Enhancing Patient/Surgeon Relations: Examining the Delivery and Reception of Diagnosis

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Enhancing Patient/Surgeon Relations:  
Examining the Delivery and Reception of Diagnosis

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Abstract

Health communication is a fairly recent and currently growing area of the medical field. The diagnostic phase of many medical encounters can be the making, or breaking point of future relationships for the physician and patient (Blum, 1972). Many studies have examined how the physician's communication affects the relationship. However, few studies have investigated diagnosis in clinical setting with the exceptions of Heath (1987), Maynard (1991), and Nikolaisen (1998). Moreover, none have been found on the delivery and reception of diagnosis in the surgical setting.

Research reveals that the diagnostic phase in physician/patient relationships is a crucial one in establishing adherence, compliance, and foundations for future relationships (Blum, 1972). As the diagnostic phase is present in every surgical encounter, it is important to further examine its content. Specifically, this study investigates delivery and reception in eleven surgery cases.

In surgery, there is more to the diagnosis and reception than there would be in an encounter with a clinician, family practitioner, or general practitioner. In the case of surgery, there is a pre-diagnosis and reception, and a post-diagnosis and reception. Thus, the diagnostic phase of medical encounters is more complex in surgical cases.

In general, the findings of this study indicate that the time span of the diagnostic delivery in surgery is longer than in general practice settings. The two-step phase of diagnostic delivery and reception in surgery is also a new finding indicated in this study. As for reception, I found, unlike others, mixed reception to be a category beyond good news and bad news reception. Overall, there were more similarities than differences between diagnostic delivery and reception in surgery to those findings of diagnostic delivery and reception in clinical settings.
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References
Patient-physician communication is an important aspect of the health care setting. Effective health care relationships have major influences on the success of health care, influencing physical outcomes, treatment adherence, and patient satisfaction (Korsch & Negrete, 1972; Lane, 1983; Street & Wiemann, 1987). The clarity, timeliness, and sensitivity of human communication in health care are often critical to the physical and emotional well-being of all concerned (Blum, 1972).

One particularly significant aspect of health information involves diagnostic delivery and reception. During the delivery the physician presents the patient with a diagnosis, and the reception is based on how the patient perceives the diagnosis. It is during this phase of the medical encounter that a physician attempts to answer a patient’s medical concerns. Furthermore, a patient’s response to this diagnostic news is offered. This process is a negotiation of the diagnosis which results from a “fiduciary relationship” (Devettere, 1995). The diagnostic phase (communication) is correlated with patient satisfaction and positive health care outcomes (Blum, 1972).

As of now, little work has been found in this area. For exceptions, see Heath (1992), Maynard (1989), and Nikolaisen (1998). However, all of this research was conducted with general practitioners in clinical settings (e.g. family practitioners, general practitioners, and cooperative health care clinics).

No research has been found on surgeons’ communication in diagnosis. In surgery, the diagnosis is different from non-surgical settings; there is a two-phase diagnosis. The pre-diagnosis is given before the surgery, and the post-diagnosis follows
the surgery. For example, a surgeon might suspect a torn posterior-cruciate ligament (PCL), and delivers this information as the pre-diagnosis. However, during surgery, the surgeon might find a torn PCL and ACL (anterior-cruciate ligament), and deliver this finding as the post-diagnosis (after the surgery is complete). This form of diagnosing contains a different format than those already examined. Thus, research on diagnostic delivery and reception, regarding surgery, is warranted.

In the current study, Chapter 2 discusses previous research related to delivery and reception in medical settings. Included in this chapter are discussions of the diagnostic phase, the patient's perspective, physician's perspective, delivery of diagnoses, and reception of diagnoses. Chapter 3 describes the method used to conduct this study, including ethnographic research and transcribing instances of diagnostic delivery and reception. Chapter 4 delineates a detailed analysis of these particular instances. Three types of delivery emerged from the findings: good news, bad news, and tentative news. Following this, three types of reception for both pre- and post-reception emerged as well: good reception, bad reception, and mixed reception. Chapter 5 provides a discussion of the analysis, a summary of the findings, and similarities and differences as compared to clinical settings. In Chapter 6, the conclusions of the study are detailed. Within this chapter, a summary of the chapters is provided, as well as a discussion of limitations, further research, and possible implications.
CHAPTER 2
PREVIOUS RESEARCH

This chapter discusses previous research pertaining to diagnostic delivery and reception. First, investigating the diagnostic phase in relation to the entire medical encounter will help us to understand why the development of relationships is so important during this phase. Second, the patient perspective in this phase will aid the readers in understanding the possible implications the diagnosis can have on others. Third, the physician's perspective will offer an understanding for their expectations in the diagnostic process. Fourth, the research on delivery and reception of diagnoses provides a foundation for the current study.

The Diagnostic Phase

Understanding the importance of the diagnostic phase in relation to the medical encounter as a whole is necessary. Frankel (1995) claimed, the purpose of an interview is that one-person (the interviewer) can "elicit specialized information from another (the interviewee) using questions and the answers they elicit as a mode of relating" (p. 234). Thus, the purpose of any medical encounter (e.g., surgery, pediatrics, neonatal, etc.) is to attempt to solve one or more problems addressed during the interview.

Several scholars have described the phases or steps of a medical interview. Blum (1972) named three phases in a physician-patient interaction: the interview, the physical examination, and the statement of findings. Northouse and Northouse (1992) identified four phases: preparation, initiation, exploration, and termination. Byrne and Long's (1976) six phases to medical consultation include: (a) relating to the patient; (b) discovering the reason for attendance; (c) conducting a verbal or physical examination or both; (d) considering of the patient's condition; (e) detailing treatment or further
investigation; and (f) terminating” (as cited in Heath, 1992). In some cases, Byrne and Long (1976) found that the presentation of diagnostic information was "relatively limited; indeed, in some cases it does not exist at all” (1992, p. 237).

It is the last phase—the statement of findings or the termination phase—that is the focus of the present study. During the termination phase, “the purpose of the interview has been accomplished, the goals have been reached, and the end of the interview is near” (Northouse & Northouse, 1992, p. 166). Specifically, during this phase, the physician presents the patient's diagnosis and makes recommendations in treating this condition. From the patient's perspective, s/he can expect to receive information about her/his health—whether it is good or bad news. According to Heath (1992), "It marks the completion of the practitioner's practical inquiries into the patient's complaint and forms the foundation to management of the difficulties" (p. 238).

It is important to note that delivery and reception may not always be perceived in the same way considering the interactional nature of patient-physician communication. For example, a physician may deliver what s/he regards as good news. However, the patient may perceive the diagnosis as life threatening or bad news due to previous medical experiences.

Now that the diagnostic phase has been described, a brief introduction to the perspective of the two participants—the physician and the patient—is warranted. This may present an increased awareness in the differing, but interactionally related, communication behaviors of patients and health care providers.

**Patient Perspective**

In understanding the patient's perspective, one must keep in mind that the role of the patient is typically involuntary. Furthermore, the patient may experience a variety of
emotions during the medical encounter. Health care systems resemble the blind man's elephant: what is perceived depends upon perspective and previous experience (Falconer, 1980). Falconer (1980) noted specific psychological states a patient may feel in medical consultation—anxiety, depression, powerlessness, dependency, depersonalization, vulnerability, guilt, alienation, isolation, and dehumanization. Of specific interest to this study, Blum (1972) explained that the diagnostic phase is intensified when a physician informs a patient of a physical disorder, especially in a case where surgery is needed. From a psychological standpoint, a physical disorder communicated to the patient that her/his body would be changed physically in some way can lead to a decrease in self-esteem regarding body image (Blum, 1972).

Patients, or their family members, very rarely challenged a physician's diagnostic presentation. When provided a chance to respond, a patient still tended to remain silent. This pattern allowed a physician to continue from a delivery into management or treatment of a condition, thus displaying greater interactional control. "Thus, despite receiving the opportunity to respond to the diagnosis or medical assessment, patients either withhold their response altogether or produce only the most minimal acknowledgment of the diagnostic information" (Heath, 1992, p.240).

Lack of participation, however, may be contributed to a physician's communication style. Diagnosis and treatment may be combined so a patient will respond to the second item, the treatment, as compared to the diagnosis. Also, a physician may exemplify certain nonverbal actions that discourage patient participation, including conducting parallel task activities such as writing in the patient's chart. A physician may nonverbally suggest that a patient should not respond, for example, through an uninterested gaze or posture. All of these methods allow a physician to control and pace the medical consultation throughout the diagnosis, management, and closure.
It is important to accept that a physician cannot soften the impact of bad news since it is still bad news however it is broken. The key to breaking bad news is to slow down the speed of transition from a patient's perception of her/himself as being well to a realization that s/he has a serious condition (Maguire & Faulkner, 1988). If one breaks the news too abruptly, it will disorganize the patient psychologically and s/he will have difficulty adapting. It may also provoke denial because the news is too painful to assimilate (Maguire & Faulkner, 1988).

The research of van Servellen (1997) took into account the actual contact with patients. When patients get a desired response, they feel good about their encounter with health care providers and their need for positive interaction is satisfied. When patients feel good about their experience, they are more willing to cooperate and are more likely to repeat their contacts with the physicians. If their experience or response is undesired, they are likely to avoid and limit further contact.

Some studies as early as the late sixties have correlated physician interaction with increased patient satisfaction. In different findings, patients were more apt to follow the physician’s orders, (Freeman, Negrete, David, & Korsch, 1971), and satisfied patients were less apt to decline health plans (Neuling & Winefield, 1988). There is a common perception throughout these studies that implies social support of physicians in medical interviews enhances positive health care outcomes.

