SERVIZIO SANITARIO REGIONALE
EMILIA-ROMAGNA
Azienda Unità Sanitaria Locale di Reggio Emilia
IRCCS Istituto in tecnologie avanzate e modelli assistenziali in oncologia

OECI COMPREHENSIVE Cancer Centre

Improving Advanced Communication Skills Towards the Family System: A Scoping Review of Family Meeting Training in Oncology and Other Healthcare Settings

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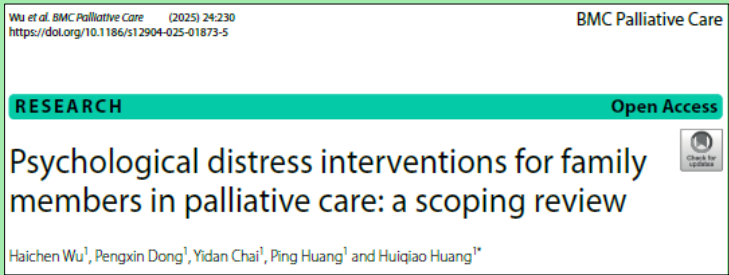
Aims of palliative care

Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness and especially of those near the end of life. It aims to improve the quality of life of patients, their families and their caregivers (Lukas Radbruch et al., 2020)

- Caregivers experiencing extreme psychological distress may deliver lower-quality care, exacerbating the patient's condition, and the patient's deterioration may also have a detrimental impact on the caregiver (Haichen Wu et al., 2025)
- The success of care for the patient and the family depends on how the team supports this "patient–family" unit of care
- In palliative care, family meetings are used to improve communication between the patient, the family, and the care team


Wu et al. BMC Palliative Care (2025) 24:230
https://doi.org/10.1186/s12904-025-01873-5
BMC Palliative Care
RESEARCH
Open Access
Psychological distress interventions for family members in palliative care: a scoping review
Haichen Wu[1], Pengxin Dong[1], Yidan Chai[1], Ping Huang[1] and Huiqiao Huang[1*]

Definition

- The “family” is defined broadly as whomever the patient considers their family, kinship bonds not withstanding. Those who offer support to the patient and take a role in care provision can be considered family (David Kissane et al., 2016)

- The history of each family is a complex and unique intertwining of individual stories, intergenerational bonds, and shared experiences; consequently, **it can be challenging to understand the nature and meaning of family functioning**

- What can we do? **The Resilient Family and the “At-Risk” Family**

Resilient family

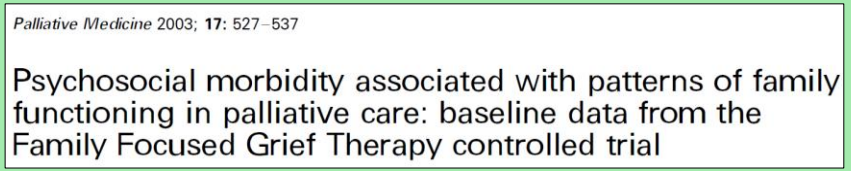
- It adapts to adversities
- It is characterized by: (a) cohesion and membership; (b) economic support; (c) nurturance, education, and socialization; and (d) protection of vulnerable members
- When a member of a resilient family becomes ill, other members are able to regroup so that the care and protection of the ill member is ensured
- Resilient families utilize teamwork to come together in times of adversity and share an optimism and spirituality that they use to transcend any suffering involved


VOLUME 34 · NUMBER 16 · JUNE 1, 2016

JOURNAL OF CLINICAL ONCOLOGY ORIGINAL REPORT

Randomized Controlled Trial of Family Therapy in Advanced Cancer Continued Into Bereavement

David W. Kissane, Talia I. Zaider, Yuelin Li, Shira Hichenberg, Tammy Schuler, Marguerite Lederberg, Lisa Lavelle, Rebecca Loeb, and Francesca Del Gaudio


Palliative Medicine 2003; **17**: 527–537

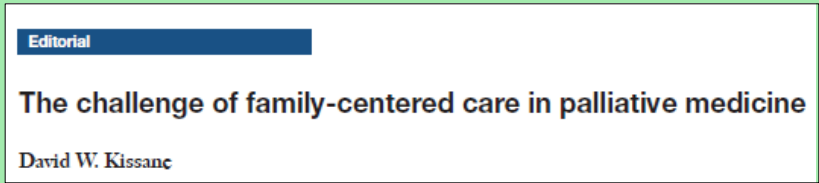
Psychosocial morbidity associated with patterns of family functioning in palliative care: baseline data from the Family Focused Grief Therapy controlled trial

