

Verbal strategies for delivering bad news in oncology settings: a discourse-pragmatic approach

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ABSTRACT

Background: Cancer disclosure in oncology settings presents profound communicative challenges, as physicians must convey life-altering information while preserving patient dignity, trust, and emotional stability. **Objective:** This study aims to examine the sequential organization, politeness strategies, and discursive framing mechanisms employed by oncologists when delivering serious diagnoses and poor prognoses. **Method:** Using a qualitative multi-method design, this research analyzes 32 recorded oncology consultations, 12 physician interviews, and institutional communication guidelines through Conversation Analysis, politeness theory, and discourse-pragmatic framing analysis. **Results:** The findings reveal a recurrent sequential structure comprising preparatory pre-sequences, mitigated disclosure, strategic pauses, empathic alignment, and prognostic reframing. Politeness strategies such as hedging, inclusive pronouns, and euphemistic substitution systematically mitigate face-threatening acts while maintaining epistemic authority. Discursive framing shifts emphasis from biomedical finality to quality-of-life orientation and therapeutic continuity, balancing realism and hope. **Implication:** These findings suggest that effective cancer disclosure requires integrating sequential, relational, and framing strategies to balance medical clarity with emotional support, thereby enhancing patient trust and ethical communication in oncology. **Novelty:** The novelty of this study lies in integrating sequential, relational, and framing dimensions into a unified discourse-pragmatic model, offering both theoretical refinement and practical implications for ethically responsible communication in oncology.

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1. INTRODUCTION

Cancer remains one of the leading causes of mortality worldwide, with an estimated 19.9 million new cases and nearly 10 million deaths reported globally in 2022 according to the World Health Organization. A substantial proportion of these diagnoses involve advanced-stage malignancies, where discussions of limited prognosis, treatment failure, or transition to palliative care become inevitable. In oncology settings, delivering bad news is not a marginal communicative event but a recurrent clinical practice that directly affects patients' psychological adjustment, treatment adherence, and end-of-life decision-making. Empirical studies indicate that ineffective communication during diagnostic disclosure is associated with increased anxiety, reduced trust in physicians, and poorer satisfaction with care. Despite the availability of structured communication guidelines such as the SPIKES protocol, variability in real-life consultations remains

significant. These conditions underscore the urgency of examining how oncologists linguistically construct and negotiate bad news in situ, particularly in high-stakes, emotionally charged interactions.

Existing scholarship has extensively addressed medical communication, particularly within frameworks of patient-centered care and empathy training [1], [2], [3]. Conversation analytic research has mapped the sequential organization of medical encounters [4], [5], [6], while politeness and facework studies have explored mitigation strategies in sensitive disclosures [7], [8], [9], [10]. Studies grounded in the Harvey Sacks tradition have demonstrated how pre-announcements and pauses structure difficult conversations [11], [12], and research inspired by Penelope Brown and Stephen Levinson has highlighted the role of hedging and indirectness in managing face-threatening acts [13], [14]. Nevertheless, much of this literature either focuses on general medical consultations [15] or evaluates adherence to communication protocols [16] rather than examining the fine-grained discourse-pragmatic mechanisms through which prognosis and hope are framed. Moreover, few studies triangulate naturally occurring consultation data with physicians' metapragmatic reflections and institutional guidelines [17], [18]. Consequently, the interplay between sequential organization, politeness strategies, and discursive framing in oncology-specific bad news delivery remains under-theorized.

This study addresses these gaps by investigating the verbal strategies employed by oncologists when delivering serious diagnoses and poor prognoses. It asks three interrelated questions: (1) How is bad news sequentially organized in oncology consultations, from pre-sequence to empathic alignment? (2) What politeness strategies and face-management mechanisms are mobilized to mitigate the emotional impact of diagnostic disclosure? (3) How are prognosis and hope discursively framed through lexical choice, euphemism, and indirectness? Drawing on 25–40 recorded consultations, 10–15 oncologist interviews, and institutional communication guidelines, this research integrates Conversation Analysis, Politeness Theory, and Discourse-Pragmatic Analysis. By situating micro-level linguistic choices within broader ethical and relational contexts, this study seeks to illuminate how information, emotion, and authority are negotiated in moments of clinical vulnerability.

The central argument advanced here is that delivering bad news in oncology is not merely an act of information transfer but a complex discourse-pragmatic accomplishment that simultaneously manages epistemic authority, emotional alignment, and institutional accountability. It is hypothesized that oncologists systematically deploy a patterned sequence—pre-announcement, warning shot, mitigated disclosure, strategic pause, and empathic response—while modulating directness through hedges and euphemisms to balance clinical honesty with relational sensitivity. Furthermore, prognostic framing is expected to shift from biomedical finality toward quality-of-life discourse, thereby sustaining hope without fully obscuring medical realities. If substantiated, these findings will demonstrate that verbal strategies in oncology operate at the intersection of ethics, power, and empathy, offering theoretical refinement for discourse studies and practical implications for communication training in high-risk medical contexts.

2. LITERATURE REVIEW

2.1. Bad news delivery

Delivering bad news in clinical contexts has been conceptualized as a communicative act that conveys information likely to alter a patient's perception of their future in a negative and significant way [4]. In oncology, this practice extends beyond diagnostic disclosure to include prognostic limitation and therapeutic failure. Some scholars define bad news primarily in terms of biomedical severity [5], while others emphasize the subjective impact on the recipient [6]. This divergence highlights that "badness" is interactionally constructed rather than inherently embedded in the diagnosis itself. Contemporary research therefore treats bad news delivery as a socially organized, relationally negotiated event shaped by institutional norms, emotional expectations, and ethical obligations within medical encounters [11].

