STRUCTURED COMMUNICATION EXERCISE:
NEGOTIATING CONFLICT IN THE FAMILY MEETING

Session Description
This session will provide skills in conducting a family meeting, an essential primary palliative care competency. We will consider indications for this common procedure, discuss and create a structured approach to leading a meeting, especially when conflict is present, and practice key skills.

Learning Objectives
1. To discuss indications for family meetings in the ICU
2. To outline a structured approach to leading family meetings
3. To discuss and practice strategies to manage conflict, including aligning with the family and developing trust, helping families deal with uncertainty and conflicting information, eliciting substituted judgment, and making a recommendation

Readings
Structured Family Meeting handout
Case
Fast Facts: Family Meeting 1-6 (#222-227)
Fast Facts: Conflict Resolution 1 and 2. (#183-184)
Structured Family Meetings: Dealing with Conflict

1. Preparation for the Meeting/ Pre-Meeting (see Fast Fact #222)

Preparation

- **Data review**: review medical issues, current treatments and their benefits/burdens, recommendations of consultants and PCP; patient/family psychosocial-spiritual data. Is there an advance directive, a legal surrogate?
- **Invitees**: who should come, including extended family and the family’s religious leader? The primary nurse, key consultants, chaplain, social worker, interpreter, primary care clinician?

Pre-Meeting: establish an agenda with key clinicians

- **Consensus-building**: agree on the details of the assessment, reasonable management options, and prognosis (functional/cognitive/amount of time), insofar as possible.
- **Goals**: what are the hoped-for outcomes of the meeting? Urgent needs versus goals that may require more time and discussion?
- **Leadership**: who will start and facilitate the meeting? Other roles in the meeting?

Setting:

- Find a quiet, comfortable, private setting where everyone can sit. Avoid interruptions; put pagers on silent.
- Try to sit intermingled with the family, and avoid having big tables or desks separating participants
- Bring tissues

2. Introductions and Setting Goals for the meeting (see Fast Fact #223)

- Meeting leader summarizes goals and asks family to confirm or amend these goals.
- Consider setting “ground rules” about confidentiality, courtesy, letting everyone talk, interruptions, being mutually supportive in a difficult situation, etc.
- Identify the official proxy, if there is one, as well as who is going to communicate with family members or other important persons who are not present.

3. Assess the Family’s Understanding and Note Family Dynamics/Conflicts (Fast Fact #225)

- Assess understanding of patient’s medical condition and prognosis, both functionally and in terms of time. What are their best- and worse-case scenarios? Hopes and fears?
- Assess preferences for information sharing and decision-making.
- Note family dynamics. Intra-family conflicts? Conflicts between staff and family?

4. Medical review

Summarize briefly the patient’s medical condition, addressing issues that do not seem clear to the family. Share your views of best- and worse-case scenarios, likely functional outcome and independence. Address family concerns and questions.

- **Give a bottom line statement followed by silence**: “Getting worse,” “Not going to improve,” “Dying and worry that time is very short.”

- **Use the D word**: when a patient is clearly deteriorating and death is likely within the next days to weeks, it is appropriate and often helpful to use the word “dying” followed by silence to let the information settle.
Structured Family Meetings: Dealing with Conflict

Tips:
- Beware of talking too much, giving too much medical detail, using jargon, while not listening enough to how the family is responding
- Check family understanding
- Address/acknowledge emotion
- Use empathic statements

5. The Patient’s Perspective: Substituted Judgement (Fast Fact #226)
- Begin with questions about what the patient is like and how she dealt with her illness. Establish trust and an alliance around an appreciation of this patient as a person.
- Explain “substituted judgment.” When the patient lacks decisional capacity, clarify the family’s role as surrogate for the patient, in which the family identifies what the person would have wanted (not what the surrogate decision maker or family would have wanted.)
- Ask if the patient expressed attitudes about acceptable outcomes, including loss of function, dependency, prolonged institutional care, and death. If patient didn’t express attitudes or preferences, ask what family can extrapolate from how the patient lived her/his life.
- Ask if anyone thinks the patient is suffering right now. Explore family’s thoughts/worries. Ask the nurse.

6. Establish Patient-Centered Goals/Offer to Make a Recommendation (Fast Fact #226, 227)
- Weigh treatment options with the surrogate/family. Focus on big picture rather than on very specific treatments.
- Explore and address family concerns and questions.
- Offer to make a recommendation for the family based on what they have told you about the patient, and the realities/uncertainties of the medical situation.
- Identify milestones and other clinical events that define success or failure. Consider a time-limited trial.
- Remember: we never withdraw “care.” But do not feel you need to identify every imaginable option, and do not offer treatment options that are inappropriate.
- Focus on what you will do and not just on what you will not do.
- Offer empathic statements, address emotions and offer additional supports, including social service and chaplaincy. Reassure about our ability to prevent physical suffering at the end of life.

7. Plan for follow-up. Assure that you and the team is accessible. Set up future meetings.

8. Document and debrief
- Document the key decisions in the chart where everyone can see them, and convey the content directly to staff that were not present.
- Clinicians should meet briefly and in a timely manner after the meeting to reflect and to offer each other constructive feedback. What were the challenges, what went well, what might one try another time? What needs to be done next and who should do it?
The Patient:

Mrs. Duncan is a 54-year-old woman with pancreatic cancer diagnosed six months ago. She has been pursuing a strategy of aggressive treatment since diagnosis, and has received 5FU, gemcitabine, and, most recently, been on a Phase I trial. Over the past two months, she has been losing weight, and her most recent work-up showed liver metastases.

