Bad News in Oncology: How Physician and Patient Talk about Death and Dying without Using Those Words*

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We focus on the socialization of patients to the process of death and dying by examining actual interactions among medical practitioners, patients, and their family members. Our data consist of three medical interviews. In each one, the oncologist delivers the news that the patient’s cancer is no longer treatable. Although not stated, the implied message is that the patient will soon die. Because, in these episodes, the same doctor is attempting to convey a similar message to three different patients, we can compare the ways in which the patients respond to the message and thus affect the delivery of the news. In various practical ways, both physician and patient exhibit interactional caution in discussing death and dying.

Social psychological approaches to death and dying have been preoccupied with individuals’ perceptions of their illness trajectories. In her classic work On Death and Dying (1969), for example, Elisabeth Kübler-Ross articulates a series of psychological stages through which people pass when confronted with death, such as denial, isolation, anger, bargaining, depression, and acceptance. Other research on chronic and terminal illness proposes the importance of awareness contexts (Glaser and Strauss 1965), identity levels (Charmaz 1987, 1991), and views of self (Corbin and Strauss 1987; Kutner 1987; Yoshida 1993) as they relate to processes of normalization (Robinson 1993) and adaptation (Davis [1963] 1991). Previous research, in short, emphasizes abstract, interpersonal experiences of individuals who confront mortal or chronic illness.

In their review of the medical literature on breaking bad news, Ptacek and Eberhardt (1996:496) identify a need for more empirical work, suggesting that “research should begin with the simple question of whether how the news is conveyed accounts for variance in adjustment before moving into more specific questions about which aspects of conveying bad news are most beneficial” (our emphasis). We want to change the emphasis of existing work and to examine the role of talk and interaction as embedded in processes of death and dying. This strategy is attuned to Longhofer’s (1980) neglected argument that dying is a social process better understood in the context of interaction and communication than as the internal and inherently progressive stages described by Kübler-Ross.

Previous research on terminal illness also relies heavily on typifications and generalizations. Glaser and Strauss (1965), for example, discuss various types of medical work including machine, clinical, safety, comfort, sentimental, and information work. In another, more interactionist approach to these issues, researchers work to make general assertions based on detailed analyses of actual interactions. Peräkylä (1991) uses specific examples from his field notes to illustrate physicians’ control over situations and their specification of identities. Sudnow

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*We wish to thank Prof. Richard M. Frankel for facilitating this study in many ways. We also gratefully acknowledge insightful comments we received from Bill Corsaro, Jeremy Freese, and Virginia Gill. We are extremely grateful to the physician who allowed himself to be taped while discussing very difficult topics with his patients and who took time from a busy clinical schedule to be interviewed. Not least, we thank the patients and their partners who participated in the study. From the Indiana University College of Arts and Sciences, the second author received a grant that supported this research. Finally, our gratitude goes to the anonymous SPQ reviewers who gave us helpful suggestions and commentary. Correspondence to: Karen Lutfey (klutfey@indiana.edu) at the Department of Sociology, Indiana University, Bloomington IN 47405.
(1967), who is oriented to hospital employees' everyday practices, discusses their typical reactions to situations and their "main strategies" for dealing with problems.

Our approach is related most closely to Sudnow's (1967) Passing On, which examines death and dying as socially organized processes. Sudnow finds that these processes are defined and managed collaboratively through the interactions and mundane practices of hospital staff members, including doctors, nurses, aides, orderlies, chaplains, and others. We also approach death and dying as socially organized interactional phenomena, but concentrate on communications that Sudnow (1967) explicitly minimized, involving direct talk between doctor and patient (and families) and the attempt to socialize patients to the dying and death process. More recently, Bor and Miller (1988) and Peräkylä (1995) have examined how, in counseling, professionals and clients address death and dying as "dreaded issues" that require preparation of an appropriate or auspicious interactional environment. A difference between these more recent studies and ours is that counseling often seeks to get clients or patients to discuss dreaded issues, whereas the physician in our data solicits specific kinds of talk from his patients but also seeks to inform them about their illness trajectories.

More specifically, we examine the ways in which a physician can convey to a patient, and how the patient receives, the news that his cancer is no longer treatable, that he is close to dying, and that the physician is shifting his treatment focus from curing the cancer to managing pain symptoms. Maynard (1996), following characterizations that subjects provide in their narratives of bad news experience, argues that the problem for recipients is one of "realization." In medical settings, for example, patients face the task of coming to understand that a feature of their lifeworld—the presumption of their body's own relatively good health or, in the cases examined here, their trajectory for recovery—has been altered significantly. The physician must deliver the bad news and elicit the realization from patients and family members that the patients' conditions are now terminal and that they are dying.

The interactional process whereby the doctor in our data attempts to generate open awareness and realization is organizationally similar to the conversation analytic phenomenon that Jefferson (1986) terms "unpackaging of a 'gloss.'" A "gloss" refers to an inaccurate, incomplete, or masked conversation-al generalization of "what really happened" (Jefferson 1985:436). That a piece of talk is a gloss is not available in its first telling, but emerges as a consequence of the recipient's activities; recipients may or may not provide an auspicious environment for the unpackaging process. Insofar as an auspicious environment exists and the gloss is actually unpackaged, the talk will be produced in a way that is sensitive to the ongoing interaction rather than by one speaker unilaterally announcing "what really happened" or "what one really means." When a recipient does not provide an appropriate environment, the potential unpackaging may not occur.

We use detailed, turn-by-turn analyses of three episodes of doctor-patient interaction to examine the interactive, contingent nature of awareness contexts and how they are shaped through conversation. We assert that physicians' attempts to achieve open awareness and realization vary in significant ways according to the contingencies of the patients' responses. Specifically, we examine the ways in which the physician, the patient, and the patient's family members cautiously approach the delicate topic of the patient's terminal illness; the interactional resources that are available to physicians for broaching the topic of death and dying; and the resources available to the recipients to deflect, divert, avoid, or euphemize the matter.

DATA AND METHODS

The second author collected the data for this study at a hospital associated with a medical school in an eastern state. The physician, a participant in a larger study of the hospital's oncology clinic, coincidentally had three male patients with different forms of terminal cancer. Two of the patients, "Robert" and "John," were recuperating in the hospital from unsuccessful surgical
attempts at treating their cancers. The third patient, "David," was visiting the oncology clinic as an outpatient. Because, in these episodes, the same doctor is attempting to convey a very similar message to three different patients, we can compare the varied ways in which the patients respond to the message and thereby affect the delivery of the news.

The second author videotaped in the hospital rooms of the admitted patients and, for the outpatient, in an examination room that was part of a clinic attached to the hospital. In each case he obtained the permission of the oncologist, the patient, and the patient’s partner. (John’s and David’s wives were present, as was Robert’s "girlfriend," to use his term.)

