ECRONICON OPEN ACCESS

EC PAEDIATRICS
Research Article

Breaking Bad News in Paediatric Care: The Essential Role of Communication Training

Ana Sofia Nunes[1]*, Alexandra Vilas Fabião[1], Rita Aldeia da Silva[2], Isabel Martins Azevedo[1] and Cátia Vilas Boas Leitão[1,3]

[1]Department of Paediatrics, Hospital de Braga, Unidade Local de Saúde de Braga (ULSB), Braga, Portugal

[2]Department of Paediatrics, Hospital de Santa Maria Maior, Unidade Local de Saúde de Barcelos/Esposende, Barcelos, Portugal

[3]Neonatal Intensive Care Unit, ULSB, Braga, Portugal

***Corresponding Author:** Ana Sofia Nunes, Department of Paediatrics, Hospital de Braga, Unidade Local de Saúde de Braga (ULSB), Braga, Portugal.

Received: December 09, 2025; **Published:** December 26, 2025

Abstract

Introduction: Effective communication of bad news in paediatrics can reduce anxiety, foster hope, and support informed decision-making. This complex skill is essential for physicians and should be systematically taught, practiced, and refined to ensure high-quality, compassionate care.

Objectives: To assess physicians' knowledge and confidence in delivering bad news and evaluate the impact of a communication training session in a Paediatric Department (PD).

Methods: Data were collected using two self-reported questionnaires, one before and one after a 30-40-minute theoretical training session on breaking bad news. All participants were actively involved in paediatric clinical care. Statistical analysis was performed using SPSS.

Results: Twenty-eight physicians participated, 85.71% female (n = 24). Most had prior training in breaking bad news (n = 18; 64.29%), mainly during undergraduate education (n = 10; 45.45%). Only half felt competent in delivering bad news (n = 14; 51.85%), and almost all reported discomfort (n = 26; 96.30%). Post-training, competence (n = 26; 92.86%) and comfort (n = 23; 82.14%) improved. Significant gains were observed in recognizing situations as bad news: communicating a diagnosis ($p = 0.021$), need for hospitalization ($p = 0.002$), and requirement for specific treatment ($p < 0.001$). The perceived importance of honesty and sincerity increased ($p = 0.001$), and identifying inappropriate language as a barrier decreased ($p = 0.031$).

Conclusion: Short, structured training can significantly improve physicians' self-perceived competence and comfort in breaking bad news in paediatric settings. Targeted programs tailored to departmental needs enhance awareness, ethical sensitivity, and communication strategies, fostering empathy, professionalism, and trust in the patient-provider relationship.

Keywords: *Breaking Bad News; Paediatrics; Communication; Communication Training; Ethics in Paediatrics; Clinical Communication Skills*

Abbreviations

CSHA: Consultant Senior Hospital Assistants; GTR: General Training Residents; HA: Hospital Assistants; PD: Paediatric Department; SHA: Senior Hospital Assistants; SPSS®: Statistical Package for the Social Sciences; STR: Specialty Training Residents; ULSB: Unidade Local de Saúde de Braga

Introduction

Breaking bad news represents a significant challenge for physicians and takes on complexity within the field of paediatrics [1-4]. In addition to conveying difficult information to parents or caregivers, communication must also involve the child in an age-appropriate manner [2,5]. This process demands a careful and compassionate approach, in which emotional sensitivity, empathy, and clarity of information help minimize the negative impact of the news and support the adjustment process [3,6,7].

Effective communication of bad news in paediatrics has a profound impact on diagnostic acceptance and treatment adherence [4,8]. Poor communication may lead to emotional distress, loss of trust, and non-compliance to treatment, while effective delivery can improve family understanding, therapeutic alliance, and informed decision-making [5,9]. Delivering bad news requires attention to cultural, religious, and emotional dimensions. Empathy, active listening, and emotional validation are essential in humanizing the process [6,10,11].

Several models have been developed to support healthcare professionals in delivering bad news more effectively. The SPIKES protocol remains an easy and well-recognized model for guiding these conversations, involving six structured steps: Setting, Perception, Invitation, Knowledge, Emotions, and Strategy/Summary [8,12,13]. Other frameworks, such as BREAKS and S-P-w-ICE-S, have also been adapted for paediatric contexts [14,15].

Despite its importance, communication of bad news is often underrepresented in medical education programs [9,16,17]. Studies show many paediatric trainees lack confidence and structured training in this area [1,18-20].

