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*Research Article*

# Pediatric Bad-News Communication in Medical Television Dramas: A Cross-Sectional Content Analysis and Educational Perspective

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## ABSTRACT

**Background:** Communicating the death of a child or other devastating clinical news to families is among the most difficult interpersonal tasks in pediatric care and remains an important target for undergraduate and graduate medical education. Medical television dramas frequently depict emotionally charged clinician-family encounters and may offer accessible teaching vignettes for discussion of communication technique, professionalism, ethics, and family-centered care.

**Objective:** To assess how television depicts death notification and delivery of bad news involving pediatric patients and to consider the educational value of these portrayals for pediatric communication education.

**Methods:** This retrospective cross-sectional study evaluated consecutive episodes from the most recent complete season of 15 popular medical television programs, totaling 255 episodes. Trained researchers identified incidents depicting death-telling or delivery of bad news involving pediatric patients and coded each event using a 16-item classification scheme developed from recommendations by academic clinicians and educators. Incidents were subsequently categorized as exemplary, good, satisfactory, or poor based on the number of criteria met, and descriptive statistics were used to summarize findings. Interrater reliability was assessed through blinded review of a random sample using kappa statistics.

**Results:** We reviewed 255 episodes across 15 prime-time medical dramas and identified 35 pediatric bad-news incidents, corresponding to an incident rate of 13.7 pediatric bad-news portrayals per 100 episodes screened. Overall, 22.9% of incidents were rated excellent to good, 37.1% satisfactory, and 40.0% poor to dreadful. Commonly depicted strengths included use of a private room, direct yet compassionate disclosure, expression of sympathy, and clinician self-introduction. Support-staff presence, time for family reaction, discussion of next steps, and follow-up information were rarely shown. Ethical and professionalism concerns were also observed, and interrater agreement was strong ($\kappa$=0.79).

**Conclusions:** Medical television dramas portray pediatric bad-news communication with variable quality and may be useful as discussion prompts in medical education. Curated clips may help learners analyze empathy, professionalism, family-centered communication, and common pitfalls in difficult conversations with children and families.

**Keywords:** Pediatrics; Death notification; Physician-patient communication; Medical education; Television medical dramas; Content analysis; Family-centered care

## Introduction

Delivering bad news is a foundational clinical communication task and is especially challenging when the patient is a child. Conversations about a child's death, life-threatening condition, or poor prognosis are emotionally charged and may occur in acute, inpatient, critical care, procedural, and subspecialty pediatric settings. The quality of these interactions may influence family understanding, trust, satisfaction with care, bereavement experiences, and clinician distress[1-3].

Pediatric bad-news communication occurs within a complex relationship among clinicians, parents or caregivers, and sometimes the child. Effective communication requires attention to developmental stage, parental expectations, diagnostic or prognostic uncertainty, culture, language, family-centered decision-making, and the potential need for ongoing support[3,4]. Parents have identified delayed or absent communication, inadequate preparation, unclear explanations of prognosis or next steps, insufficient acknowledgment of uncertainty, limited follow-up, an overwhelming number of unfamiliar clinicians, and language that families may misunderstand as key barriers to high-quality communication[3,4]. These findings underscore that effective pediatric bad-news communication depends not only on empathy but also on timing, setting, clarity, team-based support, and planning for subsequent care[4].

Despite its importance, formal instruction in breaking bad news remains inconsistent across medical education and clinical training[5]. Educational interventions that use role-play, simulation, standardized patients, structured communication frameworks, and video review suggest that difficult conversations are teachable and that targeted instruction can improve learner performance[4,6-9]. Pediatric-focused curricula further emphasize the distinct demands of communicating with children and families, including developmental considerations, shared decision-making, and follow-up after delivering serious news[3,4,8].

Medical television dramas may serve as an accessible supplementary resource for communication education. Prior scholarship suggests that carefully selected scenes from medical dramas can support teaching on communication, ethics, teamwork, professionalism, and public perceptions of health care when used in facilitated, critically reflective discussion[10-12]. For emotionally complex topics such as pediatric death notification, televised scenes may function as case vignettes that allow learners to identify effective behaviors, recognize omissions or problematic practices, and discuss how they would approach comparable encounters in clinical care. Television scenes should not be treated as models of actual practice; rather, their educational value lies in structured analysis of both exemplary and flawed communication[10-12].

Although prior studies have examined medical dramas broadly, less attention has focused on pediatric bad-news communication as a distinct educational topic. The present study sought to characterize how popular medical television programs depict death notification and the delivery of serious bad news to pediatric patients and their families, and to explore whether these portrayals may provide useful material for undergraduate, graduate, and continuing education in pediatric communication.

