



## Research Article

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# Modifying “Breaking Bad News” Communication: Cross-Cultural and Cognitive-Semantic Approaches

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## Abstract

*The paper addresses the alteration strategies to be implied by a health care professional in the situation of breaking bad news in terms of patient-centered paradigm applied to modern medical communication agenda. The investigation is based on linguistic analysis through semantic framing of “breaking bad news” situation and is specified by onomasiological and semasiological interpretations. The conventional cognitive perception of “breaking bad news” situation is realized as one predetermined by invoked framing. The diversification of ‘SPIKES’ protocol with optional implementation of a cultural component is regarded as an effective educational medium in cross-cultural medical settings. In the paper the latter is employed as a valuable tool for modification of the way the participants view the situation. The modified protocol implicates the properties to influence the prospective treatment pattern. The interdisciplinary nature of the study outlines the valuable grounding for the shift from the mutually expressed negative attitudes to situational consistency via evoked experience of the medical professionals.*

**Keywords:** frame semantics, medical discourse, action frame, breaking bad news, ‘SPIKES’ protocol

## 1. Introduction

“Avoid abusing your position as a doctor” (General Medical Council, 2003) becomes incredibly significant whilst analysing both language used in medical settings and communication produced in health care when it comes to eliciting of unfavourable diagnoses. A brief historical outline uncovers the “breaking bad news” phenomenon as one ingrained in old past. In ancient times the messengers bearing bad news were killed. Time was passing and the numerous laws were adopted to protect bad news carriers. Later the practice becomes absolutely enrooted, but **the first hypothesis** lies in the fact that purely unfavourable attitude towards such kind of messages still preserves its connotation

shared by the participants of “breaking bad news” communicative situation regardless of their nationality, status, and culture. Modern revealing of bad news is preferably bound to a medical setting and carries much of the widely spread negative attitude towards the “prime messenger”, a care provider, who is professionally obliged to deliver unpleasant results of the lab, biopsy, X-ray, computed tomography (CT), magnetic resonance imaging (MRI), ultrasound and other medical findings.

Undoubtedly, communication issue in health care obtains high status due to the fact that professionalism and interpersonal communication are listed among six basic competencies required by the Association Council for Graduate Medical Education for all specialties (University of Maryland Medical Center, n./d.; American Board of Pediatrics, n./d.). Moreover, the significance of gaining background knowledge of patient’s culture is incorporated in communicative correctness of a care provider, with different degree of explicitness, in at least eight out of the fifteen their duties formulated in *Tomorrow’s Doctors* (General Medical Council, 2003). The latter postulate that doctors must demonstrate to their patients:

- politeness and considerateness (the 2nd duty);
- respect to their views and dignity (the 3rd and the 4th duties);
- ability to elicit the data in the utmost understandable way (the 5th duty);
- readiness to absolutely involve them in any decision concerning their care (the 6th duty);
- constant care about upgrading personal educational background (the 7th duty);
- trustworthiness (the 8th duty);
- willingness to omit the conflict of beliefs (the 9th duty).

All of the mentioned duties of a modern physician face the probability of their fulfilment failure in the situations preconditioned by disclosure of life-threatening details.

### 1.1 Current “breakers”

Considering the data of the report delivered by World Health Organization (2018) on 24 May 2018 the population of all countries in the world regardless of the obtained status (high-income, upper-middle income, lower-middle-income or low-income) stays vulnerable to some definite number of the diseases. Furthermore, the latter are announced as those most commonly causing death or severe disabilities. The list of “top killers” includes: ischemic heart diseases (IHD), stroke, chronic obstructive pulmonary diseases (COPD), respiratory and digestive tract cancers, dementia, Alzheimer’s disease and many others. Due to the fact that the major part of fatal diseases worldwide are preferably chronic conditions or their consequences, these are mostly the **specialists from the secondary** (Silveira, Botelho & Valadão, 2017, p. 325-326) and the **tertiary levels of care** who face the case of eliciting unfavourable diagnoses. To add more, the number of cardiologists, surgeons, pulmonologists, gastroenterologists, neurologists, the MD staff of dispensaries and hospices are distinguished among those enjoining the title of a physician when it touches upon the constant participants of modern “breaking bad news” communicators.

### 1.2 Cross-cultural bias on the second interlocutor

The review of the current works on counselling illustrates the certain progress made since 1984, when the set of the steps to follow has been elicited in the protocols aiming to aid the physicians in the situations that required revealing of unpleasant details concerning patient’s state of health (Narayanan, Bista, & Koshy, 2010). In fact, the issue is not solved completely (Dosanjh, Barnes & Bhandari, 2001; Silveira, Botelho & Valadão, 2017) and in modern health care settings a disclosure of the findings related to life-threatening condition is considered to be a disputable subject (Gonçalves et al., 2017, p. 278). What is more there is no universal consent regarding the discovery of life-threatening details with respect to Eastern and Western healthcare settings (Macklin, 2016, p. 647). The latter is reflected in the tradition of “concealing” the information (Gonçalves et al., 2017, p. 279)