This study evaluates paediatricians' baseline knowledge and the effect of a targeted intervention on their preparedness to deliver bad news.

Materials and Methods

Study design

An observational, cross-sectional, descriptive study was conducted.

Study population and sample

The participants were all physicians involved in clinical paediatric care who attended the Paediatric Department (PD) session on "Breaking Bad News in Paediatrics" at a level III paediatric hospital in Portugal. The session was conducted by the investigators of this project. There was no minimum sample size required for this study; the aim was to include the maximum number of physicians meeting the inclusion criteria. Eligible participants were General Training Residents (GTR), Specialty Training Residents (STR), Hospital Assistants (HA), Senior Hospital Assistants (SHA), and Consultant Senior Hospital Assistants (CSHA). Exclusion criteria included medical students, healthcare professionals other than physicians, physicians not involved in providing care in the PD; physicians who had previously provided care in the PD of a level III paediatric hospital in Portugal but were not present at the PD meeting on the day the session training was delivered.

Data collection process, exposure assessment and data management

During the time allocated for one of the regular PD meetings at this hospital, the informed consent form was read and explained. Following voluntary consent to participate, data were collected using "Questionnaire A", completed by the physicians included in the

study. Subsequently, a training session titled "Breaking Bad News in Paediatrics" was conducted by the study investigators and lasted approximately 30-40 minutes. After the session, participants completed "Questionnaire B". The investigators did not intervene during the completion of the informed consent or the questionnaires, and participation was entirely voluntary.

This study was approved by the Data Protection Department and Ethics Committee of our hospital.

Statistical analysis

Data were analysed using Statistical Package for the Social Sciences (SPSS®). Frequencies described categorical variables. McNemar's test compared paired pre- and post-training responses. Fisher's exact test assessed associations between knowledge of communication protocols and perceived preparedness. A p-value <0.05 was considered statistically significant.

Results and Discussion

Sociodemographic and professional characteristics of the sample

The study sample consisted of 28 participants, whose sociodemographic and professional characteristics are presented in table 1. Most participants were female (n = 24; 85.71%), and nearly half were under the age of 30 (n = 12; 42.86%). More than half of the participants did not have children (n = 18; 64.29%) and were single (n = 16; 57.14%). When asked about religious affiliation, 75% (n = 21) responded affirmatively, with all identifying as Catholic. Regarding academic and professional level, 25% (n = 7) were STR in their first to third year, and 25% (n = 7) were CSHA. When asked about their primary area of clinical practice, Paediatrics and Neonatology were represented in nearly equal proportions.

Variables	n	%
Sex (n = 28)		
Male	4	14,29
Female	24	85,71
Age group, years (n = 28)		
< 30	12	42,86
30-40	7	25,00
41-50	3	10,71
> 50	6	21,43
Children (n = 28)		
No	18	64,29
Yes	10	35,71
Marital status (n = 28)		
Single	16	57,14
Married	12	42,86
Religious (n = 28)		
No	7	25,00
Yes	21	75,00
Type of religion (n = 21)		
Catholic	21	100,00

Academic/professional level (n = 28)		
General Training Residents (GTR)	5	17,86
Specialty Training Residents (STR) R1-R3	7	25,00
Specialty Training Residents (STR) R4-R5	2	7,14
Hospital Assistants (HA)	5	17,86
Senior Hospital Assistants (SHA)	7	25,00
Consultant Senior Hospital Assistants (CSHA)	2	7,14
Years of experience since paediatric specialization (n = 14)		
< 5	3	21,43
5-10	2	14,29
10-15	3	21,43
15-20	2	14,29
> 20	4	28,56
Principal clinical area (n = 24)		
Paediatrics	13	54,17
Neonatology	11	45,83

Table 1: *Sociodemographic and professional characteristics of the sample.*

Descriptive analysis

Table 2 presents descriptive data regarding previous training in breaking bad news in paediatrics and the experience of the participants in delivering bad news prior to attending the training session. Most participants reported having previously attended some form of communication training (n = 18; 64.29%), with nearly half of those receiving it during undergraduate education (n = 10; 45.45%). With respect to training specifically related to breaking bad news, more than half of participants (n = 18; 64.29%) indicated having received such training, predominantly during undergraduate education (n = 12; 52.17%).

