REFERENCING AND MANAGING FAMILY MEMBERS' INVOLVEMENTS DURING ONCOLOGY INTERVIEWS: AN ANALYSIS OF THE ROLE FAMILY MEMBERS PLAY IN CANCER COMMUNICATION

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This research is dedicated to my family, especially my father, for inspiring my interest in family cancer communication. Your strength and abilities to overcome health challenges inspire me each and every day. The findings of this work are also dedicated to all other families managing cancer as mine does.
Once you choose hope, anything's possible.

- Christopher Reeve
ABSTRACT OF THE THESIS

Referencing and Managing Family Members’ Involvements During Oncology Interviews: An Analysis of the Role Family Members Play in Cancer Communication

by

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The manners in which family members talk through cancer within their home settings have received considerable attention. Yet little is known about how (or if) family members contribute in shaping the organization of oncology interviews between patients and doctors. This study examines the impact of family members on oncology interviews. Particular attention is given to how absent family members are referenced, by patients and doctors, and when co-present actually participate in interactions during routine clinical encounters. Family members’ involvements during oncology interviews are important for three primary reasons. First, patients do not typically go through cancer alone. Second, doctors realize that patients routinely bring in family members during consultations. Finally, caregiving by family members is a prominent public health problem, but has not been examined as social activities occurring in the clinic. This research examines 44 instances of how patients and physicians reference family members as well as the contributions that co-present family members make during oncology interviews.
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CHAPTER 1

INTRODUCTION

As cancer affects three out of four families in the Western part of the world (American Cancer Society, 2002), it is evident that families are essential within the patient’s cancer treatment and process. However, it is not only patients that bring their fears and concerns into the cancer clinic. Patients and their family members talk through cancer outside of medical settings, and these discussions become relevant within oncology appointments. Whether a family member is referenced or is physically present to participate in conversations with patients and physicians, they can facilitate the management and communication of the patient’s care.

Both physicians and patients engage in behaviors that reference family members. Family members’ medical histories and relationships are a key focus of interviewing. Family members visiting the clinic with their loved ones also raise their concerns, advocate for patients’ treatment and wellness, and in some cases clarify diagnostic and treatment decision-making. Through these and related behaviors, family members’ histories and enacted positions about cancer care influence the course and development of relationships between patients, doctors, and family members.

A sampling of 80 out of 200 recorded and transcribed interviews have been examined, and a sub-sampling of 44 instances has been identified for investigation. Two specific activities are examined: (1) when patients or doctors reference non-present family members, and (2) when family members are present during the interview and contribute by asking doctors’ questions, offering comments, and related actions.

The first data analysis chapter seeks to determine how and why patients mention their families during oncology appointments, and the relationship of these actions to reducing fear, minimizing uncertainty, and fostering hope. This includes examples when patients mention their family members to compare his or her health, to reiterate positive family health history, or to express the impact that the cancer has on the entire family. In the second data analysis chapter, moments in which patients and/or physicians incorporate the family into
conversation are presented through actions such as invoking family history and inquiring about family health and communication about the role other family members play in their cancer care process. These collections are analyzed to better understand how family members behave within oncology encounters, or are referenced in relation to cancer care.

This research begins with an explanation of cancer as a family illness and demonstrates the need of communication among family members. A literature review of family cancer communication is provided, followed by an explanation of how conversational analysis was utilized to analyze this collection of cancer transcriptions. The second chapter of this thesis provides data that depict references to family within oncology settings and the third chapter illustrates the role of family members whom are present in oncology settings. Finally, an analysis of these findings is represented, followed by implications of these findings and a discussion of future directions for research.

**Cancer as a Family Affair**

When a patient is diagnosed with a serious illness, it affects much more than just that person, impacting the lives of individuals considered a part of that person’s “family.” Cancer is considered a “family affair” because a cancer diagnosis affects not only patients, but also their families (Duhamel & Dupuis, 2004, p. 68). It is typical for family members to play a crucial role in cancer care. The diagnosis of cancer often leads to increased involvement of family members as caregivers and decision makers for the patient (Kissane et al., 1994; Kissane et al., 2003). Cancer does not seclude and impact just the patient, but rather seeps into the everyday lives of entire families. As family members become invested in both family matters as well as dealing with physician-related communication, their presence becomes necessary within medical encounters. Cancer occurs in contexts of families, friends, coworkers, community members and other individual who participate in the care of a patient and within encounters with an oncologist (Burkhalter & Bromberg, 2003). The conceptualization of cancer as an illness of the family has gained attention due to cancer’s documented impact on family functioning (Burkhalter & Bromberg, 2003). Family members influence the ways in which patients cope with illness as they often provide emotional support and encourage adherence to treatment and health-promoting behaviors (Wortman,
1984). The family acts as a focal unit at the interface between the patient and health-care services (Arraras, Illarramendi, Valerdis, & Wright, 1995).

Family members often become the liaison between families and physicians—reiterating concerns, speaking on behalf of the patient and ultimately facilitating communication on both ends. The communication among cancer patients, family members, and health professionals is vital in cancer patients’ and caregivers’ lives (Beach, 2009). This interdependence of communication is evident in the treatment and management of cancer from all perspectives.

When a loved one is diagnosed with cancer, the dynamics of families are likely to change. Cancer is often referred to as an intruder for families (Farrow, Cash, & Simmons, 1990), altering functions and relationships. Cancer changes the course of everyday life and can alter the way family members interact. After a cancer diagnosis, family communication processes can facilitate, distort, or impede dissemination of diagnosis and prognosis information to family members (Zhang & Siminoff, 2003). Family communication processes are also engaged as part of cancer treatment decision making (Clayman, Galvin, & Arntson, 2007), the provision of social support for managing objective, and emotional demands of cancer treatment (Pitceathly & Maguire, 2003). Research has even recognized the need for clinicians and caregivers to assist in enhancing and improving the communication between patients and family members (Epstein & Street, 2007; Glimeus, Birgegard, Hoffman, & Kvale, 1995; Lewis, Pearson, Corcoran-Perry, & Narayan, 1997, Skorupka & Bohnet, 1982). While much literature has focused on cancer as a factor that alters social relationships (Gotcher, 1993; Kristjanson & Ashcroft, 1994; Maynard, 1996, 1997, 2003), how families actually interact throughout the entire cancer process is in its early stages of research. The value of family cancer communication has been recognized throughout literature as it can result in positive results for patients, family members and health care providers.

Positive Effects of Family Cancer Communication

Family cancer communication can yield beneficial effects for all participating parties. Physicians, patients, and their family members experience the impact of incorporating family into the cancer process. Effective communication with patients and their family member can increase oncology providers’ satisfaction, reduce emotional burnout and stress, and decrease
the potential for adversarial relationships and malpractice liability within care (Burkhalter & Bromberg, 2003). It is essential that family members maintain communication throughout the cancer process to best care for the patient. The extent to which cancer patients and their family members are able to communicate openly with each other is critical to cancer care (Northouse, Mood, Templin, Mellon, & George, 2000). The centrality of the family in supporting good health is well-recognized, as it has been documented that there are direct effects of family relationships on improved health status, as well as indirect effects on health through family communication regarding health and health risk behaviors (Galvin, Bylund, & Brommel, 2008; Segrin & Flora, 2005). In addition to family members communicating together about cancer, a critical component of medical examinations is the questioning of family cancer history.

**Family History of Cancer**

As illnesses such as cancer are often hereditary, the family medical history becomes a vital component of medical encounters. A family medical history is a compilation of relevant information about the medical conditions affecting a patient’s family members (Cleveland Clinic Genomic Medicine, 2010; Mayo Foundation for Medical Education and Research, 2010). As patients’ diagnosis and treatment options can be influenced if a relative has also been diagnosed with cancer, the family medical history is seen as a vital component of a patient’s medical history (Alspach, 2011). The medical history becomes an essential part of cancer conversations. A family health history allows physicians to identify the major health problems experienced by the patients or immediate family and the indications of the nature of these relationships among family members (U.S. Department of Health & Human Services, 2010). As history of cancer puts family members at risk, communication surrounding these concerns is often the focus of medical encounters. Family history is one of the most important risk factors in the development of health problems such as cancer (Alspach, 2011). An integral part of medical interviews is the physician and patient’s discussion of occurrence of family cancer or health issues. A family medical history is recorded to obtain a more inclusive description of who the patient is and what the health issues that are most likely to affect him or her due to genetic or familial influences (Alspach, 2011). Primary care physicians rely on the solicitation of adequate family history of cancer to make referrals for
treatment (Gramling, Nash, Siren, Eaton, & Culpepper, 2004; Pyeritz, 1997; Sifri, Gangadharappa, & Acheson, 2004; Summerton & Garrood, 1997). Because family history of cancer is of such great importance, it is essential that patients and physicians actively talk about these issues and all family occurrences of cancer are communicated efficiently. However, there is often a fear of family cancer history, impeding on the open communication among patients, family members and physicians.

**Fear Attributed to Family History of Cancer**

A family history of poor health such as serious illness or even care often evokes a sense of fear in most individuals. Past family history of cancer increases the fear that individuals feel towards their own health and their family members’ health. For instance, it is typical for women to fear breast cancer to a high degree due to family histories (Dolbeault, Szporn, & Holland, 1999) due to their increased risk (Karliner et al., 2007) and how susceptible family members can be to being diagnosed with the same cancer. Similarly, a family history of prostate cancer has also been found to be related to individual’s perceived risk of getting the cancer (Wolf, Philbrick, & Schorling, 1997). Researchers recognize the connection among family history, perceived risk about the disease at hand, and worry pertaining to the disease (DiLorenzo et al., 2006).

Technology and improvements in preventative cancer testing also contribute to the fear and uncertainty that patients may feel regarding family health. Genetic testing contributes a new aspect of anxiety for both the individual and their family when learning if something is a carrier of the cancer (Dolbeault et al., 1999). As family history recordings provide more definite answers about the patient and possible genetic health issues, these results can exhibit fear in both patients and their supporting family members. These concerns demonstrate the need to communicate health occurrences with family members and physicians.

**Communication of Family History**

Although cancer patients and their family members may be apprehensive to share family history, it is vital that accurate information be disseminated. Effective communication between families and health care providers collects insight into the medical history and preferences of patients, increasing family involvement and satisfaction as well as reducing
complaints (Majerovitz, Mollott, & Rudder, 2009). It is the responsibility of both physicians and patients to actively discuss family cancer history in order to best manage the illness at hand. Patients may feel hesitant or fearful of providing family cancer history information to their physicians as occurrence of cancer can harm their own health. This leads to patients having to deal with the fear of family history as they are unable to prevent genetic causes of cancer.

**Communication of Genetic Test Results**

During cancer journeys patients often undergo tests and processes to examine possible genetic factors that may contribute to their health. With this comes role of sharing negative health news and results with their family members and physicians. As mentioned earlier, genetic testing creates a new level of stress and anxiety in the lives of patients and their family members (Dolbeault et al., 1999). The patients who are receiving the tests are tasked with the responsibility to communicate the results to the individuals at-risk—their family members (DiLorenzo et al., 2006). Patients tend to feel the need to minimize fear in their family members, but also want to share results to provide risk information, encourage them to also get tested, and receive emotional support in return (Hughes et al., 2002; McGivern et al., 2004). Research has indicated difficulty in the communication of genetic tests results to family members leads to distress in patients (d’Agincourt-Canning, 2006; Kenen, Ardern-Jones, & Eeles, 2006). Patients even express the duty of sharing genetic test results to be a burden. This burden creates a dilemma between this responsibility to inform family members of potential health risk with their desire to protect these relatives from the distress and uncertainty that comes with this information (Foster, Eeles, Ardern-Jones, Moynihan, & Watson, 2004; Green, Richards, Murton, Statham, & Hallowell, 1997; Hallowell et al., 2005; McGivern et al., 2004). These feelings create a desire for support or additional resources that can help them determine which family members to tell and when they should tell them (Forrest et al., 2003; Liede et al., 2000; Segal et al., 2004). Patients realize that as the informer of genetic news to their relatives (Claes et al., 2003) as well as their own children (Forrest et al., 2003), they should be prepared to discuss the news in a way that facilitates the management of their cancer. Information that is discovered from genetic testing for hereditary cancers impacts the family members in addition to the patient.
undergoing testing (Mackenzie, Patrick-Miller, & Bradbury, 2009). While patients recognize the duty they are tasked with, little research has been conducted about the recipients’ perspectives and experiences of being told these health results (Croster & Dickerson, 2010). As the healthy individuals that are receiving news about genetic results, little is known about the reaction and impact of these individuals who are faced with the possibility of future cancer diagnosis (Croster & Dickerson, 2010).

The confidentiality and privacy regulations of medical and genetic information, health care professionals suggest patients receiving test results should be strongly encouraged to share this information with family members that are also put at risk (Mackenzie et al., 2009). Despite these recommendations, studies have illustrated that “60% of medical geneticists reported experiencing at least one patient refusal to notify an at-risk relative (Mackenzie et al, 2009, p. 27). The implications of genetic test results for family members and the ever-present conflicts in health care professionals’ dual responsibility to protect patient privacy and warn the individuals at-risk have resulted in the emergence of new models for communication to at-risk relatives (Mackenzie et al., 2009). While new approaches, strategies and justifications to disseminate cancer news are created, patients still have reasons for not wanting to share the truth about their cancer or test results with family members.

**Hesitancy to Tell the Truth to Family Members**

With such a life-altering disease as cancer, it seems that patients and physicians would want to speak honestly about their health and results about the illness. On the contrary, Baile, Lenzi, Parker, Buckman, and Cohen (2002) explain that despite the fact that truth-telling has become a worldwide trend, attitudes towards this issue are based on the related benefit or harm that the informed patient will face based on their social, geographical, and cultural issues. For instance, in cultures such as China, concealment of diagnosis or prognosis from cancer patients is common (Zhu, 2005). In other countries, patients may be informed about their diagnosis but are given ambiguous information without using the term ‘cancer’ (Tieying, Haishan, Meizhen, Yan, & Pengqian, 2011), resulting in hesitation to share news with others. This withholding of cancer information can be harmful for both patients and family members, and ultimately impact the care decided on or the support provided by family
members. With this issue comes the critical importance of better understanding the strategies of sharing bad news with family members.

**Sharing Bad News with Family Members**

Another duty that comes along with being diagnosed with cancer is sharing news with other family members. While news may be negative, unexpected, and life-altering, the dissemination of this information is often a difficult task to complete. Because cancer is often hereditary, family members have an amplified need to learn about health news. For instance, mothers, sisters, and daughters of women diagnosed with breast cancer have an increased need for factual information about the patient’s cancer (Tunin, Uziely, & Woloski-Wruble, 2010). The threat that family members of cancer face creates heightened awareness of the disease and their possibility of being at-risk as well (Tunin et al., 2010). The impact that these results have on family members demonstrates the importance of sharing news with relatives, regardless of how negative the update may be or be perceived to be.

Research on the delivery of bad news investigates patients’ reaction to information, as well as patients’ views of the physician and how the news was delivered (Friedrichsen, Strang & Carlsson, 2000a, 2000b, 2002; Mahon & Casperson, 1997). The manner in which bad news is broken is influenced by a patient’s ability to integrate bad news, the seriousness of symptoms, and the communication between physicians and patients (Friedrichsen et al., 2000a, 2000b, 2002). The delivery of this bad news typically is tailored to the way the patient and/or physician believe the recipient will respond to the news. Friedrichsen et al. (2000a) suggest that the ability to copy with bad news ranges from the individual’s sense of wellbeing, security and individual strength, when the patient’s health and ability to participate in decision making about treatment options was favorable. The difficulty lies in patients’ abilities to share news with their family members, knowing that this information will impact the way they interact and cope in their daily lives.

**Coping with Family Cancer in Every Day Life**

Whether it is the initial reaction to a diagnosis or while deciding on treatment options, family members also deal with the consequences of cancer. These changes affect the manner families function and the way in which communication occurs. Because the routine of daily
family life requires the mobility in and out of relationships and settings, attention should be paid to these encounters and their interdependence and communication significance should be determined (Beach, 2009). Family members facing a cancer diagnosis must continuously manage the ongoing interactional predicaments that result from this disease (Beach, 2009). When dealing with an illness, “cancer patients and family members are coping on a daily basis with cancer, and thus are typically not in a position to understand the communicative journey they are undertaking” (Beach, 2009, p. 315). As patients and their entire families undergo the challenges of cancer, it is common that they face fear and uncertainty of what the future holds. These feelings of fear and uncertainty are omnipresent due to the risk of cancer, yet are often paired with actions of hope to better manage their cancer.

**Fear, Hope, and Uncertainty in Family Cancer Communication**

With increasingly more families dealing with cancer each year, it is typical that family members experience a range of emotions from diagnosis through treatment of cancer. It is common for family members to initially feel fearful and uncertain about the risk of cancer, especially in the midst of such a stressful situation. However, moments of hope are present in the midst of these cancer fears. Patients, physicians and family members illustrate bids for hope as a way of countering these fears and uncertainty.

Patients offer clues to demonstrate their problems, concerns or fears about their condition such as having family members present during interaction (Beach, Easter, Good, & Pigeron, 2005). Family members’ presence within medical encounters reduces patient fear while facilitating communication with the physician(s). As family members typically serve as support systems for the cancer patient, they take on these emotions of the cancer. When faced with a diagnosis of cancer, family members typically experience a range of emotions including anger, frustration, anxiety, and anguish (Germino, Fife, & Funk, 1995; Kristjanson & Ashcroft, 1994; Persson, Rasmusson, & Hallberg, 1998). The emotional impact of cancer on the family can actually exceed that experienced by the patient (Burkhalter & Bromberg, 2003, p. 916). Typically, the range of emotion spans from uncertainty, to fear, to glimpses of hope. It is common that entire families feel uncertain when faced with cancer.
UNCERTAINTY OF CANCER DIAGNOSIS

There is evidence of the omnipresence of ‘uncertainty’ within patients—a matter of considerable theoretical concern regarding illness (Babrow, Hines, & Kasch, 2000; Babrow, Kasch, & Ford, 1998; Babrow & Kline, 2000). With the omnipresent unknown of cancer concerning cures, reoccurrence and symptoms, family members are in a constant state of uncertainty of what the future holds. Because family members display an essential lack of information and knowledge, this omnipresence of ‘uncertainty’ exists (Beach & Good, 2004). Within uncertain and typically troubling cancer journeys, a large amount of time and effort is spent by cancer patients, family members, and health professionals attempting to manage understandings, relationships and healing outcomes (Benjamin, 1987; Bloom, 1996; Dunkel-Schetter & Wortman, 1982; Hilton, 1994; Keller, Henrich, Sellschop, & Beutel, 1996; Kristjanson & Ashcroft, 1994; Northouse & Northouse, 1987; Zerwekh, 1984). Family members devote great effort and time into understanding the diagnosis at hand, treatment options, and survival rates to better cope with this intrusion.

Family members and cancer patients display behaviors to reduce the uncertainty that they may feel. “As lay persons, family members can exhibit a remarkable ability to learn technical/medical information” (Beach & Good, 2004, p. 17). Becoming educated with technical and medical information throughout a cancer process is a mechanism of reducing uncertainty. Obtaining these skills enables patients and their family members to be more equipped to communicate and manage the cancer. The management of this uncertainty is evident through repeated attempts to describe medication procedures “correctly” (Beach & Good, 2004, p. 24). Open and frequent communication between patients and their family members is necessary when working through the distress and uncertainty of cancer (Bloom, 1996; Hilton, 1994; Keller et al., 1996; Northouse & Northouse, 1987).

Analysis of a collection of family phone calls reveals how family members routinely address uncertain issues when attempting to understand cancer diagnosis, treatment, and prognosis (Beach & Good, 2004). Research focuses on the interactional achievement of social activities in family conversations such as uncertainty, lay understandings of medical issues, caregiving and receiving, humor and laughter (Beach & Good, 2004). Examinations of how family members communicate about health and illness, in both home and clinical environments, reveal an array of important questions such as how uncertainty becomes
interactionally constructed as family members work through the vast amount of problems associated with cancer (Beach & Good, 2004). Patients also display and even explicitly mention fear related to their cancer or their family member’s cancer.

**FEAR OF CANCER DIAGNOSIS**

Although cancer is progressively more treatable today and survival rates continue to increase, a pervasive fear of the diagnosis of cancer, fear of death, pain, suffering or loss associated with the illness is still widely evident (Dolbeault et al., 1999). Cancer continues to be the number one fear in the world, illustrating the seriousness of the disease. This fear transcends into family members’ lives as they take on the fear of the patient as well as the fear they have of losing a loved one. “The mere presence of a patient visiting a cancer center, even for preventive care, can be not only a fearful experience but shape the interactional organization of cancer care” (Beach et al., 2005, p. 905). Simply having to see a physician is a fearful experience, in which oncology appointments can be seen as even more of a threatening situation for patients and their family members. “Diminished quality of life is also no small matter, just as the risk of losing family and friends through death can be traumatic” (Beach et al., 2005, p. 905). These concerns become apparent through verbal and nonverbal communication of patients and family members within oncology settings. A central tenet of patient-centered care is to recognize that “patients provide cues to their feelings, fears and expectations, which, if responded to appropriately, will lead to their disclosure” (Ford, Hall, Ratcliffe, & Fallowfield, 2000, p. 554). These verbal and nonverbal behaviors allow physicians to respond in ways that can better facilitate the communication of cancer.

It is common for patients and their family members to enter oncology appointments with specific fears or issues of their own that they wish to discuss. “During medical encounters patients may directly verbalize that they have concerns, are experiencing problems, or even fearful about their condition” (Beach et al., 2005, p. 893). Patients may even explicitly state the fear that both they and their family members face. Medical encounters serve as opportunities to express fear on behalf of the entire family. However, communication problems exist in regards to mentioning family concerns. The fears and anxiety a cancer diagnosis elicits in both family members and medical staff also may contribute to intersystem communication problems (Gionta, Harlow, Loitman, & Leeman,
2005, p. 455). Lack of communication or honesty may result due to the fears family members endure. Family members may hesitate to ask members of the medical staff questions for fear of receiving bad news (Gionta et al., 2005, p. 455). Additionally, medical staff may even hesitate to share information with family members, the patient, or both, due to fear of the potential emotional physiological reaction that may occur in patients, families or even themselves (Gionta et al., 2005). Although fear and uncertainty are common emotions associated with cancer, it is typical for patients and their family members to display bids of hope or seek hopeful reassurance from physicians.

**HOPE IN THE MIDST OF CANCER DIAGNOSIS**

Although the diagnosis of cancer elicits both fearful and uncertain responses to patients and family members, the presence of hope is often still evident within oncology interviews. Family members and patients often choose to remain hopeful as a way of managing the challenges of cancer. A recurrent set of communication activities involves how family members construct hopeful and optimistic responses to potentially despairing cancer circumstances (Beach, 2002). Patients display bids of hope within conversations with family members as well as during medical appointments. “What is particular to hope work is that it is accomplished solely through conversation” (Perakyla, 1991, p. 430). When talking about cancer, patients and their family members express feelings of hope for the future, illustrating the power of overcoming fear and uncertainty. “Hope is a thing looked for...something not known, but you anticipate it. It is something good, and it keeps you going when things get really difficult, or sad, or bad, if you have hope, you keep on keeping on” (Gaskins, 1995, p. 22). Hope emerges in the midst of cancer fear and uncertainty, enabling entire families to manage this experience. Matters of hope are unique communicative expressions that embody and construct abstract, conceptual depictions (Beach, 2009) of acting hopeful and ordinary (Sacks, 1984).

Being hopeful is a decision that patients and family members make and can be verified within oncology settings. Hope has been seen to provide individuals with greater resources to manage inherently uncertain and fearful events that cannot be fully controlled (Beach, 2009). Hope helps diminish fear, just as increasing fear prevents us from overcoming significant obstacles (Groopman, 2004) experienced while undergoing cancer as well as
those providing cancer care (Beach, 2009). Most studies that focus on hope and hopefulness assume that hope is quantifiable and can be correlated with concepts such as family support, coping mechanisms, self-esteem, locus of control and humor (Beach, 2009). These studies illustrate the role that family members play in the development and sustainment of hope. Communication activities involve how family members construct hopeful and optimistic responses to cancer circumstances that can be potentially despairing (Beach, 2002). As cancer is a life-threatening illness, effective communication is crucial in solving the range of problems the patients and families face, sustaining hope, promoting adherence to treatment and achieving important health outcomes (Stewart, 1995).

