"What's Up Doc?": Diagnostic Delivery And Reception In Television Medical Dramas Versus Real-Life Medical Interviews

Jill Nikolaisen
Carroll College, Helena, MT

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Dr. Charlotte Jones

Prof. Brent Northup

Prof. David Westlake

5/1/98

Date
"WHAT'S UP DOC?: DIAGNOSTIC DELIVERY AND RECEPTION IN
TELEVISION MEDICAL DRAMAS VERSUS REAL-LIFE MEDICAL INTERVIEWS

by

JILL MARIE NIKOLAISEN

Submitted in Partial Fulfillment of
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ABSTRACT

Research reveals that many of our perceptions and expectations are based on or even originate from media, including television. Since we utilize television for news and entertainment, it is important to examine its content. Specifically, this study examines delivery and reception in two television medical dramas - “ER” and “Chicago Hope.” Within delivery, a physician provides news concerning a patient’s health, and reception pertains to a patient’s response to a physician’s diagnosis. From watching these television programs, viewers may develop expectations and personal scripts that effect personal decision-making and perceptions in real-life medical encounters.

However, depending on the television portrayals of physician-patient interaction, these expectations may be based on realistic or unrealistic information. Thus, whether or not patients’ expectations are based on inaccurate or accurate television portrayals could mean the difference between satisfaction, compliance, and overall health improvement and being dissatisfied and distrusting health care providers.

Investigation uncovered limited research on delivery and reception in real-life medical settings as well as information pertaining to media’s potential affects on audiences. However, no previous research on delivery and reception on television was found. I explored characteristics of delivery and reception in television medical dramas and compared these findings to delivery and reception in real-life clinical interviews.

In the present study, both similarities and differences were revealed. Analysis revealed common communication features in good news and bad news diagnostic delivery and reception on television and in real-life. Also, in bad news situations, patients rarely challenged a diagnosis as described by Heath (1992) in real-life medical
encounters. As for differences, no research was revealed describing tentative news delivery in emergency room or hospital settings. However, analysis of the present study revealed that diagnostic delivery was delivered in three contexts: good news, bad news, and tentative news.
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CHAPTER 1: INTRODUCTION AND RATIONALE

In this century, television has become a popular pastime and an important part of American life. With 89 to 94% of the American population watching television per day, the Television Bureau of Advertising (1991) claimed that television reaches more people than any other type of media (as cited in Wood, 1997). Signorielli (1990) claimed, "Television is first and foremost a storyteller – it tells most of the stories to most of the people most of the time – and thus it is the wholesale distributor of images, and it forms the mainstream of our popular culture" (p. 96).

We watch television to obtain news and information, as well as for entertainment purposes. This news and entertainment may influence our decision-making and personal perceptions. "Yet, as we are entertained, our minds do function. The reinforcement of values and principles in long-running shows surely must have an impact" (Alley, 1981, p. 240). Gerbner (1972) claimed, "the recurrent themes of popular television dramas exert a subtle cumulative effect on viewers beliefs and anxieties about the urban environment" (as cited in Janis, 1980, p. 162). However, one serious implication of television viewing involves the idea that television portrayals are often times inaccurate and misleading (Smith, Trivax, Zuehike, Lowinger, & Nghiem, 1972).

One important area regarding accuracy involves television’s portrayal of health. As Johnson and Johnson (1993) noted, health matters are a prominent and important part of television information and entertainment. Through television, we gather information about health, such as breakthrough treatments, new diseases, and ways to eat and exercise. Signorielli (1990) explained, "Recent public health evidence demonstrates the importance of life-style factors, including the media’s influence in both imparting health
information and impacting upon health” (p. 96). Furthermore, Janis (1980) claimed, “The television medium probably exerts enormous influence on health-related decisions of large numbers of viewers” (p. 173). Therefore, because television is a popular communication medium that addresses health issues, it is important to analyze just what television is telling the public about health.

Previous research reveals that some television portrayals of health issues are incorrect and deceptive. For example, in a study by Turow and Coe (1985), in 14 days of television programming, most illnesses presented were curable and “almost none of the television portrayals presented the illness as chronic” (as cited in Signorielli, 1990, p. 98). Treatments for these diseases focused on “biomedical-cures, pharmacological-cures, or technological-related cures” as compared to interpersonal or psychological factors (as cited in Signorielli, 1990, p. 98). In a study by Smith et al. (1972), in 130 hours of commercials, news, and television shows, less than one-third of medically-related information was useful. “In fact, 70 percent of the health material was inaccurate, misleading, or both” (as cited in Signorielli, 1990, p. 97).

One particularly significant aspect of health information involves diagnostic delivery and reception. It is during this climactic phase of the medical encounter that a physician reveals the answers to a patient’s medical concerns. Furthermore, a patient’s response to this diagnostic news is provided.

Specifically, the portrayal of diagnostic communication on television is significant considering media’s effects on viewers. That is, viewers may incorporate the television portrayals into their own thought processes and behaviors concerning medical communication. Janis (1980) argued, “the images conveyed by entertainment programs
and films shown on television can also induce personal scripts in viewers, some of which may unintentionally affect their personal policies that are carried out time and time again for many years, perhaps even for the rest of their lives” (pp. 165-166). Additionally, “the increased availability of images of physical suffering and of successful and unsuccessful medical treatments undoubtedly influences the actions of many people when they become ill, sometimes when it is a matter of life or death” (Janis, 1980, pp. 171-172).

Considering the research discussed above, one might expect a plethora of analysis investigating the portrayal of delivery and reception on television. However, investigation revealed no previous research on diagnostic portrayal on television. Thus, the purpose of this study emerged. How are deliveries and receptions portrayed in television? Are these portrayals accurate compared to real-life medical interaction? To investigate these questions, both physicians’ deliveries and patients’ reactions to the diagnoses are analyzed on television medical dramas. Subsequently, these findings are compared to previous research regarding real-life diagnostic delivery and reception. Thus, the goal of this research project is to compare and contrast diagnostic delivery and reception as portrayed in television medical dramas with real-life clinical interviews.

Considering the possible effects of media on viewers’ perceptions of reality, this research could provide important insight into how physicians as well as patients think and behave during real-life medical situations. For those in both the health communication and mass media fields as well as in the general public, this study could be beneficial in understanding reactions to and expectations of real-life diagnostic delivery and reception. For example, a patient may watch a television program in which a patient’s cancer is
cured and a physician is portrayed as a hero. This experience may be incorporated into a patient’s own personal script when s/he visits a physician for a cancer diagnosis.

Viewers see and hear physicians’ and patients’ conversational styles on television and develop expectations for their own experiences. Johnson and Johnson (1993) explained that in gaining information about health care, media sources may be more accessible to the public than professional sources, such as health care providers. However, depending on the television portrayals of conversational styles, these expectations may be based on inaccurate information. Thus, whether or not patients’ expectations are based on incorrect or correct television portrayals could lead to satisfaction, treatment compliance, and overall health improvement. Or, a patient may become dissatisfied, disappointed, and not trust health care providers.

In the current study, Chapter 2 discusses previous research related to delivery and reception in real-life medical settings. Both the patient’s perspective and the physician’s role are included in this discussion. Chapter 3 describes the method used to conduct this study, including video recording and transcribing instances of diagnostic delivery and reception. An analysis of these instances is described in Chapter 4. Three types of delivery emerged: good news, bad news, and tentative news. Following this, the two types of reception that were revealed – good news reception and bad news reception – are explained. Discussion of the analysis, a summary of the findings, and similarities and differences as compared to real-life medical dramas are provided in Chapter 5. Conclusions of this study are found in the last chapter, Chapter 6. Within this section, a summary of the chapters is provided, as well as an investigation of limitations, further research, and implications.
CHAPTER 2: PREVIOUS RESEARCH

This chapter discusses previous research pertaining to real-life diagnostic delivery and reception including: the diagnostic phase in relation to the entire medical encounter, the patient perspective in this phase, the physician's role, delivery of diagnosis, and finally reception.

The Diagnostic Phase

To examine the diagnostic phase, one must first understand its importance in relation to the medical encounter as a whole. According to Frankel (1995), 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 the clinical encounter is to solve one or more problems addressed during the interview.

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

It is this last phase – the statement of findings, the termination phase, or consideration of the patient’s condition -- 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). Also 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 his/her health - whether it is good, bad, or tentative 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).

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

The 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. Falconer (1980) noted specific psychological states a patient may feel in a medical consultation – depression, powerlessness, dependency, depersonalization, and dehumanization. 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 his/her body would be changed physically in some way; thus, this can lead to a decrease in self-esteem regarding body image (Blum, 1972).

The Physician’s Role

Related to the patient’s reaction to a diagnosis, one must also examine the physician’s role 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). Delivery of such bad news is related to Heritage’s (1991) ‘dispreferred’ action.

In any case, Northouse and Northouse (1992) described the importance of the physician’s honesty and trustworthiness toward the patient. “Effective interpersonal relationships depend on honesty and trustworthiness. This is especially the case in health care relationships where patients and family members rely on health care professional for advice in life-and-death situations” (Northouse & Northouse, 1992, p. 260).

Considering the interactional nature of patient-physician communication, it is important to note that delivery and reception will not always reside in the same contexts. 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. As described by van Servellen (1997), health care providers cannot
provide adequate care without first understanding how the patient views illness and
disease, and the meaning they have given to their disease. According to Stewart, Brown,
Weston, McWhinney, McWilliam, and Freeman (1995), disease is “the theoretical
construct, or abstraction, by which physicians attempt to explain patients’ problems in
terms of abnormalities of structure and/or function of body organs and systems and
includes both physical and mental disorders” (p. 27). Therefore, disease differs from
illness, which focuses on the patient’s perceptions and experiences of bad health. Miller
(1997) warned against physicians categorizing patients according to their illness or
injury, assuming all would respond similarly to a diagnosis. Just as patients are different,
so, too, their reactions to a diagnosis will be different.

As mentioned above, this study investigates diagnostic delivery and reception,
typically the latter portion of a clinical encounter. Attention is now turned to explicating
previous literature concerning delivery and reception of a diagnosis.

**Physician Delivery of Diagnoses**

Very limited research has been devoted to diagnostic delivery and reception,
including little to no research on delivery and reception portrayed in the media and few
investigations of real-life medical encounters. Even these are limited in scope, focusing
on for example only general practice consultation. Some studies have shed light upon the
interactional features of delivering and receiving diagnostic information, and will now be
addressed.

Heath (1992) analyzed a collection of video recordings to investigate real-life
diagnostic delivery in general-practice consultation. This study examined delivery and
reception of diagnostic information, an absence of diagnostic information in a medical encounter, and an asymmetrical relationship that may consequently develop between patient and physician. Heath found that a physician delivered a diagnosis as part of a management of a condition or as a specific turn at talk. In this discussion, Heath claimed that diagnostic delivery is more frequently spoken as a specific turn at talk and is not combined with treatment of a condition. In either situation, a patient or a patient’s family 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 response altogether or produce only the most minimal acknowledgment of the diagnostic information" (Heath, 1992, p. 240).

However, lack of patient participation may also be attributed 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.
Heath (1992) also considered an asymmetrical relationship that could exist between a physician and a patient and the effects it could have on the outcome of the consultation. Heath (1992) said, "It is, however, increasingly recognized by the profession itself that the relative absence of diagnostic and other forms of information provided by physicians to patients is consequential for compliance with treatment programs and undermines the possibility of encouraging prevention in medicine" (p. 236).

Maynard (1989) examined diagnostic delivery and reception in cases involving mental disabilities, which focused on diagnostic information in a clinical setting. Reception and delivery were examined as parents were informed of their child's mental disabilities during an "informing interview." Findings reiterated the difficult nature of delivering bad news. A physician attempted to reach common ground with parents, for example, by complimenting their determination and strength through tough times. In a case of diagnostic disagreement by a patient, a physician attempted to insert positive news regarding a patient's condition.

