

Review Article

Delivering bad news in emergency care medicine

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Forecasting is a strategy for delivering bad news and is compared to two other strategies, stalling and being blunt. Forecasting provides some warning that bad news is forthcoming without keeping the recipient in a state of indefinite suspense (stalling) or conveying the news abruptly (being blunt). Forecasting appears to be more effective than stalling or being blunt in helping a recipient to “realize” the bad news because it involves the deliverer and recipient in a particular social relation. The deliverer of bad news initiates the telling by giving an advance indication of the bad news to come; this allows the recipient to calculate the news in advance of its final presentation, when the deliverer confirms what the recipient has been led to anticipate. Thus, realization of bad news emerges from intimate collaboration, whereas stalling and being blunt require recipients to apprehend the news in a social vacuum. Exacerbating disruption to recipients’ everyday world, stalling and being blunt increase the probability of misapprehension (denying, blaming, taking the situation as a joke, etc.) and thereby inhibit rather than facilitate realization. Particular attention is paid to the “perspective display sequence”, a particular forecasting strategy that enables both confirming the recipient’s perspective and using that perspective to affirm the clinical news. An example from acute or emergency medicine is examined at the close of the paper.

Key words: Bad news, communication, conversation analysis, emergency care, interaction

In my studies of delivering diagnostic news in medical and other settings, I found that, compared with the strategies of “stalling” and “being blunt”, *forecasting* bad tidings appears more effective in procuring a patient’s or family member’s *realization* or subjective recognition of the news. This is because, as I will show, forecasting implicates a particular social relation between deliverer and recipient. This social relation is evident in a specific practice for delivering bad news that I have called the “perspective display sequence”, which will be illustrated at the end of this paper.

BAD NEWS AND REALIZATION

BAD NEWS REPRESENTS a severe disruption in the life-world of those who are its recipients. When the news is delivered, they must move from their previous taken-for-granted world into a new one. This movement from one to another world is captured in the remarks of a physician who was diagnosed with a cancer in his right leg (synovial sarcoma). Appearing in a documentary video called “When Doctors Get Cancer,” he is shown walking on crutches into a hospital with a baseball cap covering his bald

head. While sitting on a bed undergoing chemotherapy, the doctor is now a patient, and in a voiceover, he says, “Back in October, a year ago, I was given 6 months to live. So here I am today, a year later, with a new world, a continuum of my last one but essentially a new world.” That bad news can usher one into a “new world” is vividly captured not only in this statement but in the video picture of the doctor now in patient garb and in the patient role.

In this paper, I compare the forecasting of bad news with both stalling and bluntness, as other forms of delivering the news, for their effects on realization. In emergency medicine, it could be perceived or argued that the main drawback to forecasting is the time it takes to do. It could be argued that bluntness is more efficient because it streamlines the delivery, and stalling is also sometimes necessary because the physician needs to avoid the interval it would take to explain something that recipients will learn in due course. I will show both how and why forecasting works well to bring about realization, and suggest that the amount of time invested in forecasting can be relatively trivial.

STALLING AND ITS EFFECTS

STALLING OCCURS WHEN physicians have bad news to tell, and avoid doing so. This regularly entails incorrect inferences on the part of recipients in a number of ways. For example, *euphemism* or the use of understatement as a

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way of stalling can lead a recipient to believe something less extreme than the actual state of affairs. Here is a report from a wife whose husband died of cancer of the tongue:¹

I knew he was losing weight rapidly so I felt I knew there was something the matter. I was not told anything. *The doctor said it was trapped wind and I believed him.* I wish someone had told me what was wrong. No one gave me any help. They seemed to skip over things and never tell me anything. (Emphasis added.)

Also, in the face of stalling, a potential recipient who senses something amiss is bound to make guesses.²

The doctor came in and said ‘Her cheekbones are high and her eyes...it could be her German ancestry.’ You know he hemmed and hawed. *I thought she was blind or something.* He finally said it was Down’s Syndrome.