As patients experience fear and uncertainty about their cancer or their family member’s cancer, it is essential that communication with health care professionals help to manage these emotions. As the emotions felt by the family members can surpass those of the cancer patient, the physician and family members also play an essential role in the patient’s life, both inside and outside of medical encounters. Without quality patient-physician communication, these concerns cannot be attended to, decreasing the possibility of successful family cancer communication. This conveys the implications of physician communication on family cancer care.

**The Importance of Patient-Physician Communication**

The last four decades have seen extensive research on the importance of patient-physician communication. Countless studies have acknowledged the impact that physicians’ communication skills can have on their patients’ view of their cancer as well as their actual physical health. A positive relationship exists between improved patient health outcomes, such as patient emotional status or physical health, and good patient-physician communication behaviors, such as physicians asking about patients’ emotions (Stewart, 1995). Recent findings have shown that effective patient-physician communication is related to an improved adherence to medical regimens set by physicians, better decision making, fewer claims of malpractice, and overall increased satisfaction with the patient-physician relationship (Makoul & Curry, 2007). For high-quality healthcare, patient-physician communication is essential factor that influences patients’ satisfaction with the health care being provided, understanding of medical information, adherence to treatment, coping with
the disease and overall quality of life (Ong, DaHaes, Hoos, & Lammes, 1995). As studies have acknowledged the positive impact communication can have on the quality of health care, it is important that family issues be discussed inside medical settings such as oncology interviews.

Research confirms the value of physician communication within health care. Doctor-patient communication is an essential role in health care has been recognized, and some researchers even consider it the most important tool a physician holds (Cassell, 1985; Cassell, 1991). This belief is consistent among many studies of patient-physician communication. Tasso and Behar-Horenstein (2008) suggest that the ability to communicate with patients and their family members can be seen as one of the most important aspects of patient-physician relationships. Furthermore, studies posit that physicians create relationships with patients primarily through communication (Gilligan & Raffin, 1997). A final component of patient-physician communication is the relationship between the two parties, which is crafted through these dialogues. Research has suggested that the quality of patient-provider relationships and communication are related to positive patient outcomes within the primary care setting (Ratanawongsa et al., 2008). As the importance of effective physician communication has been sought after by many scholars, it is critical that effective communication be explored to better understand what patients need when diagnosed with cancer. While this positive communication is ideal in facilitating cancer care, challenges are present which prevent patients and physicians from doing so.

Challenges to Patient-Physician Communication

Just as extensive research has presented the need for effective patient-physician communication, studies have shown that barriers do exist which restrict that communication. While it is common for each party to put the blame on the other, research has shown that both patients and physicians are responsible for these challenges. Communication problems may occur from either the patient or physician, or a combination of both individuals (Desharnais, Carter, Hennessy, Kurent, & Carter, 2007). The patient and the physician are both accountable in ensuring effective communication during medical appointments. As both patients and physicians experience difficulties communicating, having family members present or even simply mentioned can serve as a bridge to mend these challenges.
Many physicians take a more medical-oriented approach with their communication, which often leaves the patients unsatisfied. Communication problems can arise as the physician may focus on the scientific view of the illness, explaining its manifestation, progression and treatment, when the patient is more concerned about the impact of care on their lives, including pain and discomfort (Desharnais et al., 2007). This approach to patient-physician communication may leave patients confused and dissatisfied with the conversations they engage in with their doctors. The physician’s biomedical preference often holds priority over the patient or family member’s desire to express their feelings and concerns.

Studies have discovered that the education level of a patient may serve as a barrier to effective patient-physician communication. More educated patients who are more willing and able to understand the physician’s scientific approach experience less difficulty in communicating with their physicians about their health care in comparison to those with little education (Desharnais et al., 2007). The same is true for family members attempting to do so. While individuals might want to establish this effective communication, their educational abilities might prevent them from doing so. Effective communication might not be reached as patients may not be able to recall or fully understand the information they receive from their physicians (Fagerlind et al., 2008). When patients are presented with a surplus of medical information or new concepts that they do not understand, communication can be seen as ineffective on both ends. This often leads to increased fear and uncertainty, which often result in the decision to have family members present within medical encounters.

Physicians’ poor communication can also be attributed to their lack of skills or perceptions of these skills. Research has shown that communication problems between physicians and patients might be due to physicians’ self-perceived lack of competence to meet and cope with patients’ distress (Kristeller, Zumbrun, & Schilling, 1999; Lampic & Sjoden, 2000). This perception of inability influences the way in which physicians shape their communication with patients. Physicians are often inadequately trained in their communication skills, which can result in distancing and avoiding in communication emotionally difficult topics with cancer patients (Baile et al., 1997). It is common that health care providers are inexperienced or feel unprepared in managing the emotions of patients and their family members, as they may not be trained to do so. This poor communication training
can lead to avoidance of certain types of communication or create a lack of dedication to this communication, worsening the relationship between the two parties.

Research has also noted that physicians may feel burnt out, leading to a lessened focus on communication with their patients. Physician burnout, which can be explained as a “syndrome of depersonalization, emotional exhaustion, and reduced sense of accomplishment” (Ratanawongsa et al., 2008, p. 1581) can affect the quality of patient-provider communication. This burnout and poor communication can influence the way patients perceive their communication with their physicians. Patients’ dissatisfaction with physician communication can negatively affect how they understand content and are able to recall the information they receive (Fallowfield, 1992). Burnout is just one possibility of poor physician communication, of which all contribute to decreased understanding and lessened retained knowledge of information about the cancer.

Research recognizes that a standardized system, training, or program is not put into place in the health care field; facilitating the poor communication between physicians and patients. A possible reason for the ineffective communication present between physicians and patients is that programs do not currently exist that can be used as models to ensure that physicians are more proactive about providing patients with relevant information even before the patient asks for it (Diefenbach et al., 2009). Studies have recommended that training, clinics, and even programs be implemented into all medical environments to improve patient-physician communication. Literature explains that this communication standardization has not yet been implemented resulting in insufficient patient-physician communication and dissatisfied patients. This ineffective communication can be magnified when family members are present or family concerns are mentioned as physicians are unprepared to deal with the distress that may come with these interactions. Ultimately, these conversations impact the way that patients feel about their care and how they decide to share news with their family members.

**Physician Communication and Patient Satisfaction**

Physician-patient communication may influence patients’ perceptions of their relationship with their physician as well as their overall cancer care. Communication is widely acknowledged as an essential component of patient satisfaction (Brown, Boles,
Mullooly, & Levinson, 1999; Homer et al., 1999; Roter et al., 1997). The communicative strategies physicians take often influence the way their patients feel about their visits and relationship with their physician. Research shows that physicians’ communication behaviors are significant contributors to patient satisfaction within an outpatient setting (Stewart, 1995; Williams, Weinman & Dale, 1998). While the behaviors of communication influence patients’ satisfaction, the actual news shared can also impact the way they feel. Patients who have heard good news or had a good health outcome may report high satisfaction with their physician’s communication, unrelated to any effects of communication or communication satisfaction (Clever, Jin, Levinson, & Meltzer, 2008). At the same time, research proves that while physicians’ communication leaves patients unsatisfied, it can actually be accredited to the actual content delivered rather than the delivery itself. This ultimately impacts the manner in which information is disseminated to family members. Physicians experience daunting challenges of communication when providing care for patients with serious illnesses (Casarett et al., 2010). As a physician dealing with cancer patients, a large challenge is sharing bad news about cancer with the patients and finding the appropriate methods to do so.

**Physician Communication of Bad News about Cancer**

A common task of a physician’s occupation description entails delivering bad news to patients about their cancer prognosis, diagnosis, and treatment. Bad news can be considered as any news that the recipient views as negative (Orgel, McCarter, & Jacobs, 2010). Research asserts that “physicians often need to deliver painful news about a new diagnosis, relapse, or worsening prognosis” (Casarett et al., 2010, p. 255). Patients may perceive their physician’s communication skills based on the type of news they receive. While physicians often do not have control over the type of news, they are able to adjust the way in which they communicate that news. Previous studies have shown that the manner in which bad news is communicated to the patient has great importance (Orgel et al., 2010). Patients’ outlook, satisfaction, and perception of their cancer can be influenced by the way their physician communicates to them. A physician’s communication style when disclosing bad news can reportedly affect the degree of anxiety a patient feels when hearing the news (Takayama, Yamazaki, & Katsumata, 2001). While bad news is inevitable when dealing with cancer
patients, communication scholars have stated that this communication can be directed in ways that improve patient-physician communication.

Studies have offered some guidelines and recommendations for disclosing bad news in the oncology setting which include giving the patient the diagnosis only after it has been confirmed, disclosing bad news honestly but not bluntly, and using simple language that does not include euphemisms (Fallowfield, 1992; Girgis & Sanson-Fisher, 1995; Okamura, Uchitomi, Sasako, Eguchi, & Kakizoe, 1998; Ptacek & Eberhardt, 1996). In line with these recommendations for improving communication, physicians can also focus more on the way they present care news, as this news is then shared with family members. Whether this news is good or bad, health care professionals play an essential role by delivering news about patients, especially when discussing critical information regarding that individual’s health.

**Physician Communication of Critical Information**

Physicians’ communication has gained more importance as patients have become more active in their health care. Within the last few decades, patients have become more increasingly involved in directing their own medical care and being involved in the decision making process (Diefenbach et al., 2009). This increased involvement symbolizes the need for effective communication throughout each stage of cancer. Studies on physician communication has validated that often patients are not satisfied with the amount or type of communication received from their physicians. Consistent research explains that when it comes to treatment options, patients and families may feel that they do not receive enough information about the patients’ illness and the possible life-sustaining treatment possibilities (Baker et al., 2000; Lynn et al., 1997; Teno et al., 2004). It becomes the physician’s responsibility to decide what information to share with patients as well as what should be withheld. Tasso and Behar-Horenstein (2008) explain that “what physicians communicate to patients often determines patient satisfaction” (p. 22). This is evident as “physicians have the tasks of concerning what information to impart to patients, the extent to which they will involve patients in treatment decision making, and the degree to which they will communicate with patients about their emotional status and other non-medical aspects of life” (Hack, Degner, & Parker, 2005, p. 842). While most physicians do not intentionally want to withhold the truth from their patients, often they are strategic with what news they
share and when they share that news. When patients are diagnosed with cancer, they not only have to cope with the attached emotional trauma, but they are also expected to process complicated and sometimes threatening information about the treatment procedures they will endure (Diefenbach et al., 2009). In order to conserve the amount of anxiety or emotional discomfort patients will experience, physicians may alter their communication for the patient’s sake. This ultimately impacts the manner in which cancer is communicated to family members as well as the amount of information provided to family members outside of oncology appointments.

The way physicians communicate also influences the patient’s satisfaction throughout their cancer process. Research suggests that during conversations with patients, physicians should provide information both empathetically and openly while supporting the patient’s and family’s choices under what can be difficult or emotionally trying circumstances (Polla et al., 2007; Quill, 2000). Physicians are able to influence this patient-physician relationship through the way they communicate difficult news. Furthermore, many studies have shown that cancer patients are more likely to be satisfied with their physician-patient interaction when physicians provide clear information, remain sensitive to their needs, answer questions that patients ask, and do not dominate the conversation (Bertakis, Roter, & Putnam, 1991; Smith, Polis, & Hadac, 1981; Stiles, Putnam, Wolf, & Sherman, 1979). For each patient, these desires are different and can range from emotional support, information retrieval, treatment reassurance, to overall guidance within their cancer journey. These conversations can impact how patients feel about their physician and treatment as well as their cancer, illustrating the importance of effective physician communication skills. The interactions between patient and physician influence the way in which information is disseminated to family members. In turn, this impacts family and patient communication of cancer.

**Family Members’ Role in Patient Communication**

Much research has discussed the significant function that families can play in cancer patients’ lives. Family members often play a very central role in patients’ cancer treatment and choices. As patients decide to explain their cancer, progress, or treatment options with their family, it becomes essential to foster effective communication with their physicians. The way that physicians communicate cancer news to a patient has the power to shape the
conversations that patient engages in with family members. This communication can impact how the patient and family members cope with the disease, which may last for years afterward the cancer (Contro, Larson, Scofield, & Cohen, 2002; Contro, Larson, Scofield, Sourkes, & Cohen, 2004; Hilden et al., 2001; Krahn, Hallum, & Kime, 1993; Ptacek & Ptacek, 2001; Strauss, Sharp, Lorch, & Kachalia, 1995). As patients often want to rely on their family for support or keep them involved in their cancer treatment, the communication about their cancer from a physician becomes even more important.

Research has recognized the significance a family has throughout the entire cancer process. Studies have shown that patient happiness and satisfaction scores are more related to good communication and family involvement than to the actual medical result (Hsiao, Evan, & Zeltzer, 2007; Mack et al., 2005). This desire to keep family members involved within their cancer care often results in more active health citizens. Cancer patients and their family members invest a great deal of time and effort speaking with medical professionals to discuss both treatment and care options (Beach, 2001). As family becomes involved in the patient’s cancer, communication can serve as a mechanism to deal with this news and treatment. Studies have illustrated that communication is an important factor in the levels of coping and distress within both patients and caregivers (Kissane, 2004; Speice et al., 2000). This communication enables both patients and their family members to cope with the cancer together, encouraging physicians to focus on their communicative skills. Just as important is the communication that physicians engage in with family members of cancer patients.

**Physician-Family Caregiver Communication**

Although family plays an essential role in decisions made on behalf of patients at the end of their lives, very few studies have examined physician-family caregiver communication (Cherlin et al., 2005). Participating in communication about treatment and progress of the cancer with a physician might actually influence the communication the patient participates in with family members. Studies have constantly shown that patients who communicate their preferences for end-of-life care with their physicians and family members experience less anxiety, feel more involved in their decision-making process and perceive their physicians to have a better understanding of their needs (Ditto et al., 2001; Kass-Bartelmes & Hughes, 2004; Smucker et al., 1993) Being engaged in communication with a
physician about cancer plays an integral role in the conversations with family members. To fully comprehend patient-physician communication at the end of life, it is important to understand how the patients and physicians interact when making these critical health care decisions (Desharnais et al., 2007). These conversations can influence the decisions made on behalf of the patient as well as what the patient expresses to his or her family.

While this is such a critical aspect of cancer communication, physicians still seem to lack the ability or desire to do so. As physicians and patients have dealt with cancer for hundreds of years, it seems reasonable to expect oncologists to be well trained, experienced and confident in their end of life conversations and treatment of patients (Trice & Prigerson, 2009). Even though research has abundantly expressed the importance of effective physician-patient communication, studies consistently suggest that physicians’ communication about end of life cancer is lacking (Thorne et al., 2005). As cancer often expands to the end of patients’ lives, studies have noted the critical need of quality physician communication. From the onset of cancer to the end of their lives, physicians influence the way in which patients perceive their cancer and even communicate this cancer to their family members.

**Communicating Cancer to Family Members**

As cancer patients often turn to their family for support and guidance, communication with a physician becomes even more impactful. Patients speak to their family members about their cancer updating them on the progress, explaining their diagnosis, and discussing treatment options. For most cancer patients, the majority of their conversations about their cancer do not exist within the clinical settings, but rather outside in their home environments that occur before and after appointments, physical exams and therapy sessions (Beach, 2001). Research has shown that cancer patients spend countless numbers outside of their physicians’ offices discussing their cancer. These are vital periods of time in which family members, friends, other patients and even acquaintances are updated on the patient’s illness (Beach, 2001). This communication between a physician and the patient often becomes apparent in conversations with family members.

Intimate relationships with the diagnosed individual are increased by communication such as informing or being informed about a loved one’s cancer and are recognized through frequent and careful monitoring of both the medical and family situation (Beach, 2001). The
amount of information as well as the way in which information about cancer is communicated to family members impacts the relationship between those individuals. The physician therefore can indirectly influence the communication of cancer patients to family members of the cancer patient. This informing of news can be communicated by telling others about changes in the diagnosis, treatment updates, and ways to cope with the good or bad news (Beach, 2001). Patients take the information provided from their physician and update family members on their cancer in terms or ways that are best suited for their needs of family support and understanding.

The way in which physicians communicate news may influence the way patients decide to communicate news to their own family members, particularly spouses and children. Research has shown that cancer patients communicate in ways that reflect the type of relationship that the two individuals have. The way in which a spouse reacts to negative disclosures impacts future disclosures from that partner (Lepore, 2001). If a spouse responds negatively to bad news about the cancer, discussions about the cancer in the future are likely to reflect this and patients may share less news or frame communication differently. Just as spouses must talk through cancer, parents face the responsibility of communicating with their children about their illness.

**Parent-Child Cancer Communication**

Much research focus has also been spent on the way in which parents communicate their cancer news to their children. The manner that a child communicates with a parent about his or her cancer diagnosis is a key topic to examine to better understand how families cope with cancer (Harzold & Sparks, 2006). Addressing the needs of children is a critical component of the care of ill parents (Forrest, Plumb, Ziebland, & Stein, 2006). Parents often engage in communication that facilitates their children’s understanding and dealing with their cancer. A study on this relationship found that the extent to which patients and their family members were able to communicate openly with each other about their cancer was critical to the process (Northhouse et al., 2000). Both parents and children employ communication methods that reflect the type of relationship they want to have regarding the cancer. The communication strategies patients and their family members use characterize interactions among family members (Harzold & Sparks, 2006). Research on parent-child communication
about cancer verified the importance of how and what types of information is communicated among family members. Research has illustrated that children struggle from fear, sorrow, anxiety, anger and withdrawal when a parent is diagnosed with cancer (Bugge, Helseth, & Darbyshire, 2008). It is considerably difficult for children to deal with a parent’s cancer diagnosis if it is unstable and incurable (Helseth & Ulfsaet, 2005). Parents typically underestimate their children’s need for information as well as the way they will react to the cancer situation (Kroll, Barnes, Jones, & Stein, 1998).

Parents who are able to competently communicate their cancer diagnosis and treatment procedures can provide their children with a better understanding of the disease (Harzold & Sparks, 2006). The quality of communication can impact children’s view of their parent’s cancer and therefore influence interactions within the family. Parents typically explain cancer to be an intrusion that interrupts the care that they could be giving to their children (Bugge et al., 2008). While this is the case, patients must invoke strategies to discuss the cancer with their parents, children and relatives.

Strategies used to communicate cancer to family members. As parents must decide how to communicate their cancer to their children, a well-researched strategy utilized is humor. Parents may take a humorous approach in breaking the news to their children about any aspect of their cancer. Cancer patients may decide to use humor as a tactic for informing their family of bad news as humor can be seen as a comfortable way to share personal and sensitive information (Sparks-Bethea, Travis, & Pecchioni, 2000). This humor serves as an outlet for parents to share upsetting news about the cancer while attempting to manage the effect on their children. Humor can play a significant role for coping with cancer diagnosis by serving as a positive aspect of the conversation between a parent and a child (Harzold & Sparks, 2006). Depicting cancer through a humorous lens allows both children and parents to deal with the life-threatening disease. Using humor reduces individuals’ stress by allowing them to view an event in a different context (Davidhizar & Shearer, 1996). Many scholars have recognized humor as a way to calm cancer patients and family members down by making light of such a serious situation. This humor can provide a different outlook than the traditional perspective on the cancer. A patient’s sense of humor can affect the entire family’s outlook of the illness (Harzold & Sparks, 2006). While research has focused on the benefits of utilizing humor to communicate cancer, discussions have also shared that it is not
right for all families. Although humor is not seen as universally appropriate for use in the cancer conversation between adult children and a parent diagnosed with cancer, it can still serve as a vital coping role for family members (Harzold & Sparks, 2006). Parents often use humor as a shield for the bad news they share about their cancer to make their children better equipped to manage the news.

Parents also can utilize humor as a method to cope with their own embarrassment or acceptance of the cancer. As cancer treatment often involve situations in which face is threatened, some patients rely on their children to assist them in everyday aspects of life, allowing humor to diffuse this attention and help patients preserve face when discussing the cancer with their children (Harzold & Sparks, 2006). In order to save face, parents may decide to use humor tactics when communicating their cancer to family members. While humor is just one way of discussing cancer, the use of narratives is another strategy for sharing information about this disease with both physicians and family members.

**Narratives and Cancer**

As humans are innate story-telling creatures, much research has focused on the benefit of using narratives within the health care field. Studies have confirmed the use of these narratives as they tend to be lived experiences of others, making it more difficult to discount them (Nisbett & Ross, 1980; Slater, 2002). As individuals share their personal, real life accounts of the subject matter being studied, these stories contribute great variety to the health discipline. Health communication serves as a way for patients to share their stories with others all the while allowing their narratives to help others understand their cancer journey. Narrative forms of cancer that focus on topics ranging from education to storytelling are emerging as critical tools for cancer prevention and control (Kreuter et al., 2007). Both physicians and patients construct narratives to better explain the cancer or understand the diagnosis and treatment, respectively.

Narratives can also assist patients’ work through their family members’ fear and anxiety of cancer. Stories may be fit to convey cancer-related information as they can help individuals overcome barriers to treatment seeking, improve the mental state of the unknown about procedures, provide role models for personal behavior change and create attitudes about cancer care based on the emotion invoked through the story (Green, 2006). Utilizing
stories of cancer patients enables others to react to the emotion felt and see cancer in a way that reflects these feelings. While research has confirmed the benefit of utilizing narratives, the intimidating nature of cancer and medical appointments often stray away from patients sharing their personal stories. Frank (1995) suggests that too often individuals seeking medical care participate in narrative surrender by articulating their story using the vernacular of the medical field. Giving patients an outlet to tell their story about cancer and communicate in ways that will benefit them, their physician, and family members is both a unique and worthwhile effort. Examining the different approaches to talk through cancer can be done through conversation analysis as cancer is something that is talked about in everyday life, both inside and outside of medical settings.

CONVERSATION ANALYSIS AS A METHOD TO EXAMINE FAMILY CANCER COMMUNICATION

Conversation analysis is an effective approach to study how stories are naturally integrated into conversations of cancer. This method is anchored in repeated listenings of recordings with detailed examination of word for word transcriptions of actual interactions (Beach & Good, 2004). Conversation analysis (CA) is used to document observations of the organization of practices by speakers who exhibit specific ways of monitoring and responding to the prior speaker (Beach & Good, 2004). Individuals spend most of their time outside of medical contexts and professional-lay relationships, yet research has limited knowledge on how family members rely on informal and routine interaction to make sense of illness (Beach & Andersen, 2004). Conversation analysis has been described as “a methodological alternative for closely examining the detailed and patterned organization of interactions in natural settings, including oncological involvements in both clinical and home environments” (Beach & Anderson, 2004, p. 2). Conversational analytic methods help decipher the interactional details of the materials being examined (Atkinson & Heritage, 1984; Drew & Heritage, 1992; Sacks, 1992). The main goal of conversation analytic research is to describe and explicate the competencies that ordinary speakers use and rely on when participating in socially organized interaction (Atkinson & Heritage, 1984). Conversation Analysis (CA) is a primary method to
understand how people talk in everyday encounters as well as in more specialized institutional settings such as medical, legal, or educational environments (Beach, 2009).

Conversation analysis helps researchers understand how patients initiate their concerns and how interviewers respond through the identification of specific practices that shape interactional involvement (Beach & LeBaron, 2002). Transcribed excerpts focusing on how family members talk through cancer on the telephone demonstrate how news delivery sequences and managing feelings of optimism are essential components for understanding and dealing with cancer journeys (Beach & Anderson, 2004). Beach (2009) asserts that investigating how family members talk at home and how their lifeworld experiences are anchored in family life can be used to understand how their lay diagnoses of biomedical aspects of cancer can affect how physicians respond to different family members’ concerns.

During communication, participants continually reveal their orientations to and understandings of moment-by-moment interactional involvements. In the precise ways speakers construct and respond to turns-at-talk and related embodied actions (e.g., gaze, gesture, touch, and the use of objects), they demonstrate first for one another (and subsequently for analysts’ inspections) their real-time and practical understandings of evolving conduct-in-interaction. The specific ways that speakers organize and respond to turns-at-talk demonstrate their real-time and practical understandings that are conducted during interaction (Beach & Anderson, 2004). What is achieved in communication can be seen as a result of how the speakers construct and offer their understandings of the environment they are a part of (Beach 1990a, 1990b, 1991, 1995; Jefferson, 1981; Sigman, 1995; Wootton, 1988). Conversations consist of individuals taking turns and sequentially working together to create meaning of messages. A speaker’s current talk projects the relevance of another individual’s next turn projecting related action (Schegloff, 1991; see Appendix).

