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Simulation-Based Training for Breaking Bad News in Geriatric Oncology: A Pilot Study Exploratory secondary analysis of a prospective, single-centre educational pilot study

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Simulation-Based Training for Breaking Bad News in Geriatric Oncology: A Pilot Study

Exploratory secondary analysis of a prospective, single-centre educational pilot study

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Abstract

Background: Communicating a cancer diagnosis to an older adult may involve age-associated vulnerabilities and family requests to withhold information. We examined oncology residents' reported practices and perceptions concerning older patients before and three months after a context-specific simulation exercise.

Methods: This descriptive secondary analysis involved the same 15 medical oncology residents enrolled in a broader communication simulation programme in Tangier, Morocco, in June 2026. A baseline anonymous questionnaire explored disclosure practices and training needs. A simulated consultation featured an alert 80-year-old woman with advanced ovarian cancer and relatives requesting nondisclosure. A geriatric-specific questionnaire was administered three months later. Responses were summarized descriptively; the nonidentical, unpaired questionnaires were not compared inferentially.

Results: At baseline, 3/15 residents (20.0%) reported preferentially disclosing a diagnosis to family members, 3/15 (20.0%) would comply with a nondisclosure request, and 2/15 (13.3%) felt adequately trained. At follow-up, 12/15 (80.0%) had participated in at least one real disclosure consultation involving an older patient, 12/15 (80.0%) reported greater confidence and 14/15 (93.3%) reported better tailoring their communication. All participants reported more frequent attention to comprehension and geriatric vulnerabilities. For family nondisclosure requests, 6/15 (40.0%) prioritized eliciting patient preferences at follow-up compared with 3/15 (20.0%) reporting this approach at baseline; these values are descriptive and are not a paired comparison.

Conclusions: Participants reported favourable changes in older-adult communication at three months. These self-reports cannot establish effectiveness. This geriatric-focused secondary analysis shares its cohort with a separately submitted programme-level evaluation.

Keywords: geriatric oncology; breaking bad news; patient autonomy; family nondisclosure; simulation; communication; medical education; Morocco

Introduction

A cancer diagnosis is an emotionally complex conversation, particularly when an older adult presents with cognitive, sensory, functional or psychosocial vulnerabilities. Older age alone, however, neither determines decision-making capacity nor establishes a patient's information preferences. A patient-centred approach requires clinicians to ask what the patient wishes to know and how family members should participate, while adapting the manner and pace of disclosure to individual needs [1,2].

Family members may seek to protect an older relative from distress by requesting nondisclosure. In this setting, clinicians must balance sensitivity to the family's fears with the patient's own preferences and autonomy. Moroccan research has described information needs among older adults with cancer, illustrating the relevance of culturally contextualized communication [3].

Simulation can offer a safe setting for practising difficult conversations without exposing patients to trainee errors. Rather than reassessing satisfaction with the overall programme, this secondary analysis focuses specifically on oncogeriatric disclosure: family requests for nondisclosure, preferences for information, and adaptations for the older adult's comprehension and vulnerability.

Methods

Design, setting and participants

We conducted a descriptive, exploratory secondary analysis of an educational programme involving 15 medical oncology residents at Mohammed VI University Hospital in Tangier. The programme was delivered in June 2026 at the simulation centre of the Faculty of Medicine and Pharmacy of Tangier. The 15 participants were the same trainees included in a separate, broader evaluation of breaking-bad-news simulation, which focused on programme acceptability and general self-reported practice at three months. The present analysis addresses a distinct geriatric-specific questionnaire and research question. Both the baseline and geriatric three-month questionnaires were completed by all 15 participants.

Geriatric simulation scenario

The exercise depicted an alert 80-year-old woman with ovarian adenocarcinoma and peritoneal carcinomatosis, accompanied by her son and daughter. Before the consultation, her son asked the resident not to use the word "cancer" and subsequently attempted to speak for her. Simulated patient and family roles were played by trained institutional staff following standardized role sheets. One resident led the consultation while others observed. The encounter lasted 20 minutes, followed by 20 minutes of structured debriefing. The desired communication behaviours included directly eliciting the patient's information preferences, checking comprehension, adapting language, and preserving a therapeutic relationship with relatives without deceiving the patient.

Questionnaires and analysis

The anonymous baseline questionnaire covered disclosure timing relative to geriatric assessment, preferred disclosure recipient, responses to family nondisclosure requests, perceived difficulties and training adequacy. The geriatric-specific three-month questionnaire explored real-world exposure, self-reported confidence, tailoring of information, assessment of information preferences, comprehension checks, attention to cognition/hearing/autonomy/vulnerability, family involvement and an open-ended reflection. Categorical data were described as counts and percentages out of 15. Open-ended responses were grouped by the themes reported in the source dissertation. As the two instruments differed in wording and response structure and were not individually linked, formal paired before–after testing was inappropriate.

