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A Comparative Study of Death Discourse in Palliative Care Wards and Regular Cancer Wards from the Conversation Analysis Perspective

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Abstract

This study explores the differences in death discourse between palliative care wards and regular cancer wards through the lens of conversation analysis, using data from the Chinese anti-cancer documentary Sheng Sheng. The research fo-cuses on the questioning strategies employed by doctors and the nature of doc-tor-patient communication in these two settings. By analyzing 81 instances of questionings and six doctor-patient interactions, the study reveals distinct pat-terns in communication, particularly in how doctors approach end-of-life dis-cussions, patient autonomy, and family involvement. The findings indicate that palliative care wards emphasize emotional support, patient-centered care, and family involvement, while regular cancer wards focus more on clinical deci-sion-making and treatment management. The study employs Hymes' SPEAKING model to provide a comprehensive framework for understanding the contextual, emotional, and cultural factors influencing these interactions. The re-sults high-light the importance of tailored communication strategies in different medical settings to improve patient outcomes and satisfaction.

Keywords

doctor-patient communication; palliative care; death discourse; conversation analysis

1. Introduction

Doctor-patient communication is a complex social phenomenon influenced by vari-ous factors, such as medical expertise, morality, and culture. Its importance lies not only in verbal exchanges but also in the ability to accurately diagnose conditions, explore treatment options, and ultimately achieve the goal of disease resolution and therapeutic care. Investigating doctor-patient communication through the lens of conversation analysis is significant because it highlights the varying degrees of un-derstanding, misunderstanding, conflict, and cooperation that arise in these interac-

tions. This process reveals the impact of linguistic, social, and cultural factors on doctor-patient communication, and further uncovers how these factors influence the presentation of treatment suggestions, the development of treatment plans, and the implementation of therapeutic interventions [1].

The communication between cancer patients, their families, and healthcare providers represents a unique form of doctor-patient interaction. This specificity is primarily evident in the need for improved death discourse between doctors, patients, and families [2]. Due to traditional Chinese cultural views that emphasize maximizing life expectancy and a taboo against discussing death, medical professionals and family members often avoid broaching the topic of death with cancer patients. However, the growing prominence of palliative care in China has begun to challenge these long-standing cultural norms [3]. Palliative care, which originated from hospice care in the United Kingdom [4-5], has been progressively developed in Western countries since the mid-1970s. In China, palliative care was introduced in 1988, and since November 2015, it has been gradually promoted nationwide with government support [6]. Over the past four decades, palliative care in China has made significant strides. However, challenges persist due to the influence of traditional Confucian values and the constraints imposed by economic factors, such as low public awareness, limited acceptance, a shortage of trained practitioners, and an underdeveloped management system—issues exacerbated by varying levels and quality of hospice care [7-8]. In China, palliative care is often referred to as "end-of-life care", which focuses on managing pain and discomfort while providing holistic care that addresses physical, psychological, social, and spiritual needs for terminally ill patients. The goal is to improve the quality of life and ensure patients pass away comfortably, peacefully, and with dignity [2]. While the concept of palliative care aligns with that of hospice care, which is designed for patients at the end of life, there remains a gap in research regarding how doctor-patient communication differs between palliative care and regular cancer ward settings, particularly in terms of questioning strategies used by doctors.

Drawing on audio recordings and transcriptions of 81 questionings and six doctor-patient interactions with cancer patients and their families from the Chinese anti-cancer documentary Sheng Sheng, this study adopts conversation analysis and Hymes' framework of communicative ethnography (the SPEAKING model) to examine the features of these interactions. It compares the patterns of doctor-patient communication in palliative care and regular cancer ward settings, focusing on the use of questioning strategies. The research questions are as follows:

RQ1: How and to what extent do doctors' questioning strategies differ between palliative care wards and regular cancer wards?

RQ2: How does death discourse in doctor-patient interactions differ between palliative care wards and regular cancer wards?

