http://medicaleducation-bulletin.ir
Liter to Editor (Pages: 1413-1416)

Longitudinal Training in Empathy and Breaking Bad News in Pediatric Oncology: An Educational and Ethical Priority in Iran

*Amir Hesabi[1]

[1]Department of Pediatric Hematology and Oncology, Faculty of Medicine, Hormozgan University of Medical Sciences, Bandar Abbas, Iran.

Abstract

Breaking bad news in pediatric oncology is a complex clinical and ethical competency involving children, parents, and healthcare professionals. In Iran, parents have emphasized the importance of compassionate communication, privacy, clear information, and psychological and spiritual support. However, communication training is often brief and reliant on informal role modeling. This article proposes a longitudinal, culturally responsive, and competency-based curriculum across undergraduate medical education, pediatric residency, and pediatric hematology-oncology fellowship. Training should include simulation, role-play, standardized patients, direct observation, structured feedback, and reflective practice. Assessment should focus on observed communication performance, empathy, developmentally appropriate language, and family understanding rather than self-reported confidence alone. Adapting such training to Iran's cultural, linguistic, ethical, and family context could support more compassionate, ethical, and family-centered pediatric oncology care.

Key Words: Breaking bad news, Longitudinal curriculum, Iran, Medical education, Pediatric oncology.

*Please cite this article as: Hesabi A. Longitudinal Training in Empathy and Breaking Bad News in Pediatric Oncology: An Educational and Ethical Priority in Iran. Med Edu Bull 2026; 7(2): 1413-16. DOI: **10.22034/meb.2026.603760.1147**

Corresponding Author:

Amir Hesabi, MD, Department of Pediatric Hematology and Oncology, Faculty of Medicine, Hormozgan University of Medical Sciences, Bandar Abbas, Iran.

Email: amir.hesabi695@gmail.com

Received date: Jun. 15, 2026; Accepted date: Sep.22, 2026

Dear Editor,

Breaking bad news in pediatric oncology—including communicating a cancer diagnosis, relapse, treatment failure, a poor prognosis, or the transition to palliative care—is among the most challenging tasks in clinical medicine. These conversations may occur repeatedly throughout the illness trajectory and often involve considerable uncertainty, distress, and conflicting expectations. Breaking bad news is not simply the transmission of medical information; it is a multidimensional interaction involving the child, parents, and healthcare team. The quality of this interaction may influence family trust, participation in decision-making, treatment acceptance, adherence to care, and psychological adjustment.

Communication in pediatric oncology is particularly complex because the child's developmental stage, level of understanding, emotional capacity, and preferences must be considered alongside the parents' role and expectations. Cultural and religious beliefs, family structure, language, socioeconomic circumstances, health literacy, and disease severity may further influence how information is delivered and received (1). Clinicians must therefore be able to provide clear and understandable information, assess what the family already knows, recognize emotional reactions, respond with empathy, maintain realistic hope, and involve children in discussions in an age- and developmentally appropriate manner.

Despite the importance of these skills, breaking bad news is often taught through brief workshops, fragmented sessions, or informal observation of senior clinicians. Although observation may expose learners to real clinical situations, it does not necessarily provide opportunities to prepare for a conversation, practice specific communication behaviors, receive structured feedback, or reflect on performance. Students and residents may consequently observe difficult conversations repeatedly without developing confidence or competence in managing them. Communication should therefore be regarded as a teachable, practice-based, and assessable clinical competency rather than as a personal characteristic dependent solely on personality or individual experience (2, 3).

The Iranian context further emphasizes the need for structured and culturally responsive training. In a qualitative study of Iranian mothers of children with cancer, receiving bad news was associated with shock, emotional distress, psychological pressure, rapid delivery of information, and a need for appropriate support (4). These findings suggest that the experience of bad news is shaped not only by the content of the message but also by the timing, pace, setting, participants, communication style, and support offered afterward.