Furthermore, Maynard (1989) claimed that a physician used a good news/bad news structure to deliver bad news. Specifically, a physician first presented the positive aspects of a patient's condition and then moved into more negative news. In addition, a physician presented a diagnosis as a finding, not as an opinion, and physician's delivery grew difficult when parents responded ambiguously.

A study by Pomerantz, Mastriano, and Halfond (1987) focused on the patterns revealed in student clinicians' diagnostic delivery. The study emphasized the importance of matching a patient's level of understanding when presenting diagnostic news,
something found to be even more difficult for students who do not consider themselves experts at such a task.

In attempting to match a patient’s or a family’s level of understanding, student clinicians relied on test results as means to presenting abnormal findings, but not when presenting normal findings. Furthermore, 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).

Maynard (in press) claimed that physicians and patients behave differently depending 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 the physician’s delivery was bold. Such behavior is similar to Heritage’s (1989) preferred. “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 did not face one another and sat asymmetrical. The delivery 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).
Patient Reception of Diagnoses

Every patient will react differently to his/her diagnosis; however some common patient reactions are noted. Blum (1972) described various patient reactions to bad news, with the most common patient reaction being anger. For example, 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 him/herself from the situation by “misunderstanding, discounting, or minimizing the physician’s reported findings” (Blum, 1972, p. 178).

In reaction to anxious and angry feelings, patients often look for a scapegoat, or someone to blame for a negative diagnosis. The person most often blamed is a physician because a patient feels abandoned or punished by a physician because of a negative news (Blum, 1972). 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.

Regarding patient reception to diagnostic news, 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.

In cases of a tentative diagnosis, patients respond by providing opinions of other sources, perhaps even non-medical persons. Heath (1992) found that patients do not
explicitly disagree with the news, but instead accept any discrepancies between his/her non-professional opinion and a physician's assessment. In such a case, a patient encourages reassessment, but does not demand one. To compensate for feelings of asymmetry between themselves and a physician, a patient would provide accounts of his/her illness, particularly why professional help was sought. Just as physicians may react differently to different types of news, patients may also exemplify different reactions. 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, 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.

In summary, media impacts the health field and health communication. 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 perspective were examined. As indicated, no information on diagnostic delivery and reception as portrayed on television was revealed. However, rationale reveals the impact that media could have on the health field and health communication. Thus, my research questions emerged:

RQ 1: How are diagnostic delivery and reception portrayed in television medical dramas?

RQ 2: How do diagnostic deliveries and receptions on television compare to diagnostic delivery and reception in real-life medical interviews?
CHAPTER 3: METHODS

To compare diagnostic delivery in television medical dramas to real-life clinical interviews, the use of conversational analysis is warranted. Conversational analysis looks at natural, everyday communication to uncover rules, patterns, or orderings by examining transcripts of audio and/or video recordings. Hopper (1988) argued that the goal of conversational analysis is “to describe participants’ practical on-the-scene practices of interaction” (p. 48).

According to Frey, Botan, Friedman, & Kreps (1991), one who conducts inductive research “first gathers data, then develops theory from them” (p. 11). To conduct this inductive study, 13 weeks or 23 total episodes of two television medical dramas – “ER” and “Chicago Hope” -were video recorded. “Chicago Hope” shows on Wednesday evenings on CBS, and “ER” appears on Thursday evenings on NBC. Both shows have acquired a large weekly audience and continue to grow in popularity.

In viewing these tapes, approximately 30 instances of diagnostic delivery and reception were identified and transcribed according to a style by Jefferson (see Appendix A). An expert transcriber then reviewed a sample of the transcripts for accuracy. Of those 30 instances, only 15 instances were analyzed for this study.¹ After transcription and repeated viewing, analysis uncovered patterns in the communication concerning delivery presentation and reception.

¹ In the 30 instances, certain instances did not involve a one-on-one patient/physician interaction. Some involved other family members or other medical personnel, which did not fit this study’s purpose and are not included in the analysis. Therefore, the remaining 15 instances involve one patient and one physician.
These instances were then used as support for theoretical claims. Finally, the television findings were compared to real-life diagnostic delivery and patient response as described in previous research.
CHAPTER 4: DELIVERY AND RECEPTION OF DIAGNOSIS

As described in the methods section of this paper, the purpose of an inductive study involves forming theories based on accumulated data. Likewise, in analyzing this study’s sample, certain communication patterns emerged. The following analysis explains the structures and patterns found in one-on-one interaction between patients and physicians during diagnostic delivery and reception.

Analysis revealed that three types of delivery emerged: good news, bad news, and tentative news. Then in the subsequent section, patients’ receptions to diagnostic news are considered in two contexts: good news and bad news. In the analysis, the interactions showed that the patient either perceived the diagnostic information as good news or as bad news. The analysis found no instances of tentative reception by patients. In certain cases, how physicians present diagnostic news is not received in the same way by patients. For example, a physician delivers what s/he considers tentative news, yet a patient perceives it as bad news.

**Delivery**

The analysis reveals that good news delivery includes those cases in which a patient’s condition is treatable or no condition exists. Bad news delivery includes chronic conditions or a diagnosis, according to a physician’s perspective, is bad news. Tentative news delivery involves cases in which a diagnosis is not final because more tests must be run or a specialist must be consulted. First, delivery in three contexts is described - good, bad, and tentative.
Good News Delivery

Of the 15 instances in the sample, six involve good news delivery in which a patient’s condition is treatable or no condition exists. The prominent features of good news delivery in television medical dramas include: a medical professionals’ relying on tests, downplaying the diagnosis, presenting initially with little or no verbal/nonverbal hesitations, and adding a jocular phrase.

Relying on tests. In our technological society, medical professionals are encouraged to utilize technology as assessment tools in evaluating patients. Such tools can include x-rays, cat scans, and MRIs. In a study by Pomerantz, Mastriano, and Halfond (1987) health care providers did not use test results in evaluating “normal areas”, but regarded test results as the “best basis for, and justification of, evaluating areas as problem areas” (1987, p. 25).

Interestingly, within four of the six good news instances in this study, physicians rely upon test results as a means to presenting good news. The test results provide grounded proof for the presented diagnosis as well as confirmation that the patient’s condition is treatable. Using test results in television programs might possibly be attributed to enhancing drama for entertainment purposes. Running tests and more tests extends the climatic diagnostic delivery throughout the episode. Moreover, when presenting diagnoses, television physicians may refer to those tests. Physicians may appear to have more medical expertise when discussing a condition in terms of test results and medical jargon.

In the following example, the physician delivers good news to a patient who has been shot in the chest with an arrow.
Example 3-1

D: Okay the u::m the x rays show that arrow missed your lung completely although? I’m not sure how? << we’ll get you prepped and ready I’ll have that [ ((points to arrow protruding from the patient’s chest))]

thing out before you can say William Tell. >>kay?

The physician describes x-ray findings (line 2) to inform the patient that his condition is treatable and “that the arrow had missed his lung completely.” The x-rays provide concrete proof that the patient is going to be okay. Considering the condition treatable, the physician uses an upbeat tone and delivers the diagnosis with little verbal (“the u::m”) and no nonverbal hesitations. She considers this situation good news and perhaps lucky, as indicated in line 3; the physician adds stress to “completely” (line 3) emphasizing the fact that not only did the arrow avoid causing serious damage, but it missed his lung altogether.

Beginning in line 3, the physician informs the patient that she could treat the condition and implies that it would be a quick and easy procedure by saying, “>> we’ll get you prepped and ready I’ll have that thing out before you can say William Tell. >> kay?” (lines 3-8). As she says “that”, the physician points to the arrow.

Example 1-1

D: We got your Gram's stain back Mister La:Fontaine [ ((looking down at medication and places it on the table next to the patient’s bed))]

(1.0) ((physician moves chair, sits down, and looks down at
In example 1-1, the physician initiates the diagnostic phase by mentioning test results (line 1). Once again, one specific test (a Gram’s stain) proves what is specifically wrong with the patient. In saying so, the physician conducts a task activity of organizing the patient’s medication. The physician uses “we” to emphasize that the findings are a team effort, and perhaps that the findings have been confirmed by other medical personnel. Initially, the physician does not reveal the diagnosis because of an interruption by the patient. Finally, in line 9, the physician grants the patient’s name request and explicitly delivers the diagnosis, “Okay Vinney (.) you have gonorrhea (.).” The patient seems familiar with the diagnosis as indicated by the physician’s utterance, “from the looks of your chart you’re familiar with da protocol?” Thus, she delivers the diagnosis in a straightforward, blunt manner.

Example 7-1

1 D: Mister Wilkes (2.2)  
2 [  
3 ((patient moves toward physician and  
4 physician squares up to patient))  
→ 5 everything’s come back ↑ negative

Here, the physician utilizes test results as a means to presenting a good news diagnosis. In this case, the physician does not provide the names of the tests, but only reports that “everything” has come back negative. The physician never explains
"everything" or what "negative" means for the patient. He uses a formal title in referring to the patient followed by a significant pause perhaps to make sure he has the patient’s complete attention. During this pause, the patient moves closer to the physician and the physician squares up to the patient in preparation for further discussion. Emphasis is placed on “back” stressing the finality of the test results. He speaks with a higher pitch when saying “negative”, indicating optimism but also that he has more to discuss.

Overall, tests and their results prove very important in presenting a good news diagnosis. From the data sample, television physicians often rely on tests as a means to presenting good news. In fact, the diagnostic phase was often initiated with a sentence referring to the tests. These tests provide proof for the diagnosis as well as confirmation for a patient that his/her condition is treatable and good news. In exhibiting this method of delivery, a diagnosis is limited to what specific tests found, and physicians did not explain the tests’ purposes, just the tests’ results.

**Downplaying the diagnosis.** In presenting good news in television medical dramas, physicians often contribute phrases or words that downplay the severity or implications of a diagnosis. It must be noted that in situations where a diagnosis is treatable or "good" from a physician’s perspective, it may not be considered "good" from a patient’s perspective. Downplaying the severity of a case can ignore other factors of a condition such as emotional, mental, or long-term effects a patient could experience regardless if a condition is treatable. In presenting news, a physician may not mention the fact that a patient’s condition is treatable or curable. Instead, s/he minimizes a patient’s case using specific words or phrases.

In the following example, the physician informs the patient of an ulcer.
Example 8-3

21 D: Mister Lacowski? ((raises eyebrows)) you have a duodenal ulcer with complicating pancreatitis rather mild pancreatitis judging
25 [((nods in direction of chart on table placed behind him))]
→ 26 from the lab figures? that’s all you have.

Here, the physician relies on tests results in explicitly presenting the diagnosis (lines 23-26). The physician describes the condition as an ulcer with mild pancreatitis as a complication, found by examining lab figures. In addition, he nods in the direction of the chart where the lab figures are recorded to emphasize the reliance on tests. This detailed presentation comes only after the patient assumes a worst-case scenario of his condition and becomes upset. To calm the patient, the physician uses very specific details and emphasizes key words such as “mild” beginning on line 21.

Following the test results, the physician downplays the patient’s condition. To calm the patient and reassure him that his condition is treatable and not cancer, he uses the phrase “that’s all you have” (line 26). In adding such a phrase, the physician mitigates the other implications this condition may have for the patient. These minimizing phrases clearly represent the physician’s perspective, but possibly do not represent what the patient may be feeling or thinking after the news. Basically, the physician tells the patient how to feel about the diagnosis.

Example 8-1

3 D: Well you know what? ( . )
4 [((holds up ankle x-ray and looks at it))}
In Example 8-1, once again the physician refers to test results in presenting the diagnosis. The physician uses “all you got” (line 6) to begin the diagnostic delivery, referring to the ankle fracture shown in the x-rays. This minimizing phrase represents the physician’s perspective of the condition, indicating that the physician does not consider the condition a serious implication. In addition, by saying “everything else is fine” (lines 6-7), the physician refers to only the physical effects of a diagnosis. If the physical impairment is treatable, for example an ankle fracture, then everything else is fine from the physician’s perspective. Unfortunately, the patient may think otherwise.

