Supplementary Material

Supplementary table 1: Electronic database search strategy

Word Group	MEDLINE (EBSCO)	PsycINFO (Ovid)	EMBASE (Ovid)	CINAHL (Ovid)
Communication	Communication/ Health Communication/ Prognosis/ communicat*.ab,ti. interact*.ab,ti. talk.ab,ti. conversation*.ab,ti. discuss*.ab,ti. prognos*.ab,ti.	Communication/ Health Communication/ Prognosis/ communicat*.ab,ti. interact*.ab,ti. talk.ab,ti. conversation*.ab,ti. discuss*.ab,ti. prognos*.ab,ti.	Communication/ Health Communication/ Prognosis/ communicat*.ab,ti. interact*.ab,ti. talk.ab,ti. conversation*.ab,ti. discuss*.ab,ti. prognos*.ab,ti.	MH "Communication" MH "Discussion" MH "Prognosis" TI or AB communicat* TI or AB interact* TI or AB talk TI or AB conversation* TI or AB discuss* TI or AB prognos*
Relatives	Family/ Caregivers/ Spouses/ Parents/ relative*.ab,ti. family.ab,ti. families.ab,ti. companion*.ab,ti. surrogate*.ab,ti. caregiver*.ab,ti. carer*.ab,ti. spouse*.ab,ti. partner*.ab,ti. parent*.ab,ti.	Family/ Caregivers/ Spouses/ Parents/ relative*.ab,ti. family.ab,ti. families.ab,ti. companion*.ab,ti. surrogate*.ab,ti. caregiver*.ab,ti. carer*.ab,ti. spouse*.ab,ti. partner*.ab,ti. parent*.ab,ti.	Family/ Caregivers/ Spouses/ Parents/ relative*.ab,ti. family.ab,ti. families.ab,ti. companion*.ab,ti. surrogate*.ab,ti. caregiver*.ab,ti. carer*.ab,ti. spouse*.ab,ti. partner*.ab,ti. parent*.ab,ti.	MH "Family" MH "Professional-Family Relations" MH "Caregivers" MH "Spouses" MH "Significant Other" MH "Parents" TI or AB relative* TI or AB family TI or AB families TI or AB companion* TI or AB surrogate* TI or AB caregiver* TI or AB carer* TI or AB spouse* TI or AB partner* TI or AB parent*
Healthcare professionals	Health Personnel/ "Attitude of Health Personnel"/ Practice Patterns, Physicians'/ Medical Staff, Hospital/ Physicians/ Nurse Clinicians/ Nurses/ Patient Care Team/ healthcare professional*.ab,ti. health professional*.ab,ti. doctor*.ab,ti. nurse*.ab,ti. clinician*.ab,ti. physician*.ab,ti. "care team".ab,ti.	Health Personnel/ "Attitude of Health Personnel"/ Practice Patterns, Physicians'/ Medical Staff, Hospital/ Physicians/ Nurses/ healthcare professional*.ab,ti. health professional*.ab,ti. doctor*.ab,ti. nurse*.ab,ti. clinician*.ab,ti. physician*.ab,ti. "care team".ab,ti.	Health Personnel/ "Attitude of Health Personnel"/ Practice Patterns, Physicians'/ Medical Staff, Hospital/ Physicians/ Nurse Clinicians/ Nurses/ Patient Care Team/ healthcare professional*.ab,ti. health professional*.ab,ti. doctor*.ab,ti. nurse*.ab,ti. clinician*.ab,ti. physician*.ab,ti. "care team".ab,ti.	MH "Professional-Family Relations" MH "Nurses" MH "Physicians" MH "Multidisciplinary Care Team" TI or AB healthcare professional* TI or AB health professional* TI or AB doctor* TI or AB nurse* TI or AB clinician* TI or AB physician* TI or AB "care team"

