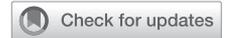


**Special Article**

# Teamwork When Conducting Family Meetings: Concepts, Terminology, and the Importance of Team-Team Practices



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**Abstract**

*Family meetings, which bring together members of a seriously ill patient's family and the interprofessional team (IPT), have been widely recognized as promoting shared decision-making for hospitalized patients, particularly those in intensive care units. The planning and conducting of interprofessional family meetings are hampered, however, by a lack of clarity about who is doing what and when, which in turn can lead to inefficiencies and uncoordinated efforts. This article describes how members of the IPT interact with one another (what we have termed team-team practices), distinguishing these interactions from how the IPT engages directly with family members (team-family practices) in preparing for and conducting family meetings. Although most research and guidelines have focused on team-family practices that directly affect patient- and family-level outcomes (e.g., safety and satisfaction), team-team practices are needed to coordinate team contributions and optimize the skills of the diverse team. Team members' knowledge and attitudes also contribute to patient and family outcomes as well as team outcomes. Yet without attention to team-team practices before, during, and after a family meeting, the family-level outcomes are less likely to be achieved as are team well-being outcomes (e.g., reduced burnout and staff retention). Drawing upon team theory, we present a set of key concepts and corresponding terms that enable a more precise description of team-team practices and team-family practices, aiming to help with team training and evaluation and to enable future research of these distinct yet inter-related practices. J Pain Symptom Manage 2019;58:336–343. © 2019 American Academy of Hospice and Palliative Medicine. Published by Elsevier Inc. All rights reserved.*

**Key Words**

*Interprofessional team, teamwork, intensive care unit, pediatric*

Family meetings, which bring together members of a seriously ill patient's family with an interprofessional team (IPT) consisting of doctors, nurses, social workers, chaplains, and other clinicians, have been widely recommended to promote shared decision-making for hospitalized pediatric patients,<sup>1,2</sup> as well as adult patients,<sup>3–5</sup> especially in the intensive care unit (ICU),<sup>6–8</sup> and to ensure that treatment plans match patient and family values and expectations.<sup>7–9</sup> Such recommendations are sensible given what is known based on studies of how IPTs perform a variety of patient care tasks, with successful teams performing

complex tasks more safely and creatively than individuals and making fewer mistakes, particularly when team members are attuned to each other's responsibilities.<sup>10</sup> The medical safety literature suggests that delineating IPT tasks and individual members' roles promotes safer and more highly reliable care.<sup>11,12</sup> When confronted with challenges, highly functioning teams arrive at solutions that are more adaptable and comprehensive in achieving patients' desired goals than those of an individual.

The planning and conduct of interprofessional family meetings are hampered, however, by a lack

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of clarity about who is doing what and when, which in turn can lead to inefficiencies and the inharmonious coordination of efforts. These deficits exist not only for specific **team-family practices** (which is to say, the ways in which the IPT engages directly with family members) but also for overlooked **team-team practices** (the ways in which members of the IPT interact with each other). Members of IPTs perform these two sets of practices not just during a family meeting but also before and after a family meeting (see Fig. 1, which provides an overview). Because the quality of team-family practices are highly dependent on the quality of the team-team practices and these team-team practices are largely uncharted, efforts to optimize family meetings and to enable IPTs to perform tasks in a highly reliable way are compromised.<sup>6</sup>

This article addresses these conceptual deficiencies. Drawing on both the pediatric and the adult patient literature and team theory,<sup>10–13</sup> we present a set of key concepts and terms that enable a more precise description of team-family practices and team-team practices. We believe that this will help in two ways. First, clear behavioral descriptions of these two sets of inter-related but distinguishable team practices will be useful for team training and evaluation. Second, this effort will help to identify the practices that high-functioning teams need to perform enabling future research to study these practices and their impact on patient and family outcomes.

We begin by briefly describing team-family practices. We will then turn to a detailed description of team-team practices. We will end by considering the connections between team-family practices, team-team practices, and family and team outcomes.

