Physicians' Use of Indirect Language to Deliver Medical Bad News: An Experimental Investigation

by

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Licenciado, University of Belgrano, Buenos Aires, Argentina, 2001

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ABSTRACT

This thesis examined the delivery of medical bad news as a situational dilemma. When physicians have to convey distressing information, they must apparently choose between two negative communicative alternatives: To convey the diagnosis directly may distress and harm the patient, but to deny the diagnosis, in order to protect the patient and preserve hope, would risk compromising informed decision-making. Following Bavelas' (1983) and Bavelas, Black, Chovil, and Mullet's (1990) theory of situational dilemmas, the author predicted that experienced physicians would solve this dilemma by communicating the bad news *indirectly* (i.e., using honest but mitigated, softened, or hedged language). The experimental test of this prediction compared the language that physicians used when they communicated a diagnosis of

metastasized cancer (the bad news condition) vs. a diagnosis of benign hemangiomas (the good news condition). In a within-subjects design, eight physicians with experience in palliative medicine conveyed these two diagnoses to 16 different volunteers who role-played the patients. The physicians and volunteers each had a schematic scenario with the medical background, but they otherwise improvised their interview, which was videotaped in split screen. Microanalysis of the physicians' language focused on the sections where the physicians presented the good or the bad news for the first time. This analysis reliably assessed whether the physicians used *direct* or *indirect* terms in their naming of the diagnosis and in their *evaluation* of the news; whether they *expressed certainty* about the diagnosis; how they referred to the *receiver* of the diagnosis; and who they identified as the *bearer* of the news. The results of the microanalysis supported the prediction in this thesis: The physicians used indirect terms at a significantly higher rate when the news was bad than when the news was good. These results suggest that indirect language was the solution that these experienced physicians found for the situational dilemma of delivering bad news. In addition, the volunteer patients' report after the bad news interview indicated that all of the volunteers understood the diagnosis and that virtually all appreciated the way the physician conveyed the bad news. These results provide evidence to support the effectiveness of indirect language in allowing physicians to convey bad news honestly while still being tactful. The findings of this study have direct implications for training physicians on how to break bad news in a manner that is both accurate and humane.

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Dedication

To my parents, Maria del Carmen Nicoletti and Juan Carlos Del Vento, for their continued support and confidence in every step I have made since I decided to move to Canada for graduate school.

To the memory of Paul Watzlawick who passed away on March 31, 2007. Paul was co-author of *Pragmatics of Human Communication: A study of interactional patterns, pathologies, and paradoxes,* and several of the ideas on this thesis are directly connected to that work.

I would also like to dedicate this thesis to anyone who, in any way, has suffered because of cancer. It is my sincere hope that this work will help physicians to communicate with their patients in a truthful but also caring way at difficult moments. My work from now on will be aimed to achieve this goal.

CHAPTER 1

INTRODUCTION

Communication is the medium by which physicians can learn about the patient's experience and, conversely, the medium by which a patient is able to understand the physician's expertise, advice, and recommendations. In this sense, skilful communication is as essential as the physician's technical knowledge for fulfillment of the objectives of the medical interview (diagnosing, assessing pain, etc.).

In medical specialties such as oncology and palliative care, good communication is crucial because of the life-altering consequences of the issues discussed (e.g., a terminal diagnosis). In bringing up any of these issues, physicians often have to make difficult communicative choices. For example, a physician who introduces a DNR designation risks focusing the patient on death, but to avoid the discussion in order to avoid alarming the patient would mean not knowing the patient's wishes about resuscitation. Or, another physician might need to discuss with the patient the transition from active treatment to palliative care, which risks implying that "nothing else can be done," but to ignore this option in order to preserve the patient's hope could leave the patient without appropriate care (e.g., continuing a futile treatment) or the ability to plan. In summary, although skilful communication is essential to most medical activities, for physicians working with seriously ill patients, knowing how to communicate with honesty and with tact is particularly important because of the critical nature of the issues they frequently address.

Communicating a terminal diagnosis such as cancer is particularly challenging for physicians because of the potentially devastating effects of this information on the patient. The following vignette (taken from a real clinical case) illustrates the dilemma that physicians face when they have to communicate bad news:

> Stephen was first diagnosed with esophageal cancer when he was 38. Recently married to a young wife, he loved life and people. He valued honesty, best friends, and determination. He was an athlete, and his passion was climbing mountains. While Stephen endured six months of radiation and chemotherapy, he continued to smile although fatigued and nauseated. He gradually recovered from the treatment, and his wife and he slowly reclaimed their life.
>
> Twelve months after the completion of his therapy, Stephen was fit, energized, and thrilled by his normal CT scan. He had regained muscle and found he could exercise again without being breathless. He tackled the task he had promised himself if he regained the health he had previously known: to climb a high mountain.
>
> He is now 40, grateful, expectant, fit, and sure that his most recent CT scan is again normal. He is ready to climb more mountains. He has come to see the physician and to learn of last week's CT scan.
>
> Last week's CT report lies in front you, the physician, and reads: "…mass…and enlarged nodes in the mediastinum…small nodule in the left lung…not present previously… *relapsed metastatic cancer*…".

At this point, the reader should take the role of the physician who has to inform this patient about the results of the recent CT scan. As such, you face two obvious communicative options: (1) You could choose to tell Stephen directly what the tests showed, disregarding the potential negative impact of your message on him, or (2) you could avoid conveying the information--a practice that is still common in some cultures (Buckman, 1992). In choosing to disclose the information, you would act in consonance with Stephen's desire for honesty

but you would also risk crushing Stephen's hope. In choosing to conceal the information, you would spare Stephen from the immediate shock but also prevent the possibility of making informed decisions. Is it possible to reconcile both sides of this dilemma? That is, how can a physician communicate painful information honestly without crushing the patient's hope?

For this thesis, I studied the solutions that experienced physicians found to a dilemma similar to the one illustrated by Stephen's case. I examined how physicians managed to tell a patient about a diagnosis of metastasized liver cancer in a way that was both truthful and tactful. There is an increasing interest to find strategies to deliver bad news more effectively and to carry out this task with both honesty and tact (Baile, et al. 2000). The importance of researching the various ways to deliver bad news is also congruent with the growing incidence of cancer world wide and the striking lack of studies examining how physicians break bad news in actual practice (Beach & Anderson, 2003).

A Situational Theory of Communicative Dilemmas and Indirect Language

This section describes the theoretical framework for investigating the delivery of bad news, which I have adapted from Bavelas (1983) and Bavelas, Black, Chovil, and Mullet's (1990) research on equivocal communication. These authors supported their theory of situational dilemmas with a series of primarily lab experiments. I propose that the theory applies to practical situations as well and, in particular, to the delivery of medical bad news.

In the paragraphs that follow, I will use an example from an innocuous nonmedical situation to illustrate Bavelas et al. (1990) theory:

> A colleague who works very closely with you has just given a presentation at a prestigious professional conference where you are both attending. Your impression of his presentation was that it was very badly done--poorly prepared and poorly delivered. After your colleague has finished presenting, he sits down next to you and asks: “How did I do?” (At this point, the reader should think about the *actual answer* he or she would give in this situation, that is, not what you think you *might* say but what you would *actually* say.)

This innocuous example portrays a communicative dilemma that, although quite different in degree, is similar in structure to the one physicians face when having to communicate bad news. That is, in both situations, the dilemma is how to present painful information without hurting the other person. Most speakers facing such a dilemma would try to find a middle ground between giving the information bluntly and being untruthful (Bavelas et al., 1990). How physicians find this middle ground when they have to communicate bad news is the goal of this thesis. First, however, it is necessary to explain the situational theory more fully.

The Situational Theory

According to Bavelas (1983) and Bavelas et al. (1990), a speaker in any given communicative situation chooses among a set of options that represent the possible messages available in that situation. Every time a speaker chooses an option, this option will have *consequences* for the participants in the situation. For the purposes of this theory, think of the consequences that a speaker’s message can have simply as *positive* or *negative*. An option or message with positive consequences is one that leads to something pleasant, whereas an option with

negative consequences is one that leads to something unpleasant. Returning to the example above, suppose your colleague's presentation was excellent. Telling him that his presentation was well done would imply that he is a good public speaker, is knowledgeable in the area, etc. Therefore, this path would be one of positive consequences. In the case in which your colleague's presentation was not well delivered, however, telling him directly that his presentation was badly done would imply that he is a bad speaker, that he does not know how to organize a professional presentation, etc. Therefore, this path would be one of negative consequences for your colleague and your relationship with him. Lying would be another path with negative consequences because, presumably, it would be against most people's moral principles or because of the risk of getting caught.

When the speaker has to choose between a message with positive consequences or one with negative consequences, the choice is obvious and simple: a path with positive consequences is preferable because it leads to a pleasant outcome. When the choice is between messages with only negative consequences, however, such as in the situation of the colleague's poor presentation, the speaker faces a problem because any path leads to an unpleasant outcome. That is, the speaker is essentially caught between being truthful and hurtful or being kind and false. Bavelas (1983) and Bavelas et al. (1990), adapting Lewin's (1938) classic analyses, referred to this problematic situation as an *avoidance-avoidance conflict*, meaning that the speaker will prefer to avoid all negative communicative options and instead seek a different

communicative path. (Throughout this thesis, I will refer to Bavelas et al.'s avoidance-avoidance conflict as a *situational dilemma* or simply as a *dilemma*.)

Returning to the medical context, I propose that a physician who has to communicate bad news such as a diagnosis of terminal cancer faces a situational dilemma. That is, following the standard of clear truth disclosure, the physician is compelled to communicate the diagnosis directly, but doing so would risk damaging the patient's morale. Avoiding a discussion of the diagnosis in order to maintain the patient's hope would, among other things, prevent the patient from making informed decisions and would therefore be irresponsible. In this situation, then, either direct communicative path that the physician decides to take (i.e., communicating the diagnosis directly or concealing the truth) would have negative consequences not only for the patient but also for the physician's relationship with the patient. For that reason, following Bavelas et al.'s (1990) theory, I predict that the physician will prefer to avoid both of these direct alternatives.

Note that, if the diagnostic news is good, the physician will have no problem choosing one of the available communicative paths because the situation offers messages with only positive consequences. In delivering bad news, though, no choice of message seems desirable, and that makes any direction of action inadequate. The question then is how does the physician solve the situational dilemma created by having to communicate bad news? In other words, how can the physician convey harmful information truthfully without being harsh?

Indirect Language: A Good Solution to a Bad Situation

In order to answer the question stated above, it is necessary to introduce another characteristic of the speaker's messages. Besides having positive or negative consequences, a message can vary in its degree of *directness* or *indirectness*. With a direct message, a speaker coveys what he or she wants to say explicitly and, in doing so, *accentuates* the effect of what is said. With an indirect message, the speaker conveys what he or she wants to say implicitly and, in doing so, *attenuates* the effect of what is said. For example, a direct criticism such as "You did badly" can be attenuated with an indirect comment such as "It wasn't great" or a direct order such as "Take out the garbage" can be attenuated with a question such as "Would you mind taking out the garbage?" In both of these indirect cases, the meaning of the message is left implicit and open for the hearer to infer it from the context of what was said, which attenuates its effect.

The logic of indirect messages is this: the indirect meaning of the message is not present in what the speaker says (e.g., "Would you mind taking out the garbage?" is a request, not a question). The hearer needs to recover this meaning by inference, using information from the context in which the message was produced. In making the inference, the hearer collaborates with the speaker in the construction of the message's meaning, and the speaker is then not the only one responsible for this meaning (Fraser, 1980). By exploiting this characteristic of indirect messages, the speaker can therefore attenuate the effect of what he or she says.

When a speaker's message has positive consequences, an obvious and *direct* choice will be more positive and desirable than an *indirect* and subtle one. Returning to the example of the colleague's presentation, supposing that your colleague did very well, then a message such as "Your presentation was good" would be a better option than "The presentation was not bad," because the former is a more obvious and direct compliment. However, as exemplified above, if your colleague's presentation was poor, then a direct message such as "I thought your presentation was bad" would be less desirable than an indirect one such as "It wasn't very good." Therefore, when the situation offers only messages with negative consequences (i.e., in a situational dilemma), an indirect and attenuated message is a better choice because it allows the speaker to mitigate the impact of the message on the hearer while still being truthful.

Indirect Language in Bad News Delivery

Because delivering bad news also creates a situational dilemma, I predict that physicians will use indirect language as a means of attenuating the impact of the painful information on their patients. The following excerpt will illustrate how physicians can use indirect language to deliver bad news. In this improvised role-played interview from the pilot data in this thesis, the physician had to inform a young patient about a diagnosis of metastatic lung cancer.

Transcription conventions (adapted from Bavelas et al., 1990):

- The abbreviation "Dr" followed by a number designates each physician. (The real names have been deleted to preserve the participants' confidentiality.)
- "Pt" designates the volunteer "patient."

- The words stressed are in CAPITALS.
- A dash (-) means a sharp break on the speech.
- A comma indicates a slight pause.
- A period denotes the pause and drop of intonation that indicates the end of a sentence.
- Three unspaced dots (…) indicate a longer pause.
- The words in parenthesis (*unintelligible*) indicate parts of what the speech that were unclear and therefore impossible to transcribe.
- The words in brackets [*smiling*] describe paralinguistic aspects of speech such as nodding, wincing, etc. When the patient's comment is a nonverbal response it will be transcribed in [brackets] in the physician's turn to facilitate the reading.
- The underlined <u>words</u> indicate an overlap in speech.

Because the reader will not be able to hear or see the video of this excerpt, it is helpful to know that the physician's voice and manner were concerned and gentle.

Example 1

1. Pt: so… I'm a little bit worried about my condition right now.
2. **Dr 9: So really nobody's told you… um anything about your condition or the results of tests, is that right?**
3. Pt: Yeah. Or at least I- if they told me I don't think I- I made much sense of what they said.
4. **Dr 9: Well the, the.. do you want me to tell you about what I think or about what the test showed or…?**
5. Pt: Sure! Yeah... [nodding] any information I think would be <u>good</u> to..
6. **Dr 9:** [nodding] **<u>Okay</u>.**
7. Pt: Yeah.
8. **Dr 9: Uh... well... is, is. Um. I mean it- From the tests it seems that that you** [nods] **do have a serious** [nods] **condition** [Pt: nods] **um…** [nodding] **involving your lungs and other parts of your body as well..**
9. Pt: [nods] Um-hum.
10. **Dr 9:** [pause] **Um...** [pause] **It, it- um.. it would APPEAR, although we haven't-** [Pt: nodding] **um... it isn't final, that uh… that you have a** [nodding] **type of cancer**
11. Pt: [nodding] Um-hum.
12. **Dr 9: um... which, which,** [nodding] **is involving the lungs and other parts of the body.**
13. Pt: [nodding] Uh-hum.

14. **Dr 9: Um… and that's why you've-** [winces] **you've not been well and you haven't been able to do the things that you...** [nodding] **you normally do, your cycling and so on.**
15. Pt: [nodding] Um-hum.
16. **Dr: Um… I think there are various... uh..** [Pt: nodding] **things and stages that have to be gone through, a little bit further in terms of investigations, in order to determine, you know, what are the possible treatments** [Pt: nodding] **that, that could be offered to you.**
17. Pt: Uh-hum.

An utterance by utterance reading of this excerpt shows that, by means of his indirect phrasing of the bad news delivery, the physician balanced truthfulness and tact when telling the patient about his diagnosis of metastatic lung cancer. On the truth-telling side of the dilemma, the physician informed the patient about the seriousness of the condition (line 8), explained to the patient that the diagnosis was lung cancer, and that the cancer had metastasized (lines 8, 10, 12). Two additional pieces of evidence in the physician's delivery indicated that the patient's diagnosis was cancer: according to the physician the cancer was the cause of the patient's symptoms (line 14), and the patient was a candidate for treatments (line 16). On the side of being tactful, the physician employed a number of indirect forms that attenuated the impact of the information and avoided the blunt truth. Table 1 outlines these forms and presents a comparison between each indirect phrasing and what the physician could have said using direct language:

Table 1

Indirect versus Direct Language in the Delivery of Bad News

What the physician said (Indirect language)	What the physician could have said (Direct language)
In line 4, the physician offered the patient the possibility of not hearing the news, asking **"do you want me to tell you about what I think or about what the test showed *or*..?"** and only communicated the diagnosis after having the patient's consent.	The physician could have communicated the news immediately (e.g., **"you have …"**), not asking the question and disregarding the patient's consent.
The physician referred to the diagnosis using terms such as **"serious condition"** (line 8) and **"type of cancer"** (line 10).	The physician could have used more direct terms such as **"aggressive cancer"** or, simply, **"cancer"**. For example, omitting the words "type of" and saying "you have cancer" would have made the same utterance more direct and blunt.
The physician used conditional verbs in line 8 when he said **"it *seems* that you do have a serious condition"** and line 10 when he referred to the existence of the cancer saying **"it *would* appear…,"** accompanied by a disclaimer in the same line (**"it isn't final"**). In doing so, he softened the definiteness of the diagnosis.	The physician could have instead used verbs in the regular form or omitted the disclaimer and used more emphatic expressions. For example, his utterance could have been **"you *do have* a serious condition in your lungs and other parts of your body as well (...) *you have* a type of cancer."**
In line 8 the physician also framed the delivery saying **"From the test it seems that you do have a serious condition"**. This framing identified the tests as the source of the bad news.	Imagine the same utterance with a different framing (i.e., **"I know that you have a serious condition"**)

In this example, the physician managed to communicate the diagnosis in a way that was neither blunt nor an avoidance of the truth. He achieved this goal by mixing a variety of indirect phrasings (e.g., using conditional verbs and euphemisms), by means of his prosody (i.e., soft intonation, pausing, the concerned quality of his voice), and by actions such as wincing while telling the patient that the cancer was the cause of his discomfort (line 14). The overall impression is one of a physician who cares and does not want to hurt the patient's feelings. Although the patient remained rather silent during the news delivery, he indicated with minimal responses such as "uh-hum" or by nodding (e.g., lines 9, 11, 13, 15) that he was following and presumably understanding the diagnosis.

Patients' Understanding of Indirect Language

It might not be completely obvious to the reader that patients will understand their actual condition when physicians communicate the diagnosis indirectly. This thesis will present evidence in favor of the claim that patients can understand the meaning of physicians' indirect messages without difficulties. Meanwhile, there is ample anecdotal support for this claim in examples of everyday conversational exchanges in which interlocutors use and understand indirect language without difficulties. These examples include the use of *polite requests,* such as when a person says "Can you reach the salt?" (indirectly meaning "Pass me the salt") and the other person responds by passing the salt rather than, for example, responding saying "yes" without passing the salt. The use of *ironic humor* is also evidence of the frequent use and understanding of indirect language*,* such as

when a wife tells her husband “I love it when you read the paper while I talk to you” (indirectly meaning “I do not like it”), and her husband stops reading and attends to her. These examples illustrate a few of the many cases in which speakers mean more than what they say literally and hearers recognize that (indirect) meaning by inference. In other words, hearers can and do successfully infer speakers’ indirect meaning from the literal meaning of the speaker’s utterances (Clark & Schunk, 1980). Besides the anecdotal evidence, there have also been empirical studies outside the medical setting indicating that hearers can distinguish between the literal and the indirect or implicated meaning of speakers' messages and therefore, that they are sensitive to indirect language (Bavelas, Black, Chovil, & Mullet, 1990; Clark, 1979).

Departure from Bavelas et al.’s (1990) Terminology

Even though Bavelas, Black, Chovil, and Mullet (1990) used the term *equivocal* to refer to what I am calling here indirect language*,* I prefer to use the latter term because it is more colloquial and emphasizes the function of these messages (i.e., to avoid going “straight” to the news). Furthermore, *indirect* also emphasizes the way in which the hearer arrives at the meaning of the messages (i.e., indirectly or by inference), and has a more positive connotation than *equivocation* which, in some contexts, implies a message that is not well constructed and that it is associated with evasion.

Although indirect language is also sometimes seen as dishonest or as a way of concealing the truth, following Bavelas et al. (1990), I propose that this negative view of indirectness ignores the *situational* dilemma in which speakers use indirect language and treats it instead as a by-product of the their intentions

(e.g., to deceive). A better approach to understanding the use of indirect language by interlocutors is to examine the situation in which the speaker produced an indirect message, rather than attributing it to the speakers' bad motivations.

CHAPTER 2:

BACKGROUND AND RATIONALE

Review of the Literature on Indirect Language

Other scholars have investigated speakers' use of indirect language and have pointed out that this kind of language accomplishes important social functions. This section will briefly review some of those studies and compare them to the definition of indirect language in this thesis. In this review, it will become obvious that previous studies on this subject have remained entirely descriptive and not experimental or quantitative. That is, previous researchers have only made observations based on examples of speakers' use of indirect language, and they have not proposed testable predictions. Furthermore, in none of these studies did the analysts develop a coding system to analyze indirect language or establish inter-rater reliability in their analyses.

A group of communication specialists known as the Palo Alto Group were among the first to capture indirect language in their concept of *disqualification* (Haley, 1959; Watzlawick, Beavin, & Jackson, 1967). According to this group, a disqualified message is one in which the different components of the message qualify each other in a way that is incongruent. For example, in saying "I think you should do that, but it is not my place to tell you so," a person tells the other what to do but simultaneously qualifies the statement in a way that denies the order (Haley, 1959, p. 157). Watzlawick et al. (1967) included self-contradictions, inconsistencies, subject switches, and tangentializations as examples of disqualified messages, and they explained that a speaker produces such a

message when he “is caught in a situation in which he feels obligated to communicate but at the same time wants to avoid the commitment inherent in all communication” (p. 77-78). (Bavelas et al.’s, 1990, theory developed out of the Palo Alto Group’s original ideas, so they are very similar in some respects.)

The majority of the published work on indirect language has been carried out by linguists who have enumerated a number of linguistic strategies by which speakers can be indirect. Brown and Levinson (1987) outlined several of these strategies in the context of their theory of *polite communication.* According to this theory, speakers’ departure from a direct message is due mainly to their motivation to be polite or to avoid imposing on the hearer. For example, rather than making a request directly (e.g., “Close the door”), a speaker would prefer to be conventionally indirect (e.g., “Can you close the door?), to hedge (e.g., “I *suppose* you can close the door”), or to use an impersonalized form (“It would be good if the door was closed”), among other various strategies. In my view, politeness or the desire to avoid imposing on the hearer with one’s utterance is a specific case of a communicative situation that poses a dilemma to the speaker. In the particular case of the bad news interview, however, it is implausible that politeness would explain the physician’s use of indirect language because the issue at hand is that the diagnostic information is essentially potentially harmful rather than potentially rude. That is, what the speaker is avoiding by being indirect is quite different in the two situations.

Mitigation is another term that has been used to refer to the strategies speakers can use to attenuate the impact of a message (Blum-Kulka, 1990; Caffi, 1999; Fraser, 1980; Haverkate, 1992; Holmes, 1984; Labov & Fanshel, 1977).

Some of these mitigating strategies include disclaimers, mitigating adverbs (e.g., “probably,” “unfortunately”), hedges that qualify the speakers’ commitment to what is said (e.g., “It *seems*…”) or that make the content of what speakers say dubious (e.g., “this *might* be…” or “it is *likely* to be…”), etc. According to the scholars studying the phenomenon of *mitigation*, speakers’ mitigate in order to reduce the harshness or hostility of a message perceived to have unwelcome effects on the hearer (Fraser, 1980). In this sense, several scholars agree that the use of mitigating forms can be regarded as a central quality of a skilful speaker (Brown & Levinson, 1987; Caffi, 1999; Holmes, 1984).

Only a few researchers have investigated the use of mitigating forms by physicians. Caffi (1990), for example, discussed physicians’ use of what she identified as bushes, hedges, and shields, following Lakoff (1973). According to Caffi, physicians use *bushes* to mitigate their talk by making the content of their message fuzzier or less definite, such as when a physician minimizes the seriousness of the patient’s diagnosis saying “yours is not a real hernia, [it is] *just a bit*” (p. 891; emphasis added). Caffi also explained that, in using *hedges,* physicians mitigate a message by weakening their own level of commitment towards this message, such as when a physician explains the cause of the patient’s diagnosis saying “it is *probably* a consequence of an intestinal problem [pause] that began with the flu… [pause]” (p. 893; emphasis added). Last, Caffi pointed out that a physician can mitigate using *shields* which make the message indefinite with regard to its source and receiver, such as when a physician says “*there’s* an estrogenic hyperplasia – *it is written here*” (p. 896; emphasis added), instead of saying “I know that you have an estrogenic hyperplasia.”

Prince, Frader, and Bosk (1982) also examined the use of two types of hedges, which they referred to as *approximators* and *shields*. Approximators corresponded to what Caffi (1999) called *bushes,* and shields corresponded to Caffi's hedges. In contrast to the studies reviewed so far, however, Prince et al. described the use of these devices as indications of physicians' actual uncertainty rather than as devices serving mitigating purposes.

Review of the Medical Literature on Breaking Bad News

There appeared to be virtually no studies in the medical literature on breaking bad news that examined indirect language as defined in this thesis. Therefore, this review will focus on the more general but equally important issue of methodology. In order to study the language of bad news delivery, it is necessary to observe the communication of bad news as it actually occurred (i.e., the method used in this thesis). However, direct observation has been the method in a minority of studies. In order to offer the reader a comprehensive view of the literature on the topic of bad news delivery, the following sections begin by reviewing the studies that investigated this topic using other methods.

Recommendations Based on Experts' Opinions

Physicians wanting to learn how to break bad news have available a series of published resources offering practical recommendations. A considerable number of those resources come in the form of editorials, anecdotal papers, and guidelines that address several aspects of the news delivery (e.g., who should tell the news, where, how to present the information). A major disadvantage of this literature, as Ptacek and Eberhardt (1996) have pointed out, has been its lack of

"empirical verification or theoretical justification" (p. 496). A closer look at these recommendations reveals that, in most cases, they lack operational definitions or even examples (i.e., what should a physician *do* to be compassionate?), leaving it up to physicians to find ways of accomplishing the proposed goals. Similarly, Buckman (1992) has offered extensive recommendations in a protocol with six practical steps on how to deliver bad news (see also Baile et al., 2000). However, as Buckman (1992) acknowledged at the beginning of his book, the principles that he outlined were only based on his own clinical experience and not on research.

