

Disclosing and responding to cancer "fears" during oncology interviews

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Abstract

Video-excerpts from routine oncology interviews are examined to reveal how patients demonstrate and doctors respond to "fears" about cancer. Vocally and visually, embodied impacts of dealing with dreaded consequences of cancer are apparent when addressing both good and potentially bad cancer news. Even a "brush" with cancer can promote negative and ongoing impacts provoking unresolved illness dilemmas. We reveal how, in the midst of extending answers and initiating concerns, patients exhibit trepidations when volunteering narrative information about their medical history and experience of symptoms. In response, doctors are shown to acknowledge yet exhibit minimal receptiveness to patients' lifeworld disclosures and demonstrations (e.g., redirecting attention away from patients' concerns by offering "textbook" symptoms and related pursuits of biomedical agendas). Discussion focuses on interactional criteria for identifying "fears", patients' lay orientations to medical visits, and implications for refining educational workshops for oncologists.

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Introduction

During medical encounters patients may directly verbalize that they have concerns, are experiencing problems, or even fearful about their condition. Patients have also been shown to indirectly offer "cues or clues" when speaking and bodily demonstrating their problems (e.g., through gesture, gaze, and related actions) (Gill, 1998; Gill, Halkowski, & Roberts, 2001; Beach & Dixon, 2001; Jones & Beach, in press; Lang, Floyd, &

Beine, 2000; Levinson, Gorawara-Baht, & Lamb, 2000; Ford, Hall, Ratcliff, & Fallowfield, 2000; Suchman, Markakis, Beckman, & Frankel 1997; Heath, 2002; Beach & LeBaron, 2002). Some of these "cues or clues" include repeating phrases or topics (Frankel & Beckman, 1988; Lang et al., 2000), being tentative when explaining or speculating about what is wrong with them (Gill, 1998; Stivers & Heritage, 2001; Beach, Good, & Pigeron, 2004), embodied expressions of embarrassment, suffering and/or emotional distress (Heath, 1986, 1988, 2002; Beach & LeBaron, 2002), offering a self or "lay" diagnosis (Beach, 2001 a; Jones & Beach, in press), constructing indirect questions and requests (Gill et al., 2001), and even having family members or friends present during the interaction (Lang et al., 2000).

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In this study, we examine how patients display being impacted by and, at times, fearful of cancer. In turn, doctors' responses to patients' fears are shown to be consequential for achieving what has historically been described as *patient-centered care*, "in which the physician respond(s) to patients in such a way that allow him/her to express all of the patient's reasons for coming, including symptoms, feelings, thoughts and expectations" (Ong, de Haes, Hoos, & Lammes, 1995, p. 911; see Barbour, 1995; Engel, 1977; Stewart, 1984; Ford, Fallowfield, & Lewis, 1996a; Felitti, 1997). A central tenet of patient-centered care is to recognize that "patients provide cues to their feelings, fears and expectations, which, if responded to appropriately, will lead to their disclosure" (Ford et al., 2000, p. 554). Because responses to patients' "lifeworld" concerns vary widely (Mishler, 1984; McWhinney, 1989; Frankel & Beckman, 1989; Roter & Hall, 1992; Ford et al., 2000; Beach & Dixon, 2001), criteria for assessing "appropriate" orientations will best emerge from close examination of actual clinical moments. So doing requires an orientation to *fears* as primal and socially constructed emotions situated within ordinary medical interviews (see Goodwin & Goodwin, 2000).

Considerable and increasing attention is being given to patient-doctor interactions in oncology clinics (e.g., see Ben-Sira, 1980; Lichter, 1987; Faulkner & Maguire, 1994; Fallowfield et al., 2002; Baile, Kudelka, & Beale, 1999a; Fallowfield & Jenkins, 1999; Ford et al., 1996a,b; Ford, Fallowfield, & Lewis, 1996b; Ford et al., 2000; Maguire & Faulkner, 1988a-c; Lutfey & Maynard, 1998; Sanden, Linell, Satterlund Larsson, & Starkhammar, 2001; Maynard & Frankel, in press). Ongoing research, and related attempts to refine communication skills for enhancing clinical care, are designed to understand and address cancer as the most ubiquitous and deadly disease in the world today (Kumar & Clark, 1990). A recent survey (2001) by the American Institute for Cancer Research AICR, (2001) reveals that cancer is the most fearful health concern for more than 1/3 Americans, and that over half of those people believe cancer is difficult or impossible to prevent. A statistical basis exists for cancer "fears":

- More than 1.2 million Americans will be diagnosed with cancer this year alone, resulting in at least 1/2 million deaths. Men have an approximate 50% and women a 33% lifetime risk of being diagnosed with cancer (American Cancer Society, 2002).
- Greater than 50% of all cancer patients cannot be cured (MacDonald, 1996). If rates of incidence remain stable, the total number of cancer cases is expected to double by 2050 (Edwards et al., 2002).
- Three out of four families in the Western world are somehow impacted by cancer diagnosis and treat-

ment (American Cancer Society, 2002; Bigel, Sales, & Schulz, 1991; Lichtman & Taylor, 1986).

Although cancer is feared more than any other serious medical condition by Americans and British alike (see Brooks, 1979), and certainly is a primary health concern worldwide, "few studies have documented fears of cancer" (Berman & Wandersman, 1990, p. 82). Indeed, while a fundamental and intuitive focus of cancer care involves understanding and responding to patients' fears, very limited empirical attention has been given to the interactionally organized and distinct nature of fearful events. In Excerpt (1), for example, a leukemia patient states being "afraid" that his pneumonia-like symptoms are similar to symptoms brought on by toxicity from earlier chemotherapy (see transcription symbols in the appendix):

(1) **SDCL: Oncology#5:5**

PAT: U:m (1.5) I w- (0.2) **was afraid that (0.5)**
i:t was some sort of:- (0.2) i:t was maybe
related- (0.2) li:ke (') before, to the
toxicity [of the] chemo I had in
Ja:nua:ry. =

In Excerpt (2), another leukemia patient expresses "concerns" about her swollen lymph node:

(2) **SDCL: Oncology#4:6**

PAT: [No.] No I don't either. ((Patient points
to right side of her neck)) **That concerns**
me about the lymph node over here.
So you think that its increased in size [a
little bit? I

And in Excerpt (3), a patient experiencing problems with "gallstones" makes clear that "cancer, cancer, cancer" is in his family and clearly on his "mind":

(3) **SDCL: Oncology#3:24**

PAT: **The first thing that re- > tha- tha- that**
was on my mind and I don't mean to
sound< like a fatalist or- or- or
hypochondriac, but **cancer cancer**
((Clenches fists)) [there's been so
much] =
DOC: [(O:h I hear ya.)]
PAT: ((Hits fist to hand)) **=cancer** in my- in
my fa:mily and all. _

In the data examined herein, patients also exhibit subtle, delicate, and often troubling orientations to moments comprising discussions about cancer diagnosis, treatment, and prognosis. We argue that vocally and visually, the embodied consequences of dealing with

cancer-as not just an inherently uncertain, but also a dreaded disease (see Perakyla, 1993, 1995)-are interactionally exhibited and thus communicatively significant for both patients and doctors. Oncology encounters are thus filled with what we might characterize as *interactional trepidations*: embodied demeanors exemplifying a host of popularized terms-concerns, problems, nervousness, unease, worry, anxiety, fear and the like-inherently "psychosocial" dimensions anchored in patients' lifeworld experiences (Engel, 1977; Mishler, 1984; Barbour, 1995).

