Supplementary Table 2: Findings of individual studies

Author (year)	Matter investigated	Findings Description of practices *Functioning of practices (in italics)*
Alhuwalia et al[23] (2013)	How doctors discuss advance care planning with patients in heart failure	Sometimes, doctors' talk about the nature of heart failure includes indirect talk about the declining disease trajectory Doctors rarely elicit patient preferences for future care, when they do so, they sometimes talk about hypothetical life-sustaining interventions in order to elicit patients' views
Beach[24] (2003)	The interactional construction of optimistic responses to uncertain / despairing cancer circumstances	All family members use 'upbeat talk' referring to: fighting the illness, perseverance, hope, and facing the illness together *Conveys and constructs optimism. Shifting to positive topics limits time spent talking on negative topics*
Leydon[25] (2008)	How experienced doctors and patients who have not previously met talk about cancer, its treatment, and uncertainty	Doctors follow bad or uncertain news with relatively hopeful and/or positive news. In response, patients focus on second thing said – i.e. they engage with the more optimistic hopeful topic. *Can suppress talk on relatively bad information thus limiting opportunities to explore its meaning*
Lutfey & Maynard[26] (1998)	Ways in which doctors, patients and family members cautiously approach the topic of terminal illness; the resources available to patients and family members to deflect, divert, avoid or euphemize the matter	1: Doctor talks allusively, indirectly via: referring to associated topics; speaking in a way that allows patient to draw own conclusions, e.g. professing emotional concern about patient, reporting issues as 'not positive' rather than 'negative'; reference to 'the' cancer, to 'it' or 'that' Three kinds of response to this by patients and family members: (1) shifting away from the topic, (2) stoic unresponsiveness (3) conveying an understanding of the topic (2) and (3) allow doctor to move to more direct reference and questions *Indirect talk is designed to elicit patients' opinions and understandings, depending on patient and carer responses it can allow for a progressive, stepwise approach to more direct talk about illness and dying. However, it also leaves room for recipients easily to deflect away from or avoid the topics, and*

		some patients and family members do so 2: Touching the patient: doctor holds the patient's hand alongside indirect talk *Demonstrate support and comforting whilst also conveying the seriousness of the topic*
Maynard & Frankel[27] (2003)	How one primary care doctor and patient talk about uncertain mammogram results	In face of diagnostic uncertainty, doctor offers optimistic version (cyst), patient proposes pessimistic version (malignancy). Both cautiously approach and exit from serious news with teasing and humorous talk. Both soften serious/inconclusive news with pieces of good news. *The doctor's and the patient's teasing, humour and softening helps maintain their social relationship and this helps balance effects of professing different perspectives*
Miller & Silverman[28] (1995)	How troubles are talked about in counselling settings	1: Hypothetical questions - counsellors ask clients to imagine future states in respect to emotions *Effective in eliciting clients' talk about troubling topics* 2: Hypothetical questions - counsellors ask clients to imagine how they will manage future difficulties and about their hopes for the future *Effective in initiating discussion of plans and identifying future actions* 3: Asking non-hypothetical questions about clients' fears and/or concerns *Variably effective - clients sometimes resist answering* 4: Counsellors summarise client's position on future plans and actions in a way that highlights and agrees with some part(s) of what client has said, then elaborate on how actions might be implemented *Convey understanding and agreement. Allows counsellor to frame client as primarily responsible for planning and proposing actions whilst specifically highlighting and thus encouraging certain elements*
Norton et al[29] (2013)	Processes of prognostic communication during palliative care consultation with seriously ill patients and their families	1: Signposting the crossroads – asking patient to consider there may be a time in the future when benefits of treatments would no longer outweigh burdens, and conveying that this would constitute a decision-making time or crossroads *Authors propose, though do not empirically demonstrate that this creates an opportunity to re-engage in a discussion of goals of care at a specifically identified future time point*. 2: Closing off a goal – clinician first elicits patient's and/or family members' understanding of illness trajectory, then describes the clinical perspective, making differences in understanding explicit, and includes explicitly stating that a particular goal was not clinically feasible. *Thereby pointing out discrepancies between what was hoped for and what clinical team felt was likely or feasible.*