She was admitted to the hospital for abdominal pain, jaundice, and a prolonged INR, and subsequently began GI bleeding. At her family’s insistence, she was treated aggressively, but aspirated massively and was intubated. Since coming to the ICU two days ago, her GI bleeding has stopped. However, she continues to require multiple pressors and has persistently elevated liver function tests. She remains on a ventilator on 100% oxygen. She is receiving antibiotics for aspiration pneumonia. In spite of lightening her sedation, she is unresponsive to pain. Her oncologist says that she has explained how terrible her prognosis is to her and her husband from the beginning.

Mrs. Duncan has a 23-year-old daughter who lives at home, and a son who is in college nearby. Her husband is a businessman. Her sister, with whom she is very close, lives about 200 miles away. She did not discuss the possibility that she might die from her illness with her husband, and consistently tried to protect her children from understanding how bad her disease was.

Although unconscious, Mrs. Duncan can be seen to become agitated and uncomfortable when suctioned. She grimaces spontaneously at seemingly random moments.

The Setting: Family meeting to review goals of care and next steps with the ICU doctor or nurse practitioner, bedside nurse, social worker, and the patient’s husband (her health care proxy), sister, 23 year old daughter and 20 year old son who was away at college and has just arrived today.
Background  A cornerstone procedure in Palliative Medicine is leadership of family meetings to establish goals of care, typically completed at a time of patient change in status, where the value of current treatments needs to be re-evaluated. As with any procedure, preparation is essential to ensure the best outcome. This Fast Fact reviews how to prepare for a Family Meeting. See also Fast Fact #16 for a concise overview of family meetings, as well as Fast Facts 223-227 for discussion of additional aspects of family conferences.

Data Review
- Review the medical history relevant to the current medical situation (e.g. history of disease progression, symptom burden, past treatments, treatment-related toxicity, and prognosis).
- Review all current treatments (e.g. renal dialysis, artificial nutrition, antibiotics) and any positive and/or negative treatment effects.
- Review all treatment options being proposed.
- Determine the prognosis with and without continued disease-directed treatments. Prognostic information includes data concerning future patient function (physical/cognitive), symptom burden, and time (longevity).
- Solicit and coordinate medical opinions about the utility of current treatments among consultants and the primary physician. If possible, families need to hear a single medical consensus—all relevant clinicians should be contacted and consensus reached prior to the meeting. If the consultants do not agree, then prior to the family meeting they should meet to negotiate these differences and attempt to reach consensus regarding the plan. If there is no consensus, a plan should be developed for how to describe these differences to families.
- If the patient lacks capacity, review any Advance Directive(s), with special attention to discover if the patient has named a surrogate decision maker, and if the patient has indicated any specific wishes (e.g. DNR status, ‘no feeding tubes’).
- Seek out patient/family psychosocial data. Focus on psychological issues and family dynamics (e.g. anger, guilt, fear) potentially impacting decision making. These issues may be long-standing, or due to the current illness. Note: talking to the patient’s social worker, bedside nurses, and primary and consulting physicians can help you get a better sense of the family and how they make decisions.
  - Review what transpired in prior family meetings.
  - Learn about particular cultural/religious values and/or or social/financial issues that may impact decision making.

Information Synthesis  Based on your review of the medical and prognostic data, make an independent determination of which current and potential tests/treatments will improve, worsen, or have no impact on the patient’s function/quality of life (physical/cognitive) and time (longevity).

Meeting Leadership  Leading a family meeting requires considerable flexibility to ensure that all relevant participants have the opportunity to have their points of view expressed. Though it is useful to have one person designated as the main orchestrator and coordinator of the meeting, the essential skills for making a family meeting successful can come from more than one participant. These skills include:
- Group facilitation skills.
- Counseling skills.
- Knowledge of medical and prognostic information.
- Willingness to provide leadership/guidance in decision making.

Invitations  A decisional patient can be asked who he/she wants to participate from his/her family/community, including faith leaders; in general it is wise not to set any arbitrary limits on the number of attendees. The medical care team should likewise decide who they want to participate. Note: it is
important not to overwhelm a family with too many health professionals. On the other hand, a physician from the primary team as well as a nurse and social worker should attend when possible; these individuals can help ensure the consistency of information as well as help deal with complicated dynamics. If the patient has a long-time treating physician whom he/she trusts, this person should ideally be present.

Setting  The ideal setting is private and quiet, with chairs arranged in a circle or around a table. Everyone should be able to sit down if they wish. For non-decisional patients, the clinical team should negotiate with the surrogate whether or not to have the meeting in the presence of the patient.

The Pre-Meeting Meeting  The participating health care members should meet beforehand to confirm: a) the goals for the meeting (e.g. information sharing, specific decisions sought), b) who will be the meeting leader to start the meeting, and c) likely sources of conflict and initial management strategies.

References

Author Affiliations: Medical College of Wisconsin, Milwaukee, WI (DEW); University of Rochester Medical Center, Rochester, NY (TEQ); University of Pittsburgh School of Medicine, UPMC Health System, Pittsburgh, PA (RMA).

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Background  Fast Fact #16 gives a concise overview of running a family meeting. Fast Fact #222 provides a list of preparatory steps in planning for a family meeting to discuss end-of-life goals; this Fast Fact reviews the early steps of the actual meeting.