Non-observational Studies

Studies of Patients' Perceptions

Other studies have approached the issue of bad news delivery through patients' (and, in some cases, family members') perceptions or preferences of this process (e.g., Friedrichsen, Strang, & Carlsson, 2002; Fujimori et al., 2005; Kirk, Kirk, & Kristjanson, 2004; Parker et al., 2001; Ptacek & Ptacek, 2001; Salander, 2002; Sapir et al., 2000; Sardell & Trierweiler, 1993; Schofield et al., 2001; Yardey, Davis, & Sheldon, 2001). These studies have been valuable in advocating consideration of patients' opinions and preferences instead of relying solely on experts' knowledge. The recommendations in these studies, however, have been drawn from methods such as semi-structured interviews or questionnaires, which can only yield reports *about* the news delivery process (i.e., after the interview) and not observations of what physicians *actually said or did* when they discussed the bad news with patients. That is, these researchers did not examine the actual delivery process.

The distinction between reports or descriptions of the news delivery process and what participants do during this process (i.e., the actual or real-time communicative exchanges) is a crucial one but, in many cases, researchers have not seen the methodological implications of this difference. For example, Ptacek and Ptacek (2001) explained that the goal of their study was “to determine not what should be done or what patients would like to see done but rather to explore *what is done* when bad news is communicated” (p. 4160; emphasis added).Even though Ptacek and Ptacek articulated the difference between patients’ reports after the bad news was delivered and observations of the bad news delivery process as it occurs in real time, and they explicitly stated that they were interested in studying the latter, they went on to assess only patients’ *recollections* of their last bad news interview, rather than recording the actual interview. That is, Ptacek et al. failed to see that the information they elicited after the interview could not be equated with what actually happened during the interview, because these two accounts are fundamentally different. For instance, it would be difficult for a person to remember all of the micro-details of an interaction, word for word, and even more difficult to do so in a distressing interaction such as a bad news interview.

The common belief among some researchers that experts’ *opinions* and patients’ *perceptions* about the bad news delivery process are comparable to actual news delivery interactions, has led researchers to underestimate the value of researching the actual communication. As a consequence, there is a lack of recording and observation to validate the recommendations and perceptions or to use as a basis for practice.

Randomized Controlled Trials

Another trend of studies on this issue has been the use of *randomized controlled trial* (RCT). These studies apply the principles of research design employed in the bio-medical literature to the study of the bad news interview and have been regarded as “the top of the hierarchy for assessing evidence” (Walsh, Girgis, & Sanson-Fisher, 1998, p. 62). RCTs essentially evaluate the impact of a loosely defined set of “communicative strategies” on patients’ outcomes, such as patients’ psychological adjustment or their knowledge and satisfaction with the interview. (See Walsh et al. for a review of this literature.) The evidence provided from RCT studies is valuable in determining which communicative interventions elicit the most desirable patient outcomes (e.g., do patients understand the bad news better when they are given an audiotape of the interview vs. a letter summarizing the main points of the interview?). However, the aim this type of research has been to manipulate some previously determined aspect of the communication to ascertain its effects instead of observing communication *per se*. This method cannot unfold new approaches to delivering bad news.

Observational Studies

Studies designed to examine the actual delivery process have been much less common but not entirely absent. These studies differ from studies of patients’ perceptions or RCT in that the researchers record and describe the news delivery process as it occurred, rather than relying on participants’ self-reports or assessing outcomes. Observational studies can be divided into studies that applied formal classification systems such as the Roter Interaction Analysis System (Roter & Larson, 2002) or applied conversation analysis (CA) to the bad

news interview. Both of these methodologies are descriptive and atheoretical (i.e., they tested no hypothesis or prediction). The data used for analysis typically consisted of audio-only recordings of the bad news delivery.

Studies Applying a Formal Classification

Researchers using a classification system to analyze the bad news interview (Ford, Fallowfield, & Lewis, 1996) place physicians' and patients' communicative actions (e.g., questions) into mutually exclusive categories (e.g., open versus closed questions) which, the researchers assume, represent the news delivery process. The problem with such categorization is that it prevents a meaningful analysis of the process of bad news delivery. For instance, although Ford et al. found that physicians tended to use more closed than open questions during the bad news interview, they did not explain how or when the physician used these questions and with what purpose. An advantage of using a formal system, however, is that researchers are able to assess the inter-rater reliability of their analysis and report statistical outcomes.

Studies Applying Conversation Analysis

Conversation analysis (CA) is a well-established qualitative approach with a strictly defined method for studying naturally occurring communication (Sacks, Schegloff, & Jefferson, 1974). Researchers using this method have provided detailed descriptions of the bad news delivery process both in medical and in ordinary conversations. In doing so, these researchers have noted some uses of language identified in this thesis as *indirect*. For example, Maynard (1989) described the *perspective display sequence*, a communicative strategy by which a physician indirectly elicits the patient's opinion before delivering bad news and

only then proceeds to confirm the patient's assessment. According to Maynard, this strategy enables physicians to communicate the bad news cautiously by confirming what the patient already knows rather than giving the information directly.

Lutfey and Maynard (1998) analyzed the words that a physician used while he was discussing the need for palliative care with three different patients. These authors found that the physician used a number of linguistic forms to soften the impact of these discussions. Some of these forms included *litotes* (i.e., suggesting an affirmative form by negating its contrary) such as saying "you *might not* get better," instead of "you will get worse" (p. 327; emphasis added), qualifiers such as "*at this point*, *probably*, the chemotherapy wouldn't do you *much good*" (p. 330; emphasis added). Lutfey and Maynard referred to these and other forms as *allusive talk*. After their analyses, they concluded:

> In our data, although the physician presented as a fact to the researcher that the three patients were in the last stages of their cancers and were dying, he did not say this to the patients straightforwardly. Instead he talked about going home, hospice, not continuing chemotherapy, relieving pain, and the like. (Lutfey & Maynard, 1998, p. 339)

Maynard (1998) also compared the delivery of good versus bad news. He found that bearers of good news presented the information as their own accomplishment (e.g., "Well *I wanted* to share some news with you"; p. 366; emphasis added), whereas bearers of bad news avoided presenting themselves as the source of the news. According to Maynard, bearers of bad news prefer to avoid presenting themselves as the source of the information because "being forthright in reporting bad news reports can occasion an immediate attribution of blame" (p. 369). That is, Maynard interpreted the absence of agency as the

speaker's intention to avoid being blamed instead of as a result of the communicative conflict created by the dilemma of delivering bad news.

In sum, conversation analytic studies have offered some interesting insights regarding the use of indirect language by physicians when delivering bad news. However, these studies have several limitations: First, as I mentioned previously, such studies have remained entirely descriptive; therefore, a critic could argue that their conclusions apply only to the idiosyncratic characteristics of the physicians analyzed. Second, these studies provided no guiding theory to explain why interlocutors used indirect language when they did, although they provided some ad hoc explanations. Last, these researchers have only been interested in describing the communicative process and they have not assessed patient outcomes.

Summary of the Literature

Previous researchers have noticed the use of indirect language by speakers to accomplish important social functions (e.g., politeness, to mitigate the unwelcome effects of a message) and, in this sense, some of them have regarded indirect language as a quality of a skilful speaker (Brown & Levinson, 1987; Caffi, 1999; Holmes, 1984). However, only a few researchers (Lutfey & Maynard, 1998; Maynard, 1989, 1998) have noticed the use of indirect language to deliver bad news and none of the studies on this topic to date have articulated the relationship between the bad news delivery as a situational dilemma and physicians' use of indirect language. Another noticeable limitation has been the absence of experimental predictions and of inter-analyst reliability in the studies

examining this topic. That is, previous researchers studied indirect language with a purely descriptive aim and their analyses of this phenomenon depended entirely on their own subjective judgments rather than on a reliable and replicable method.

Medical researchers interested in the delivery of bad news, on the other hand, have rarely investigated the news delivery process as it occurred in real time. Instead, the majority of the medical studies on this topic examined the bad news delivery process from the perspective of patients after the interview had taken place. In other cases, these studies have only been anecdotal, such as editorials giving recommendations on how to break bad news without experimental validation.

Indirect language is a subtle linguistic behavior that occurs during the medical interaction. Therefore, this phenomenon can only be noticed and explained by observing the actual communicative process. It is not surprising, then, that previous researchers have overlooked physicians' use of indirect language in delivering bad news because, in most studies in the medical literature, these researchers have not examined the delivery process as it occurred in real time. As a consequence, there is an obvious disconnect between the indirect language literature (written mostly by linguists) and the bad news delivery literature (written mostly by researchers without training in language research). To overcome this limitation, it is essential to examine the delivery of bad news as it occurs in real time and to develop a reliable and replicable system to analyze indirect language in the bad news delivery interview.

Rationale, Experimental Design, and Predictions

The present experiment tested Bavelas et al.'s (1990) theory of communicative dilemmas in the context of the cancer care interview, in particular, in the bad news delivery. Assuming that indirect language would be the best solution to the situational dilemma of conveying bad news, and, consequently, the solution preferred by experienced physicians, the analysis on this thesis compared the language that experienced physicians used to deliver good news versus the language that they used to deliver bad news.

The bad news interview represented the dilemma condition because the physicians could only choose between alternatives with negative consequences (i.e., conveying a distressing diagnosis or concealing this information). The good news interview represented the non-dilemma or control condition because, in this situation, the information that the physicians had to convey had only positive consequences for the patient.

In a within subjects design, the physicians delivered good and bad news (in counterbalanced order) to different volunteers role-playing the patients. To control for extraneous factors, the sole difference between these two conditions was the results section of the scenario that the author gave them: In the good news condition, the tests results (as portrayed in the case scenario) indicated a benign finding of hemangiomas and, in the bad news condition, the results indicated a terminal diagnosis of metastatic liver cancer.

The prediction in this thesis was that if indirect language is the preferred solution to the dilemma of conveying bad news, physicians would use a higher rate of indirect terms in the bad news than in the good news condition. In order to

test this prediction, the author developed a method to analyze indirect language and, working with an independent analyst, examined the videotapes of the good and bad news interviews looking for the occurrence of specific forms of indirect and direct language.

To determine whether the physicians had delivered the diagnostic information accurately and tactfully, after each role-played interview, the author also gathered information about the role-played patients' understanding of the diagnosis and their opinions regarding the manner in which the physicians conveyed the bad news.

CHAPTER 3:

METHOD

Participants

Eight physicians working in palliative medicine and 16 volunteers from a local hospice participated in this study. The physicians acted as themselves interviewing a patient in a cancer care interview, and the volunteers improvised the role of the patient. The combined UVic/VIHA Human Research Ethics Board approved the conditions of their participation (Appendix A).

Physicians: Recruitment and Characteristics

Two physicians on the NET grant research team (Peter Kirk and Grant MacLean) assisted the author in the initial recruitment of physicians, offering them the opportunity to learn more about communication research. The researchers (Janet Bavelas, Peter Kirk, Grant MacLean, and Agustin Del Vento) then made two formal presentations to potential participants. During each presentation, we highlighted the importance of communication research, explained the general purpose of the study, and addressed the physicians' concerns regarding their participation. A few days after the presentation, the author sent a letter of invitation (Appendix B) to each individual physician who had expressed interest in taking part in the study.

Because the purpose of the study was to learn how skilled physicians conveyed the news, we restricted participation to those physicians who had extensive experience working in palliative or end of life care, cancer care, or oncology. The mean years of experience for 7 of the 8 participant physicians was

19.30 years (*SD* = 5.41) and only 1 physician had approximately 3 years of experience. The physicians ranged in age between 40 and 60 years old. Their specialties were family medicine (3 physicians), general practice and oncology (2), radiation oncology (2), and palliative medicine (1). They reported providing care in many different settings: BC Cancer Agency Vancouver Island Center, Royal Jubilee Hospital, Saanich Peninsula Hospital, Victoria General Hospital, Victoria Hospice Society, private practice, long term care facilities, palliative care unit, walk-in clinics, and patients' homes. The physicians reported breaking bad news to patients from approximately 1 to 10 times per month, and none of them reported having received any formal training on how to break bad news.

Volunteers: Recruitment and Characteristics

The author posted a letter of invitation to participate in the study (Appendix C) in the Victoria Hospice Society's monthly newsletter to promote the study among volunteers. The volunteers who were interested in participating provided their contact information on a recruitment sheet at the Hospice, and the author contacted them individually by email or over the phone. The author also contacted the volunteers using a list of potential participants from the volunteer coordinator at Victoria Hospice. To familiarize the volunteers with the study, two of the researchers (Janet Bavelas and Agustin Del Vento) organized several presentations with small groups of volunteers, explaining the purpose of the research and addressing their questions prior to their participation.

We restricted participation to those volunteers who had both formal training and experience assisting cancer patients directly (e.g., at a patient's home or at hospice). Volunteers were more desirable than either actors or university

students for several reasons: volunteers have valuable knowledge regarding cancer patients' experience; they would also be less concerned with their acting performance, creating more realistic interviews; and they presumably had developed coping strategies for dealing with cancer and death which would presumably make them less likely to be distressed by playing the part of a cancer patient. Last, we chose volunteers instead of other medical personnel (e.g., nurses) because volunteers did not have a direct relationship with the physicians participating in this study. That is, they were not working together or in a "power over" relationship.

Nine of the 16 volunteers in the sample provided the author with information about their age, and 7 of those provided information about their years of experience volunteering for hospice. These volunteers' age ranged between 46 and 84 years old, and their mean years of experience volunteering for hospice was 17.2 years (*SD* = 8.07).

Setting and Videotaping

The experiment took place in a physician's consultation room located at the Vancouver Island Health Research Centre (Victoria, Canada). The participating physician and volunteer sat face to face (as in a regular medical interview), slightly off-centre from each other to facilitate the camera view. The camera was on a shelf in the corner of the room set up to capture the physicians' torso and face while talking to the volunteers. On the wall behind the physician and facing the volunteer, there was a high-quality mirror, which allowed the camera also to capture the volunteers' torso and face synchronously on the videotape (Figure 1).

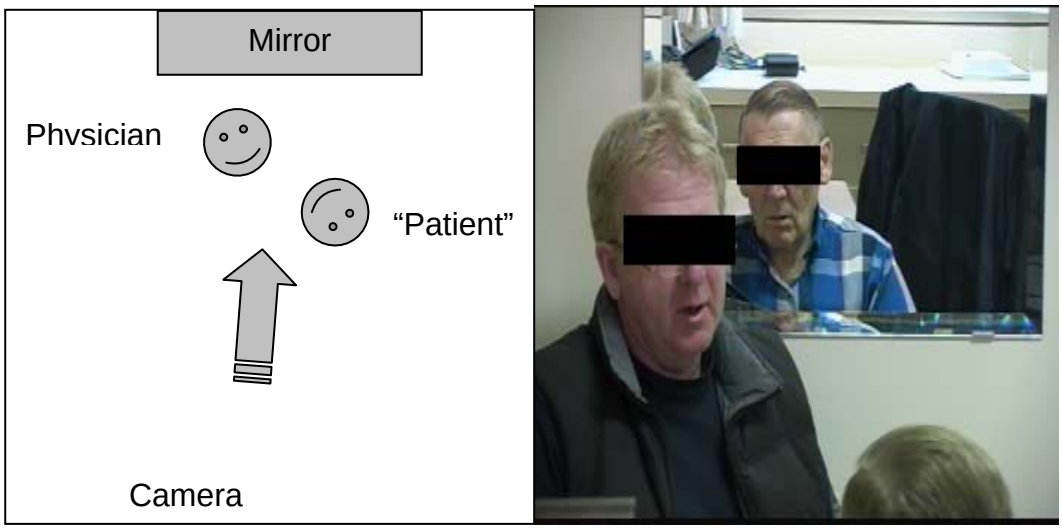

Figure 1. Room layout

Equipment

A Cannon GL2 portable camera with Mini Digital Video Cassettes was used to videotape all the interviews. A Crown Sound Grabber II directional microphone recorded the audio onto the videotape. The physicians used a hand-held tape recorder to record their dictation after each interview, and the author used another one to record the volunteers' answers to his post-interview questions.. The data were digitized from the portable camera into AVI format using Broadway software (www.b-way.com).

Materials

Two of the physicians assisting with this project (Grant MacLean and Peter Kirk) constructed the physicians' case scenarios for the good and bad news conditions (Appendix D) and a third case scenario for all of the volunteers (Appendix E). The author created several other materials: the letter of invitation to

participate in the study for the physicians (Appendix B) and another one for the volunteers (Appendix C); the instruction sheets for all the participants (Appendix F) explaining every step of the experiment; consent forms (Appendix G); the permission-to- view form (Appendix H); and the tasks after the role-played interview for the volunteers (Appendix I) and another one for the physicians (Appendix J).

Procedure

Overview

The author made appointments with three participants (one physician and two volunteers each time) to come to the research site for each interview time slot. When participants arrived, they all gave written consent for their participation. In every case, one volunteer and the physician formed a dyad while the second volunteer waited in a different room. Each physician consecutively interviewed two volunteers, one in each condition. As a result, all of the physicians were in both the good and the bad news conditions, and half of the volunteers were in each of these conditions (i.e., 8 in the bad news and 8 in the good news). After the interview, the author debriefed each participant, showed him or her the videotape of their participation, and asked them to fill out the permission-to-view form (e.g., permission to view only for the researchers, permission to show to professional audiences, etc.).

Physicians' Procedure

Pre-interview Procedure

The author welcomed the physicians in the waiting room and gave them three pieces of information: the instruction sheet (Appendix F), the consent form (Appendix G), and the case scenario corresponding to the first condition they were to role-play (Appendix D). The physicians read the following introduction from the instruction sheet, which was the same as the volunteers' instructions except for the parts in boldface:

> Today you will role-play **yourself** in an unscripted hypothetical medical interview regarding cancer care. A **volunteer role-playing a patient** will role-play this interview with you. You and the **role-played patient** will meet here for the first time. We will be videotaping the interview which should last approximately 20 minutes. When the interview is over, we will show you the tape so that you can decide if and how we can use it.

The author encouraged the physicians to act as they ordinarily would during an interview (e.g., to use their own names). The case scenarios provided the physicians with the essential background information about the patient they would be meeting. The physicians role-played the bad and good news scenarios in counterbalanced order to control for a possible order effect. Both scenarios (good and bad news) contained the same background information about the patient:

> [Robin/Pat] has recently undergone tests to further investigate "liver lesions". You are not [Robin / Pat]'s regular doctor, and have not met [Robin/Pat] before, but are covering for [his/her] regular doctor (Stewart). Dr. X, the oncologist, is not able to see the patient this week and has relayed a message asking you, covering [his/her] regular doctor, to please tell [Robin/Pat] about the results of the recent tests.
>
> [Robin/Pat] had colon cancer diagnosed 7 years ago, and underwent resection. There were no high risk factors and [Robin/Pat] was advised that

> no chemotherapy was necessary. Over the last few months [Robin/Pat] has been “tired” and has complained of vague upper abdominal discomfort after eating. Blood tests (Hematology, Creatinine, Electrolytes and Liver function) were all normal. The report of the CT scan of the chest, abdomen and pelvis states the only abnormality was in the liver, and described two small lesions inferiorly in the right lobe of the liver, and recommended further testing with a Biphasic CT of the liver and a Red Cell Scan.

Only the results sections of the good and bad news scenarios were different, creating the two delivery conditions. In the bad news condition (i.e., the communicative dilemma), the results that the physician had to convey to the patient were

> The results of the Biphasic CT scan and Red Cell scan confirmed there were two metastases in the liver. Dr X’s previous consult note had said that if cancer was confirmed that chemotherapy was a consideration, but that Pat should be referred to Dr. Y to see if surgery (partial hepatectomy) would be helpful.

In the good news condition (i.e., control condition) the results that the physician had to convey to the patient were

> The Biphasic Scan showed only the two liver lesions, with the arterial and venous phase images consistent with benign hemangiomas. The Red cell Scan confirmed that the two lesions are benign hemangiomas. Dr X’s note had said that if these proved to be hemangiomas that no further investigations were needed and Robin could be reassured.

After the physicians had signed and returned the consent form, they read and familiarized themselves with the case scenario in the waiting room. When they were familiar with the scenario, the author walked the physician to the consulting room where the patient was waiting. The interview began when the physician entered the room. The author started the camera and left the room while it videotaped the whole interview (until the physician left the room).

Post-interview Procedure

The physicians' last task was to dictate notes about the interview into a tape recorder immediately after they had interviewed each patient. Their instructions were to leave a message on the tape recorder with the details about the patient they had just seen "as [they] would normally do when composing a dictation[1]".

With the exception of signing the consent form and reading the instruction sheet, each physician repeated the pre- and post-interview procedure twice because they interviewed their two patients consecutively. When they had finished the two interviews, the author debriefed them, offered to show them the videotape, and they indicated, in writing, their choices of the various levels of permission to view the videotape of their interview. The author thanked the physicians, and the experiment was concluded. Several months later, all of the physicians attended a dinner at which we presented and discussed the completed results and thanked them for their contribution.

Volunteers' Procedure

Pre-interview Procedure

Upon arrival at the research site, the researcher welcomed the volunteers and gave them three pieces of information: the instruction sheet (Appendix F), the consent form (Appendix G), and the case scenario (Appendix E). The volunteers first read the following introduction from the instruction sheet (with differences from the physicians' instructions in boldface):

[1] It is a common practice at the BC Cancer Agency to dictate the notes from a recent interview. These notes are later transcribed and used as part of the patient's records and for communication purposes among health care professionals.

> Today you will role-play **a patient** in an unscripted hypothetical medical interview regarding cancer care. A **real doctor** will role-play this interview with you. You and the **doctor** will meet here for the first time. We will be videotaping the interview which should last approximately 20 minutes. When the interview is over, we will show you the tape so that you can decide if and how we can use it.

The author encouraged the volunteers to act as themselves during the interview (e.g., to be their own age); the case scenarios only provided them with the essential background information about their roles. Instead of instructing them how to act or feel, the scenarios deliberately omitted incidental information in order to encourage the volunteers to add their personal touches to their role.

The author randomly assigned the volunteers to either the bad news or the good news condition. In both conditions, the volunteers' scenarios and task remained the same, and they did not know whether they would hear good or bad news. The case scenarios that all volunteers received contained the following information:

> You have recently undergone tests aimed at further investigating lesions in your liver. Your regular doctor (Stewart) is away and another doctor will be covering for him today. You will have a consultation with [name of the doctor seeing the role-played patient] to talk about the results of your recent tests. You're anxious to hear what the doctor has to say.
>
> 7 years ago you had colon cancer diagnosed and a section of your colon was taken out. At the time, the doctors thought that they had removed it all and no chemotherapy was necessary. Over the last few months you have been tired and you've complained of upper abdominal discomfort after eating. You had blood tests done and they were all normal. However, the report of your CT scan found two small lesions in your liver. As a consequence of that, doctors recommended further testing (that you're waiting to hear about today).

After the volunteers had signed the consent form and returned it as well as the instruction sheet to the author, they read and familiarized themselves with the

case scenario while they waited for the physician in the consulting room. Before starting the interview, the volunteers returned the case scenario to the author (this prevented them from reading or referring to the scenario during the interview). Once the volunteer was familiar with the scenario, the author set the camera in the consulting room to start recording and informed the volunteer that the physician would enter the room at any moment.

Post-interview Procedure

After the interview, all of the volunteers (still in their role as patients) wrote a letter to their (imaginary) family physician explaining what they had just learned about their diagnosis and prognosis (Appendix I). When they were done writing the letter, the author debriefed the volunteers in the *good news condition*, offered to show them the videotape, and they indicated, in writing, their choices among the various levels of permission to view the videotape of their interview. The author thanked them, and the experiment concluded for this group. In the *bad news condition*, the author interviewed each volunteer after they wrote the letter to the family physician. This tape-recorded interview consisted of a few informal questions aimed at eliciting concrete descriptions of the volunteers' opinions regarding the bad news delivery. These questions were (1) "How would you describe the way in which the doctor conveyed the news to you today?"; (2) "What, in your opinion, were the main points that the doctor told you today?"; (3) "What did you like the most about the way the doctor talked to you?"; (4) "What did you like the least about the way the doctor talked to you?"; (5) "Was there anything the doctor said that was difficult to understand for you?"; (6) "Did the doctor give you hope in what he or she said?" If so, "Can you think of an example

of something hopeful the doctor said?; and (7) “Have you had any experience like the one of this interview, in particular, in your life?”

At the end of this interview, the researcher debriefed the volunteers in this condition, offered to show them the videotape, and they indicated, in writing, their choices among the various levels of permission to view the videotape of their interview. Finally, the author thanked the volunteers, and the experiment was concluded. Several months later, after the analysis was completed, the author invited all of the volunteers to a reception at which the NET grant research team presented the results and thanked them for their contribution to the research.

CHAPTER 4:

ANALYSIS

Selecting a Section of the Interviews for Analysis

According to the case scenarios, the physicians' task was to tell the patients the results of their most recent tests. Naturally, the physicians did more than just that; they also introduced themselves, reviewed the patient's symptoms, past tests, etc. In fact, their interviews followed a chronological structure that was surprisingly consistent across physicians but somewhat different between the bad and good news conditions. This chapter will first summarize these overall structures, then focus on identifying the news delivery sections, and last describe the development and application of an analysis system for indirect and direct language.

Typical Structure of the Interviews

Bad News Interviews

The physicians began the bad news interviews by introducing themselves and explaining that they were covering for the patient's regular physician. They went on to explain the purpose of the interview and reviewed the patient's medical history and current symptomatology. After this information-gathering phase, they typically reviewed the patient's recent tests, which led to the news delivery. Interestingly, four of the physicians in this interview condition asked for the patient's consent to receiving the results before actually delivering the news (e.g., "do you want me to go ahead and give you the results…"). The news

delivery section ended when the physician and the patient went on to discuss treatment options.

The following example illustrates the typical structure of the bad news interviews:

Example 2

The physician introduced herself and explained that she was covering for the patient's regular physician:

1. Dr 1: [enters the room] Good morning.
2. Pt: Good morning.
3. Dr 1: [shaking patient's hand] I'm Dr 1.
4. Pt: [stands up] Yes. I'm Pat Sullivan.
5. Dr 1: Nice to meet you, Pat. I'm filling in for Dr Stewart [while sitting down] who is away for a week.
6. Pt: Uh-huh

The physician explained her role in the interview:

7. Dr 1: Uh.. You've been a patient of Dr Stewart for quite a while, I see by your chart [smiling]?
8. Pt: Yes, that's right.
9. Dr 1: Uh-huh. Um… Dr X has been your oncologist.
10. Pt: Yes [nodding]
    a. Dr 1: Okay. And Dr X actually um… it- call me yesterday and asked me to give you the results of the tests you just had [nodding] done.
11. Pt: Uh-huh

The physician reviewed the patient's medical history:

12. Dr 1: Um… now let me just for a minute, I'd just like to review your history a little bit.
13. Pt: Okay.
14. Dr 1: Um… You had a diagnosis of colon cancer made seven years ago, is that <u>correct</u>?
15. Pt: <u>That's</u> right.
16. Dr 1: Okay. And at the time you had… surgery?
17. Pt: It was surgery
18. Dr 1: Uh-huh
19. Pt: and they removed part of the colon there
    Dr 1: Uh-huh
20. Pt: and they did all the tests they THOUGHT [Dr 1: nodding] were needed at the time.
21. Dr 1: [nodding] Good. Okay, so that was seven years ago
22. Pt: That's correct.

