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Breaking bad news and the pediatric physician experience at King Saud Medical City (KSMC)

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Abstract

Background

Delivering bad news is an emotionally challenging yet frequent task for pediatricians. This study aims to explore the attitudes, experiences, and barriers pediatricians in Saudi Arabia face when delivering bad news, with a focus on how these factors vary across different career stages.

Methods

A cross-sectional survey was conducted among 137 pediatricians in Saudi Arabia. Data were collected on the frequency and types of bad news delivered, the settings in which bad news was given, and the perceived barriers to effective communication. The study also examined the attitudes of pediatricians at different career stages; junior residents, senior residents, specialists, and consultants.

Results

The study found that 36.5% of pediatricians did not discuss the event after delivering bad news, indicating a gap in medical training. Concerns varied across career stages, with junior residents feeling unprepared, senior residents concerned about interaction quality, specialists worried about reactions, and consultants focused on legal issues. A significant 91.2% of participants expressed a desire for formal training in delivering bad news.

Conclusion

The findings have implications for medical education and practice in King Saud Medical City, highlighting the need for specialized training programs in communication skills and emotional intelligence. The study also adds to the existing literature by focusing on the unique cultural and legal context of Saudi Arabia.

Introduction

Background

Delivering bad news to patients and their families is one of the most challenging aspects of being a pediatrician [1, 2]. This task is challenging because it involves medical facts and emotional and psychological elements [3, 4]. In Saudi Arabia, many pediatricians feel that their medical training is needed to fully prepare them for this complex responsibility. The cultural and social norms of the country add another layer of complexity to this already challenging task [5].

Research Question

This study aims to answer two main questions that are critical for improving healthcare in Saudi Arabia:

- How confident do pediatricians, ranging from newcomers to seasoned consultants, feel about their skills in delivering bad news?
- What specific obstacles or challenges do these pediatricians face when delivering such news?

Objectives

- To understand the general feelings and attitudes of pediatricians in Saudi Arabia towards the delivery of bad news.
- To pinpoint the common problems or barriers that make this task difficult for them.
- To compare how pediatricians at different stages of their careers view this responsibility, from those who are just starting their residency to those who have reached the consultant level.

Rationale

By understanding these attitudes and challenges, we can identify areas where additional training is needed. This will help us create more effective training programs, making it easier for pediatricians to handle this sensitive aspect of their work.

Methods

This cross-sectional study was conducted between September and October 2022 at King Saud Medical City (KSMC), a tertiary care center in Riyadh, Saudi Arabia. The study targeted pediatric physicians, including residents, specialists, and consultants. Participants were recruited through internal communication channels and professional networks. Data were collected using a structured, self-administered online questionnaire developed based on existing literature and validated communication frameworks for breaking bad news. The questionnaire included sections on demographic characteristics, previous experience with delivering bad news, knowledge of communication protocols (e.g., SPIKES, BREAKS), perceived barriers, and attitudes toward breaking bad news. The primary outcomes included physicians' experience, confidence levels, perceived barriers, and training needs. Data were analyzed using SPSS software. Descriptive statistics (frequencies, percentages, means, and standard deviations) were used to summarize the data. Inferential analyses, including chi-square tests and t-tests, were performed to compare variables across different career stages. A p-value of <0.05 was considered statistically significant.

Ethical approval for this study was obtained from the Institutional Review Board (IRB) of King Saud Medical City, Riyadh, Saudi Arabia (Reference No: H1RI-18-Aug22-01) .
The study was conducted in accordance with the principles of the Declaration of Helsinki.
Participation was voluntary, and Participation in the study was voluntary, and completion of the survey was considered as implied consent to participate. Data confidentiality and anonymity were strictly maintained throughout the study.

Results

The study involved a total of 137 pediatricians practicing in King Saud Medical City. As indicated in the table, most participants were male, comprising 67.15% of the sample, while females made up 32.85%. The mean age of the pediatricians was approximately 30 years, with a standard deviation of 5.277.

In terms of their career stages, the sample was predominantly composed of residents. About 19.71% were in their first year of residency (R1), and 22.63% were in their fourth year (R4). Specialists accounted for 18.25% of the sample, while consultants made up a smaller proportion, at 9.49%.