		3: Clarifying the current path – explicitly describing most likely outcome(s) of current trajectory, sometimes by contrasting best case scenario with more likely one. *Authors propose, though do not empirically demonstrate that this helps recipients recognise staying on current treatment trajectory would likely not lead to the hoped for outcome (eg cure, recovery)* 4: Linking paths and patient's values – clinician elicits and/or confirms their understanding of the patient's values and juxtaposes these with the most likely prognostic scenarios *Authors propose, though do not empirically demonstrate that this provides a context for presenting different treatment approaches and choices between them* 5: Choosing among paths – once patient and/or family have acknowledged the current clinical course will not result in the hoped-for outcome, clinician proposes a different goal and path, often involving comfort care. Decisions then focus on how patient might want to live her life in the time that remained. *Authors propose, though do not empirically demonstrate that this provides a frame for medical decisions around continuing or withdrawing particular disease-treatments*
Peräkylä & Bor[30] (1990)	Addressing the patient's fears about the future in HIV counselling	1: Turbulent talk - counsellors' talk features pauses, self-repairs and hesitations at the point where they introduce the difficult issues. Patients pay sustained attention, and replicate turbulence themselves when answering *Elegantly manages cultural prohibitions about talking of sickness and death. Double action of conveying delicacy and sensitivity whilst also actually engaging in talk about the topic* 2: Where patient has displayed reluctance to respond to questions about the 'dreaded issues', counsellor may issue summary of what patient has already said in a way that gives extra backing to previous questions, then they repeat / rephrase a previous question *Summaries treat the sensitive topics as something the patient/client has themself raised - and thus should engage in, thus persuasive in encouraging talk on the topics* 3: One way to broach the topics is the 'information delivery format': counsellor does almost all the talking about negative/sensitive issue(s) and its implications. Patient need only acknowledge *Creates interaction in which counsellor is minimally dependent on patient's contributions. Allows issues to be covered relatively quickly* 4: Another way is the 'interview format' - where counsellor uses lengthy series of open questions to elicit talk about future from patient. Subsequently, counsellors often give their own views. *Gives patients opportunities to reflect on and express their views and concerns, and issue own proposals. Takes a relatively long time to cover issues. May work badly with reticent patients*

Peräkylä[31] (1993)	How counsellors, during AIDS counselling interviews, introduce issues such as illness and death	1: Asking questions about future matters that echo something patient already raised or hinted at *Effective in leading into discussion of sensitive future issues* 2: Hypothetical questions: counsellor describes hypothetical future situation and follows with an enquiry focusing on patient's fears about or ways of dealing with this. Done in specific ways: a) Question is conveyed as in some way connected with or touched off by patient's prior talk *Makes it difficult for patient to discount or avoid the question. Allows counsellor to avoid conveying themselves as unilaterally imposing the difficult future topic on the patient* b) Hypothetical nature of what is talked about is emphasised *Minimises the threat and seriousness of the topic* c) Includes hesitations and self-repairs *Convey sensitivity and delicacy of the topic. Also conveys counsellor as aware this is sensitive for the patient. In turn, this indirectly suggests the realness of the possible situation - thus counterbalancing the framing of the issue as hypothetical and 'not real'* *d)* Sometimes emphasising future situation as something anyone could face *Helps minimise the threat and seriousness of the topic for that individual* *Patients find it difficult not to respond to hypothetical questions. Also, treating future illness/end of life as hypothetical means professional avoids having to commit to accurate predictions about future uncertain events*
Peräkylä[32] (1995)	How counsellors in AIDS counselling introduce issues such as illness and death	1: Questions that give patients an opportunity to name an issue without focusing the enquiry at all, e.g. "Are there any issues you'd like to discuss?" *If patient then names a distressing issue, this establishes the topic more strongly than if the counsellor had taken the lead in proposing issues to talk about.* *2:* Questions that indirectly convey invitation to disclose fears or worries, e.g. 'What's your main concern today?" *Rarely effective in achieving 'on topic' responses* 3: Retrieving earlier themes when asking questions: the counsellor asks questions that refer back to potentially worry-indicative themes mentioned in, or absent from, patients' earlier talk *Allows counsellor to selectively focus on future difficult issues; conveys they have been paying attention to patient, also emphasises continuity between their enquiry and what patient has said. This makes it more difficult for clients to resist answering and engaging with the topics* 3: Hypothetical questions