still accepted by the countries of Southern and Eastern Europe (Costantini et al., 2006; Leppert, Majkowicz & Forycka, 2013), the Middle East (Khalil, 2013), and South Asia (Wuensch et al., 2013). On one hand, the tradition on “concealing” can be partially justified by the fact that breaking bad news is considered by those cultures to be likely to cast a patient into a deep depression, that causes the health care workers to apply family- determination-principle and to expose the details on unfavourable diagnosis to the family of a patient first (Silveira, Botelho & Valadão, 2017, p. 326). On the other hand, self-determination principle is strictly demanded by the western health care institutions (Macklin, 2016, p. 647). Both of the approaches tend to adhere to patient-centered paradigm in the ways altered by culture and traditions and have to be taken into account while talking about the second person among “breaking bad news” interlocutors who possibly can be of two types: **a patient** themselves or **a family member**. To sum it up, the disclosure refers to the common procedure in medical practice and some measures are required to be inevitably taken in order to cover existing mismatches. The absence of specific mandatory university training and post graduate advancement in cultural studies launches cross-cultural educational background to develop blank spaces getting later crystallized in complication of the delivery of health care services and leave the specialists from the secondary and tertiary levels of care (cardiologists, surgeons, intensive care workers, nephrologists, orthopedists, and pediatricians) “unarmed” in terms of guidelines and protocols available nowadays (Buckman, 1984, 2001; Fine, 1991; Baile et al., 2000) or any other instruments that regulate and help adapt the “breaking bad news” procedures (Silveira, Botelho & Valadão, 2017: 326) to modern health care challenges. Consequently, the vast number of specialists view “breaking bad news” as a rather difficult and uncertain issue defining the subject as one open for discussion (Kimberley et al., 2016; Baile et al., 2000; Dosanjh, Barnes & Bhandari, 2001; Silveira, Botelho & Valadão, 2017). With the prediction that the latter is not the very crux of the matter but only its explicit consequence, **the second hypothesis** can be established: the hardships connected with the “breaking bad news” issues arise from a triad composition implicated in its participants’ interpretation, perception, and attitudes towards it. Thus the study of communicative and cross-cultural aspects of the language used in the situation of breaking bad news aims at elaborating the medium to effectively navigate the care provider through modern health care cross-cultural environments.

Recent works on breaking bad news are predominantly focused on explicit aspects of medical settings that cover: 1) the stages and the planning; 2) the participants’ roles (Silveira, Botelho & Valadão, 2017; Krupat et al., 2000; Maguire & Pitcealthly, 2003; Fallowfield & Jenkins, 2004; Gonçalves et al., 2017; Macklin, 2016); 3) translation aspect (Buckman, 1984). In this case the investigation of cognitive, semantic, lingual and cultural aspects as well as their crystallizations in participants worldviews (which shape the patients’ and health care workers’ perceptions of the event) stay uncovered. As the result, from one side, the portion of information on the communicative situation of breaking bad news in medical settings has unclear nature, and from the other side, the challenges that confront the modern healthcare like immigration (Plaza Del Pinoa & Veiga, 2014) and growing number of refugees (Momir *et al.*, 2015) complicate the research of patient’s attitude towards the subject of the investigation by contributing to cultural errors and bring the cross-cultural aspect of breaking of bad news to Western agenda (Amalancei, 2014; Kokarevich & Sizova, 2015; Hordern, 2016; Pino-Postigo, 2017; Stefanel, 2014; Karpov, 2017; Gaygısız, Lajunen & Gaygısız, 2017; Momir *et al.*, 2015; Kostina *et al.*, 2015; Macklin, 2016). Among the **objectives** addressing the communicative, cultural, cognitive and semantic aspects of breaking of bad news are:

- to study the factors contributing to worldview formations in patients and doctors with different cultural backgrounds;
- to spot the cognitive structures prevailing in the understanding of medical settings in general and breaking of bad news in particular and to sort out their functions in perception of the latter;
- to establish the cross-cultural aspect and explain its function in alteration of breaking of bad news perception;

- to point out the guidelines of cross-cultural awareness of a healthcare professional reflected in their communicative strategies and personal attitude towards the "breaking bad news" situation;
- to offer the model of optimized communication.

## 2. Methods

The study is undermined by the unity of onomasiological and semasiological paradigms (Christianlehmann, n./d.). As far as onomasiological approach gives an opportunity to analyse the lexis from the perspective it is used by the participants of a situation, the researched breaking bad news was viewed from the perspective of "disclosure" event and its perception by the participants.

The corpus of lexical units serving the definition of "breaking bad news" situation was given the semasiological interpretation. Since the latter was based on semantic analyses of the lexical units applied in the situation, breaking bad news was approached with the method followed by its further correlation with the participants of the situation.

Cognitive-semantic analysis utilizes the notion of a frame as the universal tool for displaying perception of events reflected through various communicative media. Action frame's structure was employed to illustrate the relations between participants of an event of breaking bad news. The invoked frames were prioritized as those primarily serving as the structuring blocks for planning and negotiating during preparing for the patient-provider communication. Owing to the fact that the nature of evoked frames stems from accumulated experience, these structures were appreciated as valuable tools in cases either with health care professionals possessing considerable professional experience gained in the situations of the similar types or with certain life experience of the patients.