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Word Group	MEDLINE (EBSCO)	PsycINFO (Ovid)	EMBASE (Ovid)	CINAHL (Ovid)
End-of-life setting	((Critical Care/ Intensive Care Units/ "intensive care".ab,ti. icu.ab,ti. "critical care".ab,ti. "acute care".ab,ti. AND Terminal Care/ Palliative Care/ palliative.ab,ti. "end of life".ab,ti. terminal*.ab,ti. dying.ab,ti. bereaved.ab,ti.) OR (Hospice Care/ Terminal Care/ Palliative Care/ Hospices/ palliative service*.ab,ti. palliative care.ab,ti. hospice*.ab,ti.))	(("intensive care".ab,ti. icu.ab,ti. "critical care".ab,ti. "acute care".ab,ti. AND Terminal Care/ Palliative Care/ palliative.ab,ti. "end of life".ab,ti. terminal*.ab,ti. dying.ab,ti. bereaved.ab,ti.) OR (Hospice Care/ Terminal Care/ Palliative Care/ palliative service*.ab,ti. palliative care.ab,ti. hospice*.ab,ti.))	((Critical Care/ Intensive Care Units/ "intensive care".ab,ti. icu.ab,ti. "critical care".ab,ti. "acute care".ab,ti. AND Terminal Care/ Palliative Care/ palliative.ab,ti. "end of life".ab,ti. terminal*.ab,ti. dying.ab,ti. bereaved.ab,ti.) OR (Hospice Care/ Terminal Care/ Palliative Care/ Hospices/ palliative service*.ab,ti. palliative care.ab,ti. hospice*.ab,ti.))	((MH "Intensive Care Units" MH "Critical Care" MH "Acute Care" TI or AB "intensive care" TI or AB icu TI or AB "critical care" TI or AB "acute care" AND MH "Palliative Care" MH "Terminal Care" TI or AB palliative TI or AB "end of life" TI or AB terminal* TI or AB dying TI or AB bereaved) OR (MH "Palliative Care" MH "Hospice Patients" MH "Hospice Care" TI or AB palliative service* TI or AB palliative care TI or AB hospice*))
Qualitative methodology	Qualitative Research/ Interview/ Focus Groups/ Observational Study/ qualitative.ab,ti. interview*.ab,ti. focus group*.ab,ti. observation*.ab,ti. audio.ab,ti. video.ab,ti. ethnography.ab,ti. linguistic*.ab,ti. dialectic*.ab,ti. "conversation analysis".ab,ti. "discourse analysis".ab,ti. "sequential analysis".ab,ti. "interpretative phenomenological analysis".ab,ti. "content analysis".ab,ti. "framework analysis".ab,ti. "thematic analysis".ab,ti.	Qualitative Research/ qualitative.ab,ti. interview*.ab,ti. focus group*.ab,ti. observation*.ab,ti. audio.ab,ti. video.ab,ti. ethnography.ab,ti. linguistic*.ab,ti. dialectic*.ab,ti. "conversation analysis".ab,ti. "discourse analysis".ab,ti. "sequential analysis".ab,ti. "interpretative phenomenological analysis".ab,ti. "content analysis".ab,ti. "framework analysis".ab,ti. "thematic analysis".ab,ti.	Qualitative Research/ Interview/ Focus Groups/ Observational Study/ qualitative.ab,ti. interview*.ab,ti. focus group*.ab,ti. observation*.ab,ti. audio.ab,ti. video.ab,ti. ethnography.ab,ti. linguistic*.ab,ti. dialectic*.ab,ti. "conversation analysis".ab,ti. "discourse analysis".ab,ti. "sequential analysis".ab,ti. "interpretative phenomenological analysis".ab,ti. "content analysis".ab,ti. "framework analysis".ab,ti. "thematic analysis".ab,ti.	MH "Qualitative Studies" MH "Interviews" MH "Semi-Structured Interview" MH "Unstructured Interview" MH "Focus Groups" MH "Observational Methods" MH "Participant Observation" MH "Nonparticipant Observation" MH "Ethnographic Research" TI or AB qualitative TI or AB interview* TI or AB focus group* TI or AB observation* TI or AB audio TI or AB video TI or AB ethnography TI or AB linguistic* TI or AB dialectic* TI or AB "conversation analysis" TI or AB "discourse analysis" TI or AB "sequential analysis" TI or AB "interpretative phenomenological analysis" TI or AB "content analysis" TI or AB "framework analysis" TI or AB "thematic analysis"