2. Literature Review

Doctor-patient communication plays a pivotal role in the field of palliative care. How to communicate with patients and their families about end-of-life issues, especially discussing hospice-related decisions, is considered a very challenging task for doctors worldwide [9-10]. Foreign doctor-patient communication research on palliative care has been relatively mature. There has been much international research on palliative care discourse. A number of journal articles have focused on shared decision-making (SDM) [11-12]. Some have examined activity types, such as nurse handovers [13], nurse conversations in team meetings [13-14], and others explicitly use the concept "genre", e.g., Freytag [15] examined the "genre of shared decision making", Schryer et al. [16] examined the two related genres of interview outline and inheritance document in the genre chain of "dignity therapy", based on the data of 12 terminally ill patients, and found that the terminally ill patients utilized these verbal and written language resources to create discursive order for their uncontrollable lives.

The main research methods include ethnography, discourse analysis, process analysis, conversation analysis, etc. [10] [11] [17], of which the research under the perspective of conversation analysis has a unique advantage [18]. Gramling and Gramling [10] state that "conversation is the 'procedure' of palliative care. " They used the conversation analysis approach to examine palliative conversations with a range of functions, in a more comprehensive and detailed way. A careful analysis of palliative care conversations from a micro perspective is essential to understanding and improving clinical practice of palliative care.

Conversation analysis as a sociological research method appeared in the United States in the 1970s, and its founders are Harvey Sacks, Emanuel Schegloff, and Gail Jefferson. This research method takes the verbal responses occurring in natural environments as the corpus, and starts from the sequential organization of the verbal responses to reveal the social and orderly nature of human verbal responses [19]. Conversation analysis has become one of the major approaches to studying institutional conversations, as it is able to reveal the design and sequential organization of conversation, capture the ways in which conversations are extended, and elucidate the implementation of norms of interactional behaviors [20].

Maynard [21-22] has achieved rich results in the study of doctor-patient bad news delivery from the perspective of conversation analysis. Classic models such as the perspective-display sequence and the news delivery sequence provide practical guidelines for healthcare workers. The central idea is that the patient is invited to give his/her opinion and the doctor gives his/her assessment. Such a turn-taking design allows bad news to be expressed naturally and become a product of co-construction between the two parties in the interaction, which is more easily accepted by the patient and reduces the mental and psychological pressure on the doctor [23].

In recent years, there has been a shift in palliative doctor-patient communication

research from a focus on bad news delivery to end-of-life care. Maynard, Cortez, and Campbell [24] examined the order of doctor-patient interactions in oncology sessions in the United States and found that after presenting an imaging report to the patient, the doctor typically uses an appreciation sequence to guide the patient to acknowledge and positively evaluate the current treatment, followed by recommendations and plans for subsequent treatment. Tate found that oncologists would actively address the topic of death during the conversation, especially during the advice-giving phase, to promote patients' acceptance of the advice or to prevent them from resisting the advice.

Discourse research on palliative care in China has also made a promising start, including research on: communicative ethnography of doctor-patient and family communication [25], outpatient doctor-patient dialogues [6], palliative care family meetings [2-3], and genre of palliative checkups and life review ceremonies [26], and so on. The analytical frameworks used include speech act research, conversation analysis, multimodal discourse analysis, etc. However, on the whole, the discourse research on the genre of palliative care in China is still quite limited, and basically focuses on the genre of oral communication.

3. Theoretical Framework

3.1. The SPEAKING Model

The SPEAKING model, developed by sociolinguist Dell Hymes, is a framework used to analyze communication and understand the components of speech events in various social and cultural contexts. The model's acronym stands for different elements of communication, each represented by a letter in "SPEAKING". It provides a systematic approach to examining how communication functions across different settings by breaking down key factors such as context, participants, and other components of speech.

