

Communication in Palliative Medicine: A Clinical Review of Family Conferences

Ruth Powazki, MSW, LISW,^{1,2} Declan Walsh, MSc, FACP, FRCP(Edin), FTCD,^{1-3,*}
Katherine Hauser, MD,^{1,2,**} and Mellor P. Davis, MD, FCCP¹⁻³

Abstract

Aim: Family conferences are an important forum for communication, particularly for those with serious illnesses.

Design: The strength of evidence was assessed by patient, intervention, comparator, and outcome (PICO).

Data source: We searched electronic databases (MEDLINE, CINAHL, PsycINFO, Embase, PubMed), published articles, and multidisciplinary resource textbooks.

Results: Four areas investigated family conferences: acute care, family medicine/geriatrics, intensive care units (ICU), and oncology/palliative medicine. A unifying theme was the importance of improved communication. A single randomized controlled ICU study demonstrated that family conferences positively influenced bereavement outcomes. A prospective (but single-arm) ICU study and several family medicine/geriatrics cohort studies, found that family conferences reduced hospital length of stay and/or decreased resource utilization. Other articles proposed guidelines or methods for the practical conduct of family conferences.

Conclusions: ICU studies supported the benefit of a family conference to the family, health care team, and hospital administration. The family conference in other clinical areas was not supported by a strong evidence base. Well-designed prospective studies are needed in multiple medical settings to assess the proposed and observed patient and financial benefits of the family conference, and determine their generalizability.

Introduction

COMMUNICATION SKILLS in medicine are arguably as important as technical proficiency.¹ Communication skills are typically learned informally from peers and mentors, usually through trial and error. Miscommunication causes anger, confusion, and mistrust of the medical community. Timely communication may reduce inappropriate resource use, interpersonal conflicts and misunderstandings and medico-legal risks. Family conferences may facilitate acceptance of a plan of care, and improve adjustment to chronic serious illnesses and treatment adherence.² In the Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT) study, 30% of respondents in the intensive care unit (ICU) identified poor communication as a major reason for dissatisfaction with medical care.³

We believe family conferences to be an important intervention and intrinsic to optimal medical care. Anecdotal reports suggest family conferences are common in several other

areas of medical practice, e.g., rehabilitation and family medicine. Family conferences are a major time commitment because of the involvement of multiple medical professionals in timely assessment to ensure appropriate clinical management. We report the results of a clinical review to examine how various medical settings conducted and evaluated family conferences. We also examined the evidence for beneficial outcomes from family conferences.

Data Source

The literature review included MEDLINE 1966 to December 2013 (Ovid Technologies, New York, NY), CINAHL (Cumulative Index to Nursing and Allied Health Literature) 1982 to December 2013 (Information Systems, Glendale, CA), PsycINFO 1966 to January 2011 (American Psychological Association, Washington, D.C.), Embase (foreign languages included) 1988 to December 2013 (Elsevier Published, Amsterdam, The Netherlands), Cochrane Database of

¹Section of Palliative Medicine and Supportive Oncology, ²The Harry R. Horvitz Center for Palliative Medicine, A World Health Organization Demonstration Project in Palliative Medicine, An ESMO Designated Integrated Center of Supportive Oncology and Palliative Care, ³Cleveland Clinic Taussig Cancer Institute, Cleveland Clinic Foundation, Cleveland, Ohio.

*Current address: Trinity College Dublin and University College Dublin, Faculty of Health Sciences, Trinity College, Dublin, Ireland.

**Current address: Central Adelaide Palliative Care Service, The Royal Adelaide Hospital, Adelaide SA, 500 Australia

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Systematic Review, and PubMed. We also hand-searched references through December 2013. The search terms were: cancer, communication, family conferences, family interview, family meetings, family sessions, oncology, and palliative care/medicine. Indexes of recently published multidisciplinary textbooks were also searched.^{4–10} Published conference abstracts and the gray literature were not included.

Methods

Four elements from the *British Medical Journal Evidence-Based Medicine Toolkit* guided the evaluation: patient, intervention, comparator, and outcome (PICO).¹¹ Evidence was graded by the first author and independently verified by another. The grades were as follows: A, randomized controlled trial with clearly stated outcomes; B, cohort studies or case control studies with clearly defined outcomes; C, case series with outcomes of interest; D, expert opinion without explicit critique of outcomes.