To elaborate an integrative definition of breaking bad news a method of double verified defining was used. The first stage of verification aimed to provide the collective reflection on breaking bad news via analysis of various approaches to understandings of the phenomenon generated in health care settings. The method was based on profiling of the basic components originating from four definitions available in different sources. The second stage of verification included considering the meanings of the lexical units (which were composing the definitions of breaking bad news) by referencing to the data retrieved from online version of English Oxford Living Dictionary (LEXICO, n./d.). The received evidence was further sorted into separate groups of the lexis in accordance with the denotations. The method addressed the exclusion of one side view on the analyzed issue of breaking bad news.

Cultural value dimensions were downloaded from Hofstede's website (Hofstede Insights, n./d.). The open access web platform was used to determine three features of the national cultures: Uncertainty Avoidance Index (UAI), Long Term Orientation (LTO), and Indulgence (IND). The selection of the features was due to the fact of their feasible interference with the situation of breaking bad news in modern health care agendas and their opportunity to modify its cross-cultural aspect.

## 3. Results

A patient's cognitive structure representing the situation of "breaking bad news" is predominantly constructed while the development of the situation of a disclosure. The basis of formation of cognitive structure concerning the things happening to the patient is their experience. Due to this fact the reviewed definitions of bad news contain lexis: *uncertain*, *unexpected* and the feelings are described as: *difficult*, *threatening*, *drastic*, and *painful*, the ratio of the patients who repeatedly face the situation of breaking bad news is rather low. The absence of the experience on the particular situation cannot be reflected via already existing cognitive structure and the understanding of such situation is represented through the cognitive formation embodied in classical for medical settings interaction frame: WHO (physician) → ACTS (treats) → WHO (patient), which in terms of breaking

bad news tends to have no validity hence it apparently alters and builds up another frame WHO (physician) → ACTS (doesn't treat) – WHO (patient). The newly devised cognitive structure arises and hence it fails to be recognised as one pertaining to cognitive worldview that is formed from experience or specific knowledge it is accepted as “unknown”, “hostile” by the participants of the situation predetermining their vague and unpredictable behaviour. The latter is modifiable through the application of certain principles employed by a health care professional's cultural education. This process presupposes a combined implication of the specific protocols adopted by the medical establishment with joint application of three pillared PIA approach: PRELIMINARIES, INTERACTION, ASSESSMENT. The approach embraces the cross-cultural, semantic and cognitive standards to be met by a health care professional while disclosing an unfavourable diagnosis that changes the perception of a situation of breaking bad news by its participants. Through PIA approach to SPIKES physicians get opportunity to appeal to the very needs of the patients in cross-cultural setting by reshaping classical cognitive images WHO (physician) → ACTS (doesn't treat) – WHO (patient) into interaction frames: WHO (physician) → ACTS (knows) → WHO (patient); WHO (physician) → ACTS (understands / supports) → WHO (patient); WHO (physician) → ACTS (understands / supports) → WHO (patient). The latter tends to reduce the negative experience earned while undergoing “breaking bad news” situation, creates conditions for successful cross-cultural communication which, in their turn, preserve patient- provider interaction.

#### 4. Discussion

Due to the fact that medical universities' curriculum has been enjoying the reputation of an extremely overloaded one it not much space is left for cultural trainings that is of crucial importance in defining patients' personal values, owing to the fact that the latter are preserved as the fragment the patient's cognitive worldview accumulated with the experience in form of a frame – a prototypical portion of individual's culture that absorbs and translates via communicative unites the knowledge on particular situation or event (Fillmore, 1982, p. 118). These are the means of verbal and non-verbal communication that fill the definite parts of the frame (slots) with appropriate words and give an excess to its superior cognitive structure (Fillmore, 1985, p. 223) – concept. Owing to its non-finite nature a frame is capable of evoking the limitless number of its parts embedded in cognitive worldview of an individual pertaining to a definite situation or an event (Fillmore, 1982, p. 130). If there is no record on “breaking bad news” event in the cognitive worldview either of a medical professional or a patient both participants of the occurring event may face considerable difficulties in its interpretation. Consequently, such cases are served by invoked frames, which present some situational “blank spaces” when an individual is supplied with the information from universal knowledge database coming from the general experience of a society or comprehended directly from the text. In other case, an image, already existing in participant's mind, evokes frame relevant to the situation of “breaking bad news” (evoked frame) (Fillmore, 1982, p. 20) and the event becomes clear, structured and reduces the threat of unexpected outcomes. To access the structures evoking the frame of “breaking bad news” the prototype of the situation is addressed through the collective meaning of the notion. Since there is no unified definition of “breaking bad news” the collective definition is required. “Breaking bad news” notion is represented through certain groups of lexical units – the verbal and non-verbal components. The verbal constituents are expressed explicitly by certain lexical units available in different definitions of “breaking bad news”. The derived constituents are depicted via their lexical representations are:

- EVENT: situation (Narayanan, Bista, & Koshy, 2010), news (Buckman, 1984), disclosure (Dosanjh, Barnes & Bhandari, 2001);
- PARTICIPANTS: patient (Narayanan, Bista, & Koshy, 2010) relatives, health care workers (Dosanjh, Barnes & Bhandari, 2001).
- SUBJECT: physical and mental wellbeing (Narayanan, Bista, & Koshy, 2010);
- LIFE PERIOD: present lifestyle, life choices (Narayanan, Bista, & Koshy, 2010), view of the

- future (Buckman, 1984);
- EFFECT: sudden, unexpected (Narayanan, Bista, & Koshy, 2010), drastic, negative (Buckman, 1984), hurting (Dosanjh, Barnes & Bhandari, 2001);
  - REACTION / EMOTIONS: psychologically difficult, hopelessness, threatening (Narayanan, Bista, & Koshy, 2010), painful, embarrassing (Dosanjh, Barnes & Bhandari, 2001); blame, anger, mistrust (Colletti et. al., 2001). Considering the constituents derived from four definitions explored, "breaking bad news" is understood as an issue that:
    - 1) can be perceived differently: as *news* – "newly received or noteworthy information, especially about recent events"; as *disclosure* – "the action of making new or secret information known"; as *information* – "facts provided or learned about something or someone";
    - 2) has the number of participants of the defined origin: *a patient* – "a person receiving or registered to receive medical treatment"; *a relative* – "a person connected by blood or marriage"; *health care worker* – "a person engaged or qualified in a medical profession";
    - 3) encompasses the body and spiritual dimensions: *physical* – "relating to the body as opposed to the mind"; *mental* – "pertaining to the mind"; *well-being* – "the state of being comfortable, healthy, or happy";
    - 4) is terminal in its nature and can be differentiated in terms of "before" and "after" giving little or no certainty: *present lifestyle* – "the way in which a person lives existing or occurring now"; *life choices* – "the right or ability to choose the existence of an individual human being or animal"; *view of the future* – "a particular way of considering or regarding events that will or are likely to happen in time to come";
    - 5) has rather unpredictable consequences and is predominantly unpleasant to whom it may concern: *sudden* – "occurring or done quickly and unexpectedly or without warning"; *unexpected* – "not expected or regarded as likely to happen"; *drastic and negative* – "may have a strong or far-reaching effect; can be radical and extreme"; *hurting* – "injuring";
    - 6) affecting badly and driving contradictory emotions: *psychologically difficult* – "causing hardships or problems in a way that affects the mind or relates to the emotional state of a person"; *hopelessness* – "feeling or state of despair; lack of hope"; *threatening* – "having a hostile or deliberately frightening quality or manner"; *painful* – causing distress or trouble; *embarrassing* – "causing a feeling of self-consciousness, shame, or awkwardness"; *blame* – "feel or declare that (someone or something) is responsible for a fault or wrong"; *anger* – "a strong feeling of annoyance, displeasure, or hostility"; *mistrust* – "lack of trust; suspicion".

Based on the six-component definition of breaking bad news the following universally the issue is reflected as: as one that can be **perceived differently**, has the **number of participants** of the defined origin, encompasses the **body and spiritual dimensions**, is terminal in its nature and can be differentiated in terms of "before" and "after" giving **little or no certainty**, has rather **unpredictable consequences** and is **predominantly unpleasant** to whom it may concern, affecting badly and driving contradictory emotions. The latter is established through patient-physician experience worldwide, is devised in terms of medical English that is official, international, and, apparently, establishes little of what can be rendered or modified through national and religious aspects of a patient with non-English cultural background.

#### 4.1 Cognitive-semantic aspect of breaking bad news

The above study of the definitions' components sheds light to the internal structure of breaking bad news, the latter is determined by a scene (Fillmore, 1977) constructing a frame under the same name. The derived definition contains explicit data on the issues. Being reflected in universal patient-physician experience it is devised in terms of medical English that is official, international, and, apparently, establishes little of what can be rendered or modified through national and religious

aspects of a patient with non-English cultural background. The implicit details are those present in the situation but not expressed explicitly and consequently are not reflected in any of the official meanings. These belong to non-verbal components that can be either implied by the situation and establishment (interior of the building, background noise, light) or articulated through non-verbal means of communication: body language (gestures, mimics, posture). Both types of the details influence the flow and outcomes of the "breaking bad news" event and some of them are subjected to modifying. In order to sort out the explicit and implicit components that may be altered the frame analysis is applied as a tool to spot and figure out the basic characteristics of the scene (Fillmore, 1982, p. 117) like: participants, their roles, the place, time attributed to "breaking bad news". The medium for framing is provided by the collective definition derived earlier. "Breaking bad news" situation is enclosed by means of interactional frame or action frame WHO ACTS (ACTS ON) WHO (WHAT) (Zhabotynska, 2010): PHYSICIAN INTERACTS with PATIENT, and is further fractured into the slots filled with the certain lexical material.