Patients exhibit being impacted by a potential "brush" with cancer, as well as an actual diagnosis and subsequent treatment regimen for a potentially serious disease. Even in cases where patients are informed of "good news", the experience of dealing with an illness can leave patients with what Maynard & Frankel, (in press) have referred to as *symptom residue*:

Another potential irrationality is evoked when physicians *don't know* or are *uncertain* about the answers to medical questions... 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... Good news can and does go hand-in-hand with indeterminacy and certain forms of uncertainty." (pp. 27-28, 31).

In the following analysis, we begin with two instances of a patient who announces "good news" about receiving a negative cancer diagnosis. We then examine oncology interviews involving two leukemia patients as attention is drawn to diagnosis and treatment. Across each of the selected data excerpts, patients are shown to engage in activities extending beyond seeking information which cannot be definitively addressed by medical experts. Patients also make available *the impacts of cancer they are currently experiencing*. While seeking to minimize uncertainty and solicit assurance about their prognosis is a primary concern, *patients also demonstrate being in the midst of varying degrees of emotional turmoil*.

Below we identify, describe, and explain the interactional environments in which these activities occur and possible interactional consequences of these diagnostic processes for cancer care-for example, what interrelationships exist between how patients raise and exhibit their concerns, and doctors' responsiveness to matters patients treat as relevant to their bodily and mental health?

Data and method

A collaboration has been formed between medical interaction researchers, oncologists, and a Comprehen-

sive Cancer Center (designated by the National Cancer Institute) located in the Western United States to perform this study. Permission was granted to videorecord, transcribe, and analyze oncology interviews on an ongoing basis across surgical, medical, radiation, and resident oncologists. Interviews examined in this study are drawn from an initial corpus of 50 "first time" and "return visit" encounters, involving a surgical resident interviewing a melanoma patient, and two attending physicians (medical oncologists) working with separate leukemia patients. These excerpts were drawn from a larger collection of identified moments in which patients exhibit and doctors respond to a range of problems during oncology interviews.

Recordings occur at two outpatient clinic locations. Sixty clinical sessions occur each week, conducted by approximately 20 medical, surgical, and radiation oncologists. An additional eight clinical fellows are instrumental in the conduct of patient care. Approximately 422 clinic visits occur each week, providing an average of 75 weekly chemotherapy visits (3-4h in duration, approximately 2000 per month, and 24,000 patients yearly). More than 12,000 new cancer cases are reported annually across the county in which the Cancer Center resides.

Conversation analytic (CA) methods are employed (see Atkinson & Heritage, 1984; Sacks, 1992; Drew & Heritage, 1992; Heritage & Maynard, in press). This mode of analytic induction is anchored in repeated listenings of recordings, in unison with systematic inspections of carefully produced transcriptions. Priority is given to locating and substantiating participants' methods for organizing and thus accomplishing social actions. It is an explicit and working feature of this research method that participants continually and intrinsically achieve, through an array of interactional practices, displayed understandings of emergent interactional circumstances. The overriding goal, in both ordinary/casual and institutional encounters, is to identify patterned orientations to moment-by-moment contingencies of interaction comprising everyday life events.

Embodied displays of "symptom residue"

The two transcribed excerpts below (4 and 5), drawn from the same oncology encounter, involve a surgical resident and a patient concerned about melanoma. Patient had no family history of melanoma, but one melanoma had been identified and removed (0.7 mm, 3 years prior), along with several other moles that were not suspicious. Subsequent X-rays and bone scans were negative, though patient did have several swollen lymph nodes identified during physical examination. The following moments occur during two different phases of the medical encounter: near the outset of

history-taking, and following physical examination as doctor attempts to diagnose and prescribe treatments for patient's condition (Byrne & Long, 1976).

Negative impacts of "good" cancer news

Excerpt 4 (below) occurs approximately 3 min into history-taking:

- (4) **SDCL: Oncology##1:5-6 "Cause they got it (0.2) early enough"**
 ((In response to doctor's question about whether she was taking any medications, patient had just described being on a "viral suppressant".))
 DOC: Okay. (0.2).hh U:m (0.3) pt The:: other thing is u::m (0.5) you were never ((shakes head)) (') a:h (0.2) started on any chemo:: or immunothe[rapy: or anything like that.]
 PAT: [((shakes head))] _
 DOC: Okay.
 PAT: Cause they got it (0.2) early enough.
 DOC: Okay, good.
 (1.0)
 DOC: hhh How have you been feeling () lately. Have- have you had any fevers (') or chills or night sweats, loss of appetite, anything like- any constitutional symptoms.
 PAT: No. (') I'm tired but I'm the mother of three kids.
 DOC: Okay. [I understand.]
 PAT: / \$Hhhhh.\$] \$Pretty normal.\$
 Yeah. =
 DOC: = Mm hm. _

Doctor's initial turn-at-talk follows patient's description that a "viral suppressant" was the only medication she was taking. With "Okay. (0.2) hh U:m (0.3)", his pauses and floor-holding "U:m" display initial difficulty in transitioning from prior and searching for new topic. As he continues doctor queries with "you were *never* ((shakes head)) a:h started on any chemo:: or immunotherapy: or anything like that.". With this negatively valenced query (Boyd & Heritage, in press), in unison with a head shake, doctor seeks confirmation of information he treats as shared knowledge about patient's medical history. The combination of doctor's query and head shake make relevant a "no-type" answer from patient, actions restraining patient from providing a non-confirming response.

Doctor also exhibits that it is not just transitioning from one topic to another that is problematic. He also works to avoid and thus omit references to cancer

diagnosis. Grammatically, and with some hesitancy and uncertainty, doctor displays that the issues he is attempting to raise are indeed *delicate matters*. Rather than directly asking patient whether she was diagnosed with cancer or not, doctor redesigns and thus reorients his turn to accommodate a three-part listing of "started on any chemo:: or immunotherapy: or anything like that." (Jefferson, 1980). On the very cusp of raising a cancer diagnosis, even a negative one implicating good news, patient is instead and first queried about having undergone specific procedures utilized exclusively for cancer treatment. Doctor thus leaves it for patient to describe prior experiences with *treatment options*. This is an alternative to doctor's announcing, and perhaps going on record as inaccurately assuming, that patient was a recipient of cancer *diagnosis*. In this manner, however, doctor also enacts a normalized interactional practice: Not outrightly guessing or conjecturing the valence of possible bad news (i.e., patient's cancer history), but co-implicating those capable of bearing bad news to announce or pursue it (Schegloff, 1988; Maynard, 1992, 1997; Beach, 2001a).

Before doctor completes "immunotherapy:", however, notice that in overlap patient begins to shake her head and continues to do so until the doctor's "Okay" receipt. It is worth noting that doctor's "or anything like that" is inclusive of any additional treatments patient may have received. This generalized reference provides for a wider range of responses from patient, but also an additional "out" for a doctor who works to avoid directly raising or implicating cancer.