Dysfunctional family

- It stands in stark opposition to the resilient family and includes **poor cohesion, poor communication, and poor conflict resolution**

- Clinicians may ask three simple questions about family relational life to discern the presence of any dysfunctionality:

1) **communication—how openly do you communicate as a family?** Do member families talk about the illness?
2) **cohesion—how strong is family teamwork and mutual support?** What type of coping strategy uses?
3) **conflict—how well do you resolve arguments and differences of opinion?** Can the family system share the emotional distress?"


Editorial

The challenge of family-centered care in palliative medicine

David W. Kissane

Although FMs are often used, the literature shows a lack of training to conduct them or even participate too.

cancers

Improving Advanced Communication Skills Towards the Family System: A Scoping Review of Family Meeting Training in Oncology and Other Healthcare Settings

Cancers **2025**, *17*(19), 3115; **https://doi.org/10.3390/cancers17193115**

by **Sara Alquati** [1], **Loredana Buonaccorso** [2,*], **Nuria Maria Asensio Sierra** [3], **Francesca Sassi** [1], **Francesco Venturelli** [4], **Maria Chiara Bassi** [5], **Stefano David Scialpi** [6] and **Silvia Tanzi** [1]

Methods

The aim of this review is to provide an overview of the available research evidence on FM education for HPs.

Following the Arksey and O'Malley framework, our scoping review process included:

- ❑ Review question

"How are training programs on family meetings for healthcare professionals designed, organized and evaluated?"

Methods

- Study identification and selection and data charting

Search Strategy

We conducted an electronic search of the literature from inception (1960) up to 28 February
2025 on the following databases: MEDLINE (through PubMed), Embase, CINAHL, PsycINFO, and Scopus.

We included articles in English, Italian, and Spanish.

Methods

The search strategy :

(‘family meeting’[Title/Abstract] OR ‘family conference’[Title/Abstract])
AND
(education* OR learning OR training OR course* OR workshop*OR teaching OR seminar* OR class* OR instruction).

Methods

❑ The **PCC** (Population-Concept-Context) framework was used to structure the search strategy and to define the inclusion criteria.

We included studies that:
- described an educational intervention on FMs (Concept)
- focused on HPs in all settings of care and students of medicine and nursing sciences (Population)
- treated adult patients (>18 years old) with oncological and non-oncological diseases (Context)

No PICO: typical of systematic reviews which is more focused on the effectiveness of a treatment. PCC model is wide and more exploratory.

Definition

To identify eligible educational intervention, starting from Moneymaker's definition of FM:

"The FMs are meeting between the patient, their family and HPs and are undertaken for multiple purposes including the sharing of information and concerns, clarifying the goals of care, discussing diagnosis, treatment, prognosis and developing a plan of care for the patient and family carers"

Moneymaker K: The Family Conference. Journal of Palliative Medicine 2005, 8(1):157

Definition

Eligible interventions included:

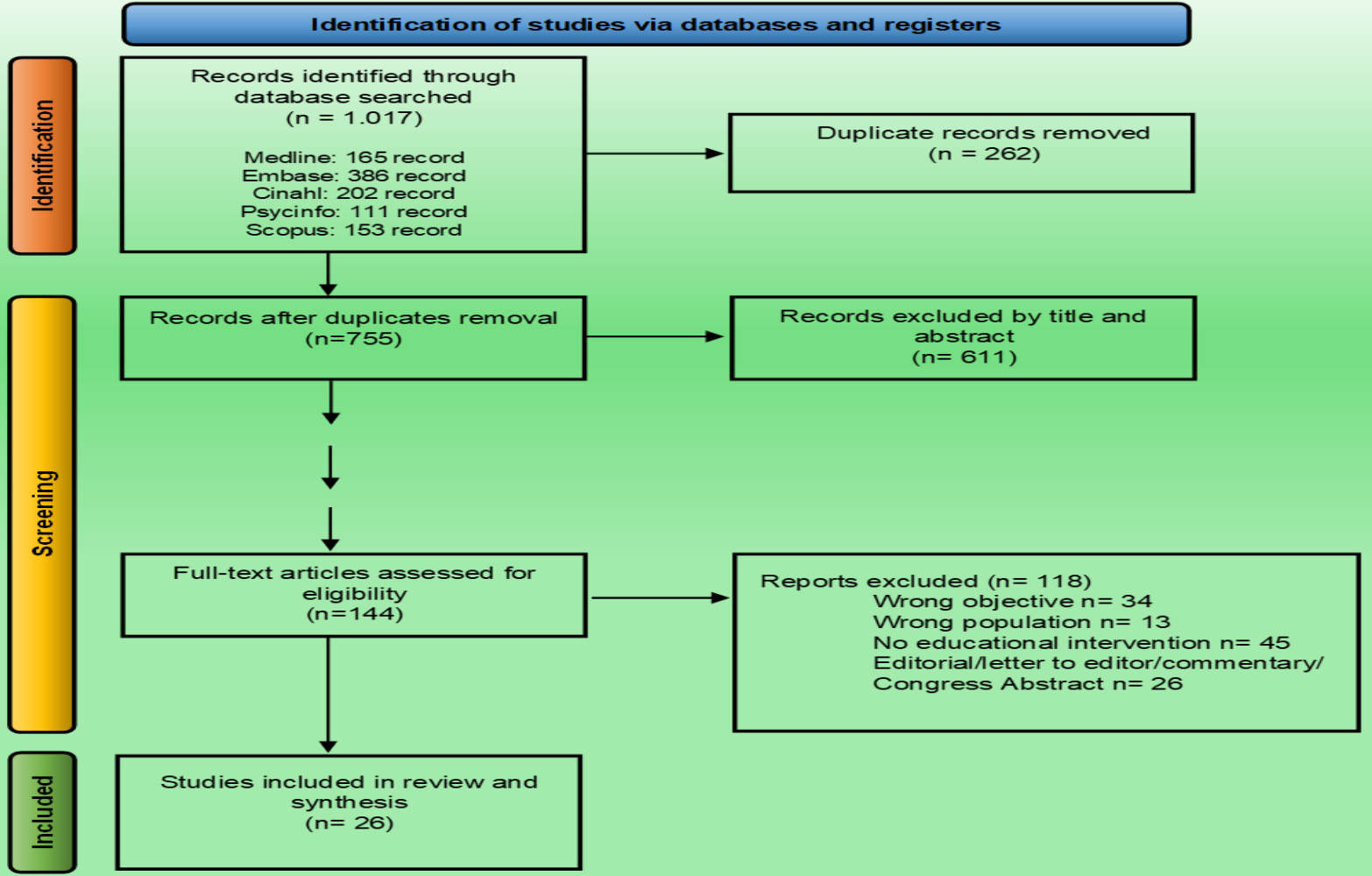
FMs and family conference training

We included studies that used research methodologies, including quantitative, qualitative, and mixed-methods programs.

Outcomes were described when available in the included studies to provide information about **how training was structured and evaluated**