Stalling can exacerbate “normalization”, which is the tendency for denial.^{3,4} Using medical jargon is one kind of stalling that encourages such a mechanism. A group of researchers in England reported on an exchange between a doctor and his patient (Pt), an older man with lung cancer.⁵

Dr: As you may remember when we first started this chemotherapy we told you that we would check your blood and X-rays before each cycle. I have looked at your tests today and there are signs that things are progressing so we do not think that you should have any more chemotherapy.

Pt: Oh so what happens now then?

Dr: Well we just want you to come and see us if you develop any further problems with the breathing and we’ll treat those symptoms.

Pt: Right then, well thank you very much doctor.

One of the researchers interviewed the patient immediately after the consultation. He remembered what the doctor said in this way:⁵

Pt: Well it’s good news really... the doctor thinks things are progressing so I don’t need any more chemo and to just come back if my breathing starts up again... getting breathless you know.

In English, the word “progressing” can have opposite meanings in different contexts. In excerpt 3, the doctor’s use of “progressing” is suggesting that the cancer is growing and getting worse, whereas in excerpt 4, the patient understood him to be saying that the cancer is getting better. “Progress”, in fact, can suggest improvement.

Self-blame

In the emergency room, when there has an unexpected death, Von Bloch⁴ (1996:94) has suggested that recipients have a tendency to engage in “if only” statements whereby they blame themselves for having done something (giving the car keys to a teenage son) or not having done something (staying home with depressed spouse instead of going shopping). However, there is another kind of self-blame that occurs in the context of stalling. When parents of developmentally disabled children suspect that something is wrong and yet can get no news from professionals, they may develop “pathological reactions, such as blaming the baby’s delayed development on their own inadequacies as parents”.⁶ For example, after months of sensing that something was wrong with her child, and being told nothing by professionals other than that the baby was not “up to other babies her age,” a mother went with the child to a specialist:⁷

She took one look at her and said ‘Turner’s syndrome. You do have a defective child.’ I was relieved. Because from that first day in the nursery I knew I had trouble. And all of that time I had accused myself, blamed myself, whipped myself. I was up all night and all day. I knew that a child who got what he needed would be contented, would be peaceful, would be happy... And I thought what am I doing wrong? Where am I failing? I tried harder and harder and harder until I ended up in the hospital.

If it is not possible for potential recipients to realize some state of affairs when deliverers withhold telling what they know, the situation may breed “excessive self-blame and guilt”.⁴

BEING BLUNT AND ITS EFFECTS

IT MIGHT SEEM that straightforward telling of bad news, as opposed to withholding, would automatically facilitate realization. According to Glaser and Strauss,⁸ bluntness may “sharpen” the disclosure and force “direct confrontation of the truth”, as when “... one doctor walks into the patient’s room, faces him, says, ‘It’s malignant’, and walks out.” However, this dropping of bad news upon a recipient with little or no forewarning is also a regular source of complaint:⁹

I was coming out of anesthesia [for a biopsy] and I had had a very, very bad cold...I had a hard time breathing coming out of anesthesia, so they called respiratory therapy, and I was being given all this stuff. And then I had theophylline injects just to get me breathing again. Then

the surgeon comes in and said, ‘Oh, by the way, it’s positive.’ And of course I’m dying again, you know.

Another example is provided by Seale:¹

It was awful. We’d gone in to see her, my daughters and me and the wife had first gone along the corridor to go to the toilet. . . and a nurse came out of the office and just said “You know your wife is dying don’t you, and the doctor wants to see you tomorrow” and she went off. We were completely shattered. We had to hide in the corridor as my wife came back and went into her ward. We couldn’t let her see us. We were in tears. Then I went to see the doctor the next morning and told him how the nurse had told us.

In the following example, a wife recollects what happened after her husband collapsed at home, and she called 911. After arriving at the home, emergency technicians used a defibrillator, tried to resuscitate the husband, and took him to the emergency room.¹⁰

At the Emergency Room, the driver directed me inside the lobby to complete papers while they took Daniel in on a gurney. After filling out the necessary forms, the receptionist said to wait there as the ER doctor would be right out. I stood in the middle of the room, surrounded by curtained cubicles, considering the kinds of changes we would have to make to the house during Daniel’s recovery. The doctor came out from one of the cubicles, looked around, saw me standing there, and came over. . . . He did not invite me to sit down. The first words I registered were, ‘Well, he’s dead.’ I remember shaking my head in disbelief and saying something like, ‘Wait. Wait. What do you mean?’, to which he responded with something like ‘Yes, the man in there is dead. Aren’t you Mrs. Mason?’ I think I remember continuing to shake my head, in silence this time, trying to grasp this information, and finally the doctor walked away.