## Team-Family Practices

Family meetings aim to promote certain patient and family outcomes, such as family understanding of the patient's diagnosis, prognosis, and treatment options, psychological support and satisfaction with decision-making regarding their loved one's care, and the achievement of goal concordant care.

To achieve these specific patient- or family-level outcomes, IPT engage in or perform specific **team-family practices** (Fig. 1, top middle box).

Team-family practices encompass processes of care and skillful conduct of these processes. For example, having a family meeting within 72 hours of ICU admission is an example of a team-family practice that has been recommended to improve parental satisfaction with communication.<sup>8</sup> This team-family practice affords the timely opportunity to engage all stakeholders in decision-making and allow for information and value sharing to occur. Family support interventions in the ICU demonstrating improvement in family ratings of quality of communication with the medical team rely on research nurses arranging regular family meetings.<sup>14</sup> As another example, considerable research has clarified the team-family practices and skills required to conduct a successful family meeting, such as introducing all members of the meeting, setting an agenda for the discussion, learning what the family understands of the patient's condition, discussing the patient's prognosis with the family, acknowledging strong emotions from the family, assessing the family's values, and making a recommendation for future treatment, if appropriate.<sup>15</sup>

What remains unclear is who on the team should do what, when, and how. Our underlying message is that, in clinical practice, these questions get worked out, for

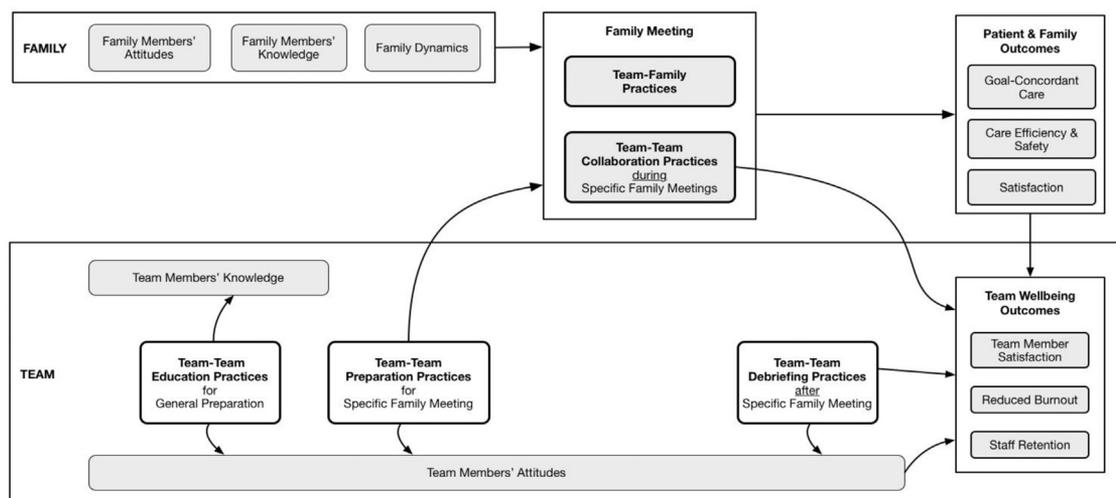


Fig. 1. How team-family practices mediate team and family outcomes.