Supplementary table 2: Full inclusion and exclusion criteria

	Inclusion	Exclusion
Study type	Qualitative Peer reviewed	Quantitative Intervention/training studies Reviews Conference abstracts Theses Book chapters Commentaries
Participants/ population	Relatives of patients approaching the end of life (i.e. palliative patients not receiving active treatment, or other patients anticipated to die in the coming days/weeks; no limit on age/illness of patient) Bereaved relatives Healthcare or allied professionals who communicate with relatives at the end of life	Paediatric/adolescent relatives
Focus	Communication between HCPs and relatives of patients approaching the end of life Prognosis and end of life care What and how communication is done	Assisted suicide/euthanasia Organ donation Hypothetical communication episodes Communication between relative & patient or HCP and patient Communication between different relatives Communication between different HCPs Communication earlier in disease trajectory (e.g. diagnosis) Communication/education needs of HCPs

Setting	Palliative care (home and inpatient) Acute care (e.g. ICU/ critical care) where patient is not anticipated to recover Adult and paediatric settings	Non-end-of-life settings (i.e. acute setting with patients receiving active treatment)
Language	English	Non-English language
Date range	All	All

Abbreviations: HCP, Healthcare professionals; ICU, Intensive care unit

Supplementary table 3: Demographic details of study population

Authors (year)	HCP sample (n, profession)	HCP professional background: 1) HCP position 2)Av years of experience	HCP demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Family sample (n of individual family members)	Relation to patient	Family demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Sample of patients being discussed	Details of patients being discussed	Patients' av age (years)
				Observational studies					
[a]Aldridge & Barton (2007)	10, physicians (others also present)	1) 6 senior critical care intensivists, 4 surgeons; 2) Not reported	1-3) Not reported	Not reported	Not reported	1-3) Not reported	20	SICU patients	Not reported
[a]Barton (2005)	5, physicians	1) 4 senior SICU intensivists, 1 surgical resident; 2) Not reported	1-3) Not reported	Not reported	Not reported	1-3) Not reported	6	SICU patients	Not reported
[a]Barton (2007)	†Not reported, physicians	1)*Senior critical care intensivists, surgeons; 2)Not reported	1-3) Not reported	Not reported	Not reported	1-3) Not reported	9/20 included in analysis	SICU patients	Not reported
[b]Curtis et al. (2002)	36, physicians	1) Attending, resident & fellow; 2) 12	35/36: 1) 34; 2) 38; 3) 86	214	*Spouse, child, sibling, parent, friend, other relative, other	163/214: 1) 61; 2) 48; 3) 82	50	*Intracranial hemorrhage, end-stage liver disease/ GI bleed, trauma, sepsis. respiratory failure, cardiac failure, other	60
[b]Curtis et al. (2005)	†Not reported, physicians	1) Attending, resident & fellow; 2)†Not reported	1-3)†Not reported	Not reported	†Not reported	1-3) †Not reported	15/51 included in analysis	†Not reported	†Not reported
de Vos et al. (2015)	27, physicians (nurses also present)	1) Intensivist, neurologist, metabolic pediatrician, other pediatric specialty; 2) 12 participants 0-5yrs, 2 participants 5-10yrs, 13 participants>10yrs	1) 44 2) Not reported 3) 96% Western	37	Parents	1) 51 2-3) Not reported	19	Congenital disorder, acute illness, neuro-trauma, ~~SIDS~~sudden infant death syndrome, cancer, perinatal asphyxia	4
Ekberg et al. (2017)	1, physician (others also present)	1) Specialist palliative care consultant; 2) Not reported	1-3) Not reported	Not reported	Parents	1-3) Not reported	8	Severe cerebral palsy, Duchenne Muscular Dystrophy, Metachromatic Leukodystrophy, schizencephaly, & T Cell Lymphoblastic Lymphoma	Not reported