The average years of experience among the participants was 4.82, with a standard deviation of 4.63. This data provides a comprehensive overview of the demographic and professional characteristics of the pediatricians involved in the study. ***Table 1***

Table 1 Sample characteristics

Male (%)	92 (67.15)
Female (%)	45(32.85)
Age (SD)	30.072 (5.277)
R1 (%)	27 (19.71)
R2 (%)	24 (17.52)
R3(%)	17 (12.41)
R4 (%)	31 (22.63)
Specialist (%)	25 (18.25)
Consultant (%)	13 (9.49)
Experience in years (SD)	4.827 (4.63)

Experience in giving bad news.

Table 2 provides valuable insights into the pediatricians' experiences in delivering bad news during their training. As the data indicates, a significant portion of pediatricians, approximately 40%, have experienced delivering bad news either between 1 to 5 times or more than 10 times. A smaller percentage, 5.84%, had never delivered bad news, and 13.87% had done so between 6 to 10 times.

In terms of the type of bad news delivered, critical diagnosis was the most common, reported by 29.47% of the participants. This was closely followed by death, which accounted for 24.94% of the bad news

delivered. Other types included fatal diagnosis (19.65%), failure of treatment (14.11%), and medical errors (10.33%).

The specialties where bad news was most frequently delivered were Pediatric/Adult Emergency and Neonatal Intensive Care, both accounting for 22.1% of the instances. General Pediatrics followed at 18.08%, Pediatric Hematology/Oncology at 9.82%, and Genetics and Metabolic at 7.37%.

Table 2 Pediatrician Experiences in given bad news.

	Frequency	%
During your training how many times have you given/delivered bad news?		
0	8	5.84
1 to 5	55	40.15
6 to 10	19	13.87
more than 10	55	40.15
Type of bad news delivered.		
Death	99	24.94
Fatal diagnosis	78	19.65
Critical diagnosis	117	29.47
Failure of treatment.	56	14.11
Medical error	41	10.33
Other	6	1.51
Specialty Where Bad News Was Given		
General Pediatrics	81	18.08
Pediatric/ adult Emergency	99	22.1
Pediatric Hematology/Oncology	44	9.82
Pediatric Intensive Care	92	20.54
Neonatal Intensive Care	99	22.1
Genetics and Metabolic	33	7.37

Pediatrician Knowledge, Attitude, and Barriers of Delivering Bad News

Table 3: This table provides an overview of pediatricians' previous experiences, training, and attitudes toward delivering bad news. A significant majority, 91.24%, had previous experience with breaking bad news, but only 56.93% had received formal training. When it comes to witnessing colleagues break bad

news, 51.82% had seen it done poorly by junior physicians, while 64.23% had seen it done well by senior physicians. Knowledge of breaking bad news protocols varied, with 43.29% familiar with SPIKES [6], 14.02% with BREAKS [7], and 8.54% with ABCDE [8]. The table also highlights that 80.29% of the participants considered having the skill to deliver bad news as very important.

Table 3 Pediatrician knowledge, attitude, and barriers of delivering bad news

	Frequency	percentage
Previous experience with breaking bad news?		
No	12	8.76
Yes	125	91.24
Previous training with breaking bad news?		
No	59	43.07
Yes	78	56.93
have you witnessed a colleague who is a junior physician break bad news?		
No	40	29.2
Yes, done poorly and the situation was not handled well.	71	51.82
Yes, done well and was very appropriate with handling the situation.	26	18.98
have you witnessed a colleague who is a senior physician break bad news?		
No	10	7.3
Yes, done poorly and the situation was not handled well.	39	28.47
Yes, done well and was very appropriate with handling the situation.	88	64.23
Do you know of any breaking bad news protocols?		
ABCDE	14	8.54
BREAKS	23	14.02
SPIKES	71	43.29
NOT KNOW	56	34.15
Attitudes about delivering bad news; Estimate of current skill		
Poor	34	24.82
Average	55	40.15
Good	40	29.2
Excellent	8	5.84
Attitudes about delivering bad news; importance of having the skill		
very unimportant	2	1.46
unimportant	1	0.73
important	24	17.52
very important	110	80.29

Attitudes about delivering bad news; Importance of having training		
very unimportant	1	0.73
important	30	21.9
very important	106	77.37
Attitudes about delivering bad news; Need for more guidance		
very unimportant	1	0.73
unimportant	3	2.19
important	38	27.74
very important	95	69.34
What do you think is the most important barrier when breaking bad news?		
Fear of being blamed.	73	12.09
Not enough experience with breaking bad news.	82	13.58
Not aware of protocols regarding breaking bad news.	63	10.43
Medicolegal concerns.	71	11.75
Lack of confidence in facing these situations.	62	10.26
Fear of the reaction of the concerned parties involved.	80	13.25
Fear of the situation not being handled properly	72	11.92
Not understanding the pathology of the disease	52	8.61
Language barrier.	49	8.11