Following doctor's "Okay", and on her own initiative, patient next and further elaborates with "Cause they got it (0.2) early enough.":

- (5) **SDCL: OCjpeg: "Cause they got it (0.2) early enough"**
 [((Fig. 1. PAT averts gaze to upper left & closes eyes.
 | ↑
 PAT: = [Cause they got it [(0.2) early enough.
 | 1
 [PAT returns gaze & kicks legs in rhythm with "early enough")]

Several key features are evident in patient's utterance and actions. First, after answering the doctor's initial query with "Okay", patient initiates "Cause they got it (0.2) early enough.". By volunteering information beyond what doctor asked for in his prior query (Stivers & Heritage, 2001; Beach & Mandelbaum, in press), patient offers what is essentially "good news" about her condition. Bodily, however, her announcement is visibly tenuous and thus contradicts otherwise "good news". Despite its "good news" status, this patient subtly exhibits being ill at ease—a bit awkward,

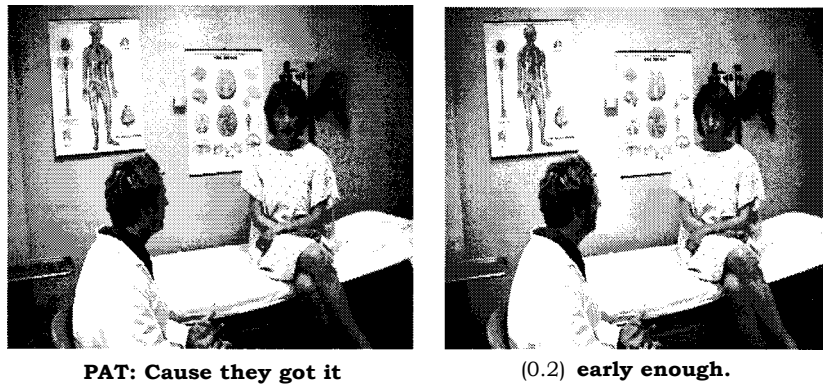


Fig. 1.

uncomfortable, and even "squirmy" at the mere mentioning of how "it" was detected "early enough". The patient's embodied actions-averted and returned gaze, closing of eyes, and "leg kicks"-provide plausible and visible evidence that patient is not just concerned with, but impacted by, a familiar and potentially fearful experience with cancer. A situated understanding of these moments begins with examination of how patient and doctor closely coordinate a single and subsequent turns-at-talk (Goodwin, 1980, 1981).

At the outset of her utterance, patient's "they got it" depicts how anonymous medical professionals somehow pursued, captured, and halted the progress of a potential cancerous growth. Her "they" references anonymous medical staff (see Beach & Good, 2004), while her "it" makes indirect reference to "cancer" that is nevertheless and directly understood as being about *her body* (see Hanks, 1992). Patient's "it" locally and indirectly references (see Schegloff, 1996), but does not specifically mention, words such as "melanoma" or "cancer". In this way patient leaves unstated and implied an association with a disease she has not been diagnosed with, but has been physically examined and biopsied for. Both the doctor (as described above) and patient have thus constructed alternative ways of *not* referencing "cancer" during this encounter.

As can be seen in Fig. 1, also at the onset of her turn while stating "Cause they got it", patient gazes away from doctor to her upper left. Here patient's averted gaze occurs in the midst of reconstructing her experience, and when completed, gaze is returned to doctor to coordinate his response (Goodwin, 1980, 1981). Following "it", patient looks back toward the doctor but does not gaze directly at him. Rather, she glances down, closes her eyes, and briefly pauses (0.2) before stating "early enough". Her reference to "early enough" reflects the upshot of searching for what to say next, and stands

in stark contrast to "too late". With "early enough" a *benchmark sensitivity* to cancer growth is exhibited as patient employs temporal and relative terms to depict how a potential or suspected problem-cancer diagnosis-was avoided by preventive measures. A recognition is displayed that early detection and treatment is a preferred and fortunate alternative. However, while "early enough" minimizes the likelihood of cancer diagnosis, it does not unequivocally eliminate future health problems associated with her "moles". As patient brings her gaze back to doctor, she accentuates "early enough" with two leg kicks. These kicks provide plausible evidence about the delicacy of her disclosures-embodied actions revealing the residual and visible impacts of living with the possibility of cancer growth.

To summarize Excerpt 5 (above): Through patient's "Cause they got it (0.2) early enough.", preliminary evidence is provided that a person's personal experiences with cancer diagnosis is consequential for how such a reporting gets offered, and received, during a medical encounter. Apparently, even a "brush" with a cancer diagnosis can promote circumstances where a patient is not only concerned about cancer, but displaying being negatively impacted by ongoing experiences. Further, doctor displays approaching potentially bad news by not conjecturing but soliciting from patient information about her symptom/treatment history.

It is important to emphasize that the patient's "Cause they got it (0.2) early enough." also *invites* and thereby *solicits* from the doctor an acknowledgment and confirmation that the news just delivered by patient is indeed "good". With "Okay, good.", doctor provides this minimal response:

(6) SDCL: OCjpeg: "Okay, good."

PAT: =Cause they got it (0.2) early enough.

DOC: Okay, (good.
 PAT: | ((Fig. 2. *PAT nods and produces a smile that (1.0) | changes into a tight-lipped "grimace"*))

In Excerpt 6 and Fig. 2, in the midst of doctor's "Okay, good.", patient's responsive smile transforms into a tight-lipped "grimace". This moment, comprised of mutual and extended (1.0) gaze, is similar to how previously described nonverbal behaviors (i.e. averted and returned gaze, closing of eyes, and "leg kicks") emerged as contradictory to a good news announcement. But what is being exhibited, in response to doctor's verbal confirmation of patient's "good news", as patient's smile becomes a grimace? Schegloff (1996) has referred to such actions as "post-completion stance markers" (p. 92) immediately following completion of a turn or turn constructional unit. The "stance" exhibited by patient is being negatively impacted by having undergone prior diagnostic procedures (e.g., biopsy). Through *symptom residue* (Maynard & Frankel, in press) she reveals that her brush with cancer has been and remains a concern as she continues to experience uncertainties associated with a possible diagnosis.

Complex relationships between good and bad news are primal features of everyday social circumstances (see Maynard, 2003), including medical interviews. Here, the alternative to this patient's "early enough" and thus "good news" condition i.e., actually being diagnosed with and requiring treatment for cancer at some unspecified time in the future-creates a *temporal quandary*: any "good news" is situated in the midst of an extended and complicated medical history and a potentially "dreaded future" (Perakyla, 1993, 1995). The transformation of her smile into a grimace thus creates a momentary contradiction in patient's demeanor and face, a shift that appears to be an upshot of and tailored

to these good/dreaded ambiguities. The reassurance and comfort embodied through a fleeting smile, responsive to doctor's "Okay, good.", quickly becomes a grimace of negative impact. This transformation mirrors how this patient treats her illness journey as unresolved (see Frank, 1995). Visibly, these actions personify how patient claims *ownership* of her lived experiences with cancer, an illness with potentially serious consequences (see Raymond & Heritage, 2004; Heritage & Raymond, 2004; Beach, 2004). A basic fact endures: patient will continue to live with the risk that established and new moles may, or may not, become cancerous melanoma. Indeed, her very presence in this medical encounter speaks to the need for preventive care, including ongoing and close monitoring of any changing status in her condition.

Moving away from patient's emotional concerns

Returning to Excerpt 6 and Fig. 2, while doctor's "Okay, good." confirmation is not elaborated, he does directly gaze at patient's facial expression during the following (1.0) pause. His next utterance, "hhh How have you been feeling (.) lately.", emerges immediately following his gaze-directed monitoring of patient's demeanor:

(7) **SDCL: OCjpegs: "feeling (.) lately"**
 |((Fig. 3. *PAT retains | grimace, gazing up and | to the left*))
 DOC: hhh How have you been feeling (.) lately. Have- have you had any fevers () or chills or night sweats, loss of appetite, anything like- any constitutional symptoms.
 PAT: No. I'm tired, but I'm the mother of three kids.
 DR1: Okay. [I understand.]



