. Furthermore, these rational elaborations often involve reciprocal displays of positive affect on the part of the participants. In short, good news is regarded as enhancing the social bond between physician and patient.

Contrariwise, physicians seem oriented to the possibility of disaffiliation from the news when it is bad. Shrouding bad news represents restraint on the part of physicians and can encourage restraint on the part of their recipients, who may be at risk for otherwise “flooding out” upon the pronouncement or confirmation of diagnosis.⁹ If Goffman (1978) is correct, response cries like those occurring as receipts of bad news are indications of this propensity for emotional loss of control. Response cries, that is, are something like “self-talk” as a kind of “externalized inward state.” As relatively brief emotional expressions of pain, they do not overwhelm their producer. Nevertheless, they are enough to threaten mutual intelligibility, and physicians are therefore concerned to “contain” the scene to which they respond and in which they may be emitted (Goffman 1978:795; Sudnow 1967:141).¹⁰ We observed that, in dealing with Mr. J’s response to the cancer diagnosis, including his response cries, his question about what it means and if it means he is “gonna die,” and his pacing around the room, Dr. H, in proceeding to discuss meaning, prognosis, treatment, and other matters, remains seated. He urges his patient, “Stay with me, Clint,” thereby calling his patient back to the discourse of rational medicine. In short, the asymmetries between good and bad news in clinical environments, in which participants behaviorally and interactionally exhibit the favoring of good news and the disfavoring of bad news,

are structures that enhance the possibility of order over disorder, intersubjectivity over a descent into the subjectivity of emotion, and explanatory rationality over emotional displays as a kind of irrationality.

Good News, Indeterminacy, and Uncertainty: The Problem of Symptom Residue

Unbounded response cries and displays of emotion represent only one potential kind of irrationality in the delivery of diagnostic news. Another potential irrationality is evoked when physicians *don't know* or are *uncertain* about the answers to medical questions.¹¹ In the cancer interview, Dr. H had difficulty with Mr. J's questions about what his diagnosis meant. These are questions of prognosis, which notoriously raise problems of indeterminacy and uncertainty when someone is diagnosed with a given disease. But even when diagnostic news is ostensibly good, there is often a *residue of symptoms* for which there is no account, and this also can send physician and patient to the edge of rationality.¹² Consider the continuation of excerpt (7), involving the cardiology patient. After Dr. T affirms that Ms. R can sign up for aerobic classes, she introduces a complaint about her back (lines 51-52 below). Dr. T acknowledges and receives this as information and, continuing to read from the file, quotes others who observed that during the electrocardiogram, the patient was fatigued and had chest pain (arrows below at lines 54-7):

(10) Dr. T/Ms. R: continues excerpt (7)

45 Dr. T: ... excellent functional aerobic capa:ci[ty .hh
46 Ms. R: [So I
47 could- coul:d uh si:gn up fer aerobic classes.
48 (0.2) ((Dr. T looking at report))
49 Dr. T: Mm hmm ((nodding))
50
51 Ms. R: The o(h)(h)nly thing is a:fterwards the ba::ck was
52 really bo[t h e r i n g m e] but .hh hh
53 Dr. T: [Oh is that ri:ght.] ((gazing at Ms. R))
54 Dr. T: ((returns gaze to file on desk)) .hh Now: they
55 said that um you sto:pped because you were,
56 fatigue:d and that you al:so did have an aching kind
57 of che[st pain]n is that cor[rect]
58 Ms. R: [Mm hmm] [Mm hmm]

This symptom residue occupies a great deal of attention during the interview after the delivery of this good-news diagnosis of excellent aerobic capacity and about the thallium test. In this way, in

Then, the production format for Dr. K's announcement about the leg xray at arrow 1a closely parallels the previous announcement containing the pap report (line 1). But Ms. V responds very differently. Instead of a relatively close positioned positive assessment, there is a substantial silence (line 5) following the announcement, and then a query about what's wrong with the leg (lines 6-7). The doctor's answer is one that occasions the patient's guess about tendinitis (line 9) and then some joking about whether the patient has tendinitis or bursitis (data not shown). Our point is that the problem of a symptom residue may disrupt a good news delivery sequence.