Exclusion Criteria

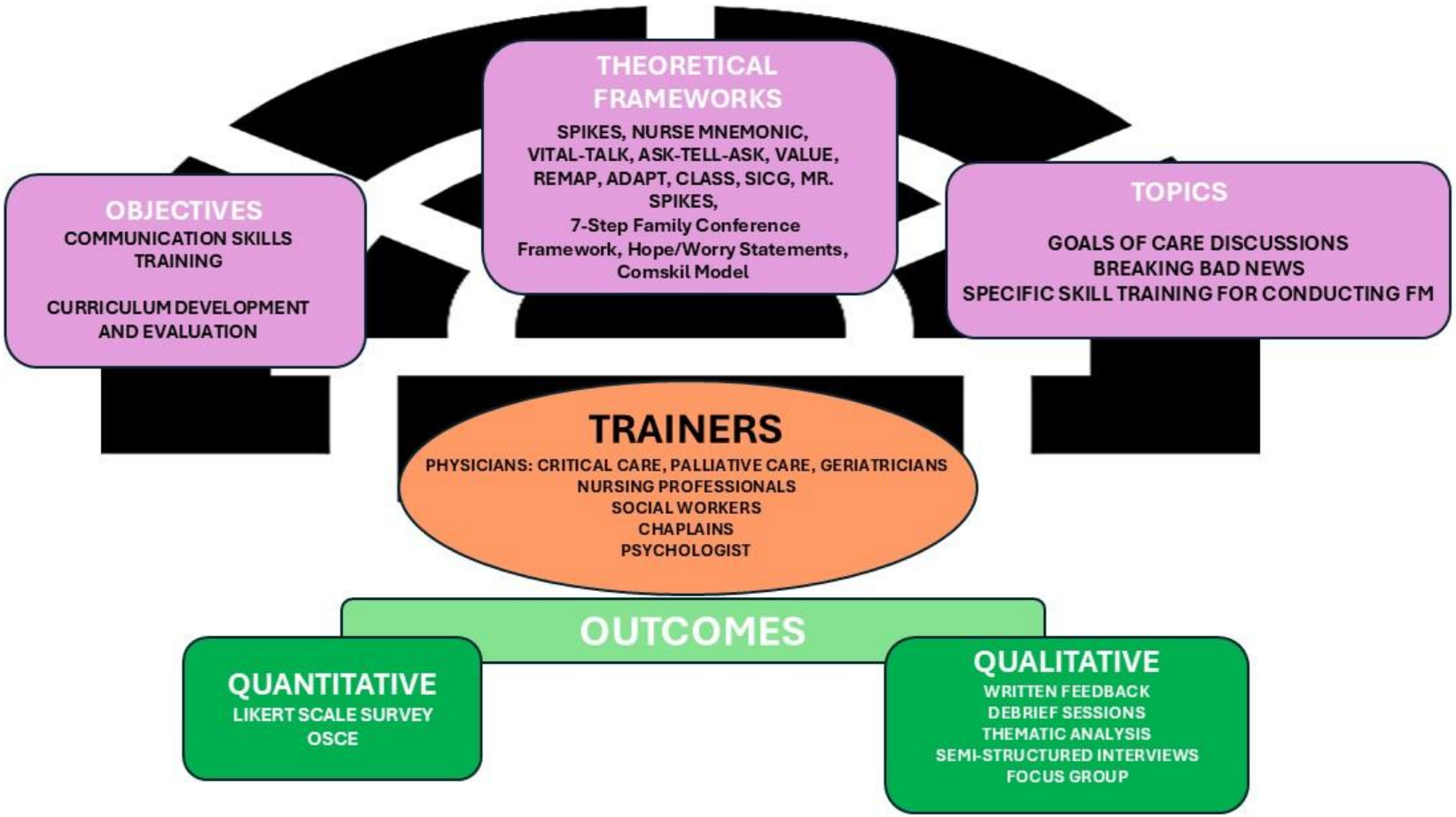
(1) described an educational intervention on advanced communication without a specific focus on FMs;
(2) included only pediatric settings or pediatric HPs.
(3) conference abstracts, case reports, systematic reviews, expert opinions, guidelines, ongoing trials, protocol articles, and book chapters.


Identification of studies via databases and registers
Identification
Records identified through database searched (n = 1.017)
Medline: 165 record
Embase: 386 record
Cinahl: 202 record
Psycinfo: 111 record
Scopus: 153 record
Duplicate records removed (n = 262)
Screening
Records after duplicates removal (n=755)
Records excluded by title and abstract (n= 611)
Full-text articles assessed for eligibility (n=144)
Reports excluded (n= 118)
Wrong objective n= 34
Wrong population n= 13
No educational intervention n= 45
Editorial/letter to editor/commentary/ Congress Abstract n= 26
Included
Studies included in review and synthesis (n= 26)

Synthesis of the Results

The results from the included studies were reported according to the following topics:

- Study Objective
- Study Design
- Trainers
- Trainees
- Setting of Training
- Intervention (Duration, Teaching Methods, Theoretical Framework)
- Topics
- Evaluation of Training (Quantitative Evaluation Tools and Outcomes, Qualitative Evaluation and Outcomes)


