

Medical Residents Perceptions of Communication Skills a Workshop on Breaking Bad News

Percepção de Médicos Residentes quanto às Habilidades de Comunicação após uma Oficina de Comunicação de Más Notícias

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ABSTRACT

Introduction: Breaking bad news although frequent among healthcare professionals and their patients is still considered a very difficult task. These communication skill main determinants in the physician-patient relationship. **Objective:** In view of the need to promote academic spaces that provide opportunities to learn breaking bad news, this study aims to evaluate the medical residents in relation to their interest in learning communication skills, as well as their skills in breaking bad news, before and after a workshop on the topic. **Methods:** All the medical residents in the first year of internal medicine of a public general hospital in Belém-Pará, Brazil were invited to answer a questionnaire sociodemographic data and questions about their communication skills in clinical practice, as well as the Communication Skills Attitude Scale (CSAS), which addressed their interest in learning communication skills. The questionnaire. This research uses both quantitative and qualitative methods. The quantified data were statistically analyzed by the Wilcoxon test (χ^2), Chi-Square test G-test adherence (quantitative variables of the questionnaire on communication skills). The qualitative evaluation Content Analysis based on Bardin. **Results:** Ten residents attended the workshop. The results show that after taking part in the workshop, the resident's perceptions of the practice of breaking bad news had improved (in 80% of the participants), as well as their attitudes to learning communication skills (CSAS = 99.5 and 105, before and after the course, respectively $p = 0.0039$). **Conclusion:** Eighty percent of residents ($n = 08$) considered their communication skills have improved as a result of the workshop ($p = 0.0078$). Most of the participants became more aware of the importance of considering the patient's perspective, and admitted positive changes following the course. **Conclusion:** A positive effect on the participants' perceptions of communication skills and on their interest in learning these skills, were identified after an intervention focused on the context of breaking bad news.

KEYWORDS

- Breaking bad news.
- Communication Skills.
- Teaching.
- Physician-Patient Relations.

PALAVRAS-CHAVE

- Comunicação.
- Barreiras de comunicação.
- Ensino.
- Relações Médico-Paciente.

RESUMO

Introdução: A comunicação de má notícia, embora frequente entre os profissionais de saúde e seus pacientes, ainda é considerada tarefa extremamente difícil. Essa habilidade de dar informação é um dos principais determinantes da relação médico-paciente. **Objetivo:** Considerando a necessidade de promover espaços acadêmicos que proporcionem a aprendizagem da comunicação de notícia difícil, o presente estudo objetivou avaliar a percepção de um grupo de residentes de Clínica Médica quanto ao interesse pelo ensino e aprendizagem de comunicação, assim como suas habilidades de dar notícia difícil, antes e após uma oficina de comunicação de má notícia. **Métodos:** Todos os médicos residentes do primeiro ano de Clínica Médica de um hospital-geral, em Belém, Pará (Brasil), foram convidados a responder a um questionário composto por dados sociodemográficos e perguntas sobre a sua prática de comunicação, além da versão da Escala de Atitudes e Habilidades de Comunicação (Communication Skills Attitude Scale) que aborda o interesse pela aprendizagem das habilidades comunicacionais. O questionário e a escala foram aplicados em dois momentos: antes e após a oficina teórico-prática de comunicação de má notícia, elaborada para esta pesquisa. Trata-se de uma pesquisa quanti-qualitativa. Os dados quantificados foram tratados estatisticamente por meio do teste de Wilcoxon (avaliação do escore do CSAS) e Qui-Quadrado e Teste G de aderência (variáveis quantitativas do questionário sobre habilidades de comunicação). A avaliação qualitativa foi feita pela análise de conteúdo de Bardin. **Resultados:** Dez médicos residentes participaram da pesquisa. Os resultados demonstraram, após a participação na oficina, melhora na percepção dos residentes quanto à prática de comunicação de notícia difícil (em 80% dos participantes) e nas atitudes relacionadas ao interesse pela aprendizagem de comunicação (CSAS = 99,5 e 105, antes e após a oficina, respectivamente – $p = 0,0039$). **Conclusão:** Um efeito positivo na percepção dos participantes quanto às habilidades de comunicação e seu interesse pelo aprendizado de tais habilidades foi identificado após uma intervenção focalizada no contexto da comunicação de má notícia.