23. Dr 1: and um…[shaking head] you didn't have any other treatments at the time?
24. Pt: At the time they suggested there was nothing wrong
25. Dr 1: [nodding] Uh-huh
26. Pt: the blood test and everything seemed to be okay but
27. Dr 1: Good.
28. Pt: you know, past history of other cases sometimes are different.

The physician reviewed the patient's current symptoms:

29. Dr 1: [nodding] That's true. So you've been feeling tired for the last little while?
30. Pt: Very tired, I'm always wanting to rest [nodding] and there's- I just don't seem to have enough rest.
31. Dr 1: Okay. [nodding] And you had… problems with discomfort in your belly, is that correct?
32. Pt: [nodding] Yes. It's worse (unintelligible) after I've eaten, it just seems that there is a block there and it doesn't go
33. Dr 1: Uh-huh [nodding]
34. Pt: and not only that, I do get diarrhea also [Dr 1: nodding] comes out (unintelligible)
35. Dr 1: Okay. Have you lost any weight?
36. Pt: Yes I have, to some degree, at times and then it just seems to come back.
37. Dr 1: Uh-huh.
38. Pt: It just.. It just- I'm all- I'm exhausted all the time.

The physician reviewed the tests the patient had recently had (leading to the new delivery):

39. Dr 1: [nodding] Okay. Alright, so um Dr Stewart had it initially arranged that you had some blood tests done, and those were normal, [Pt: nodding] and then you had a C.A.T. scan done of your chest and your abdomen and your pelvis,
40. Pt: [nodding] Uh-huh.
41. Dr 1: and at that point they found two small spots [gesturing small spots] on the right lobe of the liver, on the lower (unintelligible) of it [gesturing the location in the liver] and they recommended that you have some more tests. [nodding]
42. Pt: Uh-huh.
43. Dr 1: So you, you, you understand all that? [nodding]
44. Pt: [nodding] Yes, I understand that
45. Dr 1: Okay.
46. Dr: because I know that the liver is very delicate (unintelligible)
47. Dr 1: [smiles] And then.. when they saw those two little spots on your liver they recommended that you had another CAT scan and a Red Cell scan [nodding]
48. Pt: Uh-huh [nodding]
49. Dr 1: So you just had those last week

50. Pt: That's right [nodding]
51. Dr 1: and [nodding] these are the results that we're going to discuss today.
52. Pt: [nodding] Okay.

The physician asked for the patient's consent to receive the news:

53. Dr 1: Okay? [nodding] Um… you're fine.. you're fine with me if I just give you the results directly and ah- ah-
54. Pt: [nodding] I would like to know them because, you know, I'm a widow now
55. Dr 1: [nodding] You'd like to know.
56. Pt: and [shaking head] I don't want to… fool around with that. Whatever I have to know, I might as well know it now.

News delivery section:

57. Dr 1: [nodding] Okay. Alright, well both tests that you have done, both the biphasic C.A.T. scan and the Red Cell scan, confirm that [nodding] you've got two small deposits of tumor in the liver.
58. Pt: In the liver!? [facial display of surprise]
59. Dr 1: [nods] Uh-huh, uh-huh.

Discussion of treatment options:

60. Dr 1: [nods] Um… and... in my conversation with um.. with Dr X the other day and in the note that he's written and when he saw you previously
61. Pt: [nodding] uh-huh.
62. Dr 1: uh.. he thought that, you know, [nodding] further treatment was DEFINITELY a consideration. [interview continues]

At this point, the physician continued the interview, presenting the treatment options available to the patient, discussing the patient's wishes about treatment, etc. After answering all of the patient's concerns, the physician closed the interview by explaining the steps that the patient would follow in future interviews with other health professionals (e.g., have a consultation with the surgeon to decide whether surgery was a possible treatment for the cancer).

Good News Interviews

The beginning of the good news interviews was usually identical to the bad news interviews (i.e., the physicians introduced themselves and explained that

they were covering for the patient's regular physician). However, in this condition, the physicians seemed to move faster to the delivery of the news. Only four of the eight physicians in the good news interviews reviewed the patient's medical history or the patient's current symptoms before delivering the news. Interestingly, three of the physicians in this interview condition acknowledged the patient's presumed concerns regarding the results of the tests at the onset of the interview (e.g., "you are probably anxious about the results of your tests…"). The news delivery section ended when the physicians and the patients began the discussion of alternative explanations for the patient's symptoms (other than cancer).

The following example illustrates the typical structure of the good news interviews:

Example 3

The physician introduced herself and explained that she was covering for the patient's regular physician:

1. Dr 3: [knocks on the door] Hello.
2. Pt: (unintelligible)
3. Dr 3: Mr. Wallace? Hello Sir, I'm Dr 3.
4. Pt: Thank you.
5. Dr 3: Hi [closes door] Um.. [while sitting down] Mr. Wallace I'm- covering for your regular doctor, doctor Stewart, this week. And um.. He asked me to come in because we have some results back of the tests you had done.
6. Pt: [nodding] Okay.

The physician explained her role in the interview:

7. Dr 3: And uh… wanted to- opportunity to pass that on uh.. even though Dr Stewart is not here. Did you know Dr Stewart was going to be away this week?
8. Pt: [nodding] Yes, he mentioned he would be.

The physician acknowledged the patient's presumed concerns regarding the results of the tests:

9. Dr 3: Okay [nodding], very good then. Alright. Well.. as you know you had some tests recently and you're probably anxious for the results of them.
10. Pt: [nodding] Yes.

The physician asked for the patient's consent to receiving the news:

11. Dr 3: Um.. Would you like me to go ahead and give them to you now?
12. Pt: [nodding] I would appreciate that, yeah.

News delivery section:

13. Dr 3: Okay. Um.. The.. information that came back from the two new tests, the biphasic CAT scan and the Red Cell scan, indicate that the lesions that we're seeing on your liver uh.. are BENIGN or..
14. Pt: Oh.
15. Dr 3: are NOT, NOT related to cancer. And (unintelligible) hemangiomas, they are little… groups of blood vessels which we COMMONLY see um in people variant on normal and.. and effectively it uh.. rules OUT the CONCERNS that these lesions might in some way be related to.. cancer.
16. Pt: Oh that's (unintelligible).
17. Dr 3: not an old cancer, [shaking head, meaning "not"] a new cancer [Pt: nodding] So.. that's good news for now
18. Pt: Yes. (unintelligible)
19. Dr 3: I would say. [nodding] Yes (unintelligible). [Pt: nodding]

Discussing alternative explanations for the patient's symptoms:

20. Pt: [nodding]
21. Dr 3: So did you have any questions about that?
22. Pt: No.. I was (unintelligible) I must admit it [Dr 3: nodding] because I had uh.. (unintelligible) many years ago [Dr 3: nods]. And I was told that the lesions might turn cancers in my colon. And uh.. a… as you know a part of my colon has now been removed and I wondered if it was uh.. extending to.. other areas. But now you assured me that uh… these are benign lesions [Dr 3: nods] which are.. presumably not a problem.
23. Dr 3: [nodding] Yeah, as far as we understand
24. Pt: uh-huh.
25. Dr 3: [nods] that's right.
26. Pt: Do you recommend any treatment for them or… will they just subside by themselves.. or?
27. Dr 3: Well.. generally, we don't need to do anything specific about them.. [Pt: nods] um… they are the kind of thing that is good to know that they are there, we would watch them over time [Pt: nods]. We might repeat an investigation [interview continues]

At this point, the physician continued the interview reassuring the patient that the diagnosis was not cancer. She also reviewed the patient's symptoms and concerns and, after answering all the patient's questions, she closed the interview.

Focus of the Analysis of the Interviews

The analysis of the physicians' language was limited to the news delivery section of the interview, that is, the *first time the physicians delivered the patient's diagnosis.* This choice derived from several interrelated asssumptions: First, the news delivery section was the moment of the interview where the situational dilemma created by the experimental manipulation would have its greatest impact. That is, presenting the results for the first time should be the most difficult part of the interview for the physicians and, if the experimental prediction was correct, this section would definitely show differences in their language (i.e., more indirect language in the bad news condition). Second, when delivering the news for the first time, the physicians created a new situation for the patient who, after the bad news, was either "again a cancer patient" and, after the good news, continued to be "a healthy person." In this sense, Searle (1979) referred to diagnosing as an example of a particular activity that can only be carried out using language. This activity is comparable to saying the words "You're fired" or "I excommunicate you" (p. 13), where the speaker creates a state of affairs by the mere speaking of the words (e.g., someone is dismissed or removed from the church, respectively). Third, this news delivery section was comparable across different physicians and interview conditions. That is, all of the physicians delivered the news, although they preceded and followed it up in different ways.

Last, the section for analysis needed to be relatively brief in order to apply micro-analysis (which is a time-consuming procedure) to the 16 instances.

Procedure for Identifying the Section for Analysis

Two analysts (Sara Healing and the author), working by consensus, located in the transcripts the section that corresponded to the first time the physician conveyed the diagnosis. In both the good and bad news interviews, this section typically occurred after the physician had reviewed the patient's recent tests. The end of the delivery section usually came when the physician presented the treatment options (in the bad news interviews) or discussed the patient's symptoms (in the good news interviews). We included in this section everything the physician and the patient said (e.g., including re-starts and hesitations) but we did not analyze the patient's words. We also included what the physicians said about the diagnosis, even when what they said was not necessarily continuous (which only happened in a few cases). For example, we included only the parts in bold in the following example:

Example 4

1. Pt: Oh... you're not Dr Stewart?!
2. Dr 4: Hello
3. Pt: [looking worried] But where is my doctor?
4. Dr 4: Dr 4 Nice to meet you [shaking hands]
   Pt : You too.
5. Dr 4: Pat.
6. Pt: Pat, yes I'm Pat.
7. Dr 4: Alright. How are you today?
8. Pt: Well.. uh.. nervous.
9. Dr 4: Yes? [while sitting down]
10. Pt: Yeah, worried. Do you have good news or bad news for me? What's happening?
11. Dr 4: Well.. let me… get up to speed on a.. few things. **I have mixed-mixed news.**
12. Pt: Oh…

13. Dr 4: Alright? But I need to just uh…get a feel for- I'm standing in for your physician today and- and um… I had a talk with uh doctor X
14. Pt: [exhaling]
15. Dr 4: who is your oncologist?
16. Pt: Oh.. yes.
17. Dr 4: And he has some information for [unintelligible] asked me to pass on. So, I understand… just briefly, just so I get to sort of... know what's going on with you
18. Pt: [exhaling]
19. Dr 4: seven years ago you had a- cancer of the bowel,
20. Pt: Right [nodding]
21. Dr 4: you had it- uh… removed and everything else- [nodding] all the other tests at that time seemed to be good, [nodding] right?
22. Pt: Yeah [nodding]
23. Dr 4: And [shaking head] you- didn't have any therapies
24. Pt: [exhaling]
25. Dr 4: and.. in the last six months or so you've been feeling unwell again?
26. Pt: Well yes, I have uh.. [shaking head] not my self doctor [exhaling]
27. Dr 4: No? Can you-
28. Pt: Don't tell me this is.. all coming back again, is it uh? I thought they took it out of my- my bowel all-all-all removed.
29. **Dr 4: I- I think that part is fine, I think- um.. [shaking head] there is nothing that is showing in the abdomen, in the bowels or anything like that. There's some QUESTIONABLE**
30. Pt: [unintelligible]
31. **Dr 4: THINGS going on in the LIVER**
32. Pt: Oh, oh.
33. **Dr 4: which we will get to in a- in a minute.**
34. Pt: Is that pretty serious?
35. **Dr 4: [shaking head] Um… there's a couple of small spots in the liver,**
36. Pt: Oh…
37. **Dr 4: that ..um… you had some special tests done on them**
38. Pt: [exhaling]
39. **Dr 4: and they- there's a.. level of SUSPICION around the possibility they COULD be um.. metastatic lesions from your… um.. PREVIOUS cancer. Without an actual BIOPSY it is really hard to know for sure.** And you haven't had any recent scans.. in the last couple of years?
40. Pt: [shaking head] No.
41. Dr 4: in your liver? So we don't have any comparison to see.. you know, had they been there for a little while or not [Pt: nodding]. But you've been feeling-
42. Pt: Can they take your liver OUT?!
43. Dr 4: NO, no (unintelligible) they do in certain circumstances they do transplants but is not- not very often [shaking head] but you can.. this are isolated in one area [Pt: exhaling] so there is a

POSSIBILITY that they could actually take.. a PORTION of the liver out [nodding]

44. Pt: Oh! That's more surgery (unintelligible), isn't it?
45. Dr 4: [nodding] That'd be more surgery, yeah.

When the physician gave a forewarning of the news, we only included this as part of the news delivery section when the forewarning included information about the diagnosis. For example, a physician forewarned the patient saying:

> Okay. So... I'm just gonna tell you right now... what I'm about to tell you is not great, the results, but I have some solutions".

In this phrase the physician had explained that the results were "not great," which gave evaluative information about the diagnosis. Therefore, we included the whole phrase as part of the news delivery.

By focusing on the first time the physicians pronounced the diagnosis, we did not include instances in which the patient's diagnosis was discussed later in the interview. After the first delivery, this information was not "news" any longer but had become common ground, that is, information that both the patient and the physician shared.

Developing a System for the Analysis of Physicians' Language

Although Bavelas et al. (1990) had developed a system to analyse indirect language, we could not apply this system to these data because their system was designed to capture speakers' indirectness in an extremely controlled situation (i.e., a speaker's single responses to a predetermined, experimentally manipulated question). In contrast, the data we analysed were unstructured conversations in which very little of what the physicians said were answers to

questions, and the physicians' and patients' phrasings were entirely spontaneous, not experimentally structured.

The next step was then to develop a new system to capture indirect language that could be applied to the news delivery section of the interviews. The author developed this system inductively, using examples from both pilot data and from a few examples from the experimental data. Looking at a sub-set of the data, the author noticed patterns from which he derived several rules for analysing indirect language.

Taking an inductive approach (instead of applying an a priori coding system) was essential to learning from the videotapes and to capturing the meaning of what the physicians said and did. For example, after watching the videotapes several times, it was obvious that the physicians introduced uncertainty as a means of softening the impact of the bad news. This lead to rules for analysis of indirect language specifying that the physicians could achieve indirectness qualifying their degree of certainty. Using this principle, Sara Healing and I looked for any verb phrases with this function (i.e., indicating lack of certainty), even when the form of those verbs was different each time. Thus, in the two examples bellow, the verb phrases "are probably," "apparently confirm," and "look like," all portray the physician as less than certain about the tests results in very different ways:

> Well.. m-uh.. those two tests uh.. have indicated that th- the lesions *are probably* cancer

and

> and the.. the- *apparently* the results of the CT, specialized CT scan and the Red Cell scan *confirm* that these lu- lesions *look like* two, small, metastasis.

The author organized these rules (see Appendix K) into five analyses, each corresponding to an essential component of the news delivery message. These analyses, described in detail below, focused on

1) the physician's *term* for the diagnosis,
2) the physician's *evaluation* of the news,
3) the physician's *expressed certainty* about the diagnosis,
4) the physician's *reference to the receiver* of the diagnosis, and
5) the physician's identification of the *bearer* of the news

Developing each system involved an iterative process in which, for instance, the author created a draft of the rules, tested them on a few examples, and when problems arose (e.g., the rules did not account for a new example in the data), modified the rules to produce an explication of the analysis that would capture the new cases.

Technical Safeguards for Developing and Applying the Analysis System

Approaching the data inductively had two potential risks: developing rules that only fit the examples from which those rules were created and continuing to base the anaytical decisions on the researcher's intuition, rather than on the explicit rules (in spite of having those rules as a guide). To avoid these two problems, the author used the technical safeguards that Bavelas, Kenwood, and Phillips (2002) suggested for inductive research.

To address the first potential risk (i.e., overfitting the data), the author used a sub-set of the data to create the rules for each analysis. (See Appendix L for a list of the cases used to develop each analysis system.) Once the rules were comprehensive and clear, the author trained another analyst (Sara Healing) on

how to use them. Both analysts applied these rules to the same sub-set of data in order to refine them and, when we were confident that we had a final version, we applied them to the rest of the data set. We assumed that if the patterns that the rules were intended to capture were only random findings, these rules would not hold for the rest of the data set (Bavelas, et al. 2002).

To address the second potential risk, that is, to prevent analysts' bias or subjectivity, the two analysts applied the rules independently to the new data set and required high interanalyst agreement for every decision made.

Analysis of the News Delivery

Consider the following hypothetical, direct news delivery: "*I have bad news. You have cancer in your liver,*" or "*I have good news. You don't have cancer, you have hemangiomas*". In pronouncing these words, a physician introduces at least five components of the news delivery: the *name* of the diagnosis (i.e., "cancer" or "hemangiomas"), an *evaluation* of the news (i.e., "good" or "bad"); an *expressed degree of certainty* about the diagnosis (i.e., "you *have* cancer/hemangiomas"); a *reference to the patient* whom the message concerns (i.e., "*you* have…" and "in *your* liver"), and a *bearer of the news* (i.e., "*I* have…"). For the analysis in this thesis, the author assumed that a *departure* from any of the above direct versions of a message would constitute indirect language. The author then translated these five components into questions that guided the analysis of indirect language in the news delivery. These questions were:

1) "What term did the physician use to refer to the patient's diagnosis?". This question led to the *naming analysis*.

2) “What term or expression did the physician use to refer to his or her evaluation of the news?” This question focused on the *evaluation analysis*.
3) “What was the physician’s expressed degree of certainty about the patient’s diagnosis?” This question led to the *certainty analysis*.
4) “Did the physician explicitly refer to the patient as the receiver of the news?” This question lead to developing the *receiver analysis.*
5) “Did the physician explicitly identify him or herself as the *bearer of the news* at beginning of the news delivery?” This question was answered by the *bearer of the news analysis.*

Naming Analysis

The physicians could refer to the patient’s diagnosis using direct terms or, alternatively, indirect terms. For this analysis, direct terms were unambiguous names for the diagnosis, which could also include lay terms. Examples of direct terms were “cancer” or “metastasis” for the bad news condition, and “hemangiomas,” “benign blood vessels,” or “cysts” for the good news condition. In addition, the physicians could name the diagnosis directly by ruling out any alternative diagnosis (e.g., of cancer) and, in doing so, reassuring the patient. For example, in the good news condition, a physician said “these are totally benign *cysts* in the liver, *not cancers* at all.”

The physicians also had at least three indirect ways to refer to the patient’s diagnosis. As described in detail in the sections below, they could use euphemisms, they could use deictic expressions that pointed to the diagnosis

instead of naming it, or they could elicit the name of the diagnosis from the patient.

Euphemisms, were terms that referred vaguely to the diagnosis, such as terms designating a category in which the diagnosis was only one possible element; for example, “condition” (without further specification) or “tumor” (which can be benign or malignant).

Deictic expressions included pronoun forms such as “this” or “that” when used alone to point to an earlier use of a direct term such as “cancer.” That is, when it was possible for the patient to infer the name of the diagnosis from the information accumulated in the course of the conversation, the physicians could use a deictic expression instead of repeating the direct term. In the two examples below, the physicians used deictics to refer back to the word “cancer” (mentioned earlier in the conversation) without saying it explicitly:

> “We’re not going to be able to get rid of *this.*”
> “The biopsy does show *that.*”

Deictic expressions point out or specify a referent in the context of each particular conversation. The analysis of deictic expressions in this thesis only included those deictics that replaced a direct term for the diagnosis.

Last, instead of naming the diagnosis directly themselves, the physicians could elicit the direct term from the patient. In those cases, the physician’s role was only to confirm that the patient’s guess or assessment was correct. Maynard (1989) referred to this strategy as the “perspective display sequence.” The following example illustrates this strategy:

Example 5

1. Dr: But when you- what do you think- what has been going through your mind as what has been going on to cause this?
2. Pt: The worst of course.
3. Dr: Which is…?
4. Pt: That I have *cancer*.
5. Dr: Right.

Evaluation Analysis

The physicians could express their evaluation of the news using direct terms or, alternatively, using indirect terms or expressions. Direct terms included unambiguous words such as “good” or “bad” (news), “benign” or “malignant” (condition), etc. Indirect evaluations included euphemism or litotes, described below.

Euphemistic (or *qualified) evaluations* were terms that the physicians used to refer vaguely to their assessment of the news (rather than using other, more direct, terms). For example, instead of referring to the “bad news” explicitly, one physician referred to the news as “a *little disappointing,*” or instead of referring to the patient’s condition as “terminal,” another physician referred to it as a “*serious* condition”. Euphemistic evaluations of the good news included terms such as “*encouraging* news” or when a physician evaluated his patient’s condition as “*reasonably* good”.

The physicians could also refer to their evaluation of the patient’s diagnosis indirectly by using a form of understatement called *litotes* (Bergmann, 1992; cited in Lutfey & Maynard, 1998), that is, by negating the contrary of the original direct term. For example, a physician used the expression “this is *not great* news” instead of “this is *bad* news”. The equivalent litotes in the good news condition

would be “not bad news,” although it turned out that none of the physicians used this expression.

Certainty Analysis

The physicians could express their degree of certainty about the patient’s diagnosis at several different points: when they explained what the tests had shown (e.g., “the tests *suggest/confirm/are consistent with*…”), when they explained what the lesions in the patient’s liver were (e.g., “*these are* cancers” or “the two spots *look like* blood vessels”), or when they provided further information about the patient’s diagnosis (e.g., *it’s* a variant on normal” or “things *look* reasonably good”). When making any of these statements, the physicians could express an opinion that was less than certain, definite, or emphatically definite, about the information conveyed. For example, one physician characterized the results as *emphatically definite* about the nature of the patient’s lesions when he said “these are *not at all* cancers”, and another physician characterized them as *definite* when he said “these *are* cancers”. However, another physician conveyed a *less than certain* diagnosis when she said “the two spots *look like* blood vessels”. Less than certain statements corresponded to what Caffi (1999), following Lakoff (1973), identified as *hedges*.

(Note that this analysis focused only on the expressed degree of certainty or on how the physician characterized the results and not on the physician’s actual degree of certainty. That is, the focus and claim here was that physicians *expressed* themselves as if they had been emphatically certain, certain, or less than certain about the diagnosis and not that they felt or perceived themselves in any of these states. It is possible to treat the physician’s choice of language as

representing ways of *portraying* the information to the patient independently of the physician "internal" degree of certainty.)

Emphatically definite statements contained a verb accompanied by an adverb, another modifier, or some variation of the verb that indicated complete certainty about the information. Examples of emphatically certain statements were "the tests *did confirm*…," "this results *effectively rule out*…," or "these are *not at all* cancers". *Definite statements* contained a neutral or an unmarked verb (i.e., not accompanied by an adverb or modifier) indicating that the diagnosis was certain but no more or no less than certain. Examples of these statements were "those two tests *are consistent* with a diagnosis of cancer," "the lesions *are not* related to cancer," or "*It is* a variant on normal". Finally, *less than certain statements* contained a verb accompanied by an adverb, a modifier, or a variation of the verb that undermined or qualified the certainty of the diagnosis. Examples of these were "from the [evidence of the] tests, *it seems* that you have…," "these lesions *might be* related to cancer…," "this *looks like* a group of blood vessels," or "this *is probably* cancer".

The physicians could also indicate a lack of certainty by producing personal disclaimers that undermined or "poked holes in" their own expressed certainty regarding the diagnosis. For example, a physician said "we think that there is a cancer involving the pancreas. *Now.. um.. that's just on the basis of the test results we got,*" and another physician said "it would appear, *although we haven't- um.. it isn't final*.. that you have a type of cancer."

In connecting statements about certainty to the analysis of directness/indirectness, the analysts worked under the assumption that the

information that the physicians received in the case scenario expressed certainty about the results. Therefore, we considered those statements indicating certainty about the diagnosis (i.e., certain and emphatically certain statements) as cases of direct language, and, conversely, we considered those statements indicating lack of certainty (i.e., less than certain statements and disclaimers) as cases of indirect language. That is, the indirect statements departed from the standard (direct) news delivery.

Receiver Analysis

During the news delivery, the physicians had several opportunities to use second-person pronouns ("you" or "your") as a way of referring directly and explicitly to the patient as the receiver of the news. Alternatively, they could use a generic form that would only indirectly or implicitly identify the patient as the receiver of the news. The following examples illustrate some of the ways that the physicians did or did not introduce "you" when delivering the news: (a) When referring to the patient's diagnosis, a physician said "*You have* two dilated blood vessels" (instead of using an indirect form such as "*these are* two dilated blood vessels…" or "*there are* two…"). (b) When referring to the lesions in the patient's liver, a physician said "*your* lesions…" (instead of using an indirect form such as "*these* lesions"). (c) When referring to the location of the diagnosis, a physician said "The two spots in *your liver* look like dilated blood vessels" (instead of using an indirect form such as "The two spots *in the* liver…"). (d) When referring to what the cancer did, a physician said "*Your* colon cancer has come back" (instead of using a more indirect form such as "*the* colon cancer has come back").

For this analysis, the physicians' explicit reference to the patient (e.g., "*you* have cancer in *your* liver") were cases of direct language, and their use of a general, impersonal, or implicit reference (e.g., "*it is* cancer in *the* liver") were cases of indirect language.

Bearer of the News Analysis

Before the news delivery or at the very beginning of it, the physicians could frame the news as their own message by using a first-person pronoun. For example, a physician said "*I'm* pleased to say that the tests are entirely normal" and another physician said "*I have* mixed- mixed news". When the physicians inserted the first-person pronoun at the outset of the news delivery, they made themselves the explicit source of the news delivery and therefore were using direct language.

The physicians also had available at least two indirect strategies. They could, for instance, negotiate the source of the news delivery by asking for the patient's consent to hear the news. The following example illustrates this strategy:

Example 6

1. Dr 6: And.. [nodding] *you want me to give you*…?
2. Pt: Yeah.
3. Dr 6: [nodding] *all the results no matter what they are [while nodding] yes*, (unintelligible)
4. Pt: [nodding] I need you to, yeah I need to get- I need to [nodding emphatically]
5. Dr 6: Okay.
6. Pt: I'm hoping (unintelligible)
7. Dr 6: Of course. Yeah, that's- yeah. Whatever you want to know we'll do.