Slot "PHYSICIAN" illustrates a *health care worker*. Although the explicated lexical material representing the slot is limited to the collective notion of a *health care worker* it implicates a broad number of lexical units that index the various types of professionals engaged in health care that range from *middle level personnel* to those *professionals of primary, secondary and tertiary levels* of care and the *managers* of the establishment depending upon the policy regulating the issues of disclosure in a particular medical setting. The main focus of the investigation falls on the intended *secondary and tertiary level specialists* concerning the prevalence of chronic conditions attributed to the mortality causes worldwide.

Slot "INTERACTS" serves doctor-patient synergy through lexis like: *to communicate, to disclose, to reveal, to tell, to discuss, to work*. These verbs are generally utilised by a medical professional, but owing to the fact, that the patient-centered paradigm prevailing in modern health care, views patients as its core in order to select the utmost interaction tools, a medical professional's choice gets considerably influenced by a number of factors like: patient's age, education, mental health, previous medical history, cultural and religious background. This effect broadens the scope of lexis utilized by health care professional and such words like: *to appeal, to empathy, to reassure, to support, to undergo, to prepare* and a lot of other enter the vocabulary of a health care professional. Consequently, the interaction tools are firstly put into sets, then wrapped into specific strategies that are employed in particular cases. This is a precondition towards the shift from lexical base covering the physician-patient interaction towards attributing it vital importance. The latter shapes the new opportunity to the health care workers to communicate more effectively appealing the very personality of a unique individual patient in terms of modern health care principles.

Slot "PATIENT" describes a *patient* (and implicates one or several *patient's relatives*). The explicit lexical content of the slot can be subdivided into those describing patient's expressed feelings, understanding of the event, and realization of the possible consequences. Feelings experienced by a patient or their relatives collect the lexemes of event's the perception revealing the tendency towards selection of lexical units primarily negative in their meanings such as: *blame, anger, mistrust, hopelessness*. Their usage illustrates the negative attitude of a patient towards what is happening, underlines possible rejection of the facts, trying to transfer the guilt, and sensing personal desperateness. Understanding of the event is fixed with the nouns: *news, disclosure, and situation* that point at the event categorized by time, place, and participants collected around the subject. The presence of a "surprise effect" is experienced as *difficult, threatening, painful, embarrassing, drastic, negative, and hurting* and brings the destructive aspects to the patient's agenda. Realization of consequences is outlined via lexis that describes hindering the possibility of *present lifestyle* and plans already made. Furthermore, it rejects the certainty in things connected with *physical and mental well-being, view of the future* and diminishes *life choices*. The formation of implicit side of the slot is essentially influenced by personal qualities of a patient or a relative shaped under the influence of cultural values and their world view.

To sum the previously mentioned up the lexis serving the event of "breaking bad news" is

creating the content of the slots activated of the interactional frame structure "breaking bad news" PHYSICIAN INTERACTS with PATIENT. All slots can be expended and modified according the norms of medical as well as cultural and religious backgrounds of both a patient and a health care worker. Since the situation of "breaking bad news" is fixed in its official meaning that reflects explicit side of knowledge on it, the implicit aspect of it is referred to as the collection of means for expanding and modifying of the latter by firstly adopting the norms of cross-cultural environment and secondly through cross-cultural education and accumulation of the knowledge necessary to frame the issue turning it from invoked to evoked structure.

#### 4.2 *Adaptation to a cross-cultural setting*

Regardless of the cultural heritage the patient obtains, one of the main tasks of a physician while eliciting any kind of information to the patient is to help patient understand the function the medical establishment can perform in their treatment.

The patient's attitude towards health care and situations like "breaking bad news" is predominantly compiled considering some of the basic notions: *health, treatment / healing, disease, suffering, and death* that are directly influenced by religion, belief, and culture of an individual (Hordern, 2016, p. 589). The latter must be accurately interpreted by a healthcare worker (Hordern, 2016, p. 590) since it alters the treatment options, their consequences, and flow, moreover the background knowledge on patient's culture aid the deeper understanding of the patients' or their relatives' behavior in cross-cultural dimensions (Department of Health, 2009).

Health care in Western tradition has been marching together with the scientific progress (Yuan, 2017, p. 4) adopting itself to new changes in methods, procedures and ways of treatment while Islam has always been consistently reflected in culture and the cognitive images of health and illness shaping the core of worldview of Muslims (Ashy, 1999, p. 243). Judging from the determinants that tailor universal status of health care it must be assumed that on one hand, the understanding of physician-patient interaction is fixed in the worldview of patient with western cultural pattern and may only slightly differ from that obtained by a patient with Muslim cultural background. On the other hand, the feasible reaction to cases the patients happen to undergo seems to be rather controversial one. Since the successful performance in cross-cultural setting (e.g. "breaking bad news") is undermined by a health care worker's mastering of cultural and behavioural norms the patient is expected to adhere to, there is a need in expending the content of medical protocols regulating such kind of disclosure event in terms of their cultural component.