Considering the research done on the patient's perspective, it is crucial that encounters and diagnoses are an honest and positive form of interaction. The diagnostic phase is intensified when surgery may be the only outcome, and as surgeons are in control of the surgery --they should regard the patient's perspective as highly important in developing their current and future relationships. Falconer (1980) noted that no one chooses to become ill or disabled; the role of the “patient” is always involuntary.

Now that we have dealt with the patient’s perspective and that of the physician as well, the attention will now be turned to the physician’s perspective.
The Physician's Perspective

In general, the physician’s perspective in health communication stems from a variety of encounters with patients, administrators, sales personnel, staff, etc. The physicians cannot possibly understand how every patient views illness and disease, or the meaning that each patient has given to their illness or disease. The physicians’ perspective is often characterized by stress, time constraints, uncertainty, and conflicts of autonomy (Haney, 1979).

The stresses a physician may encounter are those of daily routine, and can range anywhere from answering a routine phone call in the middle of a medical interview to running routine tests on each and every patient. Time constraints keep a physician on task, but take away from the patient’s time—which is necessary to establish a foundation for the current illness and future treatment. In many cases, physicians will encounter a virus or an illness that throws off the routine treatment, and this too can influence the physicians’ perspective. The struggle for autonomy is to separate one’s (the physician’s) own self-determination from that of the other (the patient’s), and this task is constantly straining the physician’s perspective of the patient and the situation.

Related to the patient's perspective of diagnosis, one must also examine the physician's perspective in delivering a diagnosis. This delivery often proves difficult for the physician due to the emotions involved and possible implications of such news. In cases involving a severe diagnosis or death, Maynard (1991) claimed that this diagnostic delivery may be "one of the most difficult of clinical tasks" (p. 144).

Now that we have dealt with the patient’s perspective and that of the physician as well, attention will be directed at previous literature concerning the delivery and reception of a diagnosis.
Delivery of Diagnoses

Little research has been devoted to diagnostic delivery and reception, especially in the surgical arena. This area becomes very limited in scope when focusing on the practice of consultation with surgeons. Some studies, however, have shed light upon the interactional features of delivering and receiving diagnostic information (i.e., Heath, 1992; Maynard, 1989; Nikolaisen, 1998; Pomerantz, Mastriano, & Halford, 1987), and will now be addressed.

Heath (1992) analyzed a collection of video recordings to investigate real-life diagnostic delivery in general-practice consultations. In his study, he found that when a physician's diagnostic presentation was complete, the physician had greater interactional control because s/he was allowed to continue on with treatment options without being interrupted by the patients' response. Physicians were more comfortable with the interaction when they did not have to address the concerns of the patient.

Now that we know a little, in general, about delivery of diagnostic information from Heath, there are others who have delved deeper into diagnostic delivery regarding questioning, sequencing, characteristics, etc. As mentioned earlier, health care providers face many difficulties when delivering bad news. Several researchers have investigated this area.

In a clinical setting, Maynard (1989) examined diagnostic delivery and reception in cases involving mental disabilities. Reception and delivery were examined as parents were informed of their child's mental disabilities during an "informing interview."

Maynard (1991) suggested that when a physician is bearing bad news, they do not claim completely independent knowledge, and instead elicit a display of what the recipients—through their own knowledge or beliefs—can infer. Physicians can use a "perspective display series," a device that operates in an interactionally organized manner to co-implicate the recipient's perspective in the presentation of diagnoses (Maynard, 1991). A further effect of using the perspective display series is to portray the clinician
not as one whose assessment is an independent discovery, nor the patient as one who must be moved from a state of ignorance to a state of knowledge.

(Maynard (4) [9.001])

Dr.: Now that you've - we’ve been through all this I just wanted to know from you :-. (0.4) ‘hh how you see Judy at this time (2.2)

Mo.: The same. (0.7)

Dr.: Which is? (0.5)

Mo.: Uhm she can’t talk . . .

Some clinicians ask parents for their view of their child’s illness or situation through an indirect questioning process. This does not provide the physician with a complete understanding of the parents’ perception, but it does provide a common ground with which the physician can diagnose the child without creating an atmosphere of confusion and misunderstanding. If the parent resists problem formulation, the clinician is faced with a greater obstacle. Maynard’s findings reiterate the difficult nature of delivering bad news.

Furthermore, Maynard (1989) claimed that clinicians use a good news/bad news structure to deliver bad news. Take for instance the following example:

23 Dr: Okay now. Basically uhm Ricardo is BRIGHT, NICE little boy who
24 um is from everything that I can see in my evaluation and from uh
25 Miss Gregory’s evaluation, is you know-has real intelligence
26 that is normal. The-there aren’t any real problems with his
27 ability to USE words. The problem is that sometimes the words
28 don’t SOUND correct.
Specifically, clinicians first present the positive aspects of a patient's condition (i.e., the boy being “BRIGHT and NICE”), and then move into more negative news (i.e., Ricardo’s words “don’t SOUND correct”). In addition, clinicians present a diagnosis as a finding, not as an opinion, and thus, clinician’s delivery grows difficult when the parents do not follow the actual diagnosis.

Pomerantz et al. (1987) found health-care providers "offsetting the bad news with good news, mitigating the seriousness of the problem, presenting the Center's evaluation as confirmation of what the client already accepts, and attributing the responsibility for the problem away from the client" (p. 22). They also found that when delivering diagnostic information, physicians over relied on test results. For example, “the cath lab shows that. . .,” is an introduction to the diagnosis with a routine test as a foundation for the diagnosis. The use of test results to provide the patient with a diagnosis can cause the patient to be confused and possibly misunderstand the diagnosis.

Maynard (1997) claimed that physicians and patients behave differently depending on the type of news that is delivered: either good or bad news. Maynard (1997) found that in delivering good news, a physician faced the patient and maintained the same posture as the patient. The delivery was quick and bold. Such behavior is similar to "preferred action" (Heritage, 1989). "Actions which are characteristically performed straightforwardly and without delay are termed 'preferred' actions" (Heritage, 1989, p. 267).

Upon delivering bad news, Maynard (1997) claimed that the physician and patient sat side by side instead of face to face. The delivery also involved gaps, halting, and the diagnostic news was delayed. This delivery demonstrates a "dispreferred action" as described by Heritage (1989). "Those [responses] which are delayed, qualified and accounted for are termed 'dispreferred'" (Heritage, 1989, p. 267).

Nikolaisen (1998) focused on the delivery of diagnoses on television medical dramas, and compared them to diagnoses in real-life situations. She found that common
characteristics did exist between delivery and reception in television medical dramas and real-life medical interviews. The basic communication features found in good news delivery and reception on television were similar to Maynard's (1997) research of real-life good news delivery and reception. In addition, bad news delivery and reception on television featured characteristics found in Maynard's (1997) description of bad news delivery and reception in real-life medical interviews.

Nikolaisen (1998) found characteristics of tentative news delivery, such as: relying on tests, conducting parallel task activities, inserting pauses, and displaying tentativeness through tentative language, modals and disclaimers. She also found that in the television medical dramas, physicians downplayed the diagnosis and added light, joking phrases when delivering good news. Good news cases involved situations where the diagnosis was treatable or no condition existed. Thus, by adding jocular phrases and reassuring the patient of a treatable condition, the physician perhaps appeared as the medical hero.

Nikolaisen (1998) also found some key differences in her research. Previous research revealed no identification of tentative news delivery in hospital or emergency room situations. Her study's analysis revealed characteristics of tentative news delivery including: relying on tests, conducting parallel task activities, inserting pauses, and displaying tentativeness through tentative language, modals, and disclaimers.

In the television medical dramas, "physicians downplayed the diagnosis and added light with joking phrases while delivering good news" (Nikolaisen, 1998, p. 69). Good news cases included situations where the diagnosis was treatable or no condition existed. Thus, by adding jocular phrases and reassuring the patient of a treatable condition, the physician perhaps appeared as a reassuring factor in the practice of medicine.

Another area that is relevant to this study is the form of address used. If the address is formal (Mr./Ms. Last Name) then the interpersonal communication distance
has been increased, and this may suggest that the relationship between the surgeon and patient is also distant. However, if the address is informal (First Name), then the interpersonal communication distance is likely to be decreased, and closer relationships are more likely to be established.

Of the little amount of research covered in this section, there was none that pertained to surgery. Therefore, the findings of this study might be similar in some ways and unique in others. Now that we have examined the findings of delivery of diagnostic information in clinical settings, it only seems relevant to consider the reception process as well.

Reception of Diagnoses

Every patient will respond differently to her/his diagnosis; however, some common patient emotional reactions are noted. Blum (1972) described various patient reactions to good and bad news, with the most common patient reaction being relief in good news and anger in bad news. For example if a patient receives good news, perhaps remission of cancer, their initial reaction is one of relief, and the patient becomes less likely to inquire further information about the current condition. However, if a patient receives bad news, perhaps of a terminal illness, s/he may feel anxious and angry. A patient may either ask for more information regarding the condition, or s/he will remove her/himself from the situation by "misunderstanding, discounting, or minimizing the physician's reported findings" (Blum, 1972, p. 178). In reaction to shocking news, a patient may react passively; thus, appearing calm. However, as Blum (1972) explained, although a patient appears calm and thus accepting the bad news, s/he may actually be suppressing unhealthy anxious and angry feelings in an already unhealthy state.

So, how do patients respond interactionally upon receipt of diagnostic news? A few researchers have uncovered several patterns. Heath (1992) discovered that patient response was not common, especially explicit responses. "Even in cases where the
diagnosis of the patient's complaint is relatively serious or problematic, patients remain reluctant to respond to the information presented by the physician and apparently unwilling to elicit further details" (Heath, 1987, p. 242). If a patient did respond, it pertained to a physician's recommendations for treatment.

