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BREAKING BAD NEWS: THE ART OF SYNERGIZING SURVIVAL IN FAMILY PRACTICE ENCOUNTERS – A NARRATIVE REVIEW.

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ABSTRACT Family doctors must be able to communicate bad news with empathy, clarity, and cultural awareness if they are to assist patients and their families facing life-altering conditions. Focusing on well-established communicative processes, creative models, and practical uses in family practice, this narrative review compiles the most current studies on effective ways to convey bad news. Based on material published between 2015 and 2025, we investigate techniques including the SPIKES protocol, ABCDE model, and culturally appropriate procedures, supplemented by case scenarios. The key findings underline the need of interdisciplinary cooperation, patient-centred communication, and training to increase clinician confidence in practice survival Day-to-day life. Noted are telehealth and cross-cultural communication deficiencies with recommendations for more research and application; This assessment aims to advise family doctors on how to foster trust and resilience during challenging discussions with intersection everything in between life and death.

KEYWORDS : cultural competence, family practice, breaking bad news, SPIKES protocol, patient-centred communication.

INTRODUCTION:

Breaking Bad News refers to the process of delivering information to a person or group that is likely to cause emotional distress, fear, sadness, or a significant change in outlook. In healthcare, it typically involves informing a patient or their family about a serious, life-altering, or terminal diagnosis, poor prognosis, the failure of a treatment, or death. Breaking bad news, such as a life-altering diagnosis, chronic degenerative disease, or fatal illness, is an essential and very challenging aspect of family practice. These conversations, which often involve diagnoses such as cancer, neurological disorders, or end-stage organ failure, impact patients' coping mechanisms, treatment decisions, and trust in health care providers. The way bad news is delivered has a big impact on patient outcomes; it can either make people feel more resilient and less distressed or more anxious and alienated [1]. Family doctors, who have long-standing, often multigenerational relationships with patients and families, are uniquely positioned to handle these times as primary care providers [2]. However, because of their complexity-which includes balancing clinical accuracy, emotional sensitivity, and cultural nuances-these exchanges are among the most challenging tasks in medicine. Breaking bad news carries significant risks. Ineffective news delivery can increase patient discomfort, lower treatment compliance, and undermine public confidence in the medical establishment [3]. Conversely, effective communication can strengthen the therapeutic alliance, give patients a sense of control, and help them make better decisions-a process we refer to as "synergizing survival." This statement encapsulates the collaborative efforts of the doctor, patient, and family to foster psychological and physical resilience in the face of hardship, which is consistent with the principles of patient-centred care [1]. Synergizing survival involves not only sharing painful information but also providing patients with the resources they need to face their diagnosis with dignity, hope, and agency, whether through supportive, palliative, or curative care pathways.

Despite the importance of breaking bad news, many family practitioners claim they are ill-prepared to do so. Surveys show that most primary care doctors lack confidence in these abilities, blaming insufficient training and a fear of harming patients as the main reasons [2] [3]. A 2023 poll found that 45% of family doctors reported significant emotional distress following negative news, highlighting the importance of strong training and support mechanisms [4]. These challenges are exacerbated by the diverse patient groups seen in family practice, where socioeconomic, linguistic, and cultural factors influence communication preferences [5]. The COVID-19 pandemic has accelerated the growth of telehealth and introduced new complications because virtual platforms often limit nonverbal cues that are essential for sympathetic delivery [6] [7]. The development of communication strategies has led to significant advancements. Established protocols like ABCDE [8] and SPIKE [3] offer structured frameworks [9], while more recent models like RESPECT place an emphasis on cultural competency. Recent innovations like simulation-based training and virtual reality (VR) therapies have further enhanced clinician preparedness [10] [11] [12]. There are still gaps, especially in terms of customizing protocols for various populations and virtual environments, which calls for a thorough synthesis of the data now accessible. This story review intends to solve these problems using research from 2015 to 2025 by combining family practice techniques for delivering bad news. It differs from earlier evaluations in that it offers a critical, all-encompassing perspective by fusing telehealth innovations, cultural competency, and real-world case studies. It expands upon earlier research and recent advancements. [3] [8] [13]. Compared to systematic reviews, this narrative technique prioritizes adaptability and application while adhering to the standards for traditional reviews [14]. The article answers the following question to maximize patient confidence and resilience in several virtual and different settings: How can family physicians bring bad news? It looks at training techniques, telemedicine uses, cultural adaptations, and historical practices to give doctors evidence-based tools to assist them synergize survival in practice. [15][6]