These transcribed conversations were analyzed for references to family members, family history and family cancer as well as for instances in which family members were present and participated in oncology appointments. The justification to study references in which patients and physicians mention family members as well as instances in which family members contribute to oncology interviews is based on the prevalence of instances found within the sampled data. Overwhelmingly, the data provided reasoning as to why family
members should be incorporated into conversations or in actual oncology encounters. However, a case can also be made as to why patients and physicians would not want family members present or initiated into these oncology interviews. A number of reasons can be provided to support that argument, despite it not being the focus of this research. While patients and physicians hold reasoning for not wanting family to be incorporated into oncology interviews, the data collected and analyzed for this research focused on instances in which patients and physicians made references to family that ultimately impacted the course of the encounter and overall cancer care.

Data Collection

The video recorded interviews used for this study were initially gathered as part of larger research through the University of California at San Diego Moore Cancer Center and the National Cancer Institute. These interview recordings were obtained from 2007 to 2009 transcribed, and were later re-examined to depict family cancer communication within oncology settings for this project. As this research focuses on both references to family members as well as active participation of family within cancer settings, these transcriptions were examined for all instances of family. Twenty-seven excerpts include the manner in which family members are mentioned in medical encounters and seventeen excerpts demonstrate the role that present family members play in medical settings. After analyzing a larger sample of data, these instances depicted both representative and a variety of actions that patients and physicians engage in when discussing family during oncology interviews. Each instance portrays typical efforts of patients and their family members when discussing cancer with physicians. These instances were segmented to illustrate the themes that developed when analyzing multiple patients’ oncology interviews.

Research Questions

The following questions guide this research:

1. How do cancer patients and physicians reference family members during oncology interviews?
2. What primary social actions are involved as both patients and physicians reference family members (e.g. history of cancer, related illnesses, impacts of cancer on family life).
3. When family members are co-present, how do they contribute to the organization of interviews?

4. What primary social actions are displayed by family members when initiating contributions (e.g. asking questions, seeking clarification about treatment, speaking on behalf of the patient)?

5. What implications do these findings have for understanding and improving cancer care?
CHAPTER 2

REFERENCES TO FAMILY MEMBERS IN ONCOLOGY INTERVIEWS

This chapter examines a variety of ways both patients and physicians make references to absent family members during oncology interviews. These references accomplish important social actions (e.g. concerns about others’ health or clarification about care). The chapter begins with three case studies of unique moments referencing family members. The first two instances represent a mother speaking about her family and a third illustrates a patient who invokes her healthy family history. Following these individual case studies are two small collections of how patients (a) initiate lifeworld experiences being used to discuss family, and (b) share family health issues to compare with their own health. Secondly, moments in which physicians mention family members in medical encounters are provided. These moments make up collections of patients referencing that cancer runs in families, responding to family inquiries to express impact of cancer, and routinely answering patients to confirm family cancer history. Finally, a small collection of how both patients and physicians mention the presence of family members foreshadows the next data chapter.

This initial case study reflects a situation in which a mother reports her daughter to show her concern that she may also get diagnosed with cancer:

THREE CASE STUDIES

1) D1 P1: 12-13

1 Patient: You guys find a cure for this. [This is my ]
2 Doctor: [ We are ] working on it.
3 Patient: Oh, they’ve been saying that for thirteen years. I told my daughter
4 if she could live ten years they’d certainly have a cure for it. And they didn’t
5 Doctor: (inaudible)
6 Patient: I don’t believe it. I don’t believe it.
7 Doctor: Yeah.
8 Patient: They haven’t heard anything new, have you. ((continues))

This instance depicts a patient displaying frustration about doctors not finding a cure for her cancer. She reports that she told her daughter that a cure may emerge in ten years, a
mechanism to remove fear of the future. As a mom and a patient, her concern for her daughter’s well-being underlies this report. Her concern seems to be not just that she will suffer from this cancer, but also (although unstated) that her daughter could be diagnosed because of her genetics. The patient initially asks if “you guys”, referring to health care professionals, have found a cure for cancer, highlighting the frustration she feels with having to wait. She then responds that “they’ve been saying that for thirteen years” referring to the promise of finding a cure. Family members frequently refer to medical experts as “they/they’re/they’ve” to illustrate that they remain anonymous yet are known for playing important roles in the care process (Beach, 2009). As cancer is often viewed as an intruder for families (Farrow et al., 1990), the mother’s frustration about cancer reiterates her concern for her daughter’s future health.

Similar to mentioning concerns for children, cancer patients may invoke their role within their family as a way to explain their cancer symptoms. The following excerpt demonstrates a mother attributing effects of cancer to her role as a mother:

2) **OC 1 PAGE 6**

1 DOC: .hhh How have you been feeling (.) lately. Have- have you had any fevers (.) or chills or night sweats, loss of appetite, anything like- any constitutional symptoms.

2 PAT: No. (.) I’m tired but I’m the **mother** of three **kids**.

3 DOC: Okay. [I understand.]

4 PAT: [ $Hhhhh. $ ] $Pretty normal$. Yeah.=

5 DOC: =Mm hm.=

6 PAT: =Just normal (.) stu:ff. I mean I- my weight has always been this- [ya know ]

7 DOC: [Mm hm. ]

In this case, a patient responds to a physician’s question about her health by invoking her status as a mother. When her doctor asks her how she is feeling her immediate response is to state that she is tired, but that is because she is the mother of three kids. The patient illustrates that being tired comes with motherhood, rather than from her cancer, expressing that she would feel the same way if she had cancer or not. This is one practice for a patient to “minimize” her likelihood of being diagnosed with cancer (Beach, 2010). After providing her health update and explaining how being a mother contributes to how she feels, she mentions that this is “pretty normal” (Gutzmer, 2011). The patient normalizes her symptoms by attributing them to motherhood, rather than her cancer. This statement of “normal” is marked with laughter, which is often utilized as a valuable resource for patients to manage delicate
news (Haakana, 2001). As stated, it is common for cancer patients to minimize their symptoms, and to be seen as someone that is well and healthy. In this instance, the patient does just that by using being “a mother of three kids” to attribute to her symptoms.

Just as patients mention their family members to describe their symptoms, it is common to reference their healthy family history to justify their own health:

3) OC2 P9: 1
1 DOC: How about other medical ( ). Heart troubles, lung troubles? =
2 PAT: =Mm hm.=
3 DOC: =kidneys, diabetes? 
4 PAT: No. [ No. ]
5 DOC: [Blood pressure.]
6→ PAT: I come from a very healthy family. 
7 DOC: ↑Good. And those you’re taking are (Temoxfen) and uh and the other ( ).
8 PAT: Mm ↑hm.

In this interview, the physician asks the patient about family history of diabetes or similar symptoms, and the patient responds that he comes from a healthy family. This response is typical during medical encounters. Patients often mention positive family health as a way to make a case for their own wellness (Beach, 2010). This healthy family reference seems to be used as evidence to minimize possible threat to his health. This patient makes a case of his healthy family history to downplay his own health risk. This “very healthy family” comment seems to be a way to associate himself with his own health.

In each of these case studies patients mentioned family members to discuss a variety of social actions such as expressing concern for others in their lives, utilizing healthy family history to build a case for their own health and minimizing cancer symptoms to their role in a family. As noted earlier, specific collections of patients making reference to family members are provided, beginning with a set of instances in which patients utilize their lifeworld experiences to discuss family.

**INITIATING LIFEWORLD EXPERIENCES TO DISCUSS CANCER**

Cancer patients bring their personal lives, stories and concerns with them to medical interviews. With this comes the incorporation of lifeworld experiences into cancer conversations. For example, patients routinely talk about not only family members, but also topics relevant to their daily actions such as work, friends, events, problems, experiences,
hopes, dreams and desires. While most health care professionals focus on asking medical questions relevant to the patient’s cancer and symptoms, it is common for patients to elaborate on answers in ways that represent the experiences that make up their everyday lives. These detailed explanations provide patients with an opportunity to articulate their cancer in the midst of their daily routines. This first instance presents a patient explaining the impact of losing her husband while she was also suffering from health issues of her own:

**4) OC 2 PAGE 7 and 8**

1→ PAT: “Okay.” It was a bad accident. It was two weeks after my **husband** died
2 [ so ]
3 DOC [M:mmh.]
4 PAT: it was a bad combination.
5 DOC: Okay.
6 PAT: But I’m fine now.
7 DOC: How about other medical ( ). Heart troubles, lung troubles?

This excerpt provides an example in which a patient mentions a psychosocial condition to downplay the status of her health. She expresses that the combination of her accident and husband dying makes for a tough situation in her life. This correlation appears to be an attempt to explain how dealing with her husband while going through her own health problems make things even more challenging. The presence of additional stressors at the time of illness is recognized as an essential factor in how individuals cope with illness (Dolbeault, et al. 1999). After explaining this bad combination of her husband dying and her symptoms, the patient minimizes her sickness by stating that she is “fine now.” This psychosocial condition is used to downplay the effects of cancer and make the case that she is not as vulnerable. The physician does not even acknowledge the patient’s bid for minimization and simply moves onto his medical agenda by asking about additional symptoms. This is a classic example of a patient using an extended narrative to show how lifeworld events such as her husband dying make it even more difficult to overcome her own health issues.

Just as this patient explained her husband’s death contributing to the impact of her accident, this patient elaborates on the challenge of visiting a cancer center all while his wife was sick:

**5) UCSD4:2**

1→ Patient: A::nd↑ I happen to have a good **friend** up at- (.) at SC (Norris) Hospital.=
2 Doctor: =Mm hm.=
3 Patient: =[ Whose an ] oncolo[gist a::n]d (.)
This interview depicts an instance where a patient reports his friend’s recommendation about his health to his physician and asks for guidance on how to act. He continues to clarify this by mentioning that while he was dealing with this cancer, his wife got ill and they lost their home due to a fire. The patient bringing up his family issues immediately after his health predicament symbolizes the impact of dealing with these issues simultaneously. The doctor does not do much with the story but he does provide him with a moderate acknowledgement of his concerns. This patient not only brings in his lifeworld experiences, but he also reports advice of a friend and struggles with his personal life to support his feelings. Oncology encounters are filled with concerns, nervousness, unease, worry, anxiety and fear, which are all anchored in patients’ life world experiences (Barbour, 1995; Engel, 1977; Mishler, 1984). Stating that he was unsure of what to do based on his friend’s suggestion and then elaborating that it was at the time he lost his house and his wife was sick appears to be a request for directions of how to act. The doctor never asks about his wife or how this affected the family, but the patient expresses that the timing of all of these events also made for a “bad combination” just as the patient in the previous instance excerpt.
The statement of these lifeworld experiences seem to be a way for justifying his uncertainty on what to do as well as removing some of the responsibility for not seeing the doctor sooner. The physician minimally attends the patient’s concern by stating that he was “sorry to hear that.” This missed opportunity is then followed up by the patient transitioning from talking about his wife to the pain he feels to get back to the doctor’s medical agenda. This dismissal of talking about personal issues is common in medical encounters and may discourage patients from mentioning family or their role throughout the cancer process.

Just as this patient in the previous situation approaches the interview with uncertainty about how to proceed with his cancer care due to family impact, in the same conversation he again brings up his wife’s illness to explain why he has not had his operation:

6) **UCSD4:2**

1 Doctor = ↑So it LOOKS like and maybe you could fill in the blanks for me=that
2 about a yea::r ago: hhh You: >came into the hospital< (. ) With the ↑plan to
3 have an operation? ["Do you wanna?= ↑Okay ]
4 Patient: [ No: no no:: I came ] over here:: .hh
5 I’m tryin’ to remember what came first=the chicken or the egg here? In my
6 case.=
7 Doctor: =Okay::.
8 Patient: I’ve had so many things: Doctor=happen in my life □this last year.
9 Doctor: Okay.
10 Patient: .hh u::h uh: (it’s ) [ my wife- my wife ] My wife has =
11 Doctor: [So it’s been (. ) pretty rough. ]
12 Patient: =been ill most °of° the time=[ we lost ] our home in Julian (. ) In=
13 Doctor: [Mm hm.]
14 Patient: =a [ fire. Hh A::n: ] hh >besides he:: sickness< =
15 Doctor: [pt O::h:: ↑Okay:y°. ]
16 Patient: =↑I’VE done:- ya kno:w=.
17 Doctor: =Mm:::=
18 Patient: =Goin’ through .hhh ↑A::n:nd >so forth and so on<. NOW=as far as my health
19 goes: hh

The patient again uses his wife’s illness to raise his life troubles to his physician. Talking about how hard it was on his wife and him when they lost their house appears to be a segway to talk about challenges he faces. Here the patient discusses how his wife has been ill as a way of explaining the delay in focusing on his health. In this case the doctor asks about the patient’s operation and it seems that the patient brings up a family member’s health to make justifications for his own behavior. This reference to his wife and her illness allows the patient to provide information about a lifeworld experience while simultaneously alluding to
the reason why he has not been able to worry about his own health. Additionally, this patient repeats the issue of his wife being sick during his health process twice during this same medical interview. Beach (2009) suggests the value of examining how family members’ lifeworld experiences are anchored in family life. The repetition of family issues illustrates a desire to place focus on his lifeworld experience as a method to downplay the risk of his own health and his behavior contributing to his health. Making references to family members through lifeworld experiences such as this allows physicians to see the bigger picture of patient concerns and better understand the patient’s side of cancer.

Within these interactions, a common theme of deflecting the attention away from the patient and onto his or her family member is evident. Patients seem to talk about their family as a way to not only express concern for their impact, but also as a way to deflect the focus off themselves. This activity may be a mechanism to minimize the threat that patients feel about their own health.

In addition to explaining family members’ impact on their behavior, patients may initiate absent family members into conversation when speaking about recommendations or support for their care:

7) OC6:2
1 PAT: Ca- can I tell you what brought me here or is that premature.
2 DOC: No that’s fi:ne. Actually I was talking to Jan about that, I understa:nd .hh
3 some of the things that she was [ relating to me. ]
4 PAT: [ pt Do you know ] what Doctor Joe
5 [Lea:se [up(.)in Oregon. ]
6 DOC: [ Yes. Yes I do. ]
7→ PAT: ↓He treated my brother.
8 DOC: He was down here visiting la:st month ((Daughter coughs, covering
9 conversation)) as it we:re a:nd (. ) we’re trying to develop a: new clinical
10 protocol and actually he’s very interested in taking part.
11→ PAT: Well I sent my brother all my records. He treated my brother, gave him a
12→ bone marrow transplant from my sister, (. ) .hh at age fifty-five, which is what
13 I am, and (0.3) ah when I- (. ) because I wasn’t comfortable with the
14 information I was getting down in Apple Valley. (. ) a:h I was just told
15 tuh (. ) wait wait wait, and a:h (. ) pt maybe that’s the best advice but
16→ .hhh I’m new at this so I needed hh. my brother’s opinion, who had
17 been through it,=
18 DOC: Mm [hm.]
19 PAT: =pt [and] he gave my records to Doctor Joe up there and (. ) Doctor Joe says
20 tell your brother to go see Doctor ↑Kips (0.6) .hh a:h down in San Diego,
21 (0.3) because he (0.6) does research and he’s- (0.2) research leads to new
things all the time and (0.2) pt .hh (in his) opinion. So I did bring down all my records and I don’t know what you have in there [or not-] [I have ] some of these records ↑here.

This instance demonstrates patients’ sighting previous health experiences of family members to guide their own health appointments and decisions. During this medical encounter, the patient mentions how the physician treated both his brother and sister, which is why he is also seeing him. Prior to this, the patient talked about his own health and then used his family members to confirm what he is stating. This invoking his brother’s and sister’s experiences seems to be an attempt to reduce the threat that he faces. At the same time, he appears to be trying to convince the doctor of this by using an explanation of his siblings’ outcomes as a way to do so. The patient takes the focus off of himself and places it onto his family members by providing his brother’s opinion. Right after the patient discusses his family members’ positive experience he seems to strategically mention his own health. This sequence appears to be a way of minimizing his own risk based on his family members’ health experiences. The patient not only mentions his family and how his brother received in similar health care, but he extensive elaborates his answers to form a narrative. This narrative depicts the challenge he is facing by integrating his brother as a part of his care treatment and reiterating his positive health as an example of an ideal outcome.

Utilizing his brother’s scenario of being cared for by this physician displays a desire to be treated similarly and although unstated, to have the same results as his brother. Research acknowledges the connection among family history, perceived risk about the disease, and disease-specific worry (DiLorenzo et al., 2006). Comparing family member’s health is a typical activity when family is mentioned, as patients appear to find comfort in relating to a positive health scenario to theirs.

Within all of these instances patients invoke their everyday experiences into oncology interviews. Elaborating on personal issues allows them to justify their own behaviors and downplay health risk by integrating their family members into these experiences. Utilizing lifeworld experiences allows patients to place family members in the midst of their cancer journeys. Dealing with family members’ health problems or hardships while being treated for cancer is a challenge that patients continuously face. Being able to discuss these experiences provides health care professionals with insight into patients’ behaviors, fears,
and concerns. The information that makes up these lifeworld tellings can ultimately enhance the cancer care process and improve the communication between patients and care providers.

Another common activity that patients engage in is mentioning family members’ health as a way to compare with their own health. Actions such as talking about positive family history or utilizing family members’ health experiences provide patients with opportunities to downplay their health risk. As discussing family history is a key component of medical interviews, patients may provide additional details to clarify information, minimize risk, or elaborate on details. This first example provides a healthy family history to reflect his current health:

MENTIONING FAMILY TO COMPARE OWN HEALTH

8) D1 P4: 6
1 Patient: Except for insurance. Doctor told me to have uh have uh chemotherapy.
2 Doctor: Uh hm.
3 Patient: Nobody in my family ever had cancer.
4 Doctor: Uh hm. (.) Okay. And you are not allergic to any med[i]cine any medicines.
5 Patient: [No. ]
6 (inaudible) I uh, I uh I’ve been very healthy.
7 Doctor: Uh hm.

In most medical encounters it is common for the physician to ask questions related to the patient’s medical history. This instance represents a scenario in which a patient volunteers information about his family’s health history. The patient first reports that he was told he has to have chemotherapy but then follows it up with “nobody in my family ever had cancer.” It seems that he is invoking this positive family history as a way of minimizing the possible risk that he is at. The patient makes it seem that because of his healthy family history he should not need chemotherapy. Stating that no one else in his family has ever had cancer appears as a mechanism to illustrate that he too should not have cancer. This emission illustrates the possible fear that the patient holds in his situation. He seems to realize that no one else had an illness like this to worry about, and it is setting in that he might be the first. Family functioning in cancer has been reviewed to depict three broad categories of concerns: coping with the fear and threat associated with cancer, dealing with the emotional ramifications of the illness, and managing the daily disruptions that cancer causes (Northouse & Peters-Golden, 1993). This reference to his family’s health depicts an attempt to explain
the concern of being the first to experience cancer, particularly coming from a healthy family.

Similar to the way this patient brings up no family history of cancer, patients may also bring up family cancer history to differentiate themselves and their health situation:

9) **OC3 P9:**

1 INT: How about diabetes?
2 PAT: There’s diabetes uh history of diabetes in the family but I have been told
3 I don’t do not have diabetes.
4 INT: (2.8) ↑ Okay. ↑ All right. Well I’m going to uh check you out okay,
5 examine you a little bit. Let me:: I think this is gonna be turned off a:nd u::h
6 you can just take off your shirt.

In this instance, a patient explains that although there is an illness in his family, he has been told that he is healthy. Mentioning that he is an outlier in his family in regards to health minimizes the risk that he is at. Here the physician completes the medical review and then inquires about the possibility of diabetes. This reflects a patient initiated action (PIA) in which the patient not only responds to the question but also elaborates on his own health. The patient seems to be familiar with the risk of family history of diabetes and when offering the delicate news that there is history in his family, he pairs it with this positive news about his own health. Reporting that he has been told by another physician that he does not have diabetes indicates that he has not been impacted by his family’s health and gives credibility to his statement. This good news that “I have been told I don’t do not have diabetes” is an example of how good news is aligned with hope. The physician even responds by stating “Okay. All right” and then proceeds to the medical examination. This scenario offers insight on how patients use initiated actions to extend their answers and get a word in when physicians try to follow their medical agendas. By extending his answer beyond what the doctor asks for, the patient is able to confirm his family’s health issues and also minimize his health risk. As physicians are often short for time and have a checklist of questions to get through, patients may take advantage of answer slots to extend their responses and work in concerns of their own. Reporting this differentiation in his health from his families at this time enables him to downplay his health risk. The use of hope is recognized as a valuable resource to manage inherently uncertain and fearful events such as cancer (Beach, 2009). This interview demonstrates how confirmations of family cancer history can be utilized to contrast patient’s health and minimize their own health risks.
Similar to discussing family history of diseases, patients often compare behaviors of their family members to compare with their own health:

**10) OC6 P9: 1**

1. DOC: Mm hm? (0.5) You used to smoke cigarettes or you still do?=
2. PAT: Still do.=
3. DOC: =Huh uh. Alright so: (been about) thirty five years?
4. PAT: Yes. .hhhh For- For what it’s worth, my **brother** never smoked or drank.
5. DOC: Mm hm, mm hm.
6. PAT: And we both got this at- or at least it w- it was caught at age fifty-five for [both of us.]
7. DOC: [ "Mm hm." ]
8. DOC: =Mm hm.=

This conversation portrays an instance in which a patient mentions his brother’s health to minimize the seriousness of his own behavior being a factor in his diagnosis. The physician asks him if he used to smoke cigarettes and he explains that he still does. The physician’s response of “for thirty five years” seems to trigger a need to protect himself and make a case based for his own behavior. In return the patient responds yes, and then states: “for what it’s worth, my brother never smoked or drank.” This extended response shows that even though he has smoked for this amount of time, his brother never engaged in that behavior and still got cancer. Making this point seems to be an attempt to get off the hook for his behavior by proving that his brother as an example of cancer happening to anyone—regardless of their actions. The patient appears to be arguing that although he has been smoked for over thirty-five years this may not be the factor, or at least not the only factor, that caused this cancer, since they both got it. The patient’s reference to family illustrates a comparison of their health to reiterate that they were both equally at risk, regardless of behavior. Mentioning his brother’s health situation can be seen as a way of justifying his smoking and removing the responsibility for being diagnosed with cancer. This depicts a mechanism of comparing family members’ health to remove the responsibility of his cancer.

This conversation depicts a rationalization from the patient in which his family member’s health is used to excuse his behavior. He works to justify his claims that he and his brother both got cancer, regardless if he smoked or not. Invoking another family member to compare health behaviors allows this patient to minimize the future risk he is at. This instance reveals the use of family health history to make a case that the patient’s cancer should not be attributed to his behavior and his brother’s diagnosis of cancer is a way to
prove that. A family medical history is recorded to obtain a more inclusive description of who the patient is and what health issues are most like to affect him or her due to genetic or familial influences (Alspach, 2011). Utilizing a comparison of his brother’s health enabled this patient to express to his physician that while his behavior could have contributed to his cancer, other factors may have also, as was the case for his brother.

Patients employ different strategies to make references to family members during oncology interviews. From using family history for comparison reasons to sharing lifeworld experiences that reference the impact of family, social actions such as minimizing blame for diagnosis, downplaying threat of cancer, and exemplifying a healthy family occur within oncology appointments. These references to family members provide patients with the chance to elaborate on their family history and family members’ experiences to complete crucial social actions such as minimizing fear of their own health or bidding for reassurance from their physician. Just as patients reference family members, it is common for physicians to bring up family members in instances such as taking family history, asking about impact on family members, and discussing treatment plans or decisions.

**Physicians Referencing Absent Family Members**

Physicians are often responsible for making the initial mention of family members. Talking about family history, previous experiences of family members, or the impact of cancer on the family are typical activities of physicians during oncology interviews. Physicians’ mentions to family members often result in the explanation that cancer runs in families, patients responding about the impact of cancer or patients routinely confirming family cancer history.

**Explaining that Cancer Runs in Families**

A commonality exists in medical encounters as patients or physicians mention that cancer runs in families. This consists of explaining that family members have had cancer or stating that no cancer history occurs. These actions allow patients to make different cases such as to either reiterate that although there was cancer they will be different or to explain that there is no family cancer history so that they face a lesser risk of cancer. A main way family members are mentioned is during a medical history taking when physicians ask about
history of family disease or cancer. This first instance provides an example of a physician examining a patient for melanoma spots, and asks about family occurrence of melanoma due to its hereditary nature:

11) **OC 1 30: 1**
1> DOC: .hhh A::nd u:h right. Finally, is there anyone in your family with melanomas, or are you the only one?
3 PAT: I’m the only one.
4> DOC: Rats. (.). hh Um (.). Sometimes they run in families.=
5 PAT: =Right.