Nikolaisen (1998) found that when receiving bad news, patients portrayed on television rarely challenged the diagnosis, similar to Heath's (1992) claim that patients and their families rarely challenge diagnostic news.

Maynard (1997) claimed that upon receiving good news, a patient will respond quickly and maintain the same posture as the physician s/he is interacting with. This response is similar to Heritage's (1989) "preferred action." Contrary to this, upon receiving bad news, Maynard (1997) found that physicians respond in a halting, hesitant manner that contains gaps. Heritage (1989) described such a response as a "dispreferred action."

Pomerantz et al. (1987) found that patients were more receptive to diagnostic information when it was delivered through results of a test. Patients also received diagnostic information as confirmation of what they already knew to be true. However, when physicians mitigated the seriousness of the problem, patients were less receptive to the diagnosis, and more concerned with the lack of empathy on the physicians' behalf.

Once again, it is important to note that delivery and reception will not always reside in the same contexts, considering the interactional nature of patient-physician communication. For example, a physician may deliver what s/he regards as good news. In response, the patient may perceive the diagnosis as life threatening or bad news due to previous medical experiences.

In summary, previous research demonstrated the aspects and importance of diagnostic delivery in real-life medical interviews and its role in the medical encounter overall. Both the patient's and the physician's perspectives were examined in clinical
settings only. However, the current study is especially important because no one has
looked at diagnosing in the surgical setting. Thus, the following research questions
emerged:

RQ 1: How are the diagnostic delivery and reception accomplished in
the surgical setting?

RQ 2: How does diagnostic delivery and reception in surgery
compare with diagnostic delivery and reception in clinical settings?
CHAPTER 3

METHODS

Ethnography allows for a detailed/contextual account of the situation. The wide-
scope view of surgeons in different locations and different aspects of surgery will allow
me to maximize the possibilities. Ethnography also allows the integrity of the data to be
preserved and the underlying structures of communication to be discovered.

According to Frey, Botan, Friedman, and Kreps (1991), one who conducts
inductive research "first gathers data, then develops theory from them" (p. 11). To
conduct this inductive study, I spent approximately 200 hours with surgeons.
The aim of participant observation was to place myself in the midst of an unfolding
story. By observing in these particular situations, I gained insight about how the events
were experienced. According to Frey et al. (1991), "ethnographic research is conducted
in ways similar to the interpretive processes we use in everyday life, and application of
findings is often limited to the specific context in which the data are collected" (p. 231).

Ethnographic field data on surgical care in an U.S. Midwestern state was
analyzed. Ethnographic observation was conducted over a nine month period in 1998 in
three hospital settings and one surgery center where surgeons of specialized areas work.
Two of the hospitals were Catholic affiliated and the other contained physicians with
private practices outside of the hospital. Physicians who were affiliated with one of the
local Catholic hospitals ran the surgery center.

In studying the diagnoses and interactions of surgeons and patients, I utilized two
observation strategies. First, I followed surgeons through the course of a routine
workday in which they would see two to three patients who were having surgery in the
near future. Then, I followed the diagnoses longitudinally with most of the patients
(either the day of surgery, or a couple days later). I attended all of their medical
encounters with the surgeons from the patient’s arrival and pre-diagnosis to completion of
the surgery and post-diagnosis. The data includes detailed descriptions of diagnoses and interaction between the surgeons and patients before and after the surgeries.

The data encompasses 9 complete episodes of care provided by a total of eight surgeons to their patients. The surgeries ranged anywhere from arthroscopic to open-heart and quintuple bypasses. The patients were male and female. Five of the patients were males whose ages ranged from 42 years-of-age to 72 years-of-age, and their surgeries included clotted pulmonary arteries to quintuple bypasses. Six of the patients were females whose ages ranged from 9 months to 62 years-of-age, and their surgeries consisted of partially torn anterior cruciate ligament to punctured visceral sacs. The surgeons were also male and female. Five of the surgeons were male and three of the surgeons were female. Their ages ranged anywhere from 34 years-of-age to 56 years-of-age.

Analysis of the data for the current study uncovered patterns in the communication concerning delivery presentation and reception. These instances are then used as support for theoretical claims.
CHAPTER 4

DELIVERY AND RECEPTION OF DIAGNOSIS

In Chapter 4, we are going to discuss pre-diagnostic delivery and reception, and then we will move on to post-diagnostic delivery and reception. In this chapter, it will be argued that the data reveals more similarities than differences between diagnostic delivery and reception in clinical settings and diagnostic delivery and reception in surgical settings. However, there are some differences that emerged. The following analysis will be divided into four sections: pre-diagnosis delivery, pre-diagnosis reception, post-diagnosis delivery, and post-diagnosis reception.

Pre-Diagnosis Delivery

Delivery of good news in pre-diagnosis. In the pre-surgery diagnosis, in which good news was being delivered and the existing condition seemed to be treatable, the diagnoses seemed to be immediate with little or no verbal hesitations or nonverbal pauses. The physicians also provided direct eye contact in such cases. Furthermore, delivery of good news may exhibit a positive, enthusiastic quality through paralinguistic variations (i.e., stretched sounds, emphasized sounds, and changes in pitch). The initiation of the good news is usually by formal address and the good news is also delivered with a professional opinion (i.e., “As far as I can tell...”), as well as an occasional jocular phrase. The following example serves as an illustration of good news delivery in pre-diagnosis.

(1:1)

1. Dr: Well, Mrs. (last name), we are going to open you up today and see what’s causing your chronic pain (no delay or hesitation)

2. Pt: Okay (in breath and pause) am I going to be all right? (eyes drop, eyebrows cringe, almost a look of concern)

3. Dr: As far as I can tell, and if the cath lab is anywhere near accurate you will be just fine (pitch goes up, eye contact with patient, and a smile)
In line 1, the surgeon greets the patient with a formal address and begins to explain the procedure in layman’s terms. In line 5, where the attempt of a diagnosis occurs, the surgeon uses a personal assessment accompanied by reliance on a lab test. In a study by Pomerantz et al. (1987), some health care providers regard test results as the “best basis for, and justification of, evaluating areas as problem areas” (1987, p. 25). The test results provide grounded proof for the presented diagnosis as well as confirmation that the patients’ condition is treatable. However, they also found that reliance on test results subtracts from the physician’s authority. Considering the patients’ condition, the surgeon delivers the diagnosis with an upbeat tone and no verbal hesitations or nonverbal pauses, similar to Maynard’s findings (1997). Direct eye contact and the smile may represent the surgeon’s level of competence in the current situation.

**Delivery of bad news in pre-diagnosis.** Bad news delivery includes those instances in which the physician delivers a chronic diagnosis or a diagnosis that is considered negative according to the physician’s perspective. In the pre-diagnosis of surgery, in which bad news was being delivered, the diagnosis seemed to be delayed with other talk (i.e., procedural information, joking, or humor). This finding is similar to Maynard’s findings (1997). The delivery of bad news also seemed to follow some piece of positive information. The eye contact was directed at the surgeon’s clipboard. Delivery of bad news may exhibit a negative, less than enthusiastic quality through paralinguistic variations. Bad news delivery also contains verbal hesitations and lengthy pauses. The following examples serve as an illustration.
Dr: (First name), today we are going to take a vein out of your left interior/distal leg and use it to bypass the two clots you are currently facing (procedure run through with little eye contact)

Pt: Okay (in breath and long pause; patient is looking at me and not at the surgeon)

Dr: There are some precautions we have to take though (pause). We are going to hook you up to a bypass machine and three-fourths of the blood circulating through your body will be circulating through a machine (pause) this is to keep your blood at body temperature (eye contact has shifted back to clip-board)

Pt: Well, (out breath and pause) that's reassuring (frown with wrinkle in forehead)

Dr: Well, (first name),(long pause) currently the conditions include a blocked pulmonary artery in the supraclavicular branch and a distortion of the artery leading to the left ventricle. There could also be more that the cath lab didn't show, so I will send the nurses back to get you and we will get started (no eye contact during this dialogue, writing on clip-board, and walking toward the door)

In this case, the surgeon addresses the patient informally (by their first name), and begins to explain the medical procedures. In lines 1-3 and 5-8, the surgeon is inserting procedural information to extend and delay the diagnosis. In lines 7 and 10 the surgeon starts to present the findings with lengthy, drawn out pauses in their verbal delivery. Maynard (1997) found that when physicians deliver bad news, they present with gaps, such as those in lines 5, 7, and 10, and draw out the delivery. After this lengthy, drawn-out explanation which Maynard (1997) described as stalling, the surgeon finally brings all of the information together to initiate the diagnosis in line 10. This case is different than Pomerantz et al. (1987) findings of physicians relying on test to deliver diagnoses. In this case, the surgeon actually discounts the test results in lines 12 and 13.
Dr: Well, Mr. (last name), I thought third time was a charm, but you must have missed this place (no eye contact, smile, writing in on file, joking intonation)

Pt: Well, I still have a few dollars to my name and I can’t take it with me when I go, so I might as well spend it here (reciprocated smile and joking intonation)

Dr: (pause) Well, according to the cath lab and other chest x-rays, your heart has seen its better days (still charting, while patient is looking out the window)

Pt: (looks back to surgeon) Doc, I have lived a full life, so if the good Lord wants to take me now, so be it!

In this example, the surgeon initiates contact with proper formal address followed by informal joking in lines 1-2, “I thought third time was a charm, but you must have missed this place.” The surgeon then begins to utter with a verbal hesitations or fillers, including and “well,” exemplifying difficulty in delivering the forthcoming news. Also, the multiple pauses might indicate further difficulty in delivering bad news. Similar to Pomerantz et al. (1987) the surgeon also relies on a test to deliver the diagnosis in line 5. In lines 5-6, the surgeon indicates bad news delivery by saying, “your heart has seen its better days” indicates that the surgeon considers this news as negative.