[Later in the interview]

8. Dr 6: Well…unfortunately [wincing] *you wanted to know this*, and the.. the-apparently the results of the CT, [nodding] specialized CT scan and the Red Cell scan [nodding] confirm that these lu- lesions look like two.. small.. metastases. [nodding] That the colon cancer has come back in the liver.

The physicians could also act as if they were only passing on the information given to them by using the tests or even a colleague (e.g., the radiologist) as the source of the news. For example a physician said “Well.. m-uh.. *those two tests uh.. have indicated* that th- the lesions are probably cancer”. For the purpose of this analysis, the author considered these last two strategies (i.e., negotiating who was the source for the news delivery and just “passing on” the information) as cases of indirect language. Note that this way of being direct or indirect was different from all of the previously described ways because it could only happen once, namely, at the beginning of the news delivery where it framed the rest of the message.

Reliability

Two analysts (Sara Healing and the author) established independent reliability for each of the five analyses. As noted above, we used some of the 16 interviews to create the rules for each analysis and then tested our reliability on the remaining interviews, which were usually the majority of cases. After calculating our independent inter-analyst reliability, we resolved any disagreements together.

For the *naming analysis*, we identified all of the terms the physicians used to name the patient’s diagnosis and decided whether each term was direct, a euphemism, a deictic expression, or a case where the physician had elicited the

name of the diagnosis from the patient. The reliability for all of our decisions in 11 of the 16 interviews was high, with agreement on 37 of the 39 decisions we made (95%).

For the *evaluation analysis*, we identified all the terms or expressions the physicians used to give an evaluation of the patient's diagnosis and also decided whether they were direct terms, euphemistic evaluations, or litotes. We calculated reliability for all of our decisions in 10 of the 16 interviews, and again reliability was high, with agreement on 26 of the 27 decisions we made (96.3%).

For the *certainty analysis*, we establish reliability at three steps of analysis (instead of only one step as in the previous cases). After each step, we resolved any disagreements before proceeding to the next step. First, we identified in each of the transcripts all of the verbs and verb phases that the physician used in the news delivery. Because this was a fairly straightforward step, we calculated reliability in only 7 interviews and did not calculate reliability for the remaining 4 interviews (we had used the 5 other interviews to make the rules for this analysis). Reliability for this first step was high, with agreement on 69 of the 70 decisions we made (98%). In the second step of analysis, we selected from the verbs identified in the first step only those verbs and verb phrases used by the physicians specifically to deliver the news. For example, we did not include the verbs used by the physicians to refer to themselves (e.g., "we've received" or "I'm afraid") or verbs that the physicians used to talk about a procedure that the patient had undergone (e.g., "the biphasic CT and the Red Cell scan that were done). Inter-analyst reliability for deciding whether a verb phase was specifically about the news delivery was high for the 11 of 16 interviews tested; we agreed on

89 of the 97 decisions (92%). In the third step, the two analysts decided whether the verbs or verb phrases identified in the previous step were emphatically definite, definite, or less than certain. Inter-analyst reliability for the same 11 of 16 interviews was high, with agreement on 56 of the 57 decisions we made (98%). For the analysis of the physicians' *disclaimers*, the two authors identified in the transcripts each time a disclaimer about the diagnosis occurred. We agreed on all 9 of the 9 decisions we made independently in 8 of the 16 interviews.

For the *receiver analysis*, we identified each time the physicians referred to the patient's health, diagnosis, location of diagnosis, etc., and whether they used a second-person pronoun to identify the patient or used a generic or impersonal form. We calculated reliability for all of our decisions in 8 of the 16 interviews and it was good, with agreement on 34 of the 42 decisions we made (82%).

For the *bearer of the news analysis*, we analyzed only the beginning of the news delivery. That is, we only looked for a first-person pronoun in the first part of the transcript because we assumed that the framing of the news could only happen once, at the beginning. We decided, for 8 of the 16 interviews, whether the physician framed the news as his or her own responsibility, negotiated the responsibility of the news with the patient, or acted as if he or she was merely passing on the information. Inter-analyst reliability was very high, with agreement on all 8 of the 8 decisions we made.

CHAPTER 5:

RESULTS

There are three different kinds of effect of experimental condition: quantitative differences in the rates of direct and indirect language; qualitative illustrations of those differences; and the reports of the volunteer patients on the physicians' communication.

Quantitative Effects of the Experimental Manipulation

Calculating the Dependent Measure

The appropriate test for experimental effects of the bad versus good news condition is a comparison of the rate of direct or indirect language in each condition. As explained bellow, this rate was the frequency for each physician adjusted for the total amount the physician spoke.

To arrive at the initial frequencies, all instances of direct or indirect language were weighted equally. That is, any occurrence of a euphemism, litotes, less-than-certain verb, etc., counted as one incident of indirectness, and any use of an unambiguous term for the name of the diagnosis, definite verb, explicit reference to the patient, etc., was one incident of directness. Table 2 shows that the resulting total frequencies of indirectness and directness for both the good and the bad news conditions were in the predicted direction.

Table 2

Frequency of Indirect and Direct Terms for all Physicians as a Function of the News.

	Physicians' Language	
Condition	**Indirect terms**	**Direct terms**
Bad news	71	47
Good news	37	110

It is clear that there was a higher occurrence of indirect terms during the bad news than during the good news and, conversely, there was a higher number of direct terms in the good news than the bad news.

However, these frequencies could be related to how much the physicians talked; if he or she said more, there was more opportunity to use direct or indirect terms. Although there was no significant difference between conditions in the number of words used to deliver the news (p = .71), there was a wide variation in how much the physicians said while delivering each news (range = 30 to 132 words). The solution to this potential problem of interpretation is to convert the frequencies into *rate measures*, adjusting each physician's frequencies of indirect and direct terms for the number of words that physician used to deliver the news (e.g., the number of indirect terms in the bad news condition divided by the number of words analyzed in that condition for the particular physician). This computation creates a *rate of directness* and a *rate of indirectness* for each physician according to how much the physician talked in each condition. Because

the rates per word are necessarily very small fractions, the usual practice is to multiply them by 100 to obtain *rates of indirectness and directness per hundred words,* which are more intuitively accessible to the reader than rates per word.

Differences between Conditions

Within-subjects *t*-tests of the hypothesis revealed that the physicians used indirect language at a higher rate in the bad news condition than in the good news condition and, conversely, that they used direct language at a higher rate in the good than the bad news condition. Table 3 and Figures 2 and 3 illustrate these findings.

Note that there was still some use of direct language in the bad news condition and, conversely, some use of indirect language in the good news condition. This was possibly because, as these results reflect, some degree of indirect and direct language is normal in communication. Therefore, the prediction supported in this thesis was that the experimental manipulation would *vary* the proportion of direct/indirect language rather than claiming that indirect language would be completely absent in the good news condition and that direct language would be absent in the bad news condition.

It is important to note that, because of the small number of physicians participating in this study, there was less statistical power to detect the predicted differences. In spite of this disadvantage, there was statistical support for the hypothesis. A within-subjects research design (i.e., testing all physicians in both the good and bad news conditions instead of dividing the sample of physicians in two groups) was helpful in this regard because it increased the total number of

observations of indirect language in the data and it reduced the error variance created by individual delivery styles among physicians.

Table 3

Mean Rates of Indirect and Direct Language Per Hundred Words as a Function of Experimental Condition.

	Physicians' Language	
Condition	**Rate of Indirect Terms per 100 Words**	**Rate of Direct Terms per 100 Words**
Bad news	11.30 (3.22)	8.35 (2.07)
Good news	5.45 (1.63)	17.21 (4.01)
M_D	5.84	8.86
$t_{(7)}$	5.51*	-6.35*
SE	1.06	1.39

Note. Standard deviations are given in parentheses.

*$p < .001$, two tailed.

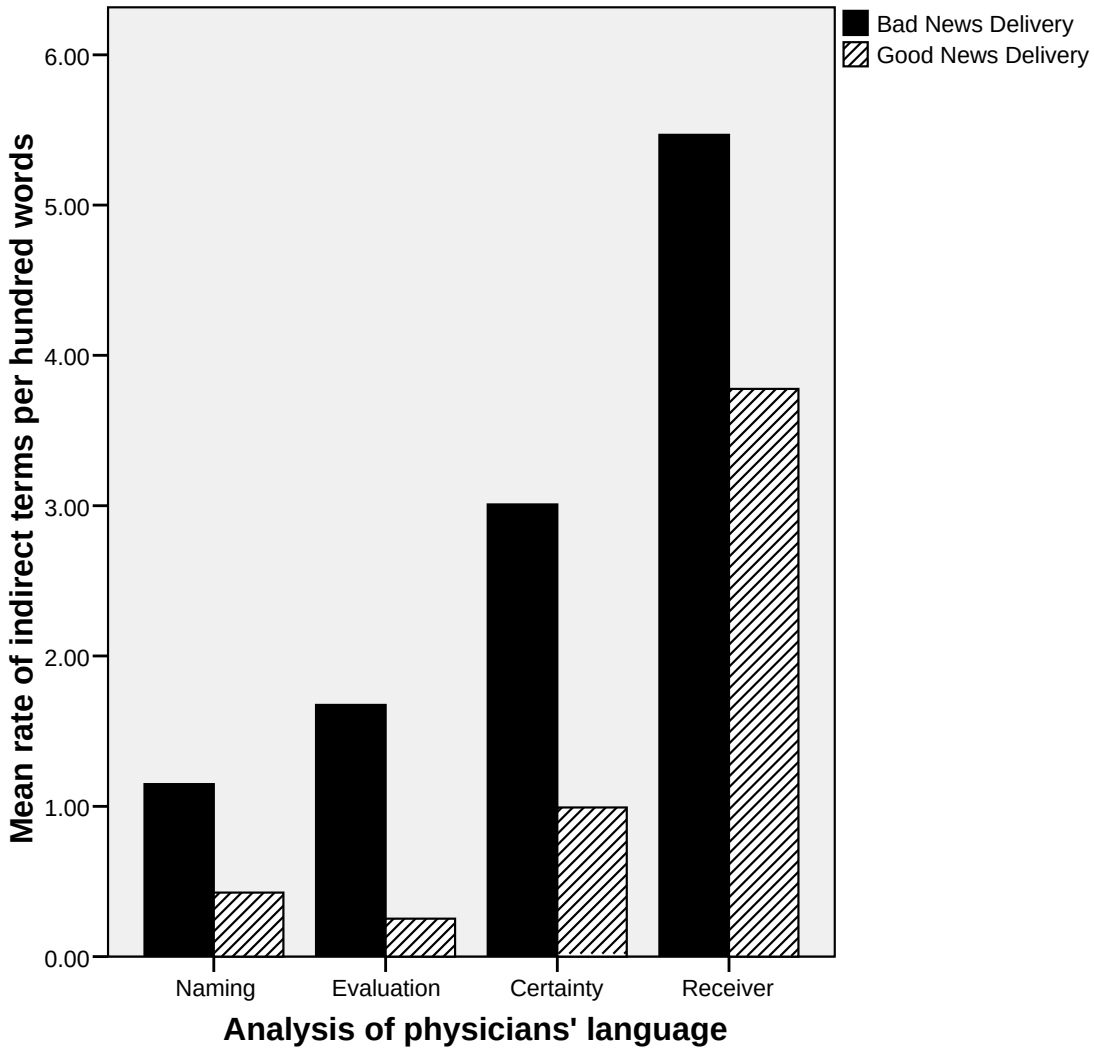

Figure 2. Mean rate of indirect terms per hundred words as a function of experimental condition.

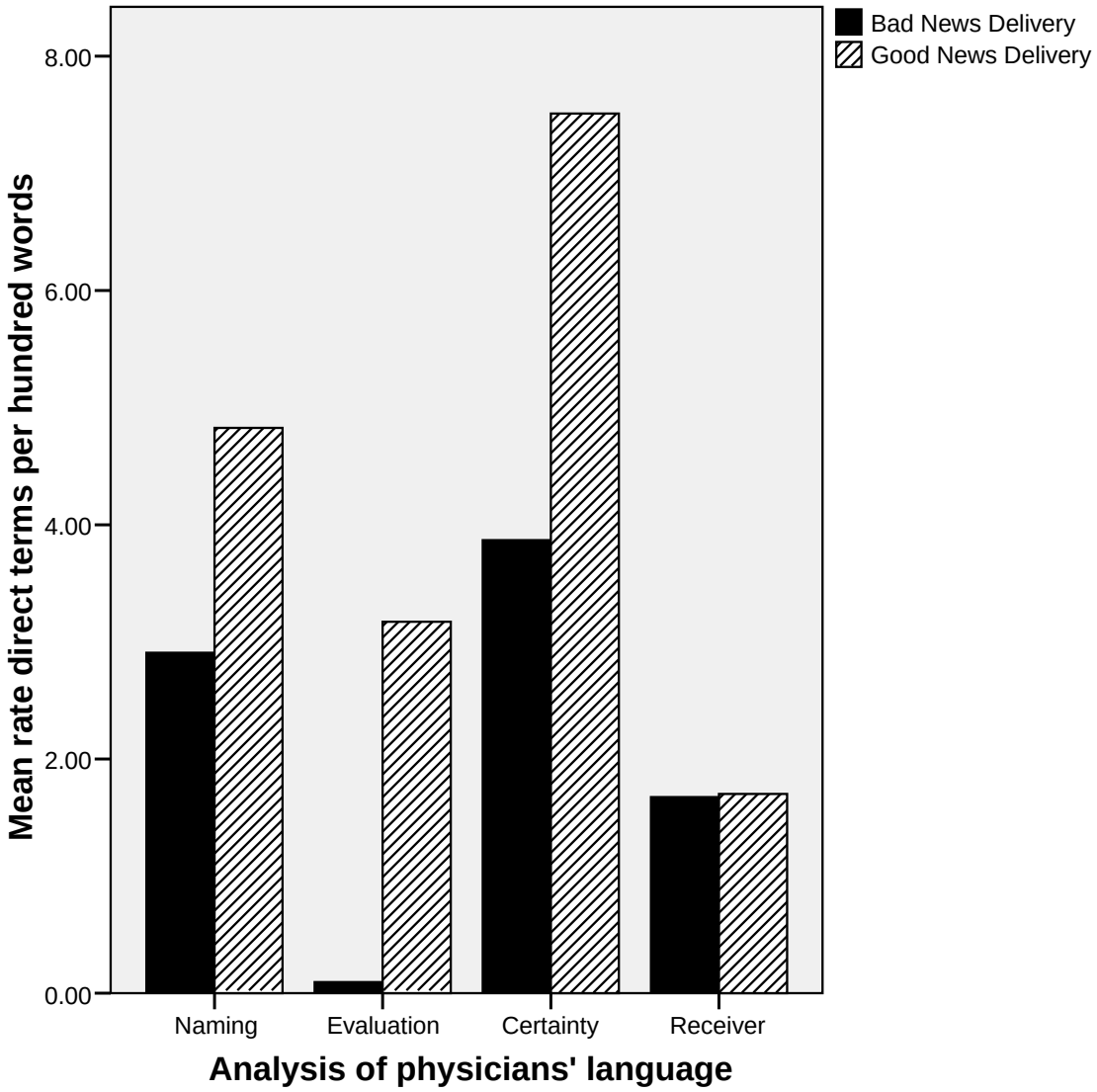

Figure 3. Mean rate of direct terms per hundred words as a function of experimental condition.

Qualitative Analyses of the News Delivery

An utterance-by-utterance (qualitative) analysis of the language that two physicians used to convey the bad and the good news will illustrate the quantitative results. What follows is a transcript of each good and bad news delivery sections for each of these physicians, with the analyzed terms in boldface. A comparison of the language that the physicians used with the language that they could have used (e.g., the direct alternative to their indirect choice) further illustrates the analysis.

Example 7: Bad News

1. Dr 1: and these are the results that **we're** going to discuss today.
2. Pt: Okay.
3. Dr 1: Um… you're **fine.. you're fine with me if I just give you the results directly** and ah- ah-
4. Pt: **I would like to know them** <u>because, you know</u>, I'm a widow now
5. Dr 1: [nodding] **<u>You'd like to know</u>.**
6. Pt: and I don't want to… fool around with that**. Whatever I have to know, I might as well know it now.**

What the physician said (Indirect language)	*What the physician could have said (Direct language)*
In line 1, the physician used the pronoun "we" to frame the news delivery discussion as a shared conversation. In line 3, she asked for the patient's consent to hearing the news and, only after receiving this consent (lines 4 and 6) did she go on to deliver the news (line 7). In requesting for the patient's consent to hear the news, this physician shared the responsibility for the delivery with the patient. It is also interesting to point out that the physician characterized her delivery as direct (line 3) when, in my terms, she was being rather indirect.	The physician could have framed her message as a "one-way" delivery, making herself the only source of the news. She could have also not addressed the patient's consent to hear the news and referred to the patient more explicitly as the receiver of the news using a personal pronoun ("you"). For example, she could have said "Here are the results that *I'm* going to give *you* today".

Example 8: Continuation from Example 7

7. Dr 1: Okay. Alright, well both tests that you have done, both the biphasic C.A.T. scan and the Red Cell scan **confirmed** that [nodding] **you've got** two **small** deposits of **tumor** in **the** liver.
8. Pt: [surprised face]In the liver!?
9. Dr 1: [nodding] Uh-huh, uh-huh.

What the physician said (Indirect language)	*What the physician could have said (Direct language)*
In line 7, the physician was more definite about the diagnosis (i.e., "both tests *confirmed* that [nodding] you*'ve got*…"), but she used a euphemistic evaluation to refer to the severity of this diagnosis ("*small* deposits of tumor"). She also used a euphemism to name the diagnosis ("deposits of *tumor*") and an impersonal form when referring to the location of the cancer ("in *the* liver").	The physician could have been more direct by omitting her euphemistic evaluation and by naming the diagnosis directly. She could have also used a personal pronoun ("*your* liver") to connect the diagnosis more explicitly to the patient. For example, the physician could have said "both the biphasic CAT scan and the Red Cell scan confirmed that you've got two *metastases* in *your* liver".

Example 9: Good news

1. Dr 1: So you just had those two tests and [nodding]those- that's the results that **I'd like to give you today**.
2. Pt: [nodding] Okay.
3. Dr 1: [nodding] Okay? Um.. and.. the **GOOD news is**.. [smiling and nodding] that the two spots in **your** liver **look like dilated blood vessels**, **they DON'T [shaking head] look like the return of your cancer [nodding]**
4. Pt: Okay. What a relief! [smiling]
5. Dr 1: What a relief! [smiling] Yeah. Um…[nodding] both tests **point** the same way
6. Pt: [nodding]
7. Dr 1: Okay? Um.. both the CAT scan and the Red Cell scan look like these **are dilated blood vessels** in **your** liver [nodding]
8. Pt: Uh-huh
9. Dr 1: **rather than tumor** [nodding]

What the physician said (Direct language)	*What the physician could have said (Indirect language)*
In line 1, the physician framed the news delivery as her own message and referred explicitly to the patient as the receiver of the news ("that's the results that *I'd like* to give *you* today). In line 3, she evaluated the news and named the patient's diagnosis using direct terms ("*good* news" and "dilated blood vessels", respectively). Although in line 3 she used a verb form that could have portrayed her as less than certain about the diagnosis (i.e., "the two spots in your liver *look like* dilated blood vessels"), she conveyed certainty by reassuring the patient twice (lines 3 and 9) that the spots in the patient's liver did not indicate cancer.	The physician could have been more indirect by not introducing herself as the bearer of the news (e.g., by asking the patient if she wanted to hear the news), using a euphemistic evaluation (e.g., "the news is not bad", and conveying more uncertainty about the diagnosis, among other things. For example, she could have said "The news is not bad. The spots in the liver don't look like the return of your cancer. However, it is hard to know for sure without a biopsy."

Example 10: Bad news

1. Pt: Do you have good news or bad news for me, what's happening? [breathing rapidly and looking worried]
2. Dr 4: Well, let me... get up to speed on a few things. **I have mixed-mixed news** [Pt: Oh!], alright?

What the physician said (Indirect language)	*What the physician could have said (Direct language)*
In response to the patient's direct question, the physician reduced the severity of the news with a *euphemistic evaluation* (i.e., "I have *mixed* news").	The physician could have been more direct by responding to the patient's question choosing the same (direct) evaluative option presented by the patient (i.e., "I have *bad* news.").

Example 11: Continuation from Example 10

3. Pt: **Don't tell me this is.. all coming back again, is it uh?** I thought they took it out of my- my bowel, it was all-all-all removed.
4. Dr 4: I- I think that part is FINE, I think- um.. [Pt: exhaling] there is [shaking head] nothing that is showing in the abdomen, in the bowels or anything like that. [Pt: exhaling] **There's** some **QUESTIONABLE THINGS** going on in **the** LIVER [Pt: Oh, oh] which we will get to in a- in a minute.

What the physician said (Indirect language)	*What the physician could have said (Direct language)*
In line 3, the patient once again confronted the physician with a difficult question. After clarifying the patient's overt concern, the physician proceeded to communicate the diagnosis (line 4). In doing so, he used several impersonal forms that did not explicitly connect the diagnosis to the patient ("There's" or "in *the* liver"), he used a euphemistic evaluation to reduced the severity of the diagnosis ("*questionable*"), and a euphemism to name the diagnosis ("*things*").	The physician could have answered directly by connecting the diagnosis more explicitly to the patient using a personal pronoun. He could have also used more direct terms for his evaluation and naming of the diagnosis. For example, he could have said "*You* have a *dangerous metastasis* in *your* liver".

Example 12: Continuation from Example 11

5. Pt: [looking worried] Is that pretty serious?
6. Dr 4: [shaking head] Um… **there's** a couple of **small** spots in **the** liver… Pt: Oh] that… um… you had [Pt: exhaling] some special tests done on them and they- **there's a..** [nodding] **level of SUSPICION** [Pt: nods] **around the possibility they COULD be** [Pt: exhaling] um.. **metastatic lesions** from **your**… um.. PREVIOUS cancer. **Without an actual BIOPSY it is really hard to know for sure**.

What the physician said (Indirect language)	*What the physician could have said (Direct language)*
In response to the patient's question, the physician attenuated the gravity of the diagnosis using a euphemistic evaluation ("*small* spots") and used a euphemism that softened the concern about the patient's diagnosis (i.e., "there is a *level of suspicion*"). He also used various impersonal forms (e.g., "*there's* a couple of…in *the* liver") and uncertainty (line 6 "*suspicion…possibility* they *could be*…," etc.). Notice that, in spite of the overall indirectness of this delivery, the physician eventually used a direct name for the diagnosis (i.e., "metastatic lesions").	The physician could have answered the patient's question more directly using personal pronouns to connect the cancer to the patient, by conveying more certainty, and by referring to himself as the source of the information. For example, he could have said "*I understand* that *you have* metastatic lesions from *your* previous cancer".

Example 13: Good news

1. Dr 4: Anyway, **I** can tell **you** that the- they're.. **VERY confident** that **these are**.. [shaking head] **TOTALLY benign**.. [nodding] **cysts**.. in **the** liver.. [shaking head] **not cancerous at all…**
2. Pt: Not cancerous? [nodding]
3. Dr 4: [shaking head] No.
4. Pt: That's a relief.
5. Dr 4: And that all the blood tests.. **are normal**. So with regards to.. liver enzymes to… um… electrolytes , hemoglobin, creatinine for kidney function
6. Pt: Uh-huh.
7. Dr 4: so... [nodding] **this is** a **very good** report [smiles]. From the- (unintelligible)
8. Pt: cancer-
9. Dr 4: **Good** report for scree- [Pt: unintelligible] for screening for.. **for… recurrence of a cancer**…

What the physician said (Direct language)

In line 1, the physician framed the good news delivery as his own message and referred explicitly to the patient as the receiver of the news (i.e., *I* can tell *you*…"). In contrast to the bad news delivery, he conveyed himself as emphatically certain about the patient's diagnosis (i.e., "these *are totally* benign…" and "*not* cancers *at all*"). The physician named the diagnosis directly ("cysts"), reassured the patient about the diagnosis (i.e., "not at all cancers"), and used a direct term each time he evaluated the diagnosis (e.g., "totally *benign,*" "all the blood tests are *normal,*" "this is a *very good* report"). Notice that some indirect terms were also present in this physician's good news delivery. For example, in line 1 when he referred to the location of the patient's "cysts," the physician used an impersonal form (i.e., "in *the* liver") instead of a direct one (i.e., "in *your* liver").

What the physician could have said (Indirect language)

The physician could have been more indirect by using the tests as the source of the good news delivery, making the diagnosis less directly related to the patient, inserting uncertainty, and using an indirect term for his evaluation of the good news. For example, he could have said: "The test results indicate that these are cysts, which are probably not a serious condition in the liver. So this is an okay result."

Patients' Accounts of the Bad News Delivery Interview

As the results have indicated, indirect language was the physicians' response to the situational dilemma of delivering bad news. This finding, however, did not provide evidence for the *effect* of indirect language on the recipients. If, as proposed in this thesis, indirect language allows the physicians to convey bad news truthfully while avoiding crushing their hope, then two questions had to be addressed: (1) "Did the volunteer patients understand the diagnosis in spite of the physicians' indirect language?" and (2) "Did the volunteer patients think that the news was delivered to them tactfully and with hope?" These two questions correspond to the two sides of the physicians' dilemma: "be honest" and "be kind." The study provided three lines of evidence addressing one or both of these questions.

Evidence in the Interviews

The transcripts of the volunteers' immediate reactions to the news provided evidence relevant to the first question. Immediately after receiving the bad news, the volunteers made statements or asked questions that *presupposed* their understanding of the news. Notice, for example, the volunteers' response to the physicians' delivery in the following two interviews:

Interview Excerpt 1

1. Dr 5: Well.. m-uh.. those two tests uh.. have indicated that th- [nodding] the lesions are probably cancer. [Pt: nods] Umm. It doesn't tell us completely what type of cancer but it uh.. PROBABLY is.. from the colon but [shaking head] we don't know for sure, we don't know.
2. Pt: **[nods] Is uh- so similar.. similar to the... uh… [nodding] type of cancer that was found in the colon?**
3. Dr 5: That's right [nodding] Yeah.

After learning from the physician that the lesions in his liver were “probably cancer” (line 1), the volunteer’s immediate reaction (line 2) was to nod and to connect his current diagnosis with his previous diagnosis of colon cancer. He did not follow up on the physician’s indication of uncertainty (“probably”) but understood it as given that this was cancer. In line 3, the physician confirmed the volunteer’s assessment both verbally (“that’s right, yeah”) and nonverbally (nodding).