		Compared with other practices, this is the most effective tool counsellors have for addressing future-related 'dreaded issues' with their clients. They constitute a powerful invitation for clients to consider their life in a dreaded future situation; an invitation difficult to resist once spelled out
Rodriguez et al[33] (2008)	The different ways prognosis is framed in consultations between oncologists and patients and family members	1: Doctors' and patients' 'prognostic statements' more frequently refer to outcomes of treatment than outcomes of actual disease. Treatment outcome statements more positive and involve more 'personalised language' whereas disease outcome statements more often involve general, depersonalised language - not mentioning patient e.g. 'The tumour will usually come back, either in the pelvis or somewhere else in the body'; 'About 50% of people, despite chemotherapy, would probably die within a year' *Authors speculate but do not demonstrate this patterning may create 'buffer zone' to mitigate effects of describing the disease as terminal, may allow patient to view disease in a more abstract way. May creates ambivalence about relevance of what is said for this patient in particular* 2: Statements more 'personalised' via you, I, your etc., e.g. 'People with your type of tumour', 'How much time do I have?' are rare *Compared to practices in (1) relevance of what is being said for that patient in particular is clearer*
Rodriguez et al[34] (2007)	The language that oncologists, incurable cancer patients, and their kin use when they talk about death and about treatment-related and disease-related prognosis	1: Implicit talk - doctors and patients use euphemisms e.g. pushing up daisies, or indirect references to death e.g. limited time frame, not going to live, shortening life *Authors speculatively propose this indicates participants recognise death as a possible outcome but wish to focus the discussion on remaining life* 2: Statements that include the word terminal or variations of the word death occur less often, doctors use them more than patients and family members. When patients and family members use these, they do so early in the consultation *Authors propose this suggests patient eagerness to know about prognosis but that physicians did not pursue this at the time patients actually raise it*
Sarangi & Clarke[35] (2002)	How counsellors and clients accomplish the process and outcome of genetic counselling	Counsellor refers to hypothetical scenarios, and combine with contrasts: e.g. 'If the test came back clear then X, but if it did show the chromosome then Y' *Creates interactional space for participants to explore alternatives*
Sarangi[36] (2010)	To examine 'reflective questions' in genetic	Reflective, hypothetical scenarios and questions: 'What if X happened?' Within these episodes, counsellors ask patient about how they have dealt with related matters in the past

	counselling	*Extend the clinical setting, both temporally and spatially, and create interactional space to deal with the wider context and consequences of knowing and letting be known one's genetic status*
Silverman & Peräkylä[37] (1990)	How professionals and clients in HIV clinics organise their talk in relation to the 'delicate' issues to be discussed - including sex and a 'menacing future'	1: Counsellor delays mentioning delicate issues through perturbations in their talk, and patient does so through delays in answering. At this point, counsellors sometimes leave silences and this sometimes results in patients going on to talk about the sensitive matter *Delays in delivery are not (merely) the result of psychological inhibitions, but also reflect the socially and culturally prescribed etiquette of approaching a delicate issue* 2: Counsellors talk about 'patients in general' rather than this particular patient, and emphasise the imaginary nature of the circumstances depicted *Downplays the relevance - for this particular patient - of the categories: ill, becoming unwell, dying, etc. This creates distance between the particular patient and e.g having dementia or dying*
Speer & Parsons[38] (2006)	Design, delivery and responses to one kind of hypothetical question in the gender clinic	Psychiatrist poses hypothetical questions about what patient would do if negative consequences arose from the treatment. Asked out of the blue - not linked to what patient has already raised *Used as diagnostic tool to test patient's commitment to their aspired to gender role*
Speer[39] (2010)	The form and function of a special class of hypothetical question that psychiatrists use in consultations with transsexual patients	Psychiatrists use hypothetical questions invoking negative scenarios concerning outcome of patients' treatment. Patients respond in ways that show steadfast commitment to treatment and aspired-to gender. Psychiatrists sometimes follow up with multiple related questions. One case of a patient posing a hypothetical question. Doctors' hypothetical questions follow failure of earlier attempts to encourage discussion of future difficulties *Remove potential barriers ordinarily associated with engaging the patient in a discussion of difficult future topics and potential problems concerning their treatment*
Tulsky et al[40] (1998)	How physicians discuss advance directives with patients	1: Posing hypothetical scenarios and determining patient preferences in these scenarios. 2: Use of vague language e.g. what patients would want if they became 'very very sick' or 'had something very serious'. These situations rarely defined, nor patients' understandings of them sought. Vague terms 'probably' 'unlikely' used in discussing outcomes 3: Doctors refer to outcomes of life-sustaining treatment in terms of death or complete recovery *Paper mainly describes practices and does not examine individual practices' functioning in detail*
Wade et	To open the ‘‘black box’’ of	1: Open questions, then using pauses and continuers, ceding the floor when patient initiates talk

al[41] (2009)	what goes on during informed consent appointments in a large multi-centre randomised controlled trial	*Encourages patients to voice their views, concerns and preferences* 2: Repeat questioning and probing *Enables in-depth exploration of concerns, tailoring information, and eliciting of further concerns*