**Delivery of tentative news in pre-diagnosis.** In certain instances, diagnoses remain uncertain. The diagnosis has been labeled as “tentative” (Nikolaisen, 1998). The diagnosis is considered uncertain because the surgeon is not sure as to whether or not the news is good or bad. In tentative news delivery there are features of good news and bad news. There are some examples of immediate diagnostic delivery and there are also examples of delayed delivery. Rises in intonation further emphasize good news, but the lengthy pauses illustrate bad news. Let the following examples serve as an illustration.
Dr: From what I can tell from the x-rays a week ago (first name), you have torn part of your ACL, not enough to replace it, but also not due fully to bowling, your frame has been off set by your weight. . . (long pause, little eye contact, preoccupied with clip-board)

Pt: My weight? (frowned forehead, squinted eyes)

In instances as this one, diagnoses remain uncertain and are delivered as such. Thus, the surgeon avoids declaring certainty of the tentative diagnosis when s/he emphasizes that the inquiry could be from factors other than bowling. In this instance, the surgeon delivers the diagnosis through neutral language and with a long pause at the end before the patient responds. Pomerantz et al. (1987) found, often in delivering disrupting or unpleasant news, health care providers over-relied upon tests to ease the hardships of delivering difficult news, as in the case in line 1 when the surgeon refers to the x-rays. Just as in delivering good news, surgeons also conduct parallel task activities when delivering tentative news (Frankel, 1995). The activity (e.g., putting in IVs or fidgeting with gloves) takes away from the full attention of the verbal diagnosis being presented. Conducting parallel activities creates a distraction.

Dr: Well, (pause) (first name), lets get this done with, so the pain will go away (increase in intonation and fidgeting with his gloves and beeper)

Pt: Great (rise in intonation)

Dr: X-rays show that the bones have not encountered fusion back together yet, so later on the screw may have to be replaced, and you will definitely have to return to your walking cast (pause, still no direct eye contact with patient)

Pt: If I have to leave the screw in (out breath) how much longer will it take?
This is another example of a tentative delivery. The surgeon initiates the interaction with another informal address, and verbal hesitation along with the utterance of "well." These signs may illustrate the surgeon's hesitation in delivering the diagnosis. There is the reliance on tests (x-rays) once again. The surgeon, in this case, may be using the x-rays to back-up his initial diagnosis. In this case as well, the surgeon was conducting parallel activities (fidgeting with gloves and beeper) and not providing the patient with his undivided attention. This may forecast that the news may include negative elements. The indirect eye contact in line 6 is also a characteristic of bad news delivery. The one part of this example that lends itself to good news delivery is the increase in intonation in line 2. The surgeon is stating the diagnosis through a positive, enthusiastic paralinguistic variation.

Pre-Diagnosis Reception

Reception of good news in pre-diagnosis. As mentioned earlier, good news in clinical settings has been found to be received by patients in specific ways (i.e., quick response, less verbal hesitations, direct eye contact, less nonverbal pauses, etc.). Good news in the surgical setting has been found to be similar. In good news reception of diagnosis, patients are more apt to make eye contact with the surgeon, and offer a quick explicit agreement of the diagnosis and surgery procedures. In these cases, many of the patients responded with positive assessments of the surgeon's diagnosis. The confirmation that they provided the surgeons with was usually, "okay," implying that there was a mutual understanding of good news, or a display of acceptance. The nonverbal clues in these instances were positive. The eye contact was usually steady between the patient and physician and the intonation of voice illustrated a form of enthusiasm. Most patients did not question the physician's diagnosis. This is similar to
Heath's (1992) finding that patients very rarely challenge a physician's diagnostic presentation. The following examples serve as illustrations.

(5:6)

1 Dr: Well, (first name), obviously things have not improved since your tread mill accident. However, I hope to make the pain very minimal after today (continuous eye contact, gesturing with hands, facing patient)

2 Pt: Great (smile on the face, rise in intonation, faster verbal delivery), I would love to get back to work and exercise soon (eye contact directed at physician)

3 Dr: Well, (pause) how soon are you planning? (eyebrows raise, and smile dissipates)

4 Pt: Tomorrow! (increase in intonation, enthusiasm, smile, chuckle, clasp hands)

5 Dr: That would be close to a miracle (in breath and pause) lets aim for two weeks (looks to floor)

6 Pt: Okay (decrease in intonation, and smile turns to a frown)

7 Dr: Well, (longer pause) currently the conditions contain a torn ACL and partially torn MCL (pause) so, lets see what we can do (glances to patient and exits the room)

It is important to understand that reception is defined according to the patient's perception of and response to the diagnostic news. The patient starts with a positive assessment ("great") of the surgeon's assurance to reduce the patient's pain. We can also notice the patient explicitly agreeing with the diagnosis, and immediately responding to the diagnosis in lines 4 and 5. There are no hesitations and the agreement occurs immediately after the presentation (lines 4, 9, and 12), indicating that the patient understands the diagnosis. The nonverbal behaviors in this case are also indicative of good news because the patient is smiling, her pitch has increased with enthusiasm, and she is maintaining direct eye contact. In fact the patient even jokes with the surgeon (line 9).
Dr: Well, Mrs. (last name), we are going to open you up today and see what’s causing your chronic pains.

Pt: Okay (pause) am I going to be all right? (eyes drop, eyebrows cringe, a look of concern)

Dr: As far as I can tell, and if the cath lab is anywhere near accurate, you will be just fine (pitch increase, eye contact with patient, and a smile)

Pt: That is great news Dr. (last name) (rise in pitch and a smile)

The diagnosis in this case is implied. The cath lab showed no abnormalities, but the surgeon was still going to investigate for the patient. This case is in contrast to Heath’s (1992) findings in which he found that patients often do not respond to the diagnosis if it is serious or problematic, but in this case the patient is very concerned of her well being. As one will notice in line 3, the patient questions in terms of her life. The verbal and nonverbal behaviors illustrate anxiety with the current conditions. However, the direct eye contact and the smile indicate that the news is good.

Reception of bad news in pre-diagnosis. In the case of bad news, there is a lot of hesitation on the patient’s behalf before and during the response. Often, denial was handled through characteristics of humor and sarcasm. The patients’ concerns often revolved around family members. There was questioning of the physician’s diagnoses in terms of sarcasm, which is in contrast to Heath’s (1992) findings. The patients’ nonverbal behaviors include few smiles, wrinkled foreheads, tears, lengthy pauses, and little or no eye contact with the surgeon. Patient reactions contain specific characteristics which are constructed as ‘dispreferred’ actions (Heritage, 1989). Let the following examples serve as illustrations.
Dr: Well, Mr. (last name), I thought third time was a charm, but you must have missed this place (no eye contact, smile, charting on file, joking intonation)

Pt: Well, I still have a few dollars to my name and I can’t take it with me when I go, so I might as well spend it here (reciprocated smile and joking intonation)

Dr: (pause) Well, (pause) according to the cath lab and other chest x-rays, your heart has seen its better days (still charting, while patient is looking out the window)

Pt: (looks back to surgeon) Doc, I have lived a full life, so if the good Lord wants to take me now, so be it!

In this case, the patient handles the delivery of the bad news through a sense of humor (lines 3-4). These characteristics exemplify the problematic and difficult nature of receiving bad news. Also, the patient displays acceptance of the surgeon’s bad news. The patient’s acceptance is that everyone must die sometime, and maybe his time has come because he has led a fulfilling life. The nonverbal behaviors, in this instance, are incongruent with bad news delivery because it is not very often that the patient will exhibit a smile, or direct eye contact in such a situation.

Dr: Well,(pause) Mr. (last name), we have know this to be in the coming for a few years, so today I am going to try an’ replace your ‘ticker’ ( a serious intonation, until Dr. said ‘ticker’ and then cracked a smile, no eye contact)

Pt: Doc, what about my family? (a serious look of concern and tears)

Dr: They will be in to see you before you join us in the operating room (exits room without another word)

In lines 1-3, the surgeon presents news that can be considered problematic or serious, and in the patient’s response (lines 4) the patient questions on behalf of his concern for his family and is reluctant to respond to the bad news delivered by the surgeon. Earlier in this encounter the patient was concerned about who would take care
of his family if anything were to happen to him during the surgery. This example is similar to Heath's (1987) findings that even in cases where the diagnosis of a patient’s complaint is relatively serious or problematic, patients remain reluctant to respond to the information presented by the physician, and in this case responds to other concerns.

(2:2)

Dr: (first name), today we are going to take a vein out of your left interior/distal leg and use it to bypass the two clots you are currently facing (procedure run through with little eye contact)

Pt: Okay (out breath and long pause) (patient is looking at me)

Dr: There are some precautions we have to take though (pause). We are going to hook you up to a bypass machine and three-fourths of the blood circulating through your body will be circulating through a machine (pause) this is to keep your blood at body temperature (eye contact has shifted back to clip-board)

Pt: Well, (pause) that’s reassuring (frown with wrinkle in forehead)

Dr: Well, (first name), (long pause) currently the conditions include a blocked pulmonary artery in the supraclavicular branch and a distortion of the artery leading to the left ventricle. There could also be more that the cath lab didn’t show, so I will send the nurses back to get you and we will get started (no eye contact during this dialogue, writing on clip-board, and walking toward the door)

In this example the patient does pause significantly before responding and inserts a verbal hesitation (“well”) into his response. This hesitation may show uncertainty, or that the patient is waiting for more information from the surgeon. The indirect eye contact with the surgeon in line 4 is an indicator that the surgeon’s news is less than optimal. In line 9, when the patient says, “that’s reassuring” (followed by a frown) may indicate sarcasm or disagreement.