Interview Excerpt 2

1. Dr 1: Okay. Alright, well both tests that you have done, both the biphasic CAT scan and the Red Cell scan confirm that [nodding] you’ve got two small deposits of tumor in the liver.
2. Pt: **In the liver!? [indicating surprise with her face]**
3. Dr 1: [nods] Um.. and.. in my conversation with um.. with Dr X the other day and in the note that he’s written and when he saw you previously
4. Pt: [nodding] uh-huh
5. Dr 1: Uh.. he thought that, you know, further treatment was definitely a consideration.
6. Pt: **[nods] [pause] wou- [facial display of surprise] would it take seven years to have a- to find out that there is something wrong?**

In this example, after hearing the results of the tests (line 1), the volunteer did not ask what the euphemism “to small deposits of tumor” meant but instead reacted with surprise (line 2) about the location of this tumor. With her question (line 6), she indicated that she understood the negative nature of her diagnosis. That is, although the volunteer did not say the word “cancer” here, her question linked the physician’s bad news delivery directly to her previous diagnosis of cancer.

Evidence in the Volunteers' Letters

Another piece of evidence to support the claim that the volunteers understood their diagnosis was the information in the letters that they wrote to their family physicians. Recall that in these letters they explained to an imaginary family physician what their diagnosis and prognosis was. The information in this letter, then, allowed the author to ensure that the volunteers understood the diagnosis and its implications. The following quotations from the letters of the volunteers in the bad news condition support this prediction:

Pt 1: "It's hard to accept that previous results in the past seven years have not shown any indication that there could be any **cancer cells present**."

Pt 2: "He [referring to the physician who interviewed this volunteer] confirmed that the result of the latest CT and other tests denote that **the lesions on my liver are indeed malignant** and that further examination should take place." "When I asked whether the **cancer** was operable…"

Pt 3: "**The results are or don't seem to be very good**. I would like to talk to you before I see anyone else about **the diagnosis of liver cancer**."

Pt 4: "I am grateful for the news that at my age **tumours** are slower growing, and prospects may be better than I anticipated."

Pt 5: "He explained the findings from the CT scan of the liver and explained the possible treatments to remedy the **cancer found in my liver**."

Pt 6: "I was very shocked when I was given **the news about my liver cancer**; I know you were unable to tell me yourself."

Pt 7: "Today I met with Dr X to learn the results of my recent tests. As you know, and as I feared, **cancer is back**."

Pt 8: "Dr Y informs me that the test results of **the lesions on my liver has metastasized and that it is at Stage 4 cancer level**."

Evidence from the Interviews with the Volunteers

In regard to the second question, that is, how the volunteers' perceived the delivery of the bad news, the prediction in this thesis was that they would perceive the physician's delivery style as tactful and hopeful. In order to answer this question, the author conducted a tape-recorded interview with the volunteers that received the bad news. (See *Chapter 3* for more details about this interview.) Note that, even though there could not be a one-to-one correspondence between the volunteers' global opinions of the physicians' communication during the interview as a whole and the very particular microanalysis of the bad news delivery section (i.e., the section selected for analysis), there was still considerable confirmation of the prediction: For 7 of the 8 bad news cases, the volunteers' answers indicated that they recognized and appreciated the tactful nature of the news delivery. They conveyed this impression by describing the physician's delivery style with terms and phrases such as the following:

Pt 1: "calm"
Pt 2: "he didn't alarm me in any way (…) he conveyed it very… quietly"
Pt 3: "very gentle," "considerate," "not giving me a specific diagnosis but leading to it"
Pt 4: "very gently," "he has a very calming effect"
Pt 5: "laid back, didn't come on hard"
Pt 6: "I would say she was being kind and gentle and she was certainly very sensitive to my feelings," "compassionate," "it wasn't at all blunt, the hope was there"
Pt 7: "It was very gentle and caring"

In their accounts, some volunteers came close to articulating the communicative dilemma faced by the physicians, and they were pleased by how the physicians resolved this dilemma. They expressed this using phrases such as:

Pt 3: “it was bad news with hope”
Pt 4: “the genius of him…was that we could talk about a difficult subject with such, kind of, non-threatening, reassuring way,” “he presented the serious information to me in a respectful way and he could have come on quite more bluntly”
Pt 6: “She was upfront and honest, but wasn’t matter-of-fact”
Pt 7: “She told me the bad news, but… just in a way that sort of matched what I felt was appropriate. She didn’t say, “You’re gonna die” or, “We’re going to have to cut you up more” or anything abrupt or shocking like that.”

Surprisingly, in a number of cases, the volunteers’ perception of the news delivery was that the physicians were *direct*. A few of the volunteers, for example, said:

Pt 1: “The doctor was pretty direct, saying what the results were”
Pt 4: “it was very conversational and very straightforward”
Pt 7: “she didn’t mess around. She came right to the point” “I liked her honesty. Very straightforward approach.”

This last finding supports one conclusion in the review of the medical literature (in *Chapter 2*) about using reports of the bad news delivery to explain what actually occurred during the delivery process. Although the physicians used indirect language to deliver bad news, the volunteers’ perceptions were that the physicians were *straightforward*. Apparently then, the amount or kind of indirect language the physicians used was within what the volunteers’ considered straightforward communication. In any case, none of the volunteers reported perceiving a physician as evasive or excessively indirect.

As noted previously, one volunteer’s assessment of the physician’s delivery style was not positive. This volunteer’s opinion was in marked contrast to the rest of the volunteers, and she used the following words to describe the physician’s bad news delivery style:

> Pt 8: “It was just telling me. I didn’t feel the compassion. But it was very business-like. It was like a straight interview with no compassion. Because, as soon as she came in, she introduced herself and--you know--asked me how I was and immediately went on to the news, like to tell me what the results of my test.”

This description of the physician’s style suggests that, in the volunteer’s view, the physician focused on the “be truthful” side of the dilemma and dismissed the “be tactful” side of it, coming across as blunt. It is interesting to speculate why this volunteer’s account is different from the accounts of the rest of the volunteers in this study. First, a possible reason for the volunteer’s negative assessment is that the physician was not as experienced delivering bad news as the rest of the physicians in this study. This is a plausible explanation considering that this particular physician was the only one with less than 3 years of experience as an oncologist. (Recall that the mean years of experience for the rest of the physicians was 19.30 years.) Second, an examination of the rate of indirect terms for each physician indicates that the physician who interviewed this volunteer produced the *highest* rate of *direct* terms per hundred words and was in the *lower end* of the rate of *indirect* terms per hundred words, compared to the other bad news interviews. These results suggest that the physician who interviewed this volunteer was the most direct and among the least indirect ones. This high rate of direct terms and relatively low rate of indirect terms may have therefore led to the volunteer’s less-than-positive evaluation of the physician’s delivery. Third, this volunteer’s opinion is a good reminder of the potential disparity between the volunteers’ perception after the interview (which encompassed the whole interview) and the specific section of the interview analyzed in this thesis. For example, further along in the interview, after having delivered the bad news, the

physician used very direct terms that could have accounted for most of the volunteer's unfavorable assessment: In response to the volunteer's question regarding the stages of care that she was going to go through, the physician responded with:

1. Dr 8: what we DO know in terms of stage, though, is when… there are cancers in… parts of the body… other than when they started
2. Pt: [nods] yeah
3. Dr 8: it is considered **metastatic**. **It is stage four out of four** in that situation
4. Pt: so that's- high level?
5. Dr 8: [nodding] It is.

In the author's interview with the volunteer, she reported the metastatic stage of her cancer as one of the salient points of the interview, possibly indicating that she was astounded by the physician's choice of terms.

CHAPTER 6:

DISCUSSION

With regard to the theoretical aim of this thesis, the results supported the prediction that physicians use indirect language as a function of the communicative situation they face. When the news was good and the situation offered communicative choices with positive consequences, the physicians communicated straightforwardly and reassured the patients. However, when the news was bad and the situation offered only negative choices, they used indirect terms at a higher rate, presumably as a means of softening the impact of the bad news. These results suggest that indirect language is a good solution to the dilemma created by having to convey distressing information. Notice that, in spite of these findings, most volunteers described the physicians' delivery of bad news as "direct" or "straightforward." This is likely to be because the volunteers' understanding of direct language was not the same as the one used here. Moreover, as discussed later in this discussion, indirect language is highly conventional and often unnoticed in conversation.

In this study, the dilemma that the physicians faced consisted of having to tell the truth about the diagnosis without being harsh or hurtful. Both the volunteers' immediate reactions during the bad news delivery and the letters they wrote after the interview provided evidence that they understood the diagnosis in spite of the physicians' indirect delivery style. In their interviews with the author, they also gave evidence of understanding and appreciating the physicians' way of delivering the news: Almost all of them referred to the physicians' style with

terms such as “caring,” “considerate,” “respectful,” and “gentle.” These three sources of evidence supported the conclusion that the physicians successfully solved the situational dilemma they faced because they were able to deliver distressing news honestly (as evidenced by the volunteers’ understanding of the diagnosis) while still being considerate (as evidenced by the volunteers’ opinions after the interview).

This chapter will begin by summarizing the potential limitations to the internal and external validity of this study and will then review some of the theoretical implications of the findings. The final paragraphs will point out the practical implications of the present study.

Potential limitations

Internal Validity Issues

Using the good news delivery as the control task ruled out several alternative explanations to the results of this study. For example, without the good news condition as a basis for comparison, a critic could argue that physicians’ indirectness is only a random occurrence or a product of physicians’ individual styles (i.e., that the physicians in this study always talk indirectly). Without a control condition, it could even be argued that the cause of the physicians’ indirectness was their lack of communication skills. Notice, however, that if any of these explanations held true, both the bad and the good news interviews would have yielded an equal rate of indirect language, and that was obviously not the case. A control group therefore adds support and credibility to the findings in this study by logically countering alternative hypotheses.

There are at least two other explanations for the occurrence of indirect language that, although less plausible, are harder to rule out. Suppose, for example, that these physicians had less training or experience in delivering bad news than in delivering good news and that indirect language is a quality of an inexperienced speaker. In that case, a higher rate of indirectness in the bad news interviews could be attributed to a lack of training or experience in delivering bad news. Such an explanation, however, is based on two assumptions: (a) that physicians are generally better trained or more experienced at giving good news than bad news, an assumption that is not intuitively plausible and that would require empirical support and (b) that using indirect language is an indication of poor communication skills, an assumption that contradicts the common use of indirect language in everyday speech.

Another possible alternative explanation for the findings in this study is that something particular about conveying a cancer diagnosis (versus a diagnosis of hemangiomas) increased the rate of indirect terms in the bad news interviews. Specifically, a critic could say that there was a higher rate of indirect terms in the bad news interviews because there are more euphemistic terms available to refer to cancer than to hemangiomas. The findings in this thesis, however, do not support this explanation: In the good news interviews, the physicians also used euphemistic terms to refer to the diagnosis of hemangiomas. Moreover, euphemistic terms were not the only measure of indirect language that contributed to the higher rate of indirectness in the bad news interviews.

External Validity Issues

At least three characteristics of the sample limit the generalizability of the findings of this study. First, although the sample size in this study was sufficient to reach statistical significance, it is a small base from which to generalize. This is more evident when comparing this study to others in the cancer communication literature and, in particular, to those studies using questionnaire methods (e.g., Ptacek & Ellison, 2000; Ptacek & Ptacek, 2001). Second, the physicians participating in this study were all affiliated with institutions in the same geographical context (Southern Vancouver Island, British Columbia), limiting the generalization of the findings to other contexts (i.e., to how physicians from other countries or even other regions within Canada would deliver bad news). Third, the physicians participated voluntarily and, in many cases, their reason for taking part on the study was that they were already sensitive to and even especially interested in patient-physician communication. This potential recruitment bias and the fact that most of the physicians were very experienced were both intentional aspects of the study and contributed to one facet of its originality, namely, its aim of examining skilful practices that are assumed to be a quality of physicians with experience.

The generalization of the findings (with exception to volunteers' accounts after the interviews) is also limited to the section of the interview analyzed, that is, specifically the *first time* the physicians presented the information about the patient's diagnosis. Recall that the reason for limiting the analysis to this section was that the first presentation of the bad news would be a crucial point of conflict for the physicians (i.e., the maximum difficulty in balancing truth and hope). In

pronouncing the word “cancer” for the first time, the physicians would have a marked effect on the patient’s . Choosing to analyze the first time the physician presented the news was also useful because it served as a natural standard unit for comparison across interview conditions.

Another limitation to the generalizability of this study derived from using role-played interviews instead of real ones. In spite of this problem, several features of this study elicited quite realistic interviews: First, all of the interviews took place in a physician’s consultation room, creating a realistic environment for the participants. Second, two physicians from our research team designed the case scenarios to ensure that the interview situation was a plausible and a normal medical activity. Third, and essential in making the role-played interviews more natural, the interviews were unscripted and improvised (i.e., beyond the initial medical details, neither the physicians nor the volunteers had any instructions about what to say or how to act). Last, a characteristic that added realism to the role-played interviews was using volunteers to role-play the patients rather than using professional actors or standardized patients. The problem with using actors in this situation is that they are trained to portray a pre-established role. The volunteers in this study, on the other hand, were able to act naturally, integrating their own life experiences into the role that each of them improvised. The fact that the volunteers were not real patients probably added to the validity of their accounts after the interview, because the bad news did not affect them as it would have affected real patients. The information they provided suggests that they were able to judge the physicians’ delivery style objectively, whereas a real patient in the bad-news condition might not.

Finally, this study also has limitations with regard to the interpretation of the desirability of indirect language. In spite of the numerous reasons in favour of indirect language that will be outlined here, the aim of this research was not to establish the superiority of an indirect approach over a direct one. Instead, this thesis tested a prediction about the *situational conditions that are more or less likely to elicit indirect language*.

Theoretical Implications

Replication and Connection to Previous Literature

This study replicates Bavelas et al.'s (1990) previous experiments on speakers' use of indirect language *(equivocation)* to solve a variety of situational dilemmas. For example, in one of their experiments, Bavelas et al. examined speakers' replies when responding (hypothetically) to a close friend's question regarding an unsuitable gift (i.e., "How did you like the gift I sent you?"; p. 112). In this everyday dilemma, Bavelas et al. found that speakers—similarly to the physicians in this study—consistently gave indirect responses (e.g., "It was-ah, not bad"; p. 135) rather than direct ones (e.g., "I did not like it"), in order to avoid hurting the friend's feelings. The results reported in this thesis therefore extend Bavelas et al.'s experimental findings to the context of doctor-patient communication.

The analysis of indirect language presented here also replicates some of the findings of scholars using non-experimental methodologies (Blum-Kulka, 1990; Brown & Levinson, 1987; Caffi, 1999; Fraser, 1980; Haverkate, 1992; Holmes, 1984; Labov & Fanshel, 1977). Specifically, the physicians in this study

attenuated the impact of the bad news by reducing their apparent degree of certainty. Brown and Levinson (1987), Caffi (1999), Fraser (1980), and Lakoff (1973) identified this strategy as *hedging*. One of the physicians also elicited the terms of the diagnosis from the patient instead of naming the diagnosis himself, a strategy that Maynard (1989) identified as the *perspective display series*. Furthermore, a number of the physicians evaluated the bad news using a term that negated the contrary of the direct term (e.g., they refer to the news as “not good” instead of referring to it as “bad”), a form that Lutfey and Maynard (1998) identified as *litotes*.

As mentioned in the introductory chapter, previous analyses of indirect language have remained primarily descriptive, and only a few researchers (Luftey & Maynard, 1998; Maynard, 1989, 1998; Prince, Frader, & Bosk, 1982) have examined the use of indirect language to convey bad news, but not always on physicians’ communication. To the author’s knowledge, therefore, this thesis was the first study to test a prediction about indirect language in the communication of medical bad news.

Generalization of the Findings in this Study

It is likely that physicians would use indirect language in other situations that pose a similar dilemma to the one of having to deliver bad news. Those situations are especially relevant (although not exclusive) to physicians working with cancer patients because of the delicate nature of the issues they frequently discuss. Physicians might also use indirect language when discussing other sensitive topics, such as conveying a distressing diagnosis other than cancer (e.g., HIV-AIDS or a child’s congenital handicap), disclosing a terminal prognosis,

answering questions about life expectancy estimates, acknowledging the absence or failure of an available treatment, referring a patient to hospice, communicating serious side effects (e.g., infertility, amputation), or discussing a "Do Not Resuscitate" order.

Why Indirect Language is a Good Choice

Besides serving to solve the physician's dilemma between honesty and harshness, choosing indirect language may express a *caring relationship* towards the patient. In fact, according to Turner, Edgley, and Olmstead (1975), one of the reasons for the use of indirect language in everyday situations is the preservation of human relations. In this sense, these authors pointed out that telling a truth when it implies hurting the other person is itself a lie at the level of the relationship with that person:

> Is it honest to tell someone a truth that would sever or greatly jeopardize your relationship with a person if that is honestly not what you want to do? In other words, being truthful and honest at all times may have consequences which are neither truthful nor honest (p. 83).

The physicians in this study expressed a genuine concern for their relationship with their patients through such actions as asking for the patients' consent before delivering the news, using understatements to explain the gravity of the diagnosis, or using expressions such as "unfortunately" or "I am afraid…" and nonverbal actions such as wincing or a compassionate tone of voice.

An indirect approach also allows physicians to deliver the information gradually, tailoring it to the patients' immediate preferences (e.g., what patients want to know or already know) and giving patients the opportunity to come to know the diagnosis at their own pace. In referring to this characteristic of an

indirect approach, D. R. McGee (personal communication, November 26, 2006) pointed out that “there is something inherently respectful about affording people the space to ‘realize’ something,” because it provides them with some control around the information they are getting.

Collaboration and the Common Use of Indirect Language in Everyday Life

Allowing a gradual delivery tailored to the patient’s needs is consistent with the way in which interlocutors in conversation encode and decode indirect messages in everyday life. As several scholars have pointed out (e.g., Clark, 1979; Fraser, 1980; Grice, 1975), both the speaker and the hearer *collaborate* in the construction of an indirect message’s meaning, rather than this meaning being determined solely by the speaker. In the bad news interview, for example, when the physician says “*Sorry*, *it looks like* cancer,” the indirect meaning of the message is implicit, because the patient has to unfold this meaning from the words said. That is, the patient has to recognize that the physician actually meant “*You have* cancer, and I am sorry that you do.” In this sense, the meaning of an indirect message depends on the hearer’s interpretation based on the information available in the context of the message (e.g., an interview with an oncologist to receive definitive test results) and on the conventions of usage that connect phrases such as “it *looks like…*” with “it is…”.

Thus, indirect language is not restricted to physicians delivering bad news. In everyday use, indirect language is very subtle and conventional and, therefore, sometimes difficult to recognize. As explained in *Chapter 1*, interlocutors use indirect language for many different purposes, such as to make polite requests (e.g., “*Can you* reach the salt?” instead of “Pass me the salt”) or when they use

irony (e.g., “That’s VERY funny”—meaning the opposite). Speakers can also use indirect language to mitigate orders (e.g., “I hope you fastened your seat belt”), to soften a criticism (e.g., “That isn’t exactly right”), and in many other exchanges in which the actual meaning of the message needs to be recovered by the hearer through inference.

The conventional character of indirect language explains why the physicians also used some degree of indirectness when they delivered good news. That is, although there was a higher rate of indirect language in the bad news condition, some level of indirect language was normal and expected in the good news condition.

Practical implications

The results of this study also have implications for physicians’ clinical practice. First, viewing the bad news delivery as a dilemma implies that what makes this task challenging is the *situation* and not a (hypothetical) deficiency in the physician (e.g., lack of training or fear of death) or an internal state of the patient (e.g., resistance or denial). Understanding the dilemma can therefore highlight the practical difficulties involved in delivering bad news and could free physicians from blaming themselves or their patients when their communication does not go as well as expected.

Second, the analysis of indirect language presented here can help physicians become more aware of how their use of language affects patients and, in particular, how they can use indirect language for the sake of their patients (e.g., preserving hope). In this sense, this study supports the view of

indirectness as a positive linguistic tool that physicians can use to deliver bad news tactfully. This positive view of indirect language can validate its use and reassure those physicians who might have learned or believed that it is always best to be direct.

Third, the examples of bad news delivery identified in this thesis can be compiled into a repertory of techniques that can be used to teach physicians how to present painful information tactfully and with honesty. The advantage of these techniques is that they resemble colloquial ways of attenuating the impact of potentially distressing messages, and they should therefore be familiar to physicians. Another advantage of the techniques identified in this thesis over previous recommendations on how to deliver bad news (e.g., Buckman, 1992) is that they come from examples of actual bad news deliveries and are supported by a theory of communication that has been empirically validated (Bavelas, et al. 1990).

Last, the videos of the role-played interviews in this study can also be used as teaching tools from which less experienced physicians can develop their own individual styles by learning from several different models of good practice.

Future Directions

The results of this study suggest some interesting directions for further research. In this section, I will discuss them in two broad categories: directions with applied purposes and directions with theoretical purposes.

Directions for Applied Research

A direction that would follow naturally from this thesis would be to examine whether physicians commonly use indirect language to communicate bad news in real interviews. Because in real life the dilemma that physicians face varies according to factors that cannot be experimentally controlled (e.g., how severe the patient's diagnosis is), such a study, unlike the present one, would be non-experimental. This limitation, however, would be compensated by an increase in external validity. Another way to increase the external validity of the present study would be to replicate it with a larger sample of physicians from a variety of geographic regions or cultures.

Because physicians working with cancer patients frequently face tasks that elicit a situational dilemma (e.g., discussing the side effects of a particular treatment), future research efforts could also be aimed at examining whether and how physicians use indirect language when they carry out any of those other tasks.

Finally, an important extension of the present experiment is to serve as material to train new physicians on how to deliver bad news in a way that is honest and yet tactful. I hope that the repertoire of techniques presented in this thesis, together with the videotapes of the role-played interviews will be a first step on that direction.

Directions for Theoretical Research

Future research could also be aimed at exploring questions that emerged from the inductive inspection of the videotapes and that are connected to the Bavelas et al. (1990) theoretical proposals. For example, it would be interesting

to investigate whether physicians' indirectness varies as a function of their patients' individual reactions to the bad news. That is, do the patient's reactions during the interview shape the physician's choice of terms in delivering bad news? Specifically, following Bavelas et al.'s theory, it could be predicted that the more pressure the patient exerts on the physician during the interview (e.g., by looking worried, putting the physician on the spot), the more this pressure will heighten the dilemma for the physician, which should increase the physician's use of indirect language.

Also, a future study could examine all of the other means, besides words, by which physicians can achieve indirectness. The videotapes of the interviews in this study suggested that the physicians also used their facial expressions (e.g., wincing) or their voice quality (e.g., using an empathetic tone) to soften the impact of their bad news.

As I pointed out in *Chapter 1*, communication studies in the medical literature are rarely informed by basic communication research. As a consequence, medical communication researchers are not aware of the principles and methods developed in other disciplines that could be useful to them. An important direction for future research should therefore be to design studies that fill this gap in the literature, testing basic communication principles in the context of the medical interview.

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UVic/VIHA Joint Application Process for Research with Human Participants

Instructions

- For applications that involve use of human participants in any agency of the Vancouver Island Health Authority (VIHA) researchers should complete this Joint Application and submit **four** copies to the VIHA Administrative Assistant, Research and Evaluation at VIHA:
  Mrs. Marilyn Fuller
  Memorial Pavilion
  Kenning Wing, 1st Floor
  1952 Bay St
  Victoria, BC, V8R 1J8

  Applications sent directly to UVic Research Services will be mailed to VIHA, causing a small delay in processing the application.
- Ensure your answers are clear, consistent and complete. If any sections are not relevant to your research, answer "N/A".
- The VIHA Administrative Assistant will keep one copy for her file, have two copies sent out to reviewers, and send one copy to UVic.
- The UVic Administrative Assistant (Ms. Leah Potter) will enter the researcher's information into the UVic database with a notation that this is a UVic/VIHA application. Refer to the VIHA number assigned to your application when contacting either VIHA or UVic about your application.
- Members of the Joint Sub-Committee will review the application and, if necessary, make recommendations for clarification or revisions that will be sent out by letter to the researcher(s). A copy of this letter will be retained by the VIHA Administrative Assistant and will be included with material sent to the UVic Administrative Assistant once the protocol has been approved.
- The researcher will send any revisions required to the VIHA Administrative Assistant who will ensure they are processed. (They will either be reviewed by staff or by Joint Sub-Committee reviewers depending upon the complexity of the changes required).

  When the UVic/VIHA application is approved, the VIHA Administrative Assistant will create a Certificate of Approval and send a copy to the researcher and a copy to UVic.
- Once approved, the VIHA Administrative Assistant will send the researcher's file copies, including the letter requesting clarification or revisions, the revisions submitted by the researcher, and the Certificate of Approval to the UVic Administrative Assistant who will add this information to the UVic file, enter the VIHA protocol number into the database and process the file.
- Any amendments to the Approved Protocol should be submitted to the VIHA Administrative Assistant.
- Approval is given for a 3 year period with a yearly confirmation that the study is still in process.

NOTE A: While the UVic Human Research Ethics Board assumes that a 'scientific review' has been conducted by the student's committee and/or supervisor, or in the case of faculty members by a peer review, the VIHA Research and Ethical Approval Committee requires that each application be given a 'scientific review'.

NOTE B: The Joint Sub-Committee operates as a Sub-Committee of the two parent committees (UVic and VIHA Committees) with membership inclusive of members of each of these parent committees. This Joint Sub-Committee is designed to review minimal risk studies only. It reports to each parent committee on a regular basis and in some cases, protocols that are minimal risk but complex may be referred to either of the parent committees for review.

Contact Information

For more information about the Joint UVic/VIHA ethics review process, consult the websites at www.research.uvic.ca or www.viha.ca. Researchers may also contact the UVic Office of Research Services at (250) 472-4545 or ovprhe@uvic.ca, or VIHA at (250) 370-8620 or marilyn.fuller@caphealth.org.