Results

Over 70 publications addressed the family conference and family meetings and included four main areas of medical practice: acute care, family medicine/geriatrics, intensive care units (ICUs), and oncology/palliative medicine (Fig. 1). A summary of articles for each practice setting is given in Appendix 1. Examples of how articles were graded are given in Table 1. The studies chosen were representative of different clinical settings. They identify the challenges to design, im-

plementation, and analysis of family conference research. Various approaches to family conferences in different clinical settings are given in Table 2.

Randomized controlled trials

Family medicine and geriatrics. One study examined nursing home placement in Alzheimer's disease. The objective was to postpone or prevent nursing home placement. Two hundred six spouse-caregivers were enrolled. Six task-oriented family sessions promoted communication, taught behavior management techniques, and gave emotional support to the primary caregiver. The treatment group were a mean of 329 days (± 144 standard error [SE]; 95% confidence interval [CI] 47–611) longer at home than controls.¹²

Intensive care unit. One study in 34 ICUs randomized families to get an information leaflet (FIL).¹³ The FIL reduced poor comprehension from 41% to 12% and improved family satisfaction. Twenty-two ICUs also randomized family members to usual care (approximately 20 minutes) or a structured "VALUE"-based family conference (approximately 30 minutes) and a bereavement brochure.¹⁴ The latter objectives were:

1. Value and appreciate what the family said.
2. Acknowledge emotions.
3. Listen.
4. Understand: ask questions that allow one to know the patient as a person.
5. Elicit questions from the family.

TABLE 1. STUDY EVIDENCE GRADE BY PICO (PATIENT, INTERVENTIONS, COMPARATOR, OUTCOME)

Study	Patient	Intervention	Comparator	Outcome	Grade
Lautrette ¹⁴	22 different ICUs <i>n</i> = 126 patients Randomized prospective cohort	Standard care 20-minute FC	Intervention: 30-minute FC communication (VALUE), + bereavement brochure	Family Less PTS (Posttraumatic Stress-anxiety depression)	A
Mittleman ¹²	Long-term care—Alzheimer Randomized controlled intervention <i>n</i> = 206	6 family sessions Caregiver spouse and family <i>n</i> = 103 to care for patient at home	No family sessions <i>n</i> = 103	Deferred institutionalization—at home 329 days longer than control group	A
Hudson ⁵⁴	Palliative care advanced cancer <i>n</i> = 19 family meeting 19 family cares	Used clinical guidelines to facilitate family meetings. Family care related family information needs	Measure unmet needs—1 family member self-report pre, post, and 2 days after FC	Information needs met Agreement—useful and effective	B
Curtis ³⁰	ICU nonrandomized Prospective cohort <i>n</i> = 50	Agreement of the physician and family to record	Recorded FC and analyzed using grounded theory	Developed framework for communication-agenda, process	C
Miller ³⁹	Palliative care consult service Prospective cohort	FC (<i>n</i> = 50) Consecutive Physician, nurse, and social worker	Nurse and social worker recorded verbatim Categorized and ranked 26 questions by patient and family	Provided agenda for inpatient FC	C

PICO, patient, interventions, comparator, outcome; ICU, intensive care unit; FC, family conference; PTS, posttraumatic stress; VALUE, value, acknowledge, listen, understand, elicit.