Recebido em: 25/02/2018

Aceito em: 03/05/2018

INTRODUCTION

Breaking bad news a common practice health professionals, is still considered a very difficult task. communication skill are main determinants in the physician-patient relationship, improve or destroy that relationship, depending on how it is performed. The connection between good communication and positive outcomes is well-known, resulting in better patient satisfaction, better treatment compliance, and less lawsuits^{1,2}.

However, the medical literature shows that patient dissatisfaction with physician's communication process is common, professionals often failing to consider the patient's perspective and expectations^{3,4}. The main problems by health professionals fear, lack of support, time restriction, concern ashow the bad news will affect the patient; fear of being responsible for pain; of saying "I don't know", and of expressing emotions⁵.

remedy this shortfall, medical schools are attempting to reorient their students, highlighting humanistic aspects of the doctor-patient relationship and emphasizing the development of empathy and communication skills^{6,7}. Ideally using a meth-

odology that prioritizes patient, students should be awarethat a good communication process is essential in establishing good behavioral patterns, and that it does not involve only words. Training in such skills gives physicians a more humanized approach⁸.

Training programs different teaching strategies in communication skills have been reported. These include theoretical classes, individual or group role-playing exercises with simulated patients, performed either by actors or by the students themselves, and didactic opportunities during clinical practice⁹⁻¹².

Although some workshops designed for resident physicians have already been described, few have been evaluated for their efficacy¹³⁻¹⁶, and studies that specifically assess interest in communication skillsare even fewer. But such studies can be useful forbetter directing teaching strategies for medical students¹⁵.

Given the limited experience in this area of training, there is a need for studies about the impact on teaching models

especially for medical residents, who often struggle. Therefore his study evaluates medical residents' interest in learning these skills, and compares their interest and their abilities on breaking bad news before and after a .

METHODS

Participants

All medical residents of internal medicine a public general hospital in Belém-Pará, Brazil, in their first year of practice, were contacted in 2017 to take part in this descriptive, longitudinal, prospective study. Ten resident physicians were included.

Ethical issues

This study was approved by the Human Research Ethics Committee of the Centro Universitário do Estado do Pará, on 23th January, 2017, under no. 1.896. 671.

Assessment instruments

*Communication Skills Attitude Scale (CSAS)*¹⁷ – This scale aims to assess interest in learning communication skills. It contains 26 statements behaviors related to the interest in learning Communication Skills. Of these, 13 relate to positive aspects, and 13 to negative aspects. It is a *Likert* questionnaire, in which a higher score represents more positive behaviors in the learning of communication skills.

For e, the CSAS translated into Brazilian Portuguese by an English language specialist, and its translation, clarity of language and theoretical importance evaluated by six doctors with experience in communication skills, who were invited instrument. After making the necessary adjustments, an initial test was performed with 15 students in the sixth term of the Medicine course, to evaluate their comprehension of the instrument; 100% agreement on the instrument's construct was obtained.

Questionnaire about skills in Breaking Bad News – The ultimate aim of the questionnaire was to investigate the participants' perceptions about their communication practices when delivering bad news, based on Oken's protocol¹⁸. It has two versions: version A – applied before the workshop, composed of sociodemographic data and questions on practices of breaking bad news practices ("what is bad news; the main issues; how to react to the patient's emotions after delivering bad news"), and version B – consisting the same questions regarding the communication skills, plus the participants' assessment of the workshop.

Data collection

1st Instance – Evaluation of medical residents' perceptions regarding the practice and interest in learning bad news com-

munication skills before the workshop. The questionnaire was administered to the participants by a trained professional who not involved in conducting the Communication Skills Workshop.