Table 1  
Team-Team Knowledge and Attitudes for Conducting Family Meetings

Concept	Behavior	Example From ICU
Knowledge of team members		
Knowledge of one's own discipline and associated skills	Capable of contributing meaningfully to care plan with discipline expertise	Heart transplant doctor clarifies for rest of the team whether patient meets transplantation criteria
Knowledge of other professionals' roles and associated skills	Leader is aware of other's expertise and coordinates who should participate in a family meeting based on that complementary expertise	Attending physician requests presence of the certified wound and ostomy nurse to review treatment plan for complex dressing.
Content knowledge about team practices and when to perform practices	Team member takes knowledge given in team orientation of team practices and applies correctly in situations	Team member recognizes that when a family meeting is being scheduled and that a premeeting also needs to be planned
Knowledge of team norms	Explicit discussion of team norms of behavior	Examples are provided in new team orientation of behaviors that are outside the teams' norms.
Knowledge of family meeting-specific roles	Leader ensures that all essential family meeting roles are filled (e.g., information giver and emotional support person)	Attending physician caring for the patient requests the presence of the clinical psychologist who is working with the family to build coping skills.
Team attitudes		
Morale	Being willing to enthusiastically participate in team-focused practices (such as premeetings before a family meeting) despite challenges of scheduling or coming to consensus	Primary nurse creates a standing IPT meeting for long-stay patients and most clinicians attend the meeting to contribute to care plan development although it is not mandatory.
Mutual trust	Teammate accepts questions made about their decisions or recommendations without becoming defensive both in team meetings and in meetings with families	Team allows for contradictory info or devil's advocate positions to be raised and considered.
Commitment to developing a shared mental model	Team members describe their understanding of the goal for the patient or care plan and check colleague's understanding and agreement with plan	Describe the anticipated trajectory of the patient's illness and discuss family needs to ensure all medical and psychosocial information is shared.

ICU = intensive care unit; IPT = interprofessional team.

better or worse, by the team themselves as they engage in team-team practices.

### Team-Team Practices

For teams to reliably perform the complicated tasks of preparing for and conducting a family meeting, **team-team practices** need to coordinate team contributions and optimize the diverse team members' skills. This is complicated by the revolving nature of clinicians who have limited experience working together. The team-team practices allow for a series of checks and balances to ensure that the full capabilities of the team are mobilized in a family meeting and new team members know their role to play even if they have not worked with other team members previously.

Importantly, patient- and family-level outcomes (Fig. 1, top right section) may be significantly enhanced by attending to these team-team practices, which build and sustain high levels of desirable team knowledge and attitudes (Table 1) and promote effective team functioning. For example, conducting family meetings without coordinating team effort before and

during the meeting may not be sufficient to achieve the desired outcomes. Studies of family meetings in the ICU that occur without adequate preparation have revealed that physicians speak the vast majority of the time, with very limited sharing of information from families, resulting in lower patient and family satisfaction scores.<sup>16</sup> Unprepared clinicians also frequently ignore family emotional cues and miss opportunities to address families' emotional needs.<sup>17</sup> When interprofessional team members are present, they may not speak because of uncertainty of what their role is in the meeting.<sup>18</sup>

Attention to team-team practices can also enhance patient- and family-level outcomes by enhancing family-centered rounds, which have been recommended for all pediatric hospitalized patients<sup>19</sup> and endorsed by critical care professional groups.<sup>20</sup> In these rounds, parents are present while the team discusses daily updates about the patient and makes the plan of care for the day. Clinical care teams that have used the team-team practice technique of checklists to prompt use of recommended elements of family-centered rounds have increased both the inclusion of the recommended elements and improved

*Table 2*  
**Team-Team Practices and Specific Examples of Behaviors and Language for Conducting Family Meetings**