Presenting initially with little/no hesitations. Another characteristic of delivering good news in television medical dramas includes initial presentation with little or no hesitations. In other words, the presentations do not include a preamble or small talk. Thus, deliveries are not drawn out within the interview. In a study by Maynard (1997), when delivering good news real-life physicians offered the news with initial presentation, an upbeat tone, and few hesitations. In comparison, when delivering bad news, physicians drew out the diagnosis and used more nonverbal and verbal hesitations. In the following good news deliveries, physicians in medical dramas follow this pattern.

This first example involves a male patient who has contracted, and has a history of, sexually transmitted diseases, specifically gonorrhea.

Example 1-1

1  D: We got your Gra:m's stain back Mister La:Fontaine
((looking down at medication and places it on the table next to the patient’s bed))

((physician moves chair, sits down, and looks down at patient’s chart; simultaneously the patient sits up in bed with his legs hanging over the edge of the bed, and faces physician))

P: Please for you? Vinney

D: Okay Vinney (. ) you have gonorrhea (. ) from the looks of your chart you’re familiar with da protocol?

In line 9 of this first example, the physician delivers the treatable diagnosis and uses a first name basis after the patient’s request. She employs an upbeat tone beginning with a high pitched “okay” (line 9), and uses only two micro nonverbal pauses and uses no verbal hesitations or fillers. The physician mentions test results as proof for the diagnosis. From the physician’s delivery the news is good, implying that the patient’s condition, gonorrhea, is treatable and not serious.

Example 3-1

→ 2 D: Okay the u::m the x rays show that arrow missed your lung although? I’m not sure ho:w? << we’ll get you prepped and ready I’ll have that [((points to arrow protruding from the patient’s chest))]

8 thing out before you can say William Tell. >>kay?

In example 3-1, the patient has been shot with an arrow in the chest. As indicated through the x-rays, the patient’s lung is saved because the arrow missed it completely. The physician is surprised (“Although? I’m not sure ho:w?”), yet optimistic of the x-ray findings and presents the good news in a quick, upbeat tone. She avoids using any
hesitations or pauses; in fact, the patient does not have a chance to respond in this brief segment.

**Adding a jocular phrase.** Within three of the six good news delivery segments, the physician presents a jocular phrase in conjunction with the diagnosis. These phrases can communicate a physician’s confidence and may be an attempt to reassure a patient that, according to a physician, a situation is optimistic and treatable. The examples to follow also contain a phrase by a physician that downplays a diagnosis. Thus, as is the case in downplaying the diagnosis, optimistic phrases represent a physician’s perspective and may not consider a patient’s perspective of a diagnosis.

In the following example, a physician addresses a young male patient who has been shot in the chest with an arrow.

**Example 3-1**

```
2  D: Okay the x rays show that arrow missed your lung
3    although? I’m not sure how? we’ll get you
→ 4  prepped and ready I’ll have that
5      [ ((points to arrow protruding from the
6    patient’s chest))
→ 8  thing out before you can say William Tell. kay?
```

Immediately after presenting the diagnosis, the physician moves right into treatment of the condition with “we’ll get you prepped and ready I’ll have that thing out before you can say William Tell.” Notice the physician’s use of the jocular phrase “I’ll have that thing out before you can say William Tell” in referring to the arrow protruding from the
patient's chest. Thus, she offers the diagnosis, moves into her opinion of the situation, and ends with a jocular phrase.

The phrase has a light, informal tone and is quickly given in this good news delivery. Perhaps the physician uses this phrase to ease the patient's fears or anxieties. Following the phrase, the physician uses “kay” to perhaps elicit the patient’s opinion; however, this response is not shown in this television segment. Instead, the physician immediately moves on to discussing treatment with a nurse.

Example 8-1

3 D: Well you know what? ( . )
4 (holds up ankle x-ray and looks at it)
5 all you got ( . ) is a fracture to your ankle ( . ) ° everything else is fine.

Here in line 3, the physician uses the “Well you know what?” phrase to reassure the patient that the diagnosis is optimistic. The phrase ends in an upward tone with emphasis placed on “what”, indicating a jocular yet optimistic, teasing tone. As described by Schegloff (1980), in everyday conversation, participants often used “pre’s” which “prefigures further talk” (p. 144). The phrase used in line 3 (“Well you know what?”) is a preliminary indication that the physician is going to reveal news, whether good or bad.

Within delivering good news, physicians in television medical dramas often rely on tests, mitigate a diagnosis, present quickly with little/no hesitations, and add jocular phrases. These characteristics all describe delivery by a physician, but may also affect a patient’s response to diagnostic news. As discussed in the analysis, deliveries often focus
on a physician’s perspective of a patient’s condition, and may not consider a patient’s perspective on his/her own condition. In these presentations, delivery involves a physicians’ perspectives (“voice of medicine”), not a patients’ perspectives (“voice of the lifeworld”) (Mishler 1984). Specifically, the voice of medicine focuses on “the body”, whereas the voice of the lifeworld regards “the person” (Cassell, 1985).

Bad News Delivery

The analysis reveals that 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. These difficult situations often involve life-threatening situations and require a delicate approach. Heritage (1989) described actions such as delivering bad news as a ‘dispreferred action.’ Maynard (1991) provided four reasons for the difficult nature of delivering bad news. During medical school training, real-life physicians rarely learn skills of delivering bad news. In addition, in our society real-life physicians often focus on curing as compared to prevention and are expected to cure patients. So, when delivering news of chronic or terminal conditions, physicians may feel unworthy and helpless. Furthermore, physicians may benefit from realizing that patients may react differently to different diagnostic news especially in bad news situations. In delivering news, physicians may take into consideration any emotional reactions, which also make delivery more difficult. In certain cases, physicians as well as patients may have emotional reactions to a diagnosis.

In analyzing bad news delivery for this study, the results indicated that deliveries are structured like ‘dispreferred action’ as described by Heritage (1989). Heritage (1989)
claimed that 'dispreferred actions' include delays, prefaces, qualifiers, and accounts for the responses. The prominent features of bad news delivery in television medical dramas include: extended presentation, pauses, and non-lexical vocalizations; prefaces; and support after delivery.

Presenting with extensions, pauses, and non-lexical vocalizations. While delivering bad news in television medical dramas, physicians insert small talk or other conversation which extend the diagnostic presentation. In addition to extending the diagnosis, physicians also use pauses and non-lexical vocalizations such as "um" and "uh" within their deliveries. Similarly when delivering bad news, Maynard (1997) claimed that real-life physicians presented in a halting manner with large gaps and drew out the delivery.

In the following instance, the physician presents a very dismal and embarrassing diagnosis to a male patient who was drugged and raped.

Example 1-2

→ 1  D: The drug is called rohypnol? (1.0) it’s also commonly called ruphees hhh or the date rape drug. (3.8) it’s very strong? can’t taste it? can’t smell it? And h it can knock you out unconscious in minutes
   2
   3  P: What’s that got to do with me
→ 7  D: Somebody must have slipped the rohypnol into your drink: at the bar (. ) it would account for your blacking out? as for as the abdominal pain you were experiencing u:h ((looks away))
   8
   9  D: •hhhhh when physician Wilkes was operating << he: found (. ) an object (. ) inserted o up: (. ) inside you >> o a bottle (. ) now in addition to the trauma caused by the bottle (. ) •hh we found evidence of: semen. ((bites lower lip and looks away)) (2.0)
→ 13  D: Steve << yo:u wer::e ↑ra:ped? >>
   14
   15  [ ((looks at patient and slightly nods head up and down))
   16
   17
The physician begins by explaining a date rape drug and its characteristics. Within his explanation, the physician uses two very significant pauses in lines 1 and 2 (1 second and 3.8 seconds respectively). In this explanation, he uses “you” (line 3) to perhaps subtly indicate that the physician is referring to the patient. However, even after the four second pause that follows the explanation, the patient acts confused and questions how the explanation pertains to him.

Beginning on line 7, once again the physician explains the patient’s condition in terms of the date rape drug, here using more “you’s” to more obviously apply these conditions to the patient. This explanation consists of brief pauses (lines 8, 10, 11, 12, 13) and in-breaths (lines 10 and 12). At one point (line 9) the physician actually looks away from the patient, possibly indicating his difficulty in delivering the upcoming bad or embarrassing news. In addition, the physician often lowers and softens his voice (line 11) and slows his rate of speech (line 10-11).

After this lengthy, drawn-out explanation which Maynard (1996) described as stalling, the physician finally brings all of this information together into a diagnostic statement (“Steve you were raped”), but not before a significant two-second pause. “Stalling implies that there is bad news to tell, but those who are ‘in the know’ and are potential deliverers avoid the telling” (Maynard, 1996, p. 119). Within the diagnostic statement, the physician uses the patient’s first name and offers the phrase “you were raped” in a slow voice with a raise in pitch on raped. This change in pitch emphasizes the physician’s certainty about the upsetting, yet true, news. After saying “semen” in line 13, the physician is approaching the difficult news. He bites his lower lip and looks away
from the patient within a two second pause. Still looking down when beginning the
diagnostic statement, the physician finally looks at the patient on the word “raped” and
slightly nods his head up and down as if to add confirmation, no matter how unbelievable
and difficult the bad news is to hear.

Example 4-1

16 P: So:: what’s ↑ up ((sits up on examination table)
17  (1.2)
→ 18 D: ((squares up with patient)) >> ↑ Uh hhh well uh: << remember
19    [(moves to square up with
20 patient as she talks))
21 when you came in last week with cystitis.
22 P: Yeah you gave me some pills.: ( . ) I took em ((looks down and
23 slightly nods head up and down)) I’m ↑ fine
24 D: Good
25    [(looks down as she talks))
26 uh: but we also talked about you and Alex being sexually active.
27 P: Look
28    [(looks down))
29 we << alwa:ys use something, >> we’re careful
30    [(shrugs shoulders, looks down))
31 okay:? 
32 D: Right
33    [(looks down and moves closer to patient)) (0.4)
→ 39 but you uh: also uh agreed to let me:: ( . ) run a few tests just in
case (2.6) ((looks up at patient)) Ivy I’m I’m::: afraid you tested
40    [(looks down))
41 positive ((looks at patient))
42 P: I’m pregnant?
43 D: No ( . )
44    [(looks down))
45 you’re HIV positive
In this bad news delivery, the patient has tested positive for the HIV virus; however, as indicated later in this segment the patient does not understand this condition. Prior to line 16, the physician had asked the patient’s boyfriend to leave the room so the physician and patient could discuss something one-on-one. This request foreshadows the bad news that will soon be delivered. Beginning on line 16, the patient uses an optimistic tone as seen in the rise in pitch on “up”, possibly indicating that she is not expecting bad news. As she says “what’s up” she quickly sits on top of the examination table.

The physician pauses and then squares up shoulder to shoulder with the patient so they are very close. The physician then begins her utterance with numerous verbal hesitations or fillers, including “uh” and “well”, with audible exhaling exemplifying nervousness or difficulty in delivering the forthcoming news. After these hesitations, she continues to extend the delivery. She moves towards the climax, the diagnostic delivery, but sets up the diagnosis by reminiscing. In response to the patient’s “fine” in line 23, the physician supplies an encouraging assessment plus adds another full turn at talk (Jones, 1997). After this encouraging assessment (“Good”), the physician returns to her movement towards delivery and continues her turn. “In other words, the speaker exhibits a brief display of social support en route to quickly getting ‘back to business’” (Jones, 1997, p. 129).