Ethics and consent

The broader oncology simulation programme received a favourable opinion from the Comité d'Éthique Hospitalo-Universitaire de Tanger (CEHUT), reference AC254OT/2026. Participants were informed of the study and provided verbal informed consent; participation was voluntary. Findings were analysed and reported in aggregate form. [Before journal submission, confirm with the ethics committee that this approval covers analysis/publication of the already collected data, given the approval letter date of 20 October 2026.]

Results

Baseline disclosure practices and perceived needs

Of 15 residents, 7 (46.7%) reported disclosing independently of a geriatric assessment, 4 (26.7%) before it and 4 (26.7%) after it. Six (40.0%) favoured speaking to patients in the presence of family, five (33.3%) adapted their approach to the situation, three (20.0%) preferred to speak first to relatives and one (6.7%) favoured speaking to

the patient alone. When relatives requested nondisclosure, five (33.3%) would negotiate with the family; three (20.0%) would first ask what the patient wanted to know; three (20.0%) would comply with the family request; three (20.0%) would disclose despite the request; and one (6.7%) described an individualized neuropsychological approach.

Six residents (40.0%) identified difficulties with patient comprehension as their leading challenge and three (20.0%) identified sensory impairment. Only two (13.3%) felt adequately trained; eight (53.3%) reported being partly trained and five (33.3%) inadequately trained.

Three-month responses

Twelve residents (80.0%) had conducted or participated in at least one disclosure consultation involving an older patient; 11 reported several such encounters, one a single encounter and three none. Twelve (80.0%) reported greater confidence and 14 (93.3%) described better adaptation of their explanations to the patient's understanding. Fourteen (93.3%) stated that they often or always sought patients' information preferences. All 15 reported more frequent comprehension checking and greater attention to geriatric communication needs.

When asked about current approaches to nondisclosure requests, six (40.0%) prioritized the patient's information wishes, five (33.3%) would discuss with the family before deciding, three (20.0%) took a situation-dependent approach, and one (6.7%) would comply with the family request. Ten (66.7%) reported doing much more or always more to keep the older patient central despite the family's presence; three (20.0%) described a moderate change and two (13.3%) little or none. Self-reported overall impact was "enormous" in five (33.3%), "substantial" in three (20.0%) and "moderate" in seven (46.7%).

Measure	Baseline (n=15)	Three months (n=15)
Patient preference explored first when family requests nondisclosure	3 (20.0%)	6 (40.0%)
Family nondisclosure request accepted	3 (20.0%)	1 (6.7%)
Adequately prepared for geriatric disclosure	2 (13.3%)	Not assessed
Greater confidence in older-patient disclosure	Not assessed	12 (80.0%)
Better tailoring of explanations	Not assessed	14 (93.3%)
More frequent comprehension checking and attention to geriatric factors	Not assessed	15 (100.0%)

Note: Baseline and follow-up responses come from different, non-paired items. Columns are not directly comparable measures of individual change.

Qualitative reflections

The dissertation grouped free-text responses into four recurring themes: simplifying language and allowing more time; inviting older patients to articulate information preferences and emotions; asking permission before sharing information with accompanying relatives while addressing the patient directly; and using silence more comfortably while navigating family intervention. These themes summarize respondents' reported reflections rather than externally verified behaviour.

Discussion

This exploratory analysis examines a specific challenge in geriatric oncology that is not captured by overall satisfaction with communication training: balancing an older patient's information preferences with relatives' requests for nondisclosure. At baseline, 20% of residents would preferentially inform relatives and 20% would comply with a request not to disclose the diagnosis. These findings describe heterogeneity, not necessarily disregard for autonomy; relatives may seek nondisclosure out of concern about distress. However, an older patient's age alone cannot justify substituting the family's wishes for the patient's own preferences [3,4].

The simulated encounter deliberately juxtaposed a lucid 80-year-old woman with a son who requested concealment and spoke on her behalf. The central educational task was therefore not merely delivering bad news using a generic protocol [5], but eliciting what the patient wished to know, seeking permission for family involvement and maintaining a therapeutic alliance without promising secrecy. A patient-centred approach also permits a competent person to defer information or delegate communication voluntarily; autonomy does not require imposing all prognostic details [4,6].

Communication accessibility is equally important. At baseline, 40% of residents identified comprehension difficulties and 20% sensory problems as salient barriers. Geriatric assessment frameworks highlight cognition, function, sensory and psychosocial vulnerabilities [1,2]. For disclosure, these domains suggest concrete adjustments: a quiet room, adequate hearing and visual aids, shorter explanations, deliberate pauses, and teach-back. Neither sensory loss nor chronological age should be equated with decisional incapacity.

At three months, 12/15 residents had participated in an actual disclosure consultation with an older patient; 80% reported greater ease, 93.3% greater adaptation of language and all reported more frequent attention to comprehension and geriatric vulnerabilities. In the separately framed nondisclosure question, 40% now prioritized exploring the patient's wishes and 6.7% would comply with the family's request. Because the baseline and follow-up instruments were different and anonymous, these proportions cannot establish within-person change or causality. They reflect perceived practice and hypothetical preferences, not observed behaviour or improved patient outcomes.