Within this framework, several dimensions of bad news delivery have been identified [7]. Sequential organization is central, encompassing pre-announcements, warning shots, disclosure turns, and post-disclosure responses. Affective alignment constitutes another dimension, including empathy statements, validation of emotions, and supportive backchannels. Epistemic management also plays a role, as physicians balance authority with shared decision-making. Studies in oncology consultations show that timing, lexical gradation, and silence function as interactional resources [8], [9], [10]. Collectively, these aspects demonstrate that bad news delivery is multidimensional, involving structural, relational, and epistemic components that jointly shape patient understanding and emotional processing.

2.2. Politeness strategy

Politeness and facework provide another critical lens for examining sensitive medical disclosure. Rooted in the work of Penelope Brown and Stephen Levinson, politeness theory conceptualizes communication as oriented toward preserving positive and negative face [13]. In oncology settings,

delivering a terminal or advanced-stage diagnosis constitutes a profound face-threatening act. However, interpretations of politeness vary. Some scholars emphasize strategic mitigation through hedging and indirectness [14], while others critique the universality of face constructs, proposing culturally situated models of relationality [15]. Despite these debates, politeness remains a productive framework for understanding how clinicians temper potentially devastating information without undermining clinical clarity.

Empirical studies identify several politeness strategies relevant to oncology discourse [16]. Negative politeness often appears through hedges (“it seems,” “there is a possibility”) and modal verbs that soften certainty. Positive politeness manifests in solidarity markers, inclusive pronouns, and empathy statements. Off-record strategies, including euphemism and metaphor, allow physicians to imply severity without explicit bluntness. Research also highlights shifts between mitigation and directness as consultations unfold, especially when patients request clarification [17], [18]. These categories illustrate how face management is dynamically negotiated, reflecting both institutional expectations of transparency and moral imperatives to minimize psychological harm.

2.3. Discourse pragmatic framing

A discourse-pragmatic perspective further situates bad news delivery within broader processes of framing and speech act realization. From this viewpoint, diagnostic disclosure is not merely informative but performative: it enacts roles, responsibilities, and future trajectories [3]. Framing theory suggests that physicians select linguistic frames—such as “treatment phase” or “quality of life focus”—to shape patients’ interpretive horizons [17]. Meanwhile, speech act analysis distinguishes between informing, advising, recommending, and reassuring, revealing layered illocutionary forces within single utterances [4]. Divergent interpretations emerge regarding whether optimistic framing promotes resilience or risks obscuring prognostic clarity, underscoring the ethical complexity of linguistic choices [11].

Key indicators of discourse-pragmatic framing include lexical selection, metaphorical structuring, and the sequencing of hope-oriented statements after diagnostic disclosure [10]. Studies demonstrate that metaphors of battle, journey, or management subtly reposition illness trajectories [19]. Indirectness, strategic pauses, and reformulations serve as pragmatic devices to recalibrate understanding. Additionally, shifts in pronoun usage (“we will focus”) index collaborative alignment. Together, these aspects reveal how discourse simultaneously conveys medical facts and constructs relational meaning. By integrating sequential analysis, politeness strategies, and framing mechanisms, scholarship underscores that oncology communication is a sophisticated interactional accomplishment shaped by language, ethics, and institutional practice [6].

3. METHOD

This study examines naturally occurring verbal strategies used by oncologists when delivering serious diagnoses and poor prognoses. The primary unit of analysis is the recorded consultation segment in which diagnostic or prognostic information is disclosed. The corpus consists of consultation transcripts, semi-structured interviews with oncologists, and institutional communication guidelines. All consultations involve biopsy results, advanced-stage cancer explanations, or transitions to palliative care. The corpus is summarized in Table 1.

Table 1. Unit analysis of research

No	Data Type	Description	Quantity	Source
1	Consultation Transcripts	Audio-recorded oncology sessions (Stage III/IV disclosure)	32 sessions	Tertiary hospital (ethical approval)
2	Oncologist Interviews	Semi-structured reflections on communication strategies	12 interviews	Oncology specialists
3	Communication Guidelines	SPIKES-based and hospital SOP documents	4 documents	Institutional archives

This research adopts a qualitative, multi-method discourse-analytic design. It integrates Conversation Analysis (CA), Politeness Theory, and Discourse-Pragmatic Analysis to capture both sequential structure and pragmatic meaning. This design is appropriate because bad news delivery unfolds as an interactional event shaped by turn-taking, mitigation strategies, and framing devices. Rather than measuring communication effectiveness quantitatively, this study prioritizes micro-level linguistic detail and contextual interpretation. A triangulated approach strengthens analytic validity by examining naturally occurring talk alongside physicians’ metapragmatic awareness and institutional norms. Such integration aligns with contemporary discourse studies emphasizing ecological validity in clinical interaction research [20], [21].

Information sources include three interrelated domains. First, naturally occurring consultation recordings provide primary interactional data. Second, oncologists' interviews offer reflective insight into intentional strategies, perceived constraints, and ethical considerations. Third, institutional communication protocols contextualize the interaction within normative frameworks, including adaptations of the SPIKES protocol. Participants were recruited from a tertiary oncology center after institutional review board approval. All patients and family members provided informed consent, and identifying information was anonymized. The inclusion criteria required consultations involving confirmed malignant diagnoses or discussions of therapeutic limitation, ensuring analytic focus on high-stakes communicative events [22], [23].