Beginning on line 27, the physician explains that because the patient is sexually active, more tests had been run to rule out any other problems. Within this turn at talk, the physician pauses and looks down right before giving the patient her diagnosis. Within this explanation, two significant pauses (line 40 and 45) delay the delivery. The physician uses the patient’s first name (Ivy) and fumbles through a very vague diagnosis,
which the patient then questions because she does not understand the terminology. The physician eliminates the possibility of a pregnancy and moves right into a straightforward diagnosis with “No ( . ) you’re HIV positive.”

Forecasting of forthcoming news. Analysis reveals that physicians in television medical dramas often preface news as a means to presenting bad news, which includes verbal and/or nonverbal indications of the news to follow. As described by Maynard (1996) forecasting or foreshadowing is “an advance indication of something to come” (p. 109). One 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.

In Example 7-2, the physician uses what Maynard (1996) described as both verbal and nonverbal forecasting. Nonverbal forecasting included the deliverers' nonverbal behavior including a sad or serious face, or even a neutral “stonewalling” face. “…it can be said that the bearers of bad news ‘give off’ impressions (Goffman, 1959) that may unintentionally provide indications of what is to come” (Maynard, 1996, p. 114).

In the following examples of television medical dramas, often the physician prefaces the news as means to easing into the diagnosis, specifically a bad news diagnosis. The physician reveals that the patient has a brain tumor in example 7-2.

Example 7-2

1. D: How’s your headache
2. P: You tell me
3. (3.0)
→ 4. D: hhhh There’s no easy way to say this ( . ) there’s a tumor in your brain
5. [ ]
6. ((shakes head side to side))
7. stem.
Prior to the physician even having to speak, the patient may know the physician has news to deliver. On line 1, the physician begins with what Maynard (1993) identified as the perspective display series with “How’s your headache.” The physician attempts to determine the patient’s perspective on her condition, perhaps as means to easing into the forthcoming bad news. The physician sought out the patient in the hospital lounge to give her news, what the patient can decipher as “a news giver identity information” (Maynard, 1996). “That is, the arrival of a particular type of person in a specific setting can forecast what news they are bringing” (Maynard, 1996, p.114). Before beginning the delivery, the physician pauses for three seconds; then, she uses another non-vocal form of forecasting, shaking her head side to side as if to say no or apologizing. The combination of nonverbally shaking her head side to side coupled with her audible exhaling prefaces bad news. According to Maynard (1996), “When anticipating news, it seems that recipients are anxious and intent observes of the setting” (p. 113); thus the patient is very keen and aware of his/her surroundings and probably has a good indication from the physician’s behavior of the bad news to come. In addition, the physician verbally explains that the news she was about to give is not easy to give, which is followed by a brief pause before the actual diagnosis is given.

Example 4-1

16 P: So:: what’s ↑up ((sits up on examination table)
17 (1.2)
18 D: ((squares up with patient)) >> ↑ Uh hhh well uh: << remember
19 [ ((moves to square up with patient as she talks))
20


when you came in last week with cystitis.

P: Yeah you gave me some pills: ( . ) I took em ((looks down and slightly nods head up and down)) I’m ↑ fine

D: Good

((looks down as she talks))

uh: but we also talked about you and Alex being sexually active.

P: Look

((looks down))

we <= always use something, >> we’re careful

((shrugs shoulders, looks down))

okay?:

D: Right

((looks down and moves closer to patient)) (0.4)

but you uh: also uh agreed to let me:. ( . ) run a few tests just in case (2.6) ((looks up at patient)) Ivy I’m I’m:: afraid you tested

((looks down))

positive ((looks at patient))

P: I’m pregnant?

D: No ( . )

((looks down))

you’re HIV positive

In the example above, the physician also prefaces the bad news delivery. In line 40, immediately before delivering the diagnosis, the physician’s use of “I’m afraid” indicates that she considers this news as negative and is almost apologetic in delivering it. “Apologizing, as a prelude to delivering bad news, seems to work as a forecast” (Maynard, 1996, p. 115). In providing this news, the physician uses the patient’s first name and slightly stutters in delivering the information.
Exemplifying support after delivery. After delivering bad news, television physicians often show support for patients. This support includes physicians stating support explicitly using affirming nods, attentive posture, and active listening.

The analysis of good news delivery revealed that television medical professionals sometimes downplay diagnoses based on the physician’s perspective, present quickly with micro hesitations, and add jocular phrases. In their good news delivery, the health care providers proceed with treatment regiments immediately following the news delivery and often did not hear the patient’s perspective on the diagnosis. In contrast to minimal support in good news delivery, exemplifying support is characteristic of bad news delivery in medical dramas. Presumably in good news delivery, the news is considered “good” and is easier to accept, so not as much support is needed as compared to situations involving bad news. According to Blum (1972), using the patient-centered approach, the physician should stand in the patient’s shoes and consider how s/he would feel if they had just received the news, whether it was good or bad news. Support after delivery of bad news can be seen in the following examples.

Examining segment 1-2, the physician delivers the bad, embarrassing news in line 14 and then remains silent. This silence allows the patient to respond and to take his time in doing so. The patient breaths deeply for a long time (7.4 seconds) and then responds.

Example 1-2

14   D: Steve << yo:u wer::e ↑ra:ped? >>
15   [  
16   ((looks at patient and slightly nods head up and down))  
17   (0.8)
18   P: ((deep breathing)) (4.2)
With the physician remaining silent, the patient takes his time in responding to the news delivery as indicated in the pauses in line 22. He then discloses his embarrassment of the situation, after which the physician remains silent for two seconds. The physician allows the patient time to take in the news and respond in a way he feels appropriate. Then, beginning in line 27, the physician explains the treatment procedure for date rape. In doing so, he continues to show his support and says, “state law is we have to file a report but I can be there with you if you’d like?” As his physician, he displays caring and lets the patient know he will be there for him.

Another example of empathy after delivering bad news can be found in example 7-2.

Example 7-2

25 P: I had a::: (.) long conversation with Aaron Shutt earlier
26 (0.8)
27 D: You did
28 P: This disease (1.5) its like a wa:r (2.2) ((nods head side to side))
29 I’ve been fighting a ↑ long time (2.0) ((looks away from physician)) I’m tired. ((looks away)) (1.0) and I think- (1.0) maybe
30 (1.0) it’s time I stop fighting
After receiving her diagnosis of a brain tumor, the patient explains that she has talked with another physician, Dr. Shutt. The physician signals that she is listening with an inquisitive response found in line 27. This indicates that she wants further information and is interested in what the patient says. Beginning on line 28, the patient provides her perspective on the situation and another physician, Dr. Shutt.

Leaning into the physician, the patient slowly provides her opinion on the situation, which includes various long pauses within her turn at talk. The patient explains the meaning she has assigned to the disease, “this disease (1.5) its like a wa:r (2.2) ((nods head side to side)) I’ve been fighting a ↑ long time (2.0) ((looks away from physician)) I’m tired. ((looks away)) (1.0) and I think- (1.0) maybe (1.0) its time I stop fighting”.

Throughout all of this, the physician remains quiet, leans toward the patient, and does not try to change the patient’s mind about how to handle her condition. Instead, she maintains good eye contact and remains physically close to the patient. She is attentive to what the patient describes and shows respect for the patient’s decision; the physician remains silent and nods her head indicating that she understands the patient’s explanation and decision. Even if she did disagree, she does not show it.

In delivery bad news, television physicians display extended presentations, pauses, and non-lexical vocalizations, prefaces of forthcoming news, and support after delivery. The drawn-out presentations, pauses, hesitations, and prefaces set up the bad news that follows. These characteristics exemplify the physician’s difficult task of delivering disruptive, often embarrassing news to the patient. Support after the diagnosis describes the physicians’ efforts to ease patients after receiving such news.
Tentative News Delivery

In certain instances, diagnoses remain uncertain and are delivered as such. The diagnosis is tentative either because more tests are needed or because a specialist must be consulted. Thus, physicians avoid naming patients' conditions or declaring certainty of tentative diagnoses. Similarly with good and bad news delivery, the patient may receive a tentative diagnosis differently than was delivered by the physician. However, reactions to tentative news will be discussed in the delivery reception section later in this paper. As found in the present study in cases of tentative news delivery, analysis revealed physicians relying on test, conducting parallel activities while delivering, and using pauses, modals and neutral language in presenting a potential diagnosis.

Relying on tests. As was discussed in the good news context, television physicians also rely on test results as a means to delivering a tentative diagnosis. When the physicians in the present study rely on test results in delivering a tentative diagnosis, the cases all involve potentially life-threatening situations such as cancer or thoracic aneurysms. Pomerantz et al. (1987) found, often in delivering disrupting or unpleasant news, real-life health care providers over-relied upon tests to ease the hardships of delivering difficult news about abnormal areas.

Example 5-1

1 D: ((back to patient and removing gloves from physical examination during entire turn at talk))
2 → 3 Uh: Breť you have a mass on your left testicle? (. ) the: (. ) chest x rays show spots on your lungs which is why you've been short of breath.
While removing her examination gloves with her back to the patient in example 5-1, the physician presents the facts discovered through a physical examination and x-rays. During the tentative diagnosis, she refers to the x-rays as proof of what she found, which provides an explanation for his symptoms. In addition, by mentioning the x-rays, she informs the patient that the condition is not contained in his testicles and implies that the situation is possibly more serious than just a single mass.

In instance 8-2, the physician informs the patient of a density in his lung.

Example 8-2

→ 3 D: We have your ↑ x rays Mister Parker
4 [ ((puts x-rays on lighted board, faces x-rays not patient))
5 x-rays not patient)) (4.0)
6 •hhh you can see there’s a density in the right middle lobe ↑ there

In presenting the findings, the physician refers to test results (line 3). In fact, while looking at the test results and referring to them, the patient faces the lighted board and describes the test findings as a means to delivering the news. This case involves dismal yet tentative news, which later in the segment, the patient assumes is cancer. The physician later reveals that she, too, believes the density is cancer, even though she does not immediately indicate so. In fact, only after the patient pursues the physician’s opinion does she provide her diagnostic opinion. Still, in initially presenting the tentative news, the physician refers to what the x-rays found, not what she found.

Conducting parallel task activities. Just as in delivering good news, television physicians in the present study also conduct task activities when delivering tentative news. The activity takes away from the full attention of the verbal diagnosis being
presented. Thus, physicians’ “participation status” towards the patient may be low (Goffman, 1981; Goodwin & Goodwin, in press; Heath, 1986).

Within this study, parallel activities include: removing examination gloves, walking, and looking at and writing in the patient’s chart. All three of the following situations involve a condition that is potentially dangerous, however the diagnosis has not been confirmed. Physicians perhaps conducts additional activities to remind patients that a situation and findings are only tentative. Conducting parallel activities creates a distraction so neither a patient nor physician dwell on any negative possibilities. Perhaps physicians are experiencing emotional difficulties in these instances and find it easier to deliver diagnoses while conducting other activities. Or, perhaps they conduct these activities and are not aware of their behavioral reactions.

In segment 5-1, the physician explains to the patient what was found through specific tests, a mass on his testicle and spots in his lungs.

Example 5-1

→ 1 D: ((back to patient and removing gloves from physical examination during entire turn at talk))
  2 Uh: Bret you have a ma:ss on your left testicle? (. ) the: ( . ) chest
  3 x rays show spots on your lungs which is why you’ve been short of breath.

Here, the physician has her back to the patient and removes her gloves while delivering the tentative diagnosis beginning in line 2. Regardless of the tentative nature of the diagnosis, the physician is talking and revealing important information with her back to the patient while removing her gloves. Later in the segment when the patient began
asking questions, the physician moves physically closer to the patient and does not 
conduct any additional activities when listening to or answering the patient’s questions.