Reception of mixed news in pre-diagnosis. There is some optimism, which is similar to reception of good news. A few of these cases entail the generic response of “that’s fine,” which implicates that maybe they understand. Some of the patients were choked up when receiving this news which is an emotional reaction. Some of the
nonverbal signs in these cases were as follows: lengthy pauses, wrinkled forehead with raised eyebrows (when in question), minimal eye contact with the surgeon, twiddling of the thumbs (a possible sign of anxiety), tears, and other general cues. In these cases, patients may receive and interpret a diagnosis differently than a physician delivers it. The following examples provide an illustration of this.

(4:5)

1 Dr: Well, (pause) (first name), lets get this done with, so the pain will go away
2 (fidgeting with his gloves and beeper)
3 Pt: Great (rise in intonation, encouraging assessment)
4 Dr: X-rays show that the bones have not encountered fusion back together yet, so
5 later on the screw may have to be replaced, and you will definitely have to return
to your walking cast (pause, still no direct eye contact with patient)
6 Pt: If I have to leave the screw in how much longer will it take?
7 Dr: To heal?
8 Pt: Yeah (waiting response with little eye contact between either)
9 Dr: Well, with the current swelling conditions I would not recommend leaving it
10 in (looks to assistant)
11 Pt: Okay, (sigh) you’re the doc and you know best

These cases are considered mixed cases because of the multiple combinations of good and bad news reception. For instance, in line 3, the patient responds to the delivery with a positive assessment and a rise in pitch – showing enthusiasm for the “good” news. However, in line 7, the patient’s tone quickly changes and they begin to discuss recovery. In line 9, there are more nonverbal behavior signs that the diagnosis may be less than hoped for because the patient pauses and the eye contact is indirect. It is apparent that having to leave the screw in is not the number one choice of the patient’s treatment options, and the pause with indirect eye contact may exemplify this. Then we move onto line 12, the patient reaffirms the surgeon’s knowledge, and seems to be more accepting
of the news. So, one cannot say whether the news was good or bad because the patient responded with a combination of verbal and nonverbal behaviors from each category.

(4:4)

1 Dr: From what I can tell from the x-rays a week ago (first name), you have torn part of your ACL, not enough to replace it, but also not due fully to bowling, your frame has been off set by your weight (long pause, little eye contact, preoccupied with clip-board)

2 Pt: My weight? (with an extreme look of question, wrinkle forehead, squinted eyes, and frown)

3 Dr: You are quite a bit heavier than the National scale suggests, but not to worry—I will provide a strict diet for you to follow—after your surgery.

4 Pt: What does this entail? (tension in her tone and expression)

5 Dr: Well, (pause) an hour of scraping, a day of bed rest, and a Healthy New Year’s resolution ought to cover it. . .(cracks a smile, intended humor)

6 Pt: Okay, (sigh) I guess I am ready (twiddling her thumbs and making direct eye contact with the observer--me)

In this example, there is more questioning as to how the patient received the news. First, the patient repairs the statement by the physician by asking for more information (line 5). Her nonverbal behaviors exemplify bad news (lines 5-6). A frown is usually a sign of dismay or disgust, and the questioning expression of the wrinkled forehead may also indicate dismay, confusion, or uncertainty. She continues to question the procedures by asking “what does this entail?” in a less than friendly manner. This does not necessarily indicate problematic news, but maybe that the patient has come to an agreement that the diet after surgery will be necessary. Usually in good news, we find patients in agreement with the physician’s recommendations. However, by hesitating to say, “Okay, I guess I am ready;” I should not think that the patient is really ready, and her nonverbal behaviors still illustrate her anxiety and tension in the situation. Once again, there is mixed reception in this case.
Dr: Mr. (last name), (long pause) today I am going to bypass the clot in your heart with a vein from your leg (pause) you won't remember anything after the anesthetics hit you (longer pause) do you have any questions?

Pt: Yeah (wrinkled eyes, frown) what are the chances of me not making it?

(look pause)

Dr: Well, (pause) I don't rate chances, but a single bypass is fairly simple surgery—in my book—if all goes well (smile, rise in intonation)

Pt: (looks to wife) See honey, there is nothing to worry about (looks back to Dr.)

Dr: (interrupts patient) I did not say there was nothing to worry about (looks to patient with direct eye contact)

Pt: You can play along with me doc, because I am going to be okay (looks back to wife and clenches her hand)

Dr: I am sure you will (pause), but I will not promise that (as Dr. turns back and exits room)

In lines 4-5, one might think the news was bad due to the patient's initial response. Facial expressions of squinting the eyes and frowning usually exemplify bad news. The patient questions his chance at life. The surgeon does not want to fulfill the patient's expectations with false hope, so she clarifies her position in lines 6-7. In such a situation one might consider the news to be less than optimal, but in lines 8-9, the patient seems to reassure his wife that there is nothing to worry about. The patient is also making direct eye contact with his wife and the surgeon, suggesting that the news is acceptable. In lines 12-13, the patient shows mixed reception through his verbal and nonverbal behavior. The patient is confident that the outcome will be okay, but his nonverbal behavior is showing a little uncertainty. By clenching his wife's hand the patient is releasing his wife's built up tension from being nervous about the current
situation. These actions seem to illustrate strength, optimism, and other characteristics within the patient.

**Post-Diagnosis Delivery**

*Delivery of good news in post-diagnosis.* In these cases, there was quite a bit of affirmation on the surgeon’s behalf—telling the patient that everything was going to be all right. The surgeons also made some personal assessments (“As far as I can tell”) almost as if the patient were going to be okay because of her/his diagnosis. A few of the cases contained topic shifts; after the surgeon initiated the good news, they followed it with “but.” The “but” was a reinforcement that the patient would have to take an active role in their current situation. When delivering good news, the level of the surgeon’s competence in their abilities was high, and medical jargon seemed to flow quite freely. The nonverbal behaviors that accompanied the good news were direct eye contact and shorter pauses, which we might expect. These nonverbal behaviors are similar to those found in the pre-diagnostic delivery. Likewise, the immediate delivery seemed to be a similarity between the pre- and post-diagnostic delivery. The following serve as examples.

(4:5)

1 Dr: Well, you want an honest answer about how long you will be back in the cast?
2 Pt: Yes, of course (sigh, no eye contact with surgeon)
3 Dr: As far as I can tell, it’ll be anywhere from three to six months
4 Pt: Really?!!! (rise in intonation, she grabs her sheet)
5 Dr: I’m not done (almost interrupts her, rise in intonation)
6 Pt: Sorry (pause, eyes fill up with tears, drop in intonation, drops eyes towards her feet)
Dr: And the screw will not have to be replaced if you follow all procedures with
the cast (gives patient a direct stare, and drops clip-board to his side)

Pt: That's great (rise in pitch, she reaches for my hand)

Initial talk precedes the good news - similar to cases of bad news delivery. The
initial talk in this case is a preliminary forecasting of the news to follow. The surgeon
initiates the diagnosis with a verbal utterance ("well") and no form of address. The
surgeon holds off the actual post-diagnosis until line 4. The direct eye contact during
this medical encounter may also be an encouraging nonverbal of good news diagnosis.
To be able to make eye contact allows for direct interaction, and illustrates that the
surgeon has nothing to hide from the patient. The surgeon relies on personal assessment,
such as, "As far as I can tell".

(7:8)

Dr: Well, Mr. (last name), you were right, all went well in surgery, and for now
you are going to be okay (long pause, and eye contact is directed toward the
window)

Pt: What do you mean by "for now"? (wrinkled forehead, frown, intonation is
stern)

Dr: Well, there is a lot you will have to change in your routine if you don't want
to return in the future (direct stare, until patient made eye contact as well)

Pt: Lay it on me doc (pause, with a smile and a little chuckle)

Dr: The bypass was easy and all went well, but you need to cut cholesterol/salt
from your diet, and start exercising—like walking on a regular basis

In this instance of good news, the surgeon is mitigating the diagnosis by saying in
line 1, "all went well in surgery." The down play of a diagnosis is often used during the
delivery of good news. In the surgeon's first turn at talk s/he addresses the surgery, and
in the second turn s/he engage the patient in small talk. It is not until the surgeon's third
turn (lines 9-10) that an actual diagnosis is given. After the pre-diagnosis, there are not any tests to rely on, and the surgeon must rely on the findings of the surgery. This leaves room for the findings to match up or not match up with the previous test results. The surgeon initiates the conversation with indirect eye contact, but terminates the interaction with direct eye contact – emphasizing the good news could turn bad if the patient is not compliant with future treatment options.

**Delivery of bad news in post-diagnosis.** In the cases of bad news delivery, during post-diagnosis, there were many similarities to those of the pre-diagnosis phase. There was a lot of verbal hesitation, introduced by “Well,...” and pausing. The introductions were usually on a formal, rather than first name, basis. Formal address usually increases the interpersonal communication distance, and lends for distant relationships in the patient-surgeon interaction. The bad news was often concealed with good news first, and then a “but” to bring the patient back to reality. Maynard found in his (1989) study that when a physician diagnoses bad news, s/he uses a good news/bad news sequence. The clinician first presents the positive aspects of the patient’s condition, and then moves into the more negative aspects of the individual’s condition.