University of Victoria

Joint UVic/VIHA Application for Ethics Approval for Human Participant Research

VANCOUVER ISLAND health authority

A. Principal Investigator:

Last Name: **Del Vento** First Name: **Agustin** Department/Faculty: **Psychology**

Mailing Address (if different from Dept/Faculty): **PO Box 3050 STN CSC Victoria, BC V8W 3P5**

Phone: **(250) 721-6691** Fax: **(250) 721-8929** Email: **delvento@uvic.ca**

Title/Position:

☐ Faculty ☐ Staff ☐ Post-Doctoral ☐ VIHA

☐ Ph.D. Student ☒ Master's Student ☐ Undergraduate

Students: Provide your Supervisor's

Name: **Janet Bavelas** Email: **bavelas@uvic.ca**

Department: **Psychology** Phone: **(250) 721-6691**

Graduate Students: Provide your Graduate Secretary's email address: ptaylor@uvic.ca

B. Project Information

1. **Project Title: "Pilot study to analyze communication in unscripted role-played interviews between patient and physicians in end of life and palliative care."**

   Keywords: 1. **Communication** 2. **Palliative Care** 3. **Microanalysis** 4. **Role-played interviews**

2. **University of Victoria Personnel:**

Name	Role in Research Project	Institutional Affiliation	Email or Phone Number
Agustin Del Vento	**Principal investigator**	**University of Victoria**	**delvento@uvic.ca**
Janet Bavelas	**Graduate supervisor**	**University of Victoria**	**bavelas@uvic.ca**

(If you require more space to list Personnel, please type "Attached" on one of the lines and attach a list of personnel to this application.)

3. **Vancouver Island Health Authority Personnel:**

Name	Role in Research Project	Time Required (Est.)	Email or Phone Number
Peter Kirk	**Co-investigator**	**10%**	**peter.kirk@viha.ca**

(If you require more space to list Personnel, please type "Attached" on one of the lines and attach a list of personnel to this application.)

Explain how you will obtain the cooperation of directly involved VIHA personnel:

The VIHA personnel involved in this project are part of the CIHR NET Grant team. The Net Grant "Overcoming Barriers to Communication in End-Of-Life & Palliative Care Transitions" (Co-Principal investigators: Peter Kirk and Francis Lau) is aimed at creating a collaborative interdisciplinary team of scholars and care providers engaged in research and training with a particular focus on the enhancement of the provider-patient communication.

4. **Other Agency Personnel Outside VIHA and UVic:**

Name	Role in Research Project	Agency Affiliation	Email or Phone Number

Grant MacLean	**Co-investigator**	**BCCA**	**gmaclean@bccancer.bc.ca**
Fraser Black	**Co-investigator**	**Victoria Hospice Society**	**Fraser.Black@viha.ca**

Note: VIHA approval signatures are required for all departments involved. Please attach letter(s).

5. VIHA Resources

Please list major equipment, if any, to be used in the process of data collection and analysis, and indicate whether it is currently available or is to be purchased with project funds. Also list any supplies and/or equipment owned by VIHA which may be required for the project, e.g. blood pressure equipment.

VIHA Staff and/or Resources Involved with the Project: **Check each line:**		If yes, Approval Signatures are Required:	Financial Services? If yes, attach agreement
Patient Care Services	☒ Yes ☐ No	X	☐ Yes ☐ No ☒ N/A
Pharmacy	☐ Yes ☒ No	X	☐ Yes ☐ No ☒ N/A
Operating Rooms	☐ Yes ☒ No	X	☐ Yes ☐ No ☒ N/A
Medical Imaging	☐ Yes ☒ No	X	☐ Yes ☐ No ☒ N/A
Health Records	☐ Yes ☒ No	X	☐ Yes ☐ No ☒ N/A
Laboratory Services	☐ Yes ☒ No	X	☐ Yes ☐ No ☒ N/A
Other:	☐ Yes ☐ No	X	☐ Yes ☐ No ☒ N/A
Other:	☐ Yes ☐ No	X	☐ Yes ☐ No ☐ N/A

6. Budget

Attach a copy of the total budget by year. If costs will be incurred by VIHA, please provide a detailed budget and approval signatures from VIHA department heads.

7. Scholarly Review

What type of scholarly review has this research project undergone?

☐ None ☒ External Peer Review (e.g. granting agency) ☐ Supervisory Committee

☒ Supervisor – required for all student research projects ☐ Other, explain below:

8. Research Summary

(As a health institution, VIHA requires that all applications receive a scientific review from their Research Ethics Boards)

Provide a brief summary of the proposed research:

Following the approved CIHR Net Grant proposal (2004), this pilot study is aimed at collecting data on the current patient-physician interactions in End Of Life and Palliative Care (EOLPC) with the primary purpose of refining our methodology and inductively generating a research question. We propose to recruit volunteers to role-play patients and physicians to act as themsleves in unscripted role-played interviews. After conducting the role-played interview, we will ask both participants to fill out a brief questionnaire about the interaction. Using role-played interviews will allow us to examine communication sequences in the medical interaction while not imposing on real terminal patients in this early stage of our research. Under the terms of the fellowship granted to Agustin Del Vento, these data will form part of his MA thesis project.

Our objectives are (1) to videotape role-played patient-physician interactions in which they discuss and decide on the goals of care in EOLPC; (2) to apply microanalysis of communication to these interactions in order to examine how patients and physicians talk about the goals of care and the extent to which the goals adopted are congruent with the patient's goals; (3) to identify barriers and effective practices in communication when discussing the goals of care (in accordance to the purpose of the NET Grant); (4) to

develop research questions from these role-played interviews that will, in a later stage of our research, be applicable to real interactions between patients and physicians; (5) to establish the extent to which physicians' communicative behaviors are consistent with the goals outlined in the Latimer Model for Ethical Decision-Making (1998). (6) A final expected outcome of this pilot study is to serve as a training resource for use in medical education.

The method we will use to analyze the role-played interactions, microanalysis of communication, is the detailed examination of actual communication sequences as they proceed, moment by moment (Bavelas, McGee, Phillips, & Routledge, 2000). Microanalysis of communication employs videotapes of actual interactions as the primary data. In addition, microanalysis takes a functional approach, looking at how language use affects participants' behaviors in the interaction. We expect microanalysis to enhance our understanding of physicians' and patients' communicative behaviors (e.g., use of gaze, questioning strategies, formulations, medical jargon, hand/facial gestures) in the EOLPC interview when discussing goals of care. Furthermore, in using videotapes of spontaneous, unscripted interactions, microanalysis has the potential value of enhancing physicians' awareness of the communicative behaviors that lead to the goals outlined in the Latimer Model (1998).

The proposed pilot study is embedded in a larger research plan divided into two distinct but interrelated stages. The first stage will involve data collection and analysis of role-played interviews, as described above, using care providers who are not directly involved in the CIHR Net Grant. The main purpose of this application is to obtain the ethics approval for this stage. The second stage will consist of videotaping real patient-physician interactions. We will submit a new ethics application for the second stage.

The time frame we envision for this pilot study (i.e., the first stage of our larger research plan) is one year. Specifically, we expect the recruitment and videotaping process to take four months, the data analysis to take four months, and another four months to interpret the results and plan the next stage.

Proposed Start Date: June, 2005; subject to ethics approval

Estimated Completion Date: June, 2006

9. Research Location

Indicate the specific facility and area/location where the research will be conducted (e.g., Jubilee, Cardiac Care):

Data collection: Human Interaction Laboratory (HIL), Cornett A169, University of Victoria.
Data analysis, report writing, and storage of the data: Cornett, A275, University of Victoria.

10. Background and rationale to the study:

This pilot study is an initiative of the CIHR Net Grant's communication team. The Net Grant "Overcoming Barriers To Communication Through End-Of-Life & Palliative Care Transitions" (Co-Principal Investigators: Dr. Peter Kirk and Francis Lau) is aimed at creating a collaborative interdisciplinary team of scholars and care providers engaged in research and training with a particular focus on the enhancement of the provider-patient communication. This pilot study will accomplish this goal in that practitioners currently working in EOPLC and researchers from the University of Victoria are involved and collaborating in this project. (This collaboration has been occurring since the beginning of 2005.) The main goal of the first stage proposed by the Net Grant proposal was to "establish the baseline" regarding the current practice patterns in patient/family-care provider in our local setting. This pilot study consisting in videotaping role-played EOLPC interviews with a view on refining our methodology and generating a research question is a preliminary action towards accomplishing this goal.

The Latimer Model for Ethical Decision-Making (Latimer, 1998) is the conceptual framework for this pilot study. According to this model, when formulating the goals of care that define the best procedures and treatments, the care provider should carefully consider the patient's experience of illness (i.e., symptoms, suffering), the nature of the illness (i.e., its nature, status, likely course, proximity to death), and the patient-as-person (i.e., the patient's wishes, goals, plans, and hopes). Presently, goals of care leading to best procedures and treatment decisions often depend on the care provider's specialized knowledge, without regard to whether these decisions are predominantly consistent with the patient's goal (Net Grant proposal, 2004). Following the Latimer model, we propose that the patient/family and the health care team should jointly establish the goals of care. The joint organization of goals of care as outlined in the Latimer Model (1998) is actualized in the communicative process and, specifically, in the arena where communication takes place, that is, patient-care provider interaction. Therefore, this pilot study will

establish the extent to which physicians' communicative behaviors (process) in actual EOLPC interviews are consistent or not with the goals (outcomes) outlined in the Latimer Model.

11. Literature Review:

There is a growing amount of literature in physician/patient communication in the cancer context. This literature has increased over the last years covering a wide range of topics that include formal analyses of doctor/patient interactions (Dettmar, Muller, Wever, Schornagel, Aaronson, 2001), surveys of patient's perceptions about their communication with health providers (Bakker, Fitch, Gray, Reed, and Bennett, 2001), analyses of patient's narratives (Salander, 2002), and assessments of patients' and their care providers' informational needs (Jenkinns, Fallowfield, and Saul, 2001; Kirk, Kirk, and Kristjanson, 2004). Other studies have considered communication an independent variable useful to predict patient outcomes such as satisfaction with the encounter (Ong, Visser, Lames, and deHaes, 2000); anxiety level (Takayama, Yamazaki, and Katsumata, 2001); and quality of life (Ong et al., 2000).

In a recent review of the literature related to communication about cancer, Arora (2003) identified two common methodological approaches. These two approaches are useful in organizing the diversity in the literature. Arora distinguished among studies where "observational/behavioral" and "perceptual" measures of physicians' communicative behavior were used. Within the perceptual measures approach, Arora included studies designed to assess patients' perspectives of physicians' behaviors, and other measures of patients' information needs and internal states (e.g., anxiety level). Researchers adhering to this approach take a quantitative stance and obtain their data from surveys, questionnaires, and measurement scales. Within the observational/behavioral approach, Arora included studies designed to look at the actual physician/patient interaction. Researchers adhering to the observational/behavioral approach take a qualitative stance and they usually employ audio-recordings of medical consultations as data for their analyses.

In the medical literature and, more specifically, in the literature related to communication in cancer care, the majority of research studies can be located in the "perceptual measures approach". That is, these studies have been designed to study the variables that influence communication in the medical encounter (instead of studying "real time" communication sequences). For example, Bruera, Neumann, Mazzocato, Stiefel, & Sala (2000) evaluated physicians' beliefs about their patients' needs regarding the patients' illness; Jenkins et al. (2001) and Kirk et al. (2004) assessed patients' information needs; Friedrichsen, Strang, & Carlsson (2002) and Gattellari, Butow, Tattersall, Dunn, & McLeod (1999) assessed patients' level of understanding and denial regarding their illness; Takayama et al. (2001) examined patients' perception of physicians' communication style; Bakker, et al. (2001) and McWilliam, Brown, & Stewart (2000) examined patients' communicative experience of the cancer consultation; and Hagerty, Butow, Ellis, Lobb, Pendlebury, Leighl, Mac Leod, & Tattersall (2005) identified patients' preferences regarding the way physicians delivered prognostic information. Perceptual measures of the communicative process are useful in providing guidelines to better tailor communication to patients' needs. These studies, however, only give reports about the actual communicative process and cannot explain how barriers to communication develop during this process.

Research studies taking an observational/behavioral approach, on the other hand, analyze several communicative behaviors (e.g., information giving, counseling, questioning) that occur during the patient/physician interaction (Beach, Easter, Good, & Pigeron, 2005; Ishikawa, Takayama, Yamazaki, Seki, Katsumata, & Aoki, 2002; Ong et al., 2000) and, in other cases, the content of these interactions (e.g., bad news, health-related quality of life issues) (Detmar et al., 2001; Ford, Fallowfield, & Lewis, 1996). Most of the observational/behavioral studies collected for this review apply formal analysis systems (FAS) to their data. (See Ong, de Haes, Hoos, & Lammes (1995) and Roter & McNeilis (2003) for a review and comparison of different FAS.) Although these studies applied a FAS to the communicative process, the majority of the studies used audio-recordings as data for their analysis. Exclusive use of audio-recordings prevented researchers in these studies from studying visible means of communication also employed by participants in the interaction (e.g., gaze, facial displays, and body orientation). Another major disadvantage of these studies is that researchers using FAS assign actual communicative exchanges to pre-established dichotomous categories (e.g., open/closed ended questions; occurrence or nonoccurrence of a behavior). These categories oftentimes do not correspond with participants' perceptions of these in the conversation. For example, a physician asking "Is there anything else you want to talk about today?" (a closed-ended question in an FAS criterion) can elicit the patient's description of a new (not previously mentioned) psychosocial concern, besides the possibility of being responded with a "Yes/No" answer. This example shows a divergence between the formal unit (close question) and the unit's functional effect (i.e., a close question serving the purpose of an open question). Formal categories, then, may not reflect the dynamic and interactive nature of the medical interview. (See

Sandvick, Eide, Lind, Graugaard, Troper, & Finset (2002) for a summary of the problems in using FAS.)

For our pilot study, like other studies falling under the observational/behavioral approach, we will focus on observable behaviors to study communication. However, our method, microanalysis of communication, differs from FAS in many respects, in our opinion, offering a better alternative to study communication. First, microanalysis is an inductive method that generates its hypotheses or explanations from the data as opposed to using a FAS that codes the data using an a priori system. Taking an inductive stance also suits our goal of learning from the data (i.e., the current practices in EOLPC in our context) in this early stage of our research. Second, and related to the previous point, when applying microanalysis, we will take a functional approach, looking at how participants use communication to affect each other in deciding the goals of care. This approach can be contrasted to a formal approach used by the FAS. The advantage of the functional approach is that it allows the researcher to look at communication at the level of the participants' meaning. We hope that focusing our analysis at the level of meaning will solve the discrepancies between observable behaviors and perceptions of these behaviors that previous studies found (Arora, 2003). Third, in accordance to our assumption about the communicative value of both audible (e.g., prosody) and visible (e.g., gaze, gestures, facial displays) features of face-to-face dialogue, our data for analysis will be video-recordings of role-played interactions. Using videotapes, instead of only audio-recordings, will allow us to capture features of the interactions between physicians and patients that were not included in previous studies. For the same reason, we will focus our analysis on how participants use communication in the context in which they produce and understand it. Last, in using microanalysis we will examine the communicative exchange at the micro-level, even down to the word or phrase (e.g., lexical choice). We are not interested in identifying "themes" (e.g., hope) or making general descriptions of the communicative exchange.

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12. Time Schedule:

The approximate time schedule for this pilot study will be:
a) Promoting the pilot study: June 2005-July 2005
b) Collecting data (i.e., recruiting and videotaping participants): July 2005-September 2005
c) Preliminary analysis on subset of data (operational definitions, inter-analyst reliability, and cross-validation): October 2005-January 2006
d) Writing results: February 2006-May 2006
e) Destruction of primary data: August 2010

13. Legal Aspects:

The investigators (i.e., Agustin Del Vento, Janet Bavelas, Grant MacLean, and Peter Kirk) will own the data.

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14. Methodology and Procedures

a) Which of the following methods will be used? (*Check all that apply.)*

☐ Interviewing participants
☐ in person ☐ by telephone ☐ group

☐ Observing participants

☐ Administering a standardized questionnaire or survey
☐ In person ☐ telephone ☐ mailback ☐ email ☐ web-based

☐ Other, describe:

☒ Conducting or administering a non-standardized questionnaire or survey
☒ In person ☐ telephone ☐ mailback ☐ email ☐ web-based
☐ Other, describe:

☐ Chart Review
☐ Prospective ☐ Retrospective

☐ Recording of participants
☒ audio ☒ video ☒ photos or slides

☐ Administering a standardized cognitive instrument or test

☐ Analyzing secondary data
☐ Anonymized data
☐ Non-anonymized data
(In 14b) describe the source of the data, (e.g. institutional, organizational, educational files, personal writings) and explain whether and how consent was obtained from the individuals for use of their data.)

☐ Computer-administered tasks

☐ Using human tissue (e.g. blood, hair, DNA)
(Ensure BioSafety Human Tissue Form is completed, signed and attached.)

☐ Other, specify:

b) Provide a sequential description of the procedures/methods to be used in your research study. List all of your research instruments and assessment tools, and in an appendix provide copies of all instruments. *(If not yet finalized, provide drafts or sample items/questions.)*

Because we will videotape dyads (e.g., a physician with a volunteer role-playing a patient), we will assort participants in accordance before their arrival. Upon participants' arrival at the Human Interaction Laboratory (HIL), we will (1) introduce ourselves to participants; (2) give and discuss with participants the consent forms (Appendix A and B); (3) have participants sign the consent forms; (4) give participants the instructions (Appendix D) and the case scenarios to role-play (Appendix C); (5) give each participant time to reflect about their role individually, if they need to, before starting to videotape; (6) videotape participants role-playing the case scenarios; (7) give participants a questionnaire about the information transmitted during the interview (we are still developing this questionnaire and we will send a copy of the finalized questionnaire to VIHA and UVic research committees as soon as it is available); (8) debrief participants; (9) let participants watch the whole video of their recently recorded interview; (10) give participants the permission-to-view forms to fill out (Appendix E). We will give participants 20 minutes to role-play the interviews. We envision the whole appointment will take approximately one hour and 10 minutes (not including the time they will take to come to UVic, approximately 20 minutes).

We expect the data collection process (i.e., promoting the pilot study, recruiting participants, videotaping participants) to take four months. Once we have the data collected, we will analyze the videotapes of the role-played interviews using the software Broadway. Broadway is a video capture system with which we will digitize the data and convert it into AVI or MPEG files. Broadway also allows us to capture specific sections of interest in our data and to isolate and replay these sections. This procedure is essential to microanalyze the data.

c) Where will participation take place? (e.g. Ward Room, personal residence, extended care unit)

Human Interaction Laboratory, Cornett Building, Room A169, University of Victoria.

d) How much time will be required of participants?

We will require approximately 1 1/2 hour of participants' time. Specifically, we estimate participants will take:
20 minutes to come to UVic and park;
10 minutes to read and discuss with us the consent form (which they would have seen already);
30 minutes to receive the instructions and role-play the interviews;
15 minutes to fill out the brief questionnaire and watch themselves on the tape;

15 minutes to debrief participants and for participants to complete the Permission-to-View form.

15. Selection and Recruitment of Participants

a) What is the target population for participant selection?

We will recruit physicians working in Palliative Medicine and volunteers from the Victoria Hospice Society.

b) Provide details of the characteristics of participants who will be included in the study. Include information on the anticipated total number of participants, the number of participants in sample group, the number of participants in control group (if applicable), the rationale for the size of group(s), and the characteristics of participants (e.g. age, gender, race, ethnicity, class, position, etc.):

Because this early stage of our research is predominately inductive and exploratory, we will recruit physicians from different disciplines (e.g., family doctors, oncologists) covering various degrees of expertise. The main criterion for recruiting physicians will be their availability and their willingness to participate in our pilot study. We are aware that our sample can be biased (e.g., only those physicians motivated to improve their communication skills will participate); however, we think we can learn a great deal from the role-played interviews in this pilot study. Furthermore, designing and carrying out this study will help us refine the next stage of our research project (see summary).

We will recruit participants throughout a four-month period with the aim of obtaining 10 to 16 role-played interviews (i.e., a total of 20 to 32 participants), using at least two case scenarios (e.g., 5 role-played interviews with each scenario). We will use volunteers to role-play patients because of their proximity with patients' experience. Also, volunteers do not have a direct relationship with physicians.
Because in this stage of our research we are interested in physicians' communicative behaviors, we will ask physicians to role-play themselves. Using the same case scenarios across dyads will allow us to compare different communicative styles and different ways of discussing goals of care among patients and physicians.

c) Provide a description of your exact recruitment process. Explain who will recruit or contact participants (e.g. researcher, assistant, third party), how the recruitment will be done (e.g. by telephone, letter, poster), and the steps in the recruitment process. Be sure to attach all relevant recruitment samples in an appendix or appendices.

We will promote our pilot study in the 'lunch loops' and other educational events organized at the Victoria Hospice Society. We will give a presentation with examples of our method to analyze communication. After each presentation, we will distribute a poster containing information about our pilot study as well as a copy of the consent form and the permission-to-view form. The poster will contain information on eligibility requirements, duration of the study, principal investigator's contact information, and contact information for the responsible VIHA ethical committee (Appendix F). In addition, two of the co-investigators, Dr Peter Kirk and Dr Grant Mac Lean, will approach potential participants individually as third party persons. These third party recruiters will hand out a letter of invitation (Appendix G) to participate in our pilot study with a copy of the consent form and the permission-to-view form to participants. If a potential participant were interested in participating in our study, he or she would have to contact to principal investigator by telephone or email. The principal investigator will set an appointment with the participant to come to the Human Interaction Laboratory for a videotaping session.

16. Benefits

Identify any potential or known benefits associated with participation and explain below.
(*When identifying and explaining the benefits, keep in mind that the anticipated benefits should outweigh any potential risks.)*

☒ To the participant ☒ To society ☒ To state of knowledge

Among the potential benefits associated with participating in this study, participants interested will have the opportunity to learn about communication research. Specifically, they will learn about the particularities of our study (i.e., analyzing actual communicative sequences); our theoretical framework (i.e., Latimer Model for Decision Making); the design of our study (e.g., technical aspects about videotaping interactions); and about the software that we use to analyze the data (e.g., use of Broadway). We hope that participants will also profit from watching their own-videotaped

interactions. During the debriefing procedure, we will give participants time to watch and discuss with us what they see on the videotape. During this time, they can become more aware of their own communicative behaviors.

In a broader sense, the society will benefit from this research initiative in that we expect this pilot study to enhance our understanding of the importance of communication between patients and care providers in EOLPC. Recall that the goal of this pilot study, in accordance with the CIHR Net Grant proposal (2004), is to overcome barriers to communication and identify effective interactions in EOLPC.

Finally, this pilot study will contribute to the current state of knowledge in that (as we explained in the literature review) there are only a few studies that look at actual communication. Furthermore, researchers in the majority of these studies restrict their analyses to audio-recorded data.

17. Inconveniences

Identify and describe any known or potential inconveniences to participants.
(*Consider all inconveniences, including time devoted to the research.)*

Potential inconveniences in participating in this pilot study are: (1) Physicians and volunteers participating in this pilot study in a time other than their free time, will be absent from work for approximately 1 1/2 hour (including the time that will take participants to come to UVic). (2) Participants being videotaped will initially be self-conscious about being videotaped or recorded.

18. Estimate of Risks

Could this study involve the following? (Please answer each question by clicking on the appropriate box.)

a) Could a participant feel demeaned or embarrassed during their participation in the research?
☒ Very unlikely ☐ Possibly ☐ Likely

b) Could a participant feel fatigued or stressed due to the research?
☒ Very unlikely ☐ Possibly ☐ Likely

c) Could a participant experience any other emotional or psychological discomfort as a consequence of participation?
☐ Very unlikely ☒ Possibly ☐ Likely

d) Is there any social risk, possible stigmatization, loss of status, privacy and/or reputation?
☒ Very unlikely ☐ Possibly ☐ Likely

e) Are there any physical risks?
☒ Very unlikely ☐ Possibly ☐ Likely

f) Is there any chance that participants may be harmed in any other way? (e.g. economic risk, risk to community)
☒ Very unlikely ☐ Possibly ☐ Likely

19. Possible Risks

a) If you indicated in Item 18 a possible risk, provide details to your answer below and describe how you will explain the risks to participants.

In the case of volunteers role-playing patients, there is a potential risk for them to feel distressed in role-playing a patient with a terminal illness.

b) Describe how potential risks will be minimalized and dealt with (e.g., provide counselling services) if they occur. Include how you will describe this minimalization to participants.

To deal with the volunteers' potential risk of feeling distressed, we will recruit volunteers who have daily experience in dealing with patients at Hospice and, presumably, have developed coping strategies to work with them. We will also give participants the opportunity to individually rehearse their roles before starting to videotape. Also, we will let participants know in the consent form that if they feel distressed with their roles, we, the researchers, will interrupt the videotaping session, offer them a break, the chance to stop and reschedule the activity; and/or the chance to stop the role-played interviews altogether.

20. Level of Risk

a) Using the TCPS definition of "minimal risk" cited below, do you believe your research qualifies as "minimal risk" research?

☒ Yes ☐ No

"The research can be regarded as within the range of minimal risk if potential participants can reasonably be expected to regard the probability and magnitude of possible harms implied by participation in the research to be no greater than those encountered by the participant in those aspects of his or her everyday life that relate to the research. The designation of minimal or non-minimal risk affects the way the application is reviewed not the substance of the ethical review."

b) Explain your answer to 20 a) by referring to the level of risk stated in the TCPS definition:

We will ask volunteers to role-play patients on the assumption that they have daily contact with patients with terminal illnesses and, presumably, have developed copying mechanisms to work with them.

21. Deception

Will participants be fully informed of everything that will be required of them prior to the start of the research session?

☒ Yes ☐ No

(If no, complete a Request to Use Deception form located on the Research Services website.)

22. Compensation

Will participants be offered any compensation for participating in the research? (e.g., gifts, money)

☒ Yes ☐ No

If yes, explain the nature of the compensation and why you consider it necessary: *(It is important to consider if the amount of the compensation is such that the participant could consider it a form of inducement.)*

We will compensate physicians only when, in order to participate in our study, they have to be absent from work in times other than their free time. We will not provide any compensation to those care providers that participate in our study during their free time. The estimated monetary value of this compensation will vary depending on the professional affiliation and rate of pay of the participants and will range from $35/hr to $100/hr. If participants begin the research activity but then withdraw for any reason, they will still receive the compensation.