1. **Introductions & setting goals for the meeting**
   - The meeting leader begins the meeting by introducing him or herself, and suggesting that each person present (medical team and family/community) introduce themselves including their relationship to the patient.
   - The meeting leader should summarize the meeting goals (e.g. *We are here to discuss next steps in the care of Mr. Jones*) and ask the family to confirm these goals and/or add other agenda items.
   - **Note:** if you do not know the patient or family well, take a moment to build relationship. Ask a non-medical question such as *I am just getting to know you. I had a chance to look at your chart and learn about your medical condition but it does not say much about your life before you got sick. Can you tell us about the things you liked to do before you got sick?* Similarly, if the patient is not able to participate in the meeting, ask family to describe the patient prior to his becoming ill: *As we get started, can you describe what Mr. Jones was like before he became ill?*

2. **Determine what the patient/family already knows**  This step is essential as it guides you in providing a synthesis of the medical information (see below). Always invite the patient and all family members to provide their understanding of the medical information. Examples of opening lines:
   - *Tell me what the doctors have told you about your condition?*
   - *Can you describe for me your sense of how things are going?*
   - For patients who have been declining from a chronic illness, you can ask: *Tell me about the past 3-6 months: what types of changes have you noted?* The patient or family will typically describe changes in terms of function (physical or cognitive) and quality of life.

3. **The Medical Review**  Once you know what the patient/family understands, you are in a good position to confirm their understanding, or provide new information/correct misunderstandings. First, ask if you can bring them up-to-date about what is going on; asking shows politeness and also signals that they should attend to what you are trying to say. The clinician most closely aligned with the patient’s ongoing treatment should begin this discussion, supplemented with information from consulting services if relevant. Do not provide information using medical jargon or in an organ system approach (e.g. *The creatinine is improving, but there is a new pleural effusion and the heart rate has become irregular*). A more patient-centered approach is to provide a succinct summary of the current condition, without any medical jargon, focusing on the issues of most importance, which are usually function/quality/time. Give a ‘bottom-line’ statement: ‘getting worse,’ ‘not going to improve,’ ‘dying and time is likely very short.’
   - *The worsening weakness and pain you describe is from the cancer which is growing despite the chemotherapy.*
   - *You are telling me that despite the recent hospitalization, you are not able to do as much around the house; unfortunately your lung disease is getting worse despite all our best treatments.*
   - *Despite our best efforts, your wife’s brain injury from the car crash is getting worse. She can no longer stay awake or move her arms/legs.*

Using the ‘D word’ if relevant: when a patient is clearly deteriorating and death is likely within the next days to weeks, or even a few months, it is appropriate to use the word *dying* in the conversation. Both patients and surrogates find that saying the word *dying*, if done compassionately, is helpful in clearing
what is often a confusing and frightening situation. I’m afraid we have run out of options to shrink the cancer. Based on your declining function, I believe you are dying.

4. Silence Whether or not you use the word dying, when you have presented bad news (such as information about disease progression), the next step is for you to allow silence, and let the family/patient respond. In truth, no matter what you might imagine the response from the patient/family to be once the bad news is delivered, you really cannot predict their emotional reaction (e.g. relief, anxiety, anger, regret, fear). This silence can be uncomfortable; resist the urge to fill it with more facts as they will not be heard. Not all patients/families express emotions at this point and instead respond practically (Well, what happens next then?). This is fine, but you need to wait, silently, to see what response the patient/family demonstrates. In addition, even practical questions have underlying emotions (Are you sure? Or – There must be something you can do?). It is important to respond to both the factual aspect of the question (Yes I am sure. Or – There are no more effective treatments available.), as well as the emotional level (I wish I had better news for you. Or – I wish our treatments worked better than they do.).

When the patient/surrogates openly acknowledge that current treatments are no longer effective, that death is coming, they will generally ask one or all of the following questions: How long? What will happen? Will there be suffering? What do we do now? Your response at this point should be to address prognosis in terms of time, function, and symptoms, as best you can (see Fast Facts #13,141,143,149,150). This will answer the first two questions; the last questions will require more discussion of patient-centered goals (see Fast Fact #227).

References

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FAST FACTS AND CONCEPTS #224
RESPONDING TO EMOTION IN FAMILY MEETINGS
David E Weissman MD, Timothy E Quill MD, and Robert M Arnold MD

Background
Family meetings are stressful events, often provoking strong emotional reactions. Fast Fact #29 presents a general outline on the topic of how clinicians can respond to emotions. The Fast Fact will provide a more detailed approach to emotions that arise during family meetings.

Consider your role.
It is important to reflect on the role of clinicians in responding to patient/family emotions at the time life-altering information is shared. The goal is not to prevent a patient/family from having those emotions. Sadness, fear, anger, and loss are normal responses to unwelcome news. Instead your role is: 1) to maintain a trusting therapeutic relationship and safe/supportive environment that allows emotions to be expressed in a way that meets the patient's/family's needs; and 2) not to worsen the experience for the patient/family by ignoring or delegitimizing their responses, or confusing them with medical information when they are not ready to hear it. Recognize that most families find clinicians’ expressions of empathy tremendously supportive and these are associated with family satisfaction.

Acknowledge that emotion is being expressed.
If you have a good sense of what the emotion is, then it is useful to name it. If not, using more general language is preferable.