Pediatricians' Experiences in the Event of Delivering Bad News

Table 4: This table shows that 36.5% of pediatricians did not discuss the event of delivering bad news with anyone, while 63.5% did. Among those who discussed, the topics ranged from the family's reaction (23.79%) to their own feelings (19.76%) and lessons learned (18.95%). When asked about their satisfaction level after the event, 32.85% were not satisfied and required more training, 49.64% were moderately satisfied, and 17.52% were very satisfied.

Table 4 Pediatricians experiences in the event of delivering bad news

	Frequency	percentage
Did you discuss the event and the interaction with anyone after the event?		
No	50	36.5
Yes	87	63.5
What did you discuss after the event?		
The family's reaction towards breaking bad news	59	23.79
Your own feelings and afflictions regarding breaking bad news to family members.	49	19.76
Lessons learned towards the event of breaking bad news.	47	18.95
Things that you would have done differently regarding breaking bad news.	46	18.55
Did not discuss the event.	47	18.95
How did you feel after the event/interaction? (Correlate with level of preparedness and knowledge and guidelines)		
Not satisfied at all and require more training.	45	32.85
Moderately satisfied with room for improvement but generally acceptable level of training.	68	49.64
Very satisfied and confident with minor room for improvement.	24	17.52
Do you think you have the ability to break bad news well?		
Able to break bad news to families with poor satisfaction	33	24.09
Able to break bad news to families with Average satisfaction	51	37.23
Able to break bad news to families with Good satisfaction	40	29.2
Able to break bad news to families with excellent satisfaction	13	9.49
How prepared did you feel you were to deliver the news?		
Poor	36	26.28
Average	46	33.58
Good	45	32.85
Excellent	10	7.3
Did you anticipate/expect the reaction of the family?		

No	47	34.31
Yes	90	65.69
Can you recall the feelings/behavior of the family after you delivered the news?		
No	15	10.95
Yes	122	89.05
In retrospect after delivering bad news would you have done anything differently?		
No	51	37.23
Yes	86	62.77
In your opinion how well did you respond to the family's reaction?		
Poor	28	20.44
Average	48	35.04
Good	44	32.12
Excellent	17	12.41
Reasons the physician was chosen to deliver this bad news?		
Primary caregiver of the patient with most clinical information	90	35.43
Most suitable one available to deliver the bad news	70	27.56
Most suitable one willing	42	16.54
Desire to gain experience/training.	29	11.42
felt would do better job than others	23	9.06
Would you like formal training in the task of "breaking bad news"?		
No	12	8.76
Yes	125	91.24
Do you feel that formal training in the task of "breaking bad news" is required for all physicians?		
No	6	4.38
Yes	131	95.62
Would you volunteer to break the bad news?		
No	65	47.45
Yes	72	52.55

In the event of delivering bad news

Table 5 reveals that 36.5% of pediatricians did not discuss the event after it occurred. Among those who did, family reaction was the most discussed topic. About half of the pediatricians felt moderately satisfied with the event but saw room for improvement. Only 9.4% were excellently satisfied with their skills in delivering bad news. These findings suggest that there is a need for improvement and specialized training in this area.

Table 5 Differences between Junior Residence, Senior Residence, Specialist, and consultant pediatricians in term of knowledge

	Junior Residence (%)	**Senior Residence (%)**	**Specialist (%)**	**Consultant (%)**	**Total**	**chi-sequare**	**p-value**
Previous experience with breaking bad news?							
No	10 (19.61)	2 (4.17)	0 (0)	0 (0)	12 (8.76)	12.4254	0.006
Yes	41 (80.39)	46 (95.83)	25 (100)	13	125 (91.24)		
Previous training with breaking bad news?							
No	33 (64.71)	21 (43.75)	1 (4)	4 (30.77)	59 (43.07)	26.112	0.000
Yes	18 (35.29)	27 (56.25)	24 (96)	9 (69.23)	78 (56.93)		
Do you know of any breaking bad news protocols?							
ABCDE	0 (0)	3 (6.38)	2 (8)	9 (69.23)	14 (10.29)	109.3391	0.000
BREAKS	1 (1.96)	5 (10.64)	10 (40)	7 (53.85)	23 (16.91)		
SPIKES	18 (35.29)	25 (53.19)	20 (80)	8 (61.54)	71 (52.21)		
NOT KNOW	32 (62.75)	21 (44.68)	2 (8)	1 (7.69)	56 (41.18)		