When this disruption happens, it may be no laughing matter, especially when the symptoms are potentially serious, as in excerpt (13) below. Dr. L, reading from the report on his desk, announces the mammogram result at arrow 1, the patient responds with a nodding continuer at arrow 2, and then Dr. L elaborates the report with a kind *best case* formulation¹³ at arrow 3, which proposes how good the news is. In the sequential position (? , line 11) where the patient's assessment could occur, Ms. S initiates a question.

(13) Dr. L w/Ms. S (2.3)

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: ? [.hh Now: wouldju answer a question for me.[On thuh=m-
12 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

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 the doctor must further consider the possibility of a cancer. The symptom residue occurs here because a diagnostic test is not comprehensive enough. And that residue of symptoms appears to interfere with the patient producing an agreeing assessment with what the doctor proposes to be good news.

In short, when some disease is ruled out, it can be “good news” from a clinical point of view. That point of view may or may not be one that the patient shares, and at times physician’s may appear insensitive “to the context of patient experience,” as Frankel (1995b:252) puts it, especially when the patient does have some residue of pain or other symptoms.¹⁴ In these circumstances, argues Heath (1992), the incongruence between doctor and patient can mean that patients will feel compelled to recount their experience of illness in order to justify having visited the doctor (Halkowski, Heritage chapters, this volume). The practitioner may re-orient from delivering news and managing closure toward re-examining the patient and possibly referring the patient for further diagnostic testing. Frankel (1995b:254) similarly proposes that the physician must “extend the assessment” of the patient by ordering further tests. Therefore, while physician may have a high level of diagnostic certainty regarding the tests already performed and what has been ruled out, they nevertheless can be faced with symptoms of indeterminate origins and consequently must deal with *uncertainty* about a larger medical picture of the patient surrounding one particular episode of diagnostic news.

In our data, the problem of symptom residue appears with great regularity. Good news can and does go hand-in-hand with indeterminacy and certain forms of uncertainty. Let us recall Heath’s (1992) argument that physicians announce their diagnoses in ways that are authoritative and that patients, when receiving diagnostic news, are largely passive and silent such that they display an orientation to this authority. At most, when there is incongruence between doctor and patient, the patient attempts to *justify* having sought the doctor’s help. Peräkylä (1998) has

suggested something else: Physicians regularly and carefully provide evidential reasons for their diagnostic conclusions, in ways that display the intersubjective rather than authoritative grounds for their diagnoses. Our investigation of good news and the problem of symptom residue adds a further dimension to previous work, for this problem puts physicians and patients at the edge of rationality where authority and intersubjectivity are in jeopardy. Despite the good news that some disease is not present, patients still have their pains and symptoms, and doctors cannot yet assert anything definitive to account for them. That is, while institutional medicine can rule out possible conditions and provide good news to patients, it neither give a name to nor explain a vast amount of symptom residue, and patients' experiences may be otherwise unintelligible to the doctor.

Conclusion

The delivery and receipt of diagnostic news is literally a defining moment in the medical interview, an integral part of the "third function" where physicians are to educate patients about their conditions and possible treatments. Where, in the past, this phase of the interview has lacked for research, we add to a number of conversation analytic investigations demonstrating the orderliness and organization of diagnostic informing events. We have shown that a generic, four-part News Delivery Sequence is adapted to the clinical setting, although articulated asymmetrically according to whether physicians have bad or good testing and diagnostic news to report. When the news is good, deliveries are dependably upbeat and rational, at least initially and before a possible symptom residue may be exposed in the talk. The participants are not at immediate risk of any rupture in mutual intelligibility and understanding. When the news is bad, however, physician and patient appear on the edge of rationality, insofar as the news may evoke a strong emotional reaction in the patient, whose display both parties often work to avert. Consequently, physicians deliver bad news in a more circumspect manner than good news, and patients may resist the news and be restrained in response. The ways in which doctor and patient exhibit the shrouding of bad news may work on behalf of preserving the interview as a rational dialogue or one that avoids the disorder and descent into subjectivity that strong displays of emotion are perceived to entail.

