Mastering Difficult Family Conversations in Surgical Care

End of Life Modules
Common Understanding

Welcome to the second module on the topic of End of Life Family Care Conferences!

Here we focus on discussions with family members when their loved ones are unable to speak or represent their own wishes. This situation is common in emergency and intensive care units. In these situations, research suggests that what matters most to family members is the quality of provider communication (along with accessibility to care team members, information, and continuity of care).

In Module 1, we discussed a 7-step model and how to prepare for the conference. Our goal in this module is to show you how to facilitate a conversation so you and the family can come to a common understanding about the patient’s condition. To achieve that understanding, you will need to find out what the family already knows; explain the purpose of the meeting; and then deliver some information.

So, why is it important to ask family members what they know and think is happening with their relative? After all, you’re the doctor: you know more than they do about medicine, and you are the one who is pressed for time and have to provide information, plus clarify the patient’s advanced directives and associated care plan.

Hopefully, you realize those aims, while valid, focus solely on the provider’s needs and miss the tenets of high quality, patient and family centered care. You will be more effective at achieving your work goals if you begin the conversation by listening. Doing so connotes respect for the family’s knowledge and validates their experience as caregivers. In most cases, they’ve spent more time with the patient than you and have insights you need. So your immediate goal is “collaborative engagement.”

By listening first, you will also better know how to describe the patient’s condition. You can avoid telling family members what they already know. You can fill gaps in their understanding, correct misperceptions, and answer
immediate questions. Listening first will help you gauge their readiness to hear
difficult news. Lastly, hearing the family explain in their own words what they
believe is happening will help you calibrate your vocabulary and translate medical
terms to be consistent with their level of sophistication.

Let’s look at how one physician engaged the family. Pay attention to what she
learns from them.

First, she presented herself as someone who really wanted to know what the
family knew. She dug a little deeper, even when they seemed willing to pass the
ball back to her. As a result, she learned that they knew the operation was
difficult and risky. What else might you have asked the family?

After hearing from the family, you’ll need to explain the purpose of the meeting.
Some providers and patient advocates refer to this as the “warning shot across
the bow.” This is a simple, direct, but gentle sentence that prepares them for
messages that follow. If you don’t do this, the family might feel confused, and
wonder what you are getting at, or why you’re meeting with them. On the other
hand, you should avoid being too direct. Don’t just blurt out, “Your mom is dying,
and we need to discuss her code status.”

Watch the video and listen for the warning shot given by this provider and how
this sets up the next part of the conversation.

Her warning shot was clear: “His course has not gone the way we would have
liked.” She described his condition as “sicker than anticipated” and “quite ill.”

You will then need to lay out the evidence of the patient’s decline in lay person
language. You should briefly summarize the medical history, review the patient
systems that are compromised, list current treatments, and end with a carefully
worded prognosis. Along the way, discuss family members’ questions openly and
honestly using lay language.
Let’s return to some view some more of the same video example. What does her narrative cover, and how is it structured? What additional “warning shots” does she give?

Her narrative connected events starting in the OR and lead to the patient’s post-op decline. She used lay language to review the effects of bleeding, the status of his breathing and heart functions. Along the way, she gave several additional warning shots, such as: “Gordon is in this more severe category;” “Even with the ventilator on its highest level, he’s not getting enough oxygen;” and “Removing those medications would be a fatal event.”

Breaking bad news is challenging. Providers who are uncomfortable in this role may express it unconsciously in a number of ways, like being irritable or frustrated; or presenting a detached, clinical demeanor; or going around and around and not coming to the point; or using vague terms on the assumption the family knows what the physician means. Watch the next video and consider why the family is reacting as they do, and what you might do differently.

In this example, the physician gave no clear “warning shot.” He had talked in a round-about fashion about the patient’s status. Along the way, he had offered various interventions that could be done if a decline continued. He jumped abruptly then to the brutal question, “Do you want to escalate or withdraw care?” before achieving a common understanding with the family that the patient was dying. The family’s frustration with the conversation then spilled over into anger.

Ok, time to go! Here is a simple checklist to add to your mental tool box.

For more ideas about what words and phrases to use (and avoid), check out the “Cue Cards for End of Life” PDF on your course website.

In closing, knowing how to facilitate the conversation to achieve a common understanding with a family takes practice and self-reflection. In Module 3, we will consider the task of clarifying a poor prognosis and dealing with family emotions.