- *I can see this is really affecting you.*
- *This information is very upsetting.*

Legitimize the appropriateness and normalcy of the reaction.
Medical professionals are in a powerful position to help patients and families feel that strong emotions under these circumstances are normal and to be expected.

- *Anyone receiving this news would feel devastated.*
- *It is completely expected to be very distressed by this kind of news.*

Explore more about what is underneath the emotion.
It is tempting to try to limit the emotion, and be prematurely reassuring. But it is generally more helpful and ultimately more time-efficient to allow the patient and family to more deeply explore their feelings and reactions.

- *Tell me what is the scariest (most difficult) part for you.*
- *Tell me more about that….* (Keep the exploration going until it is fully expressed and understood.)

Empathize (if you genuinely feel it).
Empathy means being able to emotionally imagine what the patient is going through. Clinicians can initiate the prior responses (acknowledge, legitimize, explore) without having a clear feeling for the patient’s experience. These responses can be adequate in themselves. If the clinician cannot imagine the patient’s experience, he or she can still sensitively explore the experience and provide caring and support. But if you have a strong sense of what the patient is experiencing, it can be very therapeutic to express it.

- *This seems really unfair.*
- *I can imagine that you might feel very disappointed.*

Explore strengths/coping strategies.
This may occur at this phase of the interview, or it may be postponed to a later phase when planning for next steps begins.

- *In past circumstances, what has helped?*
- *How have you adapted to difficult circumstances in the past?*
- *What are you hoping for now?*

References


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Background When family meetings are conducted with the goal of helping a patient/family cope with a shift in goals from life-sustaining treatments to a more comfort focused approach, communication can break down. This Fast Fact reviews the common causes of conflict.

Recognizing Conflict When the patient/surrogates are not psychologically ready to accept the limits of medical interventions or the finality of the impending death, you will hear comments such as these: There must be some mistake; I know there are other treatments available; We want a second opinion; We believe in miracles; She is fighter, she will never give up; There must be something (medically) you can do. Health professionals may interpret these statements as ‘denial.’ But the term denial, by itself, is insufficient to help the clinician understand what is causing the impasse. Understanding the cause is essential in planning an effective strategy to move beyond the conflict to meet the needs of the patient and surrogates.

Information Gaps
- Inaccurate understanding of the patient’s medical condition (e.g. overly optimistic/pessimistic prognosis).
- Inconsistent information (One doctor tells us one thing and another something else.).
- Confusing information (e.g. use of medical jargon, multiple treatment options presented without a clear recommendation).
- Excessive information (well-meaning family/friends/clinicians providing information without full awareness of the problems).
- Genuine uncertainty (e.g., predicting functional outcome from a brain injury in its immediate aftermath may be impossible).
- Language/translation/cultural issues (We never tell someone they are dying in our culture.).

Treatment Goal Confusion
- Inconsistent treatments and unclear goals, often due to physician/patient/surrogate emotional issues (see below):
  - Clinician initiated: We will keep your husband on blood pressure raising medicine but stop antibiotics.
  - Family initiated: We want you to do CPR, but not intubate her.
- Differing priorities about disease-directed treatment and comfort-oriented treatment between clinicians and patient/family.
- Lack of clarity about goals when several things are going on simultaneously (advanced cancer, severe infection, respiratory failure – Isn’t the pneumonia potentially treatable?)

Emotions
- Grief (I don’t know how I will live without him.)
- Fear/anxiety (I don’t want to be responsible for ending my father’s life. My family will be angry at me for doing this.)
- Guilt (I haven’t visited my sister in 20 years. I should have been here for her.)
- Anger (My mother was very abusive, I’ve never forgiven her; you are just giving up on her.)
- Hope (I’m still hoping and praying she can pull through this.)

Family/Team dynamics
- Patient/family conflicted within themselves; may want different things at different times
- Dysfunctional family system (family members unable to put the patient's needs/values/priorities above their own).
- Surrogate lack of ability (cognitive deficit, psychological/psychiatric trait/illness). In pediatrics, this can be conflict between what is in the best interest of a child vs. a caregiver or family.
• Consulting teams disagree about the optimal approach, putting the patient/family in the middle of the dispute.

**Relationship between the Clinician and the Patient/Surrogate**

- Lack of trust in the health care team/health care system.
- Past experiences where the patient has had a better outcome than predicted.
- Genuine value differences:
  - Cultural/religious values concerning life, dying, and death.
  - Clinician value to protect the patient from invasive, non-beneficial treatment while the family values wanting to prolong life no matter how much suffering it might entail.

All of these issues represent a degree of conflict and will need to be addressed before proceeding to set end-of-life goals. See *Fast Facts* #183,184 for additional discussion on managing conflict.

**Debriefing**  Conflicts are stressful for all involved health professionals. It is helpful to debrief the process – what went well, what could have been improved, and – most importantly – addressing the emotional reaction and needs of the care team. See *Fast Fact* # 203 on managing clinician emotions.

**References**


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FAST FACTS AND CONCEPTS #226
HELPING SURROGATES MAKE DECISIONS
David E Weissman MD, Timothy E Quill MD, and Robert M Arnold MD

Background
Surrogate decision makers are often placed in the difficult position of making what feels to them as life or death decisions. This Fast Fact reviews an approach to help surrogates through the decision process when patients cannot participate in decision-making themselves.