Fig. 2.

PAT: [\$ Hhhhh.] Pretty normal\$.
 Yeah. =
 DR1: =Mm hm.=

Doctor's question about "feeling (·) lately" appears at a juncture where he attempts to move his medical agenda forward. This query is designed as an upshot of doctor's just prior assessment of patient's grimaced expression. Just as patient's continued grimace makes available ongoing and negative impacts resulting from her brush with cancer, so too does doctor initiate his question as responsive to patient's exhibited feelings.

In overlap with doctor's "lately", patient averts her gaze up and to the left, retains her grimace, and searches for an answer to doctor's query. With some dysfluency ("Have-have"), however, doctor's continued and direct gaze at patient gives rise to his speaking before patient can respond. He next and quickly produces a list of biomedical (constitutional) symptoms. By offering the patient a "textbook-like" listing of symptoms, doctor qualifies what he was addressing with his just prior "feeling (·) lately". In this manner, he also quickly and efficiently moves *away* from any possibility that the patient will hear his query as asking for personal (psychosocial and/or emotional) reactions to his question-responses which may have emerged from patient's averted gaze and apparent searching (Fig. 3).

Indeed, her "No. (·) I'm tired but I'm the mother of three kids." does nominate an additional symptom being tired-and an explanation rooted in her lifeworld experience: being a mother of three children. With her symptom+explanation, patient does not confirm any symptoms nominated by doctor. Despite doctor's moving away from potential psychosocial/emotional issues, patient brings the discussion back to everyday life events by implicitly offering parenting as a reason-

able explanation for her fatigue. In this way, patient nominates a personal and potentially emotional issue for doctor's consideration, patient's own response to doctor's shift toward the relevance of bodily symptoms.

In response, doctor's "Okay. I understand" acknowledges and explicitly confirms both the relevance and normality of patient's dilemma. Through laughter (\$), however, patient's "\$Hhhhh. Pretty normal.\$ Yeah. = "normalizes her condition by marking the delicacy of her situation (see Haakana, 2001). Her response extends beyond recognizing that doctor's prior "Okay. I understand" was attentive to her quandary. She also displays some resistance to the troubles (Jefferson, 1984) associated with being tired as a result of parenting. In response to patient's actions, doctor's "Mm hm." aligns by minimally offering further assurance that the normality attributed by the patient is, indeed, "normal".

Soliciting and withholding reassurance

Now that a single instance (Excerpt 7) has been addressed in some detail, we consider the following excerpt following patient's physical examination. These moments further evidence how patient continues to be tenuous about her "good news" status. And as she directly solicits yet further assurance from doctor, he withholds providing the confirmation she is pursuing.

As a backdrop, prior to this excerpt doctor had provided a summary of symptoms-a list that could indicate melanoma had spread somewhere in the body-that patient should be aware of as she continued to monitor her health status. One specific symptom, "forgetting things", was included in doctor's list as one indication that melanoma may have spread. The excerpt below begins as patient mentions "To your bra::in" as a likely candidate, and doctor attributes to patient having conducted research on melanoma:



DOC1:... feeling (·) lately

Fig. 3.

- (8) SDCL: OCjpegs: "Thope::fully I caught mine early enough"
 PAT: =To your bra::in.=
 DOC: = Then- yeah. The (·) I'm sure you've done a lost of research on melanoma [and are] =
 PAT: [Mm hm.] ((Patient smiles.))
 DOC: = aware of =
 PAT: = Where it can go. _
 DOC: =Where it can go.
 PAT: τ Everywhere.
 (0.5)
 DOC: hh .Yeah.
 PAT: (Now we have)- ah a friend of mine- (·) a friend- (·) it wrapped around the stem <of his bra::in.> hhh ['Like] oh my God.° =
 DOC: [Mm hm.]



PAT: So: Thope::fully

Fig. 4.

- PAT: = It metastasized in his le:g (.) °Ya know.° But he's down at Anderson. _
- DOC: = Mm hm.
- 1((Fig. 4 PAT gazes up and to the left with head torque))
- PAT: I -> So: LT hope::fully I caught mine early enough.
- DOC: 2 -* Well that's the thing. If you had a ah seven millimeter=
- PAT: = Mm hm. =
- DOC: 2 = ah (.) melanoma (.) the: (.) ah (.) survival is much better (.) if yo:u do a resection early on, and I had mentioned to you about the (sentinel) lymph node biopsy.
- PAT: Mm hm.

We begin with one initial observation: that the patient even volunteered this story, regarding her friend's diagnosis, reveals her *identification and preoccupation with potential and dire circumstances caused by the potential that melanoma may spread "T Everywhere"*. At the outset of the story, with "°Like oh my God°", patient reveals her own troubled reaction to the very possibility that "it had wrapped around the stem < of his bra::in. > ". By further noting that "It metastasized in his le:g", the spreading of cancer throughout the body is treated as an increasingly "bad news" condition justifying the referral made to "Anderson" (i.e., the M.D. Anderson Cancer Center in Houston, Texas).

Following the introduction to her story, in (1-~) patient's "So: Thope::fully I caught mine early enough." achieves several key and related actions. First, prior to

initiating her utterance with "So:" (see Beach & Dixon, 2001; Raymond, 2004)-a formulation prefacing what she treated as meaningful about the prior "brain" narrative - patient averts her gaze away from doctor and to her upper left. Her head movement occurs with some torque as she emphasizes her upward-intoned "↑ hope::fully":

Similar to Excerpt 5/Fig. 1, in this moment patient averts her gaze prior to referencing the past, but also when invoking the future: An explicit citing of "hope", one key resource for managing her optimism (Beach, 2002b) about lingering concerns that melanoma problems might lead to more serious cancer diagnoses. Patient's emphasized head movement contributes to demonstrating the importance she attributes to avoiding cancer in the future.

Second, in contrast to patient's initial (and previously analyzed) reporting of "=Cause they got it (0.2) early enough." (see Excerpts 5 and 6, above), this second reference (1->, above) is personalized with "caught mine"-yet retains "early enough" as a benchmark for assessing the relative *valence* of "good vs. bad" news in her particular case.

Third, patient's unsolicited announcement pursues doctor's reassurance that her "hope" is realistic, and that positive healing outcomes will be forthcoming. In (2->), instead of acknowledging patient's concern directly and immediately (e.g., by stating "It seems that we have, and your condition is very good."), doctor proceeds to offer what begins with a pre-disagreement-relevant "Well" (Pomerantz, 1984). He then describes how "survival" is better if you enact a series of technical procedures seemingly "textbook" definitions of treatment modalities. In essence, *while doctor responds with what is essentially good news about patient's condition, he nevertheless orients biomedically to a patient's expressed hopes and fears about her melanoma spreading* ("caught mine early enough"). Left hanging is any reassurance that patient was pursuing. (see Beach & Lockwood, 2003).

Providing such comfort need not involve an unrealistic assessment about a patient's condition; rather, such actions may aid in minimizing inherent uncertainties associated with cancer biopsies, and facilitate the creation of a partnership for managing ongoing preventive care, diagnosis and treatment. Even though the ensuing technical information provided by doctor in (2-+) may be relevant and necessary, an intervening attempt to attend to the patient's exhibited fear about the future could aid in mitigating unnecessary concern. Doctor's acknowledgment could also create an interactional environment wherein subsequent and even technical explanations by the doctor could be monitored by the patient-but with less exhibited concern about the future that is apparent on the videotape.