TABLE 2. FAMILY CONFERENCE GUIDELINES AND CLINICAL SETTING

	<i>Acute care</i>	<i>Family practice</i>	<i>Intensive care unit</i>	<i>Oncology/palliative medicine</i>
Time (minutes)	40 ¹⁶	30–45 ⁴⁶	20–30 ¹⁴ 30 ³²	60 ⁵⁶
Agenda	Preparation time: 90 minutes ¹⁶ How to do ^{16,45,48, 62} Plan of care identify/modify risk factors ⁵² Education, compliance rehabilitation ¹⁷	Plan of care Identify/modify risk factors ^{10,20,21} Education ¹⁸ Access resources ^{23,24}	Patient/family needs ¹ Goals of care and plan of care ^{14,49} Decision making ^{22,23} Withhold/withdraw treatment ^{22,23} Stabilize crisis ⁶⁹ Distress posttraumatic stress disorder ¹⁴	Education medical + psychosocial ³⁸ Symptom control ⁹ Goals of care and plan of care ^{37,40,41,54} Patient and family Distress ^{61,65}
Patient participation	Yes ^{16,17,52}	Yes ^{18,19,21,66}	Usually not ³⁰	Yes if competent ^{35,37,39}
Family role	Spokesperson (available at time of discharge) ¹⁶ Peripheral ¹⁷ Support ⁴⁵ Recovery ¹⁵	Spokesperson ^{10,73} (whoever with patient) Crisis ²¹ Nonadherence ¹⁸ Transition ^{20,21,57}	Spokesperson—(any family member available at time of meeting) ^{13,14,26}	Patient-designated spokesperson ^{6,41,37} Care transition ^{5,6,8} Connectedness, self-efficacy for family ^{7,8,72,40}
Professional participants	Physician ^{16,17} Social worker ¹⁶ Nurse ¹⁵ Psychologist ¹⁵	Physician ^{19,46} Physician–Assistant ²⁰ Nurse ¹⁸ Social worker ^{12,57}	Physician ¹⁴ Nurse ³⁰ Social worker ⁶⁹ Bioethicist ⁶⁷ Spiritual care ⁶¹	Physician Physician–assistant Social worker ^{37,38,51,65,66} Nurse ^{70,71,51,55}
Process	Information ^{15,6,45,48,52} Support caregiver ⁴⁵	How to do ^{10,46,66,73} Information ⁴⁶ Reassurance ⁴⁶ Summarize decisions ⁴⁶	Information exchange ³¹ Communication ³² Empathy ³³ Nonabandonment ³⁴ Distress ¹⁴ Spiritual support ⁵⁹	Preparation ^{66,51,52} Information specific to patient ⁶ Symptom control ⁶ Advanced directives ⁷⁴ Spiritual ⁵⁶ Instill hope ⁵¹
Benefit	↑ Patient Independent ¹⁷	↑ Compliance ¹⁸ ↓ Resource utilization ¹⁹	Patient quality of death ³² ↓ Length of stay (LOS) ¹⁷ ↓ Distress ¹⁷	Quality of life Stabilize concerns ^{68,72} Access resources to meet demands of caregiving ^{38,61} ↓ Distress ^{68,61}

The VALUE-based family conference allocated more time for family members to share their views and provided information on diagnosis, prognosis, treatment, and treatment limitations. The intervention group had lower anxiety and depression (i.e., reduced posttraumatic stress disorder), fewer nonbeneficial medical interventions, and less aggressive life support. They may also have had lower bereavement morbidity. Study limitations included contamination (physician participants performed both usual care and intervention) and different family members responded before and after to the Impact Event Scale (IES) and the Hospital Anxiety and Depression Scale (HADS). Compliance with the bereavement brochure was not assessed.

Cohort studies, case series, surveys

Acute care. Family conferences in coronary care¹⁵ were offered to address anxiety and difficulties with medical knowledge and instructions. They were facilitated by coronary care nurses and a psychiatric clinical specialist. A movie on coronary artery disease was followed by discussion of disease process, psychosocial coping, and postdischarge

instructions. Addressing anxiety improved family coping and facilitated home discharge.

Hospital social workers' perceptions of family conferences were described in a small survey.¹⁶ Family conference preparation took approximately 90 minutes. Disagreement about care plans were noted: between family and hospital staff (50%), between patient and family (31%), and between patient and hospital staff (27%). Family conferences resulted in fewer hospital discharge delays. Perceived benefits included family information needed to make care plan decisions.

A qualitative study of four family conferences in a rehabilitation unit described communication characteristics (open, inclusive, respectful) that promoted joint decisions.¹⁷ Families were less engaged when patients had the capacity to express their own views and needs.