Within this encounter, the physician discusses the melanoma that the patient previously had by asking about occurrences of cancer in his family. The way the physician inquires about the family history sets the patient up to confirm that he is the only one. Within medical encounters interviewers’ formulations solicit confirming responses and disclosures from the patient (Beach & Dixon, 2001), which was evident in this response. The second aspect of this interaction is after the doctor asks about the family history of melanoma the patient responds by stating that he is the first, instead of just saying yes or no. This statement alludes to the fact that although his family had no melanoma the patient is still at risk. This discussion of being the first in the family explores the fact that although his family all had positive cancer histories, it does not mean that he is guaranteed to not have cancer. Referring to himself as the “only one” symbolizes the patient’s realization that his family history does not matter in whether or not he could be diagnosed. Making references to family members’ health allows physicians to better assess the risk a patient may face as well as enabling patients to elaborate about relatives’ health experiences or concerns related to family cancer. The physicians’ notion to rats is symbolic of moles running in families, referring to the fact that cancer can be genetic and his family health could put him at risk.

In the next portion of this same conversation the physician utilizes his reference of cancer running in families to educate the patient on family history:

12) **OC 1: 30**
1> DOC: .hhh A::nd u:h right. Finally, is there anyone in your family with melanomas, or are you the only one?
3 PAT: I’m the only one.
4> DOC: Rats. (.). hh Um (.). Sometimes they run in families.=
5 PAT: =Right.
6 DOC: Any idea what we call that?
7 (2.0)
They’re multiple (nebuses), and we call them mm-(0.7) Just plastic (nebus) syndrome. And [uh but]

PAT: Ahh. [I was ] gonna say hereditary? [Heh heh.]

DOC: [No. What strikes me and you’re not it, and this is for (them) not for you.]

PAT: =All right.=

This conversation demonstrates a physician expressing how cancer is an illness that runs in families to state the risk of cancer and to inform him of the facts. The physician begins discussing the family medical history with the patient by asking if anyone else in his family has ever had cases of melanoma. It seems that the physician is seeking for good news of him being the only one with melanoma as a positive family history of no previous melanoma will reduce the patient’s risks now and in the future. The patient explains that he is the only one and the doctor responds by stating “Rats. (.). hh Um (.). Sometimes they run in families.” as a way of discussing the threat of family history of cancer. This reference to running in families utilizes imagery to portray the risk that is possible depending on his family members’ health. The patient responds to the physician’s inquiry that he is the “only one” with cancer, demonstrating that his cancer cannot be attributed to his family health.

Beach (2010) explains that “patients initiate actions and employ diverse actions, including extreme case formulations and repeated emphases and lists of claims, to justify not only that they are well but to downgrade and minimize their fundamental need for cancer care” (p. 41). The use of this extreme case formulation supports his claim that he is the only one in his family with cancer, therefore downplaying his own health risk.

Following this family history inquiry, the physician asks questions relative to this family history threat. When the patient makes the reference to “hereditary” the physician dismisses this wrong answer and continues to elaborate on the medical explanation. This activity appears to be a way of acquiring family cancer history as well as providing patients with the knowledge to better understand their cancer care.

Just as the following physician asked about family history in relation to skin cancer, this physician brings up a medical issue that can also runs in families:

**OC 6 Page 16**

1. DOC: Uhm, I have a few more results for you. (.). A(h)nd ah (.). h I can share this with you here.=That’s your copy.
2. PAT: °Thank you.°
3. DOC: °Th:ank you.°
4. DOC: Uhm (.). and I just have a few things I c- I can go over. Uhm (0.4) You know
In this oncology interview the physician reviews test results with the patient and shortly after explains that it is not rare for these CLL to run in families and a tendency for multiple family members to have it. The physician’s words are specific in explaining that “it’s not common but it’s not rare.” This seems to be an effort to make the patient aware of the risk yet minimize some of the possible fear she could feel. After he states that it runs in families, the physician again elaborates that more than one person in the family may typically have it. This second reference makes a stronger case for the possibility of the patient to be impacted by his family health. The physician appears to be very strategic with his word selection and throughout this conversation he incorporates disclaimers to make the patient aware that while this family history is a common indicator, it is not definite. The physician discusses family health impact in a way that is informative yet still provides a sense of hope by stating that “there can be a tendency for more than one person in the family to have CLL and it’s not common but it’s not rare.” The physician’s references to family health seem to be attempts to set realistic expectations for the patient. This conversation depicts an interaction in which a physician makes a reference to family history to illustrate that cancer does run in families and is something that this patient should be aware of.

Each of these actions demonstrates common conversations in which patients and physicians talk about family members’ health playing an influential role on the patient’s cancer risk. These references provide insight on to how patients discuss the impact of having cancer run in families. Physicians can help reiterate this impact by asking about the occurrence of cancer and elaborating on the risk this holds. As health care professionals are responsible for inquiring about family history of illnesses, similar themes arise in how patients answer these questions. These responses both answer physicians’ questions about health history and complete important social activities relevant to cancer care.
RESPONSES TO FAMILY HISTORY QUESTIONS

There are two overarching themes that were identified from this data analysis when patients responded to physician questions. When asked about family health, patients either referenced the impact family cancer had on their life or engaged in routine answers to confirm family cancer. These impactful responses from patients are first analyzed.

REFERENCING IMPACT OF FAMILY CANCER

When physicians ask about family history, it is common for patients to simply confirm or deny cancer occurrence and then to elaborate on the impact that this makes in their or their family’s lives. In this first instance a patient answers family history questions and elaborates on the influence family cancer has had on their family’s lives:

14) OC 2:18-19
1   DOC: That wouldn’t matter we should do the testing. And uh I don’t do the testing until
2     we have you talk to one of our genetic counselors because there’s a lot of issues
3→ that we need to think through. First of all uh do you have sisters or-
4→ PAT: I have a sister.=
5   DOC: =Yeah.=
6→ PAT: =And she’s- ever since mother died of breast cancer she’s been an absolute nut
7     about it.=
8   DOC: =Yeah.
9   PAT: And she she examines her breasts ((Phone rings.)) probably everyday or so=
10  DOC: I’m gonna ignore that or try to ignore anyway but so one of the things I like to quiz
11     is uh suppose your sister wants to know your results could she find out.
12  PAT: I’d be glad ( ).
13  DOC: Well she doesn’t have a legal right too uh suppose you wanted to tell her but she
14     didn’t want to know cause she would sue you for having told her bad news. (. ) ( )
15     between families that’s what I’m getting at sometimes.

In this instance the patient and doctor discuss genetics when the physician asks if he has siblings. In response to this the patient elaborates on a third turn explaining how the sister has changed since the death of her mother. This sequence stands out as the patient mentions her sister and then immediately after elaborates on how “ever since mother died of breast cancer she’s been an absolute nut about it.” The patient was simply asked about having a sister and expands her reply to mention another family member’s health and even death. Family is typically mentioned in medical encounters to reference death of a loved one due to cancer. This instance shows the use of family being invoked to demonstrate how the cancer-caused death impacted the family. The patient tells the physician of her sister who also
examining her breasts after her mother passed away from breast cancer to illustrate her proactive behavior to reduce the possibility of being diagnosed with cancer. This reference illustrates how their mother’s cancer changed his sister’s behavior.

When the patient’s phone rings the physician says that he is going to try and ignore it, yet mentions that it is possible that her sister is calling to get an update on her health. He states that her sister could sue her “for having told her bad news” depicting the possibility of having to share negative health news with her family member. Research shows that when patients’ states of health are good, it is easier for individuals to cope with bad news (Stajduhar & Davies, 2005). This exaggerated reference to being sued for sharing bad news with family members illustrates the fear that cancer patients face when having to deliver bad news to their family. Informers of bad news frequently feel torn between their responsibility to inform family members of potential health threat and to protect them from the distress and uncertainty that this entails (Foster et al., 2004; Green et al., 1997; Hallowell et al., 2005; McGivern et al., 2004). This discussion of sharing the news with the sister offers insight as to how the dissemination of cancer news also impacts patients’ family members. Talking about the sister’s change in behavior as well as possible unhappiness with the delivery of bad news exemplifies how patients mention family members to discuss the impact of cancer.

While bringing up behavior changes due to cancer is a way of showing the impact of family cancer, patients may also mention similarities in family members to initiate the possibility of impact:

15) OC 2: 18
1→PAT: [ Right. ] My mother and myself and my daughter=
2  DOC: =Mm hm.=
3  PAT: =are so much alike.=
4  DOC: =A:::h.=
5→PAT: =We look alike, I can wear my mother’s shoes and rings and [you know ]
6  DOC: [ Mmmm. ]
7→PAT: I mean and my daughter too. [ She’s a little ]
8  DOC: [I wonder if there’s a corre]lation, I don’t think
9  but still=
10 PAT: Well I don’t know whether breast cancer=
11 DOC: =Mm hm.=
12 PAT: =problems follow generation to generation.
13 DOC: They do. Mm hm.
This excerpt presents a situation in which a patient discusses the relation between the generations of women in her family. By mentioning that “my mother and myself and my daughter….are so much alike” implies the possibility that these similarities could exist genetically. Ultimately, this reference to similarity seems to be an indication of the possible similarity of their genes in regards to cancer. Because her mother had breast cancer, she and her daughter are both at risk. It appears that she is saying that because they are very alike it could mean they have similar genes, putting her daughter at risk. She explains that she does not know whether breast cancer was an issue for them, depicting that her health will be a reflection of that. The patient seems to continue to talk about her family members as a way of convincing herself and the doctor that her health will not be negative because her mother’s and daughter’s are not. However, in this sequence the physician responds by confirming that problems of this nature do follow consecutive generations, clarifying the argument she just made. The manner in which the patient stated, “Well I don’t know” symbolizes doubt and reiterates that she is not claiming to have medical knowledge similar to that of the physician, but rather that it is just her speculation. The patient’s bid to talk about family impact on the cancer was dismissed immediately by the physician as he not only states that problems do follow by each generation, but also adds “mh hm” as a closing device to confirm this fact. This patient’s reference to her mother and daughter seems to be an attempt to demonstrate concern that they could have similarities in more than just clothes.

This reference to family similarities appears to be a strategy to question her physician about the possible impact they both could be having because of their genetics. The patient’s manner of bringing up a possible correlation ultimately reiterates the family nature of cancer occurrences. The patient invoking her family’s health provides her with a chance to inquire with the physician about this correlation and further understand if her family members are at risk.

Just as this patient discussed the similarities of mothers and daughters, this next instance provides a conversation in which a physician asks about mothers, sisters and daughters have breast cancer in her family:

16) OC2 4: 1
1   DOC: =How old were you when your first was born.
2   PAT:   Let’s see uh. My first live birth was at twenty-six.
3   DOC: Mm hm.
PAT: I had a lot of miscarriages [before.]

DOC: [Okay.] And how many moms, sisters or daughters. Just a Mom?

PAT: U:h=

DOC: =With breast cancer.

PAT: Just the one relative, my [mother. ]

DOC: [your Mom.] How many previous biopsies have you had?

PAT: Two.

This situation is another instance in which a physician mentions family history of breast cancer then follows up with a question that reiterates the possible impact of this family cancer. The patient confirms that just her mother had breast cancer and the physician’s immediate response is to ask how many biopsies she has personally had. This answer appears to be a way of symbolizing that because of her mother’s breast cancer she could also be at risk. The sequence of this interaction goes as follows: the physician asks about family history of cancer, the patient responds with information on cancer being present, and the doctor immediately replies by asking about biopsies the patient has had. What is achieved in communication can be seen as a result of how the speakers construct and offer their understandings of the environment they are a part of (Beach 1990a, 1990b, 1991, 1995; Jefferson, 1981; Sigman, 1995; Wootton, 1988). The pattern of this discussion shows that the family history of cancer impacts the physician’s prognosis of her health. Learning about cancer in the family and then immediately replying with a question about her biopsies of cancer symbolizes the risk the patient could be at. This questioning appears to be a strategic attempt to link the family cancer history to the patient’s current health to discuss this possible impact of cancer.

It is also common to discuss a cancer patient’s children as a way of referencing the impact that they may be at in regards to their parent’s cancer. In this same conversation the physician initially asks about the patient having children to learn more about the influence on the family:

17) OC 2: 4

PAT: U:h I was about thirteen.

DOC: Yeah. (. ) A:nd have you had kids or

PAT: Yes I had. Uh=

DOC: =How old were you when your first was born.

PAT: Let’s see uh. My first live birth was at twenty-six.
DOC: Mm hm.
PAT: I had a lot of miscarriages [before.]

DOC: [Okay.] And how many moms, sisters or daughters. Just a Mom?

PAT: U:h=

DOC: =With breast cancer.
PAT: Just the one relative, my [mother.]

DOC: [your Mom.] How many previous biopsies have you had?

PAT: Two.

DOC: Two biopsies. And were any of those uh I like to say funny-looking cells or atypical, that you know of.

The reference to family members is first made as the physician asks the patient if she has kids. The physician asks about her health and then brings up if she has kids to learn more about the possibility of her health affecting her chances of getting pregnant. The underlying reason for asking this appears to be to decipher if she has already been impacted by this health issue. She explains that she has kids and follows up that she has “had a lot of miscarriages.” This answer illustrates that she has in fact been affected by her family health history, which then leads to the physician to ask about additional family members who all could have been impacted by this cancer as well. The beginning of this conversation illustrates a physician’s initiation of family that depicts the familial impact of this type of cancer. This questioning appears to be a strategic attempt for a physician to link family cancer history to the patient’s current health.

When patients and physicians talk about family health it is typical that they make express how history of cancer may increase their changes of receiving cancer:

OC 2: 4

DOC: That’s good. Certainly better than the alternative. Let me just show you some numbers here. Uh so this is women like you, this is not exactly you because you [can’t]

PAT: [Right.]

DOC: be a statistic, you can’t have like five per cent of a cancer, [but]

PAT: [Right.]

DOC: over five years it says that uh if we took a h- hundred women just like you, five of them or five per cent would get cancer

PAT: In the next five years.=

DOC: =In the next five years, and over a lifetime fourteen per cent=

PAT: =Out of a hundred.=

DOC: =Out of a hundred. “Fourteen out of a hundred.”> Now that’s higher than normal by a little bit.= 
In this instance a physician is discussing the possibility of this patient getting diagnosed with cancer when he makes the reference that her mother could change these numbers. This mention of her mother refers to the fact that her mother having cancer can change these numbers and make the patient even more vulnerable to being diagnosed. The physician just spent a few turns explaining how the numbers increase over time and then adds in the fact that having a family history of cancer can change this. The physician is ultimately reiterating that these numbers are even higher if her mother had cancer. Breast cancer not only affects the diagnosed woman herself but also her extended family (Tunin et al., 2010). This reference to family shows how the patient’s life could be impacted by her mother’s cancer. This conversation demonstrates that while the percentage of women who get breast cancer increase over years, having a mother that also was diagnosed further increases a daughter’s chances. The impact of family history becomes apparent as the physician lays the groundwork to show her how her risk intensifies over the years and then mentions that her mom can increase these numbers. As women are increasingly being diagnosed with cancer, they continue to be aware that they are at risk or consider themselves to be at risk (Tunin et al., 2010). The physician illustrates this and magnifies the possibility of her mother’s cancer impacting her health.

In each of these situations both physicians and patients discuss the impact that family members or family history have on the patient’s lives. This impact illustrates the collective nature of cancer and how much of an influence family members have on the health and the lives of patients. As family history of cancer plays a significant role in the care and treatment of cancer patients, it is typical for them to reiterate this impact when answering questions from physicians. Similarly, cancer patients routinely respond to physicians’ questions to confirm family history, express their family’s behavior in relation to cancer and to educate physicians on the risk they may be at.
Routine Responses to Family History Inquiries

When physicians ask questions about family health history, patients commonly provide them with relatives’ who were impacted and briefly elaborate on what type of health issues they were. These routine responses to family history inquiries simply indicate whether or not a history of cancer is present. This first instance provides an example of a patient confirming multiple family members’ health situations:

19) OC6 P9: 1
1 DOC: .hhh Any other history of any other hh. (rou- auto-imuune)-
2 I mean , for example arthritis or- (.) any thing else in the family?
3 PAT: .hh Dad had arthritis.=He had two hip replacements.
4 DOC: Mm hm.
5 (2.5)
6 DOC: .hh And ah, any other brothers or sisters or, just the younger brother?°
7 PAT: Um, My brother and then my sister who gave the bone marrow to
8 him, and she’s(.) four years younger than me. She’s <fifty: one now.>

In this case the physician initiates the mention of family by asking if anyone in his family has suffered from relative health issue. The patient responds and offers specific information about his family to confirm the occurrence of health issues. Throughout this sequence the physician continues to probe about additional family members, which is routine in learning about family history. Each time the patient extends his answer and provides additional details about his family health. This is a typical way for patients to initiate their family into conversation and elaborate on concerns of their own. In response to the physician’s questions, the patient provides routine answers that confirm family history and also allow him to expand on the state of these family members. The doctor continuously asks about other relatives to collect all of the data about the patient’s family. This question and answer sequence illustrates the significance of patients being open and honest about their family’s health, particularly as the speaker’s turn at talk projects relevant action by the next (Beach & Anderson, 2004). As the medical history is a significant aspect of medical interactions, it is common that patients will discuss their family in relation to their own health. The patient’s answers about family members symbolize typical responses to family history inquiries, in which the health care professional and patient are able to move through the history exam while gaining additional insight about these individuals.
While this patient offered detailed insight on his family cancer history, it is typical for patients to simply confirm that cancer has occurred within their family:

20) D3 P3: 6
1 Doctor: Did it make you have problems with depression or mood? At the
2 time of menopause?
3 Patient: Eh it made – yeah you know nothing extremely =
4 Doctor: Mmhm. Okay.
5 Patient: = bothering me.
6→Doctor: Okay. And uh, anyone in your family (.) have history of?
7 Patient: Cancer?
8 Doctor: Yeah.

Within this encounter, the physician brings up the patient’s family by asking about a history of cancer. This portion of the interaction begins with the doctor questioning about any side effects such as depression and the patient responds in a way that both minimizes potential harm and provides hope for her situation. Using the extreme case formulation (ECF) “nothing extremely” demonstrates the patient downplaying problems that she may have experienced. According to Beach (2010), “cancer patients frequently employ specific ECF’s to mitigate, if not eliminate altogether, doctors’ reasons for being concerned about their health and the possibility of ‘sick role’ designations assigned to them” (p. 17). Immediately after the patient’s response about nothing really bothering her, the physician moves to asking about the family history.

While discussing family history seems to be a logical transition within this portion of the encounter, the patient provides a bid for hope when explaining that there was nothing to worry about, and the physician simply moves to this topic. By controlling the structure and agenda of the encounter, the introduction and development of topics, and questioning strategies, doctors suppress patients’ attempts that conflict with their medical agenda (Drew, 2005). As the patient previously downplayed her symptoms to reassure the doctor of her minimal risk, she seemed to be looking for a hopeful response in turn. It seems as if this sequence illustrates a patient asking to be consoled by the doctor through minimization, but the physician instead transitions the conversation to learn whether or not cancer is present within the family. Both of these statements seem to be standard portions of an interaction, but it is the sequence of their actions together which present implications for the way family and cancer are discussed within medical encounters. The mention of family cancer history
appears to be a way to relate the patient’s responses to the medical agenda in a way that can make her feel even more fearful or uncertain about her situation. This routine response opens up the possibility for the physician to guide the interaction in the direction of his choice, whether it be discussing the risk of family cancer or possibly minimizing the threat that she faces.

While patients can confirm family cancer, the situation of explaining no previous family history arise and allow patients to show hope, fear and uncertainty about being the first to be diagnosed:

21) **OC1 P3: 1**

| DOC: Okay. No::w a:h the area on your back, u:h when was that a:h removed (.) that melanoma. |
| PAT: Uh May of ninety-nine. |
| DOC: =May of ninety-nine.= |
| PAT: =Mm hm= |
| DOC: And there’s been nothing that recurred around that site.= |
| PAT: =Hm ↓um= |
| DOC: =O↓okay. |
| PAT: ≪No more melanoma.> Just that one. |

10→ **DOC: ((Clears voice.)) “Alright.” Uh any family history of uh melanoma?**

| PAT: I’m the first. |
| DOC: You’re the first.= |
| PAT: ↑Yeah.= |
| DOC: =Okay. |
| PAT: The lucky one. |
| DOC: And uh did you have prior history of s:- uh sun exposu::re. |
| PAT: When I was a teenager. |

In this instance a patient explains that there are lots of moles in his family, illustrating the fact that the presence of moles in his family can be just as common as cancer. As he states that they were “just moles” he illustrates that they are not cancerous, making this a reporting of health status of a family. The patient expressed that nothing recurred around the site of melanoma, which seemed as a way of remaining hopeful. This hope was reiterated again by stating “just that one” in reference to the sole spot of melanoma, minimizing the risk of the patient’s health. Cancer patients utilize extreme case formulations to control or even eliminate doctors’ concern for their health (Beach, 2010). Not only did the patient reveal information about himself and his cancer, but he also he opened up about his family by providing emotion about being the “first” to be affected. When patients are asked about
family cancer history and none exists it is common to mention something that reiterates this isolation. This is evident when the patient confirms that there is no cancer but he also states that he is the first and adds “the lucky one” onto this. By calling himself “the lucky one” and being sarcastic about his fortune of being diagnosed this patient signifies routine responses of disappointment. Stating that he is the “first” and “lucky” one in his family to have this cancer depicts a commonality of patients to make references to family that will result in reactions of physicians. This reference of being the first in the family identifies patients’ efforts to initiate discussions that minimize the risk they feel, regardless of no previous family history.

In this same conversation, family history is downplayed by referencing the commonality of mole occurrences in each family member:

22) OC 1 page 13
1 DOC: Okay. An(d) it looks like you had another-
2 PAT: That was when I was a kid.
3 DOC: Uh huh.
4 (0.7)
5 PAT: I started having mo:les removed. (0.3) At an early a:ge.
6→ DOC: And you said no family history.
7 PAT: Right. Just moles. [ Lots of ]=
8 DOC: [Just moles.] 9→ PAT: =moles. Lots of moles in our family.
10 DOC: Uh uh.=
11 PAT: =$Hhh.$
12 (2.5)
13 DOC: (    small.)
14→ PAT: I have four brothers and a sister.
15 DOC: Another one remo[ved. ]
16 PAT: [A lot of possibilities.]
17 DOC: (0.8) And you said uh you’ve got a lot of growing lymph nodes, which I feel.
18 PAT: Yeah, even more on the left side.

Here the physician and patient continue to review his moles and the physician again asks about possible family history of cancer. The patient takes an extended turn to minimize the risk the doctor perceives as she states that these are “just moles.” During this medical examination the physician points out an additional mole that the patient had already had removed and before he can even finish his sentence the patient interrupts to mention that it occurred when he was a kid. As the doctor responds by simply saying “uh huh” the patient continues to express that he has had moles removed since he was younger. This demonstrates that although there were moles and he had had them removed when he was younger, he is
still healthy. Interestingly, the physician asks about family history of moles, as it may appear that if he has been getting moles removed since a young age there is a possibility that it could be from the family history of cancer. If his family members had cancer it is more likely that these moles would be cancerous as well.

Within this sequence the patient tries to explain that the removal of these was at a time before this, rather than putting risk at his life now. He uses extreme case formulations by stating that it was when he was a kid and at an early age as a way of comparing them to his present life. The patient continuously explains that they were moles, just moles and adds that there are “lots of moles in our family.” As the doctor repetitively asks about the family history of cancer and about these moles, the patient seems to justify his reasoning by minimizing the threat of these moles—saying that they were all when he was younger and that they were “just moles,” whereas things could have been a lot worse. The patient then goes into further detail by adding that he has four brothers and a sister. This statement seems to be an attempt to explain that he has five siblings who have all had moles in his family yet no signs of cancer. His physician replies by saying that another one was removed and simply avoids this evidence that the patient provided. This dismissal and focus on the fact that he had to have another mole removed symbolizes the physician’s desire to move onto the facts of his medical health. Throughout the entire sequence the patient attempts to minimize the threat that he could be at by explaining that his family has a history of moles that are not cancerous and offers this family health should correspond to his health. This routine response to a family history inquiry demonstrates how patients can confirm family health and explain family members’ health in a way that minimizes the possible threat they face in being diagnosed with cancer.

As patients answer family history questions, they commonly speak about numerous family members that have been impacted by cancer. These routine responses include elaboration on the type of health issues each individual had and ultimately relate back to the patient’s health:

22) OC4 P1:18
1→ Doctor: And you’ve ↑already told me that your family has a history of
2  diabetes and blood pressure.
3→ Patient: Yeah my father an::d my uncle.
4→ Doctor: °Is° there any obesity running in the family?
Patient: Yeah. (2.5) We're from one of the biggest $fat cities in- $ (. ) we're from New Orleans.