2st Instance – Reassessment medical residents' perceptions regarding the practice and interest in learning breaking bad skills after the workshop. The reevaluation one month after the workshop, to determine the extent to which the participants had assimilated the strategies learned in the workshop, and whether they had applied them.

The workshop

The workshop took place over two days and consisted of both theoretical and practical activities:

– First day: Theoretical activity (lecture and conversation circle)

The goal of this phase was to present definitions about communication, topics related to communication in health, strategies, and technical and psycho-emotional aspects of the physician when preparing to deliver bad news.

Initially, two that deal with the delivery of bad news in different ways were shown. Next, a conversation circle was formed, seeking to take advantage of the participants' backgrounds and encourage reflection on the main aspects of breaking bad news, the following questions: "Was the bad news properly delivered?"; "What were the positive and negative aspects?"; "Would you do it differently?".

topics: Concepts of bad news' communicating; The importance of communication skills; Communication problems and difficulties; Whom the bad news should be given to; How and when to deliver the bad news; and Behaviors to avoid during the communication. The Spikes⁹ protocol, already validated and widely used in the training of these skills in medical schools due to its practicality, was also emphasized.

– Second day: practical role play activity

In this phase, role play was used psycho-dramatic teaching method in which participants play different roles – the patient, the physicians, the patient's relatives. The aim is to promote a better understanding of how to teach interpersonal skills^{19,20}.

The fictional clinical cases for the simulation were designed by the researchers, and involved breaking bad news on topics such as: a diagnosis of advanced neoplasia in a young person, brain death, therapeutic failure and referral to the palliative care team, and a diagnosis of Amyotrophic Lateral Sclerosis. Five clinical situations were selected, with the five pairs resident physicians each performing one role play.

After each role play, there was a debriefing session. This important step gives an opportunity critical analysis of the simulation and encourages reflection on the information and opinions expressed by the observer group and the performers²¹. In this session, feedback was also given to participants about their performance.

Data analysis

Tsociodemographic profiles of the participants were analyzed using descriptive statistics, and expressed as average, standard deviation, median and percentile, and absolute and relative frequencies, depending on the nature of the variable.

The results of the CSAS scale before and after the workshop were analyzed by the Wilcoxon test to investigate and measure the impacts of the .

The proportion of responses relating to difficulties in communicating bad news, in order of importance, was tested by the Chi-Square (adhesion). The McNemar test was used to assess the disagreement between the responses of self-assessment and the participants' in delivering bad news, before and after the workshop.

All the hypothesis tests were performed using the software program BioEstat 5.5²², and results with $p \leq 0.05$ (bilateral) were considered significant.

For the qualitative-interpretative evaluation based on Bardin (2013)²³, categories were developed based on the content found in the participants' questionnaire.

RESULTS

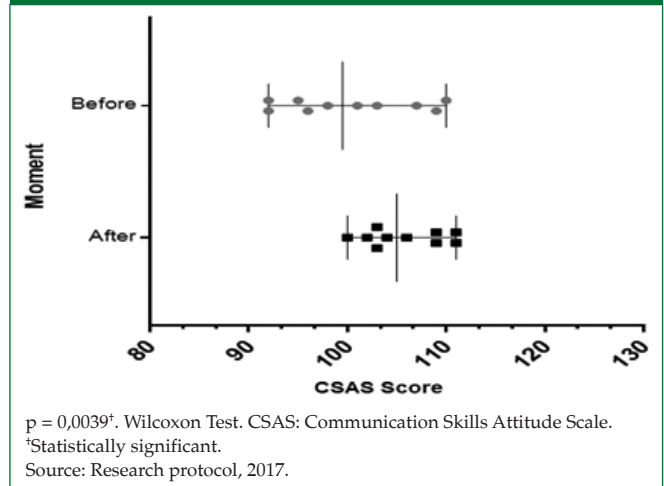
Participant characteristics

The sample consisted of 10 resident physicians in the first term of medical practice with an average age of 27.6 years (± 3.0), ranging from 25 to 34 years (95% CI: 25.8-29.5), with 80% of women ($p = 0.1058$), mostly single (90%, $p = 0.0200$). Eighty percent of the sample had completed their undergraduate studies between 1 and 2 years previously. Seventy percent (7/10) had never taken classes about delivering bad news during medical school ($p = 0.33$).