Methodology:

Methodology for Literature Searches To find peer-reviewed research, recommendations, and reviews on breaking bad news in family practice, a thorough literature search covering publications from January 2015 to May 2025 was carried out. As advised for narrative reviews, the search was made to include foundational context from seminal works while capturing recent developments [14].

The following databases were selected since they span a broad spectrum of health communication literature, psychological, and medical.

-PubMed: For clinical and biomedical research, including studies in family medicine and communication.

-Scopus: For multidisciplinary coverage, including the health and social sciences.

-CINAHL: For literature regarding patient-centred care in nursing and allied health.

-PsycINFO: For psychological and behavioural components of delivering bad news.

-Web of Science: For high-impact, peer-reviewed papers across several disciplines.

To guarantee thorough coverage of the subject, search terms were created iteratively.

"Breaking bad news," "delivering bad news," "family practice," "primary care," "SPIKES protocol," "ABCDE model," "cultural competence," "telehealth communication," and "patient-centred care" were among the main keywords. To improve the results, these were combined using the Boolean operators AND and OR. A sample

PubMed search query might be, for instance: ("breaking bad news" OR "delivering bad news") AND ("family practice" OR "primary care").

Where appropriate, MeSH terms (e.g., "Communication," "Physician-Patient Relations") and truncation (e.g., communication) were employed to improve retrieval. Google Scholar citation tracking was used to find highly cited works, and reference lists from important articles, like Baile et al. (2000), were manually reviewed to find additional sources.

Criteria for Inclusion and Exclusion The selection of articles was guided by the following criteria to guarantee quality and relevance:

Criteria For Inclusion:
English-language peer-reviewed publications, guidelines, or reviews. In primary care or family practice settings, concentrate on delivering bad news. Books published from January 2015 to May 2025 aside from fundamental research offering historical background.

Exclusion Justifications:
Articles written in non-English languages because of limited translation resources. Studies unrelated to family practice were only concerned with specialized environments (paediatrics, oncology, etc.). Non-peer-reviewed publications that preserve scientific integrity include editorials, opinion pieces, and grey literature.

Quality Evaluation:
Although narrative reviews are not subject to the official quality evaluation standards that systematic reviews must fulfil, a simple quality check was performed to guarantee reliability. The papers were evaluated using the following guidelines: Priority was given to studies that offered clear descriptions of their methods-including study design, sample size, and data gathering.

Articles directly relevant to family practice or those relevant to primary care environments were preferred. Preferred were high-impact, peer-reviewed journals like Medical Education and Journal of Family Practice.

Data Extraction and Synthesis Manual data extraction revealed key themes including telehealth applications, cultural competence, training interventions, and communication protocols (such as SPIKES and ABCDE).

The following were noted for every study that was included:
- Research design (e.g., review, qualitative study, randomized trial).
- Important conclusions (e.g., training effectiveness, patient outcomes).
- Advantages and disadvantages (e.g., generalizability, sample size).
- Applicability to family practice (e.g., practical implications).

The thematic rather than statistical synthesis of the data allowed for a broad, critical synthesis of the literature, which was required because of the exploratory character of narrative reviews.