When delivering the bad news, the surgeons did a lot of apologizing; almost as if the diagnosis was their fault. “Apologizing, as a prelude to delivering bad news, seems to work as a forecast” (Maynard, 1996, p. 115). Some bad news in these cases was introduced with medical jargon, so the patient would have to ask further questions to get to the bottom of the actual diagnosis. A second method of forecasting that Maynard (1996) identified was prefacing, which is a vocal strategy to partially inform the patient of forthcoming news and then move into the news announcement.
Some of the nonverbal cues that one will notice throughout these cases are similar to ones we have seen in most of the other cases of bad news delivery. There is a lot of eye rolling, and not a lot of direct eye contact between the two participants. In one case, the surgeon shed tears while explaining to the family that he had lost the patient in surgery. The following illustrations serve as examples.

(2.2)

1 Dr: Well, (pause) Mr. (last name), the surgery went well—like expected—but, there are a few more things we need to address (lengthy pause, no eye contact)

2 Pt: (wrinkled forehead, squinted eyes, eyebrows raised) (pause) like what? (intonation of authority)

3 Dr: Well we did have to do a bypass yesterday, but you also have 75% blockage in those arteries, so who is to say how long it will be before you are in again for another (long pause) your diet is going to have to undergo some drastic changes (eye contact is indirect from clip-board to window)

4 Pt: Such as (in a tone that would suggest his food is important)

5 Dr: No more salts, cut back on cholesterol (pause) I will give you a structured (emphasis on the word) diet

Line 1 contains the initial attempt at diagnosing and a positive description as to the outcome ("the surgery went well"), but line 2 contains a forecasting of the news to follow. The surgeon waits to formulate this actual diagnosis until line 5 when he says, "but you also have 75% blockage in those arteries." Thus, similar to Maynard's findings (1989), there is a good news/bad news sequence to the way the diagnosis is delivered. In Maynard's (1991) study, he also found that when a physician (surgeon in this case) is bearing bad news they do not claim independent knowledge, and they leave room for the patient to infer the actual diagnostic information. The patient is inquiring in lines 3-4 and 9 because the surgeon has left room for the patient to infer. The nonverbal behaviors
of this example are very congruent with bad news delivery: verbal hesitation, pausing, and indirect eye contact.

(1:1)

1 Dr: Well, (pause) Mrs. (last name), I need to start by apologizing for the cath lab not showing any abnormalities (looks to clip-board with lengthy pause and no eye contact)
2 Pt: Yeah (awaits more information from the surgeon)
3 Dr: Well, (longer pause) there is a little more than we expected to be wrong (still no diagnosis with no eye contact and more hesitance)
4 Pt: Well, what was it?! (intonation of impatience and discerned look on her face)
5 Dr: Well, um, huh, your visceral sac has been punctured which was putting pressure on the pericardium (structure surrounding the heart) and your right lung has collapsed (sigh of relief after the surgeon delivered this diagnosis, and direct eye contact with clip-board and portable computer)

In line 1, the surgeon foreshadows the bad news to follow with an apology, “I need to start by apologizing for...” “Apologizing, as a prelude to delivering bad news, seems to work as a forecast” (Maynard, 1996, p. 115). In addition, in lines 1-2, the surgeon does not claim independent knowledge such as “I have found,” but integrates the findings, or lack there of in this case, with the cath lab. In lines 5-6, the surgeon has yet to provide the patient with a diagnosis; still leaving room for the patient to infer further diagnostic information – supporting Maynard’s (1991) findings. Moreover, there is a lot of pausing and verbal hesitation, which are nonverbal indications of bad news. Take for instance line 9, where there are three verbal hesitations and pauses in a row, “well, um, huh”. Another nonverbal indication in this situation is the indirect eye contact throughout the presentation. In this example, there is another factor that is taking away from the personal interaction – the surgeon’s eye contact with the lap top computer.
Delivery of tentative news in post-diagnosis. In these medical cases, there was a cross in similarities between good news and bad news. There was the topic shift, which was quite common in bad news delivery—where the good is introduced and then there is a sudden “but.” The topic shifts in these cases are different because they don’t indicate that the patient needs to take responsibility, but they indicate that the news is tentative.

In addition, there were some instances of informal address, which might suggest a better relationship, or good news. The surgeons did not use as much medical jargon as they did in bad news, but instead there were uses of generic terminology, such as “quite a bit.” Some of the nonverbal behaviors were also shared between good and bad news. There were instances of little eye contact to absolutely no eye contact. The surgeons were also found conducting parallel task activities, using pauses, and neutral language (language that does not carry a positive or negative connotation with it) in presenting a tentative diagnosis. Let the following serve as an example.

(8:9)

1  Dr: She is going to be alright for now, but she needs greater medical attention
2    than my staff can provide (a smile, followed by a solemn look which is mirroring
3    the expression on the face of the parents)

4  Mother: (hysterical and sobbing tears) My baby!!! (she screams, and eye contact
5    is made with the father)

6  Father: Thanks for your efforts Dr. (last name), (long pause) come on honey, we
7    have to go home and pack (grabs wife’s hand and exits without another glance)

This diagnosis is tentative because other specialists may be consulted. Thus, the surgeon avoids naming the patients’ condition on declaring certainty of tentative diagnosis. In this case the surgeon mitigates the diagnosis by saying, “She is going to be alright for now” which is an indicator of good news. However, the surgeon also does a good news/bad news sequence, which is similar to Maynard’s (1989) findings of
delivering bad news. In line 1, the surgeon uses neutral language when saying “she is going to be alright... she needs greater medical attention.” The surgeon could have said, “the child’s conditions are less than optimal, and she needs emergency medical assistance beyond our capabilities immediately.” The nonverbal behavior in this case is also indicative of good news and bad news. The smile indicates that the surgeon is pleased with their diagnosis, but the immediate change to a solemn face suggests maybe that they are not so sure. Therefore, this diagnosis is tentative. This example is an exception to the limitations because this was one of the only examples that displayed tentative news in the post-diagnostic delivery.

Post-Diagnosis Reception

Reception of good news in post-diagnosis. In the cases of patient’s receiving good news, there seems to be more acceptance of the diagnosis, and positive reactions to the surgeons’ information. The patients offer positive assessments to the surgeons’ diagnosis, and eye contact is more prevalent in these cases. The responses are also more immediate. Some of the nonverbal behaviors include tears and smiles. Patients are, overall, much more receptive. Receptions to good news in surgical cases resemble preferred actions (Heritage, 1989). The following examples serve as illustrations.

(4:5)

1 Dr: Well, you want an honest answer about how long you will be back in the cast?

2

3 Pt: Yes, of course (sigh, no eye contact with surgeon)

4 Dr: As far as I can tell, it’ll be anywhere from three to six months

5 Pt: Really?!?! (rise in intonation, she grabs her sheet)

6 Dr: I’m not done (almost interrupts her, rise in intonation)
Pt: Sorry, (pause, eyes fill up with tears, decrease in intonation, drops eyes
toward her feet)

Dr: and the screw will not have to be replaced if you follow all procedures with
the cast (gives patient a direct stare, and drops clip-board to his side)

Pt: That's great (rise in pitch, she reaches for my hand!)

Dr: The nurses will finish taking care of you today, and I would like to do a
follow up in the near future, okay? (no eye contact with patient, back to patient)

Pt: um, hmm (nods head in understanding and smiles)

In this case, we must remember that reception is defined according to the
patients' perception of and response to the diagnostic news, and does not include the
physician's perspective of the diagnosis. In this case, the patient has three opportunities
to question the surgeon (lines 3, 5, and 8), but she does not do so. Even if the patient
was given the chance to respond, s/he usually remained silent (Heath, 1992). The patient
responds with a positive assessment by saying, "that's great." The nonverbal behaviors
are also affirmative in this example: rise intonation, smile, and a nod of understanding.

(7:8)

Dr: Well, Mr. (last name), you were right all went well in surgery, and for now
you are going to be okay (long pause, and eye contact is directed toward the
window)

Pt: What do you mean by "for now"? (wrinkled forehead, frown, intonation is
stern)

Dr: Well, there is a lot you will have to change in your routine if you don't want
to return in the future (direct stare, until patient made eye contact as well)

Pt: Lay it on me doc (pause, with a smile and a little chuckle)

Dr: The bypass was easy and all went well, but you need to cut cholesterol/salt
from your diet, and start exercising—like walking on a regular basis

Pt: Sounds great! When can I go? (enthusiasm in the voice, eager to leave)
Dr: If conditions stay stabilized you will be out of here in a couple of days

Pt: Thanks doc! (with a huge smile, and direct eye contact)

This example is in contradiction to Heath’s (1992) findings that even if patients are given a chance to respond after a diagnosis, s/he usually remains silent. In line 4, the patient asks a follow-up question, “what do you mean by “for now”? In line 8, the patients’ informality of, “lay it on me doc,” may suggest that they are worried about the diagnosis being bad. The nonverbal behaviors also indicate that the patient is expecting to receive good news – a smile and chuckle. Line 11 advocates another positive assessment of the surgeon’s diagnosis. The gratitude expressed in line 14, “thanks doc,” and informality of the term “doc” suggests that the patient is pleased and comfortable with the current condition/diagnosis.