In an interview with the second author, the oncologist in the data volunteered that he "felt awkward" when he was talking to Robert:

I don’t think it had anything to do with the fact that I was being observed. It was more with the fact that sometimes when I say things to patients, I’m trying to cue them. I’m trying to get them to ask me some questions, or to find out what they know about the illness. How severe it is, or whether they know that they might die, or whether they think that’s imminent. But when I talked to him I didn’t get any of the responses that I would’ve like to get that would help me to build on things.

This account is important to our analyses, and we will elaborate on it later. In terms of data collection, however, the physician’s comments suggest that, from his perspective, the presence of a video recorder and observer did not influence the interaction. The first author transcribed the data using Jeffersonian transcription conventions (Atkinson and Heritage 1984:x–xvi; see appendix).

Although much of conversation analysis is based on collections of sequential phenomena from multiple conversations, we work here along the lines of the “single-case analysis.” Schegloff (1987) organizes the conversation analytic enterprise into (at least) two types of analyses. He describes the first type as the effort to elucidate and describe the structure of a coherent, naturally bounded phenomenon or domain of phenomena in interaction, how it is organized, and the practices by which it is produced. (p. 101)

In the second “mode of data analysis,” Schegloff suggests that

[In a sort of exercise, the resources of past work on a range of phenomena and organizational domains in talk-in-interaction are brought to bear on the analytic explication of a single fragment of talk. (p. 101; our emphasis)]

Our analysis takes the latter form, although we examine three medical interviews rather than a single occasion of talk. Because single episodes are the “locus of order” (Schegloff 1987:102), we analyze each of our doctor-patient interviews as an entity in its own right. At the same time, we can draw from existing conversation analytic research on patient-practitioner interaction to link these episodes to other, similar occurrences. Our analysis is also comparative: The convergence among these three episodes in personnel, disease category, and type of informing makes it possible to investigate similarities and differences in the organization of the interviews. We also draw on ethnographic interviews that the second author conducted to supplement our primary concerns with the recorded interactional material (Kinnell and Maynard 1996; Maynard 1989).

In two of our episodes, the analysis is framed in terms of the perspective display series (PDS). This “device... operates in an interactionally organized manner to co-implicate the recipient’s perspective in the presentation of diagnoses” (Maynard 1983:333), although in the present data the physician presents a prognosis rather than a diagnosis. The PDS allows a physician to deliver news cautiously by soliciting the recipient’s opinion before providing his own assessment, and then, through suggesting clinical agreement with that opinion, co-

\[\text{Conversation analysis operates with the assumption that every interaction has locally generated orderliness, such that even single episodes of talk are interactionally coherent and meaningful for participants regardless of their background characteristics.}\]
implicating the recipient in the final presentation of the news. Further, this approach helps the physician to forecast diagnostic or prognostic news for patients instead of delivering it in a blunt or forceful way, which impedes realization and adaptation to the news (Maynard 1996).

Allusive talk is a phenomenon in our analysis. Like Schegloff (1996:181), we use the terms allude and allusion (as well as euphemism) broadly. Our work differs from Schegloff’s, however, in that we address a related but essentially different interactional phenomenon. Schegloff (1996) analyzes a sequence in which one party to conversation “plants” something in the talk that is not said “in so many words” or is not said explicitly. Then a recipient of this talk formulates an explicit understanding of the inexplicit or allusive utterance. The original speaker next repeats that “explication,” thereby confirming both the recipient’s understanding and that the original utterance was indeed an allusion. In our data, when the parties talk allusively, no such explicit understandings or confirmations occur.

The methodological advantage of the phenomenon explicated by Schegloff (1996:192) is a “data-internal verification” of what the participants understand as an allusive conveyance. Because our data contain “candidate” allusions that are not necessarily explicitly unpackaged or confirmed in the interaction, they offer a special challenge (Schegloff 1996:191); this derives from analytically proposing what participants are saying when they seem to be purposefully not saying it in so many words. Here our analytic strategy for explicating the allusive talk is to proceed with extreme caution, to discuss euphemism and allusion as possibilities in the talk, and to draw on other resources (such as post hoc interview material) beside the interaction itself.

ROBERT: MINIMAL UNPACKAGING OF THE GLOSS

Robert has been under year-long treatment for cancer of the gall bladder. He is in the hospital recovering from an operation during which the surgeon determined that the cancer was too far advanced to permit any further removal of damaged cells. Now Dr. T must convey the information that the cancer can no longer be treated, although pain management is possible. The encounter we examine involves a series of exchanges in which Dr. T approaches the topic of Robert’s dying in a progressive fashion, along the lines of a stepwise questioning strategy that Peräkylä (1995) identified. Robert and his girlfriend Katherine, however, resist each stepwise move.

Dr. T opens the interview by asking Robert how he is feeling; Robert responds that he has improved. Dr. T then says that the surgeons are happy with his recovery and broaches the topic of his discharge from the hospital (Excerpt 1a, lines 64–70). After a 1.2 second silence elapses without a response from Robert or Katherine (line 69), Dr. T comments that Robert's family is also thinking about the patient's discharge, and produces a question: “Has anybody had the opportunity to talk to you about?” (lines 70–72).

**Excerpt 1a**

64 Dr: Now (0.3) I know that the: surgical doctors have been pretty happy with how quickly you’ve recovered: (0.4) from the surgery=I was just looking at the hospital chart. That’s what their notes: notes say. I know they’re thinking about planning for: when you can get out of the hospital too::
66 (1.2)
67 69 Dr: uhm >I know your family< is thinking (.) about that too::
70 (0.4)
71 72 Dr: Has anybody had the opportunity to talk to you about:
73 (0.8)
74 ((R points to K, Dr looks to her))
Although this question is not grammatically complete and is followed by a silence (line 73), Robert responds by nonverbally selecting Katherine to speak (line 74). She replies affirmatively and names a Mrs. Parker (line 76). Dr. T then solicits a more elaborate response about the content of the interaction by using an “about” component (line 79), as he had in his earlier query. Robert now verbally indicates that Dr. T is to speak to Katherine because “she relates to what—what went on.” (line 82). After receiving this indication with an “oh” or “change-of-state token” (Heritage 1984), and after Robert’s query about their visitor’s identity (lines 86), Dr. T (line 89–91) asks his question a third time, tying (Sacks 1992:150–68) this version to the previous two by elongating and emphasizing “about” when he asks explicitly if they discussed hospice.