According to Hymes [27], in the SPEAKING model, "S" stands for setting and scene. Setting refers to the physical location and time in which the speech event occurs, while scene refers to the psychological setting or the cultural definition of the occasion. "P" stands for participants, referring to the individuals involved in the communication, including speakers, listeners, the audience, and bystanders. "E" represents ends, which refers to the purposes, goals, or expected outcomes of the speech event. "A" stands for act sequence, referring to the order of events or the structure of what is said and how it unfolds during the interaction. "K" represents key, which refers to the tone, manner, or spirit of the communication, such as serious, humorous, formal, or casual. "I" stands for instrumentalities, which refers to the forms and styles of speech, including language, dialect, and the medium of communication. "N" represents norms, which refers to the social rules governing interaction and interpretation, such as norms of turn-taking, politeness, and appropriateness. Finally, "G" stands for genre, which refers to the type of speech act or event, such as a conversa-

tion, lecture, joke, or narrative.

The SPEAKING model is widely used in fields like linguistics, anthropology, communication studies, and sociolinguistics to analyze how context influences language use. By applying the model, researchers can gain a deeper understanding of the complex dynamics of human communication.

3.2. End-of-life Talk

End-of-life talks are defined as conversations that address, either directly or indirectly, topics such as the process of life, the meaning of life, aging and death, end-of-life emotions, end-of-life planning, and grief counseling. These discussions are intended to trigger patients and their families to reflect on and prepare for end-of-life care [6]. Doctors often use such conversations to promote the concept of hospice care and introduce related services to patients. End-of-life talks typically occur in two main contexts: first, doctor-initiated, where the doctor brings up the topic during medical treatment, catching the patient unprepared; and second, patient-initiated, where the patient raises issues related to end-of-life care or seeks relevant opinions, providing the doctor with an opportunity to guide the conversation about life care in a smooth manner [6].

A study by Pino found that the primary conversational strategy employed by doctors in conducting end-of-life talks was elaboration solicitation, which involves guiding the patient or family member to expand and elaborate on the relevant issues. The sequential structure of this interaction typically consists of three stages: first, the doctor's elaboration solicitation; second, the patient's response; and third, the doctor's evaluation and follow-up response. The purpose of elaboration solicitations is to encourage the patient to express their viewpoints, thereby allowing life care discussions and education to be based on the patient's perspective. Key interactive strategies used by doctors in elaboration solicitations include: (1) indirectly guiding patients to introduce end-of-life topics through quoted questions; (2) indirectly exploring patients' views on the issues through exploratory questions; and (3) directly inviting patients to discuss relevant topics through qualifying questions.

4. Methodology

This study employs both conversational analysis and comparative research methods. The corpus selected for conversation analysis aims to uncover common features of death discourse in doctor-patient interactions within palliative care settings, utilizing both quantitative statistical analysis and qualitative descriptions. To obtain quantitative data, the study selects and labels 81 instances of doctors' questions from the Chinese anti-cancer documentary Sheng Sheng. The total length of the collected corpus is approximately 4.5 hours. For qualitative data, the study selects six instances of doctor-patient interactions with similar themes from the same documentary. The corpus was transcribed according to the transcription system used in

conversation analysis, resulting in a total word count of approximately 3,672 Chinese characters. These are subjected to qualitative descriptive comparative analyses to explore in depth the similarities and differences in death discourse between palliative care wards and general wards, using Hymes' SPEAKING model as the analytical framework. The qualitative analysis serves to support and enrich the quantitative findings, providing details that may be overlooked in the statistical analysis.

4.1. Data of the Present Study

The corpora for this study were selected from the Chinese anti-cancer documentary Sheng Sheng. For quantitative analysis, the primary sources are 81 doctors' questions, while the corpora for qualitative analysis consist of six doctor-patient interactions from the documentary (see Table 1). Among these, corpora A, B, C, and D are from interactions in the regular cancer ward setting, while corpora E and F are from the palliative care ward. Notably, corpus D differs from the others in that its atmosphere is significantly distinct: the doctor informs the patient and her husband that the cancer is benign and does not require chemotherapy, delivering good news to the patient and her family.