Authors (year)	HCP sample (n, profession)	HCP professional background: 1) HCP position 2)Av years of experience	HCP demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Family sample (n of individual family members)	Relation to patient	Family demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Sample of patients being discussed	Details of patients being discussed	Patients' av age (years)
[b]Engelberg et al. (2008)	6/36 included in analysis, physicians	1) *Attending, resident & fellow physicians 2) 8.7	6/36: 1) 50; 2) 34.7; 3) 83	Not reported	†Not reported	6/36: 1) 68; 2) 48.5; 3) 63	6/51 included in analysis	6/51: Intracranial hemorrhage, respiratory failure, cardiac failure	67.4
[b]Hsieh et al. (2006)	36, physicians (other staff also present)	1) Attending, resident & fellow; 2) 12	35/36: 1) 34; 2) 38; 3) 86	227	*Spouse, child, sibling, parent, friend, other relative, other	169/227: 1) *60; 2) 49; 3) *81	51	*Intracranial hemorrhage, end-stage liver disease/ GI bleed, trauma, sepsis. respiratory failure, cardiac failure, other	60
Kawashima (2017)	†Not reported, physicians (others also present)	1) Doctors 2) Not reported	1-3) Not reported	Not reported	Not reported	1-3) Not reported	19	Patients at risk of imminent death	60-80 (range)
Miller et al. (1992)	16, physicians	1) 7 attending physicians, 5 fellows & 4 residents; 2) Not reported	1-3) Not reported	20	5 spouses, 8 adult children, 7 siblings	1-3) Not reported	15	ICU patients	64.2
Pecanac (2017)	Not reported, physicians (others also present)	1) Physicians 2) Not reported	Not reported	Not reported	Examples included adult children, mother, siblings, cousins, sister-in-law	1-3) Not reported	36	Majority admitted for infection, lung condition, cardiac arrest or neurological condition. Intubated on breathing machine	62.7
Shaw et al. (2016)	6, physicians	1) Consultants 2) Not reported	Not reported	Not reported	Parents	1-2) Not reported 3) 33.3	9	Severe perinatal asphyxia, extremely preterm with neuro complications, threatened pre-term delivery, lethal congenital anomaly	Neonatal
[b]West et al. (2005)	†Not reported, physicians	1) Attending, resident & fellow; 2)†Not reported	1-3)†Not reported	Not reported	†Not reported	1-3)†Not reported	44/51 included in analysis	†Not reported	†Not reported
Family perspective									
Abib El Halal et al. (2013)	N/A	N/A	N/A	15	Parents	1) 60%; 2) 34; 3) Not reported	9	Children who died in PICU in previous 6-12 months	2.6

Authors (year)	HCP sample (n, profession)	HCP professional background: 1) HCP position 2)Av years of experience	HCP demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Family sample (n of individual family members)	Relation to patient	Family demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Sample of patients being discussed	Details of patients being discussed	Patients' av age (years)
[c]Gordon et al. (2009)	N/A	N/A	N/A	†Not reported	Parents	1-3) †Not reported	†Not reported	Children who died in PICU in previous 3-12 months.	†Not reported
Lind (2017)	N/A	N/A	N/A	27	Spouses, adult children, mother & siblings	1) 74; 2) 49.7; 3) Not reported	21	Patients who died in the ICU. Length of stay ranged from <4 days to >1 month	61
[c]Meert et al. (2008)	N/A	N/A	N/A	40/56 included in analysis	Parents	40/56: 1) 65; 2) 35.9; 3)72.5%	†Not reported	Children who died in PICU in previous 3-12 months	†Not reported
Odgers et al. (2018)	N/A	N/A	N/A	12	Next of kin	1) 83.3; 2-3) Not reported	Not reported	Adult patients who died in previous 3-12 months	Not reported
HCP perspective									
Bach et al. (2009)	14, nurses	1) Critical care registered nurses (10 ICU, 4 CRCU); 2) 13	1) 86; 2-3) Not reported	N/A	N/A	N/A	N/A	Dying patients	60 (Av patient admitted to unit)
Bartel et al. (2000)	22, physicians	1) 12 pediatric residents, 5 pediatric critical care fellows & 5 attending pediatric intensivists; 2) Not reported	1) 64; 2) Not reported 3) 82	N/A	N/A	N/A	N/A	Critically ill children	N/A
Bloomer et al. (2017)	21, nurses	1) Critical care nurses; 2) 13	1-3) Not reported	N/A	N/A	N/A	N/A	Treatment withdrawal in adult patients	N/A
Epstein (2008)	32, 21 nurses; 11 physicians	1) NICU registered nurses, nurse practitioners, attending, resident & fellow physicians; 2) Nurses= 12.6; Physicians= 6.9	1) Nurses= 95; Physicians= 36; 2) Nurses= 36.2; Physicians= 36.5 3) Nurses 84; Physicians 100	N/A	N/A	N/A	21	Infants who died in NICU in previous 6 weeks	71% ≤1.5