## Materials and Methods

### Study design and sample

This study was a retrospective, cross-sectional content analysis of pediatric bad-news communication scenes in popular medical television dramas. We reviewed consecutive episodes from the most recent complete season of 15 widely viewed medical television series, for a total of 255 episodes. The sampling frame focused on U.S. prime-time dramatic series broadcast between 2010 and 2025. We identified candidate programs by reviewing network schedules, online television guides, and major streaming catalogs. Series were eligible if they were predominantly dramatic and included at least one narrative arc in which clinicians delivered death notification or other serious bad news involving a pediatric patient. An academic clinical research team with experience examining depictions of clinical practice, communication, ethics, and professionalism in popular media conducted the study.

### Episode selection and inclusion criteria

For this study, bad-news communication was defined as any televised clinician-family or clinician-patient encounter in which death or other devastating clinical information was communicated to a family or patient about a child in a hospital-based setting. Eligible encounters included explicit death notification and serious prognosis or outcome discussions that would reasonably alter the family's or patient's understanding of the child's clinical future.

Episodes were included if they contained a substantive narrative involving a pediatric patient receiving hospital-based care and a clinician communicating death or other serious bad news to the patient or family. Scenes could occur in the emergency department, inpatient, procedural, critical care, waiting room, or other hospital locations. More than one reviewer evaluated series and episodes using predefined eligibility criteria and resolved disagreements through discussion and consensus. For each eligible series, the investigators selected the most recent complete season and reviewed episodes in chronological order to capture sequential depictions of pediatric bad-news communication **(Table 1)**.

**Table 1:** Pediatric bad-news incidents by television program.

| Series title | Network/ platform | Season aired* | Episodes screened | Pediatric bad-news incidents |
|---|---|---|---|---|
| ER | NBC | 2008–2009 | 22 | 5 |
| 09-01-2001 | Fox/ABC | 2024–2025 | 18 | 4 |
| Chicago Med | NBC | 2024–2025 | 22 | 3 |
| Grey's Anatomy | ABC | 2024–2025 | 18 | 3 |
| House | Fox | 2011–2012 | 22 | 3 |
| The Night Shift | NBC | 2017 | 10 | 3 |
| The Resident | Fox | 2022–2023 | 13 | 3 |
| Code Black | CBS | 2018 | 13 | 2 |
| HawthoRNe | TNT | 2011 | 10 | 2 |
| Mercy | Netflix | 2009–2010 | 22 | 2 |
| The Pitt | Max | 2025 | 15 | 2 |
| New Amsterdam | NBC | 2022–2023 | 13 | 1 |
| Pulse | Netflix | 2025 | 10 | 1 |
| The Good Doctor | ABC | 2024 | 10 | 1 |
| Trauma | NBC | 2009–2010 | 18 | 1 |

*The most recent, complete season available for each dramatic series.

Documentary-style programs, reality shows, non-dramatic formats, and episodes without substantive content related to pediatric bad-news communication were excluded.

### Coding framework and data abstraction

Coders were medical students trained in standardized data-extraction procedures before formal review began. Investigators jointly reviewed the coding scheme and abstraction protocol to ensure consistent application of study definitions. Investigators discussed questions that arose during pilot review with the principal investigator and resolved them by consensus.

A structured abstraction instrument identified and categorized incidents in which clinicians communicated death or serious bad news to pediatric patients. Each incident was defined by a specific pediatric patient storyline. For each incident, abstractors documented a brief description of the encounter, the principal characters involved, the clinical setting, the messenger's professional role, and how the communication was conducted and managed.

A panel of academic clinicians and educators evaluated each incident using a 16-item framework **(Table 2)**. The framework assessed five domains of high-quality communication: preparation and setting, professional presence, information exchange, emotional support, and planning and closure. Evaluated behaviors included verification of patient information; availability of support staff; use of a private room; professional appearance, self-identification, and role clarification; positioning at eye level; assessment of family understanding; direct but compassionate disclosure; response to questions; allowance for emotional reaction; expression of empathy; sensitivity to emotional state; discussion of next steps; and provision of follow-up information.

