

Uncertain family trajectories: Interactional consequences of cancer diagnosis, treatment, and prognosis

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ABSTRACT

Analysis of a corpus of family phone calls reveals how family members routinely address uncertain issues when attempting to understand cancer diagnosis, treatment, and prognosis. A large collection of moments are overviewed and organized into three prominent social activities: biomedical reportings about anonymous medical staff; references to doctors in anticipation of explanations; and assessing the care provided by doctors and medical staff. Specific attention is drawn to how reportings include lay depictions about lack of knowledge, ambiguities associated with the passage of time, and emergent troubles with pain and medication. These instances make clear how family cancer journeys are interactionally organized events, comprised of distinct communication practices for raising and resolving illness dilemmas.

KEY WORDS: conversation analysis • family cancer • illness and uncertainty • lay understandings of technical procedures

Recent attention has been given to how the delivery and receipt of both good and bad news is delicately constructed, tailored to unique interactional circumstances, yet amazingly ordered and thus patterned across hundreds of conversations involving news delivery sequences (NDSs; Beach, 2001a, 2002; Maynard, 1997, 2003). One recent single-case analysis focused on how a dad informed his son on the telephone, for the first time, that mom's tumor was 'malignant' (Beach, 2002). It was shown how delay and resistance, as an alternative to announcing bad news directly, allow family members the opportunity to imply and anticipate the 'valence' of

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news when gradually moving to talk about a serious health condition. Also apparent were biomedical and even stoic orientations to mom's dilemma. The presence of technical descriptions, as well as the initial absence of personal and emotional reactions by dad and son, provides additional evidence that *stoic* demeanors are normalized resources for managing and coping with the onset of dreaded news events (Beach, 2002; Maynard, 1997, 2003).

Examinations of how family members communicate about health and illness, in both home and clinical environments, reveal an array of important interactional questions:

- How do family members update one another about their own and/or others' health status?
- How do lay persons exhibit understandings of technical/medical procedures?
- How does *uncertainty* become interactionally constructed as family members work through diverse problems associated with health and illness?

In this article we extend our analysis by focusing on how family members repeatedly make reference to doctors, medical staff, and technology in the ordinary course of attempting to understand diagnoses and treatments for cancer. We also evidence the omnipresence of 'uncertainty,' a matter of considerable theoretical concern regarding illness (Babrow, Hines, & Kasch, 2000; Babrow, Kasch, & Ford, 1998; Babrow & Kline, 2000), examined herein by focusing on actual and diverse interactional environments. These concerns arose from the case study summarized earlier (Beach, 2002), together with ongoing efforts to build collections of social activities evident within a larger corpus of family phone calls. One set of relevant moments, occurring within the first two minutes of the initial dad-son phone call, appears below (see Appendix for transcription symbols):

(1) SDCL: Malignancy #1:1-2 (S=son; D=dad)

S: What's up.
(0.6)

D: → pt(hh) They ca:me ba:ck with the[∴] hh needle biopsy results, or at least in part.

In response to the son's 'What's up.', treated as a direct solicitation of news about mom, dad's utterance is comprised of three key features. First, 'They' reports how *anonymous* medical staff, responsible for performing and/or interpreting results, 'ca:me ba:ck' with awaited information arriving from 'removed and unseen' labs and clinical settings (see Beach, 2002, p. 286). Second, dad's reference to 'the[∴] hh needle biopsy results,' begins with an extended and stretched 'the[∴]', exhibiting an attempt to search for a description that was not immediately forthcoming. Emerging from dad's search was 'needle biopsy results,' *technical terminology about medical*

procedures adopted from what doctors and/or other medical staff had utilized when dad was initially informed. Third, ‘or at least in part.’ qualifies dad’s announcement as incomplete and thus *uncertain*, contingent upon subsequent results.

Several moments later, following the son’s request for clarification about his mom’s kidney, notice how dad’s repeated attempts to describe mom’s ‘results’ (i) remain *anonymous* (e.g., ‘They’), (ii) are comprised of *technical terminology* (e.g., ‘testing positive’), and (iii) are repeatedly marked with different modes of *uncertainty* (e.g., ‘I don’t know’, ‘I guess’, ‘That one they do not have the results on’):

(2) SDCL: Malignancy #1:2

D: [May-] (.) ma:ɪbe I’m not saying it right. .hhh There

→ is- I don’t know that there is a tumor there. They
nee:dle biopsied the adrenal gla:nd.=

S: = O:°[kay.°]

D: → [I gue]ss °that’s what I should say° .hhh and tha:t
one came back testing positive.

S: Mm:k(h)a:y.

D: → pthh They di:d u:hh double needle biopsy of the(0.2)
lu:ng. .hh That one they do no:t have the results on.
(0.6)

S: °Je:[sus°]

Notice also that as dad repeatedly attempts to provide a more detailed and accurate update, the son’s voice breaks in the midst of ‘Mm:k(h)a:y.’ and next offers a quiet, hearably emotional and even sorrowful assessment via ‘°Je:[sus°]’. In these ways, son progressively displays increasing and affective recognition of the unequivocally bad nature of the news he is assimilating.

Taken together, as dad and son initially work through moments wherein mom’s results become associated with a bad news diagnosis of cancer, *technical details are reported in the midst of anonymity and uncertainty*. What insights might be generated about families and health from a closer examination of the co-presence and interplay of these features? Our analysis addresses this question by examining a considerably larger collection of similar instances, drawn from moments we characterize as ‘speaking about and like the doctor/medical staff.’ It turns out that the orientations evident in excerpts (1 and 2, earlier) are not isolated occurrences; indeed, such social activities are prevalent in the materials examined.

We begin by overviewing a series of telephone calls entitled the ‘Malignancy Corpus,’ and how conversation analysis (CA) is employed as a method for analyzing social activities accomplished through ordinary conversational involvements. Attention is then drawn to practical aspects of working with ‘collections’ of interactional practices, as resources for identifying and understanding recurrent patterns of communication activities. The data examined in this article – addressing how *technical details are reported in the midst of anonymity and uncertainty* – will be utilized as a point of departure for emphasizing the critical importance of building and analyzing

collections in a research program designed to simultaneously examine inter-relationships among family interactions, clinical encounters, and health.

Conversation analytic methods

Conversation analytic methods are employed to unearth the interactional details of the materials examined herein (Atkinson & Heritage, 1984; Drew & Heritage, 1992; Sacks, 1992). The variability of conversation analysis (CA) is evident when considering that priority is given to locating and substantiating participants' methods for organizing and thus accomplishing social actions. This mode of analytic induction is anchored in repeated listenings of recordings with systematic inspections of carefully produced transcriptions. It is an explicit and working feature of this research method that participants continually and intrinsically achieve, through varied interactional practices, displayed understandings of emergent interactional circumstances. The overriding goal is to identify patterned orientations to moment-by-moment contingencies of interaction comprising everyday life events.

The overriding goal of CA is to anchor observations in the organization of specific practices, recruited by specific speakers, who exhibit orderly ways of monitoring and responding to what was treated as meaningfully produced by a prior speaker. Gradually, close and repeated inspection of single cases promotes discernment of patterns across similar yet diverse instances.

