HOW TO CONDUCT A FAMILY MEETING
(AND GOAL SETTING CONVERSATIONS)
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DISCLOSURES
• I have none

OBJECTIVES
• Understand reasons to have family conferences
• Review unique issues in family communication
• Review basics of surrogacy law in NM
• Review framework for holding goal setting discussions

WHY HAVE A FAMILY CONFERENCE?
• Can make or break the relationship you have with a patient
• Family can repeat and reinforce your message
• Family can clue you in to what’s important
• Family may learn to cope better
TRIGGERS FOR FAMILY MEETING

- When there is serious news to discuss and patient wants family involved
- The patient is too ill to participate in making decisions
- Family members disagree about decisions

WHAT IS FAMILY?

- All people who are emotionally intimate with or biologically connected to the patient.
- May include unmarried partner, close friends, others

UNIQUE ISSUES IN FAMILY COMMUNICATION

- Families bring complexity of relationships and interactions
- Family members each have their own interests
- Family members may have individual emotional needs
- Family members may have different preferences to how information is given
- Family members may disagree about the right course of action

CREATE A NEUTRAL ZONE

- Ask background questions about patient and relationships in the family
- Ask how family likes to make decisions
- Remain neutral and recognize different family members equally
- Our role is to facilitate discussions not interfere with family dynamics
- Let family members care for each other before you do
WHEN FAMILIES NEED TO DECIDE

• Help family focus on what patient would want (not their own wishes)
• Make sure legal surrogate is present but don’t focus exclusively on surrogate as decision-maker – many families make decisions by consensus
• Remember the stress of being a family member or caregiver
• Empathize with family member’s emotion

SURROGACY IN NM

• If someone is decisional, make decisions with that person
  • “But the POAHC wants us to do x, y, z…!”?
• Who makes decisions for non-decisional patients?
  • Guardian, POAHC
  • What if there is no guardian or POAHC?
    • Uniform Health Care Decisions Act
      • [Link]

UNIFORM HEALTH CARE DECISIONS ACT

• 24-7A-5. Decisions by surrogate.
  B. ... In the absence of a designation or if the designee is not reasonably available, any member of the following classes of the patient’s family who is reasonably available, in descending order of priority, may act as surrogate:
  1. the spouse, unless legally separated or unless there is a pending petition for annulment, divorce, dissolution of marriage or legal separation;
  2. an individual in a long-term relationship of indefinite duration with the patient in which the individual has demonstrated an actual commitment to the patient similar to the commitment of a spouse and in which the individual and the patient consider themselves to be responsible for each other’s well-being;
  3. an adult child;
  4. a parent;
  5. an adult brother or sister; or
  6. a grandparent.

UNIFORM HEALTHCARE DECISIONS ACT

• If none of the individuals eligible to act as surrogate is reasonably available,

  an adult who has exhibited special care and concern for the patient, who is familiar with the patient’s personal values and who is reasonably available may act as surrogate
ROLE OF A DECISION MAKER

• To reflect the wishes of the patient, not what they (the decision-maker) would want if in that situation
  • Never ask “what do you want us to do?”
  • Ask “Have you ever had conversations with your father about his wishes if he were in this situation?”
  • Ask “What would your father want if he heard this information that you just heard, and could talk with us?”

• Make sure you have explained the diagnosis, treatment options, and prognosis to the best of your ability before you ask someone to make a decision (informed consent).

GOAL SETTING CONVERSATION

• Preparation / Setting
• Introductions
• Patient/Family Understanding of the Condition
• Medical Review/Summary
• Prognostication
• Treatment Decision and Options
• Goal Setting
• Document and Discuss

PREPARATION

• Clarify your goals for the conversation
• Review chart—know the medical issues: diagnosis, treatment course, prognosis, baseline level of functioning
• Coordinate medical opinions among consultants: treatment options and realistic outcomes
• Review Advance Care planning documents (eg. POAHIC)
• If patient is not decisional, make sure appropriate legal/surrogate decision maker will be present
• Set the scene—are there chairs? Tissues? Are your phone and pager silenced?
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UNDERSTANDING OF THE ILLNESS
(AND THE HUMAN WITH THE ILLNESS!)