Summary

In Excerpts 4–8, attention has been drawn to a patient whose melanoma biopsies were negative, thus avoiding cancer diagnosis and extended treatment. Yet both patient and doctor remain vigilant and even cautious, through ongoing preventive care, to insure that patient's moles not become cancerous. Despite patient's "good news" status, she continues to manage "symptom residue" (vocally and bodily) by seeking relevant information, understanding, and support about inherent uncertainties associated with her illness.

As with this patient, a search is not always for definitive answers from an authoritative oncologist. Rather, assurance is sought about what "early enough" amounts to, in practical terms, and also the likelihood that cancer might emerge over time. Initially, with a textbook and thus biomedical question emphasizing symptoms, doctor moves away from patient's exhibited and negative impact of her "brush" or close call with cancer. Later, in response to patient's personalized reference to "hope" and pursuit of reassurance, doctor again offers a textbook response. His reply is replete with technical descriptions and jargon, a depiction that neither acknowledges nor comments on the acknowledgment patient's "Thope::fully" was designed to elicit. For patients and doctors alike, these actions exemplify how inherent uncertainties associated with cancer require ongoing management of often subtle yet critically important interactional moments comprising patient care.

Inviting doctor's understanding and advice

On other occasions, following a positive diagnosis and at times in the very midst of undergoing treatment options, patients also make available-vocally and visibly-the impacts of cancer they are presently experiencing. Rather than seeking primarily to minimize uncertainty following "good news" about their condition, patients may also exhibit *being a cancer patient* who may understandably be fearful, angry, and/or experiencing discomfort and/or pain. In the ways patients make available their unease, nervousness, and/or apprehension they embody their personal misgivings about themselves, cancer as a dreaded illness, and medical care.

Consider, for example, a patient diagnosed with chronic lymphocytic leukemia (CLL), a relatively slow-growing cancer that can decrease and/or increase the production of antibodies, compromising the immune system and therefore the body's ability to ward off infectious diseases. Below, a high school principal describes both an increase in "colds" and his "psychological" reactions to the disease:



PAT: I don't know...

Fig. 5.

- (9) **SDCL: OCjpegs: "mind is doing"**
- DOC: pt hh No chills or any a:h signs of an infection anywhere.
- PAT: hh τ Well, for the first winter in a- in a lo:ng- I used to get
-> one co:ld (.) a winter? This winter I've had four:r.
- DOC: Mm hm.
- PAT: -+A::nd. (1.9) TPsychologically I might be a:dding to all this because once I heard CLL, > and I knew what my brother went through, < (0.4)
- DOC: Mm hm.
[((Fig. 5. *PAT smiles and gazes at doctor*))
- PAT: ~ [I don't know what the ,I.mi:nd is doing [right now.]
- DOC: ['Mm τ hm,°] Mm τ hm.
- WIFE: Well, in addition, [um] =
- DOC: ['Mm.]
- WIFE: = our son had- had four or five colds, and he very seldom gets one either.
((continues))

This excerpt begins with doctor's query, another example of a negatively valenced question designed to solicit a "no problem" response (Boyd & Heritage, in press). However, patient's "hh τ Well" marks a departure by initiating a potentially troubling story: a winter with four colds rather than one, a significant contrast from the medical history he summarizes. Following doctor's acknowledgment that also facilitates patient's narrative, with "A::nd. (1.9)" patient produces an extended pause before elaborating with "τ Psychologically I might be a:dding to all this". In so

doing, patient begins to propose the possibility that unnamed "psychological" factors (e.g., worry, anxiety, and/or fear) also contribute to increased susceptibility for infection. He then cites reasons for his concerns: Having heard "CLL" and knowing what his "brother went through", who was also diagnosed with leukemia.

Although it is not possible to gain direct access to the range of patient's feelings and/or reactions to what he heard and knew, his next utterance is revealing as *a bothered announcement*: "I don't know what the .[mi:nd is doing right now. ". First, notice that as he states he is unaware of what "the .[mi:nd is doing right now.", he makes "the j. mind" out to be a separate entity (i.e., compared with "my mind" as in Excerpt 3) that he treats as unfamiliar and a source of confusion. Essentially, he distances himself from his own thoughts and feelings about the impacts of being diagnosed and living with leukemia (e.g., four rather than one cold a winter).

Second, patient's "I don't know" is not just claiming insufficient knowledge about his mental state. Clearly, he is declining to offer a fuller assessment of his condition (Pomerantz, 1984; Beach & Metzger, 1997), which he appears unable to provide. But it cannot be overlooked that in the way this patient reports his troubles in the presence of a medical expert, he is also *inviting* doctor's understanding and advice in response to patient's predicament. As evident in Fig. 4, patient smiles and gazes directly at doctor at the outset of presenting a conclusion to his narrative:

Yet vocally, patient's "I don't know what the .Imi:nd is doing right now." is hearably fatigued, confused, and even vulnerable. His smile and gaze are not contradictory with his utterance, however, since he exhibits both a resistance to the troubles he reports (Jefferson, 1984, 1988), and a personalized invitation for doctor to understand and respond to patient's problems.

Before the doctor can respond more fully to patient's stated concerns, patient's wife volunteers additional information: with "our son had- had four or five colds, and he very seldom gets one either". Here and as wife continues, she provides an alternative explanation: Husband's increase in colds is not due to impacts of CLL, but normal since their son also experienced more colds than in the past. In this way, wife seeks to minimize, if not altogether avoid the link between husband's possible diminished immunity and increased colds. An extended analysis (beyond Excerpt 9) reveals that her actively pursued contributions prompt doctor to eventually shift topic away from patient's earlier ".tmi:nd is doing". Thus, despite patient's attempts to make his concerns available to doctor, and invite his response, a family member's alternative and lay diagnosis essentially short-circuits such a possibility.

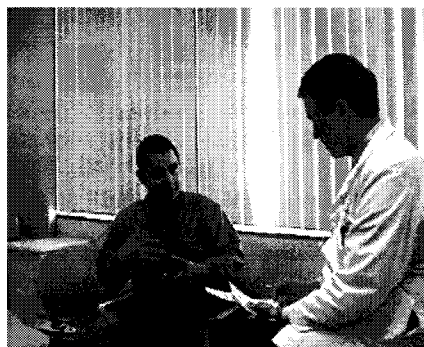
Speculating about being afraid

We conclude our analysis by examining an extended interaction between another oncologist and patient, a stem-cell transplant recipient who expresses a series of concerns about pneumonia-like symptoms he is experiencing. This excerpt begins to reveal how patient's concerns with cancer symptoms are repeatedly raised and responded to over the course of a single oncology interview (see Beach, Good, & Pigeron, 2004). Here, we examine how patient offers *three consecutive speculations* and, at the outset, explicitly states being "afra:id" of what might be causing his symptoms. Significantly, we also examine how doctor responds by progressively moving to close down patient's concerns en route to asking "Are you short of breath?".

When patients attempt to explain their symptoms through *speculations*, they routinely have been shown to exhibit "caution in displaying their knowledge about causation and in soliciting doctors' evaluations of this knowledge" (Gill, 1998, p. 346). Rather than directly requesting doctors' evaluations, patients make their beliefs, opinions, and thoughts available for possible comment. What is unique to the interaction below is not only patient's explicit reference to being "afra:id", but also "This is just spec- my speculation right?". While patients have been shown to routinely speculate about their symptoms (Gill, 1998; Jones & Beach, in press), indirectly raising their concerns while avoiding direct questions to doctors, it is rare for a patient to overtly characterize their activity as a "speculation".