TRAINEES
MEDICAL STUDENT and RESIDENT; FELLOWS; PHYSICIAN ASSISTANT; NURSES; CHAPLAINS
THEORETICAL FRAMEWORKS
SPIKES, NURSE MNEMONIC, VITAL-TALK, ASK-TELL-ASK, VALUE, REMAP, ADAPT, CLASS, SICG, MR. SPIKES, 7-Step Family Conference Framework, Hope/Worry Statements, Comskil Model
OBJECTIVES
COMMUNICATION SKILLS TRAINING
CURRICULUM DEVELOPMENT AND EVALUATION
TOPICS
GOALS OF CARE DISCUSSIONS
BREAKING BAD NEWS
SPECIFIC SKILL TRAINING FOR CONDUCTING FM
TRAINERS
PHYSICIANS: CRITICAL CARE, PALLIATIVE CARE, GERIATRICIANS
NURSING PROFESSIONALS
SOCIAL WORKERS
CHAPLAINS
PSYCHOLOGIST
OUTCOMES
QUANTITATIVE
LIKERT SCALE SURVEY
OSCE
QUALITATIVE
WRITTEN FEEDBACK
DEBRIEF SESSIONS
THEMATIC ANALYSIS
SEMI-STRUCTURED INTERVIEWS
FOCUS GROUP

Study Objective

Two primary aims:

i) Communication Skills Training

(ii) Curriculum Development and Evaluation

Setting of training

The distribution of training settings reveals a pronounced emphasis on clinical environments:

ICU and non-ICU.

Simulation centers also emerged as a setting providing controlled environments for high-stakes communication practice.

Also, exclusively academic-hosted studies were reported, primarily using classrooms or lecture halls.

