



Is there evidence that conducting palliative care family meetings are worth the effort?: results from a systematic review

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Definition: Family meeting

- Variably referred to as a “family conference” or “patient-family conference”
- In this systematic review the term “family meeting” is defined as:

A single meeting “... attended by the patient (when possible), family members, and health care providers to discuss the patient’s illness, treatment and care...”

(Fineberg et al., 2011, p. 422).



Background

Family meetings

- Enhance communication between patients, families and clinicians
- Opportunity to discuss treatment/care options, seek agreement and promote a shared understanding (Fineberg et al., 2011)
- Occur on an 'ad hoc' basis
- Potentially resource intensive

Family Meeting Guidelines (Hudson et al., 2008)

- Informed by various theoretical models, qualitative evidence and expert opinion



Background

1. Literature review of family conferences

- Acute care, family medicine/geriatrics, ICU, and oncology/palliative care
- Evidence of benefits family conferences in ICU populations
- Minimal evidence for other clinical areas

(Powazki et al., 2014)

2. Systematic review inpatient family meetings

- Acute and sub-acute settings
- Low-moderate evidence
 - reduction in family psychological distress
 - family information and support needs were met

(Reed & Harding, 2014)



Aim

To determine the evidence that supports the use of family meetings to better address patient and family palliative care needs.



Search Questions

- **What is the evidence for family meetings?**
- What is the rationale for Palliative Care Family Meetings?
- What are the processes and components of Palliative Care Family Meetings?
 - Who attends the Family Meeting?
 - When and where is a Family Meeting undertaken?
 - What are the models for Family Meetings?
 - How should a Family Meeting be conducted?
- What are the outcomes and/or benefits for participants in Family Meetings?
- What measures are used to assess the outcomes of Family Meetings for patients, families palliative care team members and services?



Method

- Adheres to the PRISMA Guidelines
- Six Specialist medical & psychosocial databases (n=6) & CareSearch
- English language peer reviewed journals (1980-March 2015)
- Eligible: RCTs, cohort, case controlled studies, case series and qualitative studies (Excluded: Case reports, “grey literature”, editorials, expert opinion e.g. guidelines).



Inclusion criteria

1. Adult in-patients with advanced cancer or life-limiting condition receiving primary or specialist palliative care;
2. Face-to-face meetings (planned/unplanned) with families clinicians, and/or patient; and
3. Description of rationale, processes, results, outcomes and/or outcome measures.