Reception of bad news in post-diagnosis. In situations where a patient perceives news as bad news, his/her reaction contains specific characteristics, which are constructed as ‘dispreferred’ actions (Heritage, 1989). In the reception of bad news there is a lot of waiting and pausing. The eye contact between the patient and surgeon is minimal, and the decrease in intonation emphasizes dismay and uncertainty in some instances. One might expect a few tears to be shed when bad news has been delivered, and there are many questions of concern— which is in contradiction to previous findings (Heath, 1992) of displaying acceptance of the diagnosis. In addition, the formality of address in these cases closes the interpersonal communication and tends to dictate the possibilities of future relationships. Consider the following instances as illustrations.
Dr: Well, (pause) Mrs. (last name), I need to start by apologizing for the cath lab not showing any abnormalities (looks to clip-board with lengthy pause and no eye contact)

Pt: Yeah (awaits more information from the surgeon)

Dr: Well, (longer pause) there is a little more than we expected to be wrong (no eye contact and more hesitance)

Pt: Well, what was it?! (intonation of impatience and discerned look on her face)

Dr: Well, um, (pause) huh, your visceral sac has been punctured which was putting pressure on the pericardium (structure surrounding the heart) and your right lung has collapsed (sigh of relief after the surgeon delivered this diagnosis, direct eye contact with clipboard and portable computer)

Pt: (gasping) What? How? Why? (lengthy pause) Now what? (a little dismayed in intonation and eyes are starting to tear up)

Dr: It is possible to function without it, but you are going to have to remain on the oxygen for quite some time (looks to clipboard)

Pt: Do I have to carry around one of those little tanks then? (no eye contact)

Dr: Yes, for some time you will have to cart around your oxygen supply. . .

Pt: Why me?! Why me?! (she starts to cry and turns to window)

In the patients first turn at talk (line 4), she initiates a conversation continuer “yeah” as in “go on” because the surgeon has yet to provide her with a diagnosis – this may be a foreshadowing of the bad news she is about to receive. In contradiction again to Heath’s (1992) findings, the patient questions the partial – diagnosis she has been given in line 7 by inquiring, “Well, what was it?!”. Lines 13-14 exemplify that upon receiving bad news, patients often pause significantly before verbally responding and/or insert pauses into their initial verbal response. The questions in these lines (What? How? Why? Now what?) are more in the form of disbelief than they are to question the actual diagnosis. The question in line 17 is for clarification of treatment procedures, and in line
19 the patient returns to disbelief. She does not understand how the outcome could be so. The nonverbal behaviors in this patient's situation are also indicators that the news she has received is less that optimal.

(3:3)

1 Dr: Well, (pause) Mr. (last name), your heart has taken a lick’n and keeps on tick’n, but the news is not so good (sighs and pauses, direct eye contact with the patient, but the patient is looking at all of the tubes)

2 Pt: Well (longer pause) I’m 80 years old—I can handle it (a stern look on his face)

3 Dr: Well, um, huh, we had to bypass the clot in your pulmonary artery, and you had an aneurysm in your aorta, which could have lead to another stroke (little eye contact between either, intonation is solemn along with expression)

4 Pt: Man, I am just going to shits, (sigh) huh? (his eyes get a little watery)

5 Dr: You are going to be fairly weak for quite some time, so I would like you to get a home nurse to take care of you and keep an eye on you (concerned intonation with direct eye contact)

6 Pt: (gets a little snappy) I have lived by myself for 20 years, and I am not about to get a (looks back to Dr.) okay, I will do it (look of sympathy and sadness)

7 Dr: (smiles at patient) Thanks, I promise he/she will be in your best interest

8 Pt: I would prefer a female (little child-like grin on face) they are better company

In line 4, the indication that the news will be bad is very present. Upon receiving the bad news, the patient pauses significantly within his verbal response. This is similar to Maynard’s (1997) findings. The vulgarity (“shits”) in line 9 may suggest that the patient is aware of his condition by equating it with a less than positive word. Moreover, the nonverbal behaviors of bad news seem to be activated when the patient’s eyes get a little watery. In instances involving bad news delivery, a patient sometimes accepts the diagnosis and does not challenge the physician’s presentation. However, in lines 13-14,
the patient is directly and verbally against the surgeon's recommendations of a "home nurse." In line 16, the patient displays acceptance of the diagnosis by stating his preference of a "female" nurse. The bad news was buried by the patient's sarcasm.

**Reception of mixed news in post-diagnosis.** In these cases there are many similarities to the delivery of good news and bad news. There were some positive indicators such as the patient saying "Thanks," gratitude is often seen as a positive aspect of appreciation, and there were some negative indicators as well, such as the amount of verbal hesitation. Some of the nonverbal cues were lengthy pausing, intonation of anger, and indirect eye contact. Let the following serve as an example.

(8:9)

1 Dr: She is going to be alright for now, but she needs greater medical attention than my staff can provide (a smile, followed by a solemn look which is mirroring the expression on the face of the parents)

2 Mother: (hysterical and sobbing tears) My baby!!! (she screams, and eye contact is made with the father)

3 Father: Thanks for your efforts Dr. (last name), (long pause) come on honey, we have to go home and pack (grabs wife's hand and exits without another glance)

This is a perfect case of a good news/bad news combination. It should be noted that the child is still alive. However, after receiving the news that their child will have to see a specialist elsewhere, the mother is hysterical. Her tears and exclamation of "My baby!" illustrate the pain she is enduring. However, the father exhibits characteristics of good new reception by thanking the surgeon for their effort. Maybe the father illustrated such characteristics in order to provide support for the mother.
CHAPTER 5
DISCUSSION

To answer the second research question, "How do diagnostic delivery and reception in surgery compare with clinical findings of diagnostic delivery and reception?", the findings regarding diagnostic delivery and reception in surgery are first summarized. Following this description, similarities and differences are drawn between diagnostic delivery in surgery and diagnostic delivery in other clinical settings. The similarities and differences in delivery will be discussed first, with reception to follow.

Delivery in Surgery

Good news. Upon delivering good news, surgeons relied on both personal diagnosis, such as “I have found...”, and test results, and surgeons usually presented their findings with little or no hesitation. Essentially, presentation of good news delivery is straightforward, with a rise in intonation, and often contains direct eye contact between the individuals. The CT scans and x-rays provided visual diagnostic evidence of the surgeon’s diagnosis. The surgeons used these test results to present concrete evidence of the news being provided.

Bad news. There were certain characteristics that reoccurred to exemplify delivery of bad news in surgery. When delivering news of a bad nature, the presentations were often drawn out, being preceded by additional information. In addition, the surgeons presented the more positive aspects of the patients’ conditions first, therefore delaying the announcing of the bad news. Moreover, the surgeons used lengthy pauses and non-lexical vocalizations such as “um” or “uh.” Surgeons also forecasted the presentation of bad news with the use of preannouncements. These included utterances such as “surgery went well.” Another facet of forecasting was
the body language exemplified by the surgeons, such as indirect eye contact and talking to the clipboard instead of the patient. Body language and verbal preannouncements help to forecast the upcoming bad news, and maybe, help to prepare and warn the patient of the bad news.

After delivering bad news, the surgeons often at times expressed their individual concern and support for the patient. This support included instances such as, “I would like for you to get a home nurse,” and “are there any questions?”, which also show involvement on the surgeons’ behalf.

**Tentative news.** These were situations in which more tests were needed, a specialist needed to be consulted, or the nature of the news could not be deciphered. In such situations, the surgeons relied on x-rays and cath lab results, they conducted parallel task activities, inserted pauses in delivery, and the eye contact seemed to vary between direct and indirect. The presentation of the diagnoses also seemed to fluctuate between immediate and delayed. In these cases, it was also necessary to include the responses of the patients’ in order to see how the news changed throughout the delivery. Fidgeting with the gloves, talking to the lap-top, or filling out the patient’s chart while delivering a tentative diagnosis were common among the parallel activities conducted. Furthermore, the diagnostic presentation included some verbal hesitations as a delay in presenting tentative news.

**Reception in Surgery**

**Good news.** Good news reception involved agreement of the diagnosis, immediate responses to the diagnosis, direct eye contact, expressions of gratitude on the
surgeon’s behalf, and there were few questions to the surgeon’s treatment recommendations.

**Bad news.** In bad news reception, the patients usually received the news as negative or life threatening, which in many cases it was. There were some patterns that began to emerge in these instances, such as: lengthy pauses within the patients’ responses; follow-up questions; tears; assumptions of the worst-case scenario; and little or no eye contact.

**Mixed news.** Mixed news reception involved a combination of characteristics revealed in good news with characteristics revealed in bad news. In some cases, the patients’ responses would be to what they perceived as bad news in the beginning of the delivery and good news in the end. There were some lengthy pauses, follow-up questioning, immediate responses, and no challenging of the treatment recommendations. The eye contact varied between direct and indirect, depending on how the patients were perceiving the diagnosis at that current time.

The reception, whether it be good, bad, or mixed lends to many observations. The delivery in clinical settings may shed light upon some of the similarities in the deliveries that lead to the characteristics of observation.