As Peräkylä (1995:241) has observed in the context of AIDS counseling, counselors who attempt to address “dreaded issues” with their clients often start with an “elicitaton” such as Dr. T uses here. When that does not induce the patient to volunteer any description of a future “hostile world,” the counselors employ a question that specifies a theme that is absent from the previous answer or narrows the relevant issues (Peräkylä 1995:254–61). Here, by proferring a Candidate Answer2 (Pomerantz 1988:365) about hospice, the physician introduces a topic associated with death and dying. Indeed, Dr. T later remarked about this interview:

Sometimes I use the discussion of hospice not so much because it’s important to me that the patient accept a home hospice program, but it’s a way of introducing them to the idea that they’re—of how sick they are, really. So I was trying to use it more as a platform . . . that’s sometimes a good idea to get the conversation really directed where you want it to go, which is on death and dying issues.

In the AIDS counseling discourse that Peräkylä (1995:262–63) examined, the device of retrieving a theme absent from the client’s previous reply can occasion talk about a fear or worry that subsequently is pursued. Robert and Katherine, however, do not respond to the “death and dying” aspect of Dr. T’s question about hospice.

Indeed, Katherine’s responses (lines 93–94, 97–98 in Excerpt 1b) to Dr. T’s questions about hospice and Mrs. Parker occasion talk that moves away from hospice care and hence from the dying process.

2In her work on Candidate Answers, Pomerantz (1988:367) suggests that “offering a Candidate Answer is functional whenever a speaker has a reason to guide a co-participant to respond in a particular way.”
Initially Katherine responds to Dr. T’s candidate answer about hospice with a “No” (line 93). Then she indicates that Mrs. Parker inquired about a “nursing home” for Robert (line 93–94). The emphasis on “nursing” suggests this as a contrast with the hospice topic. Dr. T responds in a delayed fashion with “I see” (lines 96). Subsequently (lines 97–98) Katherine claims that Mrs. Parker also discussed “life support” with them, which further displays contrast stressing and marks a difference between her interpretation of the conversation with Mrs. Parker and the topic (hospice) that Dr. T has offered with his line of questioning. Going to a nursing home also can suggest a less serious prognosis for Robert than does hospice. Nevertheless, Katherine’s talk about “life support” preserves the general topic of the illness trajectory while shifting the focus away from hospice care specifically.

In response, at line 102 Dr. T says “I see,” waits, says it again, waits, repeats it a third time, and waits yet again before producing a “my-side telling” (Pomerantz 1980) (lines 102–103). In this form of information seeking, the recipient is interactionally encouraged to volunteer information in lieu of being asked outright. Together with the “I see”s and the silences, this my-side telling “fishes” for more information about their meeting with Mrs. Parker without the need to ask them directly about the “details.”

Katherine and Robert, however, provide responses that implicate topic closure: Katherine produces an agreeing, general gloss of the conversation (line 104–105), while Robert (line 109) aligns with her assessment.

After this exchange, Dr. T asks Robert about his plans for leaving the hospital (lines 111–12). Before Excerpt 1c, in an exchange not shown here (lines 113–78), Robert states that he would like to return to the nursing home where he lived before entering the hospital. Despite this response, Dr. T suggests that Robert might consider joining the hospice program because it is a good program for patients who have had cancer; this shift from discussing the nursing home to the hospice program reintroduces a topic related

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3 Also note how Dr. T raises his intonation on “details” and attaches “huh” to the end of his utterance. These actions strongly invite an expansive response to his candidate interpretation of the earlier discussion.
to death and dying, thereby alluding to the topic of Robert's terminal illness trajectory. Robert, however, rejects the option of hospice, claiming that he would have to spend his nights alone and that it is inconvenient for his family. Then, at line 179 (Excerpt 1c), Dr. T poses an unmarked perspective display invitation by asking about what Robert sees "as happening in the future." In the doctor's previous query about where the couple plans for Robert to go after leaving the hospital (Excerpt 1b, lines 111–12), he tacitly solicited their perspective on Robert's long-term health needs and illness trajectory; in this question (lines 179, 181) he asks more overtly for their assessment of the future.

Excerpt 1c

179 Dr: wh-What do you see as (0.8) as the- happening in the future.
180 (1.4)
181 Dr: Are you hoping that you'll g-get better?
182 (0.5)
183 R: OH yes: doc [tor oh yes sure ]
184 K: [oh good lord (that's true)]
185 (1.1)
186 Dr: Do you think there's a possibility that (1.5) you might not?
187 (0.2) get better?
188 (1.1)
189 R: I've had those second thoughts.
190 Dr: Uh huh
191 (1.1)
192 R: What I went through yesterday?
193 (0.2)
194 Dr: Mm hhm.=
195 R: =and the day before.
196 Dr: Mm hhm.
197 (0.2)
198 R: You go through those
199 (0.4)
200 Dr: right
201 (0.4)
202 R: series of whatever.

After a 1.4 second silence (line 180), the doctor reformulates his question: Using a candidate answer, he asks if Robert is "hoping that (he'll) get better" (line 181). Robert and Katherine provide resoundingly positive reactions (lines 183–84), thus exhibiting a strong orientation to a desired recovery scenario. (Recall that at lines 64–65, Dr. T characterized the surgeons as pleased with Robert's recovery.) Now, in line 181, by offering an optimistic candidate answer to his previous question about Robert's future, Dr. T may have invited Robert and Katherine to adopt an optimistic outlook, which thereby partially accounts for their strong alignment at this point in the conversation.

The doctor then offers a contrastive assessment, asking if Robert has considered the possibility that he "might not (0.5) get better" (lines 186–87). This is similar to the "hypothetical questions" that Peräkylä (1995:264–71) analyzes: When the patient has not named any objects of fear or worry, as here, the physician offers a candidate "hostile world."

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4Maynard (1991:170) refers to perspective display invitations as "unmarked" or "marked," according to whether a query is stated in a neutral way or favors a particular response.
Although such a question can elicit an answer that deals with the hypothetical situation, Robert resists the premise (Peräkylä 1995:315–21). He responds that he has had such “second thoughts” in previous days (lines 189, 192, 195), thereby proposing that these “second” thoughts are less significant or less valid than his ideas about getting better. Furthermore, Robert’s generalized “you” (line 198) can refer to other people’s also having these types of thoughts when dealing with serious illness, and thereby exhibits his own reaction as relatively typical. This is consistent with Sacks’s (1984) notion of “doing being ordinary,” which suggests that interpreting a situation as normal and ordinary, as opposed to extraordinary or catastrophic, is a regular response to experience. In Jefferson’s (1984) terms, Robert may be displaying “troubles resistance.” Finally, by colloquially characterizing his thoughts about nonrecovery as a “series of whatever” (line 202), Robert offers to minimize their importance or seriousness. Therefore, in a variety of ways, the patient’s talk here is consistent with the cultural expectations described by Parsons (1951) with respect to the “patient role,” in which one of the social responsibilities of a sick person is to desire to recover and to make every effort to do so.