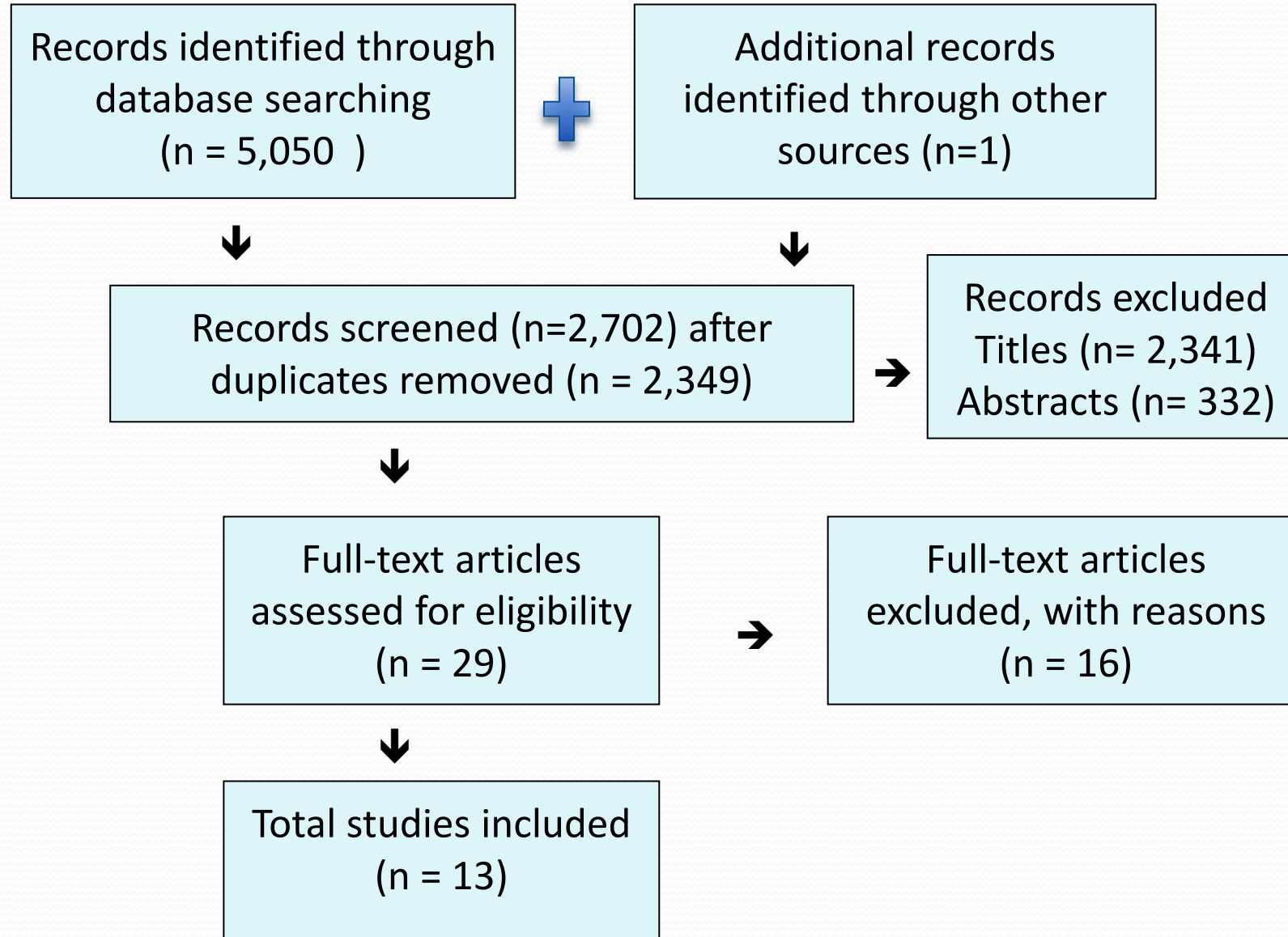


Search terms

- MeSH headings used for relevant databases
- Boolean logic and operators - “AND”, “OR”
- Key words were shortened with * to allow multiple endings e.g. meeting*, famil*
- No outcomes defined so full range of outcomes could be identified



Figure 1: PRISMA FLOW CHART





Results

- 13 Studies identified
 - Specialist palliative care (n=11)
 - Surgical ICU – specialist palliative care team input (n=2) (Lamba et., al. 2012, Mosenthal, 2008)
- 10 studies generated Level IV evidence
 - Pre-post test studies (n=3) (Fukui, 2013, Hannon, 2012, Hudson, 2009)
 - Prospective observational studies of family meetings (n=4) (Dev, 2012, Lambaa, 2012, Mosenthal, 2008, Miller, 1999)
 - Retrospective chart review (n=2) (Tobin, 2011, Yennurajal, 2008)
 - Health Professional Survey (n=1) (Rhondalai, 2014)
- Qualitative studies (n=3) (Meeker, 2014, Finberg, 2011, Radwany, 2009)



Results

- Wide variation in patient attendance (0-60%)
- High rates of family participation (99-100%)
- Variations in health professional attendance
- Two studies reported service benefits with decreased length of stay



Results: Pre-post test studies

- Significant improvements in family ratings of concerns post-meeting.
(Fukui et al., 2013, Hannon et al., 2012, Hudson et al., 2009)
- Two pre-post studies used a validated family outcome measure: Family Inventory of Needs (FIN) (Hannon et al., 2012, Hudson et al., 2009)
 - Important family needs were met post family meeting ($p < 0.0001$)
(Hannon, et. al. 2012)



Family Inventory of Needs Results

(n=28, p < 0.0001)

Family Inventory of Needs (FIN)	“Met” at T0 ^a (%)	“Met” at T1 ^b
1. Have my questions answered honestly	17 (54.8)	28 (100)
2. Know specific facts re: prognosis	8 (25.8)	24 (88.9)
3. Know exactly what is being done for patient	16 (53.3)	27 (100)
4. Know what treatment the patient receiving	15 (48.4)	27 (100)
5. Know symptoms disease/treatment can cause	6 (20.1)	26 (100)
6. Know when to expect symptoms to occur	3 (11)	23 (92)
7. Have information re: what to do for patients at home	7 (25.9)	26 (100)
8. Be told about people who can help with problems	10 (35.7)	26 (96.3)

^a Indicates item on FIN scored as “met” by family member prior to family meeting

^b Indicates item on FIN scored as “met” by family member following family meeting (Hannon et al., 2012)



Results

Table: Family Meeting Questionnaire

Study	How worried	How often	Interferes with life	Confidence to manage
Hudson et al. (2009) n=18	p < 0.01	p < 0.01	p < 0.01	Not significant*
Hannon et al. (2012) n= 31	p < 0.001	p < 0.001	p < 0.01	p < 0.01
Fukui et al. (2013) n=15	p < 0.001	p < 0.001	p < 0.001	p < 0.01



Results: pre-post test studies

Pre-post test observational study of family meetings with ICU team and palliative care clinicians to improved EOL care:

- Significant changes in outcomes – patients who died (n=31):
 - Do Not Resuscitate (DNR) status increased (p=0.03); and
 - Withdrawal of life support measures increased (p=0.024).

(Lamba et al., 2012)

Earlier study reported similar results with same intervention:

- Earlier timing of DNR
- Earlier withdrawal of life support

(Mosenthal et al., 2008)



Results: Observational studies

Family meetings (n=140) in a US palliative care unit:

- Patient present → increased discussion about goals of care ($p=0.009$), decreased discussion about prognosis ($p=0.004$) and what dying patient may experience ($p < 0.001$); and
- Patient absent → increased expression of family verbal distress ($p=0.037$)

(Dev et al., 2013)



Conclusions

- Limited evidence to support the routine use of family meetings in palliative care – to improve family outcomes:
 - No study provided evidence for patient benefits using a validated outcome measure; and
 - Limited evidence for clinician and/or service benefits.
- Further research is recommended using more robust designs to assess the impact and outcomes of family meetings on patients, families and clinicians.



Acknowledgement

The Australian Government, Collaborative Research Networks (CRN) program scholarship for Philippa Cahill supported this work as part of the research project: Healthy People, Healthy Country.