Differences in Attitudes About Delivering Bad News

Table 6 shows significant differences between junior residents, senior residents, specialists, and consultants in terms of their attitudes towards delivering bad news. Consultants were more likely to rate their skills as good, while junior and senior residents were less confident. This indicates that ongoing training and mentorship are crucial at all career stages. Moreover, 76.92% of consultants estimate their skills of being good compared to 13.73% and 27.08% junior and senior residence respectively, with significant difference (x:37.36,P:0.000).

Table 6 Differences between Junior Residence, Senior Residence, Specialist, and consultant pediatricians in term of attitude

	Junior Residence (%)	Senior Residence (%)	Specialist (%)	Consultant (%)	Total (%)	chi-sequare	p-value
Attitudes about delivering bad news; Estimate of current skill							
Poor	22 (43.14)	11 (22.92)	1 (4)	0 (0)	34 (24.82)	37.3641	0.000
Average	22 (43.14)	20 (41.67)	11 (44)	2 (15.38)	55 (40.15)		
Good	7 (13.73)	13 (27.08)	10 (40)	10 (76.92)	40 (29.2)		
Excellent	0 (0)	4 (8.33)	3 (12)	1 (7.69)	8 (5.84)		
Attitudes about delivering bad news; importance of having the skill							
very unimportant	1 (1.96)	0 (0)	1 (4)	0 (0)	2 (1.46)	5.9479	0.745
unimportant	1 (1.96)	0 (0)	0 (0)	0 (0)	1 (0.73)		
important	11 (21.57)	7 (14.58)	5 (20)	1 (7.69)	24 (17.52)		
very important	38 (74.51)	41 (85.42)	19 (76)	12 (92.31)	110 (80.29)		
Attitudes about delivering bad news; Importance of having training.							
very unimportant	0 (0)	0 (0)	1 (4)	0 (0)	1 (0.73)	8.9857	0.174
important	16 (31.37)	9 (18.75)	3 (12)	2 (15.38)	30 (21.9)		
very important	35 (68.63)	39 (81.25)	21 (84)	11 (84.62)	106 (77.37)		
Attitudes about delivering bad news; Need for more guidance							
very unimportant	0 (0)	0 (0)	1 (4)	0 (0)	1 (0.73)		

unimportant	2 (3.92)	0 (0)	1 (4)	0 (0)	3 (2.19)		
important	16 (31.37)	9 (18.75)	11 (44)	2 (15.38)	38 (27.74)	14.847	0.095
very important	33 (64.71)	39 (81.25)	12 (48)	11 (84.62)	95 (69.34)		

Barriers to Delivering Bad News

Table 7 highlights the perceived barriers to delivering bad news. Junior residents reported a lack of experience as the main barrier, while senior residents were concerned about improper handling of the situation. Specialists feared the reaction of the concerned parties, and consultants were mainly concerned about medico-legal issues. These barriers underscore the need for training programs to address these specific concerns. Junior Residence reported to not have enough experience with breaking bad news as their most barrier (74.51%), while senior Residence reported that Fear of the situation not being appropriately handled was the most barrier (64.58%), as for Specialist, 76% reported fear of the reaction of the concerned parties involved, and finally for consultants, 76.92% said that Medico-legal concerns was the most concern barrier and this difference was observed to be significant (x:322.3, P:0.000).

Table 7 Differences between Junior Residence, Senior Residence, Specialists, and consultant pediatricians in terms of barrier