Table 1. Descriptions of the quantitative data

Corpus	Data source	Age	Gender	Participants
A	Episode 1, 31:23-33.05	63	Female	D, (P), S, and Dau
B	Episode 1, 34:05-35:23	16	Male	D, M, and F
C	Episode 2, 13:56-15:06	16	Female	D, (P), M, and F
D	Episode 1, 43:20-44:13	28	Female	D, P, and H
E	Episode 2, 8:46-9:32	53	Male	D, and S
F	Episode 2, 20:18-22:52	53	Male	D, (P), W, and S

4.2. Data Analysis

4.2.1. Quantitative Analysis

In the quantitative analysis section, this study focuses on coding and statistically analyzing 81 doctors' questions from the documentary Sheng Sheng. The analysis primarily examines the types of questions posed by doctors, using the theoretical framework of interactive strategies employed in elaboration solicitations [6]. According to Li and Lu [6], the main types of questions used by doctors in elaboration solicitations include quoted questions, exploratory questions, and qualifying questions. After careful classification, the study reveals a distinct distribution of questioning strategies across different settings. In palliative care wards, qualifying questions (46.67%) are the most frequent, followed by exploratory questions (40%) and quoted questions (13.33%). In contrast, in regular cancer wards, there is a more balanced distribution, with qualifying questions and quoted questions each accounting for 36.11%, and exploratory questions comprising 27.78% (see Table 2).

Table 2. Questioning Strategies in Palliative Care Ward and Regular Cancer Ward

	Quoted Question		Exploratory Question		Qualifying Question	
Settings	Number	Percent	Number	Percent	Number	Percent
Palliative Care Ward	6	13.33%	18	40%	21	46.67%
Regular Cancer Ward	13	36.11%	10	27.78%	13	36.11%

4.2.2. Qualitative Analysis

Using Hymes' SPEAKING model to analyze the data, both similarities and differences in the communication dynamics between doctors, patients, and their families can be identified. These interactions occur within medical contexts, where the exchange of information is critical for understanding the patient's condition, making decisions, and providing emotional support. However, the nature of these conversations varies depending on medical circumstances, emotional stakes, and the roles of the participants.

5. Discussion

The analysis reveals distinct patterns in both the doctors' use of questioning strategies and doctor-patient communication in palliative care wards versus regular cancer wards. These differences reflect the differing objectives of care in these two settings, particularly with regard to emotional support, decision-making, and symptom management.

5.1. Questioning Strategies

The quantitative analysis indicates that there is a different distribution of questioning strategies used by doctors in palliative care wards compared to regular cancer wards. In palliative care wards, qualifying questions (46.67%) are the most frequent, followed by exploratory questions (40%) and quoted questions (13.33%). In contrast, in regular cancer wards, the distribution is more balanced, with qualifying questions and quoted questions each comprising 36.11%, and exploratory questions making up 27.78%.

In palliative care wards, the primary questioning strategies involve qualifying questioning and exploratory questioning. These questions are predominantly aimed at understanding the patient's emotional state, personal reflections, and decisions regarding their care. Such questioning emphasizes empathy, emotional support, and facilitating patient autonomy in decision-making. For example, questions like "Do you think I am capable of handling this?" and "I would like to hear your concerns" encourage patients to reflect on their feelings and allow them to voice their worries about their condition. These questions invite the patient to engage actively in discussions about their end-of-life care, ensuring that their dignity and comfort are prioritized. In contrast, questions in the regular cancer wards are more focused on diagnostic clarification and treatment management. For instance, questions like "Did

your symptoms improve significantly after the procedure?" serves to confirm medical facts about the patient's condition and treatment progress. Quoted questioning is the dominant strategy here, often confirming previous diagnoses, symptoms, or treatments. This type of questioning allows healthcare providers to gather essential medical data to guide ongoing treatment. While exploratory questioning is also used, it is less prevalent than in palliative care, indicating a stronger focus on physical health in regular cancer wards.

5.2. Patient-centered Care Orientation

The findings also suggest that palliative care adopts a patient-centered approach, prioritizing emotional well-being and patient autonomy. In this environment, the healthcare team actively engages patients in discussions about their preferences, offering them opportunities to make informed decisions about their care. For example, questions such as "Do you understand the consequences of that decision?" and "We will do our best to ensure you don't end up in that condition, okay?" not only reflect the healthcare provider's commitment to patient comfort but also encourage patients to actively participate in their care decisions. The emotional and relational dimensions of care are foregrounded, with questions frequently inviting patients to reflect on their desires and concerns, often involving family members in the decision-making process.