Nevertheless, Dr. T pursues this topic and produces a third component of the PDS—an announcement of the clinical perspective in lines 214–15 of Excerpt 1d—in a cautious, somewhat circuitous way. He asserts his own concern about “that,” which we take as tying to his previous reference to “not getting better,” telling them that he is personally concerned (lines 205–206). Further, by reaching for and holding Robert’s hand during this utterance (i.e., offering support or comfort), the doctor may demonstrate nonverbally that he is broaching a serious topic.

Excerpt 1d

203 Dr: “right”
204 (3.7)
205 Dr: Cause that’s something that I’ve been ((Dr reaches to holds R’s hand)) kind of conc-cerned about:
206 (0.7)
207 Dr: I mean (0.3) I don- can’t count the days, but (.) you’ve been
208 in the hos:pital like quite a- what three: wee:ks: ya know
209 (1.5)
210 Dr: kinda (0.7) lets you know: that (1.0) you’re having some
211 problems when you’re here that long.
212 (1.1)
213 Dr: “But” (.) I’m concerned that (.) >you know< there’s a
214 possibility that things might not go so: well: for you:
215 (0.8)
216 Dr: So I want to make sure that, I can anticipate any nge:ds
217 ((R shakes head)) that you might have after you leave the
218 hospital.
220 R: That’s wonderful.
221 (2.2)
222 R: You’re so much concerned.
223 (2.1)
224 R: I really appreciate that.
225 (1.8)
226 R: Can’t thank you enough.

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6Also see also Kinnell and Maynard (1995) for a discussion of the use of “you” in HIV test counseling.
By reminding them of the length of Robert’s hospital stay (lines 208–209), Dr. T implicates Robert’s and Katherine’s commonsense knowledge, suggesting that such long stays generally indicate serious problems (lines 211–12).7 Robert meanwhile remains silent.

The doctor’s talk in this instance functions as something similar to an incomplete syllogism (Gill and Maynard 1995); such a turn organization occurs frequently in the delivery of diagnoses, to parents, about their developmentally disabled children. Clinicians provide the first two components of the syllogism, suggesting, for example, that (1) people with mental retardation exhibit symptoms x, y, and z and (2) the parents’ child exhibits symptoms x, y, and z. Clinicians thereby invite parents to complete the syllogism by inferring that their child has mental retardation. In the present case, the doctor sets up the first two parts of the syllogism by noting that (1) Robert has been hospitalized for three weeks (lines 208–209), and that (2) such long hospitalizations generally indicate serious problems (lines 211–12). Formally, Robert may be invited to complete the syllogism, without its being stated, by concluding that he has serious health problems.

An ambiguity may be present here, however. The extent to which the series of “you”s in lines 211–12 refers to the general population (“let’s know one is having problems . . .”) as opposed to Robert specifically (“let us know you’re having problems . . .”) is unexplicated. Insofar as Dr. T uses “you” in a generalized fashion, he may be employing a syllogistic construction. On the other hand, insofar as Dr. T is referring to Robert in particular, he accomplishes something that is more direct than an incomplete syllogism. With this utterance, Dr. T appears to walk a fine line between bluntly informing Robert of his condition and more gently “forecasting” the news and helping him to “calculate the news in advance of its final presentation” (Maynard 1996:109).

When Robert and Katherine remain silent (line 213), Dr. T proposes an upshot or completion of the syllogism by once more using litotes and telling the couple he is concerned that “there’s a possibility that things might not go so well” for Robert (lines 214–15). Again, the doctor cautiously shifts from allusive to more explicit talk about the future as Robert and Katherine’s silences disaffiliate with the delicate topic of death and dying.

After this series of turns and silences, the doctor shifts the focus of his talk from the possibility of nonrecovery to the importance of palliative treatment, allusively indicating that he wants to be sure he can “anticipate any needs” (line 217) Robert might have after he leaves the hospital (lines 218–19). Also, in contrast to the long silences following the doctor’s talk in the four previous utterances, Robert now takes several turns of talk, responding to the doctor’s statement of concern by fashioning a series of gratuities (lines 220, 222, 224, 226).

Our analysis of this doctor-patient interview is consistent with Dr. T’s own later reflections. Recall from our discussion of the data and methods that Dr. T had felt awkward during the interview. In addition, he remarked that he was “trying” to find out what Robert knew about his illness:

But Robert, he sort of had his own agenda instead and almost at times we were talking about different things. Which in part may have been because he wanted to avoid talking about what I wanted to talk about. So it’s not that unusual that things are awkward. Because I don’t think it’s very easy to talk to people about dying anyhow, and never will be. But in that case it was probably a little MORE awkward than usual because I really didn’t see that I was getting anywhere.

Our analysis demonstrates how Dr. T could have sensed that the patient “wanted to avoid” talking about his illness trajectory and that they were “talking about different things.” The doctor attributes the avoidance
of the topic of impending death to the patient, but our analysis suggests that such resistance to delicate topics is also achieved interactionally. Dr. T employed a succession of questions that progressively can move to a fuller discussion of the "dreaded issue" of death and dying (Peräkylä 1995). Nevertheless, in their replies to Dr. T's questions, the patient and his partner glossed, shifted, and moved to close the topic. In the end, Dr. T also alluded to but did not formulate explicitly a concern with Robert's dying and death.

DAVID: LIMITED UNPACKAGING OF THE GLOSS

The patient in this conversation, David, suffers from leukemia and, with his wife, is visiting the clinic as an outpatient. Although David responds to Dr. T's proposals about discontinuing treatment by remaining stoic and largely silent during the conversation, Dr. T nevertheless meets with modest success in delivering the news as he works to co-implicate David in the decision to discontinue the chemotherapy.

The beginning of the encounter is occupied with concerns about David's shortness of breath and anemia. Dr. T marks an important topic shift with his use of "well" (line 1 of Excerpt 2a) (Sacks 1992:773) to introduce his own "known-in-advance" agenda (Button and Casey 1984).

Excerpt 2a

1) Dr: Well. (0.3) I'm glad you came in cause I did wanna (0.4) ((Dr
2) nods)) talk- talk to you about uh, a- few things::
3) (1.2) ((D nods))
4) Dr: I know when you were in the hospiital we were on the fence
5) about whether to: (1.0) consider some more ((D nods))
6) chemotherapy. hhhh hh apd hhhh I thought it was worthwhile to
7) see how you did at ho::me and how you felt::;
8) (0.2) ((D nods slightly, gazes in to his lap))
9) Dr: , hhhh hh um (2.0) my feeling is: that (0.9) at †this point
10) †probably the chemotherapy ((Dr nods)) wouldn't do (0.6) you
11) much good.
12) (0.6)
13) D: >it won't?<

Dr. T proceeds to review a previous conversation with David concerning his chemotherapy treatment (lines 4–7, 9–11), and offers his own assessment that the chemotherapy "wouldn't do much good" (lines 10–11).