This portion of the medical encounter occurs approximately five minutes into the diagnostic phase of the encounter:

- (10) SDCL: OCjpeg: "Girlfriend is not sick"
 DOC: > Okay. < τ Um anybody else um
 <that you'r:e> around ah (•) like
 > 'you know' < your girlfriend,
 >an- tha-< sick (•) besides you?
 PAT: hh Girlfriend is not sick. [Ah:] and
 she's bee:n ah with me, =
 DOC: [Okay.]
 PAT: = she was on (•) on that tri:p?
 DOC: Mm hm.
 PAT: To the east co:ast,=
 DOC: = Okay. =
 PAT: =with me:, and she has not started
 with any symptoms.
 DOC: = Okay. =
 PAT: = Urn (1.5)1 w- (0.2) was afra:id that
 (0.5) i:t was some sort of:- (0.2) i:t
 was maybe related- (0.2) li:ke (.)
 before, to the toxicity [of the] chemo
 I had in Ja:nua:ry. _
 DOC: [Mm Thm.]



PAT: This is just spec- my speculation [right?]

Fig. 6.

DOC: = Right. =
PAT: hh And maybe we're just catching it-

(.)
[((Fig. 6. PAT gazes at DOC and rotates hands))
[this phenumonia that- that's going to start up. =

DOC: = Mm [hm.]

PAT: [Um] This is just spec- my speculation [right?]

DOC: [Yeah.]

[(DOC gazes down to medical record)]

DOC: [Right. Right.]

[(Fig. 7. PAT gazes at DOC, smiles, laughs, and touches head)]

PAT: [\$Huh huh heh\$] hh [\$1 wa:s thinking that ah-\$ _

DOC: = Well- =

PAT: = [because she's not getting sick, and [I'm] going through=

DOC: . Doc looks up at patient [°Yeah°.]

PAT: =some- s:ome of the si:milar- some of the

[(Fig. 8. PAT averts gaze, closes eyes, and gestures))
[same symptoms.

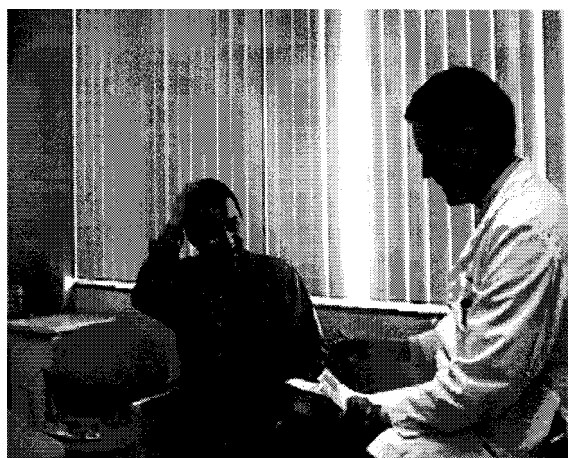
DOC: °Okay.° ((Doc looks down at chart))

PAT: °So.°

DOC: Sure. T [Are you short of breath?

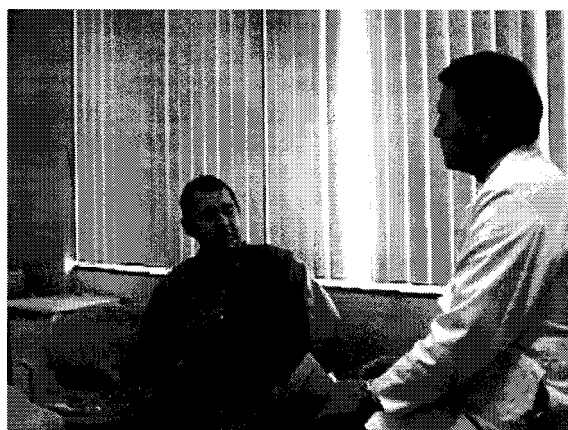
[Doc looks up at patient

PAT: hh W- w- (0.2) I did a lot of walking ((continues))



PAT: "\$I wa:s thinking that ah-\$"

Fig. 7.



PAT: some of the same symptoms.

Fig. 8.

not. Had the girlfriend experienced same or similar symptoms, corroborating evidence would exist that patient might indeed have only a virus. In the absence of girlfriend's sickness, however, this stem cell transplant patient and doctor are faced with discerning whether his symptoms are indicative of a virus or more serious possibilities: Recurrence of pneumonia and/or cancer (which, as noted, can compromise the immune system).

Our analysis proceeds by describing the organization of three serial activities: (1) Patient's initial extended answer and narrative; (2) Patient's disclosure of fear and speculations; and (3) Patient's post-speculation explanation about what he was "thinking". Throughout, attention is also drawn to how doctor monitors and responds to patient's opening narrative, repeated speculations, and final explanation before doctor initiates topic shift (" T Are you short of breath?").

Doctor's initial "> Okay. <" (see Beach, 1993, 1995) brings to close a prior topic of "anemia", while transitioning to a query about patient's girlfriend. Since patient and his girlfriend recently returned from a trip, it is noteworthy that he came back feeling sick and she did

First, notice that following ".hh Girlfriend is not sick.", patient elaborates his initial answer beyond what doctor's question had asked (Stivers & Heritage, 2001). In overlap, doctor's initial "Okay" both acknowledges that the girlfriend is not sick, and displays that he is ready to move onto the next matter (Beach, 1993, 1995). As patient continues doctor's "Mm hm." momentarily encourages patient to continue, but only minimally so before twice responding with "Okay.". Just as doctor carefully monitors but does not comment on patient's narrative, he also exhibits being on the cusp of closing down patient's volunteering of information extending well beyond doctor's opening query. At the outset of patient's opening narrative, then, doctor enacts a "state of readiness for moving to next-positioned matters" (Beach, 1993, p. 326).

Second, however, patient further retains his speaking turn by disclosing that he was "afraid" that "it" (his symptoms) was related to prior toxicity associated with a chemotherapy treatment in January. His disclosure about being afraid, and offering a possible cause of his current condition, is marked with dysfluency and hesitation: he searches for what to say, repeatedly pauses, cuts-off and restarts his words. As doctor is gazing directly at patient, he is at this moment attentive to what patient is saying. So patient's dysfluent actions are not an upshot of his bid for reciprocity *per se* (see Goodwin, 1980). Rather, the difficulty patient exhibits in describing his feelings and speculations appears tailored to presenting his/lay notions to doctor as medical expert. For example, patient hedges as he offers his suggestion that "it was sort of: (0.2) it was maybe related- li:ke (↑) before", a speculation proposing that his experiences with a prior treatment are similar and thus might explain his current symptoms. By utilizing mitigating terms "sort of" and "maybe," patient leaves it for doctor to evaluate his diagnosis and offer an official diagnosis including a re-labeling of the problem (Gill, 1998; Jones & Beach, in press).

In these moments it is obvious that, and how, patient's past experiences shape present understandings of his illness. Further, and importantly, his "brush with cancer" has become a stock of personalized knowledge for assessing ongoing symptoms and calibrating their potential seriousness (Pomerantz, 1984; Beach & Metzger, 1997). Being afraid about uncertain futures is one recurring feature of how patient's proffer *lay diagnoses* of illnesses affecting their lives (see Beach, 2001a,b; Beach & Good, 2004; Perakyla, 1993, 1995). It is also clear that patient's *delicately* offer their lay interpretations when attempting to explain symptoms to medical experts.