Similarly, a study of Iranian mothers' preferences reported that many mothers preferred bad news to be delivered by the child's physician, in a compassionate manner and in a private setting. Participants also expressed a need for adequate information about the disease and access to psychological and spiritual support (5). These findings are relevant to the development of communication guidelines and educational programs in Iranian pediatric oncology centers. They also indicate that communication training should address practical issues, including preparation of the environment, involvement of family members, assessment of information preferences, management of emotional responses, and arrangements for follow-up support.

Decision-making in Iranian families is frequently family-centered, and parents may differ in their views regarding the amount and type of information that should be communicated directly to a child or adolescent. However, family-centered decision-making should not lead to the complete concealment of information or the automatic exclusion of the child. Clinicians should be trained to respect the role of parents while considering the child's developing autonomy, cognitive maturity, emotional capacity, and preferences. This requires sensitivity, ethical reasoning, and communication strategies that can accommodate differences among families rather than relying on a single standardized approach.

A longitudinal curriculum should therefore be introduced across undergraduate medical education, pediatric residency, and pediatric hematology-oncology fellowship. At the undergraduate level, learners could be introduced to empathy, active listening, nonverbal communication, child-centered

communication, ethical disclosure, and communication with families. During clinical clerkships and internship, students could practice age-appropriate communication and discussions involving diagnostic investigations, parental anxiety, grief, or anger. Pediatric residency training could then address the communication of a cancer diagnosis, relapse, treatment failure, severe complications, uncertainty, and shared decision-making. Fellowship training should include more advanced discussions concerning prognosis, goals of care, palliative care, end-of-life decisions, death, bereavement, family conferences, conflicts in decision-making, sibling support, and clinician self-care.

Longitudinal education is important because empathy and communication skills require repeated practice and reinforcement. Systematic reviews suggest that communication-skills training can improve clinicians' empathic responses and their use of open-ended questions, although the persistence and clinical impact of these improvements may depend on the quality, duration, and follow-up of the intervention (6, 7). A single workshop early in medical school or residency is therefore unlikely to prepare clinicians for the range and complexity of conversations encountered in pediatric oncology.

Educational methods should emphasize active participation and feedback. Role-play, simulation, culturally appropriate clinical scenarios, standardized patients, video review, direct observation, clinical coaching, small-group discussion, and reflective practice can provide learners with opportunities to rehearse difficult conversations in a safe environment. Scenarios should include not only initial diagnosis but also relapse, treatment failure, uncertain prognosis, transition to palliative care, disagreement between family members, requests to withhold information from the child, and discussions following the death of a patient. Psychologists, nurses, social workers, palliative care specialists, and medical ethicists should participate in the design and delivery of these activities.

Structured frameworks such as SPIKES may help clinicians prepare the setting, assess the family's understanding, determine how much information they wish to receive, provide information gradually, respond to emotions, and summarize the care plan. However, such frameworks should not be used as rigid scripts. They should be adapted to the Persian language, Iranian culture, family preferences, the child's developmental stage, and the clinical context. The framework should support authentic communication rather than replace clinical judgment or empathy.

Simulation-based programs in pediatric hematology-oncology have been reported to improve fellows' confidence and communication performance (8, 9). Nevertheless, confidence alone should not be considered evidence of competence. Assessment should include objective structured clinical examinations, direct-observation checklists, evaluation of empathic and emotional responses, assessment of age-appropriate language, teach-back evaluation of family understanding, and multisource feedback. A longitudinal portfolio could document learners' progressive development, feedback, challenging encounters, and reflective practice.

Implementation in Iran may be affected by limited time, heavy clinical workloads, shortages of trained faculty, inadequate private spaces, and differences in resources among treatment centers. These challenges should be addressed through gradual implementation. Short Persian-language online modules, faculty-development workshops, small-group sessions, integration of communication scenarios into existing examinations, and locally developed video materials may provide feasible starting points. Administrative support and interdepartmental collaboration will be essential for sustainable integration.