This episode differs from the other two we consider (Robert and John) in that Dr. T offers his own assessment of the chemotherapy without offering a perspective display invitation to the patient. Some elements of the conversation, however, are consistent with the PDS organization. For example, although Dr. T does not explicitly solicit David's assessment of chemotherapy treatment, his talk before lines 9–11 is grounded largely in topics that he claims he discussed previously with David. Further, the series of "transition relevance places" (Sacks, Schegloff, and Jefferson 1974) in this segment (lines 3 and 8) preceding Dr. T's assessment displays "receptiveness" (Heath 1984) to David's participation and is consistent with the cautiousness demonstrated in typical PDS series. Furthermore, David's nonverbal responses (head nods) in lines 3 and 8 demonstrate that he is tracking and responding to the doctor's extended turn of talk. After providing a second opportunity for David to respond (line 8), the doctor moves into his own assessment of the prognosis, which implies that the treatment at home has not worked well.

At lines 9–11, Dr. T proposes a course of action. Notice that he characterizes the recommendation as a "feeling," a subjective evaluation, rather than as an objective clinical fact. He further mitigates the force of his recommendation with three qualifiers: "at †this point," "†probably" and "much good"
(lines 9–11). He also nods in an affirmative way. Finally, the suggestion that chemotherapy would be undesirable is placed at the very end of the utterance in a “dispreferred” fashion, displaying the caution with which the news is being broached (Pomerantz 1984). By nodding while he delivers this news (line 10), Dr. T may be soliciting an accepting response from David.

Excerpt 2b

14 Dr: .hh No ((Dr shaking head)) I don’t think so=I think it could possibly do you some harm ((Dr nodding, D nods slightly))
16 (0.2)
17 Dr: .hh "um" because it- it does have side effects that we’ve talked a"bout" .hhh ((D looks away from Dr)) and (0.6) >I think it< (...) ((D returns gaze to Dr)) might be a good idea:
19 N:OT ta (...) press on with the chemotherapy treatment.
20 ((D looks away from Dr))
22 (2.7)
23 D: "How can you keep- sp.° (0.4) how ((D motions to himself))
24 can you get better then.
25 (0.2)

Again, Dr. T mitigates his assertion by claiming that he does not “think” the chemotherapy will help.

Through his talk, Dr. T works to co-implicate David in the treatment decision in two important ways. First, he uses the inclusive “we” when talking about being on the fence (line 4 in Excerpt 2a) and having discussed side effects (line 17 in Excerpt 2b). Second, insofar as the decision to discontinue chemotherapy is based partially on knowledge that he purportedly shares with the doctor about harmful side effects (Excerpt 2b, lines 17–18), David is being asked to act in his own best interest by avoiding these side effects. Dr. T now recommends a discontinuation of the chemotherapy (note the litotes formulation, “not to press on”) (lines 18–20); after this, David turns his gaze away again, remaining silent for 2.7 seconds (line 22).

When he speaks (lines 23–24), David returns to the earlier topic of discontinuing the treatment. By asking how he will “get better” if the chemotherapy is discontinued, David may be challenging Dr. T’s recommendation on the basis of commonsense assumptions that proper medical treatment focuses on a cure, and soliciting a forthright prognostic assessment.

In a way that is organizationally similar to a perspective display series, Dr. T responds by using the issue David raises about “getting better” to help formulate his news delivery that there is no effective treatment for the cancer.

Excerpt 2c

26 Dr: Well: it- it’s- it’s hard to- it is hard to get better when
27 (0.6) you don’t have a treatment that’s effective against the
28 ×cancer .hhh mbut:
29 ((D gazes away from Dr))
30 (0.2)
31 Dr: um (1.0) I would (0.4)
32 ((D returns gaze to Dr))
33 Dr: try to work (0.3) on other things like (. ) your nutrition ( . )
34 and making sure you’re getting plenty of fluids: and
35 preventing infections: because truthfully (0.5) I don’t feel
36 like the (0.3) chemotherapy would make much of an impact
Dr. T places the news that there is no effective treatment for the cancer behind “well:,” several repetitions of “it’s,” and “it’s hard to” (lines 26–28), which again indicate the dispreferred status of this news. After this, a contrast marker (“mbut,” line 28) helps provide a transition to what the doctor can “try,” and changes the focus to palliation and the prevention of further problems such as infections (lines 33–35). Next, Dr. T reverts to his assessment of chemotherapy (lines 35–36), which David receives by nodding (line 38).

After this exchange, in talk not reproduced here, Dr. T reiterates the basis for his recommendation. David intermittently nods and gazes away or into his lap. Shortly thereafter, he asks about “the blood transfusion” (lines 54–55 below), which he and Dr. T had discussed earlier in the interview (before Excerpt 2a) as a temporary means of alleviating David’s symptoms.

**Excerpt 2d**

54 D: Do you think the blood transfusion ((D motions to himself))
55 will bring it back? a little.
56 (0.5)
57 Dr: I think the blood transfusion will make you .hh ((Dr nodding))
58 feel better at least temporarily it’ll give you more
59 (0.5) or breathing space literally you’ll [feel (comfor-)]
60 [That’s (why-)]
61 D: That’s not easy breathing ((D gazing away from Dr))
62 Dr: “Right.”
63 (0.4)
64 Dr: Um it can’t do anything (0.2) to:: (.) affect the
65 leukemia directly but it would make you feel better. ((Dr
66 nodding))
67 (1.0) ((D gazes away from Dr))
68 Dr: That’s probably something that (0.4) is (. ) worth us
69 concentrate on now. Making sure that you’re as
70 comfortable as possible in- in every way possible.

As in his previous question about “getting better” (Excerpt 2b, lines 23–24), David’s query here (Excerpt 2d, lines 54–55) questions Dr. T’s assertion that there is no effective treatment for the cancer (Excerpt 2c, lines 27–28), and does not acknowledge the preventive plan Dr. T had proposed (Excerpt 2c, lines 33–35). Dr. T responds to David’s question by formulating the palliative effects of the plan (lines 57–59), dismissing the curative possibilities (lines 64–65), and repeating the “feel better” consequences (line 65).