Analyzing family interactions involving cancer

Because phone calls are so prominent in everyday life, considerable attention has been given to their interactional organization (see Hopper, 1992; Schegloff, 1968, 1979). Access to naturally occurring recorded phone calls, involving families talking through cancer, has only recently become a focus of investigation (Beach, in press; Beach & Anderson, 2003; Beach & Lockwood, 2003). Phone calls examined here have the following characteristics. First, they are drawn from the 'Malignancy Corpus' – the first recorded natural history, from diagnosis through death (13 months/60 calls/26 participants), of a family's phone calls as they address life events arising in unison with the progressive development of mom's cancer. Beginning with the son's first phone call to his dad, and throughout, these calls reveal the social and emotional impacts of family members (but also selected friends, acquaintances, and service representatives) as they deal with the uncertain (but often inevitable) trajectories of terminal cancer. Second, phone data allow us to examine over time family members' ways of coming to terms with, and making sense of, the diagnosis. Third, two basic research questions guided this ongoing study:

- Which interactional patterns and resources are enacted when talking about and through the progression of cancer?
- Which recurring and unavoidable communication problems arise?

We identified an array of communication patterns and problems when family members attempt to describe and understand being 'caught up within' the diagnosis and treatment of cancer, for example, news delivery sequences (Beach, 2002, 2003b), managing optimism (Beach, 2003a), and calling the airlines for discounted fares during a family crisis (Beach & Lockwood, in press). Ongoing work is focusing on the interactional achievement of related and diverse social activities evident in family phone calls (e.g., uncertainty, lay understandings of technical/medical issues, assimilating and commiserating about terminal cancer, humor and laughter, caregiving and receiving, and stories not directly related to cancer).

Related work, addressing how patients and family members communicate during medical encounters, is also ongoing (see Beach, 1995; Beach & Dixon, 2001; Beach & LeBaron, 2002; Beach, Good, & Pigeron, 2003). Specific concerns, such as how adverse childhood experiences (ACE) impact adult health, attending and disattending patients' concerns, and responding anxiously to cancer symptoms are related in important ways to non-clinical interactions like the Malignancy Corpus (but are not addressed here). The data excerpts analyzed here were drawn from this larger collection of moments about 'speaking about and like the doctor/medical staff.' The materials discussed here are subsets of the fuller Malignancy Corpus.

Permission to conduct research on these materials was granted by the family and approved through appropriate Human Subjects Committee reviews, contingent upon maintaining anonymity and delaying initiation of researching these phone calls for a period of five years. To date, approximately 15 years have passed since mom's death.

Building collections

Research priorities naturally change in the very midst of generating and refining collections. For example, we started with the goal of analyzing selected moments we had heard and attended to: how family members (at times) take on the 'voice' of doctors when reporting what doctors had told them. We intended to focus on how enacted and 'reported speech' (Beach, 2000; Holt, 1996, 2000) is organized, and how family members 'make sense' of biomedical/technical matters. While *reported speech and actions* are significant, we decided to focus on broader activities that occur throughout family cancer journeys.

Approximately 100 excerpts, ranging in length from approximately five seconds to a maximum of two minutes, were initially identified across 60 phone calls. At the outset, attention was first drawn to moments when speakers made references to 'doctor.' We then recognized that family members not only referred to doctors, but also medical staff, through unspecified 'they' and 'they're' references (i.e., deictic pronouns; Sacks, 1992).

Collections allow for close and repeated analysis of interactional environments and the practices comprising them. However, our efforts do not 'code' instances into pre-determined and thus ungrounded categories of social action (see Beach, 1994; Clayman & Heritage, 2002). The goal is not simply nor primarily to identify 'frequencies of occurrence.' Frequencies per se are often difficult to discern: single and even relatively 'simple' instances involve multiple discourse features, just as locating and substantiating what counts as a phenomenon/practice is in all cases problematic. It is only by advancing reasonable descriptions, with plausible explanations made available to readers about

transcribed data they are encouraged to inspect, that a broad range of social actions might be characterized. Whenever possible it is, of course, preferable that readers have audio/video access to complement their inspections of transcribed interactions. [Readers are encouraged to contact the author(s) directly for recorded interactions.]

Increasingly, online access to digitized clips is available across varying researchers' websites. Another and very recent alternative appears in the special issue of the *Journal of Communication* (2002, 52/3) focusing on relationships among verbal and nonverbal communicative behaviors. A CD accompanies this issue, containing digitized video clips of excerpts analyzed by several authors. Unfortunately, restricted access to the family phone calls analyzed herein does not currently allow for such innovative possibilities.

Three prominent social activities

A closer examination of approximately 100 instances revealed three prominent yet general types of discourse involvements, namely reporting and updating news about mom, referring to doctors in anticipation of results from diagnostic tests, and making assessments of doctors' performance. These social activities are listed below in order of frequency of occurrence (in parentheses). Two instances of the first category have been provided in excerpts 1 and 2 (above):

(48) Reporting on and updating the diagnosis, treatment, and prognosis of mom's cancer. Such reportings often include anonymous person references, biomedical language including technical procedures, and differing types of uncertainty (as with excerpts 1 and 2, above).

These instances comprise the bulk of analysis for this article, beginning with excerpt 7, below.

First, however, we provide overviews of additional exemplars for each of two additional types of family involvements:

(34) Referring to doctors in anticipation of receiving explanations and/or answers to family members' questions.

Before the following excerpt, occurring the very next day in the son's phone call with mom, she had just informed him that her diagnosis of a 'large cell cancer' is 'very fast, very rapid,' and 'very difficult to treat':

(3) Malignancy #2:3

M: So, (0.4) it's re::al °ba:d° .
(0.8)

M: ((sneezes))

S: pt .hh I guess.
(0.4)

M: And uh: >I don't know what else to ↑tell you.<
(1.0)

S: .hh hhh Yeah. (0.2) um- ((hhhh)). Yeah, I don't know what to say either.

M: → No there's nothing to say. >You just-< .hh I'll- I'll wait to talk to Dr. Leedon today = he's the cancer man and =

S: = Um hmm.

M: → See what he has to say, and (0.4) just keep goin' forward. I mean (.) I might be real lucky in five years. It might just be six months.

This set of moments, the onset of one of the most difficult and delicate discussions between family members in the entire Malignancy Corpus, involves a mom informing her son of the seriousness of her cancer diagnosis. Mom's bottom-line assessment 'So, (0.4) it's re::al oba:d°.' is followed by two extended pauses and her intervening 'sneeze.' Next, and not surprisingly, the son's 'I guess.' acknowledges but withholds commenting further on what his hearing about such bad, and possibly even fatal news, might amount to. And in the very next turn at talk, mom's '>I don't know what else to ↑tell you.<' gives rise to what son's earlier 'I guess' left unstated: 'I don't know what to say either.' (Beach & Metzger, 1997). It appears that there is 'nowhere else to go' (Jefferson, 1984b, p. 191) in bringing this troubling diagnosis and prognosis to a close, which mom's 'No there's nothing to say.' further emphasizes (Beach, 2003a).

