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RESEARCH ARTICLE (ORIGINAL)

Family Meetings in Palliative Care: An Interactive and Intersubjective Space

A Conferência Familiar em Cuidados Paliativos: Um Espaço Interativo e Intersubjetivo

La Reunión Familiar en Cuidados Paliativos: Un Espacio Interactivo e Intersubjetivo

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Abstract
Background: Palliative care is essential for addressing the needs of the person in a palliative situation and their family. In this context, family meetings emerge as a structured communication strategy that facilitates problem-solving.
Objective: To understand the experiences of healthcare professionals in their interactions during family meetings in palliative care and to develop a decision-support tool.
Methodology: Strauss and Corbin's grounded theory. 34 interviews were carried out, 24 with healthcare professionals and 10 with family members. Four experts were consulted. Data were analyzed following the Strauss and Corbin coding procedure.
Results: The interaction process in palliative care provides the context for and influences family meetings. These unfold in three interconnected stages: preparation, meeting, and post-meeting. Their interrelation highlights the importance of standardization.
Conclusion: Family meetings in palliative care are part of the interaction between professionals, the palliative patient, and their family. This process is structured into interdependent stages. The tool proposed supports decision-making and promotes standardized practice.

Keywords: palliative care; family; nursing; interpersonal relations; communication; grounded theory

Resumo
Enquadramento: Os cuidados paliativos são fundamentais para responder às necessidades da pessoa em situação paliativa e da família. A conferência familiar emerge como uma estratégia de comunicação estruturada e facilitadora da resolução de problemas.
Objetivo: Compreender as experiências dos profissionais de saúde na interação com os intervenientes na conferência familiar em cuidados paliativos e construir um instrumento de apoio à decisão.
Metodologia: Perspetiva straussiana da *Grounded Theory*. Foram realizadas 34 entrevistas, 24 a profissionais de saúde e 10 a familiares. Foram consultados 4 peritos. Análise da informação através do procedimento de codificação de Strauss e Corbin.
Resultados: O processo de interação em cuidados paliativos serve de contexto às conferências familiares, influenciando-as. Estas desenvolvem-se em três etapas: pré-conferência familiar, conferência familiar e pós-conferência familiar, que se relacionam e se influenciam, sendo essencial a sua uniformização.
Conclusão: A conferência familiar em cuidados paliativos integra-se no processo de interação entre profissionais, pessoa em situação paliativa e família, estruturando-se em etapas interdependentes. O instrumento proposto visa apoiar a decisão e promover a uniformização da prática.

Palavras-chave: cuidados paliativos; família; enfermagem; relações interpessoais; comunicação; teoria fundamentada

Resumen
Marco contextual: Los cuidados paliativos son fundamentales para satisfacer las necesidades de la persona en situación paliativa y de su familia, y la reunión familiar se perfila como una estrategia de comunicación estructurada que facilita la resolución de problemas.
Objetivo: Comprender las experiencias de los profesionales sanitarios en su interacción con los participantes en la reunión familiar sobre cuidados paliativos y elaborar una herramienta de apoyo a la toma de decisiones.
Metodología: Perspectiva straussiana de la teoría fundamentada. Se realizaron 34 entrevistas, 24 a profesionales sanitarios y 10 a familiares. Se consultó a 4 expertos. Análisis de la información mediante el procedimiento de codificación de Strauss y Corbin.
Resultados: El proceso de interacción en los cuidados paliativos sirve de contexto para las reuniones familiares y ejerce influencia en ellas. Estas se desarrollan en tres etapas: la fase preparatoria, el desarrollo y el periodo posterior a la reunión familiar, que están relacionadas entre sí y se influyen mutuamente, por lo que es fundamental que se uniformicen.
Conclusión: La reunión familiar en cuidados paliativos forma parte del proceso de interacción entre los profesionales, la persona en situación de cuidados paliativos y la familia, y se estructura en etapas interdependientes. El instrumento propuesto tiene como objetivo facilitar la toma de decisiones y promover la uniformidad en la práctica.