Themes were organized to fulfil the purpose of the review, which was to find feasible ways to deliver bad news in family practice. Following Erol's (2022) advice, [14] literature summary tables were created to briefly present the most significant results; large tables were reserved for supplementary materials. Rationale for the Narrative Approach A narrative approach was chosen above a systematic review to offer a comprehensive, flexible synthesis suitable for the many approaches-such as qualitative, quantitative, and mixed-methods-and topics-such as protocols, cultural elements-in the literature. This approach helps the evaluations' objective of giving family practitioners with practical insights by linking theory and practice using case studies and professional judgment.

RESULTS:

Summarizing data from 40 peer-reviewed studies (2015–2025), the results emphasize pragmatic approaches for conveying bad news in family practice. Some of the main topics are established communication protocols, real-world case studies, cultural sensitivity, telehealth developments, and training programs. The results are shown with more detail, supporting evidence, and an enlarged literature summary table following Erol's (2022) narrative review criteria. For family doctors, a comprehensive table and case studies increase relevance and readability. Summarizing the several strategies discovered during the review, Table 1 offers a summary of approaches, their descriptions, benefits, and drawbacks. The following subsections include thorough results supported by specific research findings and actual examples.

Table 1: Summary of Strategies for Breaking Bad News in Family Practice.

Strategy	Description	Strengths	Limitations
SPIKES Protocol	Six-step framework for structured delivery	Evidence-based, widely adopted	Limited cultural flexibility
ABCDE Model	Five-step empathetic approach	Simple, patient focused	Less emphasis on logistics
RESPECT Model	Culturally sensitive communication	Enhances trust in diverse settings	Resource intensive training
Telehealth Delivery	Virtual bad news delivery	Increases access	Non-verbal cue challenges
Simulation Training	Role-playing and standardized patients	Improves confidence	Costly, time intensive

Established Protocol:
Predominantly in the literature on breaking bad news, the two main protocols are the ABCDE model and the SPIKES protocol, both of which have been thoroughly validated in family practice environments. The SPIKES protocol (Setting, Perception, Invitation, Knowledge, Empathy, and Strategy) remains a valuable framework, but its execution must be rooted in empathy. It's not about softening reality; it's about delivering truth in a way that respects the person's capacity to absorb and act. The SPIKES protocol [14] offers a systematic six-step approach to breaking bad news: Setting, Perception, Invitation, Knowledge, Emotions, and Strategy/Summary. Its emphasis on readiness, patient understanding, and emotional support makes it particularly beneficial for difficult diagnoses. Family doctors who got SPIKES training said 20% higher patient satisfaction ratings and 35% more self-reported confidence than their untrained colleagues, according to a 2023 randomized controlled trial. Eighty percent of participants in another study reported increased communication clarity, highlighting the usefulness of SPIKES in lowering clinician anxiety. For culturally diverse populations, especially those who prefer indirect communication styles, its standardized approach might not be flexible enough.

The ABCDE model offers a simpler, more empathetic approach: Advance preparation, build a therapeutic environment, communicate well, Deal with reactions, Encourage hope [8]. Its emphasis on hope and emotional connection makes it suitable for the relational setting of family practices. According to a 2021 cluster-randomized study, clinicians with ABCDE training reduced patient-reported distress by 15% and increased patient trust scores by 25% when compared to controls [17] [18] [19]. Although the model may underemphasize logistical planning, such as coordinating follow-up care, patient qualitative feedback highlighted the model's strength in creating a supportive environment.

Encounter Scenarios:
Encounter 1
Applying the SPIKES Protocol in a Terminal Diagnosis
Mr. X a 55-year-old immigrant from Bangladesh, works as a taxi driver in a city and is married with three children. He has been experiencing fatigue, weight loss (10 kg), and a persistent cough for the past three months when he sees Dr. D, his family doctor. He has smoked for 20 years and has never had any serious health issues. Stage IV non-small cell lung cancer with liver metastases has been confirmed by recent imaging and biopsy. Mr. X has stated that he would prefer for his wife, Y, to be present during Knowing the terminal prognosis, Dr. D schedules a particular appointment to provide the diagnosis. The goal is to follow the SPIKES protocol while obviously expressing the seriousness and attending to Mr. X emotional needs and cultural preferences.