Descriptive results

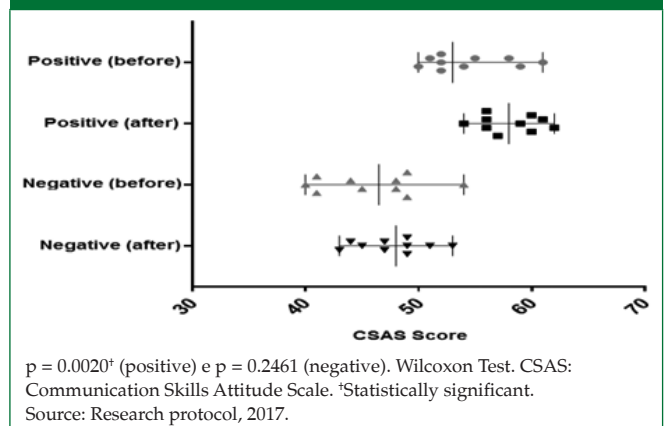
based on the CSAS Scale, median value was 99.5 (IQR = 1075), ranging from 92 to 110, and after the workshop, the median was 105 (IQR = 6,0), ranging from 100 to 111. These figures indicate a significant improvement in interest in learning about communication skills among the residents after taking part in the workshop ($p = 0.0039$) (Figure 1).

FIGURE 1
Communication Skills Attitude Scale score before and after the workshop. Belém-PA, 2017



Assessing the two groups of CSAS Scale assertions on communication skills learning separately – those with a positive connotation ($n = 13$) and those with a negative connotation ($n = 13$), higher median score was obtained in post-workshop for the group of positive statements (Md = 53 before vs. Md = 58 after, with $p = 0.0020$). However, although numerically higher, no significant difference was observed in the negative statement group (Md = 46.5 before vs. Md = 48 after, with $p = 0.2461$) (Figure 2).

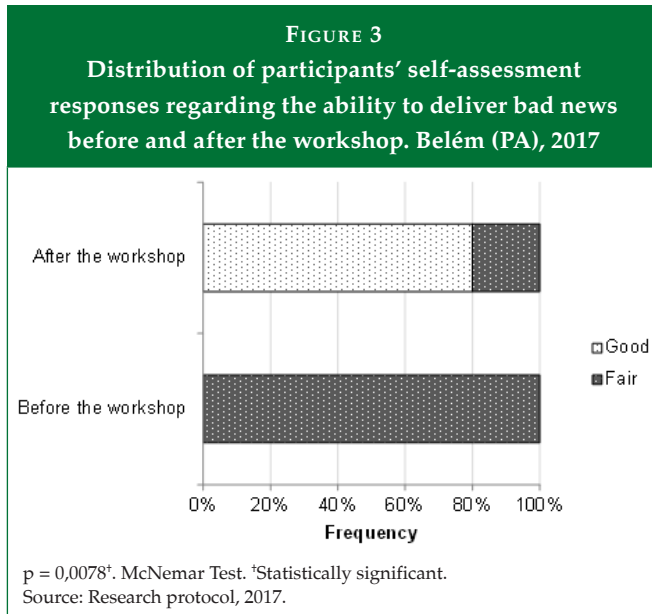
FIGURE 2
Communication Skills Attitude Scale score with positive and negative aspects, before and after the workshop. Belém (PA), 2017



Analyzing each CSAS Scale item individually, positive attitude changes were observed when comparing the responses and after the workshop in the items 'learning communication skills improved my ability to communicate with patients' (Md = 4 vs. Md = 5, respectively, $p = 0.0431$) and 'learning communication skills is fun' (Md = 3 vs. Md = 4, respectively, $p = 0.0277$).