As patient discloses being afraid and tentatively offers his speculation, doctor continues to monitor ("Mm T hm.") and with "Right.", appears to agree with patient's disclosure and lay diagnosis. Patient again hedges by hypothesizing ".hh And maybe we're just catching it- (↑) this pneumonia that- that's going to start

up.". In overlap with doctor's next "Mm hm.", he then states "[Urn] This is just spec- my speculation [right?"]". In Fig. 6 it can be observed that as patient and doctor exchange mutual gaze, patient rotates his hands to signify his speculation as uncertain and essentially incomplete, i.e. a work-in-progress:

Essentially, as patient tailors his actions to doctor as a medical expert, he treats his hypothesis as only a hunch or position he is neither convinced of nor committed to (Gill, 1998). Patient's tag-question "[right?]" seeks doctor's confirmation that patient recognizes the tenuous nature of his offerings. With "Yeah. Right. Right.", however, doctor acknowledges but does not elaborate on patient's speculations while gazing away from patient and down to his medical records. In these ways he begins to rush patient through his offerings, shift-implicative actions (Jefferson, 1980, 1993; Beach, 1993, 1995) that neither comment on patient's speculation nor encourage further hypothesizing by patient.

Third, with "\$Huh huh heh\$" patient laughs following doctor's "Yeah." and simultaneously with "Right. Right.". His laughter does not invite shared laughter by doctor (see Haakana, 2001) as he gazes at the medical records. Rather, patient marks the delicacy of the activity in which he is engaged: further explaining and speculating about his condition to a doctor who has been attentive but minimally receptive, and indeed has just begun drawing attention away from issues raised by patient. In Fig. 7 it is evident that patient continues to laugh as he gazes, smiling at doctor while stating "\$I wa:s thinking that ah-\$":

By continuing to account for what he was thinking, patient seeks to further explain his prior self-diagnosis in the absence of receptive response by doctor. As patient touches his head with his right hand, he offers a summary of his speculation: because his girlfriend is not sick, and he is going through some of the same symptoms and this is where his speculating ends.

In part, patient's incompleteness is responsive to doctor's prior "Well-", a disjunctive and disaffiliative action: It marks a pre-disagreement token (Pomerantz, 1984) that preceeds "Yeah." and is followed with "Okay"-utterances offered in the midst of doctor's continued gaze and flipping through his medical charts. As doctor increasingly displays a greater concern with his records than with patient's contributions, patient appears to implore his case in the face of doctor's attempted closure. In Fig. 8, patient averts his gaze, closes his eyes, and gestures in a manner indicative of pleading a failing case:

Verbally, patient is rushing to finish his speculation. His talk is marked initially by dysfluencies (almost stuttering) when proffering "=some- s:ome of the si:milar- some of the same symptoms." Although the alliterative "sound row" (see Sacks, 1992; Jefferson, 1996) may account for some of the dysfluencies in

patient's utterance, it is apparent that patient's rushing is responsive to doctor's hearable and visible advances towards next (biomedical) question and thus speaker-ship (Schegloff, 1982; Jefferson, 1993; Beach, 1993, 1995). As doctor utters "Okay," he also looks down at the medical charts. By shifting his focus away from the patient and towards the records, but prior to asking his next question, doctor previews and foreshadows what "is subsequently conveyed by speech" (Streeck, 1993, p. 296). In this shift-implicative environment, patient's softened "So," trails off rather than pursues a move to summarize what has transpired (see Heritage & Watson, 1979; Beach & Dixon, 2001; Raymond, 2004). This action prompts action which is not forthcoming from doctor or patient: A summary or paraphrase of the significance of the issues patient has been attempting to raise, and possible explanations for symptoms patient reports he is experiencing.

With "Sure," doctor next offers a brief display of sympathetic understanding, which is accomplice to shifting toward his next and abrupt question: "T [Are you short of breath?]. This query is one form of an "insertion sequence" (Schegloff, 1990; Sacks, 1992) which delays directly addressing, but does not wholly ignore patient's prior contributions (see Beach & Mandelbaum, in press). Shortness of breath may be relevant to patient's biomedical condition. Yet doctor's query falls short of reassuring patient about the value and reasonable nature of his narrative about, speculations on, and accounting for his own diagnosis about pneumonia-like symptoms. In response, patient appears to be caught off guard by this abrupt transition, displayed in his troubled beginning in his next turn, ".hh W- w- (0.2) I did a lot of walking ((continues))."

Through a series of continuers and acknowledgement tokens, doctor monitors what patient is saying but does not comment nor seek elaboration on the psychosocial impact of raised concerns. Doctor repeatedly moves away from rather than pursues patient's verbalized and embodied speculations about his diagnostic concerns. During this juncture of the medical interview, continual empathic opportunities to create a "therapeutic alliance" (Beckman & Frankel, 1984) with patient were thus not pursued.

Discussion

The mere presence of a patient visiting a cancer center, even for preventive care, can be not only a fearful experience but shape the interactional organization of cancer care. Being on the cusp of receiving a positive biopsy, or actually being diagnosed and treated, can and does give rise to displays of being preoccupied with and impacted by possible negative consequences of cancer. Patients and family members recognize that cancer may transform and even rupture daily life (Maynard, 1996;

Beach, 2002a), whether an "official" diagnosis is forthcoming or not. It is not just the burden of undergoing treatment options, which can be considerable and alter daily activities (e.g., due to fatigue, nausea, vomiting, loss of appetite, weight, and hair). Rather, patients' reveal that is difficult to face an uncertain and potentially dreaded future with seemingly little control. Diminished quality of life is also no small matter, just as the risk of losing family and friends through death can be traumatic.

We have examined four excerpts drawn from routine oncology visits: two from a patient concerned about her moles, and two from separate leukemia patients troubled by cold and pneumonia-like symptoms. Our analysis makes clear that different moments share common and significant interactional features. Perhaps most revealing is how, in each instance, patients' concerns are exhibited *in the midst of volunteering narrative information about their medical history and experiences with symptoms*. In these data, when patients extend their answers beyond what doctors addressed in prior questions, or otherwise initiate their own actions, underlying fears get enacted. These trepidations have been identified across a range of social actions, and begin to provide behavioral criteria for locating and understanding "fears" as interactional activities:

- *Reports* about friends or family members being diagnosed with cancer (or not, as with patient's "girlfriend" not being sick).
- *Indirect references* to cancer and its symptoms (e.g., "caught it", "catching it", and "adding to all this");
- *Dysfluencies* by patients and doctors (e.g., stuttering, word searches, cut-off and repaired words, and frequent pauses);
- *Temporal benchmarks and quandaries* indexing how "changes" are critical for preventing and monitoring cancer diagnosis (e.g., reporting a change from one cold to four, catching it "early enough", and comparing current with prior flu-like symptoms in the face of a potentially dreaded future);
- *Embodied contradictions* between "good and bad news", evident in specific verbal and nonverbal actions (e.g., smiles, grimaces, laughter, averted gaze, closed eyes, gestures, and leg kicks); and
- *Ambiguities* for two leukemia patients when discerning cold and pneumonia-like symptoms with cancer recurrence.