Although David is receptive to the doctor’s suggestion that a transfusion will give him more “breathing space” (line 61), he again disassociates by looking away after the doctor rejects the possibility of a transfusion as a curative measure (line 67) (Goodwin 1980). His gaze away continues through a long period while Dr. T summarizes his posi-

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8David is having difficulty breathing not only because the leukemia has affected his lungs, but also because he is anemic; thus it is more difficult for his blood to deliver oxygen to various parts of his body. Although he is currently using oxygen (and carries a portable supply), David is aware that blood transfusions are one way of alleviating the problem. This partially explains his suggestion of a transfusion in lines 54–55 and his enthusiastic response in lines 60–61.
tion by reiterating the importance of palliative care (lines 68–70).

In this interview, then, Dr. T informs the patient about the imminence of his dying by recommending a discontinuation of chemotherapy. David’s initial reaction questions the doctor’s position; his response to the recommendation both challenges and allows for further unpackaging of the gloss that chemotherapy is no longer useful. Dr. T states that it is hard to get better when there is no effective cancer treatment, but that palliative treatment and infection prevention are possible. David appears to receive the news stoically and resignedly. As Maynard (1996) argues, such stoicism, more than a psychological disposition, is very much an interactional product. The stoic response may reflect the matter-of-fact or “reporting” fashion (Drew 1984) by which a physician delivers bad news and avoids stating the upshot. In addition, however, stoic responsiveness and gazing away do not elicit further unpackaging of the gloss.

**Excerpt 3a**

127 Dr: Uh m (.) and (.) I think we were talking about you going home toward the end of this; wee:k.=
128 129 J: =mmmhm.
130 Dr: Do you s- do you see: that as (.) a- a- realistic goal:?= do you think you’ll feel up to ↑going home? (.) by the end of the week?
132 133 (0.8)
134 J: I know I would.=
135 Dr: =>uh huh.<=
136 J: =I would very ↑much like to go home this week.=
137 Dr: =“alright“
138 139 (0.4)
140 J: =And (0.8) as again (2.6) it’s only due to that (0.9) to (0.2) letting us (0.6) hh not take a lotta drugs, just uh (2.1) under (1.2) yer supervision

John responds enthusiastically to the possibility of returning home (lines 134 and 136) and initiates a second foray into the topic of pain medications (lines 139–41; further talk on medications is omitted (lines 142–62). Dr. T reassures John that his medication needs will be met by the hospital staff. In Excerpt 3b, line 163, he then suggests a return to John’s assessment of his situation by posing a perspective display invitation concerning how he thinks he will “manage” at home. This is a second step, which retrieves the “going home” issue (Peräkylä 1995:262).

**Excerpt 3b**

163 Dr: How do you think you’ll manage when you get home.
164 (2.8)
Notice how John responds at line 165: He asks the doctor “In what way,” which suggests a lack of specificity in the perspective display invitation. The request for specificity obtains a “hypothetical question” (Peräkylä 1995:271) from the physician, which poses a “difficult” home situation (line 167) for John to consider. In his two queries, with the glosses “managing at home” (line 163) and “it’s gonna be difficult” (line 167), Dr. T invites “unpackaging” talk that could open the topics of cancer and dying. But in response (line 170) to Dr. T’s second query, John produces an emphatic “NO”; then he repeats the rejection (“No I don’t”) and cites his “experience” in dealing with “this” as a reason why he won’t have difficulties at home (lines 170–71). John further suggests that his perspective on the illness is well known to Dr. T (“you,” line 171) and to John’s wife, Daphne (line 174), who are both aware of his “experience in this type of problem” and in “taking care of it” (lines 176; our emphasis). So far, then, physician and patient have produced general and vague references to “managing,” “difficulty,” “this,” “problem,” and “it.”

Immediately after Excerpt 3b, in lines 178–82 (Excerpt 3c), Dr. T introduces another query; he now refers to the “melanoma,” the “illness,” and “how it’s affecting” his patient.

**Excerpt 3c**

178 Dr: Do you have a sense of (0.6) what’s happening with the (.) melanoma?
179 (0.2)
180 Dr: What the illness is doing: right now, how it’s affecting you?
181 (2.6)
182 J: Yeah, I have a sense of it fer SURE=
183 (0.6)
184 Dr: =mmhm
185 (0.2)
186 J: Absolutely.
187 (0.4)
188 J: Uh:: (0.2) Doesn’t make it any easier
189 (0.2)
190 Dr: Mhmm
191 (0.6)
192 J: But it gives me a sense of knowing what’s going on.
193 (1.0)
194 Dr: “Mmhm. okay.”
195 (1.0)
196 J: “Uh” which is VERY important to me=
197 Dr: =”Uhuh” knowing=
198 J: [uh]
By line 179 the earlier, vague references become available, at least retrospectively, as possible euphemisms that allude to “what’s happening with the melanoma,” although a term such as melanoma may still be cautious in itself because it is more technical than “cancer,” for example (Coombs and Goldman 1973). Although Dr. T refers explicitly to melanoma, his uses of “what’s happening,” “what the illness is doing,” and “how it’s affecting” his patient can all be glossing and euphemizing the dying process, and may allude to it collectively as well.

These phrases are part of a turn at talk that comprises a three-part list. As Jefferson (1990:79–81) argues, speakers can employ three-part lists to accomplish a variety of interactional tasks, such as moving from a prior topic to an event that is of “focal” importance to a speaker, or introducing, in the third position on the list, a matter that might “offend” a co-participant. Notice how Dr. T’s list progresses from (1) “what’s happening with the melanoma” to (2) “what the illness is doing” to (3) “how it’s affecting you.” Parts (2) and (3) are produced after a clear point of turn transition (line 180) and other possible opportunities for turn transition (after the stretched “doing” and after “right now” (line 181). Accordingly the list is assembled interactively: Dr. T moves cautiously from referencing the illness as spectacle, to formulating its disembodied offensive activity, to mentioning John as a direct object of that activity, and the last item is a potentially more indelicate formulation than the first two. The progression involves formulations that place the illness closer to the patient, moving in a direction that potentially forms an auspicious environment for unpackaging these glosses.

In response, however, John continues to be euphemistic. At line 184 he claims he has a “sense of it” (our emphasis). In typical conversation, “tying” an utterance to a preceding one through the use of “pro-terms” such as it is a regular way of providing coherence in the talk (Sacks 1992:150–68). In this instance, the prior talk contains several possible referents of “it,” including each euphemistic segment of the three-part list, the list as a whole, and/or the allusive referent of the list. Hence we argue that the use of a tying term (such as “it” or “that”), when the candidate referents to which the terms are euphemistic and allusive in the first place, is a resource for speaking (or continuing to speak) euphemistically and allusively.