Family medicine and geriatrics. In two outpatient family medicine studies, family conferences improved glucose control in type 1 diabetes.¹⁸ Supportive family therapy sessions reduced clinical resource use, i.e., physician contact time by patients with emotional problems.¹⁹

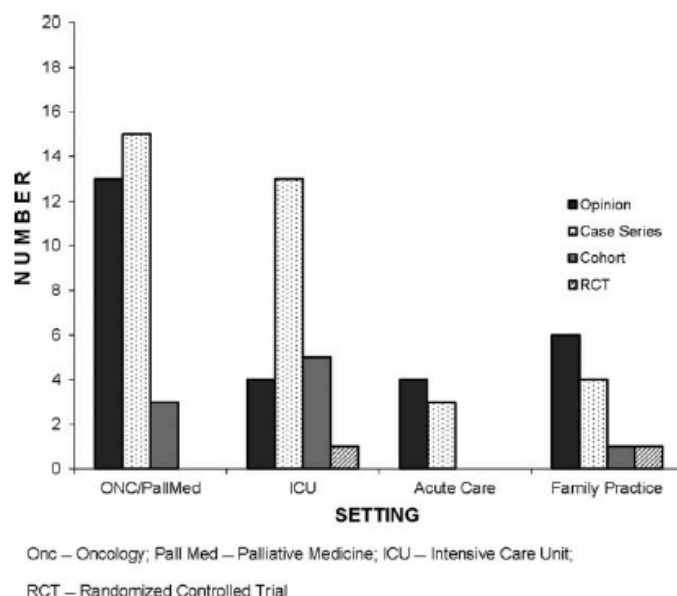


FIG. 1. Number of family conference reports by clinical setting. Onc, oncology; Pall Med, palliative medicine; ICU, intensive care unit; RCT, randomized controlled trial.

Families ($n=276$) and physicians ($n=91$) rated 21 hypothetical clinical indications for a family conference.²⁰ Families considered them important if a relative was dying, hospitalized for a serious illness, or had treatment changes for a chronic illness. Physicians felt family conferences were important if a patient was dying, hospitalized with a serious illness, or considered for nursing home placement.²¹

Intensive care units. Cohort studies^{22–24} have compared proactive family communication interventions with usual care. Interventions consisted of either a designated family communication team (physician and nurse) or early family conference (within 72 hours of admission). Both interventions were associated with shorter ICU and hospital length of stay, lower direct and indirect costs, and reduced ICU mortality.

A series of studies^{25–28} evaluated family communication. Poor comprehension of the plan of care was common and attributable to patient-, family-, and physician-related factors. Ineffective physician communication was frequent. While 91% of physicians wanted families to participate in decision making, only 39% actually involved the family. Forty-seven percent of family members wanted to participate but only 15% actually did. Risk of posttraumatic stress disorder in family members was higher when information was incomplete (48%), the patient died in the ICU (50%), or family members shared in end-of-life decisions (48%).

A study of 10 family conferences²⁹ that involved a medical translator showed that translator alterations (additions, omissions, substitutions, or editorializations) occurred in more than half. Most (75%) alterations were potentially detrimental. The study used a research interpreter and qualitative analysis of coded transcripts. Recommendations included:

1. A preparatory meeting with an interpreter pre-family conference.
2. Use short sentences and speak slowly.
3. Physicians should repeat important concepts, and seek family questions.

Family conference frameworks were also developed from qualitative analysis of 50 audiotaped family conferences (from 111 eligible) analyzed by grounded theory. The framework identified content to facilitate decision making, and strategies to process information.³⁰ Further analysis supported:

1. Explicit and implicit statements to the family of nonabandonment.³¹
2. Increased satisfaction when family members had more time to speak.³²
3. Family satisfaction was associated with frequent clinician statements of emotional support (patient comfort, support of family decisions about life-support).³³

Missed communication opportunities were also identified:

1. To listen and respond to family.
2. To acknowledge and address emotions.
3. To discuss prognosis.
4. To pursue principles of medical ethics and palliative care (patient preferences, surrogate decision-making, and nonabandonment).³⁴

Oncology and palliative medicine. In one report, inpatient palliative medicine family conferences were assessed in a retrospective chart review ($n=123$).³⁵ Fifty-nine percent were attended by both patient and family. Family conference topics were identified (in descending order of frequency):

1. Cancer overview
2. Discharge options
3. Symptom distress
4. Treatment plan
5. Prognosis

Social workers who participated identified that nearly half of families were distressed, primarily in those family conferences in which the patient did not participate. In a more recent study, the same researchers found (in a cohort of 140 consecutive family conferences) that when patients were present there was an increased discussion of goals of care and decreased discussion of prognosis and symptoms of dying.³⁶

Twenty-four FCs about poor prognosis (less than 6 months) illnesses on inpatient medical units were videotaped.³⁷ FC components/functions for both patient and family were identified:

1. Conference organization (setting, participants, structure).
2. Negotiation (building consensus, decision making).
3. Personal stance (active listening, body language).
4. Emotional work (empathy, response to emotions).

