Mastering Difficult Family Conversations in Surgical Care

End of Life Modules

Preparation

Welcome to the first of several short instructional modules on the topic of End of Life Family Care Conferences.

In this module, you’ll consider a model for structuring end-of-life conversations and how to prepare for them.

It probably goes without saying, but it should never be forgotten, that the death of a loved one represents a “watershed experience” in a family’s life. As a surgeon, your presence, your voice, your actions during this time will impact their experience tremendously. What you say or don’t say, and how you say it, will likely be remembered for months and maybe even years to come.

In the words of von Guten and colleagues, “Physician competence in end-of-life care requires skills in communication, decision making, and building relationships. Physician ability in this area correlates directly with patients feeling satisfied with their medical care and adhering to medical advice, as well as indirectly with liability litigation. It may also substantially enhance the physician’s own experiences of providing care.”

Effective care conferences can positively affect the family’s grieving process. In a randomized trial, for example, Lautrette and colleagues showed that holding an end-of-life conference and providing a brochure that discussed the grieving process and outlined available supports dramatically decreased family members’ depression, anxiety, and post-traumatic stress disorders.

Effective care conferences include some very basic principles we intuitively know to be true, but may get lost in a busy practice or dulled over time. If your mother, father, spouse, sibling, or child were at the point of death, you would hope the surgeon burdened with the responsibility of talking with you would, first, be considerate in choosing the right time and right place for the meeting. You would want them to explain the situation and answer questions using words you understand. You would want to feel that they care about your family member and you. You would want them to break the news gently, but be honest about the probability of your family member surviving with a meaningful quality of life. You would want them to be clear about treatment options, and the risks and benefits of continuing invasive care vs. palliative or comfort care. You would want them to take the time to listen to your fears or regrets and to provide information and emotional support as you face some very difficult decisions.

Talking about death is not easy. Previous research we’ve conducted with the Family Conference Objective Structured Clinical Exam (otherwise known as an “OSCE”) suggests that some people may be “naturally good” at it, but others are not, and skills vary significantly regardless of a resident’s training level. Our research also suggests that people who struggle with these kinds of conversations don’t necessarily get better at it, simply by watching how other providers talk with families, or by participating in care conferences.
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Several authors have developed simple models to help providers structure end-of-life conversations with patients. We have adopted one by von Guten, and tailored it for family care conferences. This model is described in the JAMA article that accompanies this module on your course website. Our modules roughly follow the steps in von Guten’s approach. The rest of this module (Module 1) focuses on what you should do before you even enter the room to speak with the family, and then how you introduce yourself and set up the conversation in the first several moments.

Before you meet with the family, find a private, quiet space. Make sure the room has a Kleenex tissue box and a phone for families needing to contact other relatives. Put your own pager and cell phone on mute. Most important, go see the patient, review the patient’s chart, and make sure you and the rest of the care team are “on the same page” regarding the patient’s status and prognosis. Bring nurses, social workers, or other providers to the meeting as needed. Have materials such as grief brochures, contact information for the social worker or hospital chaplain on hand. Lastly, it is best if you know ahead of time who the primary family member is, his/her name, and relationship to the patient.

It has been said that people form impressions of others in the first 20 seconds of meeting them (need citation or quote). In your first 20 seconds, you are going to introduce (or re-introduce) yourself to the family and clarify your role on the health care team. You want to physically position yourself at the same level as the family; invariably this means sitting down. Look at them directly. Be ready to refer to the patient by name and to address the family respectfully.

I want to pause here and ask you to take a look at these family members. Please avoid referring to them as “You Guys.” “You Guys” is a slang term that many of us assume is gender neutral, but it is not. It can be offensive to older women in particular, and confusing to non-native English speakers. As a reference to “all of you people,” it works fine in casual conversations between people who know each other. It is out of place in a serious conversation involving life and death. Refer to the person by name, or say, “you and your family members,” or “all of you,” or “the family.”

Let’s look at a short video of how one resident introduced himself to the family during a previous OSCE. What do you think he is doing right? What might you do differently? Try writing your thoughts down before you advance to the next slide.

On the positive side, he knew the patient’s name, he sat down and faced the family in a direct manner, and he didn’t get defensive when they asked him to explain his role on the team. He probably would have made a better impression, however, had he known the family members’ names, and didn’t say “You guys” in nearly every sentence.

Here is another short video of how a different resident handled the introductions. What do you think he is doing right? What might you do differently?

On the positive side, this resident made an effort to reinforce a prior connection with the family, showed concern for how the family was doing, and answered a question they might have had. Again, he might have made a better impression if he was a little less vague about who he was speaking with, and
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avoided saying “You guys” and “Ya” (for “you”). Beware of assuming an air of “folksiness” in your speech. Some providers may do so, thinking it puts patients at ease. It can do the opposite if it creates the impression of a jocular surgeon who is treating this event too casually. On the other hand, patients are sensitive to overly dry, clinical, or “distant” seeming doctors. So aim for something between “folksy” and “distant.”

In our final example, consider how this surgeon began the conversation and explained her role on the team.

On the positive side, she showed respect for the family by asking if this was a good time to meet and said she wanted to hear their perspectives. In addition, she clarified her role and assured them the information would be looped back to the primary surgeon. A minor suggestion is to take a breath and slow down. She is very articulate, but her pacing transmits some anxiety, like she wants to rush through this conversation. Slowing the pace would also help elderly family members, people with hearing impairments, and non-native English speakers understand her.

The 7-Step Model we’ve been discussing works well when you know the patient and can anticipate the decline. Conversations become obviously more stressful when you don’t know the patient or family, and in emergent situations that leave you and the family little time to prepare. Conversations can be especially hard when death is unexpected and untimely (in the case of a child, or a previously healthy, active adult, for example). Conversations require specific skills when family members are in conflict, arrive at the meeting with different perspectives on dying, or have been estranged from their dying relative. Cultural and language barriers require special considerations, such as including a translator or community elder in the meeting. Lastly, when the medical team has invested heavily in keeping the patient alive, it can be very hard emotionally for providers to “let go.”

Now for some “Do’s” and “Don’ts.” The 7-Step Model directs providers to do several things to prepare for a family care conference, from finding a quiet, private space to hold the meeting; to knowing the patient, the case, and the family; to ensuring that the care team is informed and in consensus about the recommended next steps. In entering the room, you should try to clear your mind of all other tasks and distractions. Turning off your pager and phone allows you to be more “wholly present” in the moment; it assures the family you are giving them your undivided attention. In your choice of words and demeanor, you want to present yourself as a caring professional, dedicated to walking them through an important conversation. Perhaps it goes without saying, but this should be a face-to-face conversation. Occasionally, “bad news” does need to be delivered over the phone, but it should be avoided. Lastly, in introducing yourself and your role, you don’t want to leave the impression that the care team is disorganized in its communication or divided in its understanding of how their family member should be cared for.

In closing, death is something you as a surgeon deal with every day. But this is not the case for families. For them, the conversation you are about to have represents a singular, watershed moment. In Module 2, we will focus on how to prepare them to hear the “bad news” you have to deliver.