	Junior Residence (%)	Senior Residence (%)	Specialist (%)	Consultant (%)	Total (%)	chi-sequare	P-value
What do you think is the most important barrier when breaking bad news?							
Fear of being blamed.	31 (60.78)	26 (54.17)	11 (44)	5 (38.46)	73 (53.28)	322.3283	0.000
Not enough experience with breaking bad news.	38 (74.51)	30 (62.5)	11 (44)	3 (23.08)	82 (59.85)		
Not aware of protocols regarding breaking bad news.	24 (47.06)	26 (54.17)	12 (48)	1 (7.69)	63 (45.99)		
Medicolegal concerns.	28 (54.9)	15 (31.25)	18 (72)	10 (76.92)	71 (51.82)		
Lack of confidence in facing these situations.	27 (52.94)	26 (54.17)	6 (24)	3 (23.08)	62 (45.26)		
Fear of the reaction of the concerned parties involved. -	25 (49.02)	28 (58.33)	19 (76)	8 (61.54)	80 (58.39)		
Fear of the situation not being handled properly	23 (45.1)	31 (64.58)	9 (36)	9 (69.23)	72 (52.55)		
Not understanding the pathology of the disease	24 (47.06)	20 (41.67)	6 (24)	2 (15.38)	52 (37.96)		

Language barrier.	19 (37.25)	11 (22.92)	13 (52)	6 (46.15)	49 (35.77)

Discussion

Interpretation

Our study comprehensively analyzes the attitudes, experiences, and challenges pediatricians in King Saud Medical City face when tasked with delivering bad news. The data reveals a multi-faceted issue that varies significantly depending on the career stage of the pediatrician.

For junior residents, the lack of preparedness is a glaring issue. A substantial 36.5% of participants did not discuss the event after it happened, suggesting they may not have the emotional or communicative tools to process such experiences. This lack of discussion could also indicate a gap in the medical training they receive, which fails to prepare them for their job's emotional and ethical complexities [9].

As pediatricians progress in their careers, their concerns evolve nuancedly. Senior residents, for example, are more focused on the quality of the interaction with patients and their families. Specialists are primarily concerned about the parties' reactions, while consultants are apprehensive about potential legal repercussions. These shifting concerns are supported by our data, which shows significant differences in experience, training, and familiarity with protocols for breaking bad news among these groups.

Implications for Medical Education and Practice

The findings of our study have far-reaching implications for the future of medical education and practice in KING SAUD MEDICAL CITY, which are consistent with previous reports [10-12]. Junior residents, who comprise a significant portion of our sample, need more specialized training in communication skills and emotional intelligence [13]. This is underscored by the fact that 62.7% of them indicated they would have approached the situation differently in hindsight.

For more seasoned pediatricians, the study highlights the need for ongoing professional development, particularly in the area of legal education and ethical considerations. This is especially relevant given that medicolegal concerns were prevalent among specialists and consultants [14].

Relation to Existing Research

Our study resonates with existing literature [15-17], but adds a unique layer by focusing on the Saudi context. Previous studies conducted in other countries have also highlighted the lack of training as a significant barrier to effective communication in healthcare settings [18-20]. However, the emphasis on legal concerns is more pronounced in our study, suggesting that cultural and legal factors in King Saud Medical City may influence the experience of delivering bad news.

Limitations and Future Directions

While our study provides a wealth of insights, it has limitations. The sample size is limited, and the data is self-reported, which could introduce bias. Future research could benefit from a larger, more diverse sample and the inclusion of objective measures such as peer reviews or patient feedback to validate the findings.

Conclusion

The study sheds light on the complex landscape of attitudes and barriers that pediatricians in King Saud Medical City face when delivering bad news. It reveals that these challenges are not static but evolve with career progression. Junior residents primarily feel unprepared, indicating a need for targeted training programs. On the other hand, more experienced pediatricians are concerned about the quality of interactions and potential legal repercussions, suggesting a need for ongoing professional development that includes legal education.

The findings of this study have important implications for medical education and practice in King Saud Medical City and could serve as a foundation for future research. Given the study's limitations, including its sample size and reliance on self-reported data, future research could include a larger, more diverse sample and employ objective measures.

By addressing these challenges head-on, we can improve the quality of healthcare delivery, enhance patient satisfaction, and ultimately provide better care for children and their families in King Saud Medical City.

Declarations

Ethics Approval and Consent to Participate:

This study was approved by the Institutional Review Board of King Saud Medical City (KSMC), Riyadh, Saudi Arabia (IRB Reference No: H1RI-18-Aug22-01). All procedures were conducted in accordance with the principles of the Declaration of Helsinki and relevant ethical guidelines. Participation in the study was voluntary. All participants provided informed consent prior to participation through completion of the survey. Participants were assured of the confidentiality and anonymity of their responses.

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Consent for publication

Not applicable.

Availability of data and materials

The datasets generated and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

Ahmed Alanazi and Fahad Abdulrahman Algaeed conceptualized and designed the study. Bati Alshammari and Wael Muharram contributed to data collection and analysis. Salem Alsuwaidan supervised the research process and provided critical revisions. All authors contributed to manuscript drafting, reviewed the final version, and approved it for submission.