Example 6-3

18 P: I guess:: we’ll have to postpone this surgery
19 D: † That’s what I came to talk to you about. (0.4) •hhhh
14 [ (looking down at chart))
16 † something’s come up and uh:: hhhh
17 [ → 18 ((looks at patient and walks toward patient in bed))
19 well (. ) I may not do the surgery after all.

Similarly, in example 6-3, the physician looks down at the patient’s chart when beginning 
the diagnostic delivery, even though it is a tentative diagnosis (line 18).

Example 8-2

11 P: There’s something in my lung
12 D: Yes that’s right
13 (2.0)
14 P: What is it ((looking at x-ray))
15 D: † Well it could be any number of things it could be an infiltrate? A
16 dense area of tissue from an old infection? •hhh it could be an
17 inhaled foreign body it could be a granuloma of some sort it
18 could be a lot of things
→ 19 ((physician walks away from patient and begins writing in chart;
20 patient is still standing and looking at the x-ray)) (4.2)
21 P: ((still looking at the x-ray)) Well what do you think it is ((turns to
22 physician
→ 23 D: ((back to patient, writing in patient’s chart)) hh There’s no way to
24 know you’ll have to undergo a bronchoscopy and possibly (0.4)
25 surgery before we know for sure.
In the preceding example, the physician presents the diagnosis, and then in line 9 the patient attempts to clarify the meaning of the news ("There’s something in my lung"). The physician confirms his question, which is followed by a two-second pause. Now that he knows there’s something in his lung, the patient requests specific information regarding that "something" (line 14). In response, the physician provides a tentative explanation and proceeds to walk away from the patient to begin reading the patient’s chart. This presentation seems to confuse the patient as he pauses and then questions what was meant by the news. This confusion can be attributed to the fact that the delivery is quickly given, the terminology is vague, and the physician walks away from him immediately after delivering the news.

Pauses. In the tentative news cases of the present study, television physicians deliver potentially bad news, although not completely confirmed. In such cases where news could be considered life-threatening, delivery contains pauses similar to those pauses found in bad news delivery. As described by Maynard (1997), real-life physicians use different styles when delivering good news and when delivering bad news. Maynard claimed real-life physicians use pauses, halts, and hesitations when delivering bad news. Just delivery may resemble Heritage’s (1989) claim of a ‘dispreferred’ action.

In example 8-2, the physician provides her opinion of the patient’s diagnosis.

Example 8-2

44 D: ((physician is looking down at the patient’s chart)) (4.0)
→ 45 hhhh You’re his:ory of coughing blood ( . ) weight loss (0.6)
46 and this x-ray
47 [ 
48 ((walks toward x-ray and away from patient))
49 ( . ) is suggestive of cancer but the diagnosis has not been
50 confirmed and it may very well be something else
Before beginning her tentative delivery on line 45, the physician pauses for four seconds during which time she looks down at the patient’s chart. Immediately before the delivery, she makes an audible out-breath, which only draws out her delivery. While delivering her opinion, the physician uses micro pauses (lines 45 and 49) and two longer pauses (lines 44 and 45). Her utterances in line 49 and 50 are accompanied by hand gestures. These gestures include both arms with open palms at waist level. She moves her hands up and down when saying “suggestive” and “confirmed.” Otherwise, her arms remain outstretched at approximately waist level.

The physician emphasizes “has not been confirmed” (lines 49 and 50) to remind the patient that she just provided her opinion. Her opinion does not mean an absolute diagnosis of cancer, but only that in her opinion the patient’s symptoms and history are “suggestive of cancer” (line 49). In reminding the patient not to draw any conclusions from her opinion, the physician uses “us” and “we.” She is not jumping to conclusions and neither should he because this assessment is only her opinion. The physician ends her turn at talk with another reminder, “that’s what I think” (line 54).

After a long six-second pause on line 55, the patient asks another question, to which the physician does not immediately respond. The patient asks a serious question pertaining to the length of his life. From this question, it seems the patient does not
believe his symptoms *suggest* cancer, but definitely *indicate* cancer. The physician just said the cancer diagnosis is her opinion and is tentative. Still, the patient considers the news life-threatening and responds with the question “*hhh* How long do I have?” (line 56).

In preparing to answer, the physician pauses for 9.6 seconds before responding and looks at the x-ray, not at the patient. After just explicitly saying the diagnosis is still tentative, the physician answers the question in very certain terms. She gives a specific length of time that the patient has left to live, “Six months <<( . ) to a year.>>”.

Example 6-3

→ 5 D: The angiogram shows about (0.4) hhh a five centimeter ( . ) thoracic aneurysm *hhhhh* with your heart rate ( . ) I think it could be dangerous to keep you on the beta blockers: ( . ) my gut says: we should schedule surgery and repair it? Probably sooner than later

Within this presentation in sample 6-3, the physician exemplifies micro pauses in lines 5, 6, and 7. She also includes a longer pause (0.4 seconds) in line 5. This longer pause in line 5 falls immediately before the physician results from the angiogram. She pauses, includes an audible out-breath and then gives the news (“a five centimeter ( . ) thoracic aneurysm”). Immediately after presenting the diagnostic news, the physician presents the treatment within the same utterance. Beginning on line 6, the physician provides her opinion on the treatment of the aneurysm.

**Displaying tentativeness.** In instances where television physicians are not specialists in a specific area or where more tests are needed, delivering a diagnosis can be
difficult. Their questionable expertise or lack of curing ability may make this delivery more difficult. While presenting a tentative diagnosis, television physicians often display tentativeness, which is manifested in three ways: tentative language, modal auxiliaries, and disclaimers. For example, physicians replace life-threatening terms such as “cancer” and “tumor” with more tentative words such as “mass,” “growth,” or “density.” In displaying tentativeness, physicians may also use modals, such as “may,” “might,” “would,” “could,” and “can.” The analysis also reveals physicians using disclaimers in presenting a tentative diagnosis. Examples of disclaimers include “I think” and “it could be any number of things.” Modals and like terms are less threatening, less negative, and communicate a more uncertain tone. In the following examples, the physicians display tentativeness when presenting unconfirmed diagnosis.

Example 5-1

1  D:  ((back to patient and removing gloves from physical examination during entire turn at talk))
2  
3  →  Uh: Bret you have a mass on your left testicle? (.) the: (.) chest x rays show spots on your lungs which is why you've been short of breath.
4  
5  6  P:  Spots (.) what:
6  
7  
8  ((sits up on examination table))

9  →  D:  The growth on your testicle may have spread to your lungs
10  
11  12 down, sitting lower than patient))

In segment 5-1, the physician includes tentative language and modals in reminding the patient of an unconfirmed diagnosis. Even though the test findings are certain, their meanings and implications are not confirmed. To describe the findings, the physician uses “mass” (line 3) and “spots” (line 4). These words communicate to the
patient that through a physical examination and x-rays, these findings are certain; however, by using tentative language, the physician reminds the patient that the implications and meaning of these findings remains uncertain. At this point, tentatively referring to the finding as a “mass”, and not as a tumor or cancer, is appropriate because the diagnosis of cancer or any other condition is not yet confirmed.

After the patient asks “Spots ( .) what” in line 6, the physician responds with a more detailed explanation. Within this turn at talk beginning on line 9, the physician uses an additional tentative word to describe his condition, “growth.” By using “growth” the physician exemplifies the tentativeness of what this growth is and its seriousness. She also uses a disclaimer “may have spread to your lungs” indicating that she is not completely certain of this spreading. Before beginning her utterance on line 9, the physician walks toward the patient and then sits down close to him when starting to talk. She leans toward the patient with an open posture and sits lower on a stool, which is lower than the patient sitting on top of the examination table. Thus, although the patient must look down at the physician and the physician must look up at the patient, both parties exemplify good eye contact.

Example 6-1

→ 12 D: Kay I think that your jaw is broken ( .) the antibiotics will keep bacteria from getting into your bloodstream at the fracture sight
13  hhh bu:t (0.8)looking at your chart hère (1.4) I guess you know the drill huh. ( .)
In example 6-1, in her presentation, the physician displays tentativeness, specifically disclaimers. In line 12, the physician uses “I think” in referring to the diagnosis of a broken jaw. Even though she uses tentative language, it appears the physician has decided upon a diagnosis because she orders certain medications for treatment and ties this specific instance to past occurrences of bodily and facial injuries in the patient’s history. Also, in line 14, the physician uses “I guess” in referring to the patient’s history with physical injuries. Perhaps, the physician uses this disclaimer to express her concern of the situation, but at the same time not seeming to forward.

Example 8-2

3 D: We have your x rays Mister Parker
4 → [((puts x-rays on lighted board, faces x-rays not patient)) (4.0)
5 •hhh you can see there’s a density in the right middle lobe ↑ there
6 (1.4)
7 8 P: What does that mean?
8 → 9 D: It means there’s something abnormal within the structure of your lung.
9 10 P: There’s something in my lung
11 12 D: Yes that’s right
13 (2.0)
14 15 P: What is it ((looking at x-ray))
15 → 16 D: ↑ Well it could be any number of things it could be an infiltrate? A dense area of tissue from an old infection? •hhh it could be an inhaled foreign body it could be a granuloma of some sort it could be a lot of things
17 18 ((physician walks away from patient and begins writing in chart; patient is still standing and looking at the x-ray)) (4.2)

In Example 8-2 the physician emphasizes a tentative diagnosis throughout her conversation with the patient. In line 6, the physician points to the x-ray to show the patient’s “density in the right middle lobe.” Here, she uses non-threatening language (“density”) and only tells the patient about the findings. After the patient asks a question,
"What does that mean", the physician once again responds tentatively ("It means there's something abnormal within the structure of your lung.") By the physician using these vague, tentative terms, the patient is confused and asks for confirmation by stating, "There's something in my lung." The physician confirms his question; however the patient is not satisfied with the vague terms, pauses, and asks for a more specific answer.

In response however, the physician provides even more vague terminology beginning at line 15, including "dense area", "granuloma", or "an inhaled foreign body." These tentative terms do not clarify the situation further. Instead, these terms, specifically the medical jargon such as "granuloma", possibly further confuse the patient, causing anxiety as well as an assumption of a worst-case scenario. Also, within this turn at talk, the physician communicates by using numerous disclaimers, such as "Well it could be any number of things" and "it could be a lot of things." These disclaimers also contain modals and emphasize the physician's tentative approach to delivery and explanation. With pressure from the patient for a straightforward answer, the physician attempts to communicate uncertainty.

When delivering tentative news, physicians in television medical dramas tend to rely on tests, conduct task activities during delivery, include pauses in their presentations, and display tentativeness by using tentative language, modals, and disclaimers. All of the characteristics are used to emphasize the tentative nature of a diagnosis either because a specialist must be consulted or additional tests must be conducted before determining a final diagnosis.
Reception

As was discussed in the delivery section, the way in which a physician delivers news --good, bad, or tentative-- is not always received in the same way by a patient. For example, a physician may perceive a diagnosis as good news and therefore deliver it structurally as good news; however, a patient may not consider the diagnosis good news.

Therefore, a patient's reception must be examined. This section of the analysis focuses on the patient's perspective. Analysis reveals two types of patient reception: good news reception and bad news reception. This reception refers to the immediate response by the patient, and it appears that in television medical dramas this immediate reception is either good or bad. Moreover, no immediate responses exemplified tentative reception. Good news reception is characterized by quick, implicit agreement of the diagnosis and treatment; whereas, bad news reception involves pausing before and during response, displaying acceptance, assuming a worst-case scenario, and soliciting the physician's opinion of the diagnosis.

Considering an interactional perspective, the ways in which a physician communicates diagnostic news does have implications for how news is received. For example, as discovered by Sontag (1990), a word such as “cancer” could hold various meanings for many individuals. Reaction to similar medically-related words or phrases could cause various reactions depending on the individual and their cognitive perceptions and experiences of such words. Therefore, it is important to understand that reception is defined according to the patient’s perception of and response to the diagnostic news, and does not include the physician’s perspective of the diagnosis.
Good News Reception

Receptions to good news in television medical dramas resemble preferred actions (Heritage, 1989). Upon receiving good news in television medical dramas, several patterns emerged: explicitly agreeing with the diagnosis, immediately responding to the diagnosis, and not challenging treatment recommendations. All three patterns show how a patient receives a diagnosis from a physician.