The quality of breaking bad news also depends on institutional conditions. Clinicians require sufficient time, appropriate private rooms, access to psychologists and social workers, availability of palliative care services, and opportunities for debriefing after highly distressing conversations. A national or university-based protocol could help reduce variation in practice while preserving honesty, confidentiality, respect, child participation, and flexibility in responding to family preferences.

CONCLUSION

In conclusion, longitudinal training in empathy and breaking bad news should be recognized as a professional, ethical, and clinical competency in pediatric oncology. Iranian evidence concerning parents' experiences and preferences, together with the cultural and family-centered nature of healthcare decision-making, supports the development of a culturally adapted, staged, interprofessional, and assessable curriculum. A committee involving pediatric oncologists, medical educators, nurses, psychologists, palliative care specialists, ethicists, parents, and, when appropriate, adolescents and childhood cancer survivors should develop a national or university-level framework for teaching and assessing these skills. Such an approach could help prepare clinicians who remain honest, clear, compassionate, and respectful while accompanying children and families through the most difficult stages of illness.

CONFLICT OF INTEREST: None.

REFERENCES

1. Hrdlickova L, Polakova K, Loucka M. Important Aspects Influencing Delivery of Serious News in Pediatric Oncology: A Scoping Review. Children (Basel). 2021 Feb 22;8(2):166. doi: 10.3390/children8020166. PMID: 33671570; PMCID: PMC7926514.

2. M. C. Mack, R. N. Claxton, R. M. Arnold, and S. H. Maurer, " Peds OncoTalk: A Curriculum to Teach Communication Skills to Pediatric Hematology/Oncology Fellows." Pediatric Blood & Cancer 72, no. 11 (2025): e31912. https://doi.org/10.1002/pbc.31912.

3. Skills for Communicating with Patients Silverman Jonathan , Kurtz Suzanne and Draper Juliet Skills for Communicating with Patients 312pp £34.99 Radcliffe Publishing 9781846193651 1846193656 [Formula: see text]. Emerg Nurse. 2014 Dec;22(8):11. doi: 10.7748/en.22.8.11.s14. PMID: 25466746.

4. Aein F, Delaram M. Giving bad news: a qualitative research exploration. Iran Red Crescent Med J. 2014 Jun;16(6):e8197. doi: 10.5812/ircmj.8197. Epub 2014 Jun 5. PMID: 25068066; PMCID: PMC4102999.

5. Mostafavian Z, Shaye ZA, Farajpour A. Mothers' preferences toward breaking bad news about their children cancer. J Family Med Prim Care. 2018 May-Jun;7(3):596-600. doi: 10.4103/jfmpc.jfmpc_342_17. PMID: 30112316; PMCID: PMC6069657.

6. Moore PM, Rivera S, Bravo-Soto GA, Olivares C, Lawrie TA. Communication skills training for healthcare professionals working with people who have cancer. Cochrane Database Syst Rev. 2018 Jul 24;7(7):CD003751. doi: 10.1002/14651858.CD003751.pub4. PMID: 30039853; PMCID: PMC6513291.

7. Barth J, Lannen P. Efficacy of communication skills training courses in oncology: a systematic review and meta-analysis. Ann Oncol. 2011 May;22(5):1030-1040. doi: 10.1093/annonc/mdq441. Epub 2010 Oct 25. PMID: 20974653.

8. Feraco AM, Brand SR, Mack JW, Kesselheim JC, Block SD, Wolfe J. Communication Skills Training in Pediatric Oncology: Moving Beyond Role Modeling. Pediatr Blood Cancer. 2016 Jun;63(6):966-72. doi: 10.1002/pbc.25918. Epub 2016 Jan 29. PMID: 26822066; PMCID: PMC5861499.

9. Becktell K, Rumler S, Tower RL. Successful Development and Implementation of Communication Skills Simulation Training Within Pediatric Hematology-oncology Fellowship Education. J Pediatr Hematol Oncol. 2025 Jan 1;47(1):7-11. doi: 10.1097/MPH.0000000000002959. Epub 2024 Oct 17. PMID: 39526965.