Palabras clave: cuidados paliativos; familia; enfermería; relaciones interpersonales; comunicación; teoría fundamentada

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Introduction

When an individual experiences an incurable and/or serious illness, their family members face a range of multidimensional challenges that require healthcare professionals to provide person- and family-centred care tailored to patients' needs (Radbruch et al., 2020). In this context, family meetings (FM) are a valuable, distinctive, and problem-solving communication strategy that significantly improves the quality of palliative care (PC; Cahill et al., 2021; Forbat et al., 2018; Hudson et al., 2021). However, despite the recognised importance of FM in PC, there remains limited systematic evidence on their implementation, and substantial research gaps persist in this area (Cahill et al., 2021; Glajchen et al., 2022). Accordingly, this study aimed to understand healthcare professionals' experiences of interacting with participants during FM in PC and to develop a decision-support instrument.

Background

In Portugal, the rise in life expectancy alongside the rapid increase in chronic and degenerative diseases has created significant challenges for healthcare services (Arias-Casais et al., 2019). In this context, PC is an essential approach to delivering comprehensive, respectful, and compassionate care aimed at improving quality of life and reducing suffering (Arias-Casais et al., 2019; Radbruch et al., 2020). This care model emphasizes the importance of communication and interaction between the patient–family unit and healthcare professionals are regarded as central to care, with the FM assuming particular importance as a structured communication method, distinguished by careful planning and a multidisciplinary approach compared to other clinical interactions (Cahill et al., 2021; Hudson et al., 2009; Hudson et al., 2021). The strong connection among participants in an FM highlights the concept of intersubjectivity—where shared meanings are built through interaction among individuals (Di Paolo & De Jaegher, 2015). Hence, exploring how interactions occur during an FM is considered highly important.

Research question

What are healthcare professionals' experiences of interacting with participants in FM in PC?

Methodology

A qualitative study was conducted using Grounded Theory (GT) following the Straussian approach (Corbin & Strauss, 2015). The study was carried out in three PC units in northern Portugal—one inpatient PC unit and two hospital-based palliative care support teams—with data collected from January 2020 to July 2022.

Theoretical sampling guided participant selection in line with the principles proposed by Corbin and Strauss (2015). Participants were recruited from three PC settings: an inpatient PC unit, a hospital-based PC support team, and a community-based PC support team. Healthcare professionals were eligible if they worked in one of these PC services and had completed basic and/or advanced PC training. Family members were eligible if they were relatives of patients receiving care from the participating healthcare professionals and had attended an FM. Healthcare professionals without PC training and family members who had not participated in an FM were excluded. The study included 24 healthcare professionals (14 nurses, five physicians, three psychologists, and two social workers), comprising 14 women and 10 men. Fourteen participants had basic PC training, and 10 had advanced training (a postgraduate degree, a master's degree, or a certification in palliative medicine). In addition, 10 family members participated in the study, including seven women and three men.

Data were gathered via individual semi-structured interviews and a questionnaire completed by expert consultants. All interviews took place in a single session with the lead researcher, who had no prior ties to the institutions involved and was experienced in qualitative research. These sessions were audio-recorded, transcribed verbatim, anonymized, labeled with identification codes (ULSP, ME, HP, EP, and WCE), and lasted about 45 minutes on average. Six preliminary exploratory interviews were carried out—four with healthcare professionals and two with family members. During the selective coding phase, four recognized experts in PC—with advanced training and at least 10 years of clinical or teaching experience—were consulted via a questionnaire to strengthen the systematic analysis. The validity of the interview script and questionnaire was confirmed through a literature review, expert feedback, and a pilot study. Although the primary focus was on healthcare professionals' experiences, including family members and experts was justified in the empirical phase to triangulate diverse perspectives.

Data analysis adhered to the open, axial, and selective coding procedures outlined by Corbin and Strauss (2015), employing the paradigm model to organize data and the constant comparative method throughout the analysis. Interviews were conducted by researchers with backgrounds in nursing, clinical, and research experience in PC, especially in qualitative research. Two coders trained in Grounded Theory independently performed the data analysis, with a third experienced qualitative researcher involved in peer debriefing. Member checking was conducted to enhance the credibility and internal consistency of the emerging theory. Data collection continued until theoretical saturation was reached, after 22 interviews with healthcare professionals and eight with family members. Four additional confirmatory interviews were later carried out. NVivo 12 software supported data management and ensured analytical rigor.

The study was approved by two Research Ethics Committees (approval numbers 01/CE/JAS and 03/20/RS). All participants gave written informed consent. Data were stored and handled following the General Data Protection Regulation (Comissão Nacional de Proteção

de Dados, 2018). Data were retained on secure digital systems with limited access to the research team and will be archived for four years after the study ends. Participant confidentiality and anonymity were maintained by coding interviews and removing all identifiable details.