Rarely in television medical-dramas do patients confront a physician regarding diagnostic presentation. Heath (1992) found that real-life patients very rarely challenged a physician’s diagnostic presentation. Even if the patient was given the chance to respond, s/he usually remained silent (Heath, 1992). In the following instances, patients respond by not challenging the physician’s diagnosis that s/he presents. This type of response includes an immediate response by the patient, as well as acceptance of the physicians’ recommendations for treatment. These three patterns can all be observed in the following example. In example (1-1), the patient receives the diagnosis in line 9, that he has contracted gonorrhea.

Example 1-1

9 D: Okay Vinney (.) you have gonorrhea (.) from the looks of your chart you’re familiar with da protocol?
10
→
11 P: >> Oc cu pa tional hazard << (.) price for being a player (1.0) you see?
12
13 D: No ((looking at patient))
14 P: That’s a damn shame cause ah:: I been in de ((moves her chair away from the patient)) hhh entertainment industry for numerous years and h with a face like yours? (0.4) pt >> you could sell a lotta platters <<
In this example, the patient responds quickly and immediately as no gap exists between the physician’s delivery in lines 9 and 10 and the patient’s response beginning on line 11. Within his response, the patient provides an excuse for his condition, “>> Occupational hazard << ( . ) price for being a player (1.0) you see?” He emphasizes “occupational” hazard in a slow, choppy voice, and explicitly accepts the diagnosis without challenging it. The patient finishes his explanation and then questions the physician’s understanding of his response with “you see?” Throughout the remaining conversation between this patient and physician, the patient continues to use small talk about his profession, but accepts the antibiotics given as treatment and never questions the physician’s diagnosis.

Example 4-2

15 D: If the tenidis continues
16 P: 
17 D: ((continuing ear examination)) The ri:ng in your ears ( . ) uh: you may have to go see a specialist just to get your hearing checked.
18 P: Kay?
19 P: Uh huh
20 (0.6)
21 P: Tha:nsks

In example 4-2, the physician uses medical jargon to explain the patient’s condition. On line 17, the patient uses a repeat in requesting clarification of (“Tenidis”). After the physician provides an explanation using common terms instead of medical jargon, the patient minimally agrees (“Uh huh”) to the physician’s diagnosis and recommendations for treatment. There are no hesitations and the agreement occurs immediately after the presentation, indicating that she understands the diagnosis. After a brief pause (line 22), the patient thanks the physician and does not ask questions or challenge the diagnosis again in the segment.
Example 8-1

3 D: Well you know what? (. )
4 ((holds up ankle x-ray and looks at it))
5 all you got ( . ) is a fracture to your ankle ( . ) ° everything else is
6 fi:ne.°
7
→ 8 P: No::w wh what’s the story doc ( . ) uh:: do I get workers comp?

In segment 8-1, the physician provides the diagnostic information beginning in line 3.
The physician describes the patient’s condition as an ankle fracture and claims that
“everything else is fi:ne.” The patient responds immediately beginning on line 8. He
does not challenge the diagnosis and continues to ask the physician questions regarding
his ankle fracture, specifically “workers comp.”

Bad News Reception

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 situations where patients receive news as life-threatening or negative, the following
patterns emerged: pausing before or within a response, displaying acceptance of the
diagnosis, assuming a worst-case scenario, and soliciting the physician’s opinion. It
should be noted that when a physician did provide a tentative diagnosis, in two out of the
four instances, a patient receives the tentative news as bad news.

Pausing before or during response. Upon receiving news as bad news, patients
often pause significantly before verbally responding and/or insert pauses into their initial
verbal response. Maynard (1997) claimed that real-life physicians used within turn
pauses, hesitations, and large gaps between turns not attributable to either person in
presenting a bad news diagnosis. Consequently, he found that patients responded in a
similar manner. These characteristics exemplify the problematic and difficult nature of receiving bad news. In the following example, the patient responds slowly to the fact that he was drugged and raped.

Example 1-2

14 D: Steve « you were raped? »
15 [ ((looks at patient and slightly nods head up and down))
16
18 → 18 (0.8)
19 P: ((deep breathing)) (4.2)
20 P: Mm
21 (2.4)
22 P: I kinda thought hh I wasn’t sure? (2.8) •hhh I didn’t say anything
23 [ ((looks at physician))
24
25 because I didn’t want anyone to know

In response to the news delivered in line 14, the patient inhales and exhales deeply and rapidly with no verbal response. The patient remains non-talkative for over seven seconds (line 14) with heavy breathing before verbally responding. During this long pause, the physician does not talk again, but instead allows the patient to take his time in reacting to the disturbing news.

In his utterance (lines 22-25), the patient reports that he suspected that he was raped, but was not sure prior to the physician's confirmation. His utterance, "I didn’t say anything because I didn’t want anyone to know" indicates he had suspicions. This statement seems to display his embarrassment about the fact that he was raped. Within this response, the patient exhales, then pauses for almost three seconds which is followed by a deep inhale. He then continues in a quiet tone.
Example 5-1

1 D: ((back to patient and removing gloves from physical examination during entire turn at talk))
2 →
3 Uh: Brèt you have a mass on your left testicle? ( . ) the: ( . ) chest x rays show spots on your lungs which is why you’ve been short of breath.
4
5 P: Spots ( . ) what
6 [ ((sits up on examination table))
7 8 D: The growth on your testicle may have spread to your lungs [ ((sits down, sitting lower than patient))
9 10 11 12 13 14 15 16

In instance 5-1, the diagnosis is presented in lines 3-5. Prior to responding, the patient pauses for 1.2 seconds. He then asks a clarifying question that contains a micro pause, followed by him sitting on the examination table.

Displaying acceptance. In instances involving bad news delivery, a patient sometimes accepts the diagnosis and does not challenge the physician’s presentation. In the following instances, the patient accepts the diagnosis presented to him/her.

In example 7-2 beginning in line 8, the patient provides an immediate response to the diagnosis of a brain tumor.

Example 7-2

4 D: hhhh There’s no easy way to say this ( . ) there’s a tumor in your
5 [ (nods head side to side))
6 in your brain stem
7 → 8 P: A mangioblastoma hhh (1.6) you collect tumors you become
9 something of an expert.
This particular case involves a woman who has had reoccurring tumors. In her response, she first names the tumor type using medical terminology ("A mangioblastoma") which exemplifies her familiarity with this condition. After naming the tumor, the patient continues by breathing in and out, followed by a 1.6 second pause. In finishing her utterance, the patient mentions her credibility on the subject by describing herself as "something of an expert" on brain tumors. Therefore, the patient accepts the diagnosis and does not challenge the finding.

Example 1-2

14   D:  Steve << you were raped? >>
15       [
16       ((looks at patient and slightly nods head up and down))
17  18          (0.8)
19   P:  ((deep breathing)) (4.2)
20   P:  Mm
21  22          (2.4)
23  →  22   P:  I kinda thought hh I wasn’t sure? (2.8)  • hhh I didn’t say anything
24          [
25  24          ((looks at physician))
26  25          because I didn’t want anyone to know

After the physician’s diagnostic statement, the patient does not challenge the diagnosis. Instead, he significantly pauses and then states that he had suspicions of being raped ("I kinda thought hh I wasn’t sure?"). This statement implicitly exemplifies agreement with the diagnosis and confirms his initial suspicions. Thus, after the physician’s confirmation of his condition and the delivery, the patient displays acceptance of the diagnosis.

Assuming worst-case scenario. Patients may receive and interpret a diagnosis differently than a physician delivers it. For example, when physicians present a tentative
diagnosis, patients may assume the worst regarding his/her condition. Considering the interactional view of communication, patients’ receptions depend on how the diagnoses are delivered by the physicians. For example, a physician may include a preannouncement, a drawn out presentation, tentative language, or vague language when delivering a diagnosis. These communication characteristics may influence a patient to assume bad news, or a worst-case scenario. A patient may assume a problem if s/he does not understand the medical jargon or believes the physician is withholding information based on his delivery style.

In the following segment, the physician begins by presenting a tentative decision to hospitalize the patient ("there’s some question in my mind as to whether that’s necessary but I think it’s better to be safe than sorry"). While doing so, the physician simultaneously conducts other task activities, including walking away from the patient and reading messages during his/her explanation. We can then observe the patient’s worst-case scenario response.

Example 8-3

5 D: Yep okay okay uh Lydia can I borrow your pen
6 [((reading messages))]
7 Mister Lacowski?
8 [((begins walking away from patient, still reading messages))]
9 I’m going to admit you to the hospital and start you on a medical regiment there’s some question in my mind as to whether that’s necessary but I think it’s better to be safe than sorry
→ 14 P: Oh go: (h) (h) (h) d ((crying))

The patient responds to the explanation by crying, which is combined with his exclamation of “oh god” (line 14). This crying continues until the physician reacts to the
patient. From this immediate "response cry" (Goffman, 1983) and crying, one would assume that the patient has assumed the worst of his situation.

In reaction to the patient crying, the physician turns to face the patient and addresses him formally ("Mister Lacowski?"). He moves closer to the patient's bed and precedes to ask the patient twice why he is crying ("what is it what's the matter Mister Lacowski?"). In this utterance, the physician emphasizes his second inquiry into the patient's crying, and once again addresses the patient by a formal title.

Beginning in line 18, the patients declares that he knows the truth ("I know the truth") and explains that the physician does not have to hide it from him. In line 19, the physician uses a repeat ("The truth") as a repair and seems confused by the patient's declaration in line 18. Once again in line 20, the patient provides his perspective on the situation and makes an attribution about the physician withholding the truth to be nice to the patient ("I know you're being ni:ce to me"). Still, the patient explains in lines 20-21 that, whether the diagnosis is good or bad, he wants the truth.

Mister Lacowski? ((raises eyebrows)) you have a duodenal ulcer with complicating pancreatitis rather ↑ mi::ld pancreatitis judging [ (nods in direction of chart on table placed behind him)] from the lab figures? that's all you have.
→  28  P:  Come on you can tell me please
29  D:  You don’t have cancer Mister Lacowski
30  P:  ((crying)) Oh I knew it I knew it its cancer (and you were hiding it)
31  ((turns away from physician))

Even after the physician’s lengthy explicit diagnosis in lines 22-27, the patient still doubts the physician’s truth-telling and almost begs for the truth with “please” (“Come on you can tell me please”). The physician then hypothesizes that the patient assumes cancer, a worst-case scenario, and explicitly disconfirms that as a possibility (“You don’t have cancer Mister Lacowski”). In this utterance, he emphasizes the disconfirming phrase and once again addresses the patient formally.

From that utterance (line 29), the patient seems to only hear the word “cancer” and responds negatively. He immediately begins crying and exclaims that his suspicions of cancer have been confirmed (“Oh I knew it I knew it its cancer”). In line 30, he also accuses the physician of hiding the truth and then nonverbally reacts. That is, in addition to verbally responding, the patient turns away from the physician after his utterance.

Example 5-1

1  D:  ((back to patient and removing gloves from physical examination
during entire turn at talk))
2  Uh:  Brêt you have a ma:ss on your left testicle? (. ) the: ( . ) chest
3  x rays show spots on your lungs which is why you’ve been short of
4  breath.
5  P:  Spots (. ) wha:t
6  [  ((sits up on examination table))
7  ]
8  D:  The growth on your testicle may have spread to your lungs
9  [  ((sits
down, sitting lower than patient))
10  (2.0)
Even though the physician provides a tentative diagnosis using tentative language such as “growth” and modals such as “may have”, the patient assumes the worst of his condition. The physician has only mentioned “growth” and a possible “spread to your lung.” Still, after a two-second pause, the patient expressed his assumption of cancer (“What cancer?”). From the physician’s tentative delivery, it appears that the patient created a worst-case scenario of an unconfirmed diagnosis.