Notice how, in each of these accounts, the bluntness of the delivery occasions some kind of disorientation on the part of the recipient: the feeling of “dying”, being “shattered”, and disbelieving.

Bluntness also results in recipients feeling angry toward the physician. Consider this account of a man learning that he had Alzheimer’s disease:¹¹

Five months after my 57th birthday, my wife, Joyce, and I sat before a neurologist. A nervous limbo had preceded the visit: a brain scan showed evidence of disease. The doctor started speaking without preface or explanation. ‘Mr. DeBaggio, you have Alzheimer’s,’ he said with the bluntness of a hammer. He offered no details of the tests

or of their results. I gasped, as much at his hurried diagnosis, as at the death sentence his words implied. I held back tears and bit angry words with silence.

Although the patient may appear stoic, hurrying the diagnostic news can activate an underlying fury.

A further effect of bluntness goes back at least to the practice among ancient Persian generals of killing messengers who brought bad news.¹² Physicians are well aware of the problem and design their death announcements to make a case for the disease process, rather than their own activities, as having killed a patient.^{13,14} Conversely, being blunt leaves the physician at risk of being faulted, and decreases the probability of realization when a recipient’s effort at eradicating the message takes the form of condemning its transmitter. A physician recalls the experience:¹⁵

A patient of mine underwent castration for prostate cancer. I don’t recall the details of my discussion but I informed him of his diagnosis and palliative nature of surgery. He died a number of months later. Sometime later the wife of the deceased yelled at me for giving him his diagnosis and prognosis and said he never got over this information and went down hill because of me.

As alternatives to forecasting bad news, both stalling and bluntness are comparatively weak in terms of facilitating realization of the news on the part of patients or family members. We now turn to a consideration of practices for forecasting bad news and how these practices enhance realization.

FORECASTING BAD NEWS: BEST PRACTICE

MY RESEARCH SUGGESTS that forecasting bad news, rather than delivering news either by way of stalling or by being blunt, is the most effective way of eliciting realization on the part of recipients. Dictionary definitions of forecasting suggest two meanings: (i) “to serve as an advance indication” of something to come, (ii) to “estimate or calculate in advance”. By and large, those who must give bad news forecast in the first sense. That is, they prepare their recipients for the coming news by giving an indication of what it is. Compared with stalling and being blunt, forecasting allows recipients to forecast the news in the second sense—to estimate and predict what the news will be, such that when the news arrives, it does so in a *prepared social psychological environment*. Thus, while forecasting is a deliverer’s strategy for conveying bad news, it ultimately facilitates realization by involving the recipient in a relational structure of anticipation and understanding.

Non-vocal forecasting strategies

Forecasting can be done at some temporal and spatial remove from the actual telling. For instance, when a person has died at the hospital, professionals may call family members at home, tell them that there is a “serious problem”.^{13,14} At less of a remove, when loved ones are already on the scene, news givers may isolate recipients,¹⁴ as when nurses take family members to the hospital chapel or a physician takes them “somewhere where it is private and discrete”.¹³ Glaser and Strauss’s⁸ term “disclosure space” is an apt one for participants’ arranging of their physical environment.

Of course, forecasting involves behavioral cues—features of a teller’s non-vocal comportment—more than spatial management. Sudnow¹⁴ noticed that surgeons entering a waiting room with bad news to deliver provide a show of solemnity. This contrasts with those who have good news to deliver and who therefore walk rapidly and smile at their recipients. In anticipating news, recipients are anxious and intent observers of the setting, and are so regarded by tellers. This is because recipients focus on the demeanor of tellers. A hospital chaplain has said:¹³

They’re reading your face, and there’s no way you’re going to go out with a smile on your face. They can tell by your face. They’ll read your face and they’ll say, ‘Oh, my God, he’s dead’ or something like that.