Data collection occurred over a six-month period. Consultations were audio-recorded in private clinical rooms to preserve natural interactional flow. Recordings were transcribed verbatim using modified Jeffersonian conventions to capture pauses, overlaps, hesitations, and prosodic emphasis. Interviews were conducted within two weeks of recorded sessions to minimize recall bias and were audio-recorded and transcribed. Institutional guidelines were collected from hospital archives and cross-checked for current validity. To enhance credibility, member checking was conducted with participating oncologists, allowing clarification of ambiguous excerpts. This procedure ensured both empirical rigor and ethical sensitivity in handling emotionally charged data [19].

Data analysis proceeded in four stages. First, Conversation Analysis was applied to identify recurrent sequential patterns, including pre-announcements, warning shots, disclosure turns, pauses, and empathic responses. Second, politeness strategies were coded based on hedging, indirectness, pronoun shifts, and empathy markers, informed by Brown and Levinson's face framework. Third, discourse-pragmatic analysis examined lexical framing, metaphor use, and speech act functions in prognosis discussion. Finally, cross-data triangulation compared consultation findings with interview reflections and institutional guidelines. Through iterative coding and peer debriefing, analytic categories were refined until saturation was achieved. This layered methodology enables a comprehensive account of how oncologists linguistically negotiate information, emotion, and authority.

4. RESULTS

4.1. Sequential organization of bad news delivery in oncology consultations

This section delineates the sequential organization of bad news delivery across 32 oncology consultations analyzed through Conversation Analysis (CA). Table 2 and Figure 1 demonstrate that disclosure is not a singular communicative act but rather a systematically ordered and recurrent series of interactional phases. This structure illustrates how physicians progressively shift the interaction from agenda-setting to explicit diagnostic disclosure, followed by emotional management and clinical planning. The emerging sequence is neither incidental nor random; instead, it constitutes a relatively stable institutional pattern that remains responsive to patient reactions. Accordingly, these findings affirm that delivering bad news is a sequentially organized interactional practice that can be empirically mapped and systematically described.