Oncology

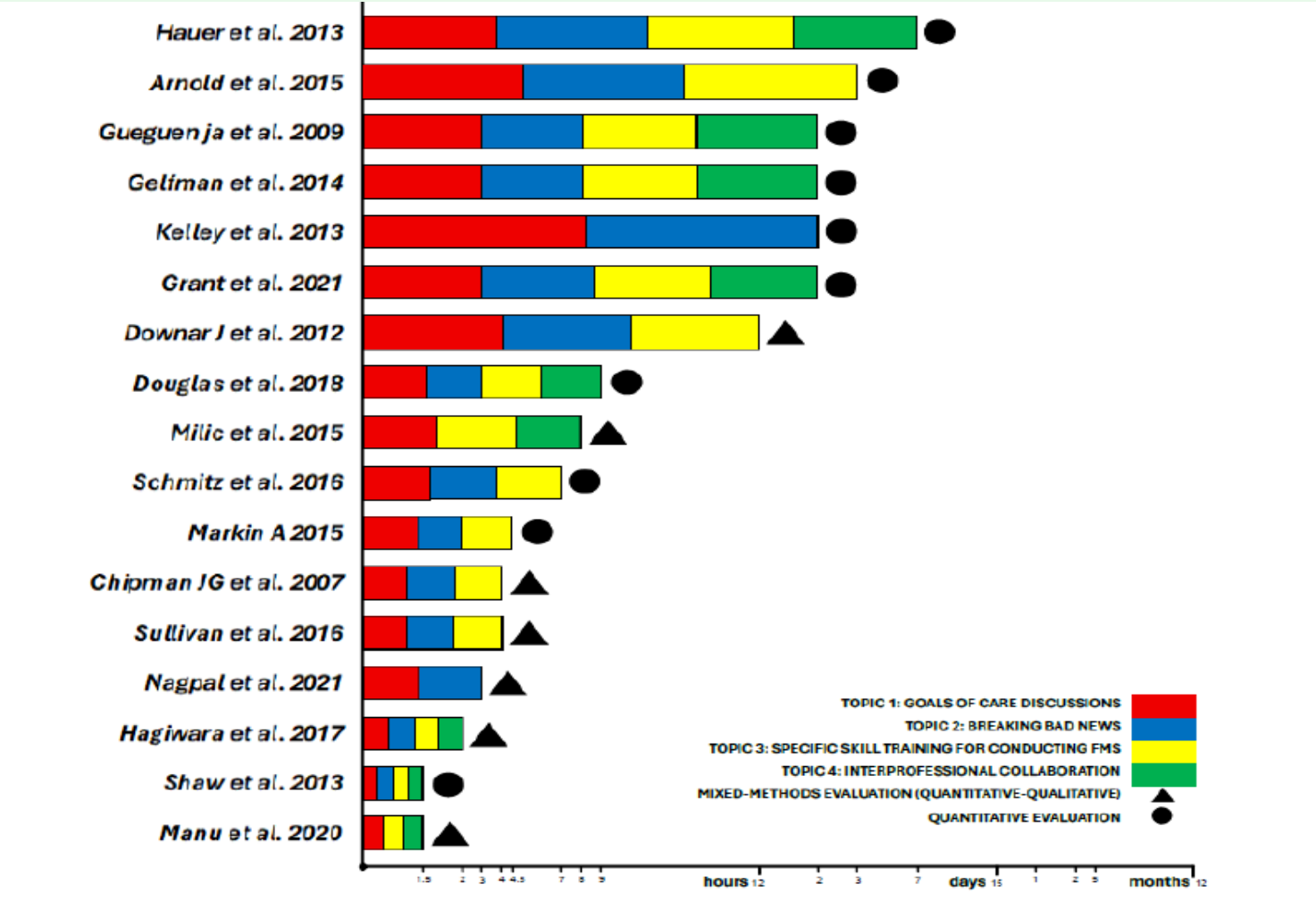
Intervention

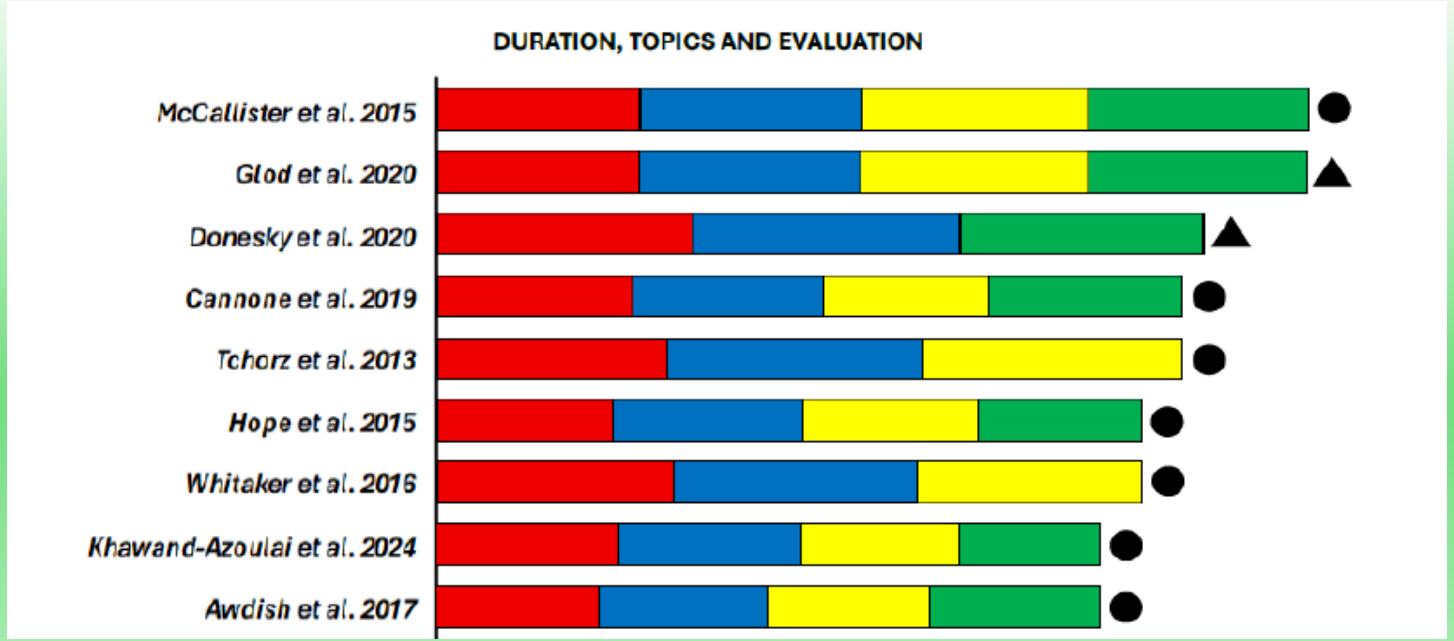
i) duration

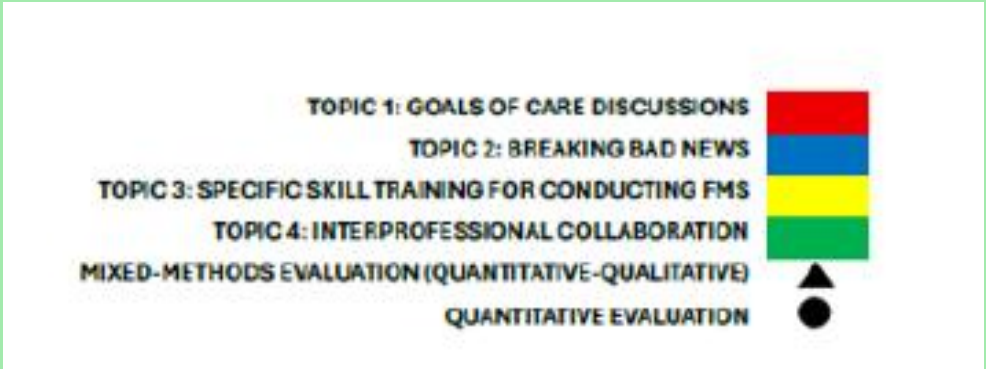
i) teaching methods

(iii) theoretical framework

DURATION


Hauer et al. 2013
Arnold et al. 2015
Gueguen ja et al. 2009
Gelíman et al. 2014
Kelley et al. 2013
Grant et al. 2021
Downar J et al. 2012
Douglas et al. 2018
Milic et al. 2015
Schmitz et al. 2016
Markin A 2015
Chipman JG et al. 2007
Sullivan et al. 2016
Nagpal et al. 2021
Hagiwara et al. 2017
Shaw et al. 2013
Manu et al. 2020
TOPIC 1: GOALS OF CARE DISCUSSIONS
TOPIC 2: BREAKING BAD NEWS
TOPIC 3: SPECIFIC SKILL TRAINING FOR CONDUCTING FMS
TOPIC 4: INTERPROFESSIONAL COLLABORATION
MIXED-METHODS EVALUATION (QUANTITATIVE-QUALITATIVE)
QUANTITATIVE EVALUATION
hours
days
months


DURATION, TOPICS AND EVALUATION
McCallister et al. 2015
Glod et al. 2020
Donesky et al. 2020
Cannone et al. 2019
Tchorz et al. 2013
Hope et al. 2015
Whitaker et al. 2016
Khawand-Azoulai et al. 2024
Awdish et al. 2017