After all, the emotional realm is one that authoritative medicine has so far minimized in the

training of students , in part because of the value placed on clinical detachment and affective neutrality (Frankel 1995a; Parsons 1951:458-9; Spiro 1992). Recently, however, there is growing recognition of the importance of empathy in the doctor-patient relationship. An implication from our analysis is that, at the point where bad news is delivered, when patients provide clear although contained displays of emotional distress, there emerges what Suchman et al. { , 1997 #68 } call an “empathic opportunity.” Instead of asking the patient to *stay with him* (as in our cancer episode), the physician can consider *going with the patient*. In other words, before turning to the rational assessment of prognosis and treatment, the physician could at least acknowledge expressions of affect and invite their exploration in a manner that facilitates understanding in the realm of emotional response .

Our analysis might end with the interactional asymmetries involved in coping with bad news as compared with sharing good news, and the need for physicians’ expressions of empathy when patients show distress upon receiving bad news. At first glance, good news appears to be largely unproblematic, as both doctor and patient interactionally handle such news in a relatively smooth and upbeat manner. However, good news can approach another territory of the irrational besides the emotional one. This area is one of indeterminate and uncertain knowledge, where authoritative medicine, having ruled out one or more candidate diseases or conditions, cannot name or explain symptoms a patient experiences and presents. In that sense, good news in medicine can have a kinship to bad news.¹⁵ Therefore, just as investigators have advocated for research and training on bad news, we argue that good news and uncertainty demand similar attention.¹⁶ In terms of medical education and curriculum design, at least three skill sets need to be developed. First, because we have barely more than a glimmer in understanding the psychological processes that physicians must navigate in order to successfully inform patients, physicians will benefit from training in self-awareness (Novack et al. 1997). Second, it is important for physicians to determine patients’ needs and desires for information and to ensure that there is agreement about what has been conveyed. Finally, besides integrating awareness of self and other, medical curricula can incorporate learning about the specific devices that effective practitioners use when they deliver diagnostic news.¹⁷ Our

aim is to contribute to a research base revealing the interactional dynamics that must be understood for diagnostic news delivery and related skill sets to be effective.

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NOTES

1. Girgis and Sanson-Fisher (1995) reviewed 750 papers on the topic of bad news and found only three that used controlled methods to test the effectiveness of various approaches to delivering bad news.

2. For an extended analysis of a single case of uncertainty, see Maynard and Frankel (2003).

3. Fallowfield and Lipkin (1995:317) observe that there is increased teaching of communication skills in medical schools, but that "...the proportion of the curriculum concerned with this important area is still woefully smaller than that given to other clinical skills."

4. Peräkylä (1998, this volume) has shown that physicians strike a balance between relatively authoritative assertions and those evidence-based formulations that work to make diagnostic news intersubjectively available and valid. That is, physicians' deliveries of news provide for the accountability of their vocalized diagnostic reports in way that is not characteristic of conversation when someone delivers bad or good news.

5. Asymmetries between bad and good news, as we are about to describe them, have been documented in a number of clinics. See Stivers (1998) regarding veterinary medicine, Heritage and Stivers (1999) on pediatrics and internal medicine, and Leppanen (1998) on nurses giving blood pressure and blood sugar results to adult patients. For a general consideration of these asymmetries, see Maynard (2003: Chapter 6).