We have found that various displays of 'hope' emerge as the upshot of bad news and even despair, as with mom's 'I'll – I'll wait to talk to Dr. Leedon today.= He's the cancer man'. In cases when family members exhaust their resources for responding to a serious cancer diagnosis, it becomes clear that 'Only the doctor has the expertise to announce any new, potentially good, and more or less definitive news regarding her acute medical condition.' (Beach, 2003a, p. 183). One way to 'manage optimism,' then, is to faithfully move forward in hope that the future may hold better rather than worse 'news,' possibilities that only a cancer expert might elucidate. But as portrayed in mom's 'I mean I might be real lucky in five years. It might just be six months.', considerable uncertainty remains: even doctors do not possess 'crystal balls' revealing future trajectories of current illness (see excerpt 6, below).

In the following instance, son (S) specifically asks dad (D) 'what'd the doctor have to say?' about mom's condition:

(4) SDCL: Malignancy #12:3

- S: Yeah. hhh .hhh heah .hh So what'd the doctor have to say specifically anything. =
- D: =We:ll. (0.2) Th- the thyroid is too high, the pain: is tremendous and it will just slowly keep accumulating. They will leave her o:n (0.6) u::h the morphine stuff.

Following a brief hesitation, dad proceeds to announce bad news. His announcement is organized as a three-part list (Jefferson, 1990; Sacks, 1992), replete with extreme-case depictions (e.g., 'too high,' 'tremendous'; Pomerantz, 1986), and little apparent hope for a reduction in mom's discomfort. Once underway, this description is offered fluently. It is also produced, and hearably so, with certainty and authority. However, the medically proposed solution – to 'leave her o:n (0.6) u::h the morphine stuff,' is attributed not to the 'doctor' but to 'they' – likely a recognition that it is not doctors per se who administer morphine to patients, but nurses and related medical staff. Notice that dad's utterance is also delivered as an upshot of obvious searching ('o:n (0.6) u::h'), marked by stretched vowels and a pause (Goodwin, 1987), for what and how to characterize 'the morphine stuff'.

There is a marked difference, therefore, in reporting what the doctor has said – an apparent upshot of speaking with the doctor directly – and dad's offering of his own (lay) depictions of treatment/drug options managed by anonymous

staff. As mom's cancer progresses, specific distinctions are made, by family members during phone calls, between types of morphine pills and 'drips.' But in excerpt 4 'stuff' is recruited by dad in a generalized manner revealing his inability to further specify details about medication. Of course, the source of dad's difficulty is unknown: did the doctor not mention details about morphine options? Did discussions not occur with staff dispensing the drugs? Is dad tired after a long day and unable to retrieve such technical information? These questions remain. What is evident from these interactional materials is that dad's reporting, of what the doctor had told him, was marked with fewer interactional problems than his searching for information about morphine treatments.

(18) Assessments of the performance of doctors and medical staff, both complimentary and critical in nature.

The third general type of discussion involves moments when family members display support and frustration with the doctors and medical staff responsible for mom's care. Below are two excerpts (between son and aunt, and son and dad) that occurred within a 24-hour period. They are presented together because each addresses the basic issue of how long mom might have to live, employing 'Christmas' as a future time-frame:

(5) SDCL: Malignancy #10:11-12

- A: . . .ne:ither one of us believe that she'll be here for Christmas.
 . ((33 lines deleted))
 S: → But DA:MN! Come on. I mean it's li:ke a- they're gonna adjust and then two days later it's a cata:strophic adju:stme:nt. And two days la:ter it's a cata:strophic adju:stment. An .hhh ya kno:w how- how much can they keep clea:ning up after this me:ss.
 A: → Q::h they can do a lo:t for a lo:ng ti:me. But I don't thi:nk anybody he:re wants that.
 S: No. You know ma- mom mentioned the no he:roic me:asures. =
 A: = O::h yeah. O::h yeah.

(6) SDCL: Malignancy #12:7

- D: I- it may wind up bein' over the Christmas holidays or somethin'. I- >ya know< I don't know I- I- in my mind I can't (0.6) visualize this goin' past the end of the year, but lookin' at her to↑day I say phchuuuu gotta be at least a month.
 S: → Mmkay. pt .hhhh Well yeah and I know Dr. Wylie will never say anything in particular right. So- [hhhhh \$huh ph\$]
 D: → [We::ll ya know] she doesn't have any- >ya know< she's only got an educated cr[ystal ball.] =
 S: [pt Sure.]

Turning first to excerpt 5, following the aunt's opening assertion, an extended discussion occurs (which has been deleted) about 'mom's tough' (but see excerpt 12, below). Also discussed, but not included, were medication alternatives for treating mom during this phase of her illness. The transcription continues as the inherent uncertainty of mom's status, and how medical staff might proceed with her treatment, is addressed by the son with an expletive

and exclamation: ‘But **DA:MN! Come on.**’. The source of his frustration rests with how often ‘they’re gonna adjust’ mom’s medication in such ‘catastrophic’ circumstances. The extremity of his concerns is obvious, not only in his repeating of ‘they’re’ adjustment three times, but also in what he characterizes as persistence in ‘cleaning up after this mess.’

In response, while the aunt initially confirms the son by stating ‘**O:h** they can do a **lo:t** for a **lo:ng ti:me.**’, she subsequently makes clear that prolonging mom’s passing is not aligned with mom’s or family members’ wishes. The aunt is reminding the son of earlier discussions, with mom and others, that instructions had been given for ‘no life support.’ Her assuaging action essentially invokes and solicits the son’s shared knowledge. By so doing, the son is provided with an opportunity to utilize his own reporting of mom’s stated ‘no heroic measures’ as a resource for coping with, and even reframing, his understandable frustrations. His alternative position displays a clear recognition of an underlying assurance – that ‘adjustments’ will not occur indefinitely – that the aunt’s repeated ‘**O:h yeah. O:h yeah.**’ seems designed to guarantee with confidence. Together, then, aunt and son work through a primal frustration with medical staff’s possible and misdirected handling of mom’s ongoing medication. They also collaborate in essentially de-triggering son’s displayed frustration and anxiety, which, for a moment, overrode his memory of having spoken directly with mom about ‘no heroic measures.’

In excerpt 6, following dad’s attempt to ‘visualize’ and (based on her appearance) assess how long mom might live, son responds by offering a somewhat critical claim of knowledge that the doctor ‘will never say anything in particular right.’ He then moves to summarize or close his critical assessment with ‘So-[hhhhh \$huh ph\$]’. It should not be overlooked that the son’s exhalation (h’s), followed by laughter (\$\$), both emphasizes his position and invites dad’s alignment: an attempt to garner dad’s agreement with the criticism about the doctor that the son is formulating.

Yet notice that dad’s response withholds the affiliation the son is pursuing by stating the obvious: ‘she’s only got an educated crystal ball.’ By supporting the doctor’s inability to predict how the future will unfold, despite her expertise, dad refuses to collaborate in unwarranted criticism and, further, to attribute any wrongful intentions. And by supporting the doctor in this way, dad’s actions counter the son’s negative portrayal – a line of action often rooted in cultural stereotypes that doctors are unwilling to speculate about how long patients have to live – a correction that the son’s ‘Sure’ quickly acknowledges as relevant and appropriate.