Approximately half of the participants (n = 14; 51.85%) reported feeling capable of delivering bad news appropriately, although only 3.70% (n = 1) reported feeling comfortable doing so. Most participants (n = 17; 62.96%) stated that they were not familiar with any protocols designed to facilitate the delivery of bad news. Among those who did report such knowledge, all (n = 6; 66.67%) identified the SPIKES protocol as one of the tools. The majority (n = 19; 70.37%) had previously delivered bad news at some point. In the three months preceding the questionnaire, 37.04% (n = 10) reported not having delivered any bad news, while 33.33% (n = 9) had done so fewer than three times. It is also noteworthy that more than half of the participants (n = 15; 55.56%) reported having experienced emotional distress when delivering bad news.

Variables	n	%
Previous training in communication (n = 28)		
No	10	35,71
Yes	18	64,29
Context of communication training (n = 22*)		
Undergraduate	10	45,45
Postgraduate	2	9,09
Congress	5	22,73
Courses	3	13,64
Other	2	9,09
Previous training in breaking bad news (n = 28)		
No	10	35,71
Yes	18	64,29

Context of training in breaking bad news (n = 23*)		
Undergraduate	12	52,17
Postgraduate	1	4,35
Congress	5	21,74
Courses	3	13,04
Other	2	8,70
Self-perceived ability to deliver bad news (n = 27)		
No	13	48,15
Yes	14	51,85
Comfort in delivering bad news (n = 27)		
No	26	96,30
Yes	1	3,70
Knowledge of protocols to assist in breaking bad news (n = 27)	17	62,96
No	10	37,04
Yes		
Which protocol(s) is known? (n = 10)		
SPIKES	6	60,00
Knows but cannot recall the name	4	40,00
Previous experience in delivering bad news (n = 27)		
No	8	29,63
Yes	19	70,37
Frequency of delivering bad news in the last 3 months (n = 27)	10	37,04
Never	9	33,33
< 3 times	6	22,22
3-5 times	2	7,41
> 5 times		
Emotional reaction when delivering bad news (n = 27)	12	44,44
No	15	55,56
Yes		

Table 2: *Descriptive measures regarding the frequency of training and participants' experience in breaking bad news prior to the training session.*

**Participants were allowed to select more than one option.*

Descriptive measures related to participants' perceptions after the training session

Table 3 presents the descriptive measures regarding participants perceived ability and comfort in breaking bad news, their views on the appropriate recipients of such news, and their perceptions of training on this topic following the session they attended. Almost all participants (n = 26; 92.86%) reported feeling more capable of delivering bad news appropriately, and the majority (n = 23; 82.14%) also stated they felt more comfortable doing so. All physicians (n = 28; 100%) agreed that bad news should be communicated both to the patient and to the family members/parents. Regarding educational opportunities, nearly all participants (n = 27; 96.44%) expressed a desire for additional training sessions on breaking bad news within the PD.

Variables	n	%
Do you feel more capable of delivering bad news appropriately? (n = 28)		
No	2	7,14
Yes	26	92,86
Do you feel more comfortable delivering bad news? (n = 28)		
No	5	17,86
Yes	23	82,14
Who do you think should be informed when delivering bad news? (n = 28)		
Child	0	0
Family member	0	0
Both	28	100,00
Would you like more training sessions on breaking bad news in the Paediatric Department? (n = 28)		
No	1	3,57
Yes	27	96,43

Table 3: *Descriptive measures regarding participants' experience with breaking bad news, the intended recipients of such news, and perceptions about training, after the educational intervention.*

Differences between pre- and post-training assessments

Table 4 presents the results of the comparative analysis between the pre- and post-training assessments concerning participants' perceptions of what constitutes breaking bad news. Statistically significant differences were observed in the following categories: "communicating a disease diagnosis" ($p = 0.021$), "communicating the need for hospitalization" ($p = 0.002$), and "communicating the need for a specific treatment" ($p < 0.001$).

There was an increase in the number of participants who considered these situations to represent breaking bad news: from 62.96% to 92.86% for communicating a disease diagnosis (with 9 participants initially not considering this a bad news situation and changing their view after the training); from 40.74% to 78.57% for communicating the need for hospitalization (with 10 participants changing their response post-training); from 29.63% to 78.57% for communicating the need for a specific treatment (with 13 participants changing their view after the session).