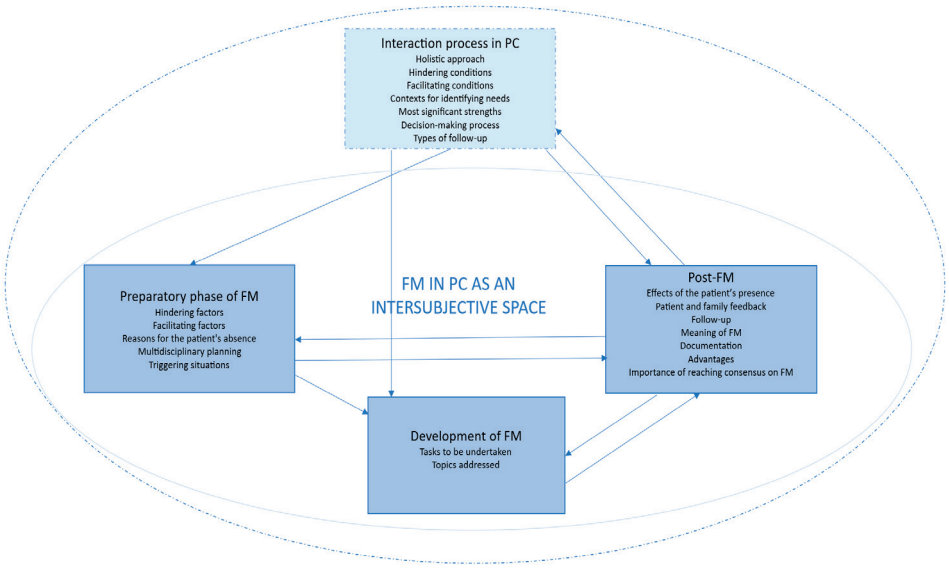
This article was reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ; Tong et al., 2007) guideline.

Results

The emerging substantive theory describes how healthcare professionals interact during FM in PC. The core category identified is: Family meetings in palliative care as an intersubjective space within the interactive process of supporting patients and their families. The main structural components of the theory are shown in Figure 1.

Figure 1

Structural components of the substantive theory



Note. PC = Palliative Care; FM = Family Meeting.

Interaction process in palliative care

The interaction process in PC constitutes a contextual condition that influences the entire FM and serves as the foundation for all of its stages.

Whether it's a scheduled outpatient consultation, consultation service, inpatient treatment, phone call, or home visit, collaboration among healthcare professionals, the palliative care patient, and their family is essential, calling for a holistic and fair approach: "A holistic approach to both the patient and the family throughout the illness trajectory and end-of-life process is imperative" (ULSP2). In this process, both facilitating and hindering factors were identified. Major barriers included unrealistic expectations—such as "When there is persistent denial of the progression of the clinical condition, it becomes one of the most challenging and complex situations" (ME2)—misinformation, family conflicts or conflicts with the healthcare team—"It is difficult to break the silence when family conflicts exist" (HP6)—and situations of conspiracy of silence—"They do not want it to be known, yet both sides are aware of what is happening and create a barrier that prevents them from sharing" (ULSP4). Discussing sensitive topics like death can also impede interactions. On the other hand, communication and interpersonal skills of healthcare professionals, along with their sensitivity and availability—"What people appreciate most is our availability" (HP3)—help facilitate interactions. Additionally, multidisciplinary teamwork and case management approaches have been identified as key enablers in this process.

The evaluation of the needs of the patient–family care dyad is conducted throughout this interactive process, forming the basis for the FM's preparatory phase. Decision-making occurs during this process and can be either patient-centered or shared: "It is the patient together with the family who make the decisions… we are there to support them" (EP2). Overall, the interaction process in PC shows significant potential, including addressing the conspiracy of silence, empowering patients and families, and enhancing family members' sense of security across the illness course.