23. Power-over Relationship

Are you or any of your co-researchers in any way in a position of authority of power over participants? (e.g., teachers-students, ward supervisors-nurses, supervisors-employees)

☐ Yes ☒ No ☐ Varies

If yes or varies, describe the justification for conducting research with participants over whom you have power, the nature of the relationship, the safeguards you will implement to minimize inducement, and how the dual-role relationship will be explained to potential participants:

24. Free and Informed Consent

The following questions address the competence of participants to give free and informed consent, the process used in your research to obtain consent, ongoing consent, and the participants' right to withdraw. Describe your prospective participants: (Check all that apply)

☒ Competent adults

☐ Non-competent adults:
- ☐ Consent of family/authorized representative will be obtained
- ☐ Assent of the participant will be obtained

☐ A protected or vulnerable popluation (e.g., patients)

☐ Competent Children

Minimal Risk research
- ☐ Children under 13: consent of parent/guardian will be obtained, and child consent will be obtained
- ☐ Youth 13 to 18: consent of youth will be obtained, and parental consent may be required due to institutional and/or clinical requirements
- ☐ Youth 13 to 16: consent of youth will be obtained, parents will be informed

☐ Youth 13 to 16: consent of youth will be obtained, parents will NOT be informed
☐ Youth 17 to 18: consent of youth will be obtained, parents will not be informed
☐ Other, explain:

Above Minimal Risk research
☐ Parent or guardian consent will be obtained and child/youth assent/consent will be obtained
☐ Other, explain:

☐ Non-competent Children
☐ Consent of parent/guardian
☐ Assent of the child/youth will be obtained

25. Means of Obtaining Consent *(Check all that apply)*

☐ Initial verbal explanation and a signed Consent Form (*Attach copies.)*

☒ A Letter of Information and a signed Consent Form (*Attach copies.)*

☐ A Letter of Information and verbal consent (*Attach a copy of the Letter of Information and describe below how you will document verbal consent. Explain below in Item 27 why written consent is not appropriate*.)

☐ Implied consent (e.g. through mail back questionnaires or surveys)

☐ Other means (*Describe and provide justification below in Item 27)*

☐ Consent will not be obtained(*Explain below in Item 27).*

26. Indigenous Community Approval
(The TCPS suggests that Indigenous community approval may be required when the research involves Indigenous people, the cultural knowledge and/or resources of Indigenous people, or where individuals speak on behalf of an Indigenous nation.)

a) Does your research specifically study and involve:

Individuals from an Indigenous community?

☐ Yes ☒ No

A particular Indigenous community or communities as a central focus of the research?

☐ Yes ☒ No

b) Have you sought approval from an Indigenous community or communities for this study?

☐ Yes ☒ No

c) If not, briefly justify your decision not to seek Indigenous community approval:
This pilot study does not specifically involve individuals from an Indigenous community.

27. Informed Consent Process
Describe the exact steps used in your informed consent process:

After our presentations in the "lunch loops" at Victoria Hospice Society, we will provide participants with a poster containing information about the study, a copy of the consent form, and a copy of the permission-to-view form. This will allow potential participants to obtain information and decide if they want to participate in our study before coming to participate. When participants arrive to the Human Interaction Laboratory at UVic, we will provide them once again with a copy of both the consent form and the permission-to-view form to discuss with us and sign. Participants will keep one copy of the consent form and we will keep another copy of the consent form and a copy of the permission-to-view form in a folder, stored in a secure office separated from the videotapes of the role-played interviews.

28. Ongoing Consent Process
(*Ongoing consent is required in research that occurs over multiple occasions or an extended period of time.)*

a) Will your research occur over multiple occasions or an extended period of time?
☐ Yes ☒ No

b) If yes, describe how you will obtain ongoing consent:

29. Participant's Right to Withdraw

(Free and informed consent requires that participants have the right to withdraw at any time without consequence or explanation.)

Describe what will be told to participants about their right to withdraw at any time from the research.
If compensation is involved, explain what participants will be told about compensation if they withdraw.

Your participation in this study is completely voluntary and you are free to refuse to participate, to withdraw from the study, or to refuse to do any particular part of the study, without any negative consequences. In the event that you withdraw from the study, we will erase your data. In the event that you withdraw, and you are using your time from work to participate in this study, you would still receive a compensation for the time of work you have lost. If you withdraw, we will destroy the data collected until the moment you decided to withdraw.

30. Use of Data if Participant Withdraws

What happens to a person's data if s/he withdraws part way through the study?

☒ It will not be used in the analysis.

☐ It is logistically impossible to remove individual participant data.

☐ It will be used in the analysis if the participant agrees to this. Describe how this agreement will be obtained*:*

31. Anonymity

(Here, anonymity means that no one, including the principal investigator, is able to associate responses or other data with individual participants.)

Are the participants anonymous?
☐ Yes ☒ No

32. Confidentiality

(Here, confidentiality means that the protection of the person's identity (anonymity) and the protection, access, control and security of his or her data and personal information during the recruitment, data collection, reporting of findings, dissemination of data (if relevant) and after the study is completed (e.g. storage).

a) Will you protect the confidentiality of the participants and their data?

☐ No

☐ Yes, completely

☒ Yes, with limits (*Check relevant boxes below.)*

- ☒ Due to the nature of group activities (e.g. focus groups) the researcher cannot guarantee confidentiality.
- ☐ Due to context: The nature or size of the sample from which participants are drawn makes it possible to identify individual participants (e.g. school principals in a small town)
- ☐ Due to selection: The procedures for recruiting or selecting participants may compromise the confidentiality of participants (e.g. participants are identified or referred to the study by a person outside the research team)
- ☐ Due to legal requirements for reporting
- ☐ Other:

b) If confidentiality will be protected, describe the procedures to be used to ensure anonymity of participants and for preserving the confidentiality of their data:

We will protect the participants' confidentiality with limits by not using their names on any records. However, because of our data are videotapes, anyone who knows the participants could recognize them in the tape. We will give participants the complete control of the access to the tape (i.e., who, if anyone, can view it) by asking them to fill out a permission-to-view form after they have seen the tape of their role-played interview. We will keep the tapes in a secure office with a code that indicates which uses participants gave permission for, and we will keep the permission-to-view form with the participants' names separately from the tapes. Only the researchers will have access to the data during analysis.

c) If confidentiality will not be protected, explain why and explain what steps will be taken to respect their privacy:

33. Use(s) of Data

a) What use(s) will be made of the data?

Under the terms of the fellowship granted to Agustin Del Vento, these data will form part of his MA thesis project.

b) Will your research data be analyzed, now or in future, by yourself for purposes other than this research project?

☐ Yes ☒ No ☐ Possibly

If "yes" or "possibly", how will you obtain consent for future data analysis from the participants?

c) Will your research data be analyzed, now or in future, by other persons for purposes other than this research project?

☐ Yes ☒ No ☐ Possibly

If "yes" or "possibly", by whom and how will you obtain consent from the participants for future data analysis by other researchers?

34. Commercial Purposes

a) Do you anticipate that this research will be used for a commercial purpose?

☐ Yes ☒ No ☐ Possibly

If "yes" or "possibly", explain the commercial purpose:

35. Maintenance and Disposal of Data

Describe you plans for preserving and protecting data or for destroying data after the research is completed: *(For all data [e.g., paper records, audio or visual recordings, disks], indicate the means or storage [e.g., a locked filing cabinet], the location of storage, time duration of storage and method of destruction.)*

Both the original videotapes and the copies of these on DVD's will be stored in a locked filing cabinet in a locked office at UVic, room A275, Cornett Building. This is the same room where we will be doing subsequent analysis. Because we need to move the data from the DVD's to the hard drive of our computer, we will use a password-protected computer.

We will have the names of all participants stored on their original consent forms and their permission-to-view forms. However, we will not record participants' names onto the videotapes, DVD's, or digitized files on our computer. In case names are required during our analysis (e.g., when transcribing), we will use pseudonyms.

Upon completion of this pilot study, we will keep the data for five years (until the summer of 2010). We will only use the data for the analysis we described in this application. In August 2010, we will destroy the data (i.e., we will electronically delete the files in the computer and destroy the DVD's used.)

36. Dissemination

How do you anticipate disseminating your research results? (*Check all that apply)*

☒ Directly to participants ☒ Thesis or dissertation

☒ Presentations at scholarly meetings ☒ Published article, chapter or book

☐ Internet ☐ Media (e.g. newspaper, radio, TV)

☐ Class presentation ☐ Other:

37. Conflict of Interest

Are you or any other research team members in a perceived, actual or potential conflict of interest in regard to this research project (e.g., in relation to participants, partners in research, private interests in companies)?

☐ Yes ☒ No

If "yes", please detail the conflict and how it will be managed:

38. Researcher(s) Qualifications

In light of your research methods, the nature of the research and the characteristics of the participants, what special training or qualifications do you and/or your research team have or need to acquire?

Peter Kirk MB, ChB

As Co-Principal Investigator of the VPRN NET, Dr. Kirk is responsible for providing overall direction to the team. He also has primary administrative responsibility for the CIHR funded NET grant and co-leads the NET Communication Team.
Dr. Kirk is a family physician with extensive experience in medical education, residency training, clinical practice and research. He was Professor and Head of the Department of Family Medicine at the University of Manitoba from 1991-2001. During his tenure at the University he established the Palliative Care Subprogram for the Winnipeg Regional Health Authority and created the first Palliative Medicine residency in Canada. During his sabbaticals he has worked at Edith Cowan University in Western Australia on curriculum revision for distance education programs in family medicine. He is currently involved in teaching through the Island Medical Program of the University of British Columbia.
As a clinician, Dr. Kirk has focused his attention on palliative care patients and patients experiencing severe pain. Dr. Kirk worked in Palliative Care at St. Boniface Hospital in Winnipeg where the first hospital based palliative care unit in Canada was created, and currently cares for patients at the Victoria Hospice Society and at the BC Cancer Agency Vancouver Island Centre.
Dr. Kirk has been actively involved in clinical and applied research. Together with Dr. Alan Katz he established the Primary Care Research Unit in the St. Boniface Research Centre in Winnipeg. He has engaged in international research studies in palliative care, most recently with Dr. Linda Kristjanson. His current research interests are on the topics of patient-provider communication in EOLPC and the development of research capacity. In addition to the CIHR award for the VPRN NET, Dr. Kirk was recently awarded a grant from the Michael Smith Foundation for Health Research to engage in a research capacity building process within the Vancouver Island Health Authority.
Dr. Kirk is currently the Director of Research and Evaluation for the Vancouver Island Health Authority (VIHA). He has overall responsibility for research and evaluation, and is also actively involved in the development of a Regional Palliative Care Program on Vancouver Island.

Janet Bavelas PhD

Dr. Bavelas is a Professor of Psychology at the University of Victoria and leader of the NET's Microanalysis of Communication Research Group. This Group is investigating communication in face-to-face dialogue involving physician providers and patients receiving end-of-life and palliative care.
Dr. Bavelas is an expert on communication research, including microanalysis techniques. She has received many honours and awards for her work, including being elected a Fellow of the Royal Society of Canada. She has had continuous research support from SSHRC for about 30 years. Most of her grant-funded research focuses on aspects of communication, including the study of equivocal communication, nonverbal communication, and face-to-face dialogue. In addition to her research expertise, Dr. Bavelas brings her publication experience to the NET. Dr. Bavelas has written three books and over 60 articles on communication. Her co-authored book, Pragmatics of Human Communication, is available in seven languages, and Equivocal Communication has stimulated research all over the world.
Dr. Bavelas has spent much of her career teaching and supervising students at the graduate and undergraduate levels. She will be involved in mentoring her clinician and researcher colleagues in microanalysis techniques, as well as psychometrics, and will also supervise students affiliated with

the NET. Dr. Bavelas also plans to assist the NET to establish the technical environment that will enable video/audio data collection of provider-patient-family interactions.

Grant MacLean

Dr. MacLean is a Medical Oncologist with many years of clinical experience. He currently provides treatment to patients at the BC Cancer Agency (BCCA), Vancouver Island Centre. Dr. MacLean's subspecialty interests are in gastrointestinal cancers, gynecologic cancers, "unknown primaries" and palliative care. He also acts as the Co-Investigator responsible for clinical trials in communication and palliative care at BCCA.
Dr. MacLean has a longstanding interest in teaching and research. He began his teaching career in Auckland Hospital in New Zealand, moving to the University of Alberta and the Cross Cancer Institute in the late 1980's, where he taught Residents and Fellows in the Faculty of Medicine and in the Department of Oncology, Medicine and Gynecology. Dr. MacLean also taught Oncology and Immunology to students in the PhD and MSc programs. He received several awards for teaching excellence from the University of Alberta, and continues to be involved in teaching in his current role as Professor with the University of British Columbia Faculty of Medicine.
Prior to his move to Victoria, Dr. MacLean was involved in a senior research capacity at Biomira Inc. and was responsible for clinical trials in cancer vaccines. Dr. MacLean has published widely on a number of topics including therapeutic cancer vaccines, immune response to cancer and use of monoclonal antibodies for cancer detection. His current interest in communications research is an extension of his longstanding commitment to patients, and his aim of teaching students how to deal effectively with the difficult issues that are presented over the course of their involvement with people living with cancer.

Agustin Del Vento

Agustin is a graduate student working under the supervision of Dr Janet Bavelas at the University of Victoria since September 2003. Agustin did his bachelors degree in psychology obtaining a degree of "Licenciado" in Buenos Aires, Argentina. After finishing his degree, he also trained and worked as a psychotherapist for two years. During his short academic career, Agustin has published two research articles, one in the field of psychotherapy and another article in face-to-face communication. This last article was published in two different journals/languages. Agustin has also made several conference presentations illustrating the use of microanalysis of communication. These conferences include the 10th Qualitative Health Research Conference (2004), the 9th International Conference on Language and Social Psychology (2004), and the Solution Focused Practices Conference (2004). More recently Agustin presented, in conjunction with Dr Grant Mac Lean and Janet Bavelas PhD, a paper on how to apply microanalysis of the communication to decisions in palliative care at the Canadian Association of Psychosocial Oncology (CAPO) held in Victoria (2005). Agustin's current interests are to apply research methods in face-to-face dialogue to the analysis and study of therapeutic and medical communication. He received a fellowship from the Net Grant to conduct his thesis applying microanalysis of communication to End of Life and Palliative Care interviews.

Fraser Black (See information attached to this form.)

39. Risk to Researcher(s)

a) Does this research study pose any risks to the researchers, assistants or data collectors?

☐ Yes ☒ No

b) If "yes", explain the nature of the risks, how they will be minimalized, and the planned response if the risks occur:

40. Multiple Site Research

a) Does this project involve collection of data at multiple sites within Canada?

☐ Yes ☒ No

b) Does this projects involve collection of data which requires the approval of another body (e.g., research ethics board)?

☐ Yes ☒ No

If “yes”, list the sites and/or bodies:

41) International Research

a) Will this study be conducted in a country other than Canada?

☐ Yes ☒ No

If “yes”, provide details of how this research addresses the law, customs and regulations of the host country:

42) Other Information

If there is anything else the UVic/VIHA Joint Sub-committee should know about this study, provide that information here:

Agreement and Signatures

Principal Investigator and Student Supervisor

I affirm that:

- I have read this application and it is complete and accurate.
- The research will be conducted in accordance with the University of Victoria and VIHA regulations, policies and procedures governing the ethical conduct of research involving human participants.
- The conduct of the research will not commence until ethics approval has been granted.
- The researcher(s) will seek further UVic/VIHA review if the research protocol is modified.

Principal Investigator	Student Supervisor
_____	_____
Signature	Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

UVic Chair, Director or Dean

I affirm that adequate research infrastructure is available for the conduct and completion of this research.

_____
Signature

_____
Print Name

_____
Date

VIHA Signator

I affirm that adequate research infrastructure is available for the conduct and completion of this research.

_____
Signature

_____
Print Name

_____
Date

APPENDIX B

Letter of Invitation to Physicians

Dear Doctor X,

We are getting in touch with you regarding our proposed first study of communication in palliative care. Your feedback at our dinner meeting was very useful, and I am available to answer any further questions you may have, in person or by phone (721-7550) or by email (delvento@uvic.ca).

At this time, we would like to invite you to contribute further by carrying out two interviews (both the same day) with two volunteers from Victoria Hospice Society who will be role-playing patients. If you agree to participate, the next step would be to give us two tentative dates and times in the near future when you would be available to participate. We could then match the two volunteer times with one of your days.

For your information, we will be videotaping the role-played interviews at VIHA's research centre located in the Memorial Pavilion, Kenning Wing 1, 2335 Richmond Avenue (very close to Hospice). We estimate that the videotaping session (including instructions, consent forms, interview, and debriefing) will take a total of 1 to 1½ hour of your time.

The videotape interviews will be confidential. You and the volunteer "patient" will control access to the tape (i.e., who, if anyone, can view it) by filling out a Permission-to-View Form after you have seen it.

Thank you very much for your help.

Best Regards,

Agustin Del Vento

APPENDIX C

Letter of Invitation to Volunteers

Dear Volunteer:

The Victoria Palliative Research Network would like you to consider being involved in a research study. The title is: “Pilot Study To Analyze Communication Sequences In Unscripted Role-Played Interviews Between Role-Played Patients And Physicians In End Of Life And Palliative Care.”

What is the purpose of this study?
This research study is an initiative of a broader research program recently funded by the Canadian Institutes of Health Research entitled “Overcoming Barriers to Communication Through End of Life and Palliative Care”. As part of this program, we are asking for your participation in a pilot study aimed at understanding patient-physician communication when discussing difficult issues (e.g., bad news). Your participation is essential to us considering your involvement in Palliative Care. If you decide to participate, you would be videotaped during an *unscripted* interview based on a scenario we will provide.

Why using videotaped role-played interviews?
Videotapes of medical interviews will give us information regarding actual communicative practices between care provider and patient, under the assumption that these practices are different from reports (e.g., questionnaires) about what happened during the medical interview. Videotapes are also very useful tools for teaching and training. Using role-played interviews will help us refine our questions and methodology for a later stage our research involving “real” patients.

What is it involved?
If you are a volunteer from Victoria Hospice Society, we will ask you to role-play a patient. If you are a physician working in Palliative Medicine, we will ask you to act as yourself (interviewing a role-played patient). We will give role-played patients case scenarios with psychosocial information. Physicians, on the other hand, will receive information about the patients’ condition and a specific task to perform during the interview (e.g., discuss patient’s wishes regarding resuscitation).

When and where will this study take place?
We are currently contacting volunteers and doctors. If you agree to participate, we will set an appointment with you to come to our research room (a doctor’s consulting room) at the Vancouver Island Health Research Centre located at the Memorial Pavilion, Kennining Wing 1, 2335 Richmond Avenue. (Next door to Hospice.)

How much of my time will this study take?
Each role-played interview will last 20 minutes. We will ask the physicians to conduct two interviews each with a different role-played patient and a different scenario. After the interview, we will ask both participants to complete a brief and simple task about the interview. We estimate the whole session (i.e., including consent forms, interview, and debriefing) to take 1 to 1½ hour of volunteers' time.

What will be the consequences of my participation in this research?
The videotape interviews are confidential. You will control the access to the tape (i.e., who, if anyone, can view it) by filling out a Permission-to-View Form after you have seen it. We will keep the tapes in a secure office with a code that indicates which uses you gave permission (e.g., education purposes; conferences presentation) and the date on which the tape was made.

Who is conducting this study?
The Victoria Palliative Research Network Communications Team is composed of Dr Janet Bavelas (Psychology Faculty, University of Victoria); Fraser Black (Family Physician, Victoria Hospice Society); Agustin Del Vento (Graduate Student, University of Victoria); Peter Kirk (Pain Management Specialist, BCCA-VIHA); and Grant MacLean (Medical Oncologist, BCCA).

Who should I contact if I am interested in participating or just knowing more about this?
If you are interested in participating or just knowing more about this study, please contact the study coordinator, Agustin Del Vento, at (250) 721-7550 or delvento@uvic.ca for more information.

We greatly appreciate your assistance in helping to facilitate this study.

Sincerely,

Agustin Del Vento
Graduate Student
University of Victoria

APPENDIX D

Case Scenarios for Physicians

Bad News

Pt's Name: Pat Sullivan
Pt's age: the same age as the volunteer

Contextual Information: Pat has recently undergone tests to further investigate "liver lesions". You are not Pat's regular doctor, and have not met Pat before, but are covering for her/his regular doctor (Stewart). Dr. XX, the oncologist, is not able to see the patient this week and has relayed a message asking you, covering her/his regular doctor, to please tell Pat about the results of the recent tests.

History: Pat Sullivan had colon cancer diagnosed 7 years ago, and underwent resection. There were no high risk factors and Pat was advised that no chemotherapy was necessary. Over the last few months Pat has been "tired" and has complained of vague upper abdominal discomfort after eating. Blood tests (Hematology, creatinine, electrolytes and Liver function) were all normal. The report of the CT scan of the chest, abdomen and pelvis states the only abnormality was in the liver, and described two small lesions inferiorly in the right lobe of the liver, and recommended further testing with a Biphasic CT of the liver and a Red Cell Scan.

Results: The results of the Biphasic CT scan and Red Cell scan confirmed there were two metastases in the liver. Dr XX's previous consult note had said that if cancer was confirmed that chemotherapy was a consideration, but that Pat should be referred to Dr. YY to see if surgery (partial hepatectomy) would be helpful.

Good News

Pt's Name: Robin Wallace
Pt's age: the same age as the volunteer

Contextual Information: Robin has recently undergone tests to further investigate "liver lesions". You are not Robin's regular doctor, and have not met Robin before, but are covering for his/her regular doctor (Stewart). Dr. XX, the oncologist, is not able to see the patient this week and has relayed a message asking you, covering his/her regular doctor, to please tell Robin about the results of the recent tests.

History: Robin Wallace had colon cancer diagnosed 7 years ago, and underwent resection. There were no high risk factors and Robin was advised that no chemotherapy was necessary. Over the last few months Robin has been “tired” and has complained of vague upper abdominal discomfort after eating. Blood tests (Hematology, creatinine, electrolytes and Liver function) were all normal. The report of the CT scan of the chest, abdomen and pelvis states the only abnormality was in the liver, and described two small lesions inferiorly in the right lobe of the liver, and recommended further testing with a Biphasic CT of the liver and a Red Cell Scan.

Results: The Biphasic Scan showed only the two liver lesions, with the arterial and venous phase images consistent with benign hemangiomas. The Red cell Scan confirmed that the two lesions are benign hemangiomas. Dr XX’s note had said that if these proved to be hemangiomas that no further investigations were needed and Robin could be reassured.

APPENDIX E

Case Scenario for Volunteers

Good and Bad News

Your Name: Pat Sullivan
Pt's age: your real age

Contextual Information: You have recently undergone tests aimed at further investigating lesions in your liver. Your regular doctor (YY) is away and another doctor will be covering for him today. You will have a consultation with [name of the doctor role-playing] to talk about the results of your recent tests. You're anxious to hear what the doctor has to say.

History: 7 years ago you had colon cancer diagnosed and a section of your colon was taken out. At the time, doctors thought that they had removed it all and no chemotherapy was necessary. Over the last few months you have been tired and you've complained of upper abdominal discomfort after eating. You had blood tests done and they were all normal. However, the report of your CT scan found two small lesions in your liver. As a consequence of that, doctors recommended further testing (that you're waiting to hear about today).

APPENDIX F

Instructions to Participants

Doctors

Thanks for participating. Today you will role-play yourself in two unscripted hypothetical medical interviews regarding cancer care. A volunteer role-playing a patient will role-play this interview with you. You will carry out two consecutive interviews with different role-play patients. You will meet each role-played patient here for the first time. We will be videotaping each interview which should last approximately 20 minutes. After you have conducted both interviews we will show you both tapes so that you can decide if and how we can use them.

The following instructions will explain what to do. If you have any questions don't hesitate to ask.

1. **Please read the consent form attached to this sheet and sign it if you agree to its terms.**

2. **After you've signed the consent form, please take a few minutes to read the sheet with information about your role (attached) and familiarize yourself with it.** Notice that we're only giving you essential information about your role and we're leaving some information out deliberately so that you can add your "personal touch" so that it feels natural to you. Please, use your real name while role-playing.

3. **We will come to pick up the consent form** before asking you to go in the consulting room.

4. **Then we will take you to the consulting room where you will meet the role-played patient for the first time.**

5. **Start acting as if you were in a real interview as soon as you enter the room.**

6. **Take approximately 20 minutes for this interview and, once you're completed, leave the room.** We will meet you again in the hallway.

7. **After the interview we will ask you to record a dictation about the interview into a tape recorder we will give you**. (We won't be videotaping you while you dictate.)

8. Once you've completed the dictation a new patient will arrive and we will give you the background for that patient. (**Steps 2 to 7 will repeat.)**

9. **After the interview we will show you the videotape and get you to complete a permission-to-view form and you can tell us whether we can keep the tape and, if so, who can see it.**

Thanks for coming today!

Volunteers

Thanks for participating. Today you will role-play a patient in an unscripted hypothetical medical interview regarding cancer care. A real doctor will role-play this interview with you. You and the doctor will meet here for the first time. We will be videotaping the interview which should last approximately 20 minutes. When the interview is over, we will show you the tape so that you can decide if and how we can use it.

The following instructions will explain what to do. If you have any questions don't hesitate to ask.

1. **Please read the consent form attached to this sheet and sign it if you agree to its terms.**

2. **After you've signed the consent form, we will take you to the consulting room where you will wait for the doctor.**

3. **While you wait in the consulting room, please take a few minutes to read the sheet with information about your role (attached) and familiarize yourself with it.** (This sheet won't be available to you during the interview.) Notice that we're only giving you essential information about your role and we're leaving some information out deliberately so that you can add your "personal touch" so that it feels natural to you. Please, use the name we give you during the role-play.

4. **After a few minutes, we will return to answer any questions you have regarding your role.**

5. **Start role-playing the patient as soon as the doctor enters the room.**

6. **When the interview is over, the doctor will leave the room and one of us will turn off the video camera. Please remain in the room.** We will come in the room and ask you to do a brief task. Once you've completed the task, the experiment will be over and we will show you the videotape.

7. **After viewing the tape, we will give you to complete a permission-to-view form and you can tell us whether we can keep the tape and, if so, who can see it.**

Thank you for coming today!

Agustin Del Vento
Project coordinator

APPENDIX G

Consent forms for Participants

Physicians

Investigators

Agustin Del Vento (Graduate student), Dr Janet Bavelas (Faculty, University of Victoria), Grant MacLean (Medical oncologist, BCCA), Peter Kirk (Pain management specialist, BCCA-VIHA), and Fraser Black (Victoria Hospice Society) are inviting you to participate in this research study.
Agustin Del Vento is a graduate student in the Department of Psychology at the University of Victoria and you may contact him if you have further questions about this study by telephone at 721-7550 or email at delvento@uvic.ca. As a graduate student, Agustin is required to conduct this research as part of the requirements for a degree in Psychology. This research project is being conducted under the supervision of Dr Janet Bavelas. You may contact Dr 2avelas at 721-7550.

Purpose and rationale

The purpose of this research project is to videotape unscripted role-played interviews in End of Life and Palliative Care (EOLPC). This research is important because there is currently a significant gap in understanding and addressing the barriers to communication between patients and care providers in the EOLPC context. Overcoming barriers to communication and developing effective interactions in EOLPC will enhance the goals and outcomes of care from the viewpoints of the patients, family, and care providers (CIHR Net Grant proposal, 2004).