A meaningful connection between the family and medical team was considered essential for positive family conference outcomes.

A descriptive study used a standard questionnaire in palliative medicine consultation service.³⁸ High levels of family psychosocial distress in families were noted. The family conferences were often the first organized opportunity families had experienced to discuss the illness and plan of care with professional guidance. A prospective descriptive study recorded verbatim and categorized 50 consecutive family conferences.³⁹ Nearly one-third questioned their ability to manage their loved ones at home. A similar proportion inquired about patient recovery potential (even though they had already been referred to palliative medicine).

A prospective study assessed effectiveness in 28 family conferences in a 36-bed inpatient hospice unit for effectiveness. A self-report instrument of needs and the Family Inventory of Needs (FIN) were completed by designated family members. Unmet needs were identified, including the specific needs of each family.⁴⁰

A semistructured interview study⁴¹ of oncology inpatients ($n = 75$) with prognosis of less than 6 months evaluated communication between patients, families, and physicians. First-order family members (spouse, 34%; children, 52%; siblings, 14%; $n = 126$) met with a physician to review diagnosis and prognosis. One-third felt the physician helped address their concerns. Those who found physician communication difficult also often misunderstood the gravity of the illness. The authors noted the potential disconnect between information communicated and family perceptions, which often resulted in helplessness and distrust of medical care. This caused family dissatisfaction, resistance to care plans, and discharge delays. They highlighted the importance of an evaluation of family insight. Identification of a family spokesperson and physician initiated communication were also important.

A psychiatric consult liaison service also evaluated⁴² family conferences in hospitalized patients with cancer near death. Hospital length of stay was shorter in those who had a family conference. The authors believed families who participated had better communication and cohesiveness. In later studies,

they identified families who might benefit from family grief therapy to manage distress and social function. Additionally they developed enquiry models to guide clinicians. In addition, strategies, skills, and tasks were recommended to ensure effective interventions. Family-focused grief therapy and Comskil (Communication skills) framed questions that explored coping, grief, death, and care needs.^{43,44}

Expert opinion

Acute care. An Alzheimer's evaluation and treatment unit described⁴⁵ their use of several family conferences to help families make plan-of-care decisions. The family conferences were designed to help the team assess family structure and needs, and educate them about the illness course, basic care needs, social skill deterioration, prognosis, and resuscitation decisions. Family conferences also assessed family psychosocial concerns, economic burden, isolation, legal issues, and loneliness.

Family medicine. In a review, the concepts and skills necessary for physicians to conduct a family conference were identified.⁴⁶ Resident physicians reported low confidence about management of family conflict. A curriculum was developed to provide the skills necessary to lead a complicated family conference.⁴⁷

Intensive care units. Family conference guidelines have been published mostly from previous research.^{48,49}

Oncology and palliative medicine. Expert opinion has long supported the value of family conferences for patients with cancer as the best method to provide accurate medical information.⁵⁰ Care improved when patient anxieties were addressed with family and friends included.⁵¹ Attention to overt and covert concerns of the patient and family helped families gain cohesiveness as they faced loss.^{52,61}

Expert panels and focus groups (which included multidisciplinary specialists) have developed family conference practice guidelines. They offer a comprehensive framework on how to conduct the family conference and measure effectiveness.^{53,54} The family conferences were needs-based (not routine) and scheduled by social workers who typically chaired the meeting. The treatment team determined attendees. The guidelines were utilized in a study done to assess effectiveness in meeting needs of family in a hospital in Japan. Pre- and postsurveys were done to rate key concerns and determine impact and report improvement in psychological well-being.⁵⁵

Others have addressed the conduct of the family conference through a social psychology framework,⁵⁶ single-session family interviews,⁵⁷ or spiritual care.^{58,59} Written information has also been developed to guide expectations.^{13,60} An online toolkit for acute care hospitals provided guidelines.⁶² No outcome data were provided.