As far as the following collection of factors: the transferring of the information, the establishing of the roles, the verbal / non-verbal ways of expressing and the conveying of emotions impact tremendously the treatment option in general and deciding for therapy in particular (Hurley et al., 2017, p. 539), a secondary or tertiary level physician is expected to possess specific knowledge in both communication and its cross-cultural variations in order to reach the utmost understanding and to develop patient's adherence/retention in medical settings specialized in chronic care. That is why the accurate study of patients' medical history and gaining basic knowledge on patient's culture and religion play a crucial role in considering the patient's perception of "breaking bad news".

#### 4.3 *Accumulation of experience*

Regardless of the cultural background, when it comes to health care, the patients keep in mind the frame of the situations primarily connected with a medical setting and a physician. Having general understanding of health care as: WHO (PHYSICIAN) → ACTS (TREATS) → WHO (PATIENT), "breaking bad news" situation becomes atypical for the patients, who share the same cultural values as the health care workers do, as well as for those participants of the situation, whose cultural backgrounds differ. As a part of treatment is perceived as: WHO (PHYSICIAN) → ACTS (TREATS) → WHO (PATIENT), but considering the above analysis of "breaking bad news" definition, the



unfavourable information disclosure is likely to be translated through the invoked frame, since predominantly the participants of the situation have no particular frame to evoke. Consequently, the invoked frame: **WHO (PHYSICIAN) – ACTS (DOESN'T TREAT) – WHO (PATIENT)**, serves the situation of breaking bad news due to the fact that invoked cognitive pattern is being established in the process of interaction since the replica of it is absent among the cognitive structures shaped via previous experience collected in health care institutions. Exceptional are cases where either the health care worker or patient has already obtained knowledge directly from the experience.

#### 4.4 PIA modification of SPIKES protocol

There exist at least two ways for the participants to perceive "breaking bad news" situation. As invoked frame and through evoked one. Considering the semantics of lexis used to describe breaking bad news, the latter is preferably translated via invoked frame: **WHO (PHYSICIAN) – ACTS (DOESN'T TREAT) – WHO (PATIENT)** or **WHO (PHYSICIAN) – ACTS (HURTS) – WHO (PATIENT)** due to the presence in the slot "PATIENT" of lexis verbalizing feelings: *blame, anger, mistrust, hopelessness, difficult, threatening, painful, embarrassing, drastic, negative, and hurting*. The invoked frames mentioned lead to a complete discrediting of a "modern breaker", who, more than likely, is a specialist (a physician from secondary or tertiary levels of care) and instead of performing their duty "to avoid abusing your position as a doctor" (General Medical Council, 2003) is perceived in the very moment of breaking bad news by the second participant as a useless health care worker in terms of treatment. The previously accumulated knowledge gives the possibility to alter such perception. The first type of knowledge accumulation is characteristic for both the patients, who have already dealt with situations of breaking bad news and created the cognitive structures containing the image of the event, and for the health care workers, who have gained the experience in similar circumstances. These ways of knowledge accumulation are not attributed to the principle of "patient-centered approach" since they are likely to cause considerable harm to the psychological condition of a patient even if they outcome with successful treatment. Grounding on the fact of previous accumulation of necessary data is a medium to create evoked frame on breaking bad news, it is suggested to address the health worker's educational background, and expending their practical communicative skills by cross-cultural education and training. It also undermines a care provider to prepare for such communication with through evaluation of protocols specifically designed to regulate the flow of the process.

Secondary and tertiary level specialists, as a rule, tend to have rather brief history of communication with the patient in their disposal in comparison with family physicians that see the patients registered with them on regular basis. This, predictably, can cause a lack of data on personal details predetermined by the national heritage of a patient. In order to omit unnecessary manipulations with time-consuming cultural studies one of the official protocols regulating the "breaking bad news" procedure is to be employed and since the latter doesn't offer the accurate instruction concerning personal values of a patient it can be expended through adding cultural component.

One of such protocols offered by the team of the researchers in 2000 year is "SPIKES – The Six-Step Protocol" (Baile et al., 2000). It is officially recommended by the Centre of Excellence in Teaching and Learning of City University of London and is widely used by health care workers worldwide. The content of the protocol is divided into six sequential steps, the titles of which, compose the acronym SPIKES, where S refers to as Setting up, P – Perception, I – Invitation, K – Knowledge, E – Emotions and S – Strategy/Summary. In terms of cognitive linguistics, the knowledge of SPIKES protocol is firstly, recorded in memory of a health care worker as a script – a variation of frame representing sequential or procedural events (Fillmore & Baker, 2009, p. 314) with a definite number of participants: a physician (predominantly from the second or tertiary levels of care), a patient or a family member. Secondly, it is preserved in the memory of a care provider, and thirdly, it is ready to be evoked any time. In order to add the cultural component, the script of SPIKES protocol

is subdivided into three coherent PIA phases: *PRELIMINARIES*, *INTERACTION*, and *ASSESSMENT*. In this way a three pillared PIA approach is established.

*PRELIMINARIES* is viewed as the phase prior to communicative event of breaking bad news. Here belong planning and structuring of communication. This phase is considered to be a key component of health care worker's cultural education that can positively modify their future compliance. Moving through *PRELIMINARIES* a health care professional is supposed to obtain the data illustrated in SPIKES protocol as well as to mount the personal details on patient's medical history (clinical aspect), their personality (psychological aspect), and their cultural background (moral aspect). Incorporation of these aspects impacts the flow and the outcomes of forthcoming interaction (UK Department of Health, 2009). Moreover, the latter presents the possibility for action frame basic component's modifications discussed in the previous paragraphs.