Variables	Pre n (%)	Post n (%)	p
Communicating a diagnosis of a disease	17 (62,96)	26 (92,86)	0,021
Communicating a poor prognosis	26 (96,30)	28 (100)	1,000
Communicating a death	26 (96,30)	27 (96,43)	1,000
Communicating the need for hospitalization	11 (40,74)	22 (78,57)	0,002
Communicating the need for a specific treatment	8 (29,63)	22 (78,57)	<0,001

Table 4: *Differences between pre- and post-training assessments regarding what is considered breaking bad news.*

A comparison of pre- and post-training assessments regarding participants' views on the appropriate recipients of bad news showed that, prior to the training, 80.77% believed it should be communicated to both the patient and their family. Following the session, this proportion increased to 100%, although the difference was not statistically significant ($p > 0.05$).

Table 5 presents the results of comparative analyses between the pre- and post-training assessments concerning participants' perceptions of the most appropriate strategies for delivering bad news. A statistically significant difference was observed only in relation to the strategy of being honest and sincere (p = 0.001), with an increase in the number of participants selecting this option from pre-training (18.52%) to post-training (57.14%). Notably, 11 participants who had not selected this option initially did so after the training. Although no statistically significant difference was found (p > 0.05), there was also an increase in participants selecting the strategy planning the location where the bad news will be delivered, from 22.22% pre-training to 39.29% post-training. For all other strategies, the number of participants who selected them decreased from pre- to post-training.

Variables	Pre n (%)	Post n (%)	p
Using simple and appropriate language for the recipient	24 (88,88)	19 (67,85)	0,070
Developing a care plan together with the patient/family	9 (33,33)	6 (21,43)	0,344
Listening, being empathetic and compassionate	21 (77,78)	19 (67,86)	0,375
Planning the location where the bad news will be delivered	6 (22,22)	11 (39,29)	0,125
Planning the conversation to be delivered	5 (18,52)	4 (14,29)	1,000
Planning who will be present during the delivery of bad news	3 (11,11)	2 (7,14)	1,000
Honesty and sincerity	5 (18,52)	16 (57,14)	0,001
Ensuring the recipient correctly understood the information	8 (29,63)	7 (25)	1,000

Table 5: *Differences between pre- and post-training assessments regarding perceived strategies for effectively delivering bad news.*

Although no statistically significant association was found, most participants who knew a communication protocol before the training (90%) reported feeling more capable of delivering bad news afterward.

Table 6 presents the results of the comparative analysis between pre- and post-training assessments of participants' perceptions regarding the most common errors and obstacles in the delivery of bad news. A statistically significant difference was found only in relation to the use of inappropriate language (p = 0.031), with a decrease in the number of participants selecting this as an error from pre-training (55.55%) to post-training (37.04%). Although not statistically significant (p > 0.05), a general decrease was observed in the number of participants identifying the following as common errors such as inadequate setting/lack of privacy (29.63% pre vs. 14.81% post), lack of confirmation that the message was correctly understood (22.2% pre vs. 7.41% post), and difficulty in managing the recipient's emotions (14.81% pre vs. 7.41% post). Conversely, there was an increase in the number of participants identifying the following as errors such as lack of planning for the conversation (7.41% pre vs. 14.81% post) and not understanding what the recipient wants to know (7.41% pre vs. 18.52% post). Additionally, new errors were mentioned only after the training, including not involving the child, not allowing time to process the information, lack of training, lack of preparation, and absence of follow-up support after breaking bad news.

Variables	Pre n (%)	Post n (%)	p
Inappropriate language	15 (55,55)	10 (37,04)	0,031
Inadequate setting/lack of privacy	8 (29,63)	4 (14,81)	0,289
Lack of time	7 (25,93)	6 (22,22)	1,000
Lack of confirmation that message was understood	6 (22,22)	2 (7,41)	0,375
Lack of empathy	5 (18,52)	3 (11,11)	0,687
Managing recipients' emotions	4 (14,81)	2 (7,41)	0,625

Not listening/not addressing doubts	3 (11,11)	2 (7,41)	1,000
Lack of planning the conversation	2 (7,41)	4 (14,81)	0,625
Absence of a multidisciplinary team	1 (3,70)	0 (0,00)	1,000
Not understanding what the recipient wants to know	2 (7,41)	5 (18,52)	0,500
Personal involvement of the professional	1 (3,70)	2 (7,41)	1,000
Not including the child	0 (0,00)	3 (11,11)	0,500
Not allowing time to process the information	0 (0,00)	1 (3,70)	1,000
Lack of training	0 (0,00)	3 (11,11)	0,250
Lack of preparation	0 (0,00)	3 (11,11)	0,250
No follow-up/support after delivering bad news	0 (0,00)	1 (3,70)	1,000