Textbooks and literature reviews

Textbooks on oncology and palliative medicine have included family conferences but only within chapters on social work, communication, and emotional problems, respectively.⁴⁻⁶ In nursing,⁷ social work,⁸ and psychology⁹ textbooks each discipline described their approach and professional competencies to address both patient and family education

and emotional needs within the family conference. The textbook, *Family-Oriented Primary Care*, has chapters on family conference-centered communication and family systems.¹⁰

A literature review of family conference studies in the ICU concluded there was enough evidence to validate them in that setting.⁶³ A systematic review of family conference studies in the ICU identified the proliferation of qualitative health research with significant findings. It is suggested that these findings should not be dismissed but incorporated in evidence-based practice.⁶⁴

Discussion

The best evidence of the positive effect of the family conference was in the ICU, with improved outcomes for the family and the hospital. The ICU family conference focus was on immediate decision-making about continued life support. Patients were usually unable to participate. Family input was therefore more important and often within a short (hours-days) timeframe. Distress around critical decisions was identified.²⁷ In contrast, in advanced cancer, frequent hospitalizations for disease complications often occur before death and family support was needed during both acute and postacute care. One evidence challenge for the family was related to the many specialists involved. Lack of consistency, discontinuity, and ineffective communication about goals of care were major issues.⁴¹ Emotional distress emerged around transitions of care from oncology to palliative medicine because of uncertainty about the future.⁶⁵⁻⁶⁸ These were evident in discharge plans, particularly when activities of daily living had deteriorated or meaningful rehabilitation was unlikely.

Family medicine data differed from both the ICU and oncology/palliative medicine settings. It is primarily an outpatient practice focused on preventive care, early diagnosis, and management of chronic illness. Individual autonomy and the physician-patient relationship were important, but families were intermittently involved only at critical points in a chronic illness. This was particularly true when the illness was serious, complex decision-making was needed, and patient decision-making capacity impaired.²⁴ A patient/family spokesperson was identified in all the clinical settings as an important component of family conference communication. Patients should ideally identify their chosen spokesperson and caregiver beforehand. Meaningful inclusion of family has been identified by the American College of Physicians⁶⁶ as important to optimize relations with family caregivers, patients, and physicians.

Various team members participated in the family conference. Physicians, nurses, chaplains, or bioethicists⁶⁷ were more likely to have a major role in the ICU than other settings. This reflected the need to prepare families to deal with sudden and often unexpected changes in a loved one's condition and the resultant limited life expectancy. ICU social workers were engaged to support family decisions.⁶⁹ In acute care and outpatient clinics social workers often shared responsibility for the family conference with nurses, physician assistants, and physicians.^{15,19,21} Medical social workers skills seemed to help facilitate family conferences and optimized family interactions.^{37,61} Joint family conference training of physicians and social workers might improve interprofessional communication.⁷¹ Such collaborative education and skill development appear to increase physician confidence with family

communication. A fully leveraged family conference has been observed to require "practice, practice, practice" for professional competence and satisfaction.⁷⁰

Family conference content and process were not easily transferrable between clinical settings. We found limited evidence to support routine family conferences in diverse medical settings. Several reports^{54,56} have examined family conference agendas, and proposed guidelines for varied practice settings. An inclusive formal family conference agenda can promote efficient time use and effective communication. Various family conference protocols^{14,44} exist, e.g., ICU: VALUE or oncology/palliative medicine: Comskil. Theoretical approaches to family communication have been matched to family conference content. Some seem complex for routine clinical practice. Others require more sophisticated communication skills, and family function assessment. The challenge is to adopt a simple yet validated approach.

Identification of family information needs is a challenge. Family conferences should be tailored to their individual and collective medical knowledge, family function, and illness management ability. Communication research has identified certain key elements for an effective family conference. Important communication skills include⁴³:

1. Information
2. Checking
3. Questions
4. Empathetic communication
5. Shared decision-making

Emotional distress and health care misconceptions often emerge in the family conference. In response, some professionals may distance themselves to minimize stressful interactions. This might include ignoring patient and family verbal and nonverbal cues. Demonstrated lack of empathy in turn teaches both patient and family it is inappropriate to raise emotional concerns. Premature reassurance facilitates emotional distancing.⁷²