Content analysis

In relation to the participants' self-assessment of their ability to deliver bad news, all the medical residents considered their skills to be 'moderate' prior to the workshop, with a high proportion (80%, 8/10, $p = 0.0078$) rating this ability 'good' after the workshop (Figure 3).

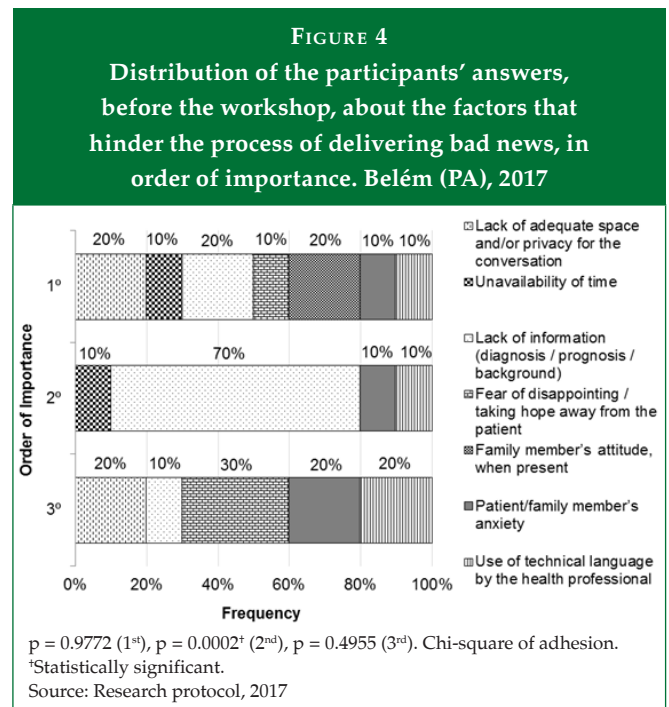


Here the characteristics the practice of breaking bad news from the perception of the resident physicians, before and after their participation in the workshop.

Three categories of response were identified in relation to the concept of bad news: 1) disease-focused; 2) patient-focused; 3) increased risk of death focused. Based on the results, a higher frequency of disease-focused reports (09 reports) was found before the workshop. However, after the workshop, there was a change in the pattern of reports, with most residents (07) prioritizing the patient's perspective on their descriptions of bad news. For example: comments made before the workshop – (R1) "bad news regarding health such as a diagnosis of terminal or incurable diseases"; after the workshop – (R1) "News of an illness that is chronic, incurable and that compromises the patient's expectation regarding his future".

Among the factors mentioned by the participants before the workshop that make it more difficult to deliver bad news were "a lack of adequate information about the patient's diagnosis/prognosis" (70%, 7/10, $p = 0.0002$), "a lack of adequate space and/or privacy for the conversation," "the presence of family members who are anxious about the disease", and "fear of disappointing or taking hope away from the patient".

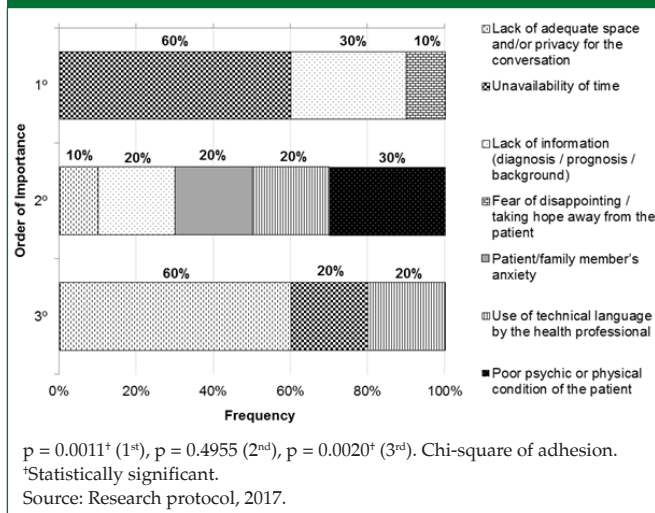
After the workshop, the factors most pointed out by the participants were: "time" (60%, 6/10, $p = 0.0011$) – considered the main factor hindering adequate communication, lack of adequate space and/or privacy for conversation", referred to as the third aspect that most interferes in this process (60%, 6/10, $p = 0.0020$) (Figures 4 and 5).