Clinical aspect is derived from integration of present and past medical facts available from patient's medical history that shapes the image of organism's physiological condition, contains data on family and social history (University of Glasgow, 2015). It also includes the guidelines issued in the first step of SPIKES protocol that manages the following parameters of "breaking bad news" communication: defining subject, location, number of people involved, communicative command (examples of opening phrases, introduction components).

Psychological aspect outlines the information of mental state of health gathered through the personal observations and those previously inspected by the other specialists.

Moral aspect is embedded in cultural norms, beliefs, and values accumulated by the society or social group a patient stems from. The accurate cultural profiling of the patient's personality facilitates, the insight into the grounding of their social behaviour models offer the prospect on their potential conduct while facing "breaking bad news" situations. As far as the cross-cultural medical setting is an environment where medical workers and patients with different worldviews counteract in terms of giving and getting medical assistance, cultural profiling, preceding the event of breaking bad news, is a lacking tool in official health care protocols regulating the disclosure situations.

According to the recently obtained data, one of the brightest examples of cross-cultural environment in health care services is illustrated by the West European Countries (*Eurostat Statistics Explained*, 2019) that constantly face interaction with Muslim culture of Syrian and Iraqi refugees (AIDA, 2018). Thus preparing for a disclosure of an unfavourable diagnosis a health care worker is supposed to be aware of the Muslim perception of the world that is predominantly undermined by the principle advocating the superiority of Islam (Ashy, 1999, p. 243), thus the second participant of "breaking bad news" situation is a patient-believer. The religion in this case performs the function of a mirror reflecting the perception and interpretation of things happening to a patient-believer. The patients of Islam confession are referred to as patient-believers since they are strongly bound to the norms of their doctrinal canons, according to which "actions are to be judged by their intentions" (Gatrada & Shekhh, 2001, p. 74), and hard times must be undergone with utmost belief and power of God through hard work and struggling (Ashy, 1999). So, the issue of bad news delivery is to be viewed from the perspective of modifying the disclosure according to the cultural and religious background of a patient-believer. The patients, adhering to such cultural traditions, are potentially prepared to face the hardship connected with long-term treatment. The cultural values and their influence on the profession and daily activities are explored by a number of scientists, for instance, G. Hofstede's team, that offer to the public *Hofstede Insights* platform. Another, possible source of cultural issues and their impact formation is also offered by online open access platform *Open Culture*. Amid the myriad of cultural characteristics, the scientific team supervised by G. Hofstede offers several criteria to shape the peculiarities of a culture: Uncertainty Avoidance Index (UAI), Long Term Orientation (LTO), and Indulgence (IND) (Hofstede, 2001). Considering the definition of "breaking bad news" derived in the previous paragraphs, the fact that this event tends to evolve crisis situations and those posing a potential risk to a psychological condition of a patient, the data on UAI, LTO, IND bear considerable significance for *PRELIMINARIES* since they are opted as useful and are available in open access to be applied by a health care worker while preparing for cross-cultural environment

communication. The platform developed G. Hofstede's team of researchers contains not only the clarifications, but also comparison of several countries' cultural backgrounds which are constantly in focus of ongoing international studies. Both platforms *Hofstede Insights* and *Open Culture* can successfully be applied to medical settings attributed to "breaking bad news" communication and serve as effective educational media for the health care professionals wanting to cultivate the necessary cultural awareness. The inspection of key principals determining cultural values of Muslim patients is constructed via calculation and clarifications of UAI, LTO, IND collected for Syrian and Iraqi citizens by *Hofstede Insights*. The results illustrate the following tendencies:

- rather high UAI underlines the strong need of a patient in following rigid instructions and rules that regulate the behaviour and ideas of Muslim;
- LTO data dwell upon the appealing to the valuable past experience and simultaneous readiness to deal with present hardship shaping prospects of future;
- IND clarifies the high level of self-control and courtesy the patient is expected to manifest.

The command on the above mentioned cultural and religious tendencies enables the health care worker to address the modifiable aspect of "breaking bad news" communication in order to reduce its negative impact on the participants of a disclosure situation in general and each of the SPIKES protocol' steps in particular. The cultural and religious issues' expertise gained while *PRELIMINARIES* contributes to utmost accuracy of a medical professional in terms of deciding for the content, place, and the participants of the planned communication.

*INTERACTION* phase is preconditioned by the communication awareness and skills mounted by a health care professional while *PRELIMINARIES*. The phase gets practical importance in optimizing the classical model of SPIKES. It comprises the second, the third, and the fourth steps "SPIKES" protocol. During this phase a health care professional is recommended to assess the patient's perception, to determine the patient's awareness, understanding, and reaction towards the facts delivered through analysis of verbal and non-verbal clues articulated by them. Also it is decisive to explore the extent and the limits of the information the patient is ready to perceive. The next comes educating of the patient on treatment options, awarding specific attention to its coping stones and other details. Here belongs the decent demonstration of empathy, neutralism, understanding, assertiveness, the extend of which, is modified by the outcomes got while *PRELIMINARIES*.