Doctor: Oh ↑re[ally. ]

Patient: [So th]ere's a lot of (1.0) fattening food and=

Doctor: = >But it's good food<.

Patient: Yeah ↓but ba: d.=

Doctor: =Any cancers or anything that run in the family beyond that.=

Patient: =YES:: u:m my grandmother ↓died of °cancer °.

Doctor: >Do you know what type?<

Patient: U:m (. ) I believe it's to be- the breast canc:er.

Doctor: Okay.

Patient: U:m.=

Doctor: =What side mothers? Or father’s [ (grand-). ]

Patient: [My mothers] side. My mother-

Doctor: pt O:kay.

Patient: So there are cancers in my family.=

Doctor: =Sure. .hh Do you smoke.

Patient: No.

This is another instance where a patient confirms her family history by answering questions about family health and mentioning several different relatives’ cancer. She not only provides the physician with the answer he wanted, but also elaborates on which family members have what cancer or health issue. The doctor’s initial question asked for her to say yes as he already had received the answer to this previously. He is thorough in the patient’s request of family history, providing insight on exactly how family genetics could be putting her at risk. This conversation consists of the physician asking the patient about family history to try to relate to the patient’s current health. She confirms that there was no diabetes or blood pressure issues and then moves into the possibility of obesity. The patient discusses reasoning for family history of obesity and then the doctor moves to asking about any additional cancers. Within this portion of the medical encounter the doctor moves from less serious to more serious concerns such as diabetes and blood pressure to cancer. The physician brings up cancer when asking about family history, in which the patient states that her grandmother died of cancer. This sequence continues with the physician asking specific questions about the cancer and then the patient again explains that her grandmother and great grandfather both died of cancer. When the doctor simply responds by stating “okay” the patient further states that “there are cancers in my family.” Typically, patients are not the
ones who will bring up the word or thought of cancer as a “devil term.” It seems that she was willing to provide the doctor with the accurate information to the doctor to ensure the best prognosis of her health. In this conversation there is an interesting blend of the physician bringing up cancer and asking about family history as well as the patient elaborating on details to express all instances of the family’s health. This common response ended with the patient being the one to state “cancer” illustrating how routine conversations can ultimately be altered to reveal concerns or agendas of patients.

In the next excerpt a physician asks about a patient’s family members’ health and the patient responds in ways that downplays her possible risk:

24) D3 P3: 7
1→ Doctor: It’s worth to consider. Um do you have sisters?
2→ Patient: I don’t have sisters.
3 Doctor: Okay.
4→ Patient: I have two brothers.
5 Doctor: Okay.
6 Patient: And no they don’t have it.
7 Doctor: And they are okay?
8→ Patient: They are okay. They have some uh (. ) health issues, but no big deal.
9→ Doctor: Uh huh. And do you have children?
10→ Patient: I have two children. Uh my daughter’s twenty-seven years.

This situation depicts a physician inquiring about family history in which a patient provides straight forward answers in response. After the physician asks about sisters the patient then elaborates that he has brothers, and quickly clarifies that they do not have cancer. Immediately afterward the physician asks if they are ok, and the patient confirms and extends his answer with a minimization of his brother’s health issues. The doctor continues to ask about other relatives to collect all of the data about the family. This question and answer sequence again illustrates the significance of patients being open and honest about their family’s health, as the speaker’s turn at talk projects relevant action by the next (Beach & Anderson, 2004). As the medical history is a significant aspect of medical interactions, it is common that patients will discuss their family in relation to their own health. This is evident as the patient routinely confirms and denies family members’ history but then explains that “they don’t have it” and asserting that all of their health issues are “no big deal.” This explanation of the family members and minimization of their health issues depicts the
tendency for patients to routinely answer questions about family health and then downplay information to lessen the risk that they may be facing.

As family history taking is a main component of medical interviews, patients respond in uniform ways by providing short answers to confirm or deny the occurrence of health issues. These answers allow patients to minimize their health threat, elaborate on family health details, and facilitate the physician’s understanding of the patient’s risk (see Table 1). The commonalities in these responses provide insight as to how patients discuss family members in response to a physician making the initial references to family

**Cultivating Moments in Which Family Members are Referenced**

The moments in each of these collections portray important social actions that occur when patients and physicians discuss family members. These instances are organized by frequency of social actions to reiterate the most prominent themes in these analyzed conversations.

In these collections patients and physicians overwhelmingly discussed family members to reiterate the possible impact that they could be at. This includes references to family history of cancer as well as how family members could be affected by the cancer that they possess. This aspect supports the argument that cancer truly is a family affair. Patients are not just worried about themselves, but are also fearful for their family members. Patients know that their health could be a result of family members’ illnesses, just as their illnesses can carry down to other family members. Oncology interviews provide an environment to place these concerns of possible impact on the table. The explanations of possible impact range from one oncology appointment to another, but all reiterate that these influences are issues that both patients and physicians are aware of and feel should be discussed. Mentioning family members to discuss the possible impact signifies that just as patients’ family members influence their cancer threat, family members are just as affected by the patient being diagnosed. This becomes an omnipresent cycle in which entire families endure the fear of cancer seeping into their lives. Patients and physicians together discuss family members and reiterate this impact. Similarly, medical professionals and diagnosed patients invoke family history to discuss the cancer at hand.
<table>
<thead>
<tr>
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<th>Utterances</th>
<th>Key Social Action</th>
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<td>“Rats. (.) hh Um (.) Sometimes they run in families.”</td>
<td>Reiterating Possible Impact of Cancer</td>
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<tr>
<td>Explaining that Cancer Runs in Families</td>
<td>“You know it’s not (.) ah rare for sometimes it to run in families.”</td>
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<td>Responses that Indicate Impact of Family Cancer</td>
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<td>Responses that Indicate Impact of Family Cancer</td>
<td>“And she’s- ever since mother died of breast cancer she’s been an absolute nut about it.”</td>
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<tr>
<td>Responses that Indicate Impact of Family Cancer</td>
<td>“Well she doesn’t have a legal right too uh suppose you wanted to tell her but she didn’t want to know cause she would sue you for having told her bad news. (.) between families that’s what I’m getting at sometimes.”</td>
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<td>Responses that Indicate Impact of Family Cancer</td>
<td>“My mother and myself and my daughter=”</td>
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<td>Responses that Indicate Impact of Family Cancer</td>
<td>“I mean and my daughter too. [She’s a little ] [I wonder if there’s a corre]lation”</td>
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<td>Responses that Indicate Impact of Family Cancer</td>
<td>“Those are pretty rational numbers. Of course what raises it up is your mom you can’t change that.”</td>
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<td>Routine Responses to Family History Inquiries</td>
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(table continues)
Table 1. (continued)

| Routine Responses to Family History Inquiries | “I don’t have sisters.” | Reiterating Possible Impact of Cancer |
| Routine Responses to Family History Inquiries | “I have two brothers.” | Reiterating Possible Impact of Cancer |
| Routine Responses to Family History Inquiries | “Uh huh. And do you have children?” | Reiterating Possible Impact of Cancer |
| Routine Responses to Family History Inquiries | “I have two children. Uh my daughter’s twenty-seven years.” | Reiterating Possible Impact of Cancer |
| **TOTAL** | 23 instances | |
| Routine Responses to Family History Inquiries | “Okay. And uh, anyone in your family (. ) have history of?” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “Lots of moles in our family.” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “I have four brothers and a sister.” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “And you’ve ↑ already told me that your family has a history of diabetes and blood pressure.” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “Yeah my father and my uncle.” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “Is there any obesity running in the family?” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “= Any cancers or anything that run in the family beyond that.” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “= YES: um my grandmother ↓ died of canc::er.” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “What side mothers? Or father’s [ (grand-). ]” | Invoking Family Cancer History |
| Routine Responses to Family History Inquiries | “[My mothers] side. My mother My grandmother. And my (. ) great grandfather died of lung cancer.” | Invoking Family Cancer History |
| Mentioning Family to Compare Own Health | “Nobody in my family ever had cancer.” | Invoking Family Cancer History |
| Mentioning Family to Compare Own Health | “There’s diabetes uh history of diabetes in the family but I I have been told I don’t do not have diabetes.” | Invoking Family Cancer History |
| Mentioning Family to Compare Own Health | “For what it’s worth, my brother never smoked or drank.” | Invoking Family Cancer History |
| Explaining that Cancer Runs in Families | “Finally, is there anyone in your family with melanomas, or are you the only one.” | Invoking Family Cancer History |
| **TOTAL** | 14 instances | |
| Referencing the Presence of Family Members in Oncology Interviews | “If you’d like I can invite your wife and daughter back in as we go over things?” | Illustrating Delicacy of Sharing Cancer News with Family Members |
| Referencing the Presence of Family Members in Oncology Interviews | “Yeah they don’t want to see my skinny legs.” | Illustrating Delicacy of Sharing Cancer News with Family Members |

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<tr>
<th>Table 1. (continued)</th>
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<th>“But if ah, but if you’d like to talk with a:h without them being he:re”</th>
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<td>Illustrating Delicacy of Sharing Cancer News with Family Members</td>
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<tr>
<td>Referencing the Presence of Family Members in Oncology Interviews</td>
<td>“He hasn’t been here since a year ago.”</td>
<td>Illustrating Delicacy of Sharing Cancer News with Family Members</td>
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<td>Referencing the Presence of Family Members in Oncology Interviews</td>
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<td><strong>TOTAL</strong></td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“He treated my brother.”</td>
<td>Utilizing Family Cancer Care Experience</td>
<td></td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“Well I sent my brother all my records.”</td>
<td>Utilizing Family Cancer Care Experience</td>
<td></td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“He treated my brother, gave him a bone marrow transplant from my sister”</td>
<td>Utilizing Family Cancer Care Experience</td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“Doctor Joe says tell your brother to go see Doctor ↑Kips”</td>
<td>Utilizing Family Cancer Care Experience</td>
<td></td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“h hh I’m new at this so I needed hh. my brother’s opinion, who had been through it,”</td>
<td>Utilizing Family Cancer Care Experience</td>
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<td><strong>TOTAL</strong></td>
<td><strong>5 instances</strong></td>
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<tr>
<td>Routine Responses to Family History Inquiries</td>
<td>“I have two children. Uh my daughter’s twenty-seven years.”</td>
<td>Reiterating Impact of Cancer</td>
<td></td>
</tr>
<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“It was two weeks after my husband died.”</td>
<td>Reiterating impact of cancer combining with daily life issues</td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“Yeah. [ hh hh ↑In the mean ] time my wife got very ill.”</td>
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<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“And my wife’s &gt;she’s been&lt; (off and on all along).”</td>
<td>Reiterating impact of cancer combining with daily life issues</td>
<td></td>
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<tr>
<td>Initiating Lifeworld Experiences to Discuss Cancer</td>
<td>“[my wife- my wife] My wife has been ill most °of° the time= [ we lost ] our home in Jullian”</td>
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Table 1. (continued)

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<tr>
<th>Routine Responses to Family History Inquiries</th>
<th>“They are okay. They have some uh (.) health issues, but no big deal.”</th>
<th>Minimizing Risk of Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Study 3</td>
<td>“I come from a very healthy family.”</td>
<td>Minimizing Risk of Cancer</td>
</tr>
<tr>
<td>Case Study 2</td>
<td>“I’m tired but I’m the mother of three kids.”</td>
<td>Minimizing Risk of Cancer</td>
</tr>
<tr>
<td>Case Study 1</td>
<td>“I told my daughter if she could live ten years they’d certainly have a cure for it.”</td>
<td>Minimizing Risk of Cancer</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>4 instances</td>
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</table>

Invoking family history serves many purposes within oncology interviews such as to compare health or minimize own risk. Mentioning this family history allows patients to then engage in discussions about concerns regarding this history or bids for hope even when history is present. Just as patients invoke possible impact of cancer and family history, physicians and patients express the delicacy of sharing news with family members.

Sharing news with family members is often difficult to do, which can explain why patients and physicians both feel the need to discuss this activity within oncology appointments. Being able to discuss this delicacy provides patient with support and reassurance that it is necessary. Illustrating the delicacy of this activity allows both parties to elaborate on the role of family in cancer care. Having to share news is typically a concern of patients, particularly if news is negative or does not depict any positive changes. Mentioning family members and news delivery provides patients and physicians with an opportunity to discuss how to share the news with them outside of a medical setting.

Another reoccurring activity from these moments was patients utilizing their family members’ care experiences to discuss their own health or reasoning for being at their cancer appointments. Mentioning other family members’ cancer experience or advice based on their own cancer journey provides patients with an avenue to then talk about how this ultimately impacts them. This can be seen as justification for being seen by the physician or that their family members have had similar situations that they can relate to.

These collections also portray patients expressing the impact of dealing with cancer in addition to the hardships of everyday life. This allows patients to place the cancer in their daily environments so that physicians can better understand how they must deal with simultaneous difficulties. This enables patients to minimize the impact of the cancer and explain their side effects to both issues. For instance, a patient could be arguing that it is not
that the cancer is making their life difficult, but rather that the cancer occurring at the same
time as a challenge like their husband dying or losing their house that creates an issue.

A final social action completed my patients when referencing family members is
minimizing risk for cancer. Bringing up family history, positive health of other family
members, talking about family members’ risk and attributing symptoms to the role they play
in their family all serve as attempts to downplay the risk of cancer. Patients reference family
to reiterate minimized risk for both themselves and their own family members. Doing so
allows them to make a case to their physicians that they or their family members may not be
at risk.

Analyzing the similarities of these moments outlined in Table 1 provides insight into
the prevalent social actions that physicians and patients engage in by referencing family
members. As this collection portrayed both parties most frequently reiterating the possible
impact of cancer, the collective nature of cancer is magnified. Just as family members are
concerned for patients’ health, patients feel concerns regarding how their cancer may impact
their family members. This pertains to the health, emotions and ability to cope with cancer.
Patients and family members alike suffer from diagnosis and must be considered when
studying cancer communication. Several other social activities are completed that support
this theme and reiterate the circular pattern of cancer, in which patients work to downplay the
effect on their family as well as the family’s impact on them. These activities illustrate the
role that family plays in cancer care, highlighting the value of investigating cancer
communication both inside and outside of oncology settings.

As patients and physicians make reference to family members, mentions are often
completed that concern the desire for family members to be present within these oncology
appointments.

**Referencing the Presence of Family Members in Oncology Interviews**

Patients and physicians both can be responsible for mentioning the presence of family
members. These references can be made to suggest family members hear results or cancer
news, provide support, or also explain why family members should be absent.
EXPRESSING DESIRE FOR FAMILY MEMBERS TO BE PRESENT FOR NEWS DELIVERY

As patients commonly want their family members to hear medical news, offer support, and include them in their cancer care, it is typical for patients or physicians to bring up the possibility of family members being present to hear the delivery of news:

25) OC6: 16
1 DOC: .hhh Well what I’d like to do is check your(.) blood (counts) from today. And get any preliminary lab results back?
2 PAT: Sure.
3 DOC: A:nd maybe you can get dressed in the mean time. And-=
4 PAT: =Sure.=
5 6→ DOC: =If you’d like I can invite your wife and daughter back in as we go over things?
9→ PAT: Yeah they don’t want to see my skinny legs.
10 DOC: S0(hh)k[(hh)a:y.$ ]
11 PAT: [(               .)]
12→ DOC: But if ah, but if you’d like to talk with a:h without them being he:re.
13→ PAT: No:. That’s fine if they come in.
14 DOC: Okay. Good.

This oncology interview illustrates a physician making the initial reference to family by asking if the patient wants to invite his family into the room to hear the results of his lab tests. The patient replies that he does want his wife and daughter to be present but immediately followed by a joke about them seeing his skinny legs. This use of humor can be seen as a way to ward off potential delicacy of his family members hearing cancer news. Laughter is often used as a tool to deal with painful experiences, saving face, and navigating through delicate and embarrassing situations (Haakana, 2001; Zayts & Schnurr, 2011). The physician seems to be aware of this delicacy or embarrassment and again asks the patient by saying that they can discuss it without the family coming into the room. This concern for the patient’s needs seems to be appreciated by the patient as she then agrees to let them in. The physician even confirms this by stating “Okay. Good.” This instance demonstrates a patient’s desire to have his family member be co-present for the delivery of news to gain information and offer support for him as well as the physician’s agreement of having the family a part of this conversation. This demonstrates how it is easier for the doctor to explain the news once rather than twice, just as it is also easier to have the family members present to collect the information at the same time, rather than having to relay it to them himself later on.
Similar to this situation is a case in which a physician refers to a patient’s family member hearing the delivery of results to then mention how this would impact the family relationship:

26) **OC2:18**

1→ **DOC:** I’m gonna ignore that or try to ignore anyway but so one of the things I like to quiz is uh suppose your **sister** wants to know your results could she find out.

2→ **PAT:** I’d be glad ( )

3→ **DOC:** Well she doesn’t have a legal right too uh suppose you wanted to tell her but she didn’t want to know cause she would sue you for having told her bad news. ( ) ( ) between **families** that’s what I’m getting at sometimes.

4→ **PAT:** I’d tell her **son.** She is a difficult person.

5→ **DOC:** Or you could for example say I’ve had a test would you like to know about the test and then [sort of introduce it that way but]

In this instance the physician makes a reference to the patient’s sister wanting to know the results as well. This situation represents a pattern in which the patient mentions a third family member as a strategy to report cancer news. Although the physician does not explicitly mention the family member being present, he does reiterate that she will probably want to hear the news. In this instance, the patient’s first initiated action is when he states “I’d tell her son. She is a difficult person.” The patient extends her response to the physician by again bringing up a family member. She reiterates that instead of telling her son she would prefer to talk with her, alluding to her previous mention of her sister being a difficult person. This excerpt portrays the mechanism of using a third member as a strategy for reporting news. The patient suggests talking with the son as a way to share the news by partnering with the family member. By expressing that the patient will want to hear the news the physician opens the possibility of having family members present in these oncology interviews. Ultimately, the reference to having to tell a family member of the news to share with the entire family signifies the role that they could play by being co-present in appointments with physicians and patients.

Similar to this instance is patients’ reference of family members being present in oncology appointments in which they are faced with the task of enduring the challenges that patients face. In this case a patient expresses why a specific family member has been absent in her oncology appointments:
Hi Linda.
Hi Dr. Ball.

[Hi]. Are you Mr. ( )?
Yeah, that’s Richard. [Yeah ].
[Yeah, hi].
He hasn’t been here since a year ago.

Di - Yeah, you were here once right?

Yeah.
Just one [( )].
[Yeah], I think, yeah.
Ok, ok.

Well I couldn’t have him when I was crying every visit.
Uh huh.
(Enough is enough).
Right, right.

This patient invokes the presence of family by explaining that she could not have her husband seeing her cry every appointment, which is why he has not attended them. She may not want to appear weak, be embarrassed, or because it may be she is trying to lessen the burden that the family already faces from this cancer. This notion to crying every visit could be a reference to her vulnerability, which she does not want to show her family. By expressing that her husband could not have seen her crying every visit she is protecting not only her family, but also herself. If her husband was always present she also may not have been able to speak honestly, express her real emotion, or bring up concerns she has to her physician. This case is an instance that portrays how patients refer to family members’ presence in oncology interviews to portray the impact that these appointments can have on family members as well as the patients. If her husband was in the room witnessing her crying at each appointment it could alter the way the appointment was conducted, how she answered questions, how the physician talked to them, and even the way the patient and family member feel about the cancer. The patient seems stern by stating that enough is enough as if she was reiterating just how hard it was for her to have him present and face the challenge of seeing her cry every appointment. This effort to discuss family in a way that reflects the disease as a family matter is present within medical settings as family members and patients both have desires on who is invited to appointments depending on the circumstances.
FAMILY MEMBERS’ PRESENCE IN ONCOLOGY INTERVIEWS

Each of these situations represents instances in which patients or physicians make references to the presence of family members during oncology interviews. Being co-present in these settings allows family members to not only simultaneously hear news delivery, but also to ask questions, raise concerns and provide support for the cancer patient. This small collection of discussions of family members’ presence in oncology appointments lays the groundwork for the next data chapter that examines the techniques and behaviors family members engage in when present in oncology interviews.
CHAPTER 3

FAMILY MEMBERS’ CONTRIBUTIONS TO ONCOLOGY INTERVIEWS

As cancer affects the entire family when an individual is diagnosed, it is common for family members to be present in oncology appointments. These co-present family members play an active role in conversations between patients and physicians by raising concerns and contributing to patient’s answers.

This chapter provides collections on how family members speak honestly for the patient, ask questions on the patient’s behalf, seek clarification regarding the patient’s cancer care, and attempt to align with the physician. A collection on family members speaking honestly on behalf of the patient is first presented.

FAMILY MEMBER SPEAKING HONESTLY FOR PATIENT

When patients are present in oncology interviews it is common that they will speak honestly on behalf of the patients. This honesty telling includes behaviors such as explaining the patient’s symptoms, reiterating how treatment how is affecting the patient, expressing concerns, and asking questions that the patient will not. The family member often serves the role of the individual that will speak openly when the patient will not, allowing physicians to know more of the truth. This first example portrays a situation where a patient explains that he has been putting off medical work due to his treatment and his daughter chimes in to ask him why in front of the physician.

1) OC6 P2: 14

1   Doctor:   Ya know five months with this- ((Patient starts to cry)) are you
2     oka↓:y?
3   Patient: (0.2) Yeah, just get a bit upset.
4   Doctor:   °Oka:y°
5   Patient: (0.2) Well. It isn’t just this. (0.1) When I came here, in January, (0.2) I
6 was due at that time for a colonoscopy and uh (0.2) what do you call
7 it? (0.1)When it’s your stomach,where they go into your stomach, cuz
8 you know I’ve got Barrett’s Disease.
9   Doctor:   Uh huh, Endo:scopy.
In this instance the physician and patient are discussing the patient’s health issues when the daughter chimes in to ask why her father has been putting off his doctor appointments. It seems as if the daughter realizes that her father is trying to avoid his appointments or is concerned that his chemotherapy will prevent him from being able to do so. In realizing this she makes the effort to bring this issue up when talking with the physician. It appears to be initiated at a strategic time in the conversation as the physician has already heard the symptoms and history of the patient, so he can help elaborate on whether or not it is a good idea to push the appointments back. This could be because the daughter knows more about what is going on in his life and wants the physician to provide clarification for her father’s concerns. An individual’s perception of cancer can determine treatment decisions and the communication surrounding the illness (Jithoo, 2010). Asking the father this question after he explained how he has been feeling allows the physician to provide recommendations for his behavior. The daughter’s question seems to be an attempt to gain the physician’s support by asking the father to be honest with his reasoning. The reaction of the patient seems to be an attempt to seek reassurance from the physician that he is ok to push back his appointments and that he is warranted for doing so. The way in which the patient asks the physician a follow-up question signifies his persistence to confirm his feelings about his health and minimize any concerns he may be experiencing.
The daughter plays an integral role in the sequence of this conversation as her interruption raises concerns about the patient’s behavior while allowing the physician to better understand what is going on in their lives. It seems as if the daughter is aware that her father is avoiding his appointments and wants the doctor to ease some of her father’s possible nerves or fear so he will not have to do so. The way in which the patient says “chemo” illustrates this fear or discomfort, which is then addressed by the physician in return. The daughter’s presence in this interaction allows her to speak on behalf of both herself and her father while providing key insight to the physician about her dad’s health behaviors. She simultaneously represents her own worries about her dad well as acknowledges her dad’s fear about enduring these treatments. The family member being present in the medical encounter serves as a representative for the whole family and acts as the mediator to bring up concerns that the patient may not do so himself.

Similar to this situation in which the daughter asks the patient to be honest in front of the doctor, family members may urge the patients to be honest with the physician when discussing their reaction to treatments:

2) \textbf{OC D9 P6}

Patient: (1.0) So, (0.2) what are we gonna do. Carry on with chemo now till
(0.2) and then, I mean I’ve had a two week (0.2) °rest°. They booked
me up, they’ve already given me appointments starting tomorrow.

Doctor: Uh huh.

\textbf{Daughter:} Those can always be cancelled, I mean it’s not, nothing is absolute.

Patient: ° True°.

\textbf{Daughter:} (0.2) °Think about what° feels good, ya know.

Patient: (2.0) What will I gonna do if-. (0.2) Well it would be a rest for you as
we:ll, (0.4) if I didn’t have to go to for that.