...ense of anguish and sadness reported, which remained before and after the workshop. Feelings of impotence, frustration and insecurity were more often reported before the workshop, and a sense of tranquility was only mentioned after the intervention, for example: comments before the workshop – (R8) "Troubled by not being able to help more", (R9) "It depends on the relationship with the patient and the family. It ranges from solidarity and compassion to indifference"; and after the workshop – (R8) "I feel calmer and prepared to deal with such emotions", (R9) "I am in the process of evolution, learning to be empathetic".

FIGURE 5

Distribution of the participants' answers, after the workshop, about the factors that hinder the process of giving the bad news, in order of importance. Belém (PA), 2017



DISCUSSION

This study, which used the CSAS to assess the interest in teaching and learning communication skills, showed an increase in the residents' interest in such skills after their participation in the workshop.

Positive CSAS sentences, such as *'learning communication skills improved my skills in communication with patients'* and *'learning communication skills is fun'*, increased significantly after the workshop, suggesting that the interventions to enhance the physicians' communication skills helped to promote and foster such changes. Loureiro et al.²⁴, when assessing the medical residents' attitudes using the CSAS, they also found higher scores on positive affirmations, particularly related to general communication skills (*"in order to be a good physician, one needs to have good communication skills"*).

In the present research, the majority of the participants had not received specific theoretical/practical training on the subject during their undergraduate studies or medical residence. The increased interest observed after the training suggests that the methodology used contributed to the increase in the CSAS score. Most of the residents gave positive feedback, especially regarding the role play, where they trained not only in the cognitive aspects of the news but also in the emotional aspects.

Kaufman et al.²⁵ report that while medical students' experience contributes to their increased confidence in basic

communication skills, this experience does not necessarily increase their confidence in performing more complex tasks. Discussing sensitive issues with patients, such as delivering the news of a terminal illness or that the patient is dying, is not always easy with clinical practice alone. Emotional aspects are a determinant for good or bad communication.

, the CSAS has its role in identifying aspects that students or residents greater difficulty in communication, which is so important in the doctor-patient relationship. guide the teaching strategies in order to develop such skills.

Regarding the participants' perceptions of the practice of breaking bad news, eighty percent of the participants considered that their ability to communicate had improved after the workshop. This majority considered their ability "reasonable" at the start of the research, and "good" after the training.

Studies have shown that communication between resident physicians and students can be taught and improved with a relatively short but intensive course^{15,26,27,28}. In a controlled clinical trial, Alexander et al.¹⁵ trained residents through discussions in small groups, theoretical classes and role play; the residents' skills improved in areas such as: breaking bad news, discussion of the prognosis, and decisions about end-of-life treatments.

In the questionnaire to evaluate the medical residents about the practice of communication, some changes were found after their participation in the workshop, which will be described below.

For most of the participants, before the workshop, bad news was associated only with the disease itself. However, after the workshop, most residents considered the patient's perspective bad news.

It is consensual that bad news is the one that negatively affect one's life expectancies due to the situation experienced directly by the person or by someone close to him. The greater the distance between the patient's expectations and reality, the worse the news will seem. When it comes to delivering bad news, it is therefore important to consider the patient's perspective^{2,5}. Otherwise, there is a high chance that the news will be disastrously presented, as it is unlikely that the health professional will use strategies proven to minimize their impact.