*ASSESSMENT* stage embraces the fifth and the sixth steps of SPIKES protocol. It presupposes the eliciting, the cooperative planning of the future treatment procedures and the summing up of the patient's reaction via interpreting the verbal and non-verbal behavioural aspects displayed by them. Additionally, in the focus of this phase is the retrospective reflection of the occurred "breaking bad news" event. The *ASSESSMENT* stage enables the health care professional to analyse the gained experience and to record it in form of frame that can be evoked any time it is referred to.

Considering PIA approach that develops three stages of "breaking bad news" situation, different parts of SPIKES protocol can get modified through adopting cultural principle, moreover there is a potential opportunity of altering the classical perception of breaking bad news situation in general and a care provider in particular. The latter is illustrated in the following table.

Table 1 depicts the example of content of the optimised model of breaking bad news as a dynamic three layered entity, that aims to address the variable cross-cultural health care setting. Additionally, table 1 contains the data on alterations of cognitive structures invoked during interpreting of the situation of breaking bad news. In this way the positive dynamics in eliciting diagnosis is explicated through changing of the status the knowledge on breaking bad news gains through **adopting the evoked framing principal**. The latter offers continuous upgrading of personal, professional, and educational qualities of a health care professional through careful reflection on the events and further upgrading professional communication skills.

**Table 1.** PIA modification of SPIKES with Muslim patients

STAGES	Steps of SPIKES Protocol	Cultural portraying of a patient-believer (by Holftede Insights Online Platform): UAI, LTO, and IND	SPIKES Protocol Modifications	Metamorphoses in perception of breaking bad news (via frame-semantic analysis)
PRELIMINARIES	Step 1. SETTING UP the Interview	1) <i>the patient is prepared for instructions to perceive, adhere to, and to follow rules and precautions</i> 2) <i>the patient values the past experience and is potentially ready to face the hardships which outline the future</i> 3) <i>the patient exhibits the stoicism and demonstrates the courtesy</i>	Study the past medical and family history of a patient or find a case already happening in the past with an aim to make an appeal to similar events. Use the collected data during “starting off” in the following way: <i>Do you remember the case when...? I can clearly recollect the events happening to / in... Your case reminds me the one we had in... etc.</i>	WHO (physician) – ACTS (does not treat / hurts) – WHO (patient) => <b>WHO (physician) – ACTS (knows) – WHO (patient)</b>
	Step 2. Assessment of patient’s PERCEPTION		Elicit the hardships to overcome and how can they affect the future. The sentences like: <i>Humans face hardships... Our hardships can be of different degree... We both have learnt that hardships train stoicism... etc.</i> Check for absence of verbal and non-verbal clues embarrassing the courtesy explicated by a patient.	WHO (physician) – ACTS (does not treat) – WHO (patient) => <b>WHO (physician) – ACTS (understands / supports) – WHO (patient)</b>
Step 3. Obtaining the Patient’s INVIATATION	Prepare to elicit the details of the case due to rather steady positioning of the personality of the patient. The milder details disclosure may start with the sentence: <i>I understand you are strong enough to hear the details. They are very important to you, aren’t they?</i>			
Step 4. Giving KNOWLEDGE and Information to the Patient	Come up with explanations (supported by links to the past cases). For instance: <i>Your case is similar to one happening to people with ..., but the differences are... I think you have experienced some kind of...”</i>			
ASSESSMENT	Step 5. Addressing the Patient’s EMOTIONS with empathetic responses		Be ready to observe the absence or a very small amount of emotions expressed by the patient in order not mix such behaviour with misunderstanding, reduce the sentences that encourage the explication of emotions to a minimum.	WHO (physician) – ACTS (does not treat) – WHO (patient) => <b>WHO (physician) – ACTS (recognises) – WHO (patient)</b>
	Step 6. STRATEGY and Summary		Assemble the set of distinct rules and instructions necessary to adhere to. After completing communication make a thorough record of cultural issues influencing breaking bad news communication, analyse them carefully in order to create a number of evoked frames.	

**5. Conclusions**

Breaking bad news appears to be a constant challenge that impacts care provider’s professionalism considerably in terms of interpersonal health care communication constructed by the specialists preferably from secondary and tertiary levels of care. The issues of framing the situation and the cross-cultural aspect of “breaking bad news” situation address the advancement of the expertise the care provider can demonstrate while dealing with an unfavourable diagnosis disclosure. Optimised strategy (PIA) of SPIKES protocol application presupposes the account of cultural peculiarities to be checked in order to hone the preparation phase for further alteration of the interaction phase component. Simultaneously, PIA approach to SPIKES enables a physician to evoke already existing frame on the disclosure situation and addresses the very peculiar personal needs of a patient during cross-cultural “breaking bad news” event. Moreover, PIA modification of SPIKES helps physicians reduce the level of negativity connected with breaking bad news by enforcing their position as doctors.

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