Authors (year)	HCP sample (n, profession)	HCP professional background: 1) HCP position 2)Av years of experience	HCP demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Family sample (n of individual family members)	Relation to patient	Family demographics: 1) Female (%) 2) Av age (years) 3) White (%)	Sample of patients being discussed	Details of patients being discussed	Patients' av age (years)
Kehl (2015)	19, home hospice clinicians	1) 9 Registered Nurses, 3 Licensed Practical Nurses , 1 Certified Nursing Assistant, 3 social workers, 2 counsellors & 1 chaplain; 2) 11 participants<2yrs; 4 participants 2-10yrs; 4 participants>10yrs	1) 84; 2) 4 participants≤ 35 yrs; 13 participants 36-50yrs; 2 participants >50yrs; 3) 100	N/A	N/A	N/A	N/A	Hospice home care patients in final days of life	N/A
Liaschenko et al. (2009)	27, nurses	1) Critical care nurses; 2) 15	1) Not reported; 2) 43; 3) Not reported	N/A	N/A	N/A	N/A	Critical care patients at end-of-life	N/A
Peden-McAlpine (2015)	19, nurses	1) ICU nurses comfortable with dying patients and their families; 2) 17	1) 100; 2) 48; 3) 100	N/A	N/A	N/A	N/A	Treatment withdrawal in adult patients	N/A
Rejno et al. (2017)	15 , 4 physicians; 11 nurses	1) 7 registered nurses, 4 enrolled nurses; 2) 11	1) Nurses 9; Physicians 25; 2) 41; 3) Not reported	N/A	N/A	N/A	N/A	Acute stoke patients at End-of-life	N/A
Richards et al. (2017)	22, physicians	1) Attending pediatric critical care physicians; 2) 55% ≥5	1) 32; 2-3) Not reported	N/A	N/A	N/A	N/A	Child ICU patients	N/A
Tan & Manca (2013)	11 physicians	1) Family physicians 2) 3-40 (range)	1) 55; 2-3) Not reported	N/A	N/A	N/A	N/A	Dying patients	N/A
Mixed perspectives									
Caswell et al. (2015)	37 interviewed (others observed), healthcare professionals	1) Healthcare professionals; 2) Not reported	1-3) Not reported	13	Not reported	1-3) Not reported	11 discussed (others observed)	Older patients who died during study period (43% had dementia)	81-88 (range of av age at death on wards)
Meeker et al. (2015)	8, 2 nurses; 2 social workers; 4 physicians	1) 2 nurses, 2 social workers, 4 physicians; 2) 8.4	1) 88; 2) 47.8; 3) Not reported	88	Adult children present at 80% of meetings, & spouses 28%	1-3) Not reported	Not reported	Hospice patients	Not reported

[a]Papers using data from Cassell (2005)[50], [b]Papers using data from Curtis et al. (2002)[22], [c]Papers using data from Meert et al. (2007)[51]

*Information gathered from other papers reporting same sample

†Where a sub-sample has been used in the analysis and characteristics are only reported for sample as a whole, this is stated as 'not reported'

Abbreviations: HCP, Healthcare professional; SICU, Surgical intensive care unit, ICU, Intensive care unit; PICU, Pediatric intensive care unit; NICU, Neonatal intensive care unit

Supplementary table 4: Quality appraisal results (Corresponding questions are on following page)