Procedures

We are asking you to participate in this study because of your experience and knowledge in working with patients in EOLPC. If you agree to voluntarily participate in this research, we will ask you to assume the role of a doctor talking to a patient (role-played by a volunteer) during the 20 minutes of the interview. We will record the complete role-played interview on video. After the interview, we will ask you to complete a brief task related to the interview. We estimate the whole session to take approximately 1 to 2 hours of your time.

Inconveniences

Participation in this study may cause some inconvenience to you such as being absent for work while you are participating in the study and being self-conscious about being videotaped.
As a way to compensate you for being absent from work in a time other than you free time, we will offer you a compensation that will cover the time that you have been absent from work. This compensation will depend on your professional affiliation and rate of pay, ranging from $35/hr to 100/hr. It is important for you to know that it is unethical to provide undue compensation or inducements to research participants and, if you agree to be a participant in this study, this form of compensation to you must not be coercive. If you would not otherwise choose to participate if the compensation was not offered, then you should decline.

Risks

We do not anticipate any risks to your participation in this pilot study

Potential benefits

The potential benefits of your participation in this research include having the opportunity to learn about communication research in EOLPC context. We also hope that you will profit from watching and discussing the videotape of your role-played interview with us. It is also anticipated that the results of this research may provide important information for developing educational programs in health communication.

Anonymity

Because we will use the videotaped role-played interviews as data for our analysis, we cannot guarantee your anonymity.

Confidentiality

We will protect your confidentiality by not using your name on any records. However, anyone who knew you could recognize you in videotape, so you will control access to the tape by filling out a Permission-to-View Form after you have seen the tape. We will keep the tapes in a secure office with a code that indicates which uses you gave permission and the date in which the tape was made. We will keep this form and the Permission-to-View form that has your name separately.
We will destroy the data from this study in August 2010. We will erase all electronic data and we will shred paper copies.

Contact information

In addition to being able to contact the researcher and the researcher's supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate

Vice-President, Research at the University of Victoria (250-472-4545) or the Regional Research Manager for VIHA, Veronica Morris veronica.morris@viha.ca or 250-370-8620.

Your signature below indicates that you understand the above conditions of participation in this study, in particular, *that you understand that you will be videotaped*, and that you have had the opportunity to have your questions answered by the researchers.

Name of Participant *Signature* *Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Volunteers

Investigators

Agustin Del Vento (Graduate student), Dr Janet Bavelas (Faculty, University of Victoria), Grant MacLean (Medical oncologist, BCCA), Peter Kirk (Pain management specialist, BCCA-VIHA), and Fraser Black (Victoria Hospice Society) are inviting you to participate in this research study.
Agustin Del Vento is a graduate student in the Department of Psychology at the University of Victoria and you may contact him if you have further questions about this study by telephone at 721-7550 or email at delvento@uvic.ca. As a graduate student, Agustin is required to conduct this research as part of the requirements for a degree in Psychology. This research project is being conducted under the supervision of Dr Janet Bavelas. You may contact Dr 2avelas at 721-7550.

Sponsor

The CIHR Team Development Grant is funding this research.

Your participation in this study is entirely voluntary and you are free to refuse to participate, to withdraw from the study, or to refuse to do any particular part of the study, without any negative consequences. In the event that you withdraw from the study, we will erase your data.

Purpose and rationale

The purpose of this research project is to videotape unscripted role-played interviews in End of Life and Palliative Care (EOLPC). This research is important because there is currently a significant gap in understanding and addressing the barriers to communication between patients and care providers in the EOLPC context. Overcoming barriers to communication and developing effective

interactions in EOLPC will enhance the goals and outcomes of care from the viewpoints of the patients, family, and care providers (CIHR Net Grant proposal, 2004).

Procedures

We are asking you to participate in this study because of your experience and knowledge in volunteering with patients in EOLPC. If you agree to voluntarily participate in this research, we will ask you to assume the role of a patient talking to a physician (role-played by a care provider) during the 20 minutes of the interview. We will record the complete role-played interview on video. After the interview, we will ask you to complete a brief task related to the interview. We estimate the whole session to take approximately 1 to 2 hours of your time.

Inconveniences

Participation in this study may cause some inconvenience to you such as being absent for work while you are participating in the study and being self-conscious about being videotaped.

Risks

There is a potential risk to you to by participating in this research. This risk includes the possibility of you feeling distressed by role-playing a patient with a terminal illness. To prevent or to deal with this risk we are only recruiting volunteers who have had experience in dealing with patients with a terminal illness and, presumably, have developed coping strategies. We will also give you time to think about your role and experience how you feel before starting to videotape. If you feel distressed with your role during the videotaping session, you can let us know and we will interrupt the videotaping session, offer you a break, the chance to stop and reschedule the activity; and/or the chance to stop the role-played interview altogether.

Potential benefits

You will not receive any direct benefits from participating in this study. However, it is anticipated that the results of this research may provide important information for developing educational programs in health communication.

Anonymity

Because we will use the videotaped role-played interviews as data for our analysis, we cannot guarantee your anonymity.

Confidentiality

We will protect your confidentiality by not using your name on any records. However, anyone who knew you could recognize you in videotape, so you will control access to the tape by filling out a Permission-to-View Form after you have seen the tape. We will keep the tapes in a secure office with a code that indicates which uses you gave permission and the date in which the tape was made. We will keep this form and the Permission-to-View form that has your name separately.
We will destroy the data from this study in August 2010. We will erase all electronic data and we will shred paper copies.

Contact information

In addition to being able to contact the researcher and the researcher's supervisor at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545) or the Regional Research Manager for VIHA, Veronica Morris veronica.morris@viha.ca or 250-370-8620.

Your signature below indicates that you understand the above conditions of participation in this study, in particular, *that you understand that you will be videotaped*, and that you have had the opportunity to have your questions answered by the researchers.

Name of Participant *Signature* *Date*

A copy of this consent will be left with you, and a copy will be taken by the researcher.

APPENDIX H

Permission-to-view Form

Principal Investigator: Agustin Del Vento, Master's student, Department of Psychology, University of Victoria.

Your tape would be kept in a secure place and labeled with a *code number* and the *date the tape was made*. Your name will not be in the label or the tape. These sheets, which connect your tape with your code number, are kept in a separate place. Obviously, however, videotapes are not anonymous to anyone who knows you or would recognize you.

With that in mind, please indicate bellow the way(s) we can use the videotape made during this session. You can select some of these options and not others- or non at all. The principal investigator will answer any questions you may have about these options.

1. Do you allow the use of this tape for **viewing and analysis by members of the Victoria Palliative Research Network team** (e.g., Agustin Del Vento, Janet Bavelas, Peter Kirk, Grant MacLean, Fraser Black):	Yes	No
2. Do you allow the use of this tape for playing it as an **example for professional audiences** inside Canada (e.g., at a professional conference, UVic, or another university other than UVic):	Yes	No
3. Do you allow the use of this tape for playing it as an example for professional audiences **outside Canada*** (e.g., at a professional conference or another university other than UVic): ***** Note that it is possible, if we cross the Canada/US border, for US Customs and Immigration to seize our computers for security purposes. In this situation, they will have access to the anonymous data on our computer, including videotaped data. Although your name will not be linked to the files in any way, it is still you're your image. We will ensure that when attending conferences outside Canada, that the videotaped data on our computers only includes participants who have agreed to accept this risk by circling "yes" in the right hand column for option (4).	Yes	No
4. Do you allow the use of this tape for playing it as an **example for classes at the University of Victoria** (e.g., Island Medical Program):	Yes	No
5. Do you allow the use of parts of this tape to be included as **examples in Agustin's master's thesis.**	Yes	No
6. Do you allow us to make parts of this tape available to the public via the **NET Grant's web site**:	Yes	No
7. Do you allow us to make parts of this tape available as a **still photo in, for example, a journal article** :	Yes	No
8. Do you allow us to make this tape available as a **CD or DVD in conjunction with a journal article**:	Yes	No
9. Do want us to **erase this tape**?	Yes	No

Participant name: Date:
Signature: **(For analyst to complete)** Group number:

APPENDIX I

Task after the Interview for Volunteers

Use this space to write a letter to your family doctor who is out of town explaining what you and the doctor you've just seen discussed today. Please, give details about your diagnosis and prognosis.

APPENDIX J

Task after the Interview for Physicians

Please, leave a message on this tape recorder [placed on a table next to the instructions] with the details about the patient that you have just seen as you would normally do when composing a dictation.

APPENDIX K

Rules for Analysis of Physicians' Language

Naming or Defining the Diagnosis

The doctor can refer to the patient's diagnosis *directly* saying what this diagnosis is. That is, using the words "cancer" or "metastasis" in the bad news condition; or the words "hemangiomas" or "(benign) blood vessels" in the good news condition. For example, in the good news condition a doctor said "The two lesions in your liver are *benign hemangiomas*" or another doctor referred to the diagnosis as "*dilated blood vessels.*" In the bad news condition, a doctor said "The two lesions in your liver are *cancer*" or another doctor said "you have two *metastases* in your liver."

The doctor may refer to the patient's diagnosis *indirectly*
A) Using euphemisms. These include any word or phrase (e.g., "questionable *things*") that serves to substitute the actual (medical) name for the diagnosis.

a) Use a more general term, i.e., a term that is a category in which the diagnosis is only an element. For example, "condition" or "tumor" (which can be benign or malignant).
b) Use a term that makes the diagnosis less specific (e.g., "*type of* cancer" (mentioned the 1st time the diagnosis is delivered).
c) Use a lay person language term to refer to the diagnosis. For example, use "cysts" to refer to the hemangiomas or "tumor" to refer to cancer.

Exceptions: We are not including euphemistic expressions substituting other things than the name of the diagnosis or any information related to the diagnosis (e.g., its location). For example, when a doctor says "this is bad news," the word "news" is not being used to substitute the name of the diagnosis. Other examples are "reports," "spots" (to refer to what the tests found), etc.

B) Having the patient name the diagnosis. Those cases in which the patient is the one who names the diagnosis after the doctor elicited it from him or her. In this case, the doctor's role may only be to confirm the patient's assessment. For example,

> Dr: But when you- what do you think- what has been going through YOUR mind as what has been going on to cause this?
> Pt: The worst of course.
> Dr: Which is…?
> Pt: That *I have* [*patient's term*].
> Dr: Right.

C) Using deictic expressions. Deictics are words or phrases that point at something else usually inferable from the context (e.g., this, that, etc) of the conversation. In this case, we're only interested in those deictic expressions used to substitute the name of the diagnosis. That is, we're interested in the doctors' narrow use of a deictic to refer to a specific referent (i.e., the words cancer or hemangiomas). In order to decide if a deictic meets this criterion, it is useful to ask yourself whether the sentence still makes sense once you've replaced the deictic with the name of the diagnosis.

> Examples of deictics are: "the biopsy does show *that* [referring to the cancer]" or "we're not going to be able to get rid of *this*", or "Both tests point *the same way* [referring to the diagnosis of hemangiomas]".

Exceptions: Pronouns are not deictics. For example, in the phrase "many people have *them*" [referring to the hemangiomas] the word "them" should not be considered a deictic. We will also not include deictics replacing things other than the diagnosis. That is, broader uses of deictics (e.g., to avoid repeating a whole sentence) that are not used to avoid repeating the diagnosis should not be included. Last, if you're not sure whether a deictic replaces the name of the diagnosis, don't include it.

Giving an Evaluation to the Diagnosis

The doctor can give his or her evaluation of the patient's diagnosis or about the news directly or unambiguously saying whether this diagnosis/news is "good" or "bad"; "common" or "abnormal"; or "benign" or "malignant".

> For example, in the good news condition, a doctor may say "It is not cancer. So it's *good* news." In the bad news condition, a doctor may say "as I said, this is your *bad* news that this is cancer."

Note: Some departures from the direct way of conveying the evaluation of the news/diagnosis in the good news condition are acceptable because the doctor is talking about a medical condition that can never completely be "good". Therefore, cases such as "It's quite common" or "reasonable good" should be considered as direct means of conveying the good news.

A doctor can refer to the evaluation of the diagnosis/news *indirectly* using
A) Euphemisms used to qualify the evaluation of the news/diagnosis substituting words such as "good" or "benign"; "bad" or "malignant".

> Examples: "(…) it's a *little disappointing* news" [this example has two euphemisms]; "(…) *encouraging* news"; "you do have a *serious* condition"; "things look *reasonable* good"; "lesions look like two, *small*, metastases" (In this case, small is the opposite of big, and big

implies “bad”. Therefore, small is used as an euphemisms for “not bad”); etc.

B) Saying what the evaluation of the news/diagnosis is negating its contrary (instead of saying what it is).

Example: “they are not good news” (instead of “they are bad news”) or “they are not bad news.”

Exceptions: We’ll only be looking at how doctors assign evaluation to the diagnosis or the news. Therefore, if the doctor is discussing something other than the news and gives evaluation to it, it should not be included in the analysis. For example, in responding to the patient’s concern regarding his cancer being in the bowels, a doctor said “I- I think that part is *fine*”. In this case “fine” should not be included in the analysis because it’s not being used to qualify the actual diagnosis.

Expressing Certainty about the Diagnosis

The doctor can express different degrees of certainty with the verbs and verb phrases he/she uses when conveying the diagnosis to the patient. In conveying that he/she is certain or emphatically certain about the patient’s diagnosis the doctor is being direct. In conveying that he/she is less than certain, the doctors is being indirect.

1st step of analysis: Identify in the transcripts *all* verbs and verb phrases used by the doctor.

2nd step of analysis: From the list of verbs and verb phrases you made in step 1, select those *used by the doctor to deliver the news/diagnosis*. These verbs can be:

a) Verbs used to talk about the tests (e.g., “test *suggest/reports/confirm*”) or about the information (e.g., “the information *shows* that…”; “this *is* very strongly suggestive…”; “it *is* strong evidence for cancer.”)
b) Verbs used to talk about what the lesions are/are not. These verbs take different forms of the verb “to be” (e.g., “they *are/might be* cancers”; “the two spots *look like* hemangiomas.”)
c) Verbs used to say something *about* the diagnosis. These verbs also take different forms of the verb “to be” (e.g., “*it’s* quite common”; “*it’s* a variant on normal”; “it *effectively rules out*…”)

Note: When doctor says “It think that’s good news” he or she is using the verb “think” to deliver the diagnosis (and not just say what his opinion is). Therefore, this case should be treated as a case of news delivery.

Exceptions: Verbs used by the doctor to convey information other than the diagnosis delivery should not be included in this analysis. Such verbs are part of utterances used by the doctors for other purposes, some of which can be:

a) Verbs used to give further information about the diagnosis or the lesions (e.g., "*probably is* from the colon"; "they *haven't been* biopsied"). (We're not including in this analysis those verbs used by the doctor to talk about where the cancer came from because this information was not provided to doctors in the scenarios we gave them. Therefore, they had good reasons to show uncertainty when explaining this information and their qualified discourse cannot be attributed to our hypothesis.)
b) Verbs used by the doctor to refer to him/herself (e.g., "*we've* received"; "*we don't* know"; "*I'm* afraid")
a) Verbs used to talk about past procedures (e.g., "the biphasic CT and the Red Cell scan that *were done*.)
b) Verbs used in a disclaimer.

3rd step of the analysis: Decide whether the verbs or verbs phrases selected in the step 2 are *emphatically definite*, *definite*, or *less than certain*.

Emphatically definite verbs can be:

a) Used when the doctor transmits the information introducing his or her personal evaluation about his/her degree of *certainty* regarding the diagnosis.
b) Followed by an adverbial, modifier, or a variation of the verb/verb phrase that indicates that the doctor is very certain about the diagnosis.
c) Examples are: "the tests *did confirm*"; "this results *effectively rule out*…"; "these *are not at all* cancers."

Definite verbs or verb phrases can be:

a) Used when the doctor transmits the information introducing his or her *neutral* personal evaluation about the degree of (un)certainty regarding the diagnosis. These are usually not followed by an adverbial or modifier. Note: When there's two adverbs (e.g., "fairly strong" or "very strongly suggestive") or an adverb and a verb that have completely opposite meanings (i.e., emphatically definite vs. less than certain) (e.g., "It certainly looks like"), consider the verb *definite*. This is because we're assuming that the two meanings cancel each other out.
b) Examples are: "the tests *indicate*"; "those two tests *are consistent* with a diagnosis of cancer"; "the lesions *are not* related to cancer"; "*It is* a variant on normal."

Less than certain verbs or verb phrases can be:

a) Used when the doctor transmits the information introducing his or her personal evaluation about his/her degree of *uncertainty* regarding the diagnosis.
b) Followed by an adverbial, modifier, or a variation of the verb/verb phrase that indicates the doctor's level of uncertainty.
c) Examples are: "this second tests *suggests*" or "from the [evidence of the] tests, *it seems* that you have;" "these lesions *might be* related to cancer;" "this *looks like a group of blood vessels* " or "this *is probably* cancer."

Disclaimers. A doctor can also use *disclaimer* to express that he/she is less than certain about the diagnosis. A disclaimer is any utterance produced by the doctor that undermines or "pokes holes" in the certainty regarding the diagnosis (e.g., "we think that there is a cancer involving the pancreas. *Now.. um.. that's just on the basis of the test results we got*"; "it would appear, *although we haven't- um.. it isn't final*.. that you have a type of cancer"). In using a disclaimer a doctor is verbalizing all the complexities of the situation, i.e., all the reservations he/she has when having to pronounce a conclusive diagnosis.

Receiver of the News

The doctor can refer to the patient explicitly or directly as the receiver of the news using a second person pronoun (you, your, or yours) or he/she can address the diagnosis only implicitly or indirectly to the patient. For this analysis, we compare each time the doctor refers explicitly to the patient to the times the doctor could have done so and didn't.

Steps for analysis:

1. Identify all possible places where doctor could have referred to the patient's health, diagnosis, etc., or when the doctor could have addressed what they are saying explicitly to the patient.
2. Decide whether the doctor used an impersonal form (e.g., in the liver") or one that explicitly addressed the patient (e.g., "in *your* liver").

Step 1: Look for instances where the doctor could have introduced the patient in the utterance. While you read the transcript, it works to ask yourself if each of the utterances would also have made sense if "you" was introduced. Below are several examples of ways in which the doctor can refer to the diagnosis as concerning to the patient (these ways are not intended to be exhaustive). Only include the "you" when is common usage (syntactically normal) to say the sentence in that way.

a) The message is for the patient: Referring directly to who is the receiver of the news "I can tell *you*…" or "I'm pleased to tell *you*" [instead of indirectly saying "I'm pleased to say…"] or "The results I'd like to give *you*" [instead of being indirect by saying "the results that we're going to discuss"]
b) Making the news specific to the patient:
    - Referring to the location of the diagnosis "The two spots in *your liver* look like…" [instead of "The two spots in the liver"]
    - Concerning the patient's overall health "they are of no significance to *your* health" [instead of "to their health"]
    - Referring to the diagnosis *the patient has* "You have two dilated blood vessels / small metastasis" [instead of "these are two dilated…" or "there are…"] or "your lesions" [instead of "these lesions"] or "Your

colon cancer has come back" [instead of "the colon cancer has come back"]
- Referring some procedure the patient could have "Without you having an actual biopsy" [instead of "without an actual biopsy"]

Exceptions: Don't include cases in which the doctor is referring to the tests as concerning to the patient because, in doing that, the doctor is not talking about the patient's diagnosis yet. For example, when the doctor says *"Your* recent tests…," "*this is* a very good report," "I think *you* had two tests done" or "what *you* have done with the CT scan…," etc. For the same reason, don't include the what the doctor says about the information that him/her and the patient already know about (e.g., the discussion about the spots that led to these new tests). Don't include broken utterances or repetitions (e.g., when a doctor repeats what the patient previously said with "*you* would like to know"). Don't include abstract talk or definitions that could apply to anyone (e.g., where the doctor is talking about a general medical principle, for people in general, as if they were lecturing to a medical class.) Last, don't include colloquial expressions such as when a doctor says "you know" to the patient in fast pace.

Step 2: Look for cases in which the doctor uses a 2nd person pronoun (you, your, or yours) to directly refer to the patient.

Bearer of the News

For this analysis we look at the beginning of each section for analysis to identify who was the responsible for delivering the news. That is, we're interested in the "framing" of the news delivery and whether the doctor takes credit for the delivery. We only count this decision once.

There are 3 options available to the doctor:
A) The doctor can insert his or herself at the begging of the news delivery or in the announcement of the news, framing him or herself as the bearer of the message. This counts a directness.
For example, a doctor can say "*I'm* pleased/sorry to say that the tests are…" or another doctor can say "So you just had those two tests and those- that's the results that *I'd* like to give you today."

Exceptions: Exclude from this analysis those cases in which the doctor expresses his or her sympathy for having to deliver the diagnosis (e.g., "*I'm* concerned that you've got…") or gives his or her own opinion about the news (e.g., or "*I think* that is good news"). In those cases, the doctors include themselves as the source of these messages but they are not introducing themselves as the bearer the news. Exclude 1st person pronouns rather than those used to convey that the doctor is the bearer of the news (i.e., exclude 1st person pronouns used in disclaimers).

B) The doctor can negotiate with the patient the news delivery, framing the delivery as a shared responsibility. In those cases, the doctor will usually ask for the patient's consent to hear the news. This counts as indirectness.
For example, a doctor can said "And.. do you want me to give you…all the results no matter what they are?" and the patient responded "I need you to, yeah [nodding]."

C) The doctor as the responsible for the news can be absent. In those cases, the doctors may just be "passing on the information given to him or her" (following the instructions we gave them in the scenarios). The responsibility of the news in those cases can be placed in the tests, the radiologist, or even be unspecific (e.g., the doctor can use the pronoun "we" to refer to the group of specialists). This counts as indirectness.
For example, a doctor said "Well.. m-uh.. those two tests uh.. have indicated that th- the lesions are probably cancer" or "Now, what you have done with the- biphasic scan and then uh- uh- which is looking at the blood flow in and out of the lesions. And that scan.. uh.. combined with a Red Cell scan, shows that those lesions are full of blood."

APPENDIX L

Cases used to Develop each Analysis System

Naming Analysis

The aim of this analysis was to capture how the doctors referred to the patient's diagnosis. A doctor had available at least 4 strategies:

1) Be direct
2) Use euphemistic expressions
3) Have the patient name the diagnosis
4) Use deictic expressions

Reliability:	Identification of either a: a) direct form b) euphemism c) having pt name it d) deictic
Dr 1_Good	RULES
Dr 1_Bad	RULES
Dr 2_Good	1/1
Dr 2_Bad	RULES
Dr 3_Good	3/3
Dr 3_Bad	RULES
Dr 4_Good	RULES
Dr 4_Bad	3/5
Dr 5_Good	4/4
Dr 5_Bad	2/2
Dr 6_Good	2/2
Dr 6_Bad	4/4
Dr 7_Good	5/5
Dr 7_Bad	4/4
Dr 8_Good	5/5
Dr 8_Bad	4/4
TOTALS	37/39 = 95%

31.25% (5/16 cases) of the data were used in developing the rules for this analysis.

Evaluation Analysis

The aim of this analysis was to code how the doctors talked about the nature of the news or diagnosis (whether it was good or bad). A doctor had available at least 4 strategies:

1) Be direct
2) Use euphemistic expressions
3) Use his or her own person disclosure re the diagnosis
4) Giving a negation of the contrary statement

Reliability:	Identification of either a: a) direct form b) euphemism c) personal disclosure d) litotes
Dr 1_Good	RULES
Dr 1_Bad	1/1
Dr 2_Good	5/5
Dr 2_Bad	3/3
Dr 3_Good	4/4
Dr 3_Bad	RULES
Dr 4_Good	4/4
Dr 4_Bad	RULES
Dr 5_Good	RULES
Dr 5_Bad	0/0
Dr 6_Good	1/1
Dr 6_Bad	RULES
Dr 7_Good	RULES
Dr 7_Bad	2/2
Dr 8_Good	4/5
Dr 8_Bad	2/2
TOTALS	26/27= 96.3%

37.5% (6/16 cases) of the data were use in developing the rules for this analysis.

Expressed Certainty Analysis

Because of the complexity of the decision making process for this analysis, we divided in 3 steps that would make it easier for the analyst to eventually decide on what verbs and verb phrases conveyed different levels of certainty.

In the 1st step of analysis, two analysts identified all verbs or verb phrases in the 16 transcripts. In the 2nd step of analysis, the two analysts identified only those verbs or verb phrases used to deliver the news. In the 3rd step of the analysis, the

two analysts decided whether the verbs or verbs phrases identified in the 2nd step where 1) emphatically definite, 2) definite, or 3) less than certain.

Reliability:	Identification of all verbs and verb phrases in the transcripts	Identification of all verbs used (specifically) to deliver the news	Decision re level of certainty conveyed by the verb or verb phrase
Dr 1_Good	6/6	5/6	5/5
Dr 1_Bad	3/3	3/3	2/2
Dr 2_Good	RULES	RULES	RULES
Dr 2_Bad	RULES	RULES	RULES
Dr 3_Good	RULES	RULES	RULES
Dr 3_Bad	5/5	5/5	3/3
Dr 4_Good	Not done	6/6	3/4
Dr 4_Bad	Done together	3/4	3/3
Dr 5_Good	Not done	8/11	6/6
Dr 5_Bad	Not done	5/6	3/3
Dr 6_Good	13/13	12/13	9/9
Dr 6_Bad	11/12	11/12	5/5
Dr 7_Good	RULES	RULES	RULES
Dr 7_Bad	14/14	14/14	7/7
Dr 8_Good	17/17	17/17	10/10
Dr 8_Bad	RULES	RULES	RULES
TOTALS	69/70 = 98%	89/97 = 92%	56/57 = 98%

31.25% (5/16 cases) of the data were used in developing the rules for this analysis.

Receiver Analysis

Reliability:	Identifying whether the doctor could have addressed the patient or not
Dr 1_Good	RULES
Dr 1_Bad	RULES
Dr 2_Good	RULES
Dr 2_Bad	7/8
Dr 3_Good	4/7
Dr 3_Bad	5/5
Dr 4_Good	RULES
Dr 4_Bad	RULES
Dr 5_Good	RULES
Dr 5_Bad	1/2
Dr 6_Good	RULES
Dr 6_Bad	RULES
Dr 7_Good	2/2
Dr 7_Bad	6/6
Dr 8_Good	5/6
Dr 8_Bad	4/6
TOTALS	34/42=82%

50% (8/16 cases) of the data were used in developing the rules for this analysis.

Note: No chart was made for the Bearer of the News Analysis.