In other words, a clinician’s perspective display invitations, particularly when they are progressively “coercive” (Peräkylä 1995:285–86), can elicit a reply that is specific enough to create an auspicious environment for the clinician, in the third turn of the series, to further designate the clinical view of diagnosis or prognosis and further name “what is going on” (Maynard 1991).9 Such an environment is not actualized here, however. At line 187 John emphasizes his claim of understanding (“Absolutely”) and then produces the “it” term twice again: when formulating a complaint about his difficulty (line 189) and when producing a contrasting, “bright side” characterization (line 193). If Dr. T is using euphemism and allusion to approach the topic of death and

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9 A patient can respond explicitly and specifically to a perspective display query, as can be seen in this patient’s narrative about receiving the news of her cancer. We have numbered the three parts of the perspective display series:

He [the doctor] let me get dressed, then he sat me down, held my hand, and (1) asked me what I thought was wrong. When (2) I said “cancer,” (3) he said that I was right but that I shouldn’t feel too worried as the lump was very small and there wasn’t any lumpiness under my arms, which is a good sign. (Fallowfield 1991:44; our emphasis)

After the doctor asked her “what” she thought was “wrong,” the patient said “cancer.” In the present data, Dr. T has already broached the cancer term (“melanoma”). The issue he poses is what the melanoma is doing to John, who claims to have a “sense” of “it” but does not say or demonstrate what his sense is.
dying cautiously, and to obtain specific talk from John about his illness, he has not succeeded. Instead of explicitly discussing his sense of the cancer, how it is progressing, and what he anticipates, John has made his own use of euphemism and allusion.

At this point (line 195), Dr. T acknowledges John’s claim of having “a sense of knowing what’s going on,” after which John emphasizes the importance of this knowledge (line 197). Dr. T then produces a clarification request (lines 198, 200), repeating John’s phrase as a candidate hearing of what is “important.” John confirms this with another emphasized repetition at lines 201–202. John has now “answered” Dr. T’s original query (lines 181–82): That answering is accomplished interactionally by Dr. T’s producing continuers (lines 185, 191, 195) and silences that invite further talk. Given the organization of the perspective display series (wherein news is provided after a recipient’s answer to the original query), the conversational environment, even if it is not auspicious in the sense that the patient has unpackaged Dr. T’s allusion to dying, implicates an informing by Dr. T.

As Dr. T delivers his news, he and John align to the idea that the cancer potentially could worsen after he leaves the hospital. Notice below how Dr. T starts the delivery (Excerpt 3d, lines 204–207) by formulating his task in terms that John has just used, thereby proposing to affirm the relevance of his own forthcoming talk. Dr. T then reviews the “facts” of John’s case, characterizing his current hospitalization as more serious than earlier ones (lines 209–11 and 213–14); John provides continuation tokens (lines 212 and 216).

Excerpt 3e

<table>
<thead>
<tr>
<th>Line</th>
<th>Dr.</th>
<th>Lines</th>
</tr>
</thead>
</table>
| 204  | Dr: | Mm hm. (0.6) Alright. (0.5) hhhh well one thing I wanted to do:
| 205  | . (.) today is to make sure you know what’s going on = I know we
| 206  | only met a few days ago (.) but . tch I feel it’s important
| 207  | that you have >ya know< all of the facts.
| 208  | (0.9)
| 209  | Dr: | tchh Uhm. (0.2) I think (.) pro:bably this: um (1.5) if you
| 210  | haven’t spent a lot of time in the hospital except for your-
| 211  | your-treatments.=
| 212  | J: | =Mm hm.
| 213  | Dr: | This is the first time I think that (.) you’ve (0.2) come in
| 214  | just because of the illness causing some symptoms for you.
| 215  | (0.4)
| 216  | J: | Mm hm?
| 217  | (0.4)
| 218  | Dr: | °Alright° hhhh And what my concern is is that (0.9) uh as time
| 219  | goes by:: (.) that there may be more (0.4) problems that the
| 220  | melanoma causes, more symptoms (0.7) or that it might affect
| 221  | your- your body more than it’s doing even now.
| 222  | (1.8)
| 223  | J: | Mmmh? (1.1) I agree with that

Dr. T subsequently states his own concern that John’s health may continue to deteriorate even beyond his current condition (lines 218–21). At line 223 John produces a delayed response, which claims agreement and enables Dr. T to forge ahead.

In Excerpt 3e below, Dr. T goes on to inform John that the doctors can no longer treat the cancer effectively; they can only treat his symptoms (lines 224–233).

Excerpt 3e

<table>
<thead>
<tr>
<th>Line</th>
<th>Dr.</th>
<th>Lines</th>
</tr>
</thead>
</table>
| 224  | Dr: | . hhhh I know that you’ve had a lot of (.) different treatments=
| 225  | s- some of them are (.) v-e:ry state of the art.
Dr. T accounts for his decision by implying that John’s “state of the art” treatments have been unsuccessful (lines 224–25), and implicates another oncologist in the decision to stop treatment (lines 231–33) (Anspach 1988). In response, John provides a minimal acknowledgment (line 234). Dr. T (line 236) offers an interpretation of this acknowledgment, suggesting that it might indicate a prior awareness, which John confirms (line 238). Next Dr. T reformulates his delivery of the news (240–43), suggesting that they “can do a good job” of pain control. After John’s quiet acknowledgment (line 245), Dr. T produces another version of the message that they cannot treat the “melanoma itself” (lines 246–48). Again, John displays agreement (line 249) and states his “unfortunate” awareness “of that” (line 251). Notice that both times, John displays agreement with Dr. T and does not further explicate or expand topically. Thus the overall message here is one about stopping the cancer treatment and starting pain treatment.

In the above segments, across Dr. T’s invitations and queries to John, we can track a particular topical trajectory of the physician. He moves from queries that do not markedly pose any problem (Excerpt 3a, lines 127–28 and 130–32), to a marked query that proposes the possibility of difficulty (Excerpt 3b, lines 167–8), to an explicit mention of “melanoma” and “the illness” and its “affecting” John (Excerpt 3c). At this point he also produces a euphemistic three-part list that may allude to John’s dying.

Although retrospectively it can be appreciated that Dr. T is pursuing a particular agenda, these invitations and queries are produced in real time. Thus, a recipient can orient to them as independent of any agenda. When John answers these queries (Excerpt 3a, lines 134, 136; Excerpt 3b, lines 170–71, 174–76; Excerpt 3c, lines 184, 187; etc.), he appears to deal only with the preceding questions. This appearance may be a feature of a more general strategy for euphemistic and allusive talk; it is possible that John perceives the trajectory that Dr. T
pursues but does not reveal that understanding through his talk. His agreement with proposals about cancer versus pain treatment suggests extinguishing rather than expanding the topic or otherwise unpackaging previous glosses.