\textbf{Daughter:} Don’t think about that mom, that’s not what we’re talking about. (4.0)
you’re feeling do:wn and you’re feeling tired and you’ve you’ve got to
stop (0.1) denying things like that cuz then you build it up and you get
(0.3) [cranky] and you get worried and you don’t (0.1) express it.

In this instance the daughter’s presence allows her to encourage her mother to speak honestly with the physician and explain her symptoms. The daughter utilizes her knowledge as a family member to actively participate in the oncology interview. It is evident that the first sequences of this conversation illustrate the mother trying to downplay her reaction to the chemotherapy and feeling a sense of unhappiness with having to continue on with her
treatment. The doctor’s “uh huh” shows that he is listening but does not attend to her emotions. In response to this the daughter chimes in to tell her mother that her appointments can be rescheduled, which could have been an attempt for the physician to provide confirmation. When this does not happen the daughter continues to inquire for mother to be honest. This is the most apparent in the final turn of the daughter’s when she tells her mom to “denying things like that cuz then you build it up and you get (0.3) [cranky] and you get worried and you don’t (0.1) express it.” This plea seems to be an attempt to make the real issues that the mother is facing apparent to her physician and provide them both with a chance to actively discuss them together.

The daughter serves as a liaison of information between the patient and physician. As she knows how her mother and how she has been affected by the treatment, she is upfront with the physician when her mother will not be honest and express her true symptoms. The systematic dynamics of communicative encounters at sensitive times like this can influence how cancer patients and their family members adapt to the care (Stajduhar & Davies, 2005). The daughter’s communicative role highlights the importance that family members can have when present in medical encounters. Being present and active within this medical appointment allowed the patient to speak openly as well as provide the physician with more understanding on how the patient felt and reacted to her treatment. The encouragement the daughter initiated facilitated this oncology appointment, which can ultimately impact the entire care of this cancer patient.

In a similar situation, another family member expresses the patient’s side effects to her treatment and then provides additional information that the patient will not share with the physician:

3) OC D9 P6
1 Doctor: WE:ll, I’m gonna leave you on this unti::l, (0.1) ya know either the cancer
2 starts growing or you start having so:me side effe:cts, [tha]t means, cuz ya
3 know if you’re having, you’re having very few side effe:cts, so if we have
4 stab:le to (0.1) slowly shrinking cancer then=
5 Patient: [Oh]. =Yeah.
6 Daughter: (0.1) She seems to have a lot of the um.
7 Doctor: (0.2) Why don’t you have a seat up here.
8 Daughter: (0.1) The um (0.1) what am I trying to say (0.1) um (0.1) Tiredness.
9 Doctor: Uh huh.
10 Patient: Well >yeah but< I don’t know if that’s just coming through a:g:e. ya [kno:w]?
71

11 Doctor: [Uh hu]h.
12 Daughter: Yeah, but last week you were (0.1) so depressed about it, you thought your cancer was so terminal because you were so tired, and I told ya it’s the (0.1) it’s the chemo, and you don’t want to admit you have side effects.
13 Doctor: Let’s have a deep breath. (0.3) Yeah. (6.0) Okay, go ahead and launch the lay down. ((Takes loud out-breath)). (0.4) Any tenderness in the:re?
14 Patient: It felt just a little bit tender there just that first time you touch, not h:urt, [but

This conversation provides an example in which a physician provides his decision for cancer care based on the patient’s expression of a lack of side effects, in which the daughter offers honest information that could impact the care decision. The doctor says that the patient is going to stay on the current treatment as she has few side effects. The daughter responds in disagreement stating symptoms that her mother actually does feel but has not reported to the physician. As soon as the doctor expresses his acknowledgement of this side effect the mother chimes in with a rationale for her tiredness that downplays the treatment’s effect. Expressing that her tiredness can be a cause of aging takes the blame off of the cancer and places it onto something else as a way of minimizing the threat she may feel. When the patient does this the doctor even reconfirms the impact of these side effects to provide the physician with honesty about the treatment’s results. The daughter even states that “it’s the chemo, and you don’t want to admit you have side effects” to display to the physician that her mother is not being honest with the physician. As a caregiver to her mother the patient is aware of the side effects that her mother is facing and wants the physician to know about them. Family members may express different views or wishes that contradict that of patients (Gilbar & Gilbar, 2009). By speaking honestly for the patient the daughter is able to express these family concerns and facilitate the decision treatments that the physician will need to make. Prior to the family member speaking up about the mom’s side effects, the physician believed that the patient was responding positively to the chemotherapy treatment and facing very few symptoms. Her treatment plan was based off of this, which can be concerning and dangerous for the patient. Her daughter’s honestly provided the physician with a more realistic assessment of her side effects, which can alter the course of her treatment and overall cancer care. The need to address children’s concerns is an acknowledged part of caring for ill patients (Lewis, Casey, Brandt, Shands, & Zahlis, 2005; Romer et al., 2007). This illustrates how cancer care needs to more prevalently consider the family members
much more, as uncertainty and fear can keep patients from expressing honesty and allowing physicians to best care for their patients.

As noted in this collection, family members can be significant contributors in oncology interviews. Speaking honestly when the patient will not allows family members to provide necessary information to entire health care teams. Each of these participations in oncology interviews depicts common behavior to support family members during their cancer care. Just as family members will take the initiative to speak honestly on the patient’s behalf, they also will ask questions that the patient may not be willing to do so.

**ASKING QUESTIONS ON THE PATIENT’S BEHALF**

Family members often play an active role in patient’s cancer journeys and with this comes concerns about their cancer care. This insight is then brought into oncology appointments in which family members and patients may have the desire to discuss these concerns with the physician. Due to the uncertainty of treatment and cancer, patients may often feel uncomfortable or fearful of bringing up these concerns. Involving family and providing time for questions sustains hope and impacts patients’ ability to cope with the transitions of cancer (Friedrichsen et al., 2002; Girgis & Sanson-Fisher, 1995). This provides family members with an opportunity or sometimes the task of being the ones who will raise questions on behalf of the patient and entire family. This collection begins with a daughter asking to postpone the patient’s treatment, depicting the impact of the side effects and her concern of her mother’s health to the physician:

4) **OC D9 P6**

1 Patient: But I, I’m pretty su:re that I probably got (Pellups) in my (0.4) colon.
2 Doctor: Um hm.
3 Patient: There’s no bleeding or anything, (0.2) but.
4 Doctor: Okay.
5 Patient: But there, I can’t do anything about that till after Ju- July, so.
6 Doctor: Right.
7 Patient: [I’ll have to che:ck] after that=
8 Daughter: We’ll what do you think about a little break for energy to get up and running after the doctor will start you back again with chemo and then maybe after that (0.1) doctor’s appointment you can schedule another [break after a while ].
9 Patient: [(I’ll have to che:ck)] after that= 
10 Daughter: =Depending on what Doctor Reeve says. (2.0) would that work?
11 Doctor: (0.2) Yea:h. Well we- I wanna do is best for y:ou.
14→ **Daughter:** Ye:ah.
15 **Doctor:** You’ve always been so perky when you come in he:re, and I’ve been 
16 so happy (0.1) because we kept the cancer under contro:l and you, 
17 you’ve had so few si:de effects.
18 **Patient:** I guess, (1.0) I guess I’ve got so worked up over it this time (0.1) ? 
19 hoping it would be an impro:vement ya know.
20 **Doctor:** Uh huh.
21 **Patient:** And to find that I’m just (0.4) sta:ble is a bit of a disappointment.
22→ **Daughter:** Is that pretty much what you’re seeing with this? That you’re just 
23 pretty much just gonna keep it stable, it won’t really (0.2) shrink 
24 much, as it.
25 **Doctor:** Well a lot, sometimes these tumors are are a part of it are scar tissues, 
26 so we don’t necessarily always see them (0.1) even if (0.1) even if we 
27 have a response, we don’t necessarily in this particular ki:nd (0.1) see 
28 them go a↑ wa:y (1.0) °completely°. (0.2) SO=
29 **Patient:** =Yeah, no, I guess I.
30 **Doctor:** So stable is very, is Good.
31 **Patient:** Yeah.

In this conversation a patient’s daughter chimes in to ask if the patient can postpone 
his treatment and even reiterates the possibility of her physician agreeing to give him a break. 
In the beginning of this excerpt the patient shows his vulnerability of his health by explaining 
his symptoms and then immediately after explains that there is nothing he can do about it. 
When the doctor does not acknowledge this fear the daughter steps in to reassure him or calm 
him down. The daughter continues to make recommendations for her father’s health care as 
an attempt to walk him through the process while gaining agreement from the physician. The 
patient then brings up his emotions by expressing his disappointment and before the 
physician can react or respond the daughter chimes in by asking a clarifying question. This 
interruption in their sequence appears to be a way of explicitly asking about the future of the 
health. The family member is able to be more direct with the physician and ultimately ask 
questions that the patient and the entire family is wondering, yet may not have the confidence 
to ask. As they both may be feeling discouraged that the cancer is stable but not improving, 
the daughter is the one who takes the initiative to ask about this. 

This worry that the daughter brings up seems to be a fear that not only she feels but 
also her father and their family. The daughter seems nervous to be asking this question as she 
repeats herself saying “pretty much” twice, illustrating her desire to appear as if she is not 
confident in her lay diagnosis. The use of “pretty much” downplays her understanding or
prognosis of her father’s situation while reiterating the fact that she does need the doctor’s reassurance. The daughter becomes the one in the vulnerable role who will face the embarrassment if she is wrong or needs to be corrected by the physician. Having the family member rather than the patient be the individual who is upfront about the health concerns and mentioning worries about the future places the patient more at ease as well as allows both the patient and physician to receive more accurate information. This instance demonstrates family members’ ability to raise issues that patients may be concerned about but have not mentioned.

Just as patient’s children accompany them to oncology interviews, parents of cancer patients are commonly a part of children’s cancer appointments. Parents may be present in these appointments to raise concerns and ask questions on behalf of the patient and the entire family:

5) **OC D1 P9**

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<td>1</td>
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<td>2→</td>
<td><strong>Dad:</strong></td>
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<td>8→</td>
<td><strong>Dad:</strong></td>
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</table>
| 9 | Doctor:  | I mean [people] without Hotchkiss have nodes that big in their [neck.]
| 10→| **Dad:** | [Yep. ] |
| 11 |   | Yeah. |
| 12 | Doctor:  | So a-they're not to worry about. |
| 12→| **Dad:** | Bu-yeah okay. Good. °Good. ° |
| 13 | Doctor:  | Okay. |
| 14→| **Dad:** | Great. [Alright.] |
| 15 | Doctor:  | [Okay. ] We'll see you Thursday. Take care. Thank you. |
| 16 | Patient: | Thanks.= |
| 17→| **Dad:** | =[Alright. ] |

This conversation depicts a father asking for the physician’s confirmation that everything is going fine in his son’s cancer care. This begins a sequence in which the physician talks the patient and his father through his health and how it should not be something to be worried about. The father setting the stage for this conversation allows the physician to continuously work with the father to minimize the risks that he and the patient may have felt. The dad shows his appreciation for this minimization when he states “Good.
Good.” He seems to be relived about the news and appreciative of the way in which the physician answered his question. He reiterates this again by saying “great” immediately after the physician acknowledges his answer. The exchange in this interaction shows a family member initiating concerns of an entire family in the form of a bid for hope. The impact on the father is evident as “the diagnosis of cancer and the treatment decisions associated with it may cause uncertainty, stress, and anxiety among parents” (Machado da Silva, Jacob, & Nascimento, 2010, p. 250). The way in which the father stepped in to confirm that he hopes everything goes well shows his protection over his son and family. He offers the physician a chance to make them both more hopeful which can be seen in the resulting examples the physician provides. The doctor explains that “those things are nothing” and that people have nodes in their neck so his case is “not to worry about.” Similar to this situation, “whenever possible, doctors also are shown to confirm patients’ ‘no problem’ bids to officially assist in reducing concerns, worries, anxieties, and fears about cancer” (Beach, 2010, p. 5).

The physician actively minimizes the father’s concerns by using examples of others’ cases to compare to. The physician utilizes worse scenarios and offers the patient and his father a sense of hope that his health could be a lot worse. Throughout this situation the family member minimizes the risk his son is at by first asking if everything should be ok, secondly by clarifying “at least in terms of this”, thirdly by being relieved when the physician provides good news, and lastly by reiterating his happiness by stating “Good. Good” followed immediately by “great.” This minimization is returned when the physician first explains that everything is good with the patient, refers to his lymph nodes as “nothing,” compares to other worse cases to show his preferable health situation and finally when he explains that these lymph nodes are “nothing to worry about.” The exchange between the physician and patient’s father is typical of those in medical encounters. In this conversation a concerned father seeks clarification of his son’s health and initiates a bid for hope. This bid was returned by the physician through multiple minimization strategies. As childhood cancer can be emotionally traumatizing for parents (Carrión, 2005; McCubbin, Balling, Possin, Friedich, & Bryne, 2002), this hopeful answer may help reassure the father in dealing with his son’s cancer. The father’s initiation allowed the physician to put the patient’s case into perspective. Together, the father and physician reduce possible fear the entire family may
feel about the patient’s cancer. By asking questions on behalf of the patient, the family member was able to gain answers and hope regarding the son’s health.

In this next situation a daughter’s presence allows her to ask questions regarding her father’s cancer treatment:

6) **OC D9 P1**

1→ **Daughter:** Yeah! $heh$. But the other, the other question is (0.4) and this is really hard to sa:y (1.2) By doing this treatment (0.4) are we going to have any quality of li:fe (0.3) u:m (0.1) is this going to b:e (0.2) something that’s going to drag him do:wn.

2 **Doctor:** M hm.

5→ **Daughter:** (0.1) That he may not wanna do (0.1) or is this gonna be something that’s gonna help him that we can be comfortable for a whi:le.

7 **Doctor:** pt. (0.1) Well that’s why we (0.1) picked this specific (0.1) treatment, I mean I think that after our discussions last ti:me it was pretty clear that your quality of life was “the” important thing we’re gonna try to treat you with a (0.1) uh a very active agent but one that has relatively few side effects.

13→ **Daughter:** Okay.

14 **Doctor:** And my ho:pe is that you’ll actually get better.

15→ **Daughter:** Oh good, okay.

16 **Doctor:** Um, usually people don’t get particularly sick with this. You don’t get a lot of nausea or vomiting pt. (0.1) um (0.1) it suppresses your immune system up ?some (0.1) >put you at some risk of infection<, but generally it’s milder than most chemotherapies.

20→ **Daughter:** °Okay°.

21 **Doctor:** And so I would say that many people get better (0.1) pt. u:h (0.1) feel better on it than off of it. (1.0) uh and all we have to do it tr: ↓y and find out.

24→ **Daughter:** Okay

This portion of this interview depicts the daughter of a patient taking the initiative to ask tough questions about her father’s health on behalf of the entire family. This difficulty is first apparent when the daughter frames her question by saying “and the other question is, and this is really hard to say.” Immediately after the doctor responds with an acknowledgment token “m hm,” leading the daughter to add on details of how her father may feel about this. This extended turn illustrates a bid for hope from the doctor to reassure both the daughter and the patient about the side effects of this treatment. The physician attends this bid and actively attempts to reassure the patient and his daughter that the result they have is the same goal he has in mind. The doctor then explicitly demonstrates hope by stating “my ho:pe is that you’ll actually get better.” This comment appears to be a way of fostering
encouragement to the family while touching on concerns that they both brought to the appointment. The daughter’s satisfaction with this comment is evident as she responds by saying “oh good, okay.” The doctor’s third turn then minimizes possible fear by utilizing typical health responses to this treatment and comparing to other patients. The physician even uses the terms “milder” than “most” chemotherapies” as a way of comparing it to other possible options. Again, the daughter is the one actively discussing this issue with the physician while her father is silent. The dynamic of this interaction is seen as the physician responds to her question by attending to her bids for hope numerous times: first by minimizing the side effects that result from this treatment, then explaining that he hopes that the patient will get better, comparing the treatment to more severe treatments to minimize its risk and finally clarifying that most people get better and see positive results of this treatment.

This interaction depicts the role of family members when initiating conversations of concern. The daughter expressed her concerns that both her father and she had as a way of asking for the physician’s opinion. Her bid for hope and reassurance was attended elaborately as the physician extended each of his turns to do so. The length and detail of his answers illustrates his willingness to provide the information this family needed. The daughter seemed to work as a liaison for the family, particularly her father as the patient, to gain the reassurance that they needed to move forward with this cancer treatment.

Family members’ presence in oncology appointments provides them with the opportunity to not only speak on behalf of the patient, but also to ask questions that the entire family wants the answers to. These questions can help ease concerns, minimize fear and provide hope for patients and their family member’s to manage the cancer. It is common to have these questions as cancer is such a complex illness. These questions often lead to family members seeking clarification about the patient’s treatment during oncology interviews.

**FAMILY MEMBERS SEEKING CLARIFICATION**

As family members commonly become responsible for caring for the cancer patient, providing support, and offering hope, they may seek clarification during oncology appointments. This can be evident in the form of asking questions or raising issues that they are unsure of. Family members become crucial in these conversations as their requests for
clarification gain insight for the patient as well as provide a look into the lives of the patient for the physician. This collection begins with an instance in which a patient’s daughter asks about side effects of his treatment:

7) **OC7 D6 P6**

1 Doctor: All right, so we just have to=
2 Patient: =What about the ((cough cough)) (0.2) tumor in th:e esophagus.
3 Doctor: Uh huh.
4 Patient: (0.2) Um.
5→ **Daughter:** Is the caus[ing the problem that the food isn’t going down] to
6 there? Is that what the problem is?
7 Patient:  [How much is that involved in the whole thing ]?
8 Doctor: (0.3) Yea:h.
9→ **Daughter:** Okay, I have, (0.1) I had some questions to ask.
10 Doctor: Okay.
11→ **Daughter:** Um (0.2) I wanted to (0.1) to uh find out about is there something
12 he could take for an upset stomach? Because his stomach is upset
13 >quite a bit<.
14 Doctor: Uh huh.
15→ **Daughter:** Also (0.1) he has a cough which is (0.1) I don’t know
16 and=
17 Doctor: =Okay let’s take ‘em one at a time [Okay ].
18→ **Daughter:** So your stomach is it upset all the time? Does it feel like acid reflex, is
19 it a burning sensation?
20 Patient: U:h yes, °it’s° more of the acid reflex.
21 Doctor: Okay.
22→ **Daughter:** It’s just, I noticed he has a cough, he coughs some during the
23 °night°. And I pt. (0.1) I wanted to write down everything so that I
24 could remember.
25 Patient: $Hehe$=
26→ **Daughter:** =And and one the next thing is that it takes him so long to digest the
27 food.
28 Doctor: Um hm.
29→ **Daughter:** Is the a reason- is it because of this growth that he’s got up here, or
30 wherever it [is]?
31 Doctor: [It ] probably is. He has a partial blockage there and
32 is uh (0.2) and you digest by- and by that you mean it’s hard for him
33 to pass it down through=
34→ **Daughter:** =Yes. He he has a lump here (0.3) in his uh (1.0) stomach.
35 Doctor: Uh huh.

In this instance the patient initiates a concern he has and his daughter then continues to ask clarifying questions of the physician in regards to this issue. After each of the physician’s responses the daughter immediately asks follow up questions to seek as much
information as possible. It appears as if her father raised the concern but she knows that he
will not ask for all of these supporting details. These action sequences illustrate the daughter
gaining information on the issue at hand for her entire family’s benefit but then also serves as
an information source to facilitate the process for the physician. The daughter repeatedly
discloses details about her father, which are met by clarifying statements by her dad. After
she explains the uncomfortable lump in his throat the patient chimes in saying that “I don’t
know exactly wh]ere it is” as a way of downplaying the severity of the issues the daughter
raised. The daughter actively speaks for her father and disseminates information for the
father that she thinks is important for the physician to know. Doing so causes the father to
interrupt and downplay these symptoms and by providing disclaimers for his daughter’s
statements. It seems that the daughter is present in this interaction to acquire information to
take back to the family on the state of her father’s health, but also as a way to ensure that her
father offers the most accurate information to help the physician manage his cancer. The
daughter even makes reference to her notes, stating that she wrote down all of the concerns
she wanted to bring up with the physician. This reporting signifies the role of family
members outside of cancer appointments and how this involvement can impact oncology
interviews.

Similarly, the daughter in this interview then asks questions regarding her father’s
next treatment steps:

8) OC6 P2: 14

1→ Daughter: (0.1) And the oth\er thing is (0.2) with (0.2) with the (0.2) with these
treatments, these are gonna to be, what are these treatments gonna
b\:e
4 Doctor: Doctor Reeve?
5 Doctor: We[:ll ].
6→ Daughter: [Wh]at are they gonna do?
7 Doctor: U:m, we are gonna give him a chemotherapy medicine, it’s going
to be a weekly injection into th:e-
8 Patient: (0.3) [nto the] vein. Into the tumor into the ve:in.
9 Daughter: [°Vein°].
10 Doctor: Not into the tumor, no. It’ll go into the vein an’ so it’ll go
everywhere. Concern is that this cancer has spread into your liver. (0.3
A:nd=
13 Patient: =And that’s where the jaundice [is coming back in].
14 Doctor: [And that’s where ] the jaundice is
15 coming from. (0.2) And so uh we need to shrink down as much of that
cancer as we can to help you feel a little bit better.

In the second portion of this conversation the daughter explicitly asks for facts on her father’s treatment. By being the individual who asks this question that could elicit a worrisome response, the daughter opens up communication between the physician and patient. The doctor is then able to mention a concern he has, which can ultimately be a concern their family feels as well. The patient is then able to display his epistemological knowledge stating what is going on with the treatment. This is met with additional details from the physician, which depicts a hopeful response. The physician states that “we need to shrink down as much of that cancer as we can to help you feel a little bit better.” First by mentioning “we” illustrates the team process of this cancer treatment and how he plans to pair with the patient to attempt to get him healthier. Secondly, he expresses a desire to get the patient to “feel a little bit better” demonstrating his desire to see a positive yet realistic outcome for the patient. The physician was able to provide these hopeful reassurances as a result of the daughter asking questions about his health care.

The daughter’s initiation of this question enables the father and physician to discuss a concern at hand all while eliciting a hopeful view for the future. The interaction within this conversation reiterates the role that family members can fill while being present in medical situations. Being in an oncology appointment can already be a fearful experience, so having the daughter a present and active part of the conversation enhances the possibility of talking through these concerns.

Just as this patient’s daughter asks questions for clarification, the next patient’s wife chimes in to receive answers about her husband’s situation:

9) **OC6 P1: 17**

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<td>1</td>
<td><strong>Doctor:</strong></td>
<td>Ok I’ve I have asked him they said you know we could potentially follow exactly the same protocol (for for patients who ) and once we finish with that depending on the response. That we would constantly compare your treatment with a (mini) with a (mina)transplant of your sister as the donor we would say ok we have achieved some kind of response here. We are gonna keep it active and and effective so long as we keep=</td>
</tr>
<tr>
<td>2</td>
<td><strong>Wife:</strong></td>
<td>=What about if the sister is not a donor at all. Do we have other people to go t::o? I mean we have a very very big sphere of=</td>
</tr>
<tr>
<td>3</td>
<td><strong>Doctor:</strong></td>
<td>=This is a the the data base search. And a= ((cough))</td>
</tr>
<tr>
<td>4</td>
<td><strong>Doctor:</strong></td>
<td>=the only problem I see with that we need to do it we will do it but but the only problem I see with that is a risk of [ (trying) i:::s]</td>
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In this instance, the physician explains the patient’s treatment by using his sister as a donor when his wife asks about the possibility of this not working. This question appears to be an attempt to clarify what the other options are in case the physician’s idea does not work. Asking this question immediately after the physician’s advice seems to demonstrate a fear of this option not working and a desire to be prepared for this scenario. The wife may be expressing concerns that her husband and entire family has, as it is very possible that his sister cannot be a donor. Her active participation in the conversation allows her to seek clarification for the entire family as to what there other options are for his treatment. In response, the physician discusses the risks and how he could be affected if this was to happen. This question-answer sequence provides the patient and his wife with more insight on his health and allows the physician to discuss additional information relevant to his health treatment process. Ultimately, the patient’s wife gains answers on her question while receiving more input about risks in the future.