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References

1. Dighe M, Marathe M, Muckaden M, et al., Breaking Bad News to Families of Dying Children: A Paediatrician's Perspective, (2012) 115-36.
2. Meitar D and Karnieli-Miller O, 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. https://doi.org/10.1080/0142159X.2021.1928618.
3. Buckman R, *How to break bad news: a guide for health care professionals*. 1992: University of Toronto Press.
4. Brouwer M, Maeckelberghe E, Heide A, et al., Breaking bad news: what parents would like you to know, Archives of Disease in Childhood 106 (2020) archdischild-2019. https://doi.org/10.1136/archdischild-2019-318398.
5. Al-Mohaimeed AA and Sharaf FK, Breaking bad news issues: a survey among physicians, Oman Med J 28(1) (2013) 20-5. https://doi.org/10.5001/omj.2013.05.
6. Baile WF, Buckman R, Lenzi R, et al., SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer, The Oncologist 5(4) (2000) 302-311. https://doi.org/10.1634/theoncologist.5-4-302 %J The Oncologist.
7. Narayanan V, Bista B, and Koshy C, 'BREAKS' Protocol for Breaking Bad News, Indian J Palliat Care 16(2) (2010) 61-5. https://doi.org/10.4103/0973-1075.68401.
8. VandeKieft GK, Breaking bad news, Am Fam Physician 64(12) (2001) 1975-8.
9. Baile WF, Kudelka AP, Beale EA, et al., Communication skills training in oncology: description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness, 86(5) (1999) 887-897.
10. Harden RM, Twelve tips on teaching and learning how to break bad news, Medical Teacher 18(4) (1996) 275-278. https://doi.org/10.3109/01421599609034177.

11. Rosenbaum ME, Ferguson KJ, and Lobas JG, Teaching medical students and residents skills for delivering bad news: a review of strategies, Academic medicine : journal of the Association of American Medical Colleges 79(2) (2004) 107-117. https://doi.org/10.1097/00001888-200402000-00002.
12. Smith S, Hanson JL, Tewksbury LR, et al., Teaching Patient Communication Skills to Medical Students:A Review of Randomized Controlled Trials, 30(1) (2007) 3-21. https://doi.org/10.1177/0163278706297333.
13. Dosanjh S, Barnes J, and Bhandari M, Barriers to breaking bad news among medical and surgical residents, Med Educ 35(3) (2001) 197-205. https://doi.org/10.1046/j.1365-2923.2001.00766.x.
14. Wolfe AD, Frierdich SA, Wish J, et al., Sharing life-altering information: development of pediatric hospital guidelines and team training, J Palliat Med 17(9) (2014) 1011-8. https://doi.org/10.1089/jpm.2013.0620.
15. Ptacek JT and Eberhardt TL, Breaking Bad News: A Review of the Literature, JAMA 276(6) (1996) 496-502. https://doi.org/10.1001/jama.1996.03540060072041 %J JAMA.
16. Fallowfield L, Fallowfield L, and Jenkins V, Communicating sad, bad, and difficult news in medicine, Lancet (London, England) 363(9405) (2004) 312-319. https://doi.org/10.1016/s0140-6736(03)15392-5.
17. Johnson J and Panagioti M, Interventions to Improve the Breaking of Bad or Difficult News by Physicians, Medical Students, and Interns/Residents: A Systematic Review and Meta-Analysis, 93(9) (2018) 1400-1412. https://doi.org/10.1097/acm.0000000000002308.
18. Biazar G, Delpasand K, Farzi F, et al., Breaking Bad News: A Valid Concern among Clinicians, Iran J Psychiatry 14(3) (2019) 198-202.
19. Sleiman J, Savage DJ, Switzer B, et al., Teaching residents how to break bad news: piloting a resident-led curriculum and feedback task force as a proof-of-concept study, BMJ Simul Technol Enhanc Learn 7(6) (2021) 568-574. https://doi.org/10.1136/bmjstel-2021-000897.
20. Khalaf H, Almothafar B, and Alhalabi N, Breaking Bad News During COVID-19 Time in Surgical, Emergency and Medical Specialties - What More we Need to Develop?, Med Arch 76(2) (2022) 131-134. https://doi.org/10.5455/medarh.2022.76.131-134.

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