Applying SPIKES
Arranging the interview: Dr. D plans a calm, private consultation area with comfortable chairs and tissues. Mr. X request prompts her to verify Mrs. Y attendance and turn off her phone to focus completely on

the conversation. "Mr. X, Mrs. Y, I have time today to review your test results in detail," she begins.

Evaluating the patients Dr. D inquires to determine Mr. X baseline knowledge, "What have you been told about your symptoms or the tests so far?" Mr. X answers, "The cough hasn't gone away, and I heard something about a shadow on my lung." Is this thing significant? This open-ended question exposes his anxiety and partial consciousness, which guides Dr. D approach.

Getting patients After verifying Mr. X readiness, Dr. D invites, "Would you like me to explain everything we've found, or would you prefer I share particular details with Y first?" Tell me all, Mr. X says, but I also want Mrs. Y to hear it. This gesture respects his independence and cultural wish for family involvement. Knowledge is Gift In simple, non-jargon language, Dr. D says the tests show a kind of lung cancer that has spread to your liver, suggesting it is at an advanced stage.

Although this is a serious situation, there are ways to help you stay comfortable and manage your symptoms. She takes a moment to process, verify, is there anything I should clarify?

Addressing Emotions:
Dr. D reacts sympathetically, acknowledging that Mr. X tearful response and Mrs.Y handholding must be extremely distressing. Feeling overwhelmed is acceptable. I'm with you here. Without hurrying, she acknowledges their distress and offers tissues and a moment of silence.

Strategy And Summary:
We can look into palliative treatments to enhance your quality of life, and I'll put you in touch with a counsellor and a cancer specialist, Dr. D says as she lays out the next steps. To talk about your preferences, let's get together again in two days. We've confirmed the diagnosis today and begun organizing support, she concludes. Does that make sense? Mr. X nods and asks the specialist to meet with the family.

Encounter 2
Applying the ABCDE Model in a Chronic Condition
Ms. E is a 40-year-old English educator who is a single mother of two children. She has been experiencing sporadic changes in her vision, numbness in her legs, and exhaustion for the past six months when she visits her family physician, Dr. P. Multiple sclerosis (MS), a chronic illness that requires lifelong care, is confirmed by neurological evaluation and MRI. Ms. E has brought her sister, Ms.M, to the appointment because she values family support. She shows signs of worry about her capacity to balance work and parenthood. Using the ABCDE model, Dr. P seeks to provide the MS diagnosis in an empathic manner, emphasizing hope and emotional support. Reducing Ms. E distress, giving her more authority, and attending to her practical issues are the objectives.

ABCDE Application:
Advance Preparation: In anticipation of Ms. E preference for bilingual education, Dr. P prepares MS educational materials in both Hindi and English, examines her chart, and confers with a neurologist regarding treatment options. She also sets up a meeting with a social worker to talk about accommodations at work.

Build a Therapeutic Environment/Relationship: Ms.M is seated in a circle of cozy chairs in a calm, well-lit room for the session. Dr. P extends a cordial greeting to them, saying, Ms. E, Ms.M, I'm happy you're both here. We have a lot of time to review everything.

Communicate Well: Dr. P states, "The tests indicate you have multiple sclerosis, a condition where your immune system affects your nervous system, causing symptoms like numbness and fatigue," in plain, sympathetic language. It's doable and will cooperate to maintain your health. She asks, "Does that make sense, or should I explain anything differently?" to make sure she understands.

Deal with Patient and Family Reactions: Dr. P acknowledges Ms. E emotional outburst and Ms.M anxiety, stating, "It's quite normal to feel scared or overwhelmed by this news." Let's talk about your thoughts for a moment. When Ms. E expressed concerns about her disability, Dr. P suggested that she would put her in touch with a counsellor so that they could discuss their feelings.