Preparatory phase

The preparatory phase of FM acts as a critical prerequisite for the meeting and is influenced by earlier interactions. Participants highlighted several situations where FM is highly advised: disease progression, family conflicts, secrecy, patient requests, young patients and families, un-

realistic expectations from patients or families, discharge planning, and situations requiring complex decisions.
Multidisciplinary planning was viewed as crucial and definitive: "The FM must be meticulously prepared, as it is not a routine or informal intervention" (ME1). This process involves scheduling the FM, selecting a facilitator, identifying participants, determining discussion topics, setting meeting goals, ensuring a suitable physical setting, and securing informed consent from the patient and family members.
During the preparatory phase, both enabling and obstructive factors were identified. Facilitators encompassed prior knowledge of the patient and family—such as "It is extremely important for us to know the family and the patient so that we can address their needs and plan our meeting accordingly" (HP1)—professional education, highlighted by "Communication training for professionals caring for patients with advanced illness is extremely important..." (ME2)—and practical training. Barriers reported included the unpredictable nature of the FM—"I feel somewhat anxious because we never know how the family will respond" (HP5)—the limited availability of participants—"One of the factors that hinders Family meetings is the difficulty of coordinating the schedules of all participants" (ME2)—and the challenges posed by involving younger patients and family members—"Meetings involving younger patients and their families are more challenging" (ULSP2).
The patient's attendance during the FM varied. Missing the meeting could be due to a decision made collaboratively by the healthcare team and family, the patient's personal choice, or the patient's inability to participate, whether physical or cognitive.

The course of the FM

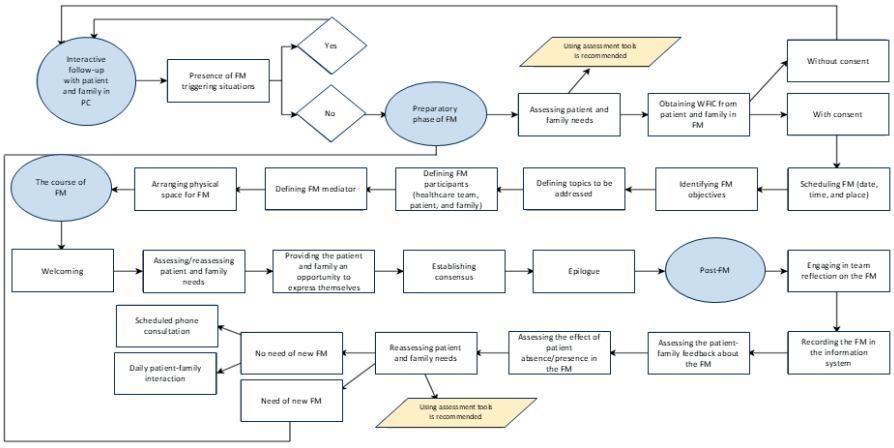
The course of the FM represents the action–interaction phase, during which healthcare professionals carry out five key tasks: welcoming participants, assessing and reassessing needs, providing opportunities for participation, building consensus, and concluding the meeting.
The initial task involves greeting family members, engaging in social introductions, ensuring participants are comfortable, and clarifying the meeting's purpose: "We meet the family, take them to the meeting room, introduce ourselves, make everyone comfortable, and explain the meeting's objectives" (ULSP3).
Although needs assessment starts during the ongoing interaction and preparatory phases, it is crucial to continuously evaluate and reassess during the FM to identify any changes or new needs. Equally important is giving patients and family members the chance to voice their concerns and participate actively in the conference: "People are given the opportunity to speak, to talk, and to engage in meaningful communication" (ULSP2).
Another important task is achieving consensus among participants. The final phase signifies the end of the FM and sets the stage for follow-up. In this stage, healthcare professionals summarize the discussion, review the agreements and decisions, establish timelines for future actions when needed, and reaffirm their support. After the patient and family depart, the healthcare team reflects collectively on the meeting.
These five tasks are performed primarily around three main topics: social support, discharge planning, and the patient's clinical condition.