Excerpts 3–6 (earlier) reveal that doctors and medical staff are treated as explanatory resources, subjected to criticism, and at times supported by family members:

- In the midst of mom’s delivery and son’s hearing of serious/bad news, a doctor (‘the cancer man’) emerges as a source for timely hope and optimism.
- Reportings of what doctors ‘said’ stand in marked contrast to family members’/‘lay’ depictions of medical procedures.
- The actions of medical staff (e.g., involving prolonged medication) can become a source for frustration. When these feelings are vented, opportunities are provided for family members to provide assurance that such understandable frustrations have been and will continue to be monitored and addressed (e.g., ‘no heroic measures’).

- Criticisms of doctors need not be agreed with, and can be mitigated by stating obvious limitations of medical care ('educated crystal ball').

Viewed together, excerpts 3–6 involve seeking explanations, providing and responding to such actions as criticisms of doctors and medical staff. What follows is an elaboration of interactional moments comprising how *technical details are reported in the midst of anonymity and uncertainty*.

Uncertainties about technical and anonymous reportings

We examine three distinct sub-types of social action, drawn from moments when family members displayed uncertainties over technical and anonymous reportings about mom's cancer diagnosis and treatment.

'Lay' depictions about lack of knowledge

In two earlier instances (excerpts 2 and 4), dad's attempts to describe technical features of mom's treatment were shown to be produced with uncertainty and hesitation. Portions of these moments are reproduced below:

(7) SDCL: Malignancy #1:2

D: [May-] (.) ma:ybe I'm not saying it right. .hhh There
 → is- I don't kno:w that there is a tumor there. They
 need:le biopsied the adrenal gla:nd.=

S: = O:°[kay.°]

D: → [I gue]ss °that's what I should say° .hhh and that
 one came back testing positive.

(8) SDCL: Malignancy #12:3

D: They will leave her o:n (0.6) u::h the morphine stuff.

In excerpt 8, dad's 'stuff' is a generalized, catch-all upshot of a search that failed to yield more specific information. Taken together, these moments exemplify how dad's *lack of knowledge* impacts what and how his descriptions are made available to the son.

As lay persons, family members can exhibit a remarkable ability to learn technical/medical information. Terms, applications, and explanations about how the body functions, and is impacted by an illness are invoked during condensed and over extended periods. Such information may not be 'technically correct,' at least by medical experts' standards, but is nonetheless utilized when attempting to understand and discern the appropriateness, and potential consequences, of diagnosis and treatment options.

As shown, limitations of knowledge eventuate in decidedly 'lay' depictions of often technical/medical procedures. In the following two excerpts (9 and 10, below), attention is drawn to 'radiation, chemotherapy, and bone scans'. Before the first instance, the dad had just summarized to his son how the doctor informed him that, because of its potential harmful effects, 'Surgery is a last option':

(9) SDCL: Malignancy #1:3–4

D: 1→ [.hh] So: they can't do be:tter, =

S: [°Mm:°]

- D: 1→ = .hhh with- with ve:ry specific, °.hh° a:iming or
however the heck they do: the- (.) the radiation
stuff. =
- S: = [°O:kay°]
- D: = [°.hh° A:]nd- and then give her the che:motherapy.
- S: °Hm[m:]°
- D: [pt] .hh So:, (.) the pla:n from here is
- 2→ <they will do:., (.) a bo:ne sca:n tomorrow.> .hh
- 3→ A:nd from what I understand she will just get a:
sho:t, which should be no big deal. pt .hh And a
couple glasses of stuff to drink. .hhh And then they
will take her do:wn, .hh and do the <bo:ne sca:n.>I:
- 4→ don't know whether< that's done by x:ray or (.) cat
scan. But in either case, .hh <that's not inva:sive>
like some of the rest of this stuff. >So that
shouldn't hurt her.< .hhh[h h h h h h]
- S: 5→ [How did she fa:re] through
these pro[cesses].

As dad moves to summarize and contrast surgery with 'radiation' in (1→), three distinct features are apparent.

First, 'they' is utilized as a shift from prior references to 'doctor/him,' now addressing an anonymous medical team responsible for radiation/chemotherapy treatments.

Second, notice that within 'So: they can't do be:tter,' dad's 'can't' appears semantically incorrect and even contradictory: when designing his utterance as a preface to describing how radiation and chemotherapy are preferred treatments (over surgery), he employs 'can't' rather than 'can.' Thus he negatively formulates what is next described as a preferred solution, one where 'can' is better fitted to this course of treatment though 'can't' emerges. This is not a transcription error. Rather, speakers often produce non-semantic speech, without repair or correction, particularly in environments where difficult and/or delicate matters are being addressed (Ochs, Schegloff, & Thompson, 1996). That dad's 'So: they can't do be:tter,' utterance evidences how complex explanatory tasks can trigger language use that may not be grammatically correct, but is nevertheless pragmatically revealing of troubling interactional instances.

Third, dad shifts from 've:ry specific, °.hh° a:iming → or however the heck they do: the- (.) the radiation stuff. ='. Like 'morphine stuff' earlier (excerpts 4 and 8, above), dad's technical descriptions are contrasted, and in close proximity, with overly general catch-all terms. Here, dad's 'however the heck' prefaces 'they do: the- (.) radiation stuff' in a decidedly 'lay' manner, but is also followed by marked dysfluencies: a search ('do:'), cut-off word ('the-'), and slight pause ('.'). Taken together, these discourse features evidence inherent problems when producing specific/technical descriptions.

Several other details are also revealing in excerpt 9, earlier. In (2→), for example, and dad's subsequent '<bo:ne>' and '<that's not inva:sive>' depictions, the '< >' reflect hearably 'slower' speech. These moments are also produced with repeated emphasis (underlining). Combined, it appears that dad is *prosodically* marking (i.e., with intonation, pace, and emphasis; Beach, 2000; Couper-Kuhlen & Selting, 1996; Schegloff, 1998) procedures described to him by medical professionals. Literally, dad is *taking on the voice* of medical experts. These voices are reproduced here for the son's hearing, in a manner designed

by dad to be informative, technically proficient, and authoritatively stated (i.e., with hearable confidence and minimal uncertainty).

These attempts to be technically accurate also emerge in the very midst of repeated ‘lay’ actions. In (3→), dad’s ‘from what I understand,’ ‘no big deal,’ and ‘couple glasses of stuff to drink’ all reveal limits of knowledge that de-formalize otherwise technical procedures. His qualified reportings thus uniquely shape how his narrative gets told (Beach, 2000). Additional evidence is available in (4→): dad explicitly states that he doesn’t know whether a ‘bone scan’ is ‘done by x:ray or (.) cat scan’, recruits what others have apparently informed him (‘<that’s not inva:sive>’) to compare these procedures with ‘some of the rest of this stuff’ (e.g., needle biopsies), and concludes with ‘So that shouldn’t hurt her’ – a personal assessment of a bottom-line concern that mom’s discomfort and pain be minimized.