**Comparing Surgery to Clinical Settings**

Below is a comparison on similarities and differences between diagnostic delivery and reception in surgery and other clinical settings. Following, there is a description of the similarities and differences and possible impacts of the differences are also considered.
Similarities in Delivery

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Clinical Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) No delays and or hesitations in good news delivery</td>
<td>1) Immediate delivery with no delays and/or hesitations in good news delivery (Maynard, 1997)</td>
</tr>
<tr>
<td>2) Extended delivery with pauses and nonlexical vocalizations in bad news delivery</td>
<td>2) Gaps, hesitations, and a halting manner in bad news delivery (Maynard, 1997)</td>
</tr>
<tr>
<td>3) Paralleling activities in tentative news</td>
<td>3) Parallel activities in delivering news (Maynard, 1989)</td>
</tr>
<tr>
<td>4) Good news/bad news sequence in delivering bad news</td>
<td>4) Good news/bad news sequence in delivering bad news (Maynard, 1989)</td>
</tr>
<tr>
<td>5) Leaving room for the patient to infer the actual diagnostic information in bad news</td>
<td>5) In bad news, the physicians leave room for the patient to infer the diagnostic information (Maynard, 1991)</td>
</tr>
<tr>
<td>6) Apologetic and supportive in cases of bad news</td>
<td>6) Apologizing as a prelude to delivering bad news (Maynard, 1996)</td>
</tr>
</tbody>
</table>

Similarities in Reception

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Clinical Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Quick implicit response to good news</td>
<td>1) Quick immediate agreement to good news (Maynard, 1997)</td>
</tr>
<tr>
<td>2) Reluctant to respond to the information presented by the surgeon in bad news</td>
<td>2) In serious cases, patients remain reluctant to respond to the information presented by the physician (Heath, 1987)</td>
</tr>
<tr>
<td>3) Receiving bad news involved pauses, halts, and large gaps</td>
<td>3) Receiving bad news involved pauses (Maynard, 1997)</td>
</tr>
</tbody>
</table>

Differences in Delivery

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Clinical Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Surgeons rely on tests in delivering good news, bad news, and tentative news</td>
<td>1) Reliance on tests to present bad news (Pomerantz et al., 1987)</td>
</tr>
<tr>
<td>2) Tentative diagnosis was often a combination of good news and bad news characteristics</td>
<td>2) Physicians (in television) often delivered a tentative diagnosis, which entailed pausing and</td>
</tr>
</tbody>
</table>
(more bad than good)  displaying tentativeness through tentative language, modals, and disclaimers (Nikolaisen, 1998)

3) Timeliness of the diagnosis was often longer and drawn out (preannouncements)  3) The timeliness of the diagnosis in the general practice setting is often shorter (Blum, 1972)

4) There is a two-step diagnosis delivery in surgery; pre- and post-diagnosis  4) In clinical encounters the diagnosis is in the last phase where consideration of the patient’s condition comes into play (Northouse & Northouse, 1992)

Differences in Reception

<table>
<thead>
<tr>
<th>Surgery</th>
<th>Clinical Settings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Mixed responses occurred when the patient was unable to decipher the diagnosis as good or bad</td>
<td>1) No research found to date</td>
</tr>
<tr>
<td>2) There are 3 types of reception revealed: good news, bad news, and mixed news</td>
<td>2) Nikolaisen (1998) found only good and bad news reception in television medical drama</td>
</tr>
</tbody>
</table>

Key Similarities between Surgery and Clinical Settings

Common characteristics were exhibited between delivery and reception in surgery and other medical encounters. The basic communication features found in good news delivery and reception in surgery were similar to Maynard’s (1997) research of good news delivery and reception (patients respond quickly and maintain the same posture as the physician). In addition, bad news delivery and reception in surgery featured characteristics found in Maynard’s (1997) description of bad news delivery and reception in medical encounters (patients respond in a halting, hesitant manner that contains gaps). Furthermore, similar to Maynard’s (1991) findings, the surgeons left room for the patients to infer the actual diagnostic information. Furthermore, surgeons used apologies as preannouncements to foreshadow the bad news to come, which supports with Maynard’s (1996) findings.
Key Differences between Surgery and Clinical Settings

The current study’s analysis revealed that surgeons rely on test results to deliver good news, bad news, and tentative news. This was in contradiction with Pomerantz et al. (1987) in which they discovered that test results were used as concrete evidence to present bad news. The delivery of tentative news was a combination of good news and bad news, and did not display more pauses or the use of tentative language as found by Nikolaisen (1998). Timeliness of the diagnostic delivery in surgery was often longer, and in contrast to Blum’s (1972) findings that the timeliness in general practice setting is often shorter. Northouse and Northouse (1992) claimed that the diagnosis is the last phase in a medical encounter where consideration of the patient’s condition comes into play. In surgery, however, diagnosis is the first and last step in which the patient’s condition comes into play—it is a two-step phase (pre- and post-diagnosis).

Considering the reception of diagnosis, this study revealed that there were three types of reception: good news, bad news, and mixed news. The mixed news contained verbal/nonverbal behaviors, which exemplified both good and bad news. Nikolaisen’s (1998) study only revealed two kinds of reception: good news and bad news.

Implications of Differences

As discussed earlier in Chapter 1, diagnostic delivery and reception is an important aspect of the health care setting. In analyzing the diagnostic phase in surgery, certain differences have emerged between what has been found in clinical settings.

One key difference was that the timeliness of the interaction in surgery was often longer than Blum’s (1972) findings of the general practice settings. The reason surgical
diagnosis is a longer process is because it is a two-step process that one might expect to entail more time. This finding does not suggest that surgery is more important because it occupies more time, but it may indicate the implications of surgery if the diagnosis is not properly delivered and received. The length of this interaction may also be an indicator of the difficulties one will encounter in surgery versus those that one will encounter with a common cold.

A second key difference yielded from this study was that diagnostic delivery and reception during surgery is a two-step process. Unlike the diagnostic phase being the last phase where the consideration of the patient’s condition comes into play (Northouse & Northouse, 1992), the surgeon has to see the patient before and after the surgery. In a general practice setting, one can see the physician, be diagnosed with a cold, and purchase the prescription on her/his way home. However, in surgery, the surgeon must present the pre-diagnosis (usually based on test results), conduct the surgery, and present the findings of the surgery in the post-diagnosis. Since the post-diagnosis can often be different than the pre-diagnosis, differences in reception also emerged.

The key difference in reception was that there were three types revealed versus the two types found in Nikolaisen’s (1998) study, and Maynard’s (1997) study. The good news and bad news reception revealed many of the same characteristics found in previous studies. However, the mixed news reception revealed a combination of good news/bad news characteristics, and was difficult to decipher the patients’ perceptions of the actual diagnosis.

Further examination might reveal why these differences have emerged, and if their possible implications are in the right direction. Physicians, patients, and surgeons alike, need to understand these differences and possible implications to respond
effectively to those expectations they have of one another. Clearly, the study of the
differences and similarities between surgery and other clinical settings has implications
for patients and surgeons alike.
CHAPTER 6

CONCLUSIONS

Summary of Chapters

Chapter 1 introduced the importance of studying diagnostic delivery and reception in the surgical setting. Considering that diagnostic delivery and reception has only been studied in clinical settings, and that surgical diagnosis is a two-step process, rather than a one-step process, examination of diagnostic delivery and reception during surgery was warranted.

In Chapter 2, previous research was reviewed. This research first focused on the diagnostic phase in relation to the entire medical encounter. To understand the interactional nature of the medical encounter, both the patient's and physician's perspective were discussed. Following these descriptions, discussion of the previous findings on physician delivery of diagnoses in clinical settings was presented, followed by the findings on patient reception of diagnoses in clinical encounters.

Chapter 3 described the methods involved in conducting this study. After approximately 200 hours of observation in surgery settings, the interaction of diagnostic delivery and reception was noted and analyzed. From this sample, 11 complete episodes of surgery were used to discover communication patterns in diagnostic delivery and reception during surgery.

In Chapter 4, diagnostic information in surgical settings was analyzed. This information involved surgeon delivery, followed by patient reception. Three types of delivery emerged: good news, bad news, and tentative news. Three contexts for reception
were also discovered: good news reception, bad news reception, and mixed news reception. Analysis revealed similarities and differences to previous research.

Chapter 5 included a discussion of the findings analyzed in Chapter 4. First, a summary is provided of the characteristics of good news delivery, bad news delivery, and tentative news delivery. This summary also highlighted a description of the characteristics found in reception of good news, bad news, and mixed news.

Finally, in Chapter 6, conclusions are drawn regarding this study. These conclusions include a summary of chapters, limitations to the present study, further research proposals, and implications of the present study.

Limitations

In gathering data for this study, the initial size of this study’s sample was significantly small. Some instances had to be eliminated because they did not adhere to the sample specifications. For example, the study focused on one-on-one interaction between one patient and one surgeon (exception of father and mother in one child’s situation). Therefore, instances where other medical personnel or non-medical persons, such as friends and family members were communicating with the surgeon had to be eliminated. Furthermore, encounters involving children were eliminated. Therefore, the sample size was reduced to 9 pairings.

The present study did not address class, gender, or other cultural effects in analyzing diagnostic delivery and reception. In addition, the study only examined surgical encounters in one mid-western state (with a rather homogenous population).
I also found that my presence might have been a limitation to the study as well. As a non-medical person, I believe both the surgeons and patients could have altered their responses in accordance with my presence and their knowing that they were being observed.

Future Research

Future research related to the present study could include a larger sample size with more diagnostic instances. A study with a larger sample size might reveal additional communication patterns featured in diagnostic delivery and reception in surgical medical encounters.

Considering that many examples were eliminated from the present study, such instances could be worth examining in the future. For example, surgical diagnoses pertaining to small children could be featured, or instances involving family members or other medical personnel could also be worthy of study. Moreover, segments involving a team approach by surgeons could provide useful insights into communication patterns.

Future research could also include an intercultural, and/or class, spectrum. To compare and contrast differences in delivery and reception of persons across a wide range of groups could prove to be useful in finding other styles of diagnostic delivery and reception.

Furthermore, research in the surgical arena of the health care setting is just beginning, and there are many fields of surgery out there to be explored. To take each one on an individual level of diagnostic delivery and reception, and combine all of the findings when complete would be a beneficial project to the field of health communication.
Implications

The implications in this study’s findings involve surgeons, patients, and the educational system of health communication as well. Surgeons are predominant medical figures in our society today and are responsible for treating many patients on a daily basis. Studies in this field could perhaps expand their communication skills and enhance their relationships with future patients to come. Likewise, research may also enhance patients’ communication skills in health care situations.

Considering the importance of each field, surgery and clinical practice, it is crucial that the research be compiled to give practitioners and patients a holistic picture of the medical encounter as they will eventually experience it. Positive health care outcomes are dependent upon this mutual understanding of the medical encounter as a whole.

The present study also provides future research possibilities and information for researchers and educators in the field of health communication. It is important for those in the health communication field to educate patients and surgeons to understand how they can work together.
References