Concept	Behavior	Example From ICU Including Example Language Where Appropriate
Continuous team-team practices		
Team education	Institutionalized orientation to the team and education about its practices and the roles of team members	Training new providers about the different roles that need to be filled during a family meeting
Mutual performance monitoring	Identify mistakes and lapses in other team member's actions and providing feedback regarding team member actions to facilitate self-correction	Facilitator in family meeting reviews team member's contributions decided in the premeeting to prompt them if the contribution has not already occurred. "Nurse Curley, when we talked before the meeting, you said you had an important conversation about what was worrying the family you wanted to raise with the physicians."
Before the family meeting		
Team preparation for family meetings with preparatory meeting	Organize and conduct premeetings	30 minutes are scheduled before the family meeting to allow for team meeting. "Can we please schedule an extra 15-30 minutes to have the team get on the same page before meeting with the family?"
Clear communication of team's objectives	Describing the goal for team's task at hand or more generally the goal of the clinical practice	Agenda for the family meeting is discussed during the premeeting allowing clinical team to reach consensus on team's main objectives for the meeting "I think the primary agenda item for this conversation is to share the worsening prognosis with the family. Does anyone else have other agenda items for the meeting today?"
Facilitation of team problem-solving/team orientation	Engagement of members of the team with different opinions about why they are supporting a position and how those positions could be incorporated into a care plan or discussion with the family and identify relevant information missing to portions of team	Elicit from team members any disagreement about treatment options or perception of what the families' goals are. "The family shared with me that they could not imagine their child indefinitely connected to a ventilator. Has anyone heard something different from the family?" Then, discuss information that may not have been shared across team members to facilitate clear presentation of options and anticipation of family's questions and concerns about potential treatment options. "I spoke with the family about how they worried that they would be giving up on their child if they didn't try every technology we recommended."
Clarification of team member roles and reporting	Clarify which team member will perform different roles in family meeting	Premeeting with designation of who will be leading/facilitating the meeting, who will be providing medical information, who will be taking notes, and who will provide emotional support to the family. "Social worker, can you facilitate the meeting so that the physician can focus on providing clear medical information. Nurse, will you keep notes on what plans we make, and chaplain, can you make sure that you pause the conversation if we are missing some emotional cues from the family that they are overwhelmed."
During the family meeting		
Synchronization of individual team member contributions	Team members with similar objectives discuss which aspects of the objective will be done by their role and how they will support each other's roles	Discussion in premeeting how physicians (from different specialties), nurses, and social workers can communicate the same message using similar language. "It seems we are

*(Continued)*

Table 2  
Continued

Concept	Behavior	Example From ICU Including Example Language Where Appropriate
Engagement of full complement of talents, skills, and knowledge of all members of the team to achieve outcomes After the family meeting Assess team performance and make adjustments	Highlighting for the team the potential unique contributions of different roles on the team (social worker, nurse leadership, case manager, etc.)  Engage in feedback sessions with team to recalibrate behavior and offer coaching to expand individual's skill set or take advantage of other team members' contributions	in agreement that we are worried that the patient may never be able to leave the CICU. It is helpful if we answer the family's questions about prognosis in a similar way." In family meeting, allowing contributions discussed in team meeting to be performed by different team members.  Postmeeting discussion to identify if objectives met and how to recalibrate for further discussions. "Our agenda was to convey the new prognosis and support the family in hearing the news. I think the information was conveyed clearly because the family demonstrated an emotional response afterward. Social worker, you offered some very helpful respect statements when the family got upset in that were essential to helping them cope."
Reinforce behavioral norms described in team education	Leader will coach team members who behave outside behavioral norms	When attending physician is disrespectful, medical director will engage and reassert behavioral norms.

ICU = intensive care unit; IPT = interprofessional team.

families' perception of team communication with the clinical care team, and increased family perception of safety in care.<sup>21</sup>

### Specific Team-Team Practices

The team-team practices (Table 2) described in this article are a compilation of the practices described in team theory, adapted to the development of care plans with families in the context of family meetings.<sup>11</sup>

### Acquiring Knowledge

Team member knowledge is acquired both through formal education practices and through experience gained while participating in family meetings. Individual members of the IPT bring to the team *knowledge of their discipline and their discipline-specific skills* (Table 1). A team member's skills may include specific communication skill training or technical expertise in a particular medical disease process. Team members will also acquire *knowledge of other team members' professional roles* (physician, nurse, social worker, etc.) and at least a basic understanding of the *skill set that this role requires* through formal on-boarding and during interprofessional teamwork.

Good team-team practices begin with *education* about each team member's role when performing the team-team practices (Table 2). Each team member

has acquired a set of skills in their professional training and previous experience that they will utilize in their role on the team. For example, physicians diagnose and create plans for treatment, nurses typically manage both medical and nursing treatments, social workers can assess coping and resource needs of patients, and all communicate with patients and families about their informational and emotional needs. Clinicians new to a team need to learn about the full range of skills that each discipline brings to the team. New clinicians also need to learn how their skills can be used when performing the team-team practices and how to coordinate their actions with those of other team members.