Just as the wife seeks clarification about treatment of her husband, patient’s children may also ask questions to be educated about the cancer and minimizing concerns of the entire family. In this excerpt previously explained, this patient’s daughter’s questions seek clarification on her father’s upcoming treatment:

10) OC D9 P6
1 Patient: (1.0) But there, I can’t do anything about that till after Ju- July, so.
2 Doctor: Right.
3 Daughter: (3.0) We’ll what do you think about a little break for energy to get up
4 and running after the doctor will start you back again with chemo and
5 then maybe after that (0.1) doctor’s appointment you can schedule
6 another [break after a while ].
7 Patient: [(I’ll have to check) ] after that=
8 Daughter: =Depending on what Doctor Reeve says. (2.0) would that work?
9 Doctor: (0.2) Yeah. Well we- I wanna do is best for you.
10 Daughter: Yeah.
11 Doctor: You’ve always been so perky when you come in here, and I’ve been
12 so happy (0.1) because we kept the cancer under contro! and you,
13 you’ve had so few side effects.
14 Patient: I guess, (1.0) I guess I’ve got so worked up over it this time (0.1)
?hoping it would be an impro:vement ya know.
Doctor: Uh huh.
Patient: And to find that I’m just (0.4) sta:ble is a bit of a disappointment.
Daughter: Is that pretty much what you’re seeing with this? That you’re just pretty much just gonna keep it stable, it won’t really (0.2) shrink much, as it.
Doctor: Well a lot, sometimes these tumors are are a part of it are scar tissues, so we don’t necessarily always see them (0.1) even if (0.1) even if we have a response, we don’t’ necessarily in this particular ki:nd (0.1) see them go a↑wa:y (1.0) °completely°. (0.2) SO=
Patient: =Yeah, no, I guess I.
Doctor: So stable is very, is Good.

This instance mirrors the previous conversation in which the daughter takes control of the conversation and leads the physician and patient through the interaction. After the patient explains his treatment schedule, the daughter asks about the possibility of treatment being postponed. Her offering of a solution seems to be done to convince the physician as well as her father. After the father agrees the daughter even then seeks confirmation from the physician. The physician responds positively and then takes an additional turn to reassure the patient of his side effects. Again, the physician expresses his “hope for an improvement” in his body’s response to treatment. The daughter engages in two key activities in seeking clarification: first she asks if the patient would be ok to take a break from the chemotherapy, and second she asks the physician of the state of her father’s health and what may possibly happen in the future. These questions allow the physician to expand on possible outcomes that they could expect and reiterate that this stability is a good thing. As interpersonal struggles are normal when patients cope with the disruptive nature of cancer (Beach, 2009), family members may raise these concerns to help patients manage these disruptions. The daughter’s involvement demonstrates how family members’ participation in oncology interviews can answer questions and minimize concerns of both the family member and the patient being cared for. The daughter communicates on behalf of both her father and herself as a way of gaining the answers they seek. While her father seems to simply talk around delicate topics the daughter will speak up and directly ask for the information she wants. It seems that having her present is a strategic decision so that this family can better understand and manage the treatment the father is facing.
Just as patients ask questions about treatment or future scenarios, they also interrupt conversations to seek clarification on medical terms or aspects of the patient’s treatment. In this scenario, a patient’s husband asks a question about a concern they wanted to bring up with the physician for clarification:

11) OC D2 P10
1 Doctor: Ok let’s look at this rash. So it’s on the sides there.
2 Husband: Didn’t we want to also talk about seeing the (.) because we don’t – she does have the (.) the hi – the port in now. That’s the one –
3 Patient: (Hickman)
4 Husband: The Hickman. Is that the one that’s buried (.) in your chest?
6 Doctor: Yeah.
7 Husband: The Hickman’s in there. We wanna make sure, they kinda had to thread around it to put this line into her carotid.
9 Doctor: Ok well let’s talk about that in just one second.
10 Husband: Yeah.
11 Doctor: Uh so where did you – where do you think the rash is? This one?
12 This this [this here]?

This interaction depicts the end of an opening medical encounter to move to the medical examination when the husband brings up a concern that they wanted to discuss. The patient provides the name of the term her husband is looking for and the husband again seeks clarification about where this is on the patient. Once the patient acknowledges this the husband again responds to explain that they want the physician to ensure that it is in properly. The physician agrees that they will do this shortly and moves onto the next portion of the medical exam. This instance demonstrates a family member actively bringing up topics of concern to make sure that they receive the information that they are seeking. The husband also mentions twice that it is “we” who wants to talk about something to make sure of her care, reiterating that it is a concern of both of them that needs to be attended to. As patients typically bring their family members with them to discuss concerns or fears, it is apparent that they may be the ones who initiate these questions or concerns to receive the information they are both looking for.

Just as this patient’s husband seeks clarification through his questions, family members may provide clarification of the patient’s answers to physician questions. This instance illustrates a family member contributing on to a patient’s answer about family history.
FAMILY MEMBERS SUPPORTING DETAILS OF PATIENT ANSWERS

When physicians ask patients questions regarding their health, it is typical that family members will chime in to support these answers or offer additional information regarding the answer. These contributions provide physicians with additional insight regarding the issue as well as display support for patients’ explanations of their health. In this first instance, a wife helps her husband locate information that he is searching for to give to the physician:

12) OC 6:9
1   DOC:  Well, um (0.4) any other (. ) past medical history that ah- any operations in
2       the past, other than the [ ( . ) ]
3   PAT:  Just a hernia. Uh.
4       About- Hernia operation about-
5    WIFE:  God, I don’t know, Kiel was (1.1) Kiel was (. ) six or ↑seven.
6   DOC:  So maybe (. ) ten- fifteen years ago.
7    WIFE:  Yeah= 
8   DOC:  =Mm hm.

In this instance the physician takes the family medical history of the patient in which the patient’s wife chimes in to provide details about this family member. The husband initially answers the question but the wife provides support and clarifies in more detail for the physician. This illustrates a family member taking an extended turn to elaborate on the patient’s response. In this station it seems that the wife’s presence serves as a way to support her husband and his answers. The patient seemed to be searching for the answer he was looking for and the wife’s presence allowed her to help provide that answer to the physician. Together they were able to offer the physician the information he needed while working collaboratively to explain their family health history.

Similarly, the patient’s husband in this next excerpt provides insight on his wife’s explanation of her symptoms:

13) OC D2P10
1   Doctor:  So you think you’re getting some new lesions on your flank. Anything else?
2   Patient:  Um (. ) well uh – or my feet too.
3   Doctor:  Ok.
4   Patient:  But in my ankles –
5    Husband:  It could have been, those could have been um like flea bites. We went over to my [father’s house] and they have a cat.
6   Doctor:  [ I see. ]
7   Patient:  But on my stomach.
Husband: It wasn’t on your stomach. I don’t know if they look the same on your stomach.
Doctor: Well we’ll look at them. I mean, you had – previously you had the rashes on the neck right?
Patient: Well I had a rash all over.
Doctor: And this is not the same rash?
Patient: No.
Husband: It’s not the same.
Doctor: So we’ll just keep an eye on it right now because – well we’ll talk about it in a second. But I think (to be honest) if it’s obviously GBH you’re not going to bring any more treatment for it.

In this conversation the husband’s presence allows him to provide clarifying information in regards to his wife’s symptoms. After the patient discusses new symptoms on different parts of her body the husband interrupts to justify a possible cause of these spots. This interruption appears to be a minimization of the threat of these lesions that the wife mentions. After the physician states his understanding and the patient explains more symptom locations the husband continues to provide details that downplay these lesions.

After each of the patient’s responses the husband offers his input before the doctor has a chance to respond. It appears that the husband realizes the threat of these new lesions present and his contributions to the conversation depict attempts to minimize the threat of them. The husband uses his knowledge of his wife’s health and symptoms to contribute to this conversation by supporting his wife’s answer. Offering additional input can help reassure the physician of the patient’s health risk as family members are often aware of the symptoms and everyday effects that patients may not express and physicians do not typically get to witness.

Similar to this situation, family members may answer on behalf of patients and then follow up with additional questions. In this next instance, a patient’s wife not only asks questions of clarification but also provides answers for the physician regarding the patient’s care:

14) OC D4 P6
1 Doctor: So this is telling me that even though we didn’t have a direct measure of how much or how little we were having at some point there’s an effect?
3 Wife: Right.
4 Doctor: And this is good. Cause we wanted to see if there was an effect from the chemotherapy. All the good cells that are these ones are always that we hope that=
7 Patient: =The major [benefit happening]
8 Doctor: [the major benefit] happening actually the major benefit
happened on the bad ones?

Wife: How do we tell that that what [was]

Doctor: [uhm] actually the numbers. The protein the
protein the is the bio:lo:gical marker. The protein is the marker that is telling
us how go:od we are do:ing. That protein stays for months. So the changes we
expect to see are not going to ha:ppe:n=

Wife: =Today?=

Doctor: = tomorrow.

Patient: It’s going to be long term.=

Doctor: So for now I would like to keep you on this double combination of of (a
freezes) chemo. I wo:uld like for jumping into the next level of treatments to
give a you ma:ybe once I was waiting for this recovery so you have recovered
I would like to give you maybe a:nother week of u::hm vacation from from
treatment and is ok with you I would like to repeat that u:hm the (two CDA)
and the (retox) is for one whole cycle.

Patient: Mm hm.

Doctor: Uhm

Wife: Four weeks (after tests).

Doctor: U::hm Yeah when with o:ne co:ntinuous we:ek of of the two CDA.

((continues))

In this instance, the physician is reviewing the treatment effects with the patient and
his wife, which is very common of medical appointments. The doctor first asks a question
about the patient’s care, in which the wife answers and confirms his statement. Throughout
the conversation the wife continuously probes the doctor and asks additional follow up
questions. She asks about the treatment planned, the care process, and the timeline for the
care. The wife acts as the representative of her entire family, seeking information on how this
treatment will affect her husband and exactly what this will entail. The wife is not present to
simply offer moral support for her husband, but also to get her own questions answered. Her
dominance in this conversation illustrates the impact that family members have over cancer
care and how active the wife wants to be during this process.

In each of these oncology interviews present family members participate in
conversations to seek clarification about the patient’s cancer. Whether they ask questions or
provide additional information to the physician, these family members facilitate the
understanding of the cancer. These contributions ensure that all parties gain the most
information or background on issues for effective care. These clarifications often lead to
family members making efforts to align their questions and concerns with the physician in
order to better manage their coping of the cancer.
ATTEMPTS TO ALIGN WITH PHYSICIAN

As family members seek to provide support for cancer patients throughout their treatment they may attempt to align with the caring physicians. This can be completed by asking questions that show their efforts for the patient, mentioning practices that they encourage for the patient, or seeking confirmation that their role will help the patient. Aligning with the physician may enable patients to understand that the family member is in fact doing the right thing and rely on their family member to help them through their cancer care. This first instance represents a family member seeking confirmation from the doctor that her advice to her father is warranted:

15) **OC D9 P1**

1 Doctor: Okay. (0.2) But you will need to keep, try to keep down some fluid
2 (now) I recommend people to try to drink about pt. (0.1) u:m to put
3 two to three quarts of fluid in the refrigerator at the beginning of the
4 day and to try to make sure you get that do:ne by pt. (0.1) late in
5 [the aftern ]o:o:-.
6 Patient: [QUArts$]$!
7 Daughter: Yes:ah. (0.1) If you ca:n.

8→ **Daughter**: Se:e, I’ve been trying to tell- and he kee:ps=
9 Doctor: =Keep, keep your hydration up a little bit.

10→ **Daughter**: He keeps giving me a bad time about tha:t. An’ I keep telling you, ya
11 gotta drink wa:ter.
12 Patient: “Water does” the same thing, just fill up real quick so I’ll just have to
13 take (0.1) have to take tak[e little amo:unts].
14 Doctor: [Take, take a litt ]le Squirt bottle with ya and
15 drink it throughout the da:y.
16→ **Daughter**: Oka:y. (1.0) I’m glad you said it.
17→ **In-law**: (1.0) (It’s been) years and now you say that.

In this situation the daughter enters the conversation to utilize the doctor’s expertise to prove her recommendations for her father’s care. It seems that she has reiterated these same suggestions but her father does not behave the way she suggests. Interrupting the conversation enables the daughter to reiterate to her dad that she is right in her advice as well as prove to the doctor that she had made efforts to do so. While she may not have been aware of this, the daughter simultaneously illustrates the support she provides her father while asking the physician to utilize his credibility to reinforce her efforts. The daughter then continues by explaining that she keeps trying to tell him this same thing but that he gives her a hard time. The use of the word “see” before this statement symbolizes a cry for attention so
that both the physician and the patient know are aware of the effort that she is putting into her father’s treatment. In a sense, it seems to be an indication of the struggle that the patient faces during cancer. She not only is dealing with her father being diagnosed with a serious illness, but also the fact that her father will not comply with her when she tries to help. In this situation, the physician responds very casually, utilizing informal language when he could have utilized his expertise and medical jargon to support the daughter’s contributions. He does this by using terms such as “little” to downplay the bottle and then using the slang term “ya” instead of you. Regardless of the way the physician said this information, he did support what the daughter was suggesting and she immediately responded by mentioning that she was glad he said it.

After the doctor aligns with the concern the daughter brought up the patient’s in-law states “(It’s been) years and now you say that” reiterating that the physician’s recommendations are ones that the patient will follow. The reference to ten years makes it evident that if the advice was something that was coming from the physician that patient would be more likely to act on it. This illustrates the value in the family member asking about this concern so that her recommendations for her father’s care will be the same as those provided by the physician.

The sequence of this conversation resembles that of the family member bidding for hope or support from the physician, the patient making excuses for behavior followed by reiteration for physician support from the family member, the physician encouraging this suggestion and finally the family members being thankful for the physician’s support. The collaboration between the physician and family member reiterates the communication struggles that families face. While family members attempt to care for the cancer patient, their communication is not always effective. This positions the presence of family members in oncology appointments to be of high value.

In this next scenario, a patient’s daughter tries to make a joke in response to the physician’s statement to reiterate that they are on the same page as him:

16) **OC D9 P6**
1 Doctor: You’re going to be able to see your internist right?. (0.3) A::nd um, 2 you know when you see your internist, (0.1) colonoscopy (0.1) ya 3 know is not something that difficult to d:o. (0.2) °I mean° and we can 4 get those (0.1) °a::nd° we can get those we can get those done, and it’s
patient and physician are discussing his health when the physician
minimizes the fear of the cancer. He states that “it’s not it’s not like we
think you have colon cancer so it’s not, it’s not a
Major worry at this point.” This unique situation depicts an
instance in which the physician is the one to downplay the risk that the
patient faces. Immediately after the physician states “it’s not a
Major worry at this point” the patient responds that he hopes not. This
sequence reiterates the concept of statements of fear being
followed by bids of hope. The doctor again mentions that “We don’t
need to worry about things that we don’t know about where we have
something that we already- (0.2) need to worry about.” It seems that the
patient initiates a concern and in response the daughter even
chimes in to support this issue. The daughter asks the question to ensure
that she understands what he is referring to. The doctor responds by
explicitly reducing the risk of this cancer and telling them both to not
worry about it currently. The daughter’s question
provides her with a chance to better understand the comment of the physician while allowing him to reduce the worry they should feel about this issue. Aligning with his thoughts on the cancer care allows the physician to provide advice on how to better manage the patient’s care. This present daughter’s participation illustrates the role that family members can play within oncology interviews.

This small collection demonstrates the power of aligning with physician’s efforts during oncology interviews. Patients and family members may better understand health care professionals’ suggestions, treatment explanations and concerns for the patient’s health as a result of doing so. Being “on the same page” as physicians minimize the uncertainty of cancer conversations as well as reducing fear of possible results of the cancer. These contributions can enhance cancer care for all parties.

**CO-PRESENT FAMILY MEMBERS’ CONTRIBUTIONS TO ONCOLOGY INTERVIEWS**

Present family members offer countless contributions to oncology interviews. Family members are able to participate in conversations, which can facilitate the dissemination of patient concerns as well as help answer physicians’ questions regarding the patient’s health. Speaking honestly for patients, asking questions on the patient’s behalf, seeking clarification, supporting details of patients’ answers and attempting to align with physicians are just some of the activities co-present family members engage in during oncology appointments. Focusing on the role that family members play within medical settings such as this can enhance the study of family illness communication, and more importantly how families both talk through and manage cancer. Table 2 cumulates these activities.

Each of these collections provides insight on the social actions that are completed when family members are present in oncology interviews. These instances are now organized by social action to demonstrate patterns that exist when family members participate in oncology in discussions with patients and their physicians.

Across these moments, the most prominent social action was family members raising concerns to physicians. The instances that portrayed family members raising concerns were overwhelming in comparison to other social actions identified. Being present in these interactions allows patients to bring up concerns that they, the patient, and the entire family
Table 2. Co-Present Family Members’ Contributions to Oncology Interviews

<table>
<thead>
<tr>
<th>Collection</th>
<th>Utterances</th>
<th>Key Social Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asking Questions on the Patient’s</td>
<td>“Yeah. Everything looks okay to you?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Behalf</td>
<td>“=At least in terms of this.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Asking Questions on the Patient’s</td>
<td>“So a-their're not to worry about.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Behalf</td>
<td>“Yeah! Sheh$. But the other, the other question is (0.4) and this is really hard</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td></td>
<td>to say (1.2) By doing this treatment (0.4) are we going to have any quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>of life um (0.1) is this going to be (0.2) something that’s going to drag him down.”</td>
<td></td>
</tr>
<tr>
<td>Asking Questions on the Patient’s</td>
<td>“That he may not wanna do (0.1) or is this gonna be something that’s (0.2) gonna help him that we can be comfortable for a while.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Behalf</td>
<td>“Is this causing the problem that the food isn’t going down? Is that what the problem is?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Family Members Seeking</td>
<td>“Okay, I have, (0.1) I had some questions to ask.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Clarification</td>
<td>“Um (0.2) I wanted to (0.1) to uh find out about is there something he could take for an upset stomach? Because his stomach is upset quite a bit.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Family Members Seeking</td>
<td>“Uhm (0.1) also he has a cough now (0.2) which is (0.1) I don’t know and=”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Clarification</td>
<td>“=And and one the next thing is that it takes him so long to digest the food.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Family Members Seeking</td>
<td>“Is the area of which is this growth that he’s got up here, or wherever it is?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Clarification</td>
<td>“=Yes. He he has a lump here (0.3) in his uh (1.0) stomach.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Family Members Seeking</td>
<td>“(0.1) And the other thing is (0.2) with (0.2) with the (0.2) with these treatments, these are gonna to be, what are these treatments gonna be? Doctor Reeve?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Clarification</td>
<td>“[What] are they gonna do?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Family Members Seeking</td>
<td>“=What about if the sister is not a donor at all. Do we have other people to go to? I mean we have a very very big sphere of=”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td>Clarification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table 2. (continued)</td>
<td></td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td><strong>Family Members Seeking Clarification</strong></td>
<td>“Didn’t we want to also talk about seeing the (.) because we don’t – she does have the (.) the hi – the port in now. That’s the one – “</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Family Members Seeking Clarification</strong></td>
<td>“The Hickman. Is that the one that’s buried (.) in your chest?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Family Members Seeking Clarification</strong></td>
<td>“The Hickman’s in there. We wanna make sure, they kinda had to thread around it to put this line into her carotid.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Family Members Supporting Details of Patient Answers</strong></td>
<td>“How do we tell that what [was]”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Family Members Supporting Details of Patient Answers</strong></td>
<td>“=Today?=”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Family Members Supporting Details of Patient Answers</strong></td>
<td>“And what is that for?”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Attempts to Align with Physician</strong></td>
<td>“See, I’ve been trying to tell and he keeps=”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Attempts to Align with Physician</strong></td>
<td>“He keeps giving me a bad time about that. An’ I keep telling you, ya gotta drink water.”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Asking Questions on the Patient’s Behalf</strong></td>
<td>“Well what do you think about a little break for energy to get up and running after the doctor will start you back again with chemo and then maybe after that (0.1) doctor’s appointment you can schedule another [break after a while].”</td>
<td>Raising concerns to physician</td>
</tr>
<tr>
<td><strong>Asking Questions on the Patient’s Behalf</strong></td>
<td>“Is that pretty much what you’re seeing with this? That you’re just pretty much just gonna keep it stable, it won’t really (0.2) shrink much, as it.”</td>
<td>Raising concerns to patient/physician</td>
</tr>
<tr>
<td><strong>Family Member Speaking Honestly for Patient</strong></td>
<td>“She seems to have a lot of the um.”</td>
<td>Raising concerns to physician</td>
</tr>
</tbody>
</table>

**TOTAL** | 28 instances |
| **Family Members Supporting Details of Patient Answers** | “God, I don’t know, Kiel was (1.1) Kiel was (.). six or seven.” | Contributing to Patients’ Answers |
| **Family Members Supporting Details of Patient Answers** | “It could have been, those could have been um like flea bites. We went over to my [father’s house] and they have a cat.” | Contributing to Patients’ Answers |
| **Family Members Supporting Details of Patient Answers** | “It wasn’t on your stomach. I don’t know if they look the same on your stomach.” | Contributing to Patients’ Answers |
| **Family Members Supporting Details of Patient Answers** | “It’s not the same.” | Contributing to Patients’ Answers |

**TOTAL** | 4 instances |

(table continues)
feel. In each of these instances a family member takes the initiative to raise concerns on behalf of both of them, as a way of getting answers from the physician. As patients often face these appointments with fear and uncertainty, family members may attend to ensure that questions are answered and concerns such as these are attended to. As patients may not have the confidence or desire to raise these concerns, the family member serves as a resource to do so. In a sense, the concern being initiated from the family member removes some of the vulnerability a patient may feel if he or she was to ask the physician. This is just one way for family members to support cancer patients, just as family members contribute to patients’ information provided to physicians.

<table>
<thead>
<tr>
<th>Table 2. (continued)</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempts to Align with Physician</td>
<td>“Oka:y. (1.0) I’m glad you said it.”</td>
<td>Seeking reassurance from physician</td>
</tr>
<tr>
<td>Asking Questions on the Patient’s Behalf</td>
<td>“=Depending on what Doctor Reeve says. (2.0) would that work?”</td>
<td>Seeking reassurance from patient/physician</td>
</tr>
<tr>
<td>Attempts to Align with Physician</td>
<td>“There’s something you don’t k[now about, $hehe$?”</td>
<td>Seeking reassurance from physician</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3 instances</td>
<td></td>
</tr>
<tr>
<td>Family Member Speaking Honestly for Patient</td>
<td>“) So why, why are you putting it off? I thought you had an appointment with the doctor for Janu- July=”</td>
<td>Confronting patient in front of physician</td>
</tr>
<tr>
<td>Family Member Speaking Honestly for Patient</td>
<td>“Don’t think about that mom, that’s not what we’re talking about. (4.0) you’re feeling do:wn and you’re feeling tired and you’ve got to stop (0.1) denying things like that cuz then you build it up and you get (0.3) [cranky] and you get worried and you don’t (0.1) express it.”</td>
<td>Confronting patient in front of physician</td>
</tr>
<tr>
<td>Family Member Speaking Honestly for Patient</td>
<td>“Those can always be cancelled, I mean it’s not, nothing is absolute. And so you need to.”</td>
<td>Confronting patient in front of physician</td>
</tr>
<tr>
<td>Family Member Speaking Honestly for Patient</td>
<td>“Think about what” feels good, ya know.”</td>
<td>Confronting patient in front of physician</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2 instances</td>
<td></td>
</tr>
<tr>
<td>Family Member Speaking Honestly for Patient</td>
<td>“The um (0.1) what am I trying to say (0.1) um (0.1) Tiredness.”</td>
<td>Portraying honest depiction of patient symptoms</td>
</tr>
<tr>
<td>Family Member Speaking Honestly for Patient</td>
<td>“Yeah, but last week you were (0.1) so depressed about it, you thought your cancer was so terminal because you were so tired, and I told ya it’s the (0.1) it’s the chemo, and you don’t want to admit you have side effects.”</td>
<td>Portraying honest depiction of patient symptoms</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2 instances</td>
<td></td>
</tr>
</tbody>
</table>
The next section of moments displays the tendency for family members to chime in and support patients’ answers to physicians’ questions. Whether it is providing additional facts or just confirming their original answers, family members try to support the information that the patient provides to the physician. These contributions help make the case that the patient is trying to convey to the physician (e.g. minimizing their symptoms or clarifying information about treatment side effects). These contributions show family members actively supporting the patient while portraying the role that family members play in discussions with patients and physicians.

Additional instances illustrate patients’ contributions serving as attempts to gain reassurance from physicians in regards to the patient’s cancer. Patients ask questions, align with physicians and chime into conversations to gain reassurance on issues. These are often questions that the entire family wants answered, but the patient may not feel comfortable asking him or herself.