6. Indeed, Ms. B's response represents a regularity in the way patients receive relatively bad diagnostic news: they produce *stoic* responses (Maynard 2003: Chapter 5). An implication here is that withheld responses in the context of bad diagnostic news may not necessarily indicate a

patient's orientation to physician authority, as per Heath's (1992:262) argument. Rather, they may display the normatively-constrained fashion by which recipients handle bad news in which they are the primary figure. Stoicism in the face of one's own bad news represents a balance between showing too much *distance*, on one hand, and, on the other, too much *involvement*, which can verge on self-pity.

7. See also Robinson's (this volume) analysis of different ways—for example, the “open-ended” or “closed-ended” questions—in which doctors ask about patients' health problems.

8. Recall that the physician in each interview delivers the diagnostic news in answer to solicitations from the patient; i.e., as a responsive activity. As Schegloff (1988:446) succinctly observes, the sequential and temporal feature of preferred and dispreferred responses is that “... preferred comes early, dispreferred is commonly delayed.”

9. For examples of such flooding out, see the example in Maynard (1989) of a mother who cries and sobs when hearing the diagnosis of “mental retardation” for her son, and the example of a woman who shows what Quill (1991) calls “rage” and “terror” when she finds out that she has been diagnosed with AIDS.

10. For a study of how strong displays can impede the work of professionals in an organizational setting, see Whalen and Zimmerman (1998). They analyze the use of “hysteria” as a label that 9-1-1 call-takers apply to those callers whose behavior overwhelms the interactional demands of gathering information necessary to the dispatch of help.

11. Researchers and scholars have devoted considerable attention to the problem of uncertainty in medicine. Traditionally, the emphasis has been on the anxiety that uncertainty produces in physicians (Buckman 1984), and how they have attempted to conceal their lack of knowledge from patients (Fox 1957; Katz 1984). Such problems are not our focus per se, although they also point to forms of irrationality associated with medical uncertainty.

12. See Abbott's (1988:42-4) discussion of how, within any professional classification symptom, there can be "areas of unclassified, residual problems."

13. See Pomerantz's (1986) discussion of "extreme case formulations" and the way they are used to "legitimize claims."

14. In a study involving 38 patients referred by their cardiologists for echocardiography, all of whom received the news that their results were normal, over half or 21 patients reported residual doubt and anxiety about the condition of their hearts (McDonald, Daly, Jelinek, Panetta, and Gutman 1996). Ten of the 38 patients were referred for the test because they came to the clinic with worries about palpitations or pain or both, and all ten had doubt and anxiety after their favorable tests. Out of the 28 who were referred to cardiologists, and by them for testing, because a primary care physician detected a systolic murmur during routine examination, 11 had residual doubt and anxiety after the test. In another study, which involved a sample of patients who were referred for neurological examinations because of headache, 40% were still worried three months after received "reassuring results" from the specialist that their symptoms reflected serious disease (Fitzpatrick and Hopkins 1981).

15. And vice versa. That is, sometimes "bad" news, because it provides relief from situations of indeterminacy, is experienced as relatively "good" news. See, for example, Fallowfield (1991:39).

16. In a *British Medical Journal* editorial, Fitzpatrick {, 1996 #73} refers to the McDonald et al. {, 1996 #72} and the Fitzpatrick and Hopkins {, 1981 #74} studies showing that normal examination results (and hence good diagnostic news) do not always relieve patient anxiety (see endnote 16). Fitzpatrick {, 1996 #73} suggests that poor communication is the "usual culprit" in the failure to reassure patients, and calls for physicians to engage in "direct discussion of patients' concerns." But medical curricula, as we have noted, do not ordinarily provide training in how to conduct such

discussions. Teaching about the conveyance of good news is probably more neglected than the problem of bad news. Furthermore, Hewson {, 1996 #11} suggests that because the handling of uncertainty is also rarely articulated in the medical curriculum, physicians in practice end up using a set of undeveloped, taken-for-granted and tacit skills when having to communicate about indeterminate conditions.

17. However, see Buckman (1984), Frankel (1994a), and Quill (1991), for example.