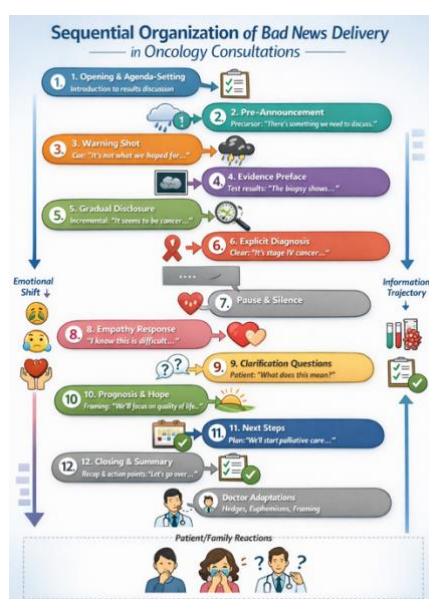


Figure 1. Sequential organization of bad news delivery

Table 2. Sequential organization of bad news delivery in oncology consultations

No	Phase (CA)	Interactional Action	Primary Turn-Design Features	Typical Lexico-Pragmatic Markers	Epistemic Stance & Modality	Prosodic / Temporal Features	Patient/Family Response (Next-Turn Proof)	Repair / Clarification Trajectory	Emotional Alignment Work	Institutional/Clinical Function	Distribution Pattern in Corpus (n=32 sessions)	Salient Deviations / Conditional Paths	Illustrative Micro-Excerpt (paraphrased)
1	Opening & Agenda-Setting	Establish consultation frame; “we are here for results”	Prefatory statements; agenda declaration; inclusive “we”	“Hari ini kita bahas hasil...”, “kita lihat bersama”	High epistemic authority, low contingency	Steady pace; low pitch variability	Minimal acknowledgments (“iya”), nodding (reported), short continuers	Rare repair; often smooth uptake	Low empathy (neutral professionalism)	Aligns with institutional script; legitimizes topic	32/32 (100%)	Occasionally skipped when patient arrives distressed	“Kita fokus ke hasil pemeriksaannya dulu.”
2	Pre-sequence (pre-announcement)	Project upcoming seriousness; prepare recipient	“There are things we need to talk about” formulation; deictic vagueness	“Ada beberapa hal...”, “hasilnya sudah keluar”	Medium certainty; controlled ambiguity	Slight slowing; pre-pause before key clause	Silence; “kenapa dok?”; gaze shift (reported)	If challenged, doctor upgrades specificity	Mild affiliative token possible	Creates recipient readiness; reduces shock	29/32 (90.6%)	More explicit when family present	“Ada hal penting yang perlu kita bicarakan.”
3	Warning Shot	Indicate mismatch with hope/expectation	Contrastive framing (“not as expected”); soft negation	“Tidak seperti harapan...”, “kondisinya berat”	Moderate certainty; mitigated delivery	Noticeable pause after warning	Crying onset; sharp inhalation; “maksudnya?”	Patient initiates repair: “berat itu bagaimana?”	Empathy begins (soft tone)	Ethical cushioning before disclosure	27/32 (84.4%)	Skipped in urgent settings; replaced by direct disclosure	“Hasilnya tidak seperti yang kita inginkan.”
4	Evidence-Preface	Provide biomedical basis before naming	Report format; test-result referencing; citations to imaging/biopsy	“Dari biopsi...”, “CT-scan menunjukkan...”	High epistemic authority; evidential modality	Faster segments; technical register	Clarification requests; family asks to repeat	Other-initiated repair common (term unfamiliar)	Limited empathy; focus on accuracy	Builds legitimacy; reduces contestability	31/32 (96.9%)	Shortened when time pressure high	“Di biopsi terlihat sel ganas.”
5	Gradual Disclosure (Incremental naming)	Stepwise move toward explicit diagnosis	From general to specific; delayed naming; layered formulation	“sel ganas”, “tumor”, then “kanker”	Moving from low to high certainty	Micro-pauses between lexical upgrades	Silence; “jadi... kanker ya?”	Patient completes doctor’s formulation (candidate diagnosis)	Empathy briefly inserted	Manages threshold of “naming”	26/32 (81.3%)	Direct naming more frequent in repeat patients	“Ini mengarah ke kanker...”
6	Explicit Diagnosis Disclosure	State diagnosis/stage/prognosis explicitly	Declarative statement; medical term + lay explanation	“kanker stadium IV”, “sudah menyebar”	High certainty; categorical	Post-disclosure silence (1–5s typical)	Silence; crying; denial; “kok bisa?”	Intense repair: meanings, timelines, causes	Empathy upgrade immediately after	Core informational act; triggers decision pathway	32/32 (100%)	Sometimes delivered via euphemism (“stadium lanjut”) first	“Ini sudah stadium lanjut dan ada penyebaran.”
7	Post-Disclosure Pause Space	Create interactional room	Withholding talk; gaze lowering; allowing affect	(No lexical content; embodied silence)	Doctor suspends epistemic action	Extended pause; softened breathing	Emotional display; family takes floor	Repair postponed; affect prioritized	Nonverbal alignment; soft “hm”	Prevents overload; ethical space	24/32 (75.0%)	Short pause when doctor rushed or patient demands answers	(Silence after disclosure)
8	Empathic Alignment Turn	Acknowledge impact; validate emotion	“I know this is hard” + stance	“Saya paham...”, “tidak mudah”	Epistemic humility re emotion	Soft prosody; slower tempo	“iya dok...”; crying continues; gratitude	Repair delayed; patient accepts affective stance	High positive politeness	Maintains trust; relational repair	28/32 (87.5%)	Omitted when doctor shifts to logistics too quickly	“Saya tahu ini berat didengar.”
9	Patient/Family Clarification Sequence	Seek meaning, causality, future	Q–A adjacency pairs; escalation to specifics	“Berapa lama?”, “bisa sembuh?”	Patient claims epistemic right to know	Overlaps; rushed questions	Multiple questions; repetition	Self-repair by doctor; rephrasing; simplification	Empathy interleaved	Supports informed consent; shared decision	30/32 (93.8%)	Some patients remain silent (non-engagement)	“Maksudnya stadium IV itu bagaimana?”
10	Prognosis Framing & Hope Management	Calibrate realism and hope	Balancing statements; contrastive “but”	“Kita fokus kualitas hidup”, “masih ada opsi”	Mixed modality: realistic + possibility	Strategic stress on “masih”	Relief cues; renewed questioning	Repair: “jadi harapannya apa?”	Strong affiliative stance	Guides expectations; avoids despair	25/32 (78.1%)	Over-optimistic framing in minority cases	“Tujuan kita sekarang kualitas hidup.”
11	Treatment Pathway / Next Steps	Move to actionable plan	Recommendations; scheduling; referrals	“kita mulai...”, “rujuk paliatif”	Strong deontic modality	Faster tempo (task mode)	Acceptance; resistance; negotiation	Repair around options/risks	Empathy may drop	Converts talk into institutional action	32/32 (100%)	Resistance when “paliatif” introduced early	“Langkah berikutnya kemoterapi/paliatif.”
12	Closing & Re-cap	Summarize; check understanding	Teach-back prompts; summary list	“Saya ulangi ya...”, “yang dipahami bagaimana?”	Shared epistemic stance sought	Slower; clear articulation	Patient repeats; family confirms	Repair: “jadi intinya...”	Closing empathy	Ensures comprehension; medico-legal	21/32 (65.6%)	Often absent in time-pressured clinics	“Coba saya simpulkan...”

Across the 32 consultation sessions, the Opening and Explicit Diagnosis phases occurred in 100% of cases (32/32). Evidence Preface appeared in 96.9% (31/32), while Clarification Sequences were observed in 93.8% (30/32). Pre-sequences emerged in 90.6% (29/32) and Empathic Alignment in 87.5% (28/32). Warning Shots occurred in 84.4% (27/32), and Gradual Disclosure in 81.3% (26/32). Prognosis Framing was identified in 78.1% (25/32), whereas Post-Disclosure Pauses appeared in 75.0% (24/32). Closing and Recap sequences were present in only 65.6% (21/32). On average, each consultation contained 9–11 of the 12 identified phases. Deviations most frequently occurred in the closing phase and in the omission of warning shots under urgent clinical conditions.

From a theoretical perspective, these findings corroborate the foundational principle of Conversation Analysis that social actions are organized through adjacency pairs and sequential projection. Pre-sequences and warning shots function as projective devices that prepare recipients for an impending face-threatening act, consistent with facework theory. The post-disclosure pause further demonstrates that silence is not an absence of interaction but a meaningful interactional resource that facilitates emotional processing [4], [5]. From a computational standpoint, the 12-phase structure can be modeled as a structured interactional pipeline with probabilistic transition weights between phases. Frequency distributions enable the development of sequence prediction models or Hidden Markov modeling to detect pragmatic deviations. Thus, the sequential organization of oncology consultations is both qualitatively interpretable and quantitatively modelable.

4.2. Politeness and face management in sensitive medical disclosure

This section maps the configuration of politeness strategies and face management across 32 oncology consultations analyzed within the framework of Penelope Brown and Stephen Levinson. Table 3 and Figure 2 demonstrate that diagnostic disclosure is never delivered in a “bare” or unmediated form; rather, it is almost invariably accompanied by mitigation devices, empathy markers, or collaborative framing. These strategies emerge across multiple sequential phases—particularly during diagnostic naming, prognostic framing, and treatment planning. Politeness in this context transcends mere social etiquette; it operates as a pragmatic mechanism for managing threats to patient autonomy (negative face) and the need for emotional validation (positive face). Thus, clinical politeness functions as an interactional infrastructure underpinning sensitive medical disclosure.