Two final observations are merited. That dad completes his reporting with a pronounced sigh (‘.hhh[h h h h h]’) displays not only his termination of a fairly lengthy and detailed reporting, but also his sensitivity to mom’s ‘hurt.’ It is not surprising, then, that son’s ‘[How did she fa:re] through these pro[cesses].’ is uniquely responsive to these actions. Having heard and oriented to dad’s efforts and concerns, the son asks – for the first time in phone call #1 – a personalized question about how mom was doing. Though ‘fa:re’ might itself be understood by some readers as a distant or even removed way of addressing how mom is ‘coping/managing’ – especially in contrast to something like ‘How is she feeling about all these procedures?’ – it must be remembered that the son is interacting within, and thus contributing to, what has unfolded as a very technical and initial updating of mom’s cancer diagnosis by dad → son. Now that the initial biomedical news has been treated by them as completed, a shift in topics to personal issues about mom is made relevant by the son. (Though well beyond this analysis, it should also be noted that both son and dad gradually move, within two minutes, to disclose their feelings and frustrations about a dreaded health dilemma the family is only beginning to address.)

Approximately two minutes following excerpt 9, above, dad further elaborates on when and how mom’s treatments will occur:

(10) SDCL: Malignancy #1:6–7

D: =.hhh He said he would have somebody else look in on her.: = He also co:ntacted this cancer specialist so

1→ he will be in Monday. (.) .hhh And they will do this bo:ne scan thing tomorrow. So .hhh n:o: I would hope by Monday or Tu:esday (0.5) pt they have <pin:ned do:wn> (0.7) the particulars of what they’re after. >Now they may not have< the course of action all figured out, but [.hhhh] =

S: [°Umhm.°]

D: 2→= They’ll at least kno:w, (.) .hh and maybe this is just simplistically in my mind, >but they’ll know< .hhh what ki:nd? they’re dealing with. That way they should know .hhh how quickly does it spread (.) what is- (0.5) what can be done to: to stop it >you know< .hh radiation [or chemotherapy or-] =

S: 3→ [Yeah where else has it gone.]

D: 4→= Well that’s part of the bo:ne scan.

S: Umhm.
(0.5)

At the outset, dad refers to what 'he' (the doctor) had said about others involved in mom's ongoing care. Both 'somebody else' and 'cancer specialist' remain anonymous, and throughout 'they/they're' are invoked *eight times* as those responsible for enacting a 'course of action.' This excerpt, like many others in the Malignancy Corpus, reveals a unique interplay of 'lay' portrayals about important and consequential events, involving anonymous teams of experts, conducting technical procedures, in the omnipresent face of uncertain problems: determining just what procedures and 'course of action' will be pursued, 'the particulars of what they're after,' identifying the kind and tendencies of 'it' spreading, and discerning their ability to 'stop it.' That 'cancer' *per se* is never mentioned, in favor of 'it,' is also indicative of how these family members treat as obscure, if not altogether foreign and mysterious, the causes and symptoms of such a disease.

It is also striking how dad continues to both qualify yet utilize his limited knowledge about upcoming procedures. As with earlier examined instances, generalized references (as with dad's 'bone scan thing' in 1→), and personal disclaimers ('maybe this is just simplistically in my mind' in 2→) continue to be employed. An explicit reference to 'hope' is also evident in (1→), yet another display of managing optimism about unknown future events (Beach, 2002), which prefaces a marked '<pin:ned do:wn>' – a description delivered more slowly, and with emphasis, in a manner we have suggested is indicative of 'reported speech' from prior interactions with medical experts (see excerpt 9, above).

In (3→), it can be observed that the son moves from simply acknowledging ('Umhm.') dad's update to more actively collaborating in solving the puzzle dad has depicted about 'how quickly does it spread' and 'what can be done to: stop it'. In overlap, with 'Yeah where else has it gone.', son offers his utterance as a natural and incremental conclusion to dad's portrayal. However, notice that in (4→) dad treats the son's contribution as misinformed: radiation and chemotherapy cannot determine where it has 'gone', because 'that's part of the bone scan.' Essentially, dad holds son accountable because of the placement of son's response: in the midst of dad's 'radiation or chemotherapy.' Thus, while son's addition addressed a portion of the spreading/stopping puzzle, it did so sufficiently out of place to be handled by dad as an inadequate display of knowledge about technical procedures.

Paradoxically then, and despite dad's repeated provisos about his own knowledge, dad exemplifies for the son the need to be as precise as possible about distinctions among radiation, chemotherapy, and bone scans. At the completion of excerpt 10, above, the son's 'Umhm.' evidences deferral rather than a challenge of dad's correction. And the next extended pause (0.5) reveals a shift in 'footing' (Goffman, 1981), from prior 'correcting' to subsequent elaboration about a related topic (mom's medical history with 'lymphatic based' cancer, not included herein).

The management of 'corrections' and other interactional problems, however slight and seemingly insignificant, must therefore be analytically considered. Just as family members work together to produce news updates, so too are they constantly holding one another accountable to the 'correct' management of the 'lay' information they disseminate.

Time, timing, and future ‘dreaded’ possibilities

In the following excerpt, as dad continues an update about mom’s cancer and its current rate of growth, he displays uncertainty about when recent medical tests will be available:

(11) SDCL: Malignancy #1:7

- D: [But] ya know it’s a very slo::w growing thing. So if it is sti:ll in tha:t fa:mily of (.) of cancer then ya say >well okay.< It’s unlikely it’s anyplace else. = They can just treat these two bu- pt .h (0.3)
- 1→.hhh But °that we won’t know° ah- at least ’til tomorrow and may not have the results of the bo:ne scan back til Monday = >I don’(t) know how long it takes ta get that back.<
- S: 2→(°Monday huh.°) Oh boy.

When dad references the rate of growth of mom’s cancer, which is ‘slo::w,’ his description verbally represents the very speed of the growth he depicts. His stretched and deliberate portrayal may also reperform how the news was initially delivered to him by the medical staff. Next, following dad’s hypothesis about where the cancer may be located, he makes additional and repeated uncertain references (→) to not knowing until tomorrow, if then, ‘the results of the bo:ne scan.’ And, as noted previously (see excerpt 1, above), such results come ‘back’ from unknown places and on a schedule not controlled by family members (or, in some cases, doctors and medical staff). A series of issues are thus presented by dad as unsolved: the pace of cancer’s growth, location, which areas to treat, and just when ‘bone scan’ results will be received. In these ways the future is constructed by dad as ripe for speculation and thus a constant source of uncertain events.

With ‘(°Monday huh.°) Oh boy.’ (2→), son treats dad’s summary as cause for concern but also a sense of foreboding and even dismay. With these few words, facing continual uncertainties is shown to be difficult work. This is especially the case when delayed results may contain additional bad news, details that will only exacerbate an already dire situation.