Team members will also develop *content knowledge about the team's practices and when to apply the practices*. After being oriented to the team's practices, team members should activate those practices in appropriate clinical situations. One example would be coordinating a premeeting whenever a family meeting is being scheduled.

Leaders should ensure that team members have *knowledge about the team norms and behavioral boundaries*. These norms may be developed by the group and revisited when new members join the team. These behavioral norms help ensure the psychological safety necessary for a team to perform well,<sup>22</sup> and the team leader bears the responsibility of holding people accountable to these norms once delineated. Finally, team members will acquire *knowledge of family*

*meeting-specific roles* to conduct a successful family meeting and gain an appreciation for which roles match their skill set.

### *Fostering Attitudes and Mutual Support*

Three team member attitudes that improve team functioning include morale, shared mutual trust, and commitment to developing a shared mental model (Table 1). To a greater degree than team-team knowledge, these attitudes of members of IPTs are highly dependent on the full gamut of team-team practices, which in their entirety build, calibrate, and reinforce these attitudes.

Team *morale* is an attitudinal resource that promotes the willingness of team members to navigate challenges in care that require significant effort and concentration. When morale is low, teams often lack the fortitude to continue to identify creative solutions to problems that arise. A team with high morale will be more willing to take on burdensome tasks such as coordinating time for a premeeting to ensure that all team members are on the same page.

A second team attitude is *shared mutual trust*,<sup>10,11</sup> which supports team members in accepting feedback from others on the team and acknowledging opportunities for improvement. A team that is mutually trusting will allow members to avoid becoming defensive and to shift behavior when prompted by a teammate to consider adjustments in thinking. For example, if one team member is providing information to a family during a meeting and another team member worries that the family is not following the information, the nonspeaking team member can respectfully interrupt the information giver to pose a clarification question. When there is mutual trust between team members, the information giver will take this cue as a sign to pause, reduce the complexity of the information provided, and assess for parental understanding and what the family needs for decision support.

Team members also should possess a *commitment to developing a shared mental model*<sup>10,11</sup> or a common understanding of a patient's disease narrative and trajectory and then become oriented to similar objectives in communication with the family and treatment goals. The process of developing this shared mental model may require explaining to teammates how the team or family has arrived at an understanding of the current medical condition. The team leader should confirm that teammates have adopted the new mental model by openly addressing concerns they have regarding shifts from the previous model and questions they have about why the new information may necessitate a new care plan.

### *Preparing for a Family Meeting*

Team-team practices performed for all family meetings include use of *preparatory meetings* such as a team meeting in advance of serious conversations with families. Preparatory meetings would bring together all the relevant team members caring for the patient. Participants may include care providers outside the ICU, such as the primary care attending or other subspecialists with long-standing knowledge of the family. In this premeeting, leaders ensure *clear communication of the team's objective* for the meeting. The team leader who is responsible for coordinating activities and ensuring completion of the tasks can offer the initial description of the agenda items that she believes should be covered and those can be modified by the group. Team members should also be given the opportunity to *facilitate team problem-solving in communication* by identifying potential areas of challenge in communicating with the family and previous solutions, which have alleviated some of those challenges. The leader should explicitly engage all team members, asking them about other problems identified (e.g., pain management) and if they have suggestions for novel solutions to these challenges.

Although the attending physician of one service may believe she is aware of all relevant information that should be covered in the meeting, the nurses or social workers may have identified other needs not known to the attending physician or a unique perspective that is important to the family. Team collaboration centrally includes inviting information from all team members and potential approaches to act on that information in care plan formation and communication. For families that attempt to pit team members against each other by pointing out inconsistencies in information shared with them, the IPT premeeting allows its members to identify and commit to consistent messaging. In addition, the premeeting provides an important opportunity to *clarify each member's role* for the family meeting. This can include the assignment of a facilitator, medical information sharer, emotional support person, and even a recorder to document the information for the team and family. Although any team member may offer emotional support during the meeting, having one member designated to ensure the emotions of a family are not overlooked will help avoid frequent missed opportunities to respond to their emotion.<sup>17</sup>