This “reading” of a knowledgeable person’s physiognomy can create discomfort for those who indeed are aware of the news but who may not be in a position to tell it. Nurses sometimes wish the attending physician to bring the bad news to a family member, and must stonewall recipients until the physician arrives.^{8,16}

In a variety of non-vocal ways, deliverers can forecast the bad news to come. It pays for physicians to be aware of this matter so that they can be intentional about it rather than unintentionally conveying information that is better said than shown. Then, the presenter’s non-verbal cues can be coupled with vocalizations of one kind or another.

Vocal forecasting strategies

Preannouncements

These are devices by which an announcer can discover whether a recipient already knows the news. That is, pre-announcements act as precursors to some news and yet withhold it; following a recipient’s subsequent request—a “go-ahead” signal that completes a pre-announcement sequence—the news will be announced.¹⁷ While pre-announcements can be minimal and provide few clues as to the nature of the news (e.g., “Have you heard?”), some

pre-announcements clearly do foreshadow that the news is “awful”, “bad”, “sad”, or “terrible”.¹⁸

Two weeks ago, she thought she had a case of the flu. Her husband persuaded her to see a doctor. That evening, the doctor called. “It’s bad,” he said.

← **Pre-announcement**
← **Go-ahead**
← **Announcement**

A chilling pause. “You have acute myelogenous leukemia—you have to go to the hospital tonight.”

In this example, the patient allows for the delivery of the news by being silent—a kind of resistive stance. Despite the rapidity with which the news arrives after the brief pre-announcement, it nonetheless does so in a prepared social psychological environment that can facilitate realization.

Prefaces

A variation of the pre-announcement is a device that seems to preclude a proposed recipient’s “go-ahead” utterance or silence. If one is reasonably sure that the recipient does not know the news, it may be relevant to simply signal what is coming and proceed with the announcement immediately. Here is an instance of a neurologist talking to a patient in New York Hospital:¹⁹

This combination of cerebellar dysfunction in one arm and corticospinal tract dysfunction in the other (shakes head, raises eyebrows, looks at patient). I’m sorry you know it’s stronger than any other laboratory test we have. It’s... there’s no other disease but multiple sclerosis that will do it.

Because the neurologist is also talking to residents, he uses some technical terms addressed mostly to them. However, the references to “dysfunction in one arm and corticospinal tract dysfunction in the other” also can be considered a type of “online commentary”²⁰ or description of what they have seen and can see, and helps to forecast the news. Then, by gazing at the patient, the physician turns his attention fully to the patient and launches the diagnostic news with an apologizing preface and reference to the diagnostic strength of visible symptoms. If the online commentary and apologizing seem minimal, nevertheless the news itself occupies a later and prognosticated position in the announcing utterance. Once again, the news is delivered in a prepared social psychological environment.

Citing the evidence

Clinicians often postpone or delay asserting the news by citing evidence that leads to asserting the condition of a patient.²¹ Clark and LaBeff¹³ refer to “elaborate” reports, a listing of a *logical sequence* of progressive events and the attempts to deal with them:¹³

We (nurses) saw them privately and indicated that there had been some complications and that she had started bleeding. We told them what we had done for her in terms of starting an i.v., giving whole blood, and everything we did in spite of all our efforts we were unable to save her. She passed away.

Anspach’s²² research includes an example of a resident who, wanting to encourage parents to withdraw life support from a struggling infant, uses an elaborated report that consists of citing a variety of evidence—test results (electroencephalogram, computed tomography scan, liver functioning), the baby’s lack of improvement, consultations with other experts, the medical staff’s own efforts to do “everything” for the child, and other factors that would logically seem to suggest discontinuing the support mechanisms.

Perspective display sequence

A major or primary way in which physicians can forecast bad news and aid recipients in realizing the news is through the “perspective display sequence” (PDS), a practice I have studied in some detail.^{23–25} This is a three-part sequence whereby: (i) the physician elicits a view of the matter at hand from potential recipient(s) (family members, patient), (ii) the

recipient(s) report their perspective or view, (iii) the physician delivers the news. I will give two examples, one from a primary care setting that illustrates how little time the practice takes, and one from an acute care setting, an emergency room.