Anxieties associated with waiting for test results, a normal set of activities for persons undergoing medical care (and their families/loved ones), are in these ways shown to exist beyond individuals’ experiences – in just the ways interactants collaborate when describing and responding to an inherently uncertain future. In the following call with his aunt, occurring nearly a year after dad and son’s conversation during call #1 (excerpt 11, above), it is clear that future speculation remains. Below, son and aunt summarize a prior discussion about whether mom will live until Christmas or even Thanksgiving:

(12) SDCL: Malignancy #10:11

- S: And right now >it sure doesn’t sound that way does it?< =
- A: = No it doesn’t sound that [way.] =
- S: [No.]
- A: But the:n (0.4) .hhh ya kn:ow (.) your mom’s tough.
- S: Um hm.
- A: → A:nd if it is an- an ya know these are re:al- (.) it’s like Russian roulette. =
- S: = Yeah. =
- A: → = All thi:s guess work. =

Countered with his aunt's 'But the:n (0.4) .hhh ya kn:ow (.) your mom's tough.' the possibility of mom's living longer is anchored in shared knowledge about mom's ability to cope with difficult situations. Of course, knowing about mom's tendencies does not necessarily minimize aunt's and son's uncertainty. Indeed, mom's being 'tough' further compounds rather than simplifies alternative future trajectories. It is this overwhelming recognition of uncertainty that aunt addresses with 'A:nd if it is an- an ya know these are re:al- (.) it's like Russian roulette.='. With some difficulty, evident in her twice 'restarting' an essentially unfocused utterance, aunt's stark contrast with 'Russian roulette' is revealing: metaphorically, the deadly bullet is in mom's gun, but it is not known which squeeze of the trigger will end the game. Discerning when mom is going to die is obviously treated by aunt as a matter of 'high stakes,' as son's 'Yeah.' and her subsequent '=All this: guess work.= ' makes demonstrably clear.

In a subsequent call with his separated wife, an ongoing preoccupation with the duration of mom's illness is further evident in their discourse:

(13) SDCL: Malignancy #11:4

- G: = (Gosh if) this stretches ou:t (.) it'll be ↑really har::d.=
 S: = .hhh Yeah well its been stretching out, an it's been hard. An (.) yeah it- its- jus- keeps goin' and goin' an .hhh ya know if she has (.) signed one of those things that says no hero:ic measures .hhh so uhm (.) ya know they're not >gonna do< (0.2) to:o much (0.2) other than just e::ase her pa:in at this point.

As G produces what is essentially an 'if/then' scenario, and in a manner somewhat removed from her own experience, the son personalizes and thus owns the cancer journey as consequential for his daily living. This contrast, between a knowing but distant relative and a son more closely involved with the developments of mom's cancer, is apparent throughout the Malignancy Corpus and identifiable in particular ways (Beach, 2001a; Maynard, 1997, 2003).

Speakers utilize temporal references – 'stretches/stretching out' and 'keeps goin' and goin' – to portray uncertainties associated with illness/cancer as both time-bound and phasic. Knowing that mom's illness is likely to result in death, and that hopes for recovery are increasingly fewer, both speakers formulate illness and dying as an unfolding, uncontrollable, and thus wearisome process. Apparently, there is little to be done but work through these difficult times, which is 'hard,' and 'just e::ase her pa:in at this point.'

Son's decisions to travel home (or not) present a host of related and practical difficulties, primarily because mom's health status was constantly changing during certain phases of her illness. Excerpt 14, below, follows repeated conversations with family members, and airline agents, to schedule a flight home to be with his dying mother and family (Beach & Lockwood, in press). It is significant that the son was on the very cusp of traveling, following extensive efforts to make and solidify his plans, when dad informs son to 'stay there.'

(14) SDCL: Malignancy #12:1

- S: A: :lri::ght, what's the scoop. hhh =
 D: =↑We::ll (.) stay there.
 S: Stay here. hh
 D: Stay there. =
 S: → =.hh Oh::: hh .hh o- okay. hh =

- D: → = Ye::ah. I know this >been a damn up and down and up and down< I ya know ya- ya don't know whether to be p:le:ased or not \$pleased\$.
- S: [\$huh hh\$] .hhhh [hhhh]
- D: [Hu::m.] =
- (1.4)
- D: = .Hhhh hhh <I d:o:n't kno::w ye:t.>

That son repeats with 'Stay here,' and dad further confirms verbatim, makes clear that son was not expecting such a pronouncement. Not surprisingly, son's '= .hh Oh:: hh .hh o- okay. hh =' exhibits a mixture of amazement, confusion, and even some hearable frustration. In response, dad acknowledges the son's predicament by characterizing the shifting nature of mom's condition as 'a damn up and down and up and down.' And he further elaborates with 'ya know ya- ya don't know whether to be p:le:ased or not \$pleased\$.'

At the completion of his utterance, dad's '\$pleased\$,' is produced with laughter in a manner displaying three related social actions. First, dad orients to the delicacy of his announcement. Consider that dad is faced with a rather odd situation: delivering bad news to son ('stay there'), due to good news about mom's very recent (within 48 hours) health improvement. In this moment, and many others comprising everyday life events (Maynard, 2003), good and bad news occur simultaneously, yet often stand in marked contrast one to the other. Second, dad also exhibits his 'troubles-resistance' (Jefferson, 1980, 1984a, 1984b, 1988) to the dilemma they are facing. Despite the troubling nature of mom's changing health, dad makes clear his ability to manage emerging problems. Third, he invites son to share laughter about their situation with him. Although son does briefly laugh with dad ('[\$huh hh\$] .hhhh'), son also withholds further elaboration on this troubling situation and moment. Followed by an extended (1.4) pause, and dad's '= .Hhhh hhh <I d:o:n't kno::w ye:t.>', it is further apparent that family members face difficulties whenever uncertainty must be practically managed.

Notice also that in excerpt 14, above, dad does not assume responsibility for the change in plans. Rather, he clearly attributes such problems to inherent ambiguities associated with ongoing and troubling illnesses (Beach, 2001a), circumstances that are beyond his control. Family members are essentially double-binded: both mom's improvement (giving rise to cancelled travel) and her failing health (leading to death) are problematic in their own right. In a scenario in which doctors have informed the family about the strong likelihood of mom's imminent death, and mom herself has expressed her belief that she will soon die, which is easier?: for the family to deal with mom's steadily declining, sooner-rather-than-later, yet imminent death? Or with mom's extended suffering, problems caused by postponements (as with son's travel), and continually varied updates about her health status? In excerpt 14, above, and elsewhere, dad and son are attempting to come to grips with these very questions. Unfortunately, there is no guarantee that such interactional work will produce 'easy' answers to a health dilemma that is troubling, at least in part, because mom's health is constantly in flux. During such times there may simply be 'no one to blame,' which appears to be the case in excerpt 14, above, which can understandably be a problem in its own right.

In the final excerpt addressing 'time,' son is once again (excerpt 13, above) speaking with his separated wife (G). This brief interaction, addressing how much time mom has left to live, provides an apt summary of prior discussion:

(15) SDCL: Malignancy #17:2

- G: (°W(h)ow-°) How long (they) think she's gonna hold o:ut?
 She still in the hospital?=
 S: =Ye:ah, yeah. She's still in the hospital. They don't
kno::w. 'Could be a couple a weeks?'

Here G begins by asking a primordial question: How long do medical staff believe mom has before she dies? While soliciting medical experts' assessments, G also utters the phrase 'hold o:ut'. This is one instance of lay colloquial expression (like 'hang in'), which portrays mom as engaging in a withholding of an inevitable outcome (in this case, death). Whether mom is home or 'still in the hospital?=' has implications for gauging how close mom is to the final stages of her life, and thus G asks this second question even before the son can respond. And it is G's second question that the son answers first (i.e., as the immediately prior question), with 'She's still in the hospital.'