**Table 2:** Proposed 16-item evaluation framework for pediatric bad-news communication scenes[2,7-9].

| Domain | Example elements evaluated |
|---|---|
| Preparation and setting | Verifying patient information, support staff availability, private room |
| Professional presence | Professional appearance, introduction, description of role, positioning at eye level |
| Information exchange | Assessing what family knows, recapping events, direct but compassionate disclosure, answering questions |
| Emotional support | Allowing reaction time, empathy, alleviating guilt, sensitivity to emotional state |
| Planning and closure | Discussing next steps, follow-up information |

After coding, incidents were assigned an overall quality category based on the number of criteria met: exemplary (more than 13 of 16 criteria); good (10 to 12 criteria); satisfactory (7 to 9 criteria); or poor (fewer than 6 criteria).

### Outcomes and analysis

The primary outcomes were the frequency and overall quality of pediatric bad-news communication encounters identified across the sampled programs. Secondary outcomes included the clinical setting, the messenger's professional role, commonly met and omitted communication criteria, barriers to effective communication, and ethical or professionalism concerns.

Formal a priori sample-size calculations were not performed because the sampling frame comprised the most recent complete season of each eligible series, and all episodes within that frame were reviewed. The study was designed as a descriptive content analysis of a finite corpus of publicly available television episodes rather than a hypothesis-driven clinical investigation requiring power-based sample-size estimation. We used descriptive statistics to summarize categorical data.

To assess abstraction reliability, one investigator conducted a blinded review of a random 50% sample of episodes, and we estimated interrater agreement using Cohen's kappa. Because the study analyzed publicly available television content and did not involve human participants or protected health information, we did not require institutional review board approval.

## Results

### Incident frequency and distribution across programs

We reviewed 255 episodes from 15 prime-time medical television dramas and identified 35 pediatric bad-news communication incidents, corresponding to an incident rate of 13.7 incidents per 100 episodes screened. Incidents were distributed across all included programs, with counts ranging from 1 to 5 incidents per series (Table 1). The greatest numbers of pediatric bad-news incidents were observed in ER (n = 5), 9-1-1 (n = 4), and Chicago Med, Grey's Anatomy, House, The Night Shift, and The Resident (n = 3 each).

### Clinical setting and messenger characteristics

Of the 35 pediatric bad-news encounters, 31 (88.6%) occurred in the emergency department and 4 (11.4%) in hospital waiting rooms. Physicians most often delivered bad news (31/35, 88.6%), followed by nurses (3/35, 8.6%) and medical students (1/35, 2.9%).

### Quality and communication behaviors

Across all incidents, 8 of 35 encounters (22.9%) were rated excellent to good, 13 of 35 (37.1%) were rated satisfactory, and 14 of 35 (40.0%) were rated poor to dreadful, indicating that high-quality portrayals of pediatric bad-news communication were relatively uncommon. Frequently depicted strengths included moving family members to a private room, delivering the news directly yet compassionately, expressing sympathy, and introducing oneself. These behaviors aligned with key domains in the study framework, particularly preparation and setting, professional presence, and information exchange **(Table 2)**.

In contrast, several important communication behaviors were rarely observed. Rarely depicted elements included the presence or availability of support staff, time for emotional reaction, discussion of next steps, and follow-up information. These omissions were concentrated in the emotional-support and planning-and-closure domains of the evaluation framework, suggesting that televised encounters often emphasized disclosing the news itself more than the broader relational and practical work that follows.

### Contextual barriers, ethics, and reliability

Multiple contextual and relational barriers to effective communication were identified in televised pediatric bad-news encounters. Common complications included impersonal settings such as hallways; sudden death, homicide, or suicide; time pressure from other patients; delayed notification; limited access to clergy or other support staff; euphemistic or jargon-

heavy language; language barriers; spiritual concerns; cultural or social barriers; interruptions during the conversation; clinician inexperience; and unrealistic patient or family expectations. These factors frequently co-occurred within individual scenes and contributed to communication that appeared fragmented, rushed, or less supportive **(Table 3)**.

**Table 3:** Complications affecting pediatric bad-news communication in televised encounters.

| Complication category | Specific complication |
|---|---|
| Environment and setting | Impersonal setting (eg, hallway) |
| Clinical circumstance | Sudden death |
| Clinician communication | Lack of empathy |
| Clinical circumstance | Homicide or suicide |
| Workflow and system factors | Time constraints related to the needs of other patients |
| Workflow and system factors | Delay in notification |
| Support resources | Clergy or other support staff not readily available |
| External constraints | Pandemic or related consequences |
| Language and message clarity | Euphemisms or medical jargon unfamiliar to survivors |
| Language and communication barriers | Language barriers |
| Family and belief systems | Spiritual concerns |
| Family and sociocultural context | Cultural, ethnic, and social barriers |
| Clinician factors | Inexperience or lack of clinician training |
| Workflow and setting factors | Interruptions during the meeting with the family or patient |
| Family expectations | Unrealistic patient or family expectations |

We identified ethically questionable departures from standard practice in 4 of 35 incidents (11.4%), and professionalism concerns in 5 of 35 incidents (14.3%). Examples included disclosure in non-private settings; misleading or euphemistic language that obscured the seriousness of the situation; failure to involve appropriate support resources despite visible family distress; lack of empathy; dismissive responses to questions; interruptions without adequate closure; and visible frustration or blame directed at patients or families. Interrater agreement was strong, with a Cohen's kappa of 0.79.