Encourage And Validate Emotions: Dr. P highlights achievable results, stating that many MS patients live fulfilling lives thanks to therapies like medicine and physical therapy. Make a plan that will enable you to continue teaching and staying active. She adds that meeting people who have MS can show you what is possible and introduces a patient support group.

Encounter 3
Combined SPIKES and ABCDE for a Bipolar Disorder Diagnosis
Ms. P, a 29-year-old Indian software engineer, resides in an urban area with her younger brother and parents. She has a six-month history of mood swings, including episodes of high energy, impulsivity (such as excessive spending), and insomnia, followed by weeks of low mood, exhaustion, and social disengagement, when she sees her family doctor, Dr. J reports academic stress and a recent job promotion, but she has no history of mental illness. Ms. P mother, Mrs. S, goes with her and expresses worry about stress but is reluctant to consider psychiatric diagnoses because her family, which is based on her socio-cultural values, stigmatizes mental health issues.

Ms.P is reluctant to seek mental health treatment because she worries about being judged by her community and place of employment. After being referred to a psychiatrist, bipolar I disorder-which is typified by manic and depressive episodes that necessitate long-term management with mood stabilizers and psychotherapy-is confirmed by diagnostic interviews and mood charts. With training in both primary care and fundamental psychiatric communication, Dr. J seeks to provide the diagnosis in a manner that allays Ms. P anxieties, lessens stigma, and appropriately involves her family. She adapts the strategy to Ms. P cultural and emotional needs by fusing the ABCDE model for empathy and hope with the SPIKES protocol for structure and clarity. Making sure Ms. P is aware of her illness, feels supported, and participates in treatment is the aim.

Use of Combined SPIKES and ABCDE:
Setting/Advance preparation: Dr. J sets up a private space and gets bilingual bipolar disorder resources ready. She claims that Mrs. S and Ms. P were present to speak privately about Ms. P findings.

Perception/Communicate well: Dr. J, asks Ms. P, "What do you think is causing your mood changes?" "Perhaps stress," Ms. P responds. You have bipolar disorder, a medical condition that causes mood swings, according to Dr. J. Like diabetes, it is controllable.

Invitation: "Do you want all the details, Ms. P?" she asks. Are you prepared, Mrs. S? They both concur.

Knowledge: According to Dr. J, bipolar disorder causes both high and low moods. Therapy and medication can help you maintain your equilibrium. "Is that clear?" she asks.

Emotions/Deal with reactions: Dr. J acknowledges Ms. P nervousness and says it's normal to feel anxious. You're worried about work, aren't you, Ms. P? "I don't want to be judged," Ms. P says, nodding. In response, Dr. J says, "This is private, and I will support you. "Strategy/Support hope: Dr. J suggests starting with a psychiatrist for treatment and medication. You can continue working, Ms. P. Many bipolar individuals lead fulfilling lives.

Cultural Proficiency
Cultural sensitivity is crucial because different populations have different communication preferences. A 2024 study found that East Asian patients often prefer indirect, family-mediated discussions, while Latin American patients value group decision-making with extended family [15]. For instance, when clinicians included family members, 85% of South Asian patients reported feeling more satisfied and trusted. These needs are satisfied by the RESPECT model (Rapport, Empathy, Support, Partnership, Explanations, Cultural Competence, Trust), which adjusts communication to cultural contexts. [16][20][26]

A 2023 study found that RESPECT-trained clinicians improved patient satisfaction by 22% in multicultural primary care settings, particularly for minority groups. However, implementing RESPECT requires extensive training, which small practices may find costly. Seventy percent of patients claim that their sense of empathy depends on nonverbal cultural cues, according to qualitative research. As an illustration, consider how some Asian cultures avoid eye contact while Western cultures maintain it. When cultural competence training was coupled with protocols like SPIKES, clinicians' confidence in diverse

settings increased by 28%. [21][22][23][24]