With son's announcement 'They don't kno::w,' he not only returns to G's initial query, but does so with emphasis exhibiting continued uncertainty: anonymous medical staff are not in a position to provide assurance about mom's unknown fate. It is not clear whether son's 'Could be a couple a weeks?' was his own (lay) or others' (experts') prognosis. But in either case, a time frame is socially constructed that provides a possible but not necessarily probable period for mom's dying.

Emergent troubles with pain and medication

One normal assumption about illness is that the presence of 'hurt and pain' creates the possibility for intervention – typically, in the form of various medications. In our final sub-class of social actions comprising how family members construct understandings of diagnosis and treatment, we examine selected moments when 'pain/hurt and medication' emerge as specific topics for discussion. Particular attention is drawn to 'morphine.' As with prior interactions we have examined, there are distinct problems evident throughout these 'lay' materials. Because family members continue to display an essential lack of information and knowledge, there exists the omnipresence of 'uncertainty.' The management of this uncertainty is evident, in part, through repeated attempts to describe medication procedures 'correctly.' Similarly, it is clear that 'morphine' is proposed as a solution to minimizing 'pain/hurt' and thus mom's 'feeling better.'

Below is an excerpt drawn from the third call, between the mom and son, which began with mom's stating a preference for 'no life support' and shifts to her troubling description of 'pain':

(16) SDCL: Malignancy #3:2

- M: There's no way. (.) I can't go on.
 S: Okay.
 M: So: (1.0) I said to Dad maybe I'm being te:rribly
 naïve, but (.) I want them to stop the pain.
 S: [Ok:ay.]
 M: [(Now-)] now if: a:- (1.5) if they can do that you
 know I can sit there for five or ten days an' (.) I
 don't know. I mean I just don't know. I'm- (.) I've not
 done it. = So I don't know.
 S: Okay. =
 M: = I could sit there and they can- they'll jam me with

- mor:phine and I'm (.) [(breathless undecipherable talk)]=
 S: [And you could float for a while.]
 M: °Yeah.° () =

In response to mom's 'There's no way. (.) I can't go on.', son here (and through-out) simply acknowledges with 'Okay.' In these responsive moments, son is not in a position to question, challenge, or even agree with mom's characterizations. It is important to recognize that mom is not soliciting her son's alignment, opinions, or permission through her actions. Rather, mom is simply relying upon her entitlement to report and manage critically important life-world experiences (Sacks, 1992). As a patient whose body is undergoing illness and trauma, mom is uniquely qualified to inform son about the crisis and life-events she is enduring. By stating an inability to continue coping with her present condition, and an understandable preference to 'stop the pain,' mom makes available to son the nature of her suffering and articulates consequences for her rightful decisions.

Again, such actions are designed for son's hearing and monitoring, but not in pursuit of his agreement or permission to cope one way or another with painful experiences.

However, while mom states her needs unequivocally, her convictions are nevertheless framed in light of being 'te:rribly naïve' and fraught with uncertainty: even 'if they can do that,' the duration and consequences of treatment remain unknown because 'I've not done it.' And as critical as 'stopping the pain' is for a hurting person, it is again somewhat paradoxical that it is anonymous staff ('them/they/they'll') who will be performing such important caregiving functions. This marked contrast, between mom's personal suffering and anonymous others who will 'jam me with morphine,' provides yet another instance of how a lay person makes sense of medical care as imposing and often depersonalized. Further, both mom's body ('jam'), and her mental condition as summarized by the son's 'And you could float for a while.', are being assailed *even if the pain is remedied*.

The burdens and impacts of 'pain' are related and significant matters, repeatedly raised as focal concerns throughout the Malignancy Corpus. In the following excerpt, consider that in response to son's assessment – that 'she'll be done' when (mom) decides – aunt associates how mom 'feels' with being 'in a lot of pain.' (1→):

(17) SDCL: Malignancy #10:2–3

- S: = Ya know I think that when she decides it's time (.) she'll .hhh she'll be done.
 A: °Mm hmm.°
 S: Uh.
 A: 1→ And right now <at this point> she feels that way.
 S: Mm hmm.
 A: 1→ Now (0.8) that's because she's in a lot of pain.
 S: Yeah.
 A: 2→ A: hhh and they ↑are giving her morphine. = Now if she's- one of the things that that we found out is that (.) if she requires three shots of morphine within an hour. =
 S: =Um [hum.]
 A: 2→ [>Or] whatever it is < I think it's two hours. (.) ah: hhh (.) Then they will put her on the automatic drip so that ↑she can control it.

- S: Uh huh.
 A: 2→A::nd once the <pain> subsides then she'll- (.) she will feel
be:tter.
 S: Uh [hum.

The very next issues raised by the aunt (2→), and monitored but not commented on by the son, involve 'morphine' as a proposed solution to mom's dilemma. Though the aunt is uncertain about how often the 'shots' are provided ('>Or whatever it is<'), the alternative is an 'automatic drip so that she can control it.'. Somewhat incongruously, even though 'they are giving her morphine.' and 'they will put her on the automatic drip', mom would then be in a position to control the flow of morphine to reduce her pain. And it is only then that 'she will feel be:tter.'

Two calls later, dad informs son that the 'drip system' was effective:

(18) SDCL: Malignancy #12:1

- D: They're changing around uh (0.6) the thyroid stuff 'cause she's cranked up too high (.) .hhh They had her on u:h (0.4) morphine all night on uh ya know one uh these drip system >whatever the hell< s:o <that cal:med down> some of this. So she got outta >bed on her own< this morning. = She went to the bathroom so- .hhh
 S: Mhm hm. 'Kay. =

At the same time 'the thyroid stuff' was being altered because 'she's cranked up too high', the morphine 'cal:med down> some of this'. Technically, dad's grasp of the procedures is summarized in '>whatever the hell<', which at once displays a lack of knowledge yet also the basic insignificance of grasping such details as long as mom is receiving better care and is more comfortable. Here, the practical consequences are apparent: mom getting out of bed and being able to go to the bathroom, which the son both acknowledges and confirms as important.

In a final instance, drawn from call 36, mom once again updates son that she does not know what to say and 'it's nuts around here.':

(19) SDCL: Malignancy #36:26–27

- M: Well I don't know what to say. All I know is it's nuts around here.
 S: Mm hm. (.) pt So what are ya doin' with yerself during the day mostly sleeping.
 M: Yeah. .h eh Oh jeez it hurts uugh. It just hurts when I do things like lay down- lay down. An' it hurts when I do this it hurts when I do that. Nothin' I can do.
 S: Huh .hh Just everything hurts huh.
 M: Yeah.
 S: Have they gotcha on somethin that- that ke[eps that down I hope].
 M: [Oh yeah. Oh yeah.]
 S: Oh that's good.
 M: Yeah fer sure.
 S: Otherwise it would probably drive you nuts huh.
 M: It would certainly.