Table 6: *Differences between pre- and post-training assessments regarding perceptions of the most common errors and obstacles to effective communication.*

Effective communication in pediatric healthcare, particularly when delivering bad news, is an essential component of high-quality, compassionate care [1-4]. It enables healthcare professionals to approach situations with greater sensitivity, empathy, and clarity. This skill not only improves the emotional and psychological experience of the patient and their family, who are often in highly vulnerable situations, but also fosters a relationship of trust between healthcare providers and their patients [2,5-7].

The results of this study demonstrate that even short, structured training sessions can significantly enhance physicians perceived competence and comfort in managing these challenging moments. These findings align with existing literature that recommends multimodal, practical communication training based on frameworks like the SPIKES protocol, which has proven effective in various clinical contexts [8,12-15,18].

Additionally, after the session, there was an increase in the recognition of specific clinical situations as constituting bad news, including the communication of a disease diagnosis, the need for hospitalization, and the prescription of a specific treatment. This conceptual reinforcement represents a meaningful step forward, as the ability to identify what constitutes bad news is a critical prerequisite for effective and humanized communication, echoing current literature that broadens the scope of bad news beyond prognostic issues alone [3,4,9,11]. This heightened awareness reflects growing professional sensitivity to the emotional and psychosocial implications of medical communication [5,6,10].

Honesty and sincerity emerged as strategies whose perceived importance increased significantly after the training, indicating a shift toward valuing clear, transparent, and ethical communication. This aligns with recent studies advocating for empathetic and ethically sound communication approaches, where conversations often involve not only the patient but their families as well [6,7,14,15]. At the same time, while other strategies, such as planning the location of the conversation or active listening, did not show statistically significant changes, they continued to be valued by most participants. Training programs that emphasize honesty, emotional intelligence, and the ability to respond to patient and caregiver emotions have shown positive outcomes in multiple settings [8,12,18].

Participants also began identifying previously underrecognized barriers to communication, such as the exclusion of children from discussions, lack of preparation or privacy, and emotional overload, issues consistently highlighted in literature [2,5,9,16]. Including children in these conversations, when developmentally appropriate, has been linked to reduced anxiety and increased trust in medical teams, reinforcing the principles of autonomy, truthfulness, and participation as advocated in paediatric clinical ethics [3,4,11].

The SPIKES protocol remains a valuable framework and was positively referenced by participants. However, prior protocol knowledge did not statistically correlate with improved outcomes—likely because true mastery stems from experiential practice, such as role-playing or simulation training [8,12-15,18-20]. Our findings confirm that combining structured protocols with simulation and reflective feedback creates more meaningful learning experiences and improves knowledge retention [13,15,18].

One of the major strengths of this study lies in its specific focus on medical knowledge related to breaking bad news in paediatric care. By targeting healthcare professionals who work directly with children and adolescents, the study explored both educational gaps and real-world perceptions, contributing to a more accurate understanding of their needs and challenges in this area [1,2,5,9,17]. Furthermore, the study enabled the identification of common communication errors - many of which may go unrecognized by clinicians themselves - as well as promoting critical reflection on routine practices. Importantly, this initiative served as a catalyst for the development of several training sessions on communication in difficult clinical contexts. These sessions aim not only to consolidate the knowledge gained but also to foster a culture of structured, humanized, and empathetic communication among healthcare professionals [6,7,10,14].

Nevertheless, this study has some limitations. The primary limitation concerns the size and composition of the sample, which may not fully represent the broader population of physicians working in this paediatric department. The relatively small sample and potential selection bias (e.g. higher interest in communication among those who chose to participate) may limit the generalizability of the results to other hospital settings or paediatric teams with different profiles [16,17]. Moreover, the evaluation relied mainly on participants' self-perceptions, rather than on objective assessments of acquired skills. Future studies, particularly multicentre ones including other healthcare professional groups, would benefit from the inclusion of control groups and practical skill-based evaluation methods [18-20].

This study also emphasizes a critical gap in medical education. Despite its importance, communication of bad news remains underrepresented in many undergraduate and postgraduate curricula [9,16,17]. In conclusion, the results of this study reinforce the importance of incorporating systematic and practical training in breaking bad news into ongoing professional development programs in healthcare, especially in paediatrics. Improving communication skills not only enhances the quality of care provided but may also reduce the emotional burden experienced by healthcare professionals in these demanding situations [1-4,8].