Authors (year)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Abib El Halal et al. (2013)	No	Yes	Yes	Unclear	Yes	Yes	Yes	Yes	Yes	Yes
Aldridge & Barton (2007)	No	Yes	Yes	Yes	Yes	No	No	Unclear	Yes	Yes
Bach et al. (2009)	No	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Bartel (2000)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Barton et al. (2005)	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Barton et al. (2007)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Bloomer et al. (2017)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Caswell et al. (2015)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Curtis et al. (2002)	No	Yes	Yes	Unclear	Yes	Yes	Yes	Unclear	No	Yes
Curtis et al. (2005)	No	Yes	Yes	Unclear	Yes	Yes	No	Unclear	Yes	Yes
deVos et al. (2015)	No	Yes	Yes	No	Yes	No	Yes	Yes	Yes	Yes
Ekberg et al. (2017)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Engelberg et al. (2008)	No	Yes	Yes	Unclear	Yes	No	No	Yes	Yes	Yes
Epstein (2008)	Yes	Yes	Yes	No	Unclear	No	No	Yes	No	Yes
Gordon et al. (2009)	Yes	Yes	Yes	No	No	Yes	Yes	Yes	Yes	Yes
Hsieh et al. (2006)	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Kawashima (2017)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Kehl (2015)	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Liaschenko et al. (2009)	No	Yes	Yes	Yes	Yes	No	No	Unclear	Yes	Yes
Lind (2017)	Yes	Unclear	Yes	No	No	No	No	Yes	Yes	Yes
Meeker et al. (2015)	No	Yes	Yes	Yes	Yes	No	No	Unclear	Yes	Yes
Meert et al. (2008)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Miller et al. (1992)	No	Yes	Yes	No	No	No	Yes	Unclear	No	Unclear
Odgers et al. (2018	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Pecanac (2007)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Peden-McAlpine et al. (2015)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes

Authors (year)	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
Rejno et al. (2017	Unclear	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Richards et al. (2018)	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Shaw et al. (2016)	No	Yes	Yes	Yes	Yes	No	No	Yes	Yes	Yes
Tan & Manca (2013)	No	Yes	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes
West et al. (2005)	No	Unclear	Yes	Unclear	Yes	No	No	Yes	Yes	Yes

Questions in Joanna Briggs Institute Critical Appraisal Checklist for Qualitative Research (potential responses: yes, no or unclear)

1. Is there congruity between the stated philosophical perspective and the research methodology?

2. Is there congruity between the research methodology and the research question or objectives?

3. Is there congruity between the research methodology and the methods used to collect data?

4. Is there congruity between the research methodology and the representation and analysis of the data?

5. Is there congruity between the research methodology and the interpretation of results?

6. Is there a statement locating the researcher culturally or theoretically?

7. Is the influence of the researcher on the research and vice-versa addressed?

8. Are participants and their voices adequately represented?

9. Is the research ethical according to current criteria, or for recent studies, is there evidence of ethical approval by an appropriate body?

10. Do conclusions drawn in the research report flow from the analysis, or interpretation of the data?

Supplementary table 5: Extracts from original papers demonstrating themes

Highlighting Deterioration

Problem listing from Meeker et al. (2015):
For family members, changes that were nearly imperceptible on a day-to-day basis would be clarified and placed in the context of illness progression. As reported by one physician, "Recalibrating or reframing the events is very, very, very important so that they can understand that they really haven't been eating for three months very well. They can't walk anymore, and that that's dying" (PR5).
(p.1287)

Perspective display invitation from Peden-McAlpine et al (2015):
'It's overwhelming, so let's backtrack to 'How was he yesterday?' – and helping them follow the trajectory of what happened to him before he showed up to the hospital, because they're in shock and they need to go over the story. 'How has he been in the last two weeks?' 'He wasn't feeling well.' 'Has he ever had any kind of situations like this where he ended up in the hospital before?' (5 3 (26:33).
It is important to note that in the nurses' narratives the construction of the story is not a one-way process of simply giving information. Rather, nurses reported that they elicit the family's understanding, identify the need for clear and direct communication about poor prognosis, and modify that understanding as necessary.
(p. 1153)