Surrogate decision making
The surrogate’s role is clearly to exercise “substituted judgment” – that is, to make decisions as the patient would make them using the patient’s values and preferences as previously expressed. The challenge was clearly expressed by the New Jersey Supreme Court in the Quinlan case: if (the patient) could wake up for 15 minutes, understand his current medical situation completely, and then had to go back into it, what would he tell us to do? In the case of children, surrogate decision makers (usually parents) are expected to make decisions that represent the child’s ‘best interests’; depending on the age and capacity of the child to participate in his/her own healthcare decision making, the applied ‘best interest’ judgment by the surrogate and healthcare providers may incorporate the patient’s values and preferences to the extent possible, or may be solely based on the decision maker’s interpretation of best interest. If there is conflict about what is in a child’s best interest, or in cases of developmentally disabled adults who have never had capacity, consultation from ethics and law may be appropriate, as the rules governing decision-making vary considerably.

Helping surrogates
1. Before making a recommendation, make sure there is a common understanding of the patient’s condition and prognosis. Following this, the next step is to try to understand the patient’s goals in light of these medical facts.
2. Bring the patient’s “voice” into the decision process even if he/she cannot participate directly: If your father were sitting here with us, what would he say? If available, share a copy of any advance care planning document with the surrogate. Realize that it is common for the surrogate never to have seen the document.
3. Whenever possible, frame the decision around the treatment goals (e.g. life prolongation, allowing a peaceful death) in light of the patient’s current condition, rather than focusing on very specific treatments (e.g. thoracentesis, antibiotics). The details of the medical plan should flow from the overall goals of care.
4. Do not make the surrogate feel that they are taking full responsibility for medical decisions, especially those which may result in the death of their loved one (We can do option a or b; what would like me to do?). Once you have a sense of the patient’s goals in light of his/her medical condition, offer to make a recommendation that reflects those goals. Note: Many families are looking for support and guidance from medical professionals, especially the physician. Given what you have told me about your mother, and what we know about her medical condition, I would recommend….. Start with what you are going to do to achieve the patient’s goals and then talk about what does not make sense given those goals. Remember, however, that some families may want information but not your recommendation. It is therefore important to offer your recommendation (Would it be helpful for me to say what medically makes the most sense, given what you’ve told me about your Dad?).
5. Remember that we are talking about the potential death of the surrogate’s loved one. Emotions – sadness, frustration and guilt – are appropriate and to be expected. Use previously discussed emotion management skills to acknowledge, legitimize, empathize and support the family’s emotional response (see Fast Facts #29 and #224).
6. Do not argue over the facts; repeating the facts over and over again is not likely to be effective. When the surrogate says He is a fighter, acknowledge that he is and has really fought hard. The surrogate saying I want you to do everything is as much a sign of emotional desperation as it is a factual request. Respond with empathy: It seems this is really hard for you. If hope for a miracle is
expressed, it is appropriate to acknowledge that you hope for an unanticipated recovery as well, but
that a miracle is truly what it would take at this point.

7. Rather than reiterating what medicine cannot do, consider using “I wish” statements to keep you in
touch with the surrogate’s feelings, while simultaneously expressing medicine’s limitations (I wish our
medicines were more effective; I wish we had more medical treatment to offer than we do…).

8. Recognize the importance of time and support for surrogates to do their necessary grief-work. Offer
counseling services, either informal through the work of a palliative care team, or more formal
resources available at your institution. Bring together your clinical care team and strategize potential
resources for support such as chaplaincy, social services, psychology, palliative care or ethics
consultation.

Remember that time is your ally. The surrogate needs to process that their loved one is dying and
conceptualize what life will be like without him or her. This grief work takes time and psychological
support. Often, letting people think about what you have said and talking again over subsequent days
provides them the space to do grief work. It also allows them to see for themselves that what you have
advised is coming true (e.g. the patient is not getting better).

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Author Affiliations: Medical College of Wisconsin, Milwaukee, WI (DEW); University of Rochester
Medical Center, Rochester, NY (TEQ); University of Pittsburgh School of Medicine, UPMC Health
System, Pittsburgh, PA (RMA).

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FAST FACTS AND CONCEPTS #227
THE FAMILY MEETING: END OF LIFE GOAL SETTING AND FUTURE PLANNING
David E Weissman MD, Timothy E Quill MD, and Robert M Arnold MD

Background  End-of-life goal setting is a key palliative care skill, typically occurring as part of a family meeting (see Fast Facts #16, 65, 222-226). This Fast Fact discusses an approach to goal setting when the expected length of life is short.

Establishing patient-centered goals  Here is an example of how to start the conversation (the patient should be given sufficient time to respond to each of these questions):

I/we have discussed your current condition and that time may be short. With that in mind –

- What are you hoping for now?
- What is important to you?
- What do you need to accomplish?
- Who do you need to see in the time that is left?

Common responses invoke family, home, and comfort; often surviving until a specific future family event/date or visit with a key family member is described as an important goal. Re-state your understanding: What I hear you saying is that you want to be home, comfortable, and survive until your daughter gives birth – you hope to meet your next grandchild.  Note: if you believe the patient’s goal of survival to a specific event/date is not practical, it is important to say so and discuss alternative plans.