The single-centre cohort (n=15), absence of a control group, locally developed nonvalidated measures and potential recall and social-desirability biases limit generalizability. Only one trainee actively led each simulated encounter while peers observed; individual experiential exposure therefore varied. Nevertheless, the scenario generates testable educational questions for future studies using observed structured encounters, standardized communication ratings and older patients' assessments. It also suggests that family requests for nondisclosure, patient authorization of family participation and adaptation to sensory/cognitive needs warrant explicit teaching.

This report is a pre-specified-topic-focused exploratory secondary description from the same 15-person educational programme as a manuscript submitted to the Journal of Cancer Education examining overall workshop acceptability and perceived clinical application. The present report instead analyzes older-adult disclosure preferences, family nondisclosure decisions and geriatric adaptations using the dedicated geriatric questionnaires. The shared cohort and related submission are explicitly disclosed to permit editorial assessment of overlap; no independent cohort or replicated intervention is claimed.

At baseline, three residents (20%) said they would preferentially disclose to the family and three (20%) would comply with a family request to withhold the diagnosis. Such responses cannot be reduced to a simple opposition between autonomy and family involvement. Relatives frequently provide transport, caregiving, financial assistance and emotional support, and requests for nondisclosure may reflect a genuine fear that frank communication will harm the older person. The ethical problem arises when presumed protection is substituted for an exploration of what the patient actually wants to know. The Moroccan study by Lkhoyaali and colleagues [3] offers relevant contextual evidence about the diversity of information preferences among older adults with cancer. Its implications are not that all older patients demand maximal disclosure, but that preferences should be elicited individually rather than inferred from age or family wishes.

Disclosure should also be distinguished from indiscriminate delivery of prognostic detail. Respect for autonomy permits a patient to request comprehensive information, defer some information, or voluntarily delegate discussion to a trusted relative. The key clinical sequence is to ask the patient what they already understand, establish how much they wish to know, and request permission before involving others. The SPIKES framework [5] and the ASCO communication guidance [4] offer adaptable structures for this exchange, but neither removes the need to account for relational and cultural circumstances. In a family request for silence, a clinician can first acknowledge the family's fear, then explore the patient's preferences privately or inclusively as appropriate, without promising nondisclosure or imposing immediate disclosure.

Family involvement itself should not be treated as an adverse outcome. The desirable model is a negotiated, patient-authorized conversation in which relatives remain allies without systematically replacing the patient's voice. At follow-up, six residents (40%) selected first exploring the patient's information wishes when presented with a nondisclosure request, compared descriptively with three (20%) at baseline; only one (6.7%) then selected compliance with the family's request, compared with three (20%) at baseline. Five residents (33.3%) still preferred to discuss with the family first. These findings are compatible with increased attention to the patient's preference but also show that the family continues to shape clinical choices. Because questions and response categories were not identical across assessments and responses were not linked at participant level, these percentages cannot establish a within-person change or statistical improvement.

This geriatric-focused report is a secondary analysis of the same 15 residents and broader simulation programme described in a separate manuscript addressing overall acceptability and self-reported clinical application. The present questions and questionnaire are more specific to older-patient disclosure and patient–family dynamics, but the cohort, exposure and follow-up period are shared. To avoid fragmenting the evidence, the relationship between manuscripts must be transparently disclosed to editors and clearly cross-referenced when either work becomes publicly available. Separate publication would be justified only if a journal considers these analyses to provide sufficiently distinct scientific contributions; the reported findings should never be represented as independent cohorts or replications.

Despite these limitations, the findings help formulate a practical training agenda: scenarios in which relatives request nondisclosure; structured exploration of a patient's desired level of information; accommodation for hearing, cognition and health literacy; explicit consent before sharing details with accompanying relatives; and debriefing that examines both emotional safety and patient agency. Future multisite work should prospectively specify geriatric communication outcomes, use validated observational checklists, assess trainees before and after exposure with linked data, and where feasible include the perspectives of older patients and families. Such work would clarify whether perceived improvements translate into observable, person-centred clinical practice.

An oncogeriatric simulation scenario addressing family requests for nondisclosure was associated with favourable resident perceptions concerning patient-centred communication three months later. It provides a clinically relevant educational question, but not evidence of objectively improved competence. Future prospective studies should observe communication behaviours and include older adults’ own experiences.

Ethics approval: The oncology simulation programme received a favourable opinion from CEHUT (AC254OT/2026).

Consent for publication: Not applicable; no individually identifiable participant information is presented.

Competing interests: All authors declare that they have no competing interests.

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Related manuscript / overlap disclosure: This exploratory secondary analysis uses the same 15 residents and June 2026 simulation programme as a manuscript currently submitted to the Journal of Cancer Education on overall simulation acceptability and perceived clinical application. The present report focuses on dedicated geriatric questionnaires and patient autonomy, older-adult disclosure and family nondisclosure requests. The related manuscript can be supplied confidentially to the editor on request.

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