In contrast, questions in regular cancer care are more focused on diagnosing and managing the patient's condition. For instance, questions like "You didn't have a vein graft last time, only a bypass, right?" aim to clarify specific medical procedures. Although some exploratory questioning is employed, the focus remains on understanding the physical condition to guide treatment decisions, rather than reflecting on the patient's personal feelings or decisions.

From the perspective of the SPEAKING model, in the regular cancer ward, the Ends element of interactions primarily centers on the patient's medical treatment. Conversations often focus on managing symptoms, evaluating treatment efficacy, and deciding on further interventions. The primary goal is to communicate information about treatment options and outcomes, with little explicit attention to the patient's emotional well-being.

The setting here is clearly clinical, focusing on medical treatment and surgical intervention. The doctor's explanation centers around the details of the patient's condition and the necessary surgical procedures. There is minimal exploration of the patient's emotional state or well-being beyond immediate medical concerns. The primary goal of the interaction is to provide detailed medical information about the surgery and its potential complications. The conversation focuses on the technical aspects of the patient's condition, such as the removal of parts of the bone or the risk of nerve damage. Although the mother engages with the doctor, showing concern for the patient's condition, the emphasis is overwhelmingly on clinical out-

comes. Emotional support for the patient, while implied by the mother's involvement, is not explicitly addressed. The conversation prioritizes medical necessity and practical considerations over the emotional or psychological impact on the patient or family.

In contrast, in the palliative care ward, the Ends of interactions shift toward providing comfort and emotional support, with a clear patient-centered orientation that considers the patient's mental, emotional, and spiritual needs. This is exemplified in Example 1, where the doctor's tone and approach in the palliative care ward aim to empower the patient, making them an active participant in decisions about their comfort and care preferences—aligning with a strong patient-centered care orientation.

Example 1:

11 Doctor: But this process (0.2) I feel:: .hhhh. might be very painful.
12 (3.0)
13 Doctor: Yet I think it's quite regrettable.=
14 Doctor: =We actually (0.5) really wish he could:: fulfill his:: tsk: wish ah::: =
15 Doctor: =But given his current condition. I really can't say like that::.

In this example, the conversation takes place in a palliative care ward, where the focus is not only on managing the patient's comfort but also on providing emotional support. The doctor addresses not just the medical aspects of care but also acknowledges the emotional and psychological burden of the treatment process. The goal of the conversation is not only to convey medical information but also to empathize with the patient's and family's situation. The doctor acknowledges the possibility of pain and expresses regret that the patient's wishes cannot be fully realized. This marks a clear shift toward recognizing the patient's emotional and existential needs. The emotional tone of the conversation is softer and more compassionate, with the phrasing suggesting hesitation, which signals sensitivity to the patient's and family's feelings. This demonstrates the doctor's efforts to acknowledge the emotional toll of the situation while managing the patient's physical condition. Furthermore, the doctor's reference to the patient's wishes illustrates an understanding of the patient's desires and a willingness to fulfill them as much as possible within the constraints of the medical situation. This is a hallmark of patient-centered care, where treatment goals align not only with medical outcomes but also with the patient's values and wishes.

5.3. Family Involvement and Emotional Support

Family involvement plays a significant role in both palliative and regular cancer care wards, though it manifests differently in these settings. In palliative care, the importance of family involvement is evident. Questions often engage not only the pa-

tient but also their family members, facilitating open communication and ensuring that the family's perspectives are integrated into decision-making. For example, "Would you like to send this bouquet to your husband?" and "Shall we tell him?" emphasize the role of family members in the patient's emotional journey, helping them express their final wishes and fostering meaningful connections. This engagement is particularly vital in providing emotional support during the end-of-life phase. In contrast, regular cancer wards tend to focus more on the individual patient's condition, with less direct involvement of family members. While emotional concerns are acknowledged, the primary focus remains on treatment plans and symptom management. For instance, "How are you feeling right now?" seeks a direct response from the patient, without explicitly involving family members in the conversation.