Conclusion

This study reinforces the vital importance of structured communication training in paediatric settings. Even short-duration programs can significantly improve physicians' self-perceived ability and comfort in delivering bad news. The training promoted greater awareness of what constitutes bad news, increased ethical sensitivity, and identified areas for future improvement, such as involving paediatric patients in age-appropriate ways. Embedding these training initiatives within routine medical education and departmental activities can foster more humane, transparent, and emotionally supportive care for patients, families, and professionals alike.

Conflict of Interest

No financial interest or any conflict of interest exists.

Bibliography

1. Zanon Bruna P., *et al*. "Communication of bad news in pediatrics: integrative review". *Revista Brasileira de Enfermagem* 73.4 (2020): e20190059.

2. Brouwer Marlou A., *et al*. "Breaking bad news: what parents would like you to know". *Archives of Disease in Childhood* 106 (2021): 276-281.

3. Rodrigues da Silva Júnior E., *et al*. "Breaking bad news in pediatrics". *Revista Bioética* 31 (2023): e3536EN.

4. Soeiro Ana., *et al*. "Communication of bad news in pediatric intensive care: bioethical reflections". *Revista Bioética* 30.1 (2022): 72-81.

5. Meyer Elaine C., *et al*. "Improving the quality of end-of-life care in the pediatric intensive care unit: parents' priorities and recommendations". *Pediatrics* 117.3 (2006): 649-657.

6. Traiber Cristian and Paulo M Lago. "Comunicação de Más Notícias em Pediatria". *Bioética Pediátrica* 12.1 (2012): 7-15.

7. Gilbey Paul. "Qualitative analysis of parents' experience with receiving the news of the detection of their child's hearing loss". *International Journal of Pediatric Otorhinolaryngology* 74.3 (2010): 265-270.

8. Baile Walter F., *et al*. "SPIKES—A six-step protocol for delivering bad news: application to the patient with cancer". *The Oncologist* 5.4 (2000): 302-311.

9. Johnson Jennifer and Matina Panagioti. "Interventions to improve the breaking of bad or difficult news by physicians, medical students, and interns/residents: a systematic review and meta-analysis". *Academic Medicine* 93.9 (2018): 1400-1412.

10. Jalali Reza., *et al*. "Breaking bad news in medical services: a comprehensive systematic review". *Heliyon* 9.4 (2023): e14734.

11. Herreros Belén., *et al*. "Breaking bad news in Spain: A survey of doctors' perceptions and practice". *PLoS One* 5.4 (2010): e10488.

12. Lino Cláudia A., *et al*. "Uso de protocolo SPIKES no ensino de habilidades em transmissão de más notícias". *Revista Brasileira de Educação Médica* 35.1 (2011): 52-59.

13. Meitar Dafna and Orit Karnieli-Miller. "Twelve tips to manage a breaking bad news process: using S-P-w-ICE-S—A revised version of the SPIKES protocol". *Medical Teacher* 44.10 (2022): 1087-1091.

14. Narayanan V., *et al*. "BREAKS protocol for breaking bad news". *Indian Journal of Palliative Care* 16.2 (2010): 61-65.

15. Warrier Veena and Anindya Pradhan. "A narrative review of interventions to teach medical students how to break bad news". *Medical Science Educator* 30.3 (2020): 1299-1312.

16. Crosnier-Schoedel Claire., *et al*. "Pediatricians' experience in announcing bad news". *Archives de Pédiatrie* 25.2 (2018): 100-106.

17. Gold Rachel and Ari Gold. "Delivering bad news: attitudes, feelings and practice characteristics among speech-language pathologists". *American Journal of Speech-Language Pathology* 27.1 (2018): 108-122.

18. de Moura Villela Elidio F., *et al*. "Effects on medical students of longitudinal small-group learning about breaking bad news". *The Permanente Journal* 24.2 (2020): 19-157.

19. Abel Julian., *et al*. "Breaking bad news-development of a hospital-based training workshop". *The Lancet Oncology* 2.6 (2001): 380-384.

20. VandeKieft Gregory K. "Breaking bad news". *American Family Physician* 64.12 (2001): 1975-1978.

Volume 15 Issue 1 January 2026