### *Conducting a Family Meeting*

Clear delegation of tasks to be performed during a family meeting allows for the *synchronization of individual team member contributions*. This synchronization ensures that all necessary tasks are covered and that team members know with whom to collaborate

on shared tasks and who will need updates on information that has been acquired. Synchronization could include multiple medical information providers sharing different treatment options with the family while also ensuring that they do not provide inaccurate information or information out of their area of expertise. Synchronization could also allow for optimal performance support of the family after the meeting by ensuring consistent language is used to describe the patient's condition and treatment options. If difficult news needs to be shared with the parents and child, the social worker may coordinate with the child life specialist how to assist the parents in speaking with their child after the family meeting.

A team-team practice of ensuring that all team members are *engaged in their full complement of professional skills* will allow team members to contribute in the unique ways their training allows. For example, when the team discusses how they will synchronize their contributions to communicate with and care for the family, each team member will have an opportunity to offer their services in the family meeting and in follow-up. If the social worker is tasked with meeting the family's psychosocial needs, he is given the opportunity to perform that role in the family meeting. Nurses practicing the mutual participation model of care,<sup>23</sup> who have specific skills to help parents cope with the stress of caring for a seriously ill child longitudinally, will be asked to complement the work of social workers in the family meeting with follow-up at the bedside.

### *Continuous Mutual Performance Monitoring Practices*

Team members must also be continuously aware of each other's responsibilities and roles so that they can perform *mutual performance monitoring* and identify if there is a lapse in anyone's ability to complete their task. An example might be when the facilitator of the family meeting asks a clarifying question to the person providing medical information because she is worried, the family is confused about what was said. The information giver may recognize that they have not adequately read the family's cues and will pause to offer the information again in a different way.

### *Practices After a Family Meeting*

High-functioning teams *assess team performance and make adjustments for future meetings*. This requires setting aside time for feedback sessions after the family meeting to engage in self-assessment and plan for future meetings.

Post-family-meeting discussions also ensure that if the family raised some unexpected questions or concerns and that the team still is able to navigate the

decision process and has adequate responses to those questions moving forward in care plan development.

Teams also should have structures in place to *reinforce behavioral norms that had been laid out in the initial team education process*. One example would be if a team leader were openly dismissive of a team member's input in a way that was perceived as disrespectful by the team member. In many circumstances, unit leadership will need to meet individually with team members to provide feedback and offer suggestions for how to handle situations differently in the future. Constructive feedback offered to team members who are perceived to transgress behavioral norms can help protect the team's function and morale. Changes in team dynamics would be perceivable over a series of meetings, including changes in the behavior of the individual who needed coaching.

### *Team Practices and Outcomes*

High-functioning teams are more likely to meet patient and family outcomes that hospitals often explicitly prioritize (Fig. 1, upper right), such as goal concordant care, the efficiency and safety of care, and family satisfaction.

Team members and the teams themselves will also benefit by improved team-team practices (Fig. 1, lower right). In successful IPTs, members perceive their work to be meaningful and their input valued because they are taken seriously by their colleagues and have some control over how decisions are made. To the degree that team-team practices enhance knowledge of each other's roles and foster a clearer shared mental model of team collaborative processes, team members are more likely to have improved mutual trust, a greater sense of psychological safety,<sup>24</sup> and increased job satisfaction.<sup>25</sup> This in turn may lower rates of staff burnout,<sup>26,27</sup> improved retention of staff, and greater long-term team composition stability and heightened function.

### *Conclusion*

Despite recommendations for IPT involvement in family meetings, little emphasis has been placed on team-team practices necessary to achieve goal concordant care. Our proposed model, linking team-team practices to success in achieving patient-level outcomes, offers insights into why opportunities are missed in achieving these important goals when team-team practices are overlooked. In addition, the model underscores how within-team practices play a central role in achieving team-team outcomes such as team well-being. Future research that tests these conceptual links will facilitate the development of

training plans to ensure success in providing highly reliable care and better evaluation of team function.

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