It is believed that workshop encouraged the participants to develop strategies to better deal with the emotional responses of the patients and/or family members and thus "the presence of anxious family members at the time of the conversation" was no longer reported as a difficulty after the workshop at. Likewise, the decreased reports of *"lack of adequate information on the diagnosis, prognosis of the patient"* after the workshop was

no doubt due to the fact that the training, based on the SPIKES protocol, included preparation for the conversation, such as detailed collection of the patient's clinical history and knowledge of the probable evolution of the disease and prognosis, before talking to the patient and/or family member.

When resident physicians were questioned about the skills necessary for breaking bad news, it were revealed deficits of skills needed for task, representing barriers to interaction with patient. Much of this problem is associated with fears, lack of support from supervisors, and time restriction^{4,27,28,29}.

It is worth mentioning that the untime and the lack of a place that allows privacy for the conversation are not normally factors that can be controlled by the physician. With regard to the availability of time, it is known that medical residents, especially those working at public health institutions, high patient demand. As for the appropriate place for the conversation, which should be part of the preparation for the breaking bad news⁹, this is something that is not always possible in the hospital environment, especially for patients in wards and intensive care units. The medical residents who participated in this research work in a public hospital where the vast majority of patients are in two-bed wards, and sometimes the conversation takes place on this ward without proper privacy.

One of the most significant and reported difficulties in the literature is the widespread belief that telling the patient a bad will negatively affect the patient's progress and their adherence to the treatment³⁰. The "fear of disappointing or taking away the patient's hope" was reported more frequently before the workshop (40%). one resident still cited this difficulty after the workshop. Communication training also teaches that the news, no matter how bad it is, should be transmitted with honesty and sincerity, accessing and perceiving how far the patient can bear the truth, without taking away their hope. It is known that patients usually prefer to know their diagnosis and to talk to the doctors about their anxiety and concerns³¹.

The act of delivering unpleasant news is uncomfortable for the physician as it is for the patient, for several reasons. First, the physician finds him/herself in the difficult situation of having to deal with the patient's emotions and reactions. in most cases, the health professional must also address the patient's family members, which can be an additional source of stress. physicians must also learn how to deal with their own emotions and fears, especially in situations that cause them to reflect on their own. Added to this is the fact that most physicians do not receive formal training during their undergraduate studies on how to deliver bad news, which would give them greater confidence³², a fact that was also reported in the present research.

As observed in the study by Gorniewicz et al.³³ and Lienard et al.⁷, who demonstrated a positive change in the emotional reactions of residents after training in communication skills, observed that the contents of the participants' reports suggest a change in this aspect, particularly in terms of discomfort and insecurity, which were most mentioned before the workshop. These feelings were also recorded in the role play practice. role of doctors, the residents conveyed a range of emotions such as sadness, anguish and discomfort, as well as communication difficulties.

These feelings be present to a greater or lesser extent, depending on the relationship the doctor has developed with the patient and/or the family, and on or her level of empathy, which is important at the time of communication. It is necessary to be aware of address these emotions of the professional, so that they do not have a negative impact on the communication.

Therefore, the idea of training communication skills must go beyond theoretical teaching. In order to develop empathy and verbal and non-verbal communication skills, practical method should be included in both undergraduate studies and medical residency.

CONCLUSION

A interest was observed among medical residents learning communication skills, based on the *Communication Skills Attitude Scale*, as well as an improvement in self-perception regarding the practice of delivering bad news, after the workshop.

Despite the small sample size, it is important to note that this study was carried out *in locu* (ecological validity study), in the participants' own context of practice. Being in this environment meant that participants could put into practice what they had learned in the workshop.

The goal of this training is to improve communication techniques in order to minimize the negative impact of bad news, not only for the patient but also for the doctor. The proposed training simple and effective, and is accomplished in a short period of time, with no additional cost to the service.

This study confirmed the need for discussion this issue in medical education, either as part of undergraduate or medical residency, as it is a subject that is essential for the curriculum of healthcare professionals.

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ACKNOWLEDGEMENTS

Thanks to all internal medical residents who agreed to be assessed for this study.

CONFLICT OF INTERESTS

The authors declare that they have no conflict of interest.

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