Post-family meeting

The post–FM phase captures the consequences of the meeting, shaping subsequent interactions and the preparation for future FM. Within this component of the theory, the effects of the patient's presence during the FM emerged. The participation of the patient receiving PC may heighten their emotional distress and inhibit open communication and emotional expression among healthcare professionals and family members: "It ultimately becomes an unproductive conference because family members do not express what they are really thinking" (ULSP4). Conversely, the patient's presence in the FM promotes their inclusion in the care process.
Overall, feedback from the patient–family care dyad on participation in an FM was marked by satisfaction and gratitude: "They are very grateful for having had a formal opportunity, with privacy and tranquility, to discuss their concerns and difficulties" (HP5).
Follow-up also emerged as an essential component of this phase and may be carried out through scheduled or unscheduled telephone consultations—"We agree on a follow-up phone call, or they contact us if they need anything" (HP5)—by scheduling a subsequent FM, or through routine day-to-day interactions: "Over the following days, I ask them about the impact of the FM and whether all their questions have been answered" (WCE5).
The meaning attributed to the FM was constructed by participants after its completion, who described it as a structured, multidisciplinary, and interactive family-centered space. However, documentation of the FM was found to be poorly standardized, both in paper records and electronic health information systems.
Participants identified numerous benefits of the FM for healthcare professionals, patients, and families, including support for decision-making, improved information sharing, facilitation of emotional expression, management of expectations, enhanced mutual understanding between healthcare professionals and family members, improved continuity of care, strengthening of the therapeutic relationship, facilitation of adaptation to illness, increased security for the patient–family care dyad, more effective responses to identified needs, and greater professional satisfaction.
Finally, the need to standardize FM implementation arose from the lack of clear criteria for selecting families, absence of formal guidelines, and inconsistent documentation practices: "We do not actually select the families" (HP1); "There is planning, but it is not formalized..." (ULSP6). To fill these gaps, a decision-support tool (Figure 2) was created based on the study's findings and existing scientific evidence.

Figure 2

Deci sion-support tool



Note. PC = Palliative Care; FM = Family Meeting; WFIC = Written Free Informed Consent.

Discussion

The middle-range theory developed in this study explains the interaction process established in PC and how this process both influences and is influenced by FM, conceptualized as an intersubjective space that evolves across three interconnected phases. Intersubjectivity is central to the theory, as each participant communicates and interacts with others by moving beyond their own subjective perspective to understand and engage with the other, thereby co-constructing an intersubjective space (Di Paolo & De Jaegher, 2015).

Interaction process in FM

Interactions among healthcare professionals, palliative patients, and their families form the basis for numerous interventions, including FM. In this context, fostering relationships grounded in trust, safety, and mutual understanding is fundamental to delivering high-quality PC. Given the multidimensional nature of the suffering experienced by patients and their families, care must be directed toward the patient–family care dyad from a holistic perspective (Payne et al., 2022).

In this interactive context, the needs of each member of the care dyad are identified, enabling healthcare professionals to recognize situations that warrant an FM and to gather relevant information for its planning. This assessment is essential for interventions aimed at alleviating suffering, as only identified needs can be effectively addressed.

The findings suggest that decision-making should be shared among all participants to facilitate consensus-building and support the deliberative process. Such deliberation is fundamental and requires critical and analytical reflection to ensure that decisions take into account both the physiological and ethical issues involved in the provision of care (Gracia, 2011).

Finally, although the interaction process in PC is shaped by both facilitating and hindering factors, it has considerable potential to address the conspiracy of silence, empower palliative patients and their families, and enhance the perceived sense of security within the patient–family care dyad.

Preparatory phase

The emerging theory indicates that FM should not be applied indiscriminately across all family systems but should instead be guided by clearly defined triggering situations, in line with current evidence (Cahill et al., 2021; Cunha et al., 2024; Hudson et al., 2021). The absence of rigorous selection criteria may compromise both the planning and the outcomes of FM.

Among the aspects most strongly emphasized by participants was the importance of multidisciplinary planning. An FM is a structured meeting with a predefined agenda agreed in advance to optimize interaction among participants (Glajchen et al., 2022; Vendetta et al., 2023). Current evidence further highlights that patient-centered planning —rather than healthcare professional—centered planning, as is often the case—maximizes the benefits of the FM by giving palliative patients and their family members a genuine opportunity to be heard (Cahill et al., 2021; Sanderson et al., 2017).

Although the assessment of the needs of the patient and family system is a fundamental component of FM planning, in this theory it is conceptualized within the broader interaction process in PC, reflecting its dynamic and ongoing nature. Although not explicitly mentioned by participants, the use of standardized assessment instruments before and after the FM appears highly relevant and is supported by the literature (Fukui et al., 2013).

The implementation of FM is influenced by multiple factors, with participants' limited availability emerging as the principal challenge. It is therefore essential to demonstrate the true value of this communication strategy to justify allocating additional resources and to enable its routine implementation in clinical practice (Feiteira & Cerqueira, 2018).