Such ambiguities are a major and recurring problem for cancer care. As Roter & Hall have noted:

The physician who dismisses a debilitating flu as "only the flu" may miss, from the patient's perspective, the full impact of the illness experience and its meaning. For the patient, the flu may be seen as an indication of a compromised immune system and an early sign of cancer. Failure to appreciate this kind of significance

arises from a fundamental difference between doctors and patients in their worldview. (1992, p. 23)

Contrasts between patients' and doctors' orientations are most apparent in how questions and answers get organized during medical interviews. In two of the excerpts (4 and 9) doctors' questions were designed as "no problem" queries (see Heritage & Boyd, *in press*): Actions shaped not to invite, but restrict the likelihood that patients will further elaborate their circumstances. Ironically, imposing constraints on patient-initiated attempts to volunteer additional information-on the assumption that allowing such contributions promotes unnecessary details wasting valuable interview time-can effectively prohibit disclosure of significant events and fears comprising patients' lifeworld experiences.

Yet, with few and passing exceptions (e.g., see Excerpts 4 and 9), doctors were revealed as attentive but only minimally receptive to patients' lifeworld disclosures and demonstrations. We identified a tendency for doctors to provide neither reassurance nor commentary on patients' contributions, essentially working to close down and move away from patients' emotional concerns. These findings are resonant with oft-cited and established regularities in medical interviews, orientations emphasizing biomedical priorities at the expense of patients' full range of "biopsychosocial" concerns (Engel, 1977; Beckman & Frankel, 1984; Beach, 1995; Marvel, Epstein, Flowers, & Beckman, 1999; Roter & Hall, 1992; Felitti et al., 1998; Suchman et al., 1997; Perakyla, 1998; Roberts, 2000; Stivers & Heritage, 2001; Beach & Dixon, 2001; Heath, 2002; Jones & Beach, *in press*). As Barbour (1995, p. 23) observed, "the human situation is invariably bypassed by the reductive process of diagnosis and treatment".

Future research needs to closely attend to moments when patients report their everyday experiences, and how doctors affiliate with and/or redirect attention away from what patients treat as important. As Gill (1998) discovered, when patients offer explanations they cautiously downplay their knowledge in an attempt to avoid doctors' disaffiliative responses. Yet such disaffiliation may be unavoidable. For example, when patients tentatively seek "premature" diagnostic information-before and during medical history-taking and physical examination-doctors exhibit resistance to identify with patients' concerns and to engage in joint participation and decision making (Jones & Beach, *in press*).

The consequences of avoiding, failing to acknowledge, and/or unduly constraining patients' displayed impacts of illness, particularly their "cancer journey" (Kristjanson & Ashcroft, 1998), are considerable. Systematic avoidance and reduction of patients' lifeworld experiences contributes significantly to patient dissatisfaction, enhanced likelihood of malpractice, and decreased likelihood for healing outcomes (Levinson et al., 2000). Clearly, for

many patients the main reason for visiting the doctor is to receive medical professionals' opinions of what, if anything, is wrong with them and what options exist for promoting healing (Beisecker & Beisecker, 1990; Eisenthal, Kopman, & Stoeckle, 1990; Good & Good, 1982; Like & Syzanski, 1987; McKinley & Middleton, 1999). Similarly, there is little doubt that a patient's desire to reduce uncertainty plays a large role in his or her reason for visiting the doctor (Babrow, 2001; Babrow, Hines, & Kasch, 2000; Babrow, Kasch, & Ford, 1998; Babrow & Kline, 2000; Molleman et al., 1984): a change in the body is cause for alarm and can lead to heightened states of uncertainty and possible anxiety (Babrow et al., 1998; Frank, 1991, 1995; Molleman et al., 1984). But from our data it is clear that addressing fears experienced and communicated by patients is equally important key features of the "embedded context" (Goodwin, 2003), so tightly interwoven as to be indistinguishable from biomedical features of diagnosis, treatment, and prognosis. Patients' prior experiences with illness form the basis for describing and enacting current symptoms, and for hypothesizing about what is and what may happen to them. Patients rely on this residual knowledge, of their experiences and their bodies, when providing speculations for doctors' consideration and when reporting about their friends, family members, and more generally the worlds they inhabit (see Beach & Mandelbaum, *in press*).

Finally, how might basic oncological research identify "communication practices" which might enable communication training? Empirical findings about oncology interviews, generated from conversation analytic investigations such as the present study, can hopefully provide valuable resources for refining skills assessments, and for educational workshops grounded in close and repeated examination of naturally occurring, videorecorded and transcribed oncology visits. It remains to be seen how these findings and methods might compliment long-standing and ongoing concerns with how cancer patients present, and doctors respond, to a range of concerns and problems (e.g., see Maguire & Faulkner 1988a-c; Maguire, 1990, 1999; Maguire, Faulkner, & Regnard, 1993; Maguire, Booth, Elliott, Jones, 1996a; Maguire, Faulkner, Booth, Elliott, Hillier, 1996b; Ford et al., 1996a,b; Baile et al., 1997; Baile et al., 1999a,b; Fallowfield, Lipkin, & Hall, 1998; Fallowfield & Jenkins, 1999; Ford et al., 2000; Fallowfield et al., 2002). Such cross-disciplinary dialogue will no doubt be heuristic and, ultimately, promote discoveries with considerable potential to enhance care and healing outcomes for patients and families navigating their way through inevitable cancer dilemmas.

Appendix A. Transcription symbols

In data headings, "SDCL" stands for "San Diego Conversation Library", a collection of recordings and

transcriptions of naturally occurring interactions; "OC" represents "Oncology", followed by vernacular extracts drawn from the video-excerpts being analyzed (e.g., "feeling (') lately"). The transcription notation system employed for data segments is an adaptation of Gail Jefferson's work (see Atkinson & Heritage (Eds.), 1984, pp. ix-xvi). The symbols may be described as follows:

	<i>Colon(s)</i> : extended or stretched sound, syllable, or word
	<i>Underlining</i> : vocalic emphasis
(.)	<i>Micropause</i> : brief pause of less than (0.2)
(1.2)	<i>Timed pause</i> : intervals occurring within and between same or different speaker's utterance
(())	<i>Double parentheses</i> : scenic details
○	<i>Single parentheses</i> : transcriptionist doubt
	<i>Period</i> : falling vocal pitch
	<i>Question Marks</i> : rising vocal pitch
↑	<i>Arrows</i> : pitch resets; marked rising and falling shifts in intonation
° °	<i>Degree Signs</i> : a passage of talk noticeably softer than surrounding talk
	<i>Equal Signs</i> : latching of contiguous utterances, with no interval or overlap
	<i>Brackets</i> : speech overlap
	<i>Double Brackets</i> : simultaneous speech orientations to prior turn
!	<i>Exclamation Points</i> : animated speech tone
	<i>Hyphens</i> : halting, abrupt cut off of sound or word
> <	<i>Less than/greater than signs</i> : portions of an utterance delivered at a pace noticeably quicker than surrounding talk
OKAY	<i>CAPS</i> : extreme loudness compared with surrounding talk
hhh hhh	<i>H's</i> : audible outbreaths, possibly laughter. The more h's, the longer the aspiration. Aspirations with periods indicate audible inbreaths (e.g., .hhh). H's within (e.g., ye(hh)s) parentheses mark within-speech aspirations, possible laughter
pt	<i>Lip Smack</i> : often preceding an inbreath
hah	<i>Laugh Syllable</i> : relative closed or open position of laughter
Heh	
Hoh	
§	<i>Smile voice</i> : words marked by chuckles and/or phrases hearable as laughed-through

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