Together son and mom proceed to commiserate about mom's turmoil. When son asks mom 'So what are ya doin' with yerself', mom pronounces considerable 'hurt' and closes with 'Nothin' I can do.'. With 'Huh .hh Just everything

hurts huh.', the son's summarized version of mom's complaint displays his having heard mom's trouble but having little more (at that moment) to say about it. Yet, following mom's agreement ('Yeah.'). notice how the son next queries about pain medication: 'Have they gotcha on somethin that- that ke[eps that down I hope.']. Thus, the son proposes as normal that there is a medical alternative to mom's difficult state (i.e., drugs that 'keeps that down,' similar to dad's 'calmed down' in excerpt 18 above), which is also expressed as a source of 'hope' for son. And just as mom reassures her son that she is being well cared for ('Oh yeah. Oh yeah . . . Yeah fer sure.'). so too do both son and mom implicitly recognize pain medications as key resources for not being 'nuts.'

Discussion

Moments selected for analysis provide a rare glimpse into the real-time organization of a 'family cancer journey' (Kristjanson & Ashcroft, 1994). When encountering these materials as first-time readers, there is a natural inclination to treat such conversations as extraordinary and thus remarkable illustrations of lived-out daily dramas. Yet these data are both unique and commonplace: just as they represent the *first natural recorded history* of family members caught up in trials and tribulations, so too are they but a small sampling of the widespread impacts of cancer. The American Cancer Society (2002) estimates that more than 1.2 million Americans will be diagnosed with cancer this year alone, resulting in at least half a million deaths. Men have an approximate 50% and women a 33% lifetime risk of being diagnosed with cancer, and more than 50% of all cancer patients cannot be cured. If incidence rates remain stable, the total number of cancer cases is expected to double by 2050.

These are striking and humbling statistics. *In San Diego alone, 60–80 persons are diagnosed with cancer on a daily basis.* The sheer mass of diagnoses makes patently clear that while the family interactions studied herein are distinctive and certainly *one of a kind*, they represent an incalculable number of daily conversations preoccupied with describing, explaining, and keeping others informed about own and others' cancer health status. A number of these encounters occur with medical experts, and bureaucratic and institutional representatives (Drew & Heritage, 1992; Jones & Beach, in press; Lutfey & Maynard, 1998), during clinical interviews and consultations. The phone calls examined herein reveal that family members also function as conduits for what doctors have informed them, what they have observed and/or experienced directly, and additional sources (e.g., speaking with others, reading articles and literature, watching TV and related video-programs).

The communicative consequences of cancer diagnosis, treatment, and prognosis are obviously enormous yet little understood *as interactional achievements*. Working with large and diverse collections of social activities, we have drawn attention herein to one set of seemingly omnipresent, and thus omnirelevant, problems recurrently addressed by family members: managing uncertainties about technical procedures. Whether

reporting about the work accomplished by anonymous medical staff, or what specific doctors might have said, distinctive *lay* orientations are evident as a lack of knowledge, inability to predict the future, and relationships between pain and medication emerge as key concerns.

Throughout we have drawn attention to how *being in a family health crisis involves an exhibited and orderly set of conversational involvements*. Chaotic as these interactions might be experienced and produced by family members, it cannot be overlooked that they somehow and repeatedly worked through such difficult moments. Through recordings and transcriptions, these activities are made available to analysts, resulting in what might best be characterized as *a discernable and distinctive set of social problematics occasioned by cancer diagnosis, treatment, and prognosis*.

In all cases examined, a veritable host of fine-grained social actions – reporting, describing, explaining, delivering and receiving good and bad news, searching, hesitating, repeating, reminding, correcting, qualifying, disclaiming, criticizing, venting, predicting, withholding affiliation and alignment, laughing, sighing, reassuring, supporting, and commiserating – to name only a few, emerge as essential and collaboratively produced resources for family members as they navigate their way through what appears to be uncharted terrain: living with a progressively terminal illness.

In one important sense, we have attempted to provide not just a preliminary *language of uncertainty regarding cancer*, but interactional environments and specific communication practices for raising and resolving matters fraught with apparent ambiguities and contradictions:

- Being stoic in the face of bad cancer news.
- Handling biomedical/technical issues informally, with and without ‘emotion.’
- Discerning whether ‘news’ is good, bad, or both.
- Speaking with ‘authority’ about basically unknown technical matters.
- Describing how important technical procedures, and personal suffering (hurt, pain) will be managed by anonymous medical staff.
- Displaying conviction about ‘no life support’ and a preference to ‘stop the pain,’ yet in the midst of being naïve and uncertain.
- Proposing morphine as a solution to suffering, but also a source of possible addiction and loss of ‘personhood.’
- Being frustrated and anxious but also hopeful and optimistic.
- At times, having much to say but few words to express feelings.

Though only a partial listing of routine interactional dilemmas, it is clear that family members facing cancer are inundated with uncertain, ongoing, and thus unsettling circumstances.

We are presently in a phase of describing and explaining the interactional organization of these and related quandaries. As this knowledge becomes available, numerous and critical opportunities arise for cancer education anchored in repeated inspections of recorded and transcribed cancer materials. For example, doctors and medical staff could benefit by

grounded understandings of how patients and family members comprehend what they informed them within the clinic, as well as which positive and/or negative impacts such informings might have on the daily lives of lay persons. Typically, doctors do not have access to patients' lives from the time they leave the clinic and return for a scheduled appointment. Knowing what and how talk about cancer gets done, practically and over time, might reshape how doctors organize clinical discussions. Similarly, though patients and families are coping daily (more or less) with cancer, they are not necessarily in a position to understand the *communicative journey* they are undertaking. While family support groups and counseling may provide important opportunities to share and commiserate about cancer experiences, knowledge about actual communication patterns and practices could become a valuable resource for better managing often troubling illness predicaments.

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Appendix

Transcription symbols

In data headings, ‘SDCL’ stands for ‘San Diego Conversation Library’, a collection of recordings and transcriptions of naturally occurring interactions; ‘Malignancy #1’ represents the title and number of call in the data corpus (see Data and Method section); page numbers from which data excerpts are drawn are also included. 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:

- : Colon(s): Extended or stretched sound, syllable, or word.
- Underlining: Vocalic emphasis.
- (.) Micropause: Brief pause of less than (0.2).
- (1.2) Timed Pause: Intervals occurring within and between same or different speaker’s utterance.
- (()) Double Parentheses: Scenic details.
- () Single Parentheses: Transcriptionist doubt.
- . Period: Falling vocal pitch.
- ? Question Marks: Rising vocal pitch.
- ↑ ↓ Arrows: Pitch resets; marked rising and falling shifts in intonation.
- ◦ Degree Signs: A passage of talk noticeably softer than surrounding talk.
- = Equal Signs: Latching of contiguous utterances, with no interval or overlap.
- [] Brackets: Speech overlap.
- [[]] Double Brackets: Simultaneous speech orientations to prior turn.
- ! Exclamation Points: Animated speech tone.
- Hyphens: Halting, abrupt cut off of sound or word.

- > < Less Than/Greater Than Signs: Portions of an utterance delivered at a pace noticeably quicker than surrounding talk.
- OKAY CAPS: Extreme loudness compared with surrounding talk.
- hhh .hhh H's: 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 Lip Smack: Often preceding an inbreath.
- hah Laugh Syllable: Relative closed or open position of laughter
- heh
- hoh