Cancer diagnosis in primary care

“Clint Jones” is a 37-year-old patient in a primary care clinic affiliated with a medical school in the USA. On a Friday, he reported to the clinic with complaints about stomach pain, weight loss, and an inability to tolerate solid foods. Dr. “Edward Hoffman”, a third-year resident in the primary care internal medicine training program referred him to a gastroenterologist, Dr. Smith, for evaluation. Dr. S’s endoscopy, for which Dr. H was also present, revealed a suspicious-looking mass in the esophagus, and a biopsy was carried out. The growth proved to be malignant, and on the Monday after the procedure, Dr. H arranged to see Mr. J back in the clinic. The physician produces a how-are-you-doing query (line 1). After the patient’s answer and question about what was decided (lines 2–3), Dr. H acknowledges the patient’s report about losing weight, and then issues a preface or pre-announcement: “there is a problem” (line 6). Now Dr. H could have gone from this utterance (labeled **0** at line 6) directly to the delivery of the diagnosis (labeled **3** at line 32). Instead, he engages in a directed PDS between lines 7 and 31. By “directed,” I mean that Dr. H suggests what he would like Mr. J to remember the procedure he had undergone on Friday. The following is a simplified transcript of their conversation (see details in Maynard and Frankel);²⁶ numbers in parentheses are the duration of silences in tenths of seconds, and underline indicates emphasis.

1	Dr. H:		So how are ya <u>doing</u> .	
2	Mr. J:		I’m doin’ good, I’m losin’ weight? Whatever. What	
3			was the <u>problem</u> . What was decided on.	
4	Dr. H:		Sh- so you lost - yuh - you lost weight. (0.5) <u>Uhm</u> .	
5			(2.5)	
6	Dr. H:	0 →	There <u>is</u> a <u>problem</u> .	
7			(1.6)	
8	Dr. H:	1 →	Uhm hh (2.8) Do you remember what we <u>talked</u> about	
9			at the end o’ the procedure, you had on Friday.	←A
10	Mr. J:		No. [Shaking head.]	
11			(0.5)	
12	Dr. H:		Okay well let’s - let’s <u>go</u> over that too. Um. (3.6)	
13			Ya <u>know</u> we put the <u>scope</u> down into your <u>stomach</u> ,	
14			to look around and see what - what it was that we	
15			could see. <u>And</u> uh <u>Doctor Smith</u> an’ I were there	
16			and we looked, into your stomach. Do you <u>remember</u>	
17			we said we saw something <u>growing</u> in your stomach?	←B
18	Mr. J:		Mm hm.	

19	Dr. H:		D' you remember that?	←C
20			(0.6)	
21	Mr. J:	2→	Yeah I guess.	
22	Dr. H:		Okay. Well <u>that</u> 's what we <u>did</u> see. We– we <u>looked</u>	
23			into your <u>stomach</u> and we saw (0.6) <u>right</u> at the	
24			<u>spot</u> where you feel like (0.2) the <u>food</u> is	
25			getting stuck,	
26	Mr. J:		Mm.	
27			(1.0)	
28	Dr. H:		Uhhh, there is something <u>growing</u> in your stomach.	
29			(4.0) [Mr. J gazes downward.]	
30	Mr. J:		You can't <u>tell</u> what it is?	
31	Dr. H:		I can <u>tell</u> you what it is, Clint.	
32	Mr. J:		Mm hm.	
33	Dr. H:	3→	Uh, it's a <u>cancer</u> .	
34			(0.4)	
35	Mr. J:		Jeesus. (1.2) Oh my god (1.2) TCH! (2.5) Ohhh no.	
36			[Mr. J bends forward, resting both elbows on his	
37			knees and hanging his head low.]	