Involvement in decision-making

Medical team's decision from Abib el Halal et al (2013):
From the reports it was evident that parental participation was limited to being informed of prior decisions taken by the team. Parents referred to being compelled to accept treatments and interventions defined by the medical PICU staff. They were regularly informed about what was happening, but emphasised they did not decide anything. Decisions regarding the available therapeutic options for their children were not discussed with clarity, especially when they were related to limiting life support or do not resuscitate orders…
'We received the information of what was to be done or what could be done, without deciding.' (U12)
(p. 498)

Collaborative decision-making by invoking patient wishes from Hseih (2006):
Clinicians often used recentering to help families consider the situation from the patient's viewpoint, including patient experience, desires, and preferences. Clinicians urged family members to see their role as the surrogate or advocate of patients.
Physician: You have to exercise what's called substituted judgment, not what you would want, not what your aunt would want, but what you think your mother would want.
Different conference:
Nurse: If he could sit up right now, what would he say to you. Would he say he wants to go on with all this? Would he say, stop, that's enough?
(p. 300-301)

Post-decision interactional work

Emphasizing continued care from deVos (2015):
At the end of the (last) meeting, all parents expressed their great concern that their child might suffer in the process of dying. In turn, the physicians promised that everything would be done to ensure the child's comfort and peace. Moreover, several parents asked whether it would be possible to let their child regain consciousness so they could speak with him or her for the last time.
(p. e471)

Justifying the decision as 'right' from Barton (2007):
Reviewing the decision as a family-initiated topic thus merges the voices of the lifeworld and medicine in terms of the decision being warranted from the medical perspective as well as appropriate from the perspective of the lifeworld—the term families use is right, a term that is often used by physicians as well. In the corpus, the lifeworld review of the EOL decision was often repeated in Phase 4 of the discussions. In closings, both physicians and families often repeated their satisfaction with the decision, both using the term right:
(8) Fam: If you had known her, you would know that we're doing the right thing.

Dr: And that's important. And again I want everybody to know that from the doctors' standpoint we're doing the right thing. So I don't want down the road people thinking, well you know should we— No.
(p. 135)

Tailoring

Tailoring to previous experiences of death from Kehl (2015):
This hospice nurse used both the family's experience in caregiving and the patient's symptoms to tailor the message:
I would first I think ask you if you have ever had experience before taking care of someone who is nearing the end of their life. And then if you'd say, "No," I'd say, "Well here are some changes I'm seeing, I'm noticing that from last I was here their breathing is different, they're not eating as much, they seem weaker," and just kind of go by the symptoms I'm seeing and explain why that's happening. (RN 1)
(p.133)

Honesty and clarity

Honesty from Bach (2009):
One aspect of speaking up was truth telling, which frequently became a contentious issue. The nurses expressed differing approaches with regard to truth telling, including responsibility for information and decisions on how information was to be handled. Some of the nurses supported being straightforward with families, saying that "nurses spend far more time with a family" and "it's the nurse they end up speaking to." As one participant commented, the nurse was "better off telling them... being honest." However, some nurses tempered this direct approach by expressing the need for compassion and not taking away hope. Alice said that although she did believe in honesty, and "although telling [families and patients] this is the worst scenario . . . there's always hope that people can do better."
(p. 505)

Specific techniques for information delivery~~Communication practices of HCPs~~:

Pacing & staging of information from Bloomer et al (2017):
Another consideration was that that families may struggle to cope with information about treatment withdrawal, the impending death and a possible request for organ donation. From this, participants were aware that information needed to be delivered in an incremental way, and in stages:
...they've just had really bad news, so there's got to be a bit of decoupling [emotional processing] with what they do, and I try and give it to them in small amounts so they don't get a big waft of information all at once. (4/2)
(p. 694)

Roles of different HCPs

Nurses providing individualised care from Bach (2009):
Providing emotional support and coordinating resources were also significant aspects of this theme. Ben spoke about this as "a supportive role, somebody here to . . . help the family after a family meeting to come to terms with it, answer any questions." For these nurses, coming to terms meant ensuring that all family members understood the health situation and prognoses and that they were all in agreement with the plan of care. This involved the nurses in a variety of roles. Jane described her role as expanding on the implications of a diagnosis and asking questions for the families. She affirmed the importance of detailed information for families to be able to make informed decisions because often once families understood all the information, "they may not have agreed . . . if they'd known all that."
(p. 506)