From the perspective of the SPEAKING model, in the regular cancer ward, the Participants (doctors, patients, and families) are involved in clinical decision-making, but family involvement is typically limited to supporting the patient's treatment decisions.

In this clinical setting, the conversation is focused on treatment options for the patient's condition. While the father is involved in the decision-making process, particularly regarding the medical approach, his role is largely centered on supporting treatment decisions. His concern about the possibility of the patient being able to walk again highlights his focus on the physical recovery of the patient, but the overall tone of the exchange remains centered on medical decisions. The family's emotional involvement, though present, is secondary to the clinical conversation. The doctor's response is primarily medical, offering information about the surgical procedures and potential outcomes.

Conversely, in the palliative care ward, family involvement is much more pronounced, particularly in providing emotional support and making end-of-life decisions. In Example 2, for instance, the family is deeply involved in the emotional and personal aspects of the patient's care, reflecting a more patient-centered and family-centered approach.

Example 2:

46 Son: =%Actually I also feel regretful%.=

47 Son: =%If we really (0.5).. don't (0.2) don't make it in time%.=

48 Son: =%It's just tsk (0.2) missing it by mere days%.=

49 Son: =Just now while talking with you (0.2) one ::thought I had was::::=

50 Son: =Um:::: I don't want him to:: feel too much regret.=

51 Son: So could I:: for example wear my (0.5) ceremony clothes for that day::.=

52 Son: =Have my wife put on her wedding dress too.=

53 Son: =[For him to see.]

54 Doctor: [You mean] hold a special wedding just for him in the hospital room.=

55 Son: =Right.

56 Doctor: Well::. We can do that.

In this exchange, the son takes an active role in ensuring the patient's emotional comfort. He expresses regret about the patient's potential passing, which highlights his emotional investment in the situation. The son suggests organizing a small, meaningful wedding in the hospital, reflecting his deep concern for the patient's emotional well-being. The family's involvement here extends beyond medical decisions to include actions aimed at making the patient's final days emotionally fulfilling. The tone of the conversation is significantly more emotional, with the son expressing regret and his desire to make the patient's last moments more meaningful. The suggestion of a wedding ceremony shows a profound level of care, with the intention of fulfilling the patient's final wishes and providing comfort. The doctor is receptive to this emotional request, offering approval with the statement, signaling a collaborative approach to ensuring that the patient's last memories are positive and meaningful. This contrasts sharply with the clinical stance observed, where the doctor's focus remains on medical decision-making, not on accommodating emotional needs. The doctor's willingness to support the family's emotional wishes in the palliative care ward reflects a holistic, patient-centered approach, where both the patient's comfort and the family's emotional needs are prioritized alongside medical care.

6. Conclusion

This study underscores the significant differences in doctor-patient communication between palliative care wards and regular cancer wards, particularly in the context of death discourse. The analysis reveals that palliative care settings prioritize emotional support, patient autonomy, and family involvement, often using qualifying and exploratory questions to facilitate deeper, more reflective conversations about end-of-life care. In contrast, regular cancer wards tend to focus on clinical decision-making and treatment management, with a more balanced use of quoted and qualifying questions aimed at clarifying medical facts and guiding treatment plans.

The findings suggest that the palliative care approach aligns more closely with a patient-centered model, where the emotional and psychological well-being of the patient is given equal importance to their physical health. This is evident in the way doctors in palliative care settings engage patients and their families in discussions about their preferences and final wishes, fostering a more holistic and compassionate care environment.

The study also highlights the role of family involvement in palliative care, where family members are actively engaged in the decision-making process, providing emotional support and helping to fulfill the patient's final wishes. In regular cancer wards, while family members are present, their involvement is often secondary to

the clinical focus on treatment and symptom management.

Overall, the research demonstrates the importance of adapting communication strategies to the specific needs of patients in different medical settings. By understanding the distinct patterns of communication in palliative care and regular cancer wards, healthcare providers can better address the emotional, psychological, and cultural needs of patients and their families, ultimately improving the quality of care and patient satisfaction.

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