- Tell me about your mother
- What have the doctors told you about your mother’s illness?
- What is your understanding of your illness?
- What does dementia mean to you?
- What was life like before coming into the hospital for your father?
MEDICAL REVIEW/SUMMARY

- Ask how people like to hear information? Is direct communication okay? Do they like details or big picture?
- Summarize big picture in a few sentences—use the word dying if appropriate
- Avoid jargon!
- Speak slowly
- Pause often
- Check for understanding and assume there are questions: “that was a lot of new information. Can you tell me what you understood from that?”

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TREATMENT DECISIONS AND OPTIONS

- Review options, including an option of comfort focused care rather than life prolongation.
- If you have enough information about patient’s priorities, values, prognosis, MAKE A RECOMMENDATION!
- For a decisional patient, ask “what options are you considering?”
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GOAL SETTING

- Allow patient to state their goals: Knowing that time is short, what is important to you in the time that is left?

- Non-decisional patient: What would your mother choose if she was with us in this room and heard this information? "Would she want to look into options for further chemotherapy or would she want to focus on her comfort and be at home?"

- Summarize all decisions made and plan of action

DOCUMENT AND DISCUSS

- Write a note: who was present and what decisions were made and follow-up plan

- Discuss with relevant team members (consultants, nurse, social worker, case manager, etc.)
Primary MD: ________________  Primary Service: ________________  DATE: ____________

Primary diagnosis: ____________________________________________________________________

Reason for meeting (circle):  
□ Information sharing  
□ Goal Setting  
□ End-of-Life Planning  
□ Other: ____________________________________________________________________________

Current Medical Issues: __________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

ATTENDEES—Patient/Family  ATTENDEES—Medical/Palliative Care Team
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

PROCESS:
Following introductions, the patient/family was asked to state their understanding of the current illness. The current medical information was then provided to the family. Questions were answered to confirm that patient and all family members understand the current diagnosis and prognosis. Following this, a discussion was held regarding future goals and treatment options.

Other issues discussed in meeting: ______________________________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

__________________________________________________

At the conclusion of the meeting, the following mutually agreed upon goals and plans were decided:

Goals of Care:
___ Continue full aggressive support  ___ Continue limited support: specify: ______________________
__________________________________________________________________________
___ Withdraw current support and focus solely on comfort with death as the expected outcome  
___ No decision made at this meeting  
___ Other: ______________________

Disposition plans:
____ Home w/wo Home Care  ____ Home with Hospice  ____ Hospice Residence
____ Nursing Home  ____ Nursing Home with Hospice  ____ Sub-acute Rehabilitation

Next Steps—Describe Plan of Care and dates for future family meetings (if indicated):
____________________________________________________________________________________________________________________

__________________________________________________________

REMEMBER…

• These are not YOUR decisions.

• Your role is to give the decision-maker the pertinent medical information, to clarify the goals and to help guide them. They use this information and their knowledge of the patient to make an informed decision.

• Don’t make assumptions about goals: “They wouldn’t have come into the ED if they didn’t want aggressive treatment.”

RESOURCES

• American Academy of Hospice and Palliative Medicine:  www.aahpm.org
• Palliative Care Fact Sheet:  http://www.aahpm.org/tip-fact
  • Concise, practical, evidence-based summaries on key palliative care topics—pain management, prognostication, vent withdrawal, etc.
• Center to Advance Palliative Care: www.capc.org
• CPC:  
  • Education in Palliative and End-of-Life Care  
  • www.cpcalliance.org
• Specializing in Palliative Medicine:  
  • Fellowship: www.aahpm.org

REFERENCES

• Sharma RK, & Dy SM. (2011). Cross-cultural communication and use of the family meeting in palliative care. The American Journal Of Hospice & Palliative Care, 28(6), 437-44. doi:10.1177/1049909110394158
MANY THANKS!