The course of the FM

The emerging theory identifies five key tasks to be undertaken during FM: welcoming participants, assessing and reassessing needs, providing opportunities for participation, building consensus, and concluding the meeting. Scientific evidence reinforces the importance of ensuring a comfortable environment for all participants, clearly defining participants' roles, establishing ground rules for communication, and clarifying the FM's objectives. It is essential to provide family members with opportunities to express themselves, thereby enabling the assessment of their needs, concerns, and fears. Active listening, an empathic attitude, and the free expression of emotions are fundamental prerequisites for effective FM (Cahill et al., 2021; Vendetta et al., 2023).

The findings also highlight the importance of conducting a team debriefing after the FM as the starting point for follow-up. Team reflection is crucial for evaluating the intervention's impact, planning continuity of care, and providing healthcare professionals with an opportunity to process and express their emotions (Vendetta et al., 2023). The topics addressed during the FM primarily focus on social support, discharge planning, and the patient's clinical condition, consistent with the existing evidence (Durepos et al., 2018; Glajchen et al., 2022).

Post-FM

Our findings indicate that the presence of the palliative patient during FM has ambivalent effects. While it may intensify the patient's distress and inhibit communication and emotional expression among participants, it also promotes the patient's inclusion in the care process, consistent with previous evidence (Cahill et al., 2021). Palliative patients and their family members reported high levels of satisfaction and gratitude for the experience, recognizing the benefits of FM. These findings are supported by three previous studies (Forbat et al., 2018; Hudson et al., 2009; Sanderson et al., 2017). Collectively, the wide range of benefits identified reinforces the need to further investigate the impact of FM in PC (Vendetta et al., 2023).

The findings also showed that FM follow-up may occur through scheduled telephone consultations, subsequent FM, or routine day-to-day interactions. Follow-up is a key component for evaluating participants' feedback, assessing the extent to which identified needs have been addressed, and identifying any new needs that may have emerged (Widera et al., 2020). Participants described FM as a structured, multidisciplinary, and interactive family-centered space. Its structured planning and multidisciplinary nature were consistently identified as major strengths, in line with previous research (Cahill et al., 2021; Cunha et al., 2024; Glajchen et al., 2022; Hudson et al., 2021). The richness of the information generated during FM highlights the need for standardized documentation. Establishing a minimum dataset to be systematically recorded in health information systems is essential to enable the extraction of consistent indicators for this communication strategy. The decision-support tool developed in the present study may provide a foundation for such standardization.

The absence of clear criteria for selecting families to participate in FM was also identified and may lead to inefficient use of resources. Therefore, it is important to establish well-defined indications for FM, and further research is needed to develop standardized selection procedures (Hudson et al., 2021). In this process, nurses play a pivotal role because their continuous proximity to the patient–family care dyad places them in an optimal position to identify unmet needs and situations that warrant FM.

Although clinical guidelines facilitate the implementation of FM, their use in practice remains limited (Cunha et al., 2024; Durepos et al., 2018). This study therefore developed a decision-support tool to standardize the implementation of FM and improve its use in clinical practice. The findings also underscore the need for structured training programs to enable multidisciplinary teams to implement FM consistently and systematically. Finally, previous studies have primarily focused on the actions performed during FM, placing less emphasis on understanding participants' experiences and the meanings they ascribe to them. The present study was fundamental to interpreting these experiences and meanings and provides a valuable foundation for future research.

The transferability of the findings is constrained by the geographical concentration of the sample and the data collection period. These limitations underscore the need for future studies to validate the decision-support tool developed in this study and to explore the implementation of FM across other PC settings.

Conclusion

This study offers a thorough understanding of FM in PC as an intersubjective space within the interactive process of supporting palliative patients and their families. The results highlight that FM should be viewed as an integrated process that includes its planning stage, the meeting itself, and the follow-up, all shaped by and influenced by the ongoing interaction fundamental to PC. Additionally, the study led to the creation of a decision-support tool aimed at making FM implementation more practical and consistent. We recommend that PC teams adopt this tool and integrate it into electronic health records to ensure a uniform and systematic approach to FM.

Author contributions

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Validation: Feiteira, B. M., Amorim, M. M.
Visualization: Feiteira, B. M., Amorim, M. M.
Writing – original draft: Feiteira, B. M.
Writing – review & editing: Feiteira, B. M., Amorim, M. M.

Thesis/Dissertation

This article is derived from the master's dissertation entitled *Healthcare Professionals' Interactions During Family meetings in Palliative Care*, submitted to the Portuguese Catholic University in 2024.

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