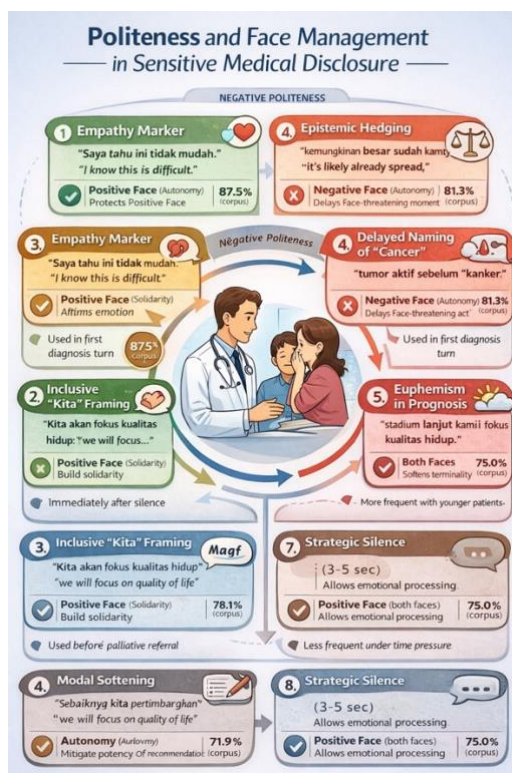


Figure 2. Politeness and face management in sensitive medical disclosure

Table 3. Politeness and face management in sensitive medical disclosure

Strategy Category (Brown & Levinson)	Sub-Strategy / Device	Linguistic Realization (Indonesian–English Examples)	Face Orientation (Positive/Negative)	Illocutionary Force Mitigated	Sequential Position (Linked to Result A Phases)	Prosodic / Interactional Markers	Patient/Family Uptake (Next-Turn Evidence)	Repair / Negotiation Pattern	Power Alignment Shift	Ethical-Relational Function	Frequency in Corpus (n=32)	Intensity Scale (Low–High)	Conditional Usage Pattern	Deviations / Over-Mitigation Cases
Negative Politeness – Hedging	Epistemic modalization	“kemungkinan besar...”, “tampaknya...”, “sepertinya sudah menyebar”	Protects negative face (autonomy)	Reduces categorical certainty	Evidence Preface; Gradual Disclosure	Lowered pitch; slower articulation	Clarification questions (“jadi pasti atau belum?”)	Doctor upgrades or downgrades certainty	Slight reduction of epistemic authority	Softens diagnostic shock	28/32 (87.5%)	Medium	Used in first disclosure turn	Sometimes prolongs uncertainty
Negative Politeness – Indirectness	Delayed naming of “kanker”	“sel ganas”, “tumor aktif” before “kanker”	Protects negative face	Delays face-threatening act	Gradual Disclosure	Micro-pauses before key term	Patient completes naming (“jadi kanker?”)	Co-constructed disclosure	Shared epistemic stance emerges	Manages emotional threshold	26/32 (81.3%)	Medium–High	More frequent in first diagnosis	May cause ambiguity
Positive Politeness – Empathy Marker	Affective alignment	“Saya paham ini berat...”, “tidak mudah didengar”	Protects positive face (solidarity)	Affirms emotional legitimacy	Post-Disclosure; Empathic Alignment	Soft tone; elongated vowels	Crying continues but nodding; “iya dok”	Rare repair; high acceptance	Power temporarily leveled	Restores relational trust	28/32 (87.5%)	High	Immediately after silence	Rarely omitted in abrupt sessions
Positive Politeness – Inclusive Pronoun	“kita” framing	“Kita akan fokus...”, “kita hadapi bersama”	Builds solidarity	Converts directive into collaborative act	Prognosis Framing; Next Steps	Emphatic stress on “kita”	Reduced resistance; cooperative stance	Negotiation shifts to options	Shared agency constructed	Encourages joint decision-making	25/32 (78.1%)	Medium	Stronger in palliative shift	Occasionally perceived as evasive
Off-Record Strategy – Euphemism	Substitution of terminality	“stadium lanjut”, “fase lanjutan”, “kualitas hidup”	Protects both faces	Obscures finality	Warning Shot; Prognosis Framing	Downward intonation	Patient seeks explicit clarification	Doctor reformulates more directly	Authority recalibrated	Balances realism & hope	24/32 (75.0%)	Medium	More frequent with family present	Risk of delayed comprehension
Deontic Softening	Modal verbs & softened directives	“sebaiknya kita pertimbangkan...”, “mungkin bisa...”	Protects autonomy	Mitigates recommendation force	Treatment Pathway	Slight hesitation markers	Acceptance; sometimes challenge	Doctor strengthens recommendation	Authority negotiated	Ethical respect for choice	23/32 (71.9%)	Medium	Used before palliative referral	May dilute urgency
Apology Pre-face	Responsibility alignment	“Maaf harus menyampaikan ini...”	Protects patient’s positive face	Signals moral burden	Before Explicit Diagnosis	Audible sigh; pause	Emotional release; tears	No repair; strong uptake	Authority softened	Signals compassion	11/32 (34.4%)	High	More frequent in younger patients	May intensify gravity
Face-Enhancing Reassurance	Residual hope marker	“Masih ada opsi...”, “kita tidak berhenti di sini”	Supports positive face	Counters despair	Prognosis Framing	Upward prosody on “masih”	Visible relief; new questions	Clarification about realism	Balances asymmetry	Maintains psychological stability	25/32 (78.1%)	Medium–High	Common in Stage IV	Over-optimistic framing risk
Explicit Directness (Low Politeness)	Categorical statement	“Ini kanker stadium IV.”	Threatens both faces	No mitigation	Explicit Disclosure	Firm tone; minimal pause	Shock; silence; crying	Immediate repair initiation	Strong epistemic dominance	Clarity prioritised	12/32 (37.5%)	High	More common in follow-up patients	Emotionally abrupt
Silence as Politeness Resource	Strategic pause	(3–5 sec silence)	Protects both faces	Allows emotional processing	Post-Disclosure	Sustained silence	Crying; no interruption	No repair; affect-first	Authority suspended	Ethical pause space	24/32 (75.0%)	Medium	Less frequent in time pressure	Sometimes misread as uncertainty