Recommend a care plan based on the goals  Once the goal(s) is/are established, you can then review the patient’s current treatments (e.g. antibiotics, chemotherapy), monitoring (e.g. pulse oximetry), planned tests (e.g. colonoscopy), and medications (e.g. anti-hypertensives), and decide which will help meet, or not, the patient’s goals. Anything that will not help meet the goals should be discussed for potential discontinuation. Depending on the specific disease/patient condition, other issues that are naturally discussed at this point include:

- Future hospitalizations, ICU admissions, laboratory and radiology tests.
- Resuscitation orders/code status (see Fast Facts #23-24).
- Current/future use of blood products, antibiotics, artificial hydration/nutrition.
- If present, the potential continuation or stopping of dialysis or cardiac devices.
- Role of a second (or third) opinion.
- Exploration of experimental therapy.
- Exploration of treatment options the patient or family may bring into the conversation.
- Disposition options to best meet the goals (e.g. home hospice referral).

Note: There is no need to ask about each option as a yes/no question (Do you want blood products?). Based on what you know about the patient’s goals, make a recommendation about what should and should not be done in light of the patient’s goals, condition and prognosis. If you are unsure, you can explore the issue with the patient/family (Given that your dad wanted to get home as soon as possible and yet he was also willing to do easy things that might help him live longer, I am unsure whether it makes sense to stay in the hospital an extra day or two to finish the antibiotics. What do you think he would say?).

‘Long-shot’ goals  If patients are going to pursue ‘long-shot’ or experimental therapy, perhaps even against the recommendation of the treating team, it is useful to ensure the following:

- Reinforce the team’s respect for the decision, and desire to make sure the treatment has the best possible chance of working.
- Simultaneously try to maximize quality of life in the present, including the best possible pain and symptom management and support.
- Encourage the patient and family to prepare in case treatment is not successful and the patient dies sooner rather than later. Useful language is to say, *I'd encourage us all to hope for the best, but prepare for the worst.*
- Reinforce that the team will not abandon the patient and family even if the decision is not what is being recommended.

**Close the meeting** Following this discussion, restate your understanding of the patient’s goals and agreed-upon next steps to meet those goals, invite and answer questions, and close the meeting.

**Discussion & documentation** Discuss the goals with key staff not in attendance (e.g. consulting physicians, patient’s nurse, discharge planner, primary care provider). Document the goals, preferably using a templated family meeting note (see Reference 1): who was present, what was discussed (e.g. treatment options, prognosis), what was decided, next steps.

**Debriefing** A useful step after every family meeting is to debrief the process – what went well, what could have been improved and, most importantly, addressing the emotional reaction and needs of the care team.

**References**

**Author Affiliations:** Medical College of Wisconsin, Milwaukee, WI (DEW); University of Rochester Medical Center, Rochester, NY (TEQ); University of Pittsburgh School of Medicine, UPMC Health System, Pittsburgh, PA (RMA).

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Background  Conflicts about medical care occur frequently at the end of life. These conflicts threaten therapeutic relationships and lead to patient, healthcare provider, and family dissatisfaction. Conflict between the patient/family and physician may arise from simple factual misunderstandings about medical care. Frequently, however, conflict is driven by a patient’s or family’s emotions such as feeling unheard or ignored, as well as having goals that conflict those of the medical team. In these instances, attempting to convince a patient or family through providing additional medical information will not work. This Fast Fact provides an alternative approach to conflict resolution based on understanding a patient’s or family’s story, attending to their emotions, and establishing shared goals. A subsequent Fast Fact (#184) will focus on conflict resolution employing the techniques of Principled Negotiation.

1. Learn the patient’s and family’s story
   - Begin discussions with a genuine curiosity to learn what they perceive to be the course of events during the illness.
   - Explore the context of the patient’s illness narrative with attention paid to their relationships with doctors, their sources of medical information, and their life goals (see Fast Fact #26)
   - Avoid presenting agenda items for a meeting that are defined by the medical team’s priorities. Instead, focus on the patient’s and family’s concerns.
   - If a patient or family is asking for treatment against the recommendation of the medical team, focus on the context of the request. Have they been let down by the medical system in the past? Have they found that others in their family have benefited from the treatment they request?
   - Find out how they want information presented to them. Do they want specific benefits and risks? Do they want written information?

2. Attend to emotions
   - Conflict can cause strong emotions in healthcare providers including guilt, anger, and resentment. Acknowledge these emotions to yourself and other professionals, but strive to prevent them from interfering with your interactions with the patient and family.
   - Patient and family emotions such as grief, disappointment, and anger are to be expected in these situations. Compassionately acknowledge and address these emotions as they arise, and allow the patient and family to express what is making a situation frustrating for them (see Fast Facts #29, #59). When people are emotionally stressed, they may have trouble cognitively processing information. Empathically attending to emotions often allows a patient or family to move on to understanding medical information.
   - If a family is focusing on what they believe was an error in care, be transparent about where a mistake may have been made (see Fast Facts #194, 195). Apologize. Even if it was not an error, one can acknowledge how frustrating the situation is. Saying “I can tell that this situation is frustrating for you,” is not an admission of error—it is empathic.

3. Establish shared goals for treatment
   - Use the patient’s core values as a foundation for developing a treatment plan. “I would like to know more about your mother and what her values have been during her life.”
   - Ask about a patient’s goals including what they would want if they were dying or if there were no curative treatments available for their condition.
   - When there are requests for ineffectual treatment, describe instead where the medical team can make a difference for the patient, in relation to their goals. “Please correct me if I’m wrong, but it sounds like your mother really values her independence and freedom from being in pain. Let’s try to figure out how we can best help her achieve these goals.”
Summary  Providing medical information to patients and families may seem at first to be the most natural approach to resolving conflict. Addressing the underlying roots of conflict will have a longer lasting effect. The above approach emphasizes resolving conflict through finding mutual trust and shared goals between physicians, patients, and families.