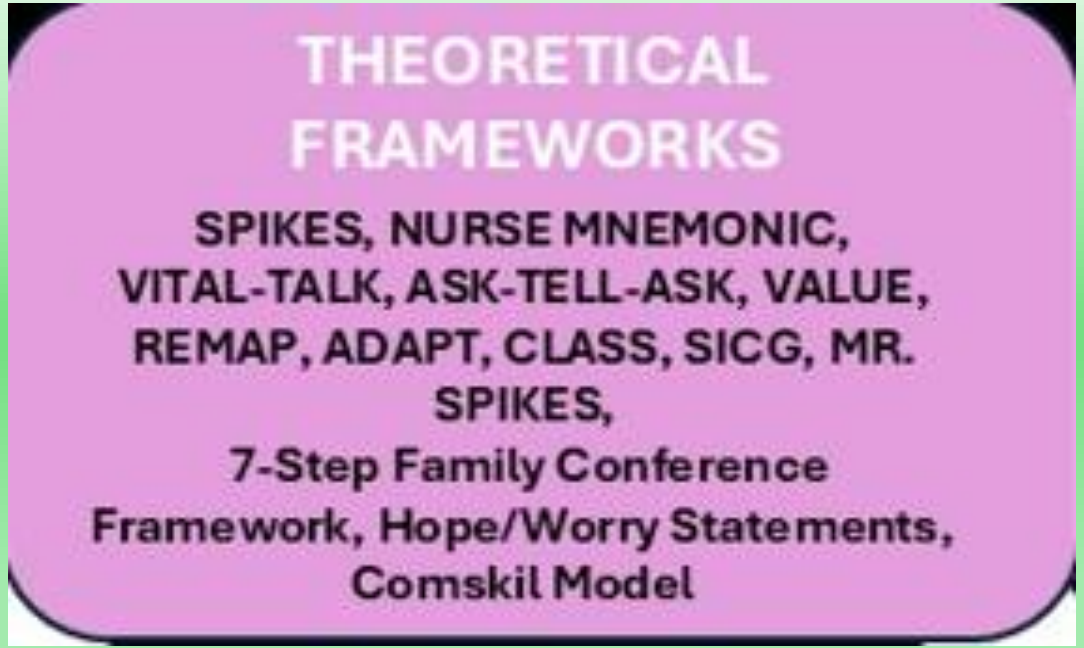

TOPIC 1: GOALS OF CARE DISCUSSIONS
TOPIC 2: BREAKING BAD NEWS
TOPIC 3: SPECIFIC SKILL TRAINING FOR CONDUCTING FMS
TOPIC 4: INTERPROFESSIONAL COLLABORATION
MIXED-METHODS EVALUATION (QUANTITATIVE-QUALITATIVE)
QUANTITATIVE EVALUATION

Teaching methods

Preference for **active learning methodologies**:

- Simulation-based training dominates: including standardized patient encounters, role-playing exercises, and high-fidelity clinical scenarios

This experiential approach frequently combines with other methods in blended designs that integrate didactic instruction with hands-on practice and clinical application



These models address diverse aspects of communication, such as prognosis discussions, general communicative strategies, and family conferences.

Evaluation of training

We presented a summary of two main types of evaluation and outcome:

i) Quantitative evaluation tools and outcomes

i) Qualitative evaluations and outcomes

Lack of European studies

Communication Skills
Training
Curriculum Development and Evaluation

Physicians/students
4 study with nurse

Topics:

- Goals of care
- Breaking Bad News
- Interprofessional collaboration
- **Specific FM training:**

Importance of preparation phase;
Conflict mediation;
Active listening and attention to family members'concerns

Setting ICU

Training on FMs should be proposed based on **cultural specificity**, because the goals of care, the values and desires of patients, and the communication of bad news have different meanings depending on patients'culture

Essential for HPs to assess the **family system**.
Few of the analyzed studies reported specific training on recognizing family dynamics.

Few educational interventions have been designed for **teams** (physicians and nurses)

Oncology fellows and radiation **oncology** residents participated in standardized training programs such as Oncotalk and VitalTalk, conducted in specialized communication simulation centers

Only three studies occurred in dedicated **palliative care units**

Methodological heterogeneity

Implication for future training

- Few of the analyzed studies reported specific training on recognizing family dynamics
- According to the family systems approach, each family member is interdependent on the others to cope with the disease
- Future training on FMs should also consider the most important information about the type of family
- Evaluating these topics helps clinicians offer personalized care, intercepting families with dysfunctional communication styles so they can work preventively to activate the specialists
- For instance, the Psycho-Oncology Unit has organized a training on the type of family in Oncology and Palliative care and how clinicians can assess and communicate with it

Family type	Team's observation	Team'experience
Functional Family	No significant critical issues are observed. The family appears supportive and cohesive, with adequate relational functioning.	The team experiences effective collaboration both with the family and internally. **Risk:** Potential underestimation of the need for continuous reassessment of relational dynamics.
Conflictual Family	Presence of either explicit or latent conflicts affecting family interactions and decision-making processes.	The team may experience insecurity in interpreting relational dynamics and concern in defining appropriate relational goals. **Risks:** impulsivity, collusion, withdrawal, and personalization of conflicts.
Controlling Family	Strong need for control over care processes; heightened attention to therapies and communication; closed attitude; limited listening; resistance to change; extension of control to the team's work.	The team may experience a sense of failure due to lack of trust and anger related to perceived exclusion. **Risks:** poor team alignment, ineffective communication, relational symmetry, excessive pragmatism without relational sensitivity, and technicism (increase in interventions).
Silent / Closed Family	Limited or absent communication within the family system; difficulty in expressing needs and emotions.	The team may encounter relational blocks, including lack of collaboration and communication difficulties. Frustration may arise due to the gap between expected care processes and actual interactional constraints. **Risks:** intra-team conflict, emotional distancing, or excessive involvement.
Disqualifying Family	Devaluation within the family system; distrust toward healthcare professionals; devaluation of care and services provided.	The team may experience mortification related to their professional role and anger linked to perceived loss of role. **Risks:** performance anxiety, increased interventions without adequate needs assessment, relational symmetry, and difficulty maintaining appropriate professional involvement.


Thank
You