## Discussion

This study identified a substantial number of pediatric bad-news communication scenes in popular medical television dramas, but most portrayals were mixed or poor rather than consistently exemplary. Across 35 incidents, fewer than one quarter were rated excellent to good, whereas 40.0% were categorized as poor to dreadful. These findings suggest that medical television may be less useful as a source of communication models to imitate directly than as a source of case material for guided analysis and discussion[10,11].

Several findings support the educational value of these scenes when used critically. Commonly depicted strengths included moving to a private room, disclosing directly yet compassionately, expressing sympathy, and the clinician's self-introduction. These behaviors align with the study's communication framework, particularly the domains of preparation and setting, professional presence, and information exchange. They also provide recognizable examples of core communication behaviors that educators can highlight during debriefing[10].

At the same time, key elements of high-quality pediatric communication were often missing. Support-staff involvement, time for emotional processing, discussion of next steps, and follow-up information were rarely depicted, suggesting that televised scenes tended to emphasize the moment of disclosure more than the broader relational and practical work that should follow difficult conversations[10,11]. For pediatric communication education, these omissions may be especially instructive because they create opportunities for learners to identify what was absent, consider how families might experience those gaps, and discuss how a more complete response could be structured in practice[1].

The findings also highlight the value of television clips for discussing contextual barriers to communication. Many encounters occurred in impersonal settings or under conditions such as sudden death, interruption, time pressure, limited support resources, language barriers, or cultural and spiritual complexity. These features make the scenes pedagogically valuable not because they depict ideal communication, but because they enable learners to analyze how challenging circumstances can affect tone, clarity, empathy, and closure in high-stakes conversations with children and families **(Table 3)**[11].

The ethical and professionalism concerns observed in a subset of incidents further reinforce the relevance of these clips for medical education. Scenes involving nonprivate disclosure, euphemistic or misleading language, inadequate support, lack of empathy, dismissive responses, or frustration toward families can prompt discussion of the boundaries of acceptable practice, professionalism under stress, and the difference between dramatic storytelling and patient-centered care[11]. In this respect, televised portrayals may help educators address not only communication techniques but also professional identity formation and the hidden curriculum surrounding emotionally difficult encounters[12].

These results also have implications beyond formal teaching sessions. Medical dramas may shape how learners, patients, and families imagine serious conversations in health care, including who delivers bad news, where it occurs, and what emotional and practical support accompanies it[13]. Because of that influence, media-based teaching may serve a dual purpose: helping trainees critique communication behaviors and recognize how popular portrayals can shape expectations brought into real pediatric encounters[8].

Several limitations should be considered when interpreting these findings. The analysis was limited to a finite sample of U.S. prime-time medical dramas and to the most recent complete season of each included series, which may limit generalizability to other programs, eras, or international media. The number of pediatric incidents was modest, the 16-item framework was educator-derived, and televised scenes are scripted for dramatic effect rather than intended to reflect actual clinical practice.

Future work could extend this approach by examining additional series and seasons, evaluating non-U.S. medical dramas, and linking selected clips to simulation, role-play, or structured debriefing within pediatric communication curricula. Comparative studies assessing learner outcomes after exposure

to media-based vignettes versus traditional teaching methods would help clarify the incremental educational value of this approach. Qualitative work with learners, clinicians, parents, and caregivers could also explore how televised depictions of pediatric bad-news communication shape expectations, trust, and perceptions of professionalism.

## Conclusion

Pediatric bad-news communication in medical television dramas is portrayed with variable quality. Although scenes often demonstrate valuable elements such as privacy, direct yet compassionate disclosure, sympathy, and professional role identification, they frequently omit support resources, opportunities for emotional processing, discussion of next steps, and follow-up information.

Television portrayals should not be used as communication models without critical appraisal. However, carefully selected clips, paired with structured debriefing and established communication frameworks, may provide accessible teaching materials for medical students, residents, and clinicians, helping them recognize both effective and problematic approaches to difficult conversations with children and families.

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