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Background When conflicts about medical care persist despite gaining mutual trust and a deep understanding of goals (see Fast Fact #183), it may be effective to use principled negotiation. Principled negotiation is an approach to resolving conflict that avoids power struggles and unwanted compromises. The following is an illustration of the steps that are involved. Within each step, we will refer to a case example: a family who is requesting artificial feeding against medical advice for their father who is dying from end-stage dementia.

1. **Separate people from the problem.** Identify the fundamental problem, separating that from individuals—one on both sides—intentions and culpability.
   - The problem is not that the family members are “in denial” that their loved one is dying or “uneducated” when they do not hear the medical team’s recommendations.
   - The problem is not that the family is acting out their frustration by making unreasonable demands.
   - Nor is the problem that the medical team and hospital are trying to withhold treatment from the patient or “giving up” on him.
   - The problem is that the patient is dying, no longer able to eat properly, and that artificial nutrition does not improve quality or quantity of life in this situation.

2. **Focus on interests.** Listen to requests and demands but try to look into underlying interests. In addition, express the intentions and goals of the medical team.
   - The family wants what is best for the patient. Their intent may be to provide comfort and to build up the patient’s strength, and to prevent a painful starvation.
   - The medical team wants to provide the best medical care for the patient. Their intent may be to avoid an intervention that has no clear benefit for the patient, may cause harm, and may not have been desired by the patient.

3. **Invent solutions.** Avoid contrasting different philosophies of medical care. Instead, propose a plan of care that meets a family’s expectations without detracting from good medical care. Consideration could be given to:
   - Meeting the family’s goals of providing food by allowing for the patient to taste home cooked meals.
   - A short trial of tube-feeding with the plan to continue only if the overall quality of life for the patient improves.
   - A trial of attentive oral feeding with a plan to reconsider tube feeding if the patient appears to be hungry or otherwise suffering.
   - Solutions that do not promote mutual interests are: placing a feeding tube without a plan to measure its success or failure at meeting a goal, arranging for another medical team to take over the patient’s care, or referring the case to an ethics committee.

4. **Outline objective criteria.** If a time trial is being pursued, agree upon what the deciding factors would be in determining a trial’s success. Provide objective information to substantiate medical recommendations.
   - Establish signs of improvement or worsening such as functional ability, weight, ability to interact, and level of consciousness.
   - Establish criteria for harm such as infections, restraint or sedative use, hospitalizations or emergency department visits.
   - Consider providing publications from organizations that advocate for patients and families, and are not associated with physicians or hospitals.
• Provide opinions or guidance from individuals outside of the conflict. These could include social workers, case managers, chaplains, or therapists.

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Because most critically ill patients do not have decision-making capacity, family members frequently become involved with clinicians in discussions about the goals of care and often must represent patients' values and treatment preferences in these discussions. Therefore, clinician-family communication is a central component of good medical decision making in the ICU. Prior studies suggest that family members view clinicians' communication skills as more important than our clinical skills. However, clinician-family communication in the ICU is often inadequate. One study found that only half of families of ICU patients sufficiently understand basic information about patients' diagnoses, prognoses, or treatments after a discussion with clinicians. Another study found that clinician-family communication commonly does not meet the basic...
standards of informed decision making. The purpose of this narrative review is to provide a context and rationale for improving the quality of communication with family members within the ICU and to provide practical, evidence-based guidance on how to conduct this communication. We propose that this approach be used for major decisions that depend heavily on patients' values and preferences, such as decisions about limiting life-sustaining treatments when survival is unlikely but possible and when survival may come with significant future functional impairment. We do not advocate this approach for routine medical decisions or for cases of strict medical futility.

**Rationale for Focusing on Communication With Family Members**

Family members are becoming an increasing part of caregiving for seriously ill patients, whether this is informal support and care in the home or surrogate decision making in the ICU. Informal care and decision making provided by family, partners, and friends constitute a growing portion of the health care provided to seriously ill patients. Furthermore, approximately 20% of deaths in the United States occur in the ICU, and most of these deaths involve family members acting as surrogates for the patient. However, being a family caregiver is a difficult job, associated with significant emotional burdens, and is frequently performed by people who are themselves elderly, ill, or disabled. Studies demonstrate that almost half of all family caregivers and surrogate decision makers experience significant symptoms of anxiety, depression, and posttraumatic stress disorder. Caregiving is also associated with increased caregiver mortality. Despite the emotional and health burdens of being a family caregiver, our health-care system does not provide adequate support for family caregivers. Many physicians and health-care systems do not consider the family to be a focus of their care. The American Medical Association has called on the health-care system to acknowledge that family and clinicians are interdependent and to develop a care partnership in order to improve outcomes for patients and family members, but this is often an unrealized goal. Several critical care professional societies have highlighted the importance of focusing on the family.

In the ICU setting, there is an additional reason to focus on the needs of the family. Since family members are often serving as surrogate decision makers, decisions about the care of the patient depend in part on the family. To the extent that family members' distress affects their ability to provide substituted judgment, these burdens of family members can interfere with patient care. Therefore, effective communication with family members that minimizes stress on the family and provides support for the family will improve not only family outcomes but also medical decision making for the critically ill patient.