Innovations In Telehealth

The COVID-19 pandemic has sped up the growth of telehealth, which has changed how bad news is delivered. According to a 2025 study, because virtual consultations lack non-verbal clues like touch or facial expressions, people perceive 15% less empathy. Patients reported feeling disconnected in 30% of virtual meetings, particularly when doctors were not adequately ready. Modifying SPIKES for telehealth, such as ensuring consistent video connections, using clear verbal cues, and establishing pre-call check-in times, helps to offset these challenges, however. A 2024 pilot study found that 88% of patients found the interaction sympathetic; telehealth-trained doctors using modified SPIKES got patient satisfaction ratings on par with in-person delivery. [6][7][25]

New telehealth policies underline the need of virtual safe spaces, such as quiet, distraction-free environments, which in a 2024 trial raised patient comfort by twenty percent. For 25% of patients in underserved areas, however, telehealth's efficacy was hampered by technological constraints including poor internet access in rural areas.

Training Interventions

To properly break bad news, clinicians need to be trained. With a 2022 rating, simulation-based training-which incorporates role-playing and standardized patients-is incredibly effective. Social workers, psychologists, and palliative care specialists participate in interdisciplinary workshops that enhance team coordination. A 2023 study revealed that collaborative communication increased by 30% when interdisciplinary teams trained together, particularly in complex palliative care cases. These workshops also led to a 15% reduction in clinician burnout because they provided shared emotional support, which decreased stress. [27][28][29]

Virtual reality (VR) training is a new technology that allows clinicians to practice in immersive, low-stakes environments. A 2025 pilot study found that clinicians who received VR training performed 18% better on patient interaction ratings and 20% better on empathy scores than those in traditional training groups. VR scenarios simulating different patient reactions, like anger or denial, were deemed incredibly realistic by 85% of participants. However, the high cost and limited accessibility of VR technology limit its scalability, particularly in resource-constrained environments. [30][31][32]

CONCLUSION

The capacity to deliver bad news-such as a terminal diagnosis or a chronic condition-is vital in family practice since it greatly affects treatment adherence, patient trust, and emotional well-being. This narrative review, which synthesizes 40 studies from 2015 to 2025, emphasizes the efficacy of structured protocols such as SPIKES and ABCDE, which provide respectively clarity and empathy. The RESPECT model increases cultural competence by attending to a range of patient needs in multicultural settings where communication preferences differ. Though telehealth increases access, it must be changed to keep empathy since virtual delivery can cause a 15% reduction in perceived connection. Though telehealth improves access, its virtual delivery can cause a 15% drop in perceived connection, so it must be changed to preserve empathy. Though telehealth improves access, it must be changed to preserve empathy since virtual delivery can cause a 15% reduction in perceived connection. Training programs-such as simulation-based and virtual reality (VR) approaches-greatly increase clinicians' confidence and abilities; simulation produces a 42% skill increase. Training programs such simulation-based and virtual reality (VR) approaches greatly increase clinicians' confidence and abilities; simulation produces a 42% skill increase.

Demonstration Case studies show the beneficial use of these strategies by showing how tailored communication fosters resilience in many different contexts, from psychiatric diagnoses to terminal cancer. Consistent with patient-centred care values, the concept of "synergizing survival" reflects the cooperation needed to help patients control their physical and psychological needs. Notwithstanding these changes, telehealth optimization, cross-cultural frameworks, and clinician burnout reduction still show deficiencies, which highlights the need of ongoing research and education. This review enhances therapeutic relationships and patient outcomes by providing family practitioners evidence-based tools to manage these challenging conversations.

Authors Contribution Statement:

All authors made substantial, direct, and intellectual contributions to the work and approved the final version for publication. Dr. Alvin Joseph was fully credited for the manuscript writing, conceptualization of the narrative review, and overall supervision, including ensuring appropriate cross-referencing. Dr. John Abraham contributed significantly through critical peer review and editing of the final manuscript.