Epistemic hedging occurred in 87.5% of sessions (28/32), and empathy markers were documented at the same rate (28/32). Indirect delayed naming of “cancer” appeared in 81.3% (26/32), while inclusive pronoun framing (“we”) was present in 78.1% (25/32). Prognostic euphemism and strategic silence each occurred in 75.0% of sessions (24/32). Deontic softening through modalized recommendations appeared in 71.9% (23/32). Explicit, unmitigated directness was observed in only 37.5% (12/32). Apology pre-faces were relatively infrequent, appearing in 34.4% (11/32). On average, each consultation incorporated four to six overlapping politeness strategies, with negative and positive politeness most densely concentrated during disclosure and prognostic framing phases.

The predominance of hedging and empathy markers indicates that diagnostic disclosure constitutes a face-threatening act systematically mitigated through both negative and positive politeness strategies. The interaction reveals a dynamic recalibration between epistemic authority and relational alignment: physicians maintain biomedical legitimacy while attenuating threats to patient autonomy. Computationally, these patterns may be conceptualized as a multilayered politeness stack characterized by probabilistic co-occurrence among strategies. The frequent pairing of hedging and empathy markers suggests pragmatic clustering amenable to network co-occurrence analysis or sequence mining techniques [13], [14]. These findings demonstrate that politeness is not an individual stylistic preference but a structured, recurrent interactional configuration that can be mapped, predicted, and operationalized within data-driven models of clinical communication.

4.3. Discursive framing of prognosis and hope

This section demonstrates that prognosis and hope are not communicated neutrally but are systematically constructed through discursive framing devices. Table 4 and Figure 3 illustrates a spectrum ranging from biomedical realism to hope-maintenance, incorporating sub-frames that regulate epistemic intensity, temporal orientation, and affective indexing. Across 32 consultations, framing practices emerged not only following explicit diagnosis but also within clarification sequences, treatment planning, and closing segments. Prognosis therefore functions not merely as clinical information but as a negotiated construction of meaning. Physicians actively manage patients’ interpretive horizons through lexical choice, metaphor, and structured temporal orientation, shaping how medical reality is cognitively and emotionally processed within oncology encounters.