The specific communication skill of empathetic response and reframing was consistently identified as important in all clinical settings.^{33,59} Having an identified clinical spokesperson, and empathic team responses increased family satisfaction,³¹ decreased distress and conflict,⁷³ improved communication effectiveness,⁴⁰ and decreased family emotional burden.⁶⁸ Family conferences are also an important opportunity to address advanced care plans. This is an important avenue of future research.⁷⁴

Family conference research requires major resources and skilled clinician researchers. Methodological barriers include inadequate sample sizes, attrition, heterogeneous populations, and varied family conference content. Outcomes^{75,76} would ideally be documented using well-validated instruments sensitive to change over time. Randomized controlled trials are hampered by incomplete blinding and contamination between intervention and control. Meaningful research on the financial impact seems important. Costs include preparation time (in addition to that actually in family conferences) and follow-up. Opportunity costs in professional time include more conventional, reimbursable or otherwise worthwhile activities. Intangibles such as improved patient and family coping and satisfaction (if documented) might offset these costs. Complicated grief or exacerbated distress due to ineffective communication also has a potential negative economic impact.

Practical outcomes should also include reduced resource utilization, often difficult to measure, but important to capture. Well-designed prospective studies in diverse medical settings with objective outcomes are needed.

The ICU studies revealed beneficial family conference outcomes. Other research was inconclusive about whether the family conference is truly an effective intervention. Despite this, some believe family conferences should be routine medical practice and all medical professionals trained. Family conference practices across health care systems nationally and internationally is unknown. Various medical settings will have different goals, barriers and outcomes. Family conferences aim to achieve multiple outcomes, and improve the effective use of scarce and/or expensive resources. Comprehensive evaluation across medical settings is necessary.

Summary

The evidence base supports the value of family conferences only in the ICU but is insufficient to support this practice in other clinical settings. Communication research has identified key elements of effective family conferences. An inclusive formal agenda helps to guide the family conference. Various team members participated. Medical social workers were often paired with physicians. Emotional distress emerged in the family conference around transitions of care, health care misconceptions, and need for immediate decision making. Empathic response and reframing was identified as important in all clinical settings. The practical and financial impact of the family conference should be researched further. Family conference research itself is complex and requires major resources.

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Address correspondence to:
 Declan Walsh, MSc, FACP, FRCP(Edin), FTCD
 Cleveland Clinic (M77)
 9500 Euclid Avenue
 Cleveland, OH 44195
 E-mail: walshtd@tcd.ie

APPENDIX 1. AN OVERVIEW OF THE SEVENTY-THREE REVIEW PUBLICATIONS

Author	Oncology/Palliative Medicine/Hospice (n = 31)	Grade
2 Fallowfield	Literature review showed need for physician communication training to help patient and family	D
4 Berger textbook	Oncology textbook	D
5 Doyle textbook	Textbook multidisciplinary palliative medicine (Monroe) family conference assessment and follow-up role of social worker	D
6 Walsh textbook	Palliative Medicine: chapters on communication with patient and family, how to do family conference	D
7 Ferrell textbook	Textbook nursing: chapter detail on how to do content and process for nurses	D
8 Altio textbook	Palliative social work, Fineberg and Bauer communicating with families in family conferences	D
9 Holland textbook	Psychooncology patient focused; Loscalzo-consult	D
35 Yennurajalingam	Characteristics of 123 family consultations assess for distress needed	C
36 Dev	Family conference: patient presence impacts emotional expression, prognosis discussion 140 Prospective	C
37 Fineberg	Communication with families facing life-threatening illness: A research-based model for family conferences	C
38 Miller	Impact psychosocial care, family distress/ consult service family conference first opportunity to ask questions	C
39 Miller	Impact consult palliative care team, prospective study, questions asked by patient and family in 50 family conferences	C
40 Hannon	Family conference effectiveness study pre-post	B
41 Krant	Impact/sequence of poor communication, need for family spokesperson	C
42 Kissane	Consult service identifies need for family conferences in outpatient setting	C
43 Dumont/Kissane	Techniques for framing questions in conducting family meetings in palliative care	C
44 Gueguen/Kissane	Comskil communication with family	C
50 Day	Opinion: Family meeting important for patient—early opinion	D
51 Liebman	Opinion: Family conference supportive—early opinion	D

(continued)

APPENDIX 1. (CONTINUED)