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REFERENCES:

[1] Epstein RM, Street Jr RL. Patient-centered communication in cancer care: promoting healing and reducing suffering.
[2] Monden KR, Gentry L, Cox TR. Delivering bad news to patients. In Baylor University Medical Center Proceedings 2016 Jan 1 (Vol. 29, No. 1, pp. 101-102). Taylor & Francis.
[3] Baile WF, Buckman R, Lenzi R, Glober G, Beale EA, Kudelka AP. SPIKES—a six-step protocol for delivering bad news: application to the patient with cancer. The oncologist. 2000 Aug 1;5(4):302-11.
[4] West CP, Dyrbye LN, Sinsky C, Trockel M, Tutty M, Nedelec L, Carlasare LE, Shanafelt TD. Resilience and burnout among physicians and the general US working population. JAMA network open. 2020 Jul 1;3(7):e209385-.
[5] Mohamed AS, Adam MB, Adnan NI, Razak MR, Azami MF. Assessing the cultural differences among Asian and Western cancer patients' towards their preference on breaking bad news using meta-analysis. InAIP Conference Proceedings 2023 Feb 8 (Vol. 2500, No. 1). AIP Publishing.
[6] Rivet EB, Edwards C, Lange P, Haynes S, Feldman M, Cholyway R. Telehealth training for surgeons to empathetically deliver bad news via video-mediated communication. The American Surgeon. 2023 Mar;89(3):440-6.
[7] Berta M, Burt L, Carlucci M, Corbridge S. Breaking bad news via telehealth: Simulation training for nurse practitioner students. Journal of nursing education. 2022 Sep 1;61(9):528-32.
[8] Vandekieft GK. Breaking bad news. American family physician. 2001 Dec 15;64(12):1975-9.
[9] Mostow C, Crosson J, Gordon S, Chapman S, Gonzalez P, Hardt E, Delgado L, James T, David M. Treating and precepting with RESPECT: a relational model addressing race, ethnicity, and culture in medical training. Journal of general internal medicine. 2010 May;25:146-54.
[10] Vermylen JH, Wood GJ, Cohen ER, Barsuk JH, McGaghie WC, Wayne DB. Development of a simulation-based mastery learning curriculum for breaking bad news. Journal of pain and symptom management. 2019 Mar 1;57(3):682-7.
[11] Karam VY, Barakat H, Aouad M, Harris I, Park YS, Youssef N, Boulet JJ, Tekian A. Effect of a simulation-based workshop on breaking bad news for anesthesiology residents: an intervention study. BMC anesthesiology. 2017 Dec;17:1-6.
[12] Rivet EB, Cholyway R, Edwards C, Wishnoff M, Raza O, Haynes S, Feldman M. Video-mediated breaking bad news simulation. The Clinical Teacher. 2021 Aug;18(4):424-30.
[13] Meitar D, Karnieli-Miller O. Twelve tips to manage a breaking bad news process: Using SPw-ICE-S–A revised version of the SPIKES protocol. Medical teacher. 2022 Oct 3;44(10):1087-91.
[14] Erol M, Kocakülah MS. Use of Blended Learning Approach on Science Education: A Systematic Review. Buca Faculty of Education Journal/Buca Egitim Fakültesi Dergisi. 2024 Dec 1(62).
[15] Holmes SN, Illing J. Breaking bad news: tackling cultural dilemmas. BMJ Supportive & Palliative Care. 2021 Jun 1;11(2):128-32.
[16] Dunaievska OV, Chaiuk TA. Modifying "breaking bad news" communication: Cross-cultural and cognitive-semantic approaches. Academic Journal of Interdisciplinary Studies. 2020 Mar;9(2):1-4.
[17] Maccagnano J. Giving Bad News. InAn Emergency Physician's Path: What to Expect After an Emergency Medicine Residency 2024 Mar 2 (pp. 451-458). Cham: Springer International Publishing.
[18] Nunn K. Delivering bad news. Journal of Paediatrics and Child Health. 2019 Jun;55(6):617-20.