Soliciting the physician’s opinion. In television medical dramas, a patient may not receive a diagnosis or receive a tentative diagnosis and then solicit a physician’s opinion of his/her condition. The following two segments revolve around a tentative news delivery in which the diagnosis is not certain because more tests must be conducted or a specialist must be consulted. Thus, the patient responds by asking for an immediate evaluation of the condition or the physician’s opinion.

Beginning on line 14 of segment 8-2, the patient asks about the x-ray findings.

Example 8-2

14  P:  What is it
15  D:  Well it could be any number of things it could be an infiltrate? A dense area of tissue from an old infection? hhh it could be an inhaled foreign body it could be a granuloma of some sort it could be a lot of things
19  ((physician walks away from patient and begins writing in chart; patient is still standing and looking at the x-ray))

In response to the patient’s question, the physician provides a tentative explanation containing medical jargon (“infiltrate”), modals (“could”), and disclaimers (“it could be a
After a 4.2 second pause, the patient continues to examine the x-rays and then explicitly asks for the physician’s opinion on the findings (“Well what do you think it is”). He wants her opinion, not the test results. To answer the patient’s question, the physician refers to having more tests to gain a certain diagnosis, including a “broncho:spity” and “exploratory surgery” (24-25). In doing so, the physician conducts a task activity, writing in the patient’s chart, with her back to the patient. The patient comments that he understands the uncertainty of the final diagnosis (“I understand”) followed by a pause (0.6), but repeats his request for the physician’s opinion. He wants to know what the physician thinks “in the meantime” (line 26). He ends his request in an abrupt manner and cuts off the ending “t” in “just.”

In the previous example, the patient pursues the physician’s opinion twice; however, in segment 5-1 that follows, the patient proceeds to solicit the physician’s opinion three separate times. The patient “pursues a response” (Beach, 1993; Pomerantz, 1984) from the physician twice.

Example 5-1

25 P: Kay so: ( . ) >> so so what happens now what cha draw up some
D: Right: um: then I’ll send you back to radiology for the cat scan
P: Mm hm

((looking down and writing in notebook))

D: And then I’ll call an oncologist down to see you

((looks at physician)) (0.2) hh hh Kay so how bad’s how bad’s the cancer?

In lines 32 and 33, the patient offers his first request for the physician’s opinion. The physician has not explicitly stated “cancer” as the diagnosis prior to this comment. Still, the patient assumes a worst-case scenario and requests the physician’s opinion about the severity of the cancer (“Kay so how bad’s how bad’s the cancer?”). He begins this utterance with a slight pause and audible inhaling and exhaling.

D: We’re not certain that it is cancer
P: Yeah but you think so so what happens if it is?

Here, the physician responds to the patient’s assumption of cancer and disconfirms a guaranteed diagnosis of cancer. She uses “we’re” implying that she and other medical personal have not decided upon cancer as the diagnosis. Also, with the “we’re”, the physician could be reminding the patient that neither she nor the patient are certain of cancer and is reinforcing the uncertainty. In response, the patient shows understanding that the diagnosis is not certain with “Yeah”, but continues to clarify his soliciting in line 35. He seems to believe the physician assumes cancer and requests her opinion of this assumption (“Yeah but you think so so what happens if it is?”). In this utterance, he places emphasis on “think so”, possibly implying that he realizes the physician has not guaranteed a cancer diagnosis but thinks the condition is cancer.
D: You know what? These are things that you should really [((stands))]

discuss with an oncologist

P: Look I don’t wanna wait for somebody else to tell me if you could
tell me now?

In line 36, the begins by using an opening remark “You know what?”. Unsure of the
diagnosis and seemingly reluctant to draw any conclusion on tentative findings, the
physician stands up and recommends a specialist to answer his concerns. She seems
frustrated by not being able to reassure the patient of a tentative diagnosis. In a forceful
voice beginning on line 40, the patient speaks in a forceful voice and demands an
immediate opinion on his condition. He assumes the physician has something to tell him
and claims “I don’t wanna wait for somebody else to tell me if you could tell me now?”
He requests an immediate opinion but still uses “if” in referring to the fact that the
physician must have something to add.
CHAPTER 5: DISCUSSION

To answer the second research question, “How do diagnostic deliveries and receptions on television compare to diagnostic delivery and reception in real-life medical interviews?”, the findings regarding diagnostic delivery and reception in television medical dramas are first summarized. A brief description of diagnostic delivery and reception in real-life medical encounters is then provided. Following this description, similarities and differences are drawn between television medical dramas and real-life medical interviews. The similarities and differences in delivery are discussed, with reception to follow.

Television Delivery

Good News

Upon delivering good news, television physicians often a) relied on tests, b) downplayed diagnoses and implications, c) presented initially with little or no hesitations, and d) added jocular phrases. Essentially, presentation of good news delivery is straightforward, with an upbeat tone, and often contains a phrase or word that downplays the implications of the diagnosis. The test results provided grounded proof for the diagnostic information and confirmation of a treatable, curable condition. In other words, the physician reiterated the positive aspects of the news and presented concrete evidence of these aspects through test results.

In cases where no condition existed or the condition was treatable, television physicians often downplayed diagnoses. The physicians contributed phrases or words
that decreased the severity or implications of the medical situation, including “that’s all you have” and “all you got.” Specifically, physicians presented the news according to the “medical perspective” and ignored the “patient perspective.” As Cassell (1985) and Mishler (1984) described, the physician presented the “voice of medicine” or the physician perspective as compared to the “voice of the lifeworld” or the patient perspective.

In delivering good news, the diagnosis was presented initially with little or no hesitation. Included in their delivery, the physicians often added jocular phrases. These phrases exemplified the physicians’ confidence and attempts to reassure the patients of optimistic and treatable diagnoses. In these findings, the delivery contained an upbeat tone.

Bad News

Certain characteristics typified the delivery of bad news in television medical dramas. Delivering chronic diagnoses involved the physicians often using drawn-out presentations, pauses, and non-lexical vocalizations, prefaces, and support after delivery. In drawing out the presentation, the physician inserted other talk such as questions or the patient’s history, and therefore not immediately announcing the diagnostic news. Also, the physician may have used pauses within delivery or non-lexical vocalizations such as “uh” or “er”.

Television physicians also exemplified forecasting, for example by prefacing forthcoming news. Another facet of forecasting includes nonverbal forecasting, such as nodding the head from side to side. These forecasting techniques preview the
forthcoming bad news, and, perhaps, help prepare and warn the patient of the bad news. After delivery, television physicians often expressed support. This support included remaining silent and listening to the patient's perspective and meaning of the condition. Nonverbally, the physician remained attentive to the patient while s/he talked by leaning into the patient and maintaining appropriate eye contact.

Tentative News

In situations where more tests were needed or a specialist needed to be consulted, television physicians delivered a tentative diagnosis. In such situations, the physicians relied on tests, conducted task activities during the delivery, inserted pauses in delivery, and displayed tentativeness language. The tests were used to ease the hardships of delivering potentially life-threatening news. Parallel activities conducted while delivering a tentative diagnosis included removing examination gloves, walking, and looking at the patient's chart. Also, the diagnostic presentation included pauses as a delay to presenting the tentative news. In displaying tentativeness, the physician used tentative language, modal auxiliaries, and disclaimers.

Television Reception

Good News

In examining the diagnostic delivery, one must also consider the patient's reception of the news. In the analysis, only good news reception and bad news reception were revealed. No instances of tentative reception existed. Good news reception
involved: implicit agreement of the diagnosis; immediate response to the diagnosis; and no challenge of treatment recommendations.

Bad News

In bad news reception, the patient perceived the news as life-threatening or negative. In these situations, the following patterns emerged: pauses before or within a patient's response; agreement with the diagnosis; assumption of worst-case scenario; and soliciting the physician's opinion.

Real-life Delivery

Heath (1992) examined diagnostic delivery in general-practice consultation. In nearly all medical encounters, he found that neither the patient nor the patient's family challenged the physician's diagnostic presentation. Even when given the chance to respond, patients rarely responded, thus allowing the physician to maintain control of the interaction. The physician can also maintain control through his/her communication style. For example, the physician may combine the diagnosis and treatment, thus eliminating the patient's immediate response to the diagnosis. Also, the physician may use nonverbal action that discourage patient participation, such as an uninterested gaze or posture. Such actions may communicate to the patient that the physician is uninterested in what the patient is saying. The lack of diagnostic information combined with minimal patient participation produced an asymmetrical relationship between physician and patient may occur. Heath also claimed that physicians delivered bad news in a good
news/bad news sequence, where s/he would present positive findings previous to negative findings.

Maynard (1989) claimed that in delivering bad news to parents of a child diagnosed with mental disabilities, the physicians had a difficult time and attempted to reach common ground with the parents and inserted positive news regarding the patient’s condition.

Pomerantz et al. (1987) found that student clinicians relied on test findings to deliver abnormal findings, but not to deliver news of normal areas. Also, the study found the physicians “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” (Pomerantz et al., 1987, p. 22)

Maynard (1997) found that physicians act differently when delivering good news, as compared to bad news. In delivering good news, the physician faced the patient and maintained the same posture as the patient. The delivery was quick and the physician’s delivery was bold. In delivering bad news, the physician and patient did not face one another and sat asymmetrically. The deliver involved gaps, halting, and the diagnostic news was delayed.

Real-life Reception

Heath (1992) found that patients rarely responded explicitly to a diagnosis. If a response did exist, it pertained to the physician’s recommendations for treatment. In cases where the patient disagreed with a diagnosis, the patient only encouraged reassessment, but did not demand it. This encouragement included the patient providing
more detailed accounts of his/her illness. In cases of a tentative diagnosis, the patient responded by providing opinions of other sources, perhaps even non-medical persons.

As was discussed in physician delivery, patients also reacted differently to good news or bad news. In good news reception, patients sat facing the physicians and maintained posture similar to the physicians. Patients responded quickly to the good news. However, when receiving bad news, patients did not face the physician as the two sat asymmetrically to one another. Just as the physician used gaps, and a halting and delaying manner to present bad news, so did the patients in receiving bad news. The patients also tended to be hesitant in their reception.

Comparing Television to Real-life

Similarities and Differences

Below is a comparison of similarities and differences between television medical dramas and real-life medical interviews. A description of key similarities and differences follows this chart; additionally, possible impacts of the differences are considered.

Similarities in Delivery

<table>
<thead>
<tr>
<th>Television</th>
<th>Real-life</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 non-lexical vocalizations in bad news delivery</td>
<td>2. Gaps, hesitations, and a halting manner in bad news delivery (Maynard, 1997)</td>
</tr>
</tbody>
</table>
**Similarities in Reception**

<table>
<thead>
<tr>
<th>Television</th>
<th>Real-life</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Quick, immediate agreement to good news</td>
<td>1. Quick, immediate agreement to good news</td>
</tr>
<tr>
<td></td>
<td>(Maynard, 1997)</td>
</tr>
<tr>
<td>2. Accepting a bad news diagnosis</td>
<td>2. Patient's nor patient's family rarely challenge the diagnosis (Heath, 1992)</td>
</tr>
</tbody>
</table>

**Differences in Delivery**

<table>
<thead>
<tr>
<th>Television</th>
<th>Real-life</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reliance on tests in delivering good and tentative news</td>
<td>1. Reliance on tests to present abnormal areas, not normal areas (Pomerantz, Mastriano, and Halfond, 1987)</td>
</tr>
<tr>
<td>2. Downplayed the diagnosis and added a jocular phrase in presenting good news</td>
<td>2. No real-life research found in good news delivery</td>
</tr>
<tr>
<td>3. Physicians often delivered a tentative diagnosis, which included pauses and displaying tentativeness through tentative language, modals, and disclaimers</td>
<td>3. No real-life research found</td>
</tr>
</tbody>
</table>

**Differences in Reception**

<table>
<thead>
<tr>
<th>Television</th>
<th>Real-life</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assumed a worst-case scenario and even solicited the physician's opinion when receiving a tentative diagnosis</td>
<td>1. No real-life research found. Instead, Heath (1992) claimed that real-life patients only provided opinions of other sources, perhaps even non-medical persons.</td>
</tr>
</tbody>
</table>
Key Similarities

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. When receiving bad news, patients portrayed on television rarely challenged the diagnosis, similar to Heath’s (1992) claim that patients nor their families rarely challenge diagnostic news.