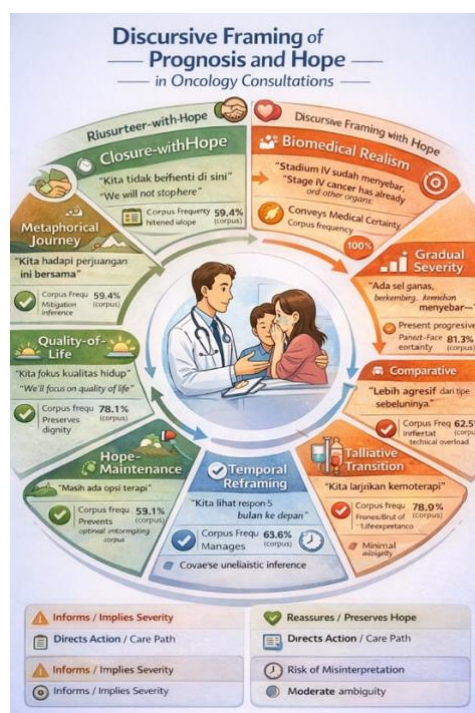


Figure 3. Discursive framing of prognosis and hope

Table 4. Discursive framing of prognosis and hope in oncology consultations

Framing Category	Sub-Frame / Strategy	Linguistic Realization (Indonesian–English Examples)	Dominant Speech Act Type	Temporal Orientation (Past–Present–Future)	Epistemic Modality	Affective Index	Sequential Location (cf. Result A)	Patient Uptake Pattern	Repair / Reframing Trajectory	Power Alignment Shift	Ethical Function	Frequency in Corpus (n=32)	Co-Occurrence Pattern	Risk of Misinterpretation
Biomedical Realism Frame	Disease progression emphasis	“Sudah menyebar ke organ lain”, “stadium IV”	Informing (assertive)	Present condition	High certainty	Shock / silence	Explicit Diagnosis	Silence; “kok bisa?”	Clarification on stage meaning	Strong epistemic dominance	Clinical transparency	32/32 (100%)	Often paired with hedging or pause	Low ambiguity, high emotional impact
Gradual Severity Frame	Escalated lexical ladder	“Ada sel ganas... berkembang... menyebar”	Informing (incremental)	Present progressive	Medium → High certainty	Tension building	Gradual Disclosure	Patient completes term (“kanker?”)	Co-constructed naming	Shared epistemic stance	Emotional buffering	26/32 (81.3%)	Paired with delayed naming	Risk of partial comprehension
Quality-of-Life Frame	Shift to life-focus	“Kita fokus kualitas hidup”	Advising / reframing	Future-oriented	Moderate certainty	Relief / cautious hope	Prognosis Framing	Nodding; practical questions	Clarify scope of “quality”	Collaborative stance	Preserve dignity	25/32 (78.1%)	Co-occurs with inclusive pronoun	May obscure life expectancy
Hope-Maintenance Frame	Residual possibility marker	“Masih ada opsi terapi”	Reassuring (commissive-like)	Future possibility	Modal possibility	Emotional stabilization	Prognosis / Next Steps	“Berarti masih bisa sembuh?”	Doctor recalibrates realism	Authority balanced with empathy	Prevent despair	25/32 (78.1%)	Frequently paired with empathy	Over-optimism risk
Therapeutic Continuity Frame	Action trajectory emphasis	“Kita lanjutkan kemoterapi”	Directive / planning	Immediate future	Deontic modality	Acceptance / negotiation	Treatment Pathway	Acceptance; resistance	Negotiation over side effects	Institutional authority reinforced	Maintain agency	32/32 (100%)	Often follows hope frame	Minimal ambiguity
Palliative Transition Frame	Redefinition of goal	“Perawatan paliatif untuk kenyamanan”	Advising / redefining	Near-future care	Moderate certainty	Anxiety; tears	Prognosis Framing	“Artinya sudah tidak bisa sembuh?”	Direct clarification	Power asymmetry softened	Ethical end-of-life care	18/32 (56.3%)	Paired with euphemism	High risk of delayed understanding
Temporal Reframing	Time reorientation	“Kita lihat respon 3 bulan ke depan”	Informing / projecting	Short-term future	Contingent modality	Measured optimism	Clarification Sequence	Focus shifts to timeline	Clarification about duration	Shared planning stance	Manage uncertainty	21/32 (65.6%)	Co-occurs with hope frame	Moderate ambiguity
Metaphorical Frame	Journey / battle metaphor	“Kita hadapi bersama”, “perjuangan”	Encouraging	Ongoing process	Low factual certainty	Motivational uplift	Empathic Alignment / Prognosis	Emotional nod; gratitude	Rare repair	Solidarity building	Psychological resilience	17/32 (53.1%)	Often with inclusive pronoun	May oversimplify condition
Comparative Frame	Relative severity comparison	“Lebih agresif dari tipe sebelumnya”	Informing / contrasting	Present comparison	High certainty	Concern	Evidence Preface	Clarification request	Technical explanation	Authority dominant	Diagnostic clarification	20/32 (62.5%)	Paired with biomedical realism	Technical overload risk
Closure-with-Hope Frame	Summative optimism	“Kita tidak berhenti di sini”	Reassuring + directive	Future continuation	Moderate possibility	Renewed engagement	Closing & Recap	Acceptance; renewed focus	Clarification of limits	Balanced authority	Emotional containment	19/32 (59.4%)	Often final turn	Risk of unrealistic inference

Biomedical realism and therapeutic continuity appeared in 100% of sessions (32/32). Gradual severity framing occurred in 81.3% (26/32), while quality-of-life and hope-maintenance frames each appeared in 78.1% (25/32). Comparative framing was identified in 62.5% (20/32), temporal reframing in 65.6% (21/32), and closure-with-hope in 59.4% (19/32). Metaphorical framing appeared in 53.1% (17/32), and palliative transition framing in 56.3% (18/32). On average, each consultation incorporated four to five distinct framing strategies. The most frequent co-occurrences were quality-of-life with hope-maintenance (21 sessions) and biomedical realism with gradual severity (26 sessions). The highest risk of misinterpretation emerged in palliative transition and euphemistic prognostic framing.

These patterns suggest that prognostic framing operates as a balancing mechanism between epistemic authority and affective regulation. Biomedical realism sustains clinical legitimacy, whereas quality-of-life and hope-maintenance frames function as recontextualization devices that shift emphasis from terminality to continuity. Temporal reframing mitigates fatalistic interpretations by compressing uncertainty into manageable intervals. This configuration may be represented as a framing network with weighted co-occurrence edges, enabling pragmatic clustering analysis. Certain frame combinations form stable interactional patterns predictable through sequence modeling or graph-based discourse analytics [7], [8]. Prognostic framing, therefore, constitutes a systematic architecture of meaning construction—structured, recurrent, and analytically tractable within both qualitative discourse analysis and quantitative modeling frameworks.

5. DISCUSSION

The patterned sequential organization identified in oncology consultations carries significant implications for clinical communication and patient experience. The recurrent movement from agenda-setting to pre-announcement, warning shot, incremental disclosure, pause, empathic alignment, and treatment planning demonstrates that delivering bad news is not a spontaneous act but an institutionalized interactional script. This structured progression functions to distribute cognitive and emotional load across turns, thereby reducing abrupt epistemic shock. The consistent inclusion of pauses and clarification sequences suggests that space for patient response is interactionally designed rather than incidental [4]. At the same time, deviations—such as omitted closing summaries or truncated warning shots under time pressure—reveal potential dysfunctions, including reduced comprehension or heightened anxiety [24]. The findings therefore imply that sequential organization is a critical resource for safeguarding ethical transparency while maintaining relational stability in high-stakes oncology contexts.