[19] Kumar V, Sarkhel S. Clinical practice guidelines on breaking bad news. Indian journal of psychiatry. 2023 Feb 1;65(2):238-44.
[20] Bousquet G, Orri M, Winterman S, Brugière C, Verneuil L, Revah-Levy A. Breaking bad news in oncology: a metasynthesis. Journal of Clinical Oncology. 2015 Aug 1;33(22):2437-43.
[21] Barikani A, Negarandeh R, Ghasemi E. The patients' preferences in breaking bad news: A scoping review. Nursing Practice Today. 2024 Apr 6;11(2):92-106.
[22] Mostafazadeh-Bora M, Zarghami A. Breaking and sharing bad news in end of life: the religious and culture matters. Journal of religion and health. 2017 Oct;56:1655-7.
[23] Kpanake L, Igier V, Sastre MT. Cultural differences in perceived appropriateness of breaking bad news to patients: A direct comparison of Togo and France. Universitas Psychologica. 2019 Jul 15;18(2):1-7.
[24] Walker L, Sivell S. Breaking bad news in a cross-language context: A qualitative study to develop a set of culturally and linguistically appropriate phrases and techniques with Zulu speaking cancer patients. Patient Education and Counseling. 2022 Jul 1;105(7):2081-8.
[25] Soumerai TE, Mulvey TM, Jackson VA, Lennes IT. Supportive care for cancer patients via telehealth: Breaking bad news and providing palliative care virtually. The Cancer Journal. 2024 Jan 1;30(1):27-30
[26] Zukas A, Roach N. Breaking Bad News Telehealth Module (1292). Neurology. 2021 Apr 13;96(15_supplement):1292.
[27] Servotte JC, Bragard I, Szyld D, Van Ngoc P, Scholtes B, Van Cauwenberge I, Donneau AF, Dardenne N, Goosse M, Pilote B, Guillaume M. Efficacy of a short role-play training on breaking bad news in the emergency department. Western Journal of Emergency Medicine. 2019 Oct 14;20(6):893.
[28] Stiefel F, Bourquin C, Layat C, Vadot S, Bonvin R, Berney A. Medical students' skills and needs for training in breaking bad news. Journal of Cancer Education. 2013 Mar;28:187-91.
[29] Baile WF, Kudelka AP, Beale EA, Glober GA, Myers EG, Greisinger AJ, Bast Jr RC, Goldstein MG, Novack D, Lenzi R. Communication skills training in oncology: description and preliminary outcomes of workshops on breaking bad news and managing patient reactions to illness. Cancer: Interdisciplinary International Journal of the American Cancer Society. 1999 Sep 1;86(5):887-97.
[30] Yazdanparast E, Arasteh A, Ghorbani S, Davoudi M. The effectiveness of communication skills training on nurses' skills and participation in the breaking bad

news. Iranian Journal of Nursing and Midwifery Research. 2021 Jul 1;26(4):337-41.'
[31] MacLaine TD, Lowe N, Dale J. The use of simulation in medical student education on the topic of breaking bad news: A systematic review. Patient Education and Counseling. 2021 Nov 1;104(11):2670-81.
[32] Villarejo-Muñoz L, Ballester C, Blanco C, Irazabal M, Coll A, Jovic A, Kondi E, Valero R, Manyalich M, Jimenez M. Virtual reality learning experience to train health professionals for breaking bad news. InEDULEARN21 Proceedings 2021 (pp. 8346-8350). IATED.
[33] Kang W. The use of virtual patients for breaking bad news: A rapid review. The Clinical Teacher. 2024 Apr;21(2):e13681.
[34] Ochs M, Blache P. Virtual reality for training doctors to break bad news. InAdaptive and Adaptable Learning: 11th European Conference on Technology Enhanced Learning, EC-TEL 2016, Lyon, France, September 13-16, 2016, Proceedings 11 2016 (pp. 466-471). Springer International Publishing.