Key Differences

Previous research revealed no discussion of tentative news delivery in hospital or emergency room situations. The study’s analysis revealed characteristics of tentative news delivery including: relying on tests, conducting parallel task activities, inserting pauses, and displaying tentativeness though tentative language, modals, and disclaimers. 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.

In situations involving bad news delivery, this same heroic manner was evident. For example, when delivering news of a brain tumor, the physician showed support and remained attentive as the patient spoke. The physician did not attempt to interrupt the
patient and respected the patient’s wishes to not undergo treatment. This instance was just one example where the physician displayed empathy towards the patient and the bad news s/he just received.

**Implications of Differences.**

As discussed in Chapter 1, previous research showed that information on television may be incorrect. In fact, inaccurate, even deceiving health information may exist on television. In analyzing television medical dramas, certain differences exist between what is portrayed on television and the actual events in real-life medical encounters.

One key difference between television and real-life diagnostic communication involves the use of tentative news delivery in television medical dramas. This finding does not suggest that tentative diagnoses do not take place in real-life medical encounters. Rather, it is more likely attributable to the lack of research in hospital and emergency room settings. Perhaps future research in these two contexts will reveal tentative diagnostic communication in real-life encounters.

Considering the popularity and frequency of viewing television, previous research also claimed that viewers may incorporate into their thinking information gained from television. Such information may affect decision-making and expectations. Realizing health is a prominent feature of television, viewers may gain information that could affect their decision-making and create expectations of real-life medical experiences. Considering the fact that information on television may be inaccurate and/or deceptive, these expectations and decisions could be based on unrealistic health information.
As a second key difference, it was noted in the present study that television physicians often appeared heroic whether presenting good news or bad news. In presenting good news, the physician made light of the situation by downplaying the diagnosis and provided joking phrases. In bad news delivery, the physician was often the hero. In such cases, the physician provided empathy after the delivery – remaining attentive and respectful towards the patient. Considering this, viewers could create expectations for heroic, supportive physicians in their own medical experiences.

However, this idealized portrayal contradicts real-life perceptions of physicians. Previous research revealed that most persons perceive physicians as not supportive (Francis, Korsch, & Morris, 1969; Dunkel-Schetter, 1984; Korsch & Negrete, 1972). This example demonstrates how television and real-life may contradict. When expectations are not met, dissatisfaction, non-compliance, and distrust could result when real-life patients and physicians interact.

As the charts (see page 68) show, significant differences exist between real-life and television – specifically in the delivery and reception of medical information. Research shows that each day, 89 to 94 % of Americans watch population. Research also shows that this saturation can influence perceptions (Alley, 1981; Gerbner, 1972). These media realities set the stage for the clash between perceptions and television medical “reality” and the “reality” of an actual medical encounter.

Further investigation could follow these possibilities to their conclusion by examining specific misconceptions regarding delivery and reception, and examining how these misconceptions might affect the perceptions and/or health of these television
viewers. Conversely, physicians need to understand these misconceptions to better understand patient expectations and to respond effectively to those expectations.

Clearly, the study of the differences and similarities between television and real-life medical interviews has wide implications for patients and physicians alike.
CHAPTER 6: CONCLUSIONS

Summary of Chapters

The following summary provides a description of each of the six chapters of this study. This description will highlight the major purpose or findings in each chapter. The first chapter introduced the popularity of television and its dissemination of both entertainment and information. One serious implication of television involves the idea that television portrayals are often times inaccurate and misleading. Television's portrayal of health is examined citing previous research demonstrating such inaccuracies. More specifically, the important diagnostic phase on television must be examined. However, pre-thesis investigation revealed no information of diagnostic delivery and reception on television. Considering the importance of the diagnostic phase in the medical interview, lack of information pertaining to this subject, and previous studies demonstrating television's inaccuracies, this study emerged. The goal of the research project was to reveal any similarities and/or differences between diagnostic delivery and reception as portrayed in television medical dramas and real-life clinical interviews.

In Chapter 2, previous research was reviewed. This research first focuses on the diagnostic phase in relation to the entire medical interview. To understand the interactional nature of the medical encounter, both the patient’s perspective and the physician’s role are discussed. Following these descriptions, an explanation of physician delivery of diagnoses is presented, followed by patient perspective of diagnoses.

Chapter 3 described the methods involved in conducting this study. After video recording 13 weeks of two television medical dramas – “ER” and “Chicago Hope” – 30
segments were transcribed and reviewed for accuracy. From this sample, 15 segments remained to discover communication patterns in diagnostic delivery and reception in these two medical dramas.

In Chapter 4, diagnostic information in television medical dramas was analyzed. This information involved physician delivery, preceded by patient reception. Three types of delivery were discovered: good news, bad news, and tentative news. Two contexts for reception emerged: good news reception and bad news reception. Analysis revealed no instances of patients tentatively receiving news.

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 included reception and a description highlighting the findings of good and bad news reception.

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 significant. However, after multiple viewings and analysis of the segments, the sample size was decreased by one half. Instances were eliminated that did not adhere to the sample specifications. For example, the study focused on one-on-one interaction between one patient and one physician. Therefore, instances where other medical personnel or other non-medical persons, such as family members, were present had to be
eliminated. Therefore, the sample size was reduced in size; however, my findings may suggest general trends in television medical dramas overall.

In referring to the sample specifications and the fact that instances involving other non-medical personnel were eliminated, diagnoses pertaining to small children or infants could not be analyzed. Specifically, these younger persons are unable to make decisions or talk on their own. Therefore, at least one parent or legal guardian had to be present, thus eliminating this type of pediatric interaction from the sample.

The present study did not address racial, gender, or other cultural effects in analyzing diagnostic delivery and reception. In addition, the study only examined two television medical dramas on United States television. Furthermore, the study only focused on medical dramas on television and did not consider other television contexts featuring physician-patient interaction, such as commercials, comedies, soap operas, or motion picture movies.

**Future Research**

Future research related to the present study could include a larger sample size with more diagnoses instances. Combining the findings from the present study and one with a larger sample size could reveal additional communication patterns and rules featured in diagnostic delivery and reception in television medical interviews.

Considering that segments not involving one patient and one physician were eliminated from the present study, such instances could be worth examining in the future. For example, diagnoses pertaining to small children could be featured, or instances involving family decision-making could be worth of study. Moreover, segments
involving multiple medical persons, or a team approach, could provide useful insights and communication patterns.

Future research could also compare and contrast differences in delivery and reception of persons across a wide spectrum of cultural groups. This type of study could contain a male/female comparison of reception styles and also delivery styles. Furthermore, medical dramas featured in other countries could be worth examining and possibly compared to the findings in medical dramas in the United States. In addition, analyzing all types of television contexts involving health information is a possible research project. Television medical dramas are just the beginning. Other possible contexts could include other forms of television, major movie motion pictures, or plays.

Implications

The implications of this study’s findings involve both the mass media and health communication fields, as well as the general public. Television in our society today is a very popular medium for both informational and entertainment purposes. Previous research on television reveals that its content may not always be accurate and honest. In this study, these findings were reiterated.

Considering the general public, from viewing television medical programs, viewer could create personal scripts and expectations based on what they see in television. Research proves that all that appears on television may not be correct, but rather deceptive and incorrect. Thus, as health consumers, those who view television medical dramas must realize the fictitious nature of television and learn to separate television from reality.
The present study also provides important research possibilities and information for researchers and educators in the health communication field. Patients may base expectations of their real-life medical experiences on television. Physician then may have to interact and deal with patients’ high expectations. Therefore, it is important for those in the health communication field to understand what is being portrayed on television. Such examination could be helpful for compliance and improving health and the patient/physician relationship.

This study reveals important research for producers and writers of medical dramas. Considering the effects of television on viewers’ expectations and personal scripts, these medical dramas could be designed to entertain and disseminate accurate health information simultaneously. On a larger scale, the mass media field could integrate the ideas presented in this study into health and prevention campaigns to reach a mass audience.

Considering the importance of both fields, the mass media and health communication areas could work together to produce more realistic, accurate medical information for television. Such information, while still entertaining, could contribute to distribution of vital information such as ideal physician-patient interaction, introduction to worldwide epidemics, as well as prevention and compliance techniques.
I. **Marking Speaker Turns and Boundaries**

Speaker is identified as on a ply script: justified at the left margin and followed by a colon. Full name (one acronym) is used for the first speaking part and three-letter shortened names are used as identification thereafter. The conversation progresses chronologically beginning at the top of the page.

[ ] Brackets are used to indicate overlapping utterances. Left brackets note the beginning of the overlap, and right brackets close or end the overlap.

= The “equal” sign indicates two contiguous utterances that do not overlap (ordinarily these appear between speakers).

II. **Marking Prosody: Emphasis, Pitch, Volume, etc.**

---

Underlining indicates stress/emphasis.

CAPS Capital letters are used to show extreme loudness, and the first letter of each turn unit.

: A colon indicates the extension or stretching of the sound that it follows.

↑ An upward arrow appears just before a sound that shows a marked rise in pitch, unless that sound is a vowel.

^ A high-pitched vowel is shown by a carat above it.

- A hyphen following a sound indicates a cut-off, a definite stopping of sound, a glottal stop.

? A question mark is used to indicate rising pitch at a word or phrase ending, not necessarily at the end of an utterance, sentence, or complete thought.

. A period indicates sliding or falling pitch at the end of a word or phrase, not necessarily at the end of an utterance, sentence, or complete thought.

, A comma indicates a continuing intonation, a subtle or slight stretching of sound with perhaps a small upward or downward pitch that shows possible completion (used sparingly).

° ° A degree sign preceding and following a word or phrase indicates that I was said more quietly than the surrounding talk.
APPENDIX A
Transcript Symbols

III. Marking Timing/Rhythm

» « "Less than/Greater than" signs bracket talk that is spoken faster than the surrounding talk.

<< >> "Greater than/Less than" signs bracket talk that is spoken slower than the surrounding talk.

(0.4) Single parentheses enclosing numbers indicates a pause in a conversation (used both within and between turns). The numbers express seconds and tenths of seconds. Brief pauses are expressed as ( . ).

( ) Single parentheses enclosing words or blank space are used to indicate doubtful hearings.

IV. Marking Nonverbal

hhh h’s indicate audible out-breaths, sighing, or nonverbal laughter. These sounds are especially clear during telephone conversations.

•hh A superscripted period followed by h’s indicates audible in-breaths.

hah hah Laughter should be transcribed as individual vocal syllables.

Y(h)es Within-speech laughter is shown by ( h ).

pt This symbol indicates an audible lip smack. It can often be heard preceding an in-breath.

* An asterisk indicates a gravelly voice, break, or catch in pronunciation.

u::m Particles like “um” and “uh” should be transcribed as they sound. Frequently, these particles are lengthened in speech.

(( ))) Double sets of parentheses are used for transcriber’s comments, usually descriptions of gestures, body movement, non-speech sound (e.g., doorbell, cough).

Gail Jefferson developed most of the transcribing symbols presented.

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