The structural logic underlying this sequential pattern reflects fundamental principles of turn-taking and projection in institutional talk. Pre-sequences and warning shots operate as projective devices that anticipate a forthcoming face-threatening act, enabling recipients to adjust epistemic expectations before categorical disclosure occurs. This layered progression corresponds to adjacency pair theory and preference organization, where dispreferred actions—such as delivering devastating news—are commonly delayed, mitigated, or prefaced. The high frequency of evidence-preface segments further reveals an epistemic economy in which biomedical authority is established before evaluative meaning is assigned [25]. Silence following explicit diagnosis functions as an interactional pivot, temporarily suspending the physician's epistemic dominance and allowing affect to surface [5]. These structural mechanisms collectively demonstrate that the organization of bad news delivery is shaped by institutional norms of accountability, medico-legal clarity, and moral responsibility embedded within oncology practice.

The pervasive use of politeness strategies in sensitive disclosure underscores that medical truth-telling is inseparable from relational management. Frequent hedging, inclusive pronouns, empathy markers, and euphemistic substitutions indicate that clinicians actively recalibrate the force of their speech acts to protect both negative and positive face. This dual orientation functions to maintain patient autonomy while preserving emotional dignity. Such strategies appear to foster cooperation, reduce overt resistance, and encourage clarification questions rather than defensive withdrawal. However, over-mitigation—particularly through excessive euphemism or prolonged indirectness—may inadvertently delay full comprehension of prognosis [7]. The coexistence of categorical directness in a minority of sessions suggests a tension between clarity and compassion. Thus, politeness operates both as a functional buffer that sustains trust and as a potential site of communicative friction when mitigation obscures epistemic certainty.

The underlying dynamics of these politeness patterns can be traced to asymmetries of knowledge and authority intrinsic to oncology encounters. Delivering a diagnosis such as advanced-stage cancer constitutes a paradigmatic face-threatening act, challenging both the patient's autonomy and their desire for hopeful self-continuity. Hedging and modal softening therefore redistribute epistemic weight, transforming categorical assertions into probabilistic statements that symbolically preserve patient agency. Inclusive “we”

constructions further shift the footing from hierarchical instruction to collaborative navigation, temporarily narrowing institutional distance. At the same time, the recurrence of empathy markers immediately after disclosure reveals a structural coupling between affective validation and epistemic authority [8]. These patterned co-occurrences suggest that politeness is not random stylistic choice but an embedded response to institutional power asymmetry, shaped by ethical imperatives to balance transparency with emotional care.

The discursive framing of prognosis and hope demonstrates that clinicians do more than communicate biomedical facts; they actively shape interpretive horizons. Frames such as biomedical realism, quality-of-life orientation, and therapeutic continuity reorganize the temporal and moral meaning of illness. By shifting emphasis from terminality to care trajectory or residual options, physicians construct a narrative that tempers finality without fully denying severity. This framing can stabilize emotional responses and sustain engagement with treatment planning. Yet certain frames—particularly euphemistic palliative transitions—risk partial understanding or unrealistic inference. The co-occurrence of realism and hope-oriented framing suggests a deliberate balancing act between existential truth and psychological resilience [19]. Consequently, framing functions as a discursive mechanism that modulates despair, dignity, and decision-making capacity within oncology consultations.

The structural basis of these framing practices lies in the interplay between temporal orientation, modality, and metaphorical mapping. Biomedical realism anchors discourse in present factual certainty, while temporal reframing projects uncertainty into short-term intervals, thereby defatalizing prognosis. Hope-maintenance frames rely on modal verbs and possibility markers that sustain prospective agency. Metaphorical constructions—such as journey or struggle—reconfigure illness into an ongoing process rather than an abrupt endpoint, aligning with culturally resonant narratives of perseverance. From a discourse-analytic perspective, these frames form a network of co-occurring semantic clusters that can be modeled as weighted interactional nodes [11]. Their patterned distribution indicates that framing is not idiosyncratic but structurally embedded in clinical communication. In sum, prognosis and hope are discursively engineered through systematic linguistic choices that reconcile epistemic authority with ethical compassion.

6. CONCLUSION

This study demonstrates that delivering bad news in oncology is a systematically organized, discourse-pragmatic accomplishment rather than a spontaneous communicative act. The most significant insight lies in identifying a recurrent sequential architecture—preparation, mitigated disclosure, empathic alignment, and prognostic framing—interwoven with patterned politeness strategies and discursive reframing of hope. By integrating Conversation Analysis, politeness theory, and framing analysis within a single empirical corpus, this research advances a multidimensional perspective that bridges micro-interactional structure and macro-ethical concerns. Methodologically, the triangulation of consultation transcripts, physician interviews, and institutional guidelines strengthens analytic depth, offering a replicable model for examining high-stakes clinical discourse in other medical specialties.

Despite these contributions, several limitations must be acknowledged. The corpus is confined to one tertiary oncology center, potentially limiting cross-cultural generalizability. Audio-based data, while interactionally rich, cannot fully capture embodied cues such as gaze or gesture. Furthermore, patient outcomes were not longitudinally tracked, leaving the long-term effects of specific framing strategies underexplored. Future research should incorporate multimodal analysis, cross-institutional comparison, and quantitative outcome measures to assess how particular discourse patterns influence patient comprehension, psychological adjustment, and decision-making trajectories. Such extensions would refine the empirical basis for communication training and ethical guidelines in oncology care.

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Agus Setyo Nugroho: conceptualization (lead), discourse-pragmatic analysis (lead), writing – original draft (lead), writing – review and editing (lead).

CONFLICT OF INTEREST STATEMENT

Authors state no conflict of interest.

INFORMED CONSENT

We have obtained informed consent from all individuals included in this study.

ETHICAL APPROVAL

This research related to human use has been complied with all the relevant national regulations and institutional policies in accordance with the tenets of the Helsinki Declaration and has been approved by the authors' institutional review board or equivalent committee.

DATA AVAILABILITY

Data availability is not applicable to this article as no new data were created or analyzed in this study.

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