**The Role of Shared Decision Making**

There is general consensus that physicians caring for critically ill patients have an obligation to disclose information about a patient's medical condition and prognosis to family members, and also that family members are an important source of information about the patient's values and treatment preferences. Furthermore, there is consensus that family members' fulfilling this role should be counseled to use the principle of substituted judgment to guide decisions when possible, attempting to answer the question of what the patient would say if he or she were able to participate. Although a number of distinct approaches to conceptualizing the physician-patient or physician-surrogate relationship have been proposed in our experience critical care physicians often conceptualize their role in one of three distinct ways: (1) parentalism, in which the physician makes the treatment decision with little input from the patient or family; (2) informed choice, in which the physician provides all relevant medical information but withholds his or her opinion and places responsibility for the decision on the family; and (3) shared decision making, in which the physician and family each share their opinions and jointly reach a decision. In 2005, five European and North American critical care societies issued a joint consensus statement advocating shared decision making about life support in ICUs. This consensus statement characterizes a shared decision as one in which "responsibility for decisions is shared jointly by the treating physician and the patient's family." Similarly, shared decision making was also endorsed by the American College of Critical Care clinical practice guidelines for support of the family during patient-centered critical care.

Family members of critically ill patients vary in how involved they want to be in decisions about life support. The majority want the physician to provide a recommendation about whether to limit life support and then share in the final decision. However, it is important to realize that there is a spectrum of preferences, ranging from letting the physician decide to the family member assuming all responsibility for the final decision. Therefore, family-centered decision making requires that clinicians assess the families' preferred role in decision making rather
Table 1—Components of Shared Decision Making Adapted to the ICU Family Conference*

<table>
<thead>
<tr>
<th>Dimensions of Shared Decision Making</th>
<th>Example of Physician Behaviors and Questions</th>
</tr>
</thead>
</table>
| Providing medical information and eliciting patient values and preferences | Discuss nature of decision  
What are the essential clinical issues we are addressing?  
Describe alternatives  
What are the clinically reasonable choices?  
Discuss pros/cons  
What are the pros and cons of the treatment choices?  
Discuss uncertainty  
What is the likelihood of success of treatment and how confident are we in this estimate?  
Assess understanding  
Is the family now an “informed participant,” with a working understanding of the decision?  
Explore patient’s values/preferences  
What is known about patient’s medical preferences or values? What is important to the patient? |
| Exploring family’s preferred role in decision making | Discuss family’s role  
What role should the family play in making the decision?  
Assess desire for other’s input  
Is there anyone else the family would like to consult? |
| Deliberation and decision making | Explore “context”  
How will the decision impact the patient’s life?  
If the family is to participate in decision-making, elicit family opinion about best treatment choice  
What does the family think is the most appropriate decision for the patient? |

*Adapted from White and colleagues.4

than assume “one size fits all.” In addition, high-quality shared decision making is a process with a number of important components and not simply an agreement to allow family members to be involved in decision making. Table 1 describes the components of shared decision making based on prior theoretical models and empiric evaluation of communication during ICU family conferences.4,34

We advocate that clinicians should tailor their approach to communication to the individual families’ decision-making preferences. Figure 1 outlines a potential approach to match the clinicians’ role with the families’ needs, for which the default starting position is one of shared decision making. This default position is modified by three subsequent steps. First, the clinicians should consider the prognosis and the certainty of the prognosis. As the prognosis becomes poorer and the certainty about this prognosis becomes higher, physicians should be more willing to offer to take on some of the burden of decision making. For some family members, the process may be best conceptualized as providing “informed assent.”35 This informed assent approach allows family members to cede responsibility for difficult decisions to clinicians and generally requires both a very poor prognosis and a high level of certainty about the prognosis. However, it is important that physicians allow family members the opportunity to be involved in decision making if they choose to do so. Therefore, steps two and three are to inquire into the families’ preferred role, then adapt one’s approach to these patient and family factors. Our experience has been that elicitation of role preferences is often ineffective when it occurs before the family understands the nature of the decisions at hand. We therefore advocate for a

![Figure 1. Three-step approach to patient- and family-centered decision making that advocates for a default starting place of shared decision making that can be modified by prognosis and certainty of prognosis and also by family preferences for role in decision making.](image-url)
process of ongoing conversations during which clinicians look for cues from family members about their preferred role in decision making, and then use those cues as a starting point for explicit discussion about roles in decision making. In addition, the chosen approach should be reassessed over time because family preferences may change over time or with a changing prognosis. In this way, shared decision making is not viewed as “one size fits all” or as a static one-time decision, but rather as a process that is responsive to the needs of the family.

Shared decision making also requires physicians to be expert in helping family members understand and articulate patients’ values. Exploring patients’ preferences and the appropriate influence of those preferences on medical decision making is one of the common missed opportunities during ICU family conferences. An important approach to accomplishing this component of shared decision making is asking open-ended questions that allow the family to describe what is important to the patient and explore how this informs decision making about treatments. It is also important to focus the family on what the patient would say if he or she were able to participate in the decision making.

COMMUNICATION WITH FAMILY MEMBERS OF ALL CRITICALLY ILL PATIENTS

With increasing focus on improving end-of-life care in the ICU, we run the risk of forgetting the family of patients who survive their ICU stay. There are several reasons to focus on communication with the families of all critically ill patients. First, it is generally