Similarly, family members may use their knowledge of the patient to confront them in front of the physician or provide honest information that contradicts to patients’ answers. Family members typically see, experience and know more about what the patient endures during their cancer journeys. This privileged knowledge allows them to provide insight in oncology appointments that can facilitate both the physician’s understanding of the patient’s impact of cancer as well as the treatment the physician provides. This also enables family members to provide information to the physician that the patient may not typically elicit.

The organization of these moments demonstrates some of the fundamental actions family members commit when present in oncology interviews. These moments overwhelmingly illustrate that family members’ presence facilitates the initiation of concerns. These concerns not only depict how family members feel, but also express issues or questions that patients will not ask themselves. The prevalence of these concerns magnifies the dual benefit of having family member attend oncology appointments: supporting patients in attempts to manage conversations and attaining information for themselves. While family members often attend these appointments to provide moral support for the patient, they actually can act on the opportunity to ease their own fears, get their questions answered and raise concerns of their own. This overlap provides support for the argument to study how family members are present or presented in oncology interviews.
CHAPTER 4
DISCUSSION OF RESEARCH FINDINGS AND IMPLICATIONS

As this project has demonstrated, family members play a large role in cancer care. Whether present or not, these individuals contribute to the way the cancer is discussed in oncology interviews. Terminal illnesses such as cancer often depend on the involvement of family members as they are the individuals who typically provide care to the patient (Gilbar & Gilbar, 2009). As it is often members of the patient’s family, rather than clinicians, who provide family support during cancer (Hubbard, Illingworth, Rowa-Dewar, Forbat & Kearney, 2010), their presence becomes necessary within oncology interviews. Family members’ support continues into medical settings, in which the doctor and patient need to acknowledge the family’s views and concerns (Gilbar & Gilbar, 2009). As cancer often impacts a patient’s entire family, working in partnership with health care professionals can provide a better understanding of treatment decision making and the role of cancer within (Hubbard et al., 2010). Incorporating family members into cancer conversations allows both patients and physicians to better envision the fuller picture of cancer care. As communication is considered effective if it results in positive outcomes for one or more participants, such as patients, family members, and health care professionals (Eggly et al., 2009), each of these data analysis chapters demonstrate the benefits for each participating party. This chapter reviews the findings of each chapter of data analysis, offers implications of this research, provides limitations on this work, future research possibilities, and concludes with a discussion of these implications.

CHAPTER 2: REFERENCES TO FAMILY MEMBERS DURING ONCOLOGY INTERVIEWS

As family members are also greatly impacted by a patient being diagnosed, they are commonly referenced within oncology interviews. Whether the patient or physician makes the initial mention of family members, the discussion of these individuals contributes to the
patient’s oncology interactions and the provided health care. Analysis of references to family members demonstrates how patients invoke family members’ health or raise delicate issues pertaining to their family to illustrate the impact their cancer has on the entire family. These social actions portray the fears and concerns that patients and their families face every day, which do not disappear when they enter oncology appointments. Referencing family members and their health provides patients with the opportunity to then discuss concerns they have or raise issues that they may not have originally mentioned. Discussing these family aspects enables patients to gain reassurance of their feelings as well as provides physicians with insight into their dealing of cancer.

Patients make references to family members to discuss both positive and negative family health history, family members’ behaviors contributing to their cancer, and the impact of family health. Mentioning these issues allows patients to then discuss concerns they have for their own care or for their family, raise questions pertaining to this impact, gain reassurance about their treatment and cancer, reduce uncertainty, and minimize the threat they feel towards their own health. Completing these social actions facilitates how entire families manage cancer and how patients and physicians can work together to better communicate about the family’s role in their cancer journey. This spans as family members actively participate in oncology interactions.

CHAPTER 3: CO-PRESENT FAMILY MEMBERS’ CONTRIBUTIONS TO ONCOLOGY INTERVIEWS

Family members attend oncology appointments to accomplish much more than simply providing moral support for the cancer patient. They raise questions, provide additional information, and seek clarification in regards to the patient’s care. These actions result in the need for patients to provide honest insight to physicians as well as physicians to take a deeper look at the impact of the cancer, treatment and overall experience on the patient. This allows family members to serve as a liaison between both parties to ensure that the patient receives the best care possible. Through communication, family members can enhance oncology interviews and impact the way care is provided to cancer patients. Studies have shown that patients desire as much information as possible from their physicians to cope with the abundance of uncertainty and anxiety (Roter, 2000). These collections illustrate
how family members can help to ensure that the information desired is received. Patient satisfaction and well-being are correlated to the communication of cancer, including having patients’ questions and concerns answered during their consultations (Butow, Dunn, Tattersall, & Jones, 1995; Uitterhoeve, Bensing, Dilven, Donders, & deMulder, 2009). Attempts to acquire this information may include having family members initiate these issues into conversation to be further attended and discussed.

It is typical for patients to enter oncology appointments with concerns to be raised, questions to ask, and issues to be discussed. At the same time, physicians have medical agendas as they have many topics they must cover in a short amount of time. This medical dialogue creates a battle in which the patient’s problems are anchored in a biomedical or disease context (Mishler, 1984). In result, it is easy and for patients to adopt a passive role in oncology interviews (Roter, 2000), resulting in unanswered questions and continued uncertainty. As this struggle exists within all types of medical appointments, a common behavior is to bring family members to help ensure that topics of concern are discussed. As the patient-physician relationship should be facilitative in eliciting patients’ full spectrum of concerns and appointment agenda (Roter, 2000), having family members present or mentioned can be a way of doing so. The presence of family members reiterates that during cancer care there are issues that patients and their family wish to be addressed to better cope with the illness. This indicates the value of having family members actively participate in oncology interviews as both physicians and patients are at an advantage.

The analyses of co-present family members’ contributions during oncology interviews demonstrate the facilitation of patient-physician communication. While patients may have concerns or issues they wish to talk about with their physician, they are not always completed during oncology appointments. If a family member is present they can help remind the patient of these concerns or even be the ones to raise them to the physician directly. At the same time, patients may be fearful of bringing up negative symptoms, side effects of their treatment or family history of cancer due to the consequences they could inhibit. Patients may fear having to endure additional care, more severe treatment, or simply hearing that they are at an increased risk based on the information they provided. Having family members present can help to ensure that these issues are addressed and that the most accurate information is provided to physicians. This facilitation of communication illustrates
the benefit of welcoming family members into oncology interviews. Their participation also allows them to support answers of patients so that health care plans can be better created by health care professionals. Another common theme within oncology appointments is for patients to downplay their health, symptoms or side effects. While this may seem like a way of protecting themselves, it can cause worsened effects for patients’ health in the long run. Patients may omit information, embellish the truth, or even withhold facts from their physicians. The presence and participation of family members in oncology interviews reduces the possibility of this as they can be the ones who speak up. Family members witness and often face the same struggles that cancer patient’s experience, allowing them to realize the importance of proper health care. This starts with effective and honest communication from the patient, which can be facilitated by the help of family members. Analyzing these instances magnifies family members’ role within cancer care and provides justification for the participation within oncology interviews.

EXAMINING REFERENCES AND PRESENT FAMILY MEMBER CONTRIBUTIONS AS A WHOLE

While these two data chapters provide different exemplars of family members’ involvement in oncology interviews, they illustrate similar actions and outcomes. A prominent theme in the moments in both chapters is the expression of concerns about the impact of cancer on family members. Patients and their family members raise concerns to discuss about family history, past family members’ health experiences, and fears about future family members’ health with physicians. These references indicate the support system that families provide both inside and outside of medical settings. Making reference to family members illustrates that concerns exist for the entire family, just as family members raising concerns depict issues that also arise based on patient fears.

Similarly, the conversations in both chapters demonstrate how minimization of cancer risk occurs with or without family members present. When family members are simply mentioned, patients use family history to downplay risk, whereas present family members can contribute information that reduces threat of the patient’s health. These activities depict both family members’ and patients’ need to minimize their health issues to provide reassurance for themselves as well as the physicians. While these efforts may ease fears in
the patients and family members, it can also harm the care provided to them or their health in the future. If physicians are told that patients do not have serious family history of cancer, that severe symptoms are not present, or that they are not seeing negative results to treatment, their health could worsen as a result. This minimization may serve as a barrier as communication on behalf of both patients and family members impacts the treatment plans that physicians create. Ultimately, activities such as discussing concerns and minimizing health risks contribute to the management of cancer, illustrating the significance of family communicating and being communicated.

While similar activities occur in these two chapters, differences are still present that illustrate the variance in family members actually being present or simply mentioned in oncology interviews. Findings from analysis of references to family members reiterate the differentiation between other family members’ health much more than comments from present family members. When family members are not co-present, patients often discuss them as a way to compare their health and make a stronger case for their own health. In comparison, present family members have the option of teaming up to support the patient’s answers in interviews as well as confronting them to show disagreement. This ability to accomplish both activities set these two stations apart and magnifies the significance of having family members attend oncology interviews. The activities and communication completed by patients and physicians are altered when family members are present, providing patients with the task of speaking more openly and sharing greater depth of information with their physicians.

As both of these chapters examine the way in which family members are incorporated into oncology interviews, these findings reiterate the need to expand family cancer communication research into the clinic. Patients often bring their family members to cancer appointments as a way of overcoming their fear of their disease as well as verbalizing that they have concerns about their condition (Beach et al., 2005). The support of family members allows patients to raise these concerns and address the fears that they are facing. Utilizing conversation analysis to examine the way family members are referenced when talking to physicians as well as the manner in which family members join conversations portrays the manner cancer impacts their everyday discussions. The specific ways individuals organize and shape their interactions demonstrate the consequentiality of communication
The way patients and physicians discuss family and the responses to these references illustrates important social actions of cancer care such as raising concerns, discussing fears, and invoking family history. These interactions that mention or include family members provide implications for family cancer communication research.

**Implications of Findings**

The study of how family members are mentioned as well as the contributions family members make during oncology interviews can enhance the study of family cancer communication and cancer care. As this project supports the extensive research on cancer being a family illness, the family of cancer patients should more consistently be a part of oncology settings as well. So often analysis of cancer patients and family members occurs outside of clinics and medical settings, and the findings of this research demonstrate the essentiality to examine family within cancer interviews. Doing so can illustrate the way family members provide care to patients, offer social support, and participate in these cancer journeys. Beach (2009) asserts that a cancer journey is not just a journey that a patient takes, but rather a journey of the entire family. This provides a fuller grasp on the role family members play within cancer care.

References to family members as well as present family members’ contributions in oncology settings can enhance both patient advocacy and family advocacy within cancer care. As patients seek to express their concerns, fears, hopes and desires, family members can provide them with an outlet to do so. Family members may make the initial mention of these concerns and provide physicians and patients with the opportunity to further discuss these issues. As family members are typically aware of the way patients feel or the issues they hold regarding to their cancer, they can utilize their role as a caregiver or support system to make them evident in front of a physician. Ultimately, family members are influential within oncology interviews and this topic should receive greater scholarly attention. Their presence and contributions impact the way cancer is discussed, concerns are raised, and feelings of fear and uncertainty are managed. The individuals that make up a cancer patient’s journey work to facilitate their care and ultimately support them each step of their cancer process.
This research magnifies not only the benefit for patients to have family members present, but also the positive effects that family members can gain. Studies have shown that caregivers often face great barriers in communicating with their loved ones about their illness and its impacts (Kilpatrick, Kristjanson, Tataryn, & Fraser, 1998). These difficulties in communication can be overcome by having family members present in oncology settings and raise these issues while a physician is present. Family members seek to acquire information about the cancer even if patients do not wish to talk about it. These may be questions about the treatment, clarification about the family risk, or even reassurance about their own health in relation to the patient’s cancer. As both behavioral and genetic risk factors can impact family members, this risk information can have implications for the entire family (Burke, 2006; Mitchell et al., 2003). As efforts to collect and disseminate family health history requires family members’ cooperation (Koehly at al., 2009), being present in oncology interviews is beneficial for patients, family members, and the physicians treating them.

While cancer may be difficult to discuss, some family members may decide to avoid the topic all together. Caregivers and patients often engage in mutual buffering or avoidance of talking about fears or concerns as a way of protecting each other (Vess, Moreland, Schwebel, & Knaut, 1988). If family members and patients are present during delivery of cancer news, these topics become less avoidable. The presence of family within oncology settings can enhance the care process for not just the patient. Studies have reiterated that the communication of genetic test results to other family members can be distressing (d’Agincourt-Canning, 2006; Kenen et al., 2006), resulting in a desire for additional support or resources to help them do so (Forrest et al., 2003; Liede et al., 2000; Segal et al., 2004). As patients have explained that the responsibility to communicate results of genetic testing as a burden (Croster & Dickerson, 2010), having family members present in these appointments provides a solution to doing so. As sharing these results can affect family members as well as the patient being tested (Mackenzie et al., 2009), family members become just as important in oncology appointments. This research reiterates that just as physicians and patients benefit from family members being present in oncology interviews, these family members also can benefit from participating in these appointments.
Implications for Advancing Public Health

The findings from this analysis provide insight of value for not only the study of family cancer communication, but also for related issues in the study of public health. More specifically, these findings can serve as an educational resource for improving patient-physician communication, help foster effective behavioral changes within families and provide guidance on the interaction with family members during medical interviews.

A possible incorporation of these findings into the field of public health is to better understand the way patients and family members interact in regards to behavioral change. These collections of family member references and family contributions illustrate the benefit of talking about family history, the impact of family health, and addressing concerns about the patient’s health. As family members facilitate patient’s honesty, explanation of health, dissemination of information, and communication approach with physicians, this behavioral change can be of value within public health studies. If family members can enhance the communication of these cancer appointments, their involvement may also be applied to other fields of health care to inspire behavioral change of patients. These findings can serve as a framework to better understand the role of family inside medical interviews and provide education as to how to improve the interactions among family members, patients and physicians.

An additional use of these findings is as an educational tool to improve communication between patients and health care professionals. Public health efforts seek to educate individuals about their health choices, views and actions. These efforts can be expanded into the education of health care professionals so that both physicians and nurses could better recognize the experience of including family members more prevalently in medical appointments. If the importance of this involvement could be stressed more to health care professionals, better care could be provided for patients’ within any type of care. Physicians, patients and their family members could utilize these insights to enhance more effective and open communication. Family members offer their opinions, ask questions, and provide accurate information during oncology interviews. These contributions impact treatment decisions and care processes for cancer patients. As family members speak openly and ask questions that patients will not, physicians can gain insight that improves cancer care. Family members’ involvement can help inspire changes in the way health care
professionals deal with and support both their patients and their family members. So often it is the case that physicians do not take concerns of family members into consideration and simply continue with their medical agendas. This type of research that focuses on bringing the family members of cancer patients into clinics can be used as a resource to make the case to better train doctors and nurses to properly engage in effective communication with both patients and their family members.

This research provides potential for family members to play a larger role in health interventions. Being able to educate physicians on the everyday effects of the illness/cancer at hand while supporting cancer patients’ needs can facilitate the perceptions and behaviors of patients. These findings magnify the behavior change that can occur when family members help patients face health issues. As they spend great amounts of time caring for and supporting patients, family members hold the ability to partner with medical professionals to provide these interventions for patients. Family members’ involvement within oncology settings can demonstrate to health care what kind of interventions can be made and what type of education can be available for medical professionals to better facilitate family cancer communication.

**Limitations of Current Study**

While this study examined two aspects of family cancer communication, multiple limitations are still present. The study of nonverbal communication such as gestures, gaze, body positioning and vocalics could greatly facilitate the interaction between physicians, patients and their family members. Being able to study patients’, physicians’ and family members’ embodied actions could greatly contribute to the study of family cancer care. As a finding of this research project was the reoccurring theme for family members to answer questions that physicians direct to patients, the lack of analysis on the frequency of this behavior and the social actions that are accomplished should be recognized. As family members answer questions intended for patients, nonverbal aspects such as gaze and eye contact would be beneficial to investigate as well.

In addition, this study could benefit from incorporating further analysis on the medical professional’s perspective of interacting with patients and their family members within oncology appointments. Including this insight could impact the way in which family
members’ presence or references are perceived by health care professionals. While family members and patients typically benefit from being co-present in interviews, time is taken from the physician in completing his agenda. A closer look at the way family members guide interviews off track, create controversy or negatively impact the dissemination of information could be beneficial to the field of family cancer communication.

This research project analyzed 44 instances in which family members were referenced or participated in cancer conversations. While this small collection of moments provided great initial insight on the role of family members play in oncology interviews, this study can be developed even further. A larger sample size would contribute to the knowledge of family references as well as family member contributions. As time constraints only allowed for this amount of moments, an expanded study should look at a greater number of collections to ensure higher validity in results.

An additional limitation to this research is the lack of analysis on physicians directly asking questions to family members as opposed to patients. As family members play important roles when present in these interviews, exemplars of physicians and patients directing questions to family members or providing instances for their contribution could enhance the arguments being made in this project. As these collections only provide family members chiming in to raise issues or supporting patients’ answers, it neglects instances where they are explicitly asked to provide insight. These limitations provide opportunities to conduct future research, utilizing the findings of this project as framework.

Finally, this research does not take into consideration the ethnicity or demographic information of participating physicians, patients or family members. As materials were utilized from previous grant research, the convenience of the sample omits ethnicity diversity. Including a more diverse sample could enhance the credibility of these findings as well as generalize to a greater span of individuals. Incorporating participants of different ethnicities should be an asset of future studies to better learn about how demographics such as ethnicity can impact the way physicians, patients and their family members communicate about cancer.
Directions for Future Research

The findings of this research indicate the need to continue further research on the way family members contribute to oncology interviews. As previously mentioned, a future study should focus on the embodied actions of patients, physicians and family members when making references to family members. This should include aspects of eye contact, gaze, vocalics and positioning of individuals when questions regarding family are asked as well as when these individuals respond to or initiate topics about their family. Future research should take into consideration how patients and their family members react to news delivered from the medical professional. For instance, the way in which a physician explains stability in the patient’s cancer as a good sign can be compared to the manner in which patients and family members express dissatisfaction that the individual is not getting better. This analysis could focus around the role family members play in the news delivery and how these concerns are raised. A larger, longitudinal study should examine the way families talk through cancer both inside and outside of oncology appointments. These conversations could be compared and contrasted to better understand how patients and their family members discuss the cancer at home, and how these discussions are manifested into oncology interviews. It would be of value to study whether issues were raised, questions were clarified and if emotions that are displayed at home are cultivated into these appointments with health care professionals.

Much more research should be completed on the role that family members complete during cancer care. As cancer affects entire families, studies should provide a complete view of patients’ life and depict the interactions both outside and inside medical appointments. Studying the involvement of family members in both settings can facilitate the care that physicians provide to patients and their family members as well as the social actions that they all achieve while interacting in oncology interviews. In order to better understand the role of family members, a longer study should examine when and why family members join cancer appointments. This study should look for commonalities in this participation. For instance, do family members attend every appointment from diagnosis to final treatments or do they simply start joining after bad news regarding the health? Do family members feel more obligated to attend these appointments when a patient’s health takes a turn for the worse? With these questions in mind, it would be beneficial to analyze the process of inviting family members to cancer care appointments. This would consist of analyzing the way patients feel
about doing so, reasoning for wanting patients to be present at some appointments but not others, and the process of talking to family members about their desires to have them present. Research should also focus on the health care professionals’ role in inviting family members and whether or not this is something that either physicians or nurses encourage. This can then be examined even further to understand how family members feel about being present in these oncology interviews and what roles they feel they must serve when doing so.

Additional research can focus on the role of family members in not only cancer interviews, but also in genetic counseling meetings. This should examine the contributions that family members make when discussing the risk of genetics, the impact of receiving news, and how this news is shared with family members who will also be at risk.

**Final Thoughts on Family Members’ Involvement in Oncology Interviews**

This research illustrates the need for health care professionals to be better equipped to support and interact with patients and their family members within medical settings. Having particular knowledge of the needs of cancer patients and their family members would better prepare staff to address these needs (Daughtery, 2010). If patients and their family can partner with their health care team, the entire cancer process can be a less threatening experience. Oncology staff are often the individuals who provide care for patients that are trying to cope with their diagnosis and the effects of cancer treatment (Kruijver, Kerkstra, Bensing, & van de Wiel, 2000), making their roles even more important. Allowing family members and patients to discuss concerns with individuals from their health care team impacts the overall cancer management. Opportunities, such as having family members present within oncology appointments, exist to better meet the needs of patients and their family members through communication (Daughtery, 2010). Research recognizes the necessity for physicians and caregivers to facilitate the enhancement and improvement of communication between patients and their family members (Epstein & Street, 2007; Glimeus et al., 1995; Lewis, et al., 1997, Skorupka & Bohnet, 1982). This acknowledgement supports the findings of this research and stresses the importance of improving the way physicians and patients integrate their family members into their cancer interviews.
As a family illness, cancer impacts the way individuals in families communicate and function (Sales, Schultz, & Biegel, 1992; Blanchard, Ruckdeschel, & Albrecht, 1996). Cancer is something that is threatening, difficult and omnipresent. Patients are not the only ones who are uncertain and fearful about cancer, as family members are greatly impacted when a patient is diagnosed. Families typically do not know how to interact with or understand individuals coping with cancer, illustrating the significance of studying how family members participate in oncology interviews together. Examining how patients and physicians make reference to family members illustrates the impact that these individuals have on their cancer care and magnifies the collective process of health care. Studying family cancer communication from oncology settings presents an opportunity to better understand how practices of family involvement can be implemented in health care routines and processes.
REFERENCES


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APPENDIX

TRANSCRIPTION SYMBOLS
The transcription notation system employed for data excerpts are modified from Beach (2009) who adapted them from Gail Jefferson's work. The symbols are summarized in Table 3.

**Table 3. Transcription Notation**

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Name</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>:</td>
<td>Colon(s)</td>
<td>Extended or stretched sound, syllable, or word</td>
</tr>
<tr>
<td>*</td>
<td>Okay</td>
<td>Vocalic emphasis</td>
</tr>
<tr>
<td>(</td>
<td>Micropause</td>
<td>Brief pause of less than (0.2)</td>
</tr>
<tr>
<td>(1.2)</td>
<td>Timed Pause</td>
<td>Intervals occurring within and between same or different speaker's utterance</td>
</tr>
<tr>
<td>(( ))</td>
<td>Double Parentheses</td>
<td>Scenic details</td>
</tr>
<tr>
<td>( )</td>
<td>Single Parentheses</td>
<td>Transcriptionist doubt</td>
</tr>
<tr>
<td>.</td>
<td>Period</td>
<td>Falling vocal pitch</td>
</tr>
<tr>
<td>?</td>
<td>Question Marks</td>
<td>Rising vocal pitch</td>
</tr>
<tr>
<td>↑ ↓</td>
<td>Arrows</td>
<td>Pitch resets; marked rising and falling shifts in intonation.</td>
</tr>
<tr>
<td>° °</td>
<td>Degree Signs</td>
<td>A passage of talk noticeably softer than surrounding talk</td>
</tr>
<tr>
<td>=</td>
<td>Equal Signs</td>
<td>Latching of contiguous utterances, with no interval or overlap</td>
</tr>
<tr>
<td>[ ]</td>
<td>Brackets</td>
<td>Speech overlap</td>
</tr>
<tr>
<td>[[]</td>
<td>Double Brackets</td>
<td>Simultaneous speech orientations to prior turn</td>
</tr>
<tr>
<td>!</td>
<td>Exclamation Points</td>
<td>Animated speech tone</td>
</tr>
<tr>
<td>-</td>
<td>Hyphens</td>
<td>Halting, abrupt cut off of sound or word</td>
</tr>
<tr>
<td>&gt; &lt;</td>
<td>Less Than, Greater</td>
<td>Portions of an utterance delivered at a pace noticeably quicker than surrounding talk</td>
</tr>
<tr>
<td>OKAY</td>
<td>CAPS</td>
<td>Extreme loudness compared with surrounding talk</td>
</tr>
<tr>
<td>hhh .hhh</td>
<td>H’s</td>
<td>Audible outbreaths, possibly laughter. The more h’s, the longer the aspiration. Aspirations with periods indicate audible inbreaths (e.g., .hhh). H’s within (e.g., ye(hh)s) parentheses mark within-speech aspirations, possible laughter.</td>
</tr>
<tr>
<td>pt</td>
<td>Lip Smack</td>
<td>Often preceding an inbreath</td>
</tr>
<tr>
<td>hah</td>
<td>Laugh Syllable</td>
<td>Relative closed or open position of laughter</td>
</tr>
<tr>
<td>heh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hoh</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$</td>
<td>Smile Voice</td>
<td>Laughing/chuckling voice while talking</td>
</tr>
</tbody>
</table>