By way of the PDS, the news here is presented in a cautious and affiliative way. Dr. T initially engages queries that euphemistically solicit expressions of anticipated difficulties and painful symptoms due to a now-un treatable cancer. Although John is also euphemistic in his replies, he nevertheless provides opportunities for Dr. T to move forward with more explicit reports about the state of the disease, the effects it will have, and the shift from curative to palliative treatment. That is, the physician becomes progressively less allusive and more explicit as John provides displays of understanding; these displays, although also euphemistic, permit Dr. T’s stepwise movement. As a result, the doctor and the patient seem more attuned to one another than in either of the other interviews to the news that the cancer can no longer be treated.

Once again, our analysis is consistent with Dr. T’s subsequent comments:

I think very often in whatever way possible there’s a lot of nonverbal communication between physicians who’ve gotten to know their patients well and the patients themselves. So that sometimes I think that when I come in and talk to the patient about one thing they actually understand that I’m talking to them about something else. And so that, but somehow the message gets through... very often patients and their families know exactly what’s going to happen, or almost know exactly, yet there’s some validation when the physician tells them that again. Sometimes it’s a sense of relief, or some sense of confirmation. I met with John’s wife today, and that’s exactly what she said to me. She said, “Well we knew that that’s what you were going to say, but we still needed to hear you say it,” when I was talking to her about how long he might live or what was going to happen next. So that’s one thing I’ve observed is that often the patients know what to expect but still they need to or they want to hear you say it as the physician.

In short, because of a tacit understanding of the practices we have identified and analyzed in the preceding excerpts, Dr. T can vernacularly characterize how his “message gets through” as part of the “nonverbal” communication between physicians and patients.

DISCUSSION

Whereas previous research on death and dying focused on individual perceptions and abstractions about patient-practitioner communication, we examine the actual interaction in which a physician attempts to inform patients of their prognoses. We find that the conversational trajectories in our data are highly contingent on the activities of the physicians, the patients, and the patients’ family members. Across conversations, the physician in our data exhibits interactive caution in discussing death and dying with the patient. Through the use of a PDS, and through a progressive questioning strategy that can provide an auspicious environment for patients’ talk about a dreaded future, Dr. T attempts to solicit patients’ perspectives about their situations before providing his own assessment. He does not succeed fully in overcoming his patients’ resistance, but once patients give their opinions, Dr. T works to fit his clinical perspective with those assessments.

The patients’ responses strongly affect the course of the news delivery. Although Dr. T begins the conversations with glosses about the patients’ situations, the extent to which the glosses are unpackaged is contingent on conversational practices that impede or facilitate the delivery of the news. Robert and Katherine, for example, by introducing competing topics of conversation, declining invitations to provide more detailed information, and being silent at particular junctures, eventually derail the doctor’s efforts to topicalize Robert’s non-recovery. David, who appears stoic throughout his interaction with the physician, avoids discussing palliative care but nevertheless enables the doctor to unpackage the gloss and deliver the news that he will no longer receive chemotherapy. John and Daphne respond to Dr. T in a way that permits unpackaging “what’s happening with the melanoma,” although this is done through euphemistic and allusive talk. In
each of these instances, the recipients’ responses to the physician’s cautious approaches enter into the trajectory of the conversation and help to shape just what information is conveyed by affecting how it is delivered.

In his extensive ethnographic study, Sudnow (1967:63–64) suggests that, even when death may be imminent, “dying” does not stand as a proper answer to a patient’s question “what’s wrong with me?” Disease categories and descriptions of symptoms may, and do, serve in the place of “dying,” even though the notion of a patient’s “dying” furnishes medical providers with a schema for caring for that person. In our data, although the doctor presented as a fact to the researcher that the three patients were in the last stages of their cancers and were dying, he did not say this to the patients straightforwardly. Instead he talked about going home, hospice, not continuing chemotherapy, relieving pain, and the like. In circumstances that are not, once and for all, biologically definitive, we can see a fundamental social component to talk about “dying” and “death.” This component resides in the interactional and collaborative assessments made between doctor and patient, which are some distance from these more graphic terms.

Accordingly, a physician’s conveyance of news to a patient about dying and death may lack direct reference to a putative organic state. Instead, it may comprise sequences of talk that broach an unpackaging of the news. How far that unpackaging can go depends strongly on the patient’s responses to the physician’s initiatives. And even when the patient facilitates rather than resists the unpackaging, both parties may retain allusive and euphemistic stances in which dying and death are not mentioned explicitly. It is not only that dying and death are everyone’s individual inevitability, then; these “states” enter into actions and activities that are profoundly social in their organization as patients and their families, along with the professionals who serve them, come to “realize” the bad news (Maynard 1996).


1. Overlapping speech
   A: Oh you do? R[really] 
   B: [Um hmmm] 
2. Silences
   A: I’m not use ta that. 
   (1.4) 
   B: Yeah me neither. 
3. Missing speech
   A: Are they? 
   B: Yes because ... 
4. Sound stretching
   B: I did oka::y. 
5. Volume
   A: That’s where I REALLY want to go. 
6. Emphasis
   A: I do not want it. 
7. Breathing
   A: You didn’t have to worry about having the hh hhh curtains closed. 
8. Laugh tokens
   A: That(h)t was really neat. 
9. Explanatory material
   A: Well ((cough)) I don’t know 
10. Candidate hearing
    B: (Is that right?) ( )

    Left hand brackets mark a point of overlap, while right hand brackets indicate where overlapping talk ends.

    Numbers in parentheses indicate elapsed time in tenths of seconds.

    Ellipses indicate where part of an utterance is left out of the transcript.

    Colon(s) indicate the prior sound is prolonged.
    More colons, more stretching.
    Capital letters indicate increased volume.

    Underline indicates increased emphasis.

    The “h” indicates audible breathing. The more “h’s” the longer the breath. A period placed before it indicates inbreath; no period indicates outbreath.
    The “h” within a word or sound indicates explosive aspirations; e.g., laughter, breathlessness, etc.
    Materials in double parentheses indicate audible phenomena other than actual verbalization.
    Materials in single parentheses indicate that transcribers were not sure about spoken words. If no words are in parentheses, the talk was indecipherable.
11. Intonation.
A: It was unbelievable. I ↑ had a three point six?
    I ↓ think.
B: You did.

12. Sound cut off
A: This- this is true

13. Soft volume
A: "Yes. " That’s true.

14. Latching
A: I am absolutely sure.=
B: = You are.
A: This is one thing [that I=
B: [Yes?
A: = really want to do.

15. Speech pacing
A: What is it?
B: > I ain’t tellin< you

REFERENCES


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