53	Hudson	Content: Study of family conference structure and agenda multidisciplinary clinical guidelines; social worker facilitates	C
54	Hudson	Multidisciplinary experts develop family conference guidelines pre/post	B
55	Fukui	Effectiveness of using clinical guidelines to conduct family conferences with primary family caregivers pre/post	B
56	Ambuel	Supportive, Oncology how to do	D
58	Tan	Recruiting palliative patients /the Murphy's Family Meeting Model/ spiritual care	C
60	Moneymaker	Content family conference Leaflet 1 page leaflet of guidelines given to family before family conference	D
61	Powazki	Family distress APGAR	C
65	Zaider/Kissane	Assessment and management of family distress during palliative care	D
68	Radwany	Family emotional burden survey, grounded theory, semi structured interview	C
71	Fineberg	Physician and social worker in training together	C
72	Faulkner	Talking to relatives	D
74	Steinhauser	Preparing for the end of life: national survey: preferences patients, family, physician	C
Intensive Care Unit (n=23)			
1	Hickey	Literature review on needs of families—information, reassurance and empathy	D
3	Baker	Support study—Poor communication impact-dissatisfaction with care	B
13	Azoulay 2002	Impact Information leaflet to increase family comprehension of diagnosis, prognosis prior to family conference	C
14	Lautrette	Bereavement issues, Pre-post evaluate—traumatic stress less with structured family conference	A
22	Ahem	Physician/nurse: consistent communication reduced length of stay and resource use	B
23	Lily	SUPPORT Usual care vs. Proactive communication (decreased length of stay)	B
24	Lily	Repeated same results	B
25	Delgado	Multidisciplinary family meetings facilitate end-of-life decision-making	C
26	Azoulay 2004	Half of families did not want to participate in decision-making survey	C
27	Azoulay 2000	Half of families experience inadequate communication with physicians	C
28	Azoulay 2005	Informative communication reduced posttraumatic stress	B
29	Pham	Altered translation by interpreters	C
30	Curtis 2002	Develop framework for content and process 50 family conferences	C
31	West	Assure nonabandonment	C
32	McDonagh	More family speaks, more satisfied	C
33	Stapleton	Family satisfied when supported for decisions	C
34	Curtis 2005	How to do—Missed opportunities in process. Limited studies, more needed	C
49	Billings	Indications for family conference	D
59	Wall	Pastoral care: spiritual needs of family if met increased satisfaction	C
63	Lautrette 2006	Literature review of family conference ICU rooted in the evidence	D
64	Cypress	Literature review need to value qualitative studies	D
67	Watkins	Role of bioethics in family conference-consultant, mediator, persuader	C
69	McCormick	Assessment social worker role in ICU stabilize crisis	C
Acute Care (n=7)			
15	Holub	Retrospective—family supported/recovery sooner for heart patients	C
16	Hansen	Retrospective content/operation of family conference—patient participates in planning	C
17	Fronek	Process observations of family conference process—patient primary in rehabilitation	C
45	Fabisewski	Alzheimer family meetings	D
48	Frank	Geriatrics how to do family conference	D
52	Worby	Consult Psychiatry—case report helping patient and family to cope using family meeting	D
62	Ceronsky/Fairview	Content Toolkit of forms Guidelines to family conferences in hospital	D

(continued)

APPENDIX 1. (CONTINUED)

Family Practice (n=12)			
10	McDaniel textbook	How to do/ content and process family conference chapters	D
12	Mittleman	RC intervention Family sessions defer placement of Alzheimer	A
18	Chase	Improved glucose control in adolescent patient with family conference vs follow-up phone calls	C
19	Comley	Family conference reduced resource use—comparative	B
20	Kushner, Meyer 1986	Needs Survey—physician underestimates family need for family conference	C
21	Kushner, Meyer 1989	Needs Survey—patient and family want family conference—when seriously ill	C
46	Butler 2001	How to do—when meeting with families	D
47	Butler	Develop curriculum on family conferences based on study reviews	D
57	Erstling	Process physician/ family share decision making—single session family interview-spokesperson	D
66	Mitnick	Involving caregivers, patients, and physicians	D
70	Begel	Process How to do—practice-family systems theoretical and practical perspectives	D
73	Tilden	Process clarify roles of family—family spokesperson/group consensus preferred	C