This utterance (lines 8–9) is a perspective display invitation. It turns out to be the first of three such invitations (arrows A, B, and C in the right-hand margin). At first, Mr. J denies remembering (line 10), and this occasions Dr. H's suggestion for going "over that too" (line 12); he then describes the procedure through a brief narrative (lines 13–16) and also invokes the medical observer, Dr. Smith, besides himself, as jointly witnessing the evidence (lines 15–16). Embedded in this narrative are a number of breathy hesitations and silences, which prolong a halting quality to Dr. H's presentation. Then at arrow B (lines 16–17), Dr. H produces the second of his perspective display invitations, this one proposing a specification of what Mr. J should "remember". Mr. J, at line 18, responds with a minimal utterance. In a third invitation at arrow C (line 19), and showing an orientation to the minimalism of his recipient's previous utterance, Dr. H asks for a stronger display of recollection. Mr. J produces such a display, although it is delayed (line 20), spoken quietly, and the affirmative "Yeah" is muted with "I guess."

Dr. H then produces an agreeing proposal that they saw something growing (lines 22–3) and locates the growth in relation to what is suggested as the patient's own account of a symptom (lines 23–25). In regular PDS fashion, he confirms what Mr. J saw and his experience of symptoms, and (after Mr. J's token at line 26) uses that perspective to affirm the pre-diagnostic formulation at line 28, "there is something growing in your stomach." Mr. J is silent (line 29) until vocalizing a response asking for confirmation that Dr. H "can't tell what it is" (line 30). Dr. H, by suggesting that he "can tell" what it is (31), disconfirms the proposal of his

patient. After Mr. J's acknowledgment (line 32), Dr. H hesitatingly declares "it's uh cancer" (line 33). At line 35, Mr. J, amidst a series of silences, produces whispered expletives, a tongue click, and a very soft denying utterance ("Ohhh no"). So Mr. J clearly has difficulty receiving this diagnosis, but his difficulties in fact can indicate a realization of the condition the doctor has named.

As indicated in this analysis, there are features of the PDS in this exchange. As the physician elicits the patient's perspective, he is able to *confirm* his experience, *affirm* the clinical diagnosis, and thereby *co-implicate* the patient's perspective in the delivery of the news. Now, hypothetically, Dr. H could have delivered the diagnosis by going directly from the line 6 utterance, "There is a problem" to the diagnostic news at line 33, "Uh, it's a cancer." That would have been a more blunt delivery, and a question arises as to how much time it takes to use the PDS instead. The total is 51 seconds—*much less than a minute* to use this device, and thereby perhaps to avoid the misattributions that bluntness entails: disorientation, anger, and blaming the doctor.

Perspective display sequence in emergency care/acute medicine

Is the PDS a relevant device to use in emergency care? While this question can be answered in a more detailed fashion than can be done here, Pecanac²⁷ is currently addressing the issue in her dissertation research. The rough answer is yes, although the circumstances in which it is relevant are varied and detailed. Most especially, in using a PDS, physicians often ask not for the perspective of the news recipient

but whether the recipient knows the wishes of the patient regarding end-of-life care:

Did he — at any point, you know, when you became his power of attorney, discuss with you what he would — you know, did he discuss this kind of situation or scenario? And what he would want done for himself?²⁷

I will give just one other brief example, in which the question is about the family member's [FM] perspective. At line 1, the doctor uses a topic-proffering pre-inquiry to initiate the topic of the patient's "code status" or type of intervention the healthcare team might use. Following a silence (line 2) and a family member's audible outbreath (line 3), which may indicate the family member's resistance to the trajectory of talk, the physician produces a perspective query (lines 4–5). A nurse (RN) offers a completion of his query at line 6, which the doctor repeats, adding a component to the utterance about being "very aggressive" (line 7). The following is a simplified transcript of their conversation.²⁷

The family member displays her perspective with a one-word answer ("No," line 8). Then the doctor continues by specifying under what circumstances they would attempt

with the doctor's just previous proposal that CPR would not be "doing her any justice" (line 21).

So again, hypothetically, the doctor could have followed his line 1 topic proffer ("we need to discuss her code status", with an immediate recommendation not to do any aggressive CPR. For example, he could have articulated something along the lines of lines 20–22, where he is suggesting that if the patient's heart is "stopping" it would be inadvisable to do CPR even though they could: it "wouldn't be doing her any justice". Instead, by eliciting the family member's perspective in lines 4–7, which she displays at line 8 with a brief "No", he is able to deliver the recommendation in such a way as to confirm that perspective, use it to affirm the medical view of things, and co-implicate the family in the decision not to resuscitate. It needs to be noted that there are, from the beginning (as noted about lines 2–3) and continuing throughout the physician's delivery, indications of resistance on the part of the family (note the silences occurring in lines 9 through 14). However, the approach using a PDS can be said to facilitate the family's realization of the imminent death of the patient.

1	Dr:	We've been saying we need to discuss uh (1.7) her <u>code</u> status?
2		(0.5)
3	FM:	Hhhh
4	Dr:	Like if her <u>heart</u> were to <u>stop</u> , (0.7) would you <u>want</u> us to rush
5		in there (1.2) and <u>shock</u> (1.0) and
6	RN:	Do CPR [cardiopulmonary resuscitation]
7	Dr:	Do CPR (0.7) and you know, very aggressive.
8	FM:	<u>No</u> .
9	Dr:	Now, we'd <u>only</u> do that if her <u>heart</u> were to <u>stop</u> . (1.2) <u>Have</u> to
10		do that. (1.0) Um (0.5) if we <u>did</u> something like that? (1.7) Eh,
11		the chances of su- of success are <u>extremely low</u> , if we <u>did</u> get
12		her blood pressure <u>returned</u> her <u>neurological</u> status would almost
13		(0.2) <u>certainly</u> be <u>worse</u> .
14		(1.5)
15	Dr:	It is a (1.0) we would <u>highly</u> recommend <u>not</u> doing that,
16		(1.2)
17	Dr:	just because it's, it's <u>pain</u> and suffering it's not gonna change
18		the final outcome. If her heart, comes to that point where it's
19		<u>stopping</u> ? (0.7) That, kinda means, <u>God</u> is (1.0) ready to <u>take</u> her.
20		(0.5) And I- I- I <u>don't</u> think eh, we can go in and do CPR but I
21		don't (0.5) <u>wouldn't</u> be doing her any justice.
22	FM:	<u>Mm</u> mrm. [No]

resuscitation (lines 9–10), and what the chances of success would be (lines 10–13). Subsequently, he issues the medical recommendation (line 15). Following a silence (line 16), he further explains the recommendation (lines 18–21). The family member aligns (line 23)—by showing agreement

CONCLUSION

IN FORMER YEARS, for various cultural reasons, Japanese physicians would avoid telling patients "bad" news, such as a cancer diagnosis,²⁸ although as early as the 1970s

and 1980s, debates emerged at medical conferences and among the general public about the practice of concealment.²⁹ A relatively recent study,³⁰ in which the investigators surveyed 529 Japanese cancer outpatients regarding preferences for the disclosure of bad news, revealed that more than 90% of patients strongly preferred to discuss their current medical condition and treatment options with their physician and to have physicians take the feelings of family members into consideration and provide emotional support as well. Although 30% of those surveyed did not want information regarding their life expectancy, fully 50% of subjects did want to learn this information directly from the doctor. Overall, there seems to be an orientation toward a “collaborative role in the decision making process”.³⁰

Additionally, there is evidence of a movement toward an “independent” as opposed to “interdependent” mode of decision-making regarding health care in Japan, where “informed consent” has come to be regarded as important.³¹ Still, as Akabayashi and Slingsby³¹ suggest, patients and family members in Japan may prefer an inclusive “family-facilitated” (rather than Western-style patient-centered) approach to medical decision-making. In this light, practices for informing patients and family members about bad medical news suggest an approach in which physicians avoid stalling or bluntness, and engage in forecasting unfavorable tidings. By way of pre-announcements, prefaces, citing the evidence, and, when possible, online commentary,²⁰ physicians can prepare their recipients for the bad news to come. The PDS—asking the recipients for their beliefs and knowledge about the medical situation so that the clinical news can be tied to the recipient’s stance—appears as a particularly effective forecasting device. Overall, the various practices for forecasting can aid emergency room recipients in their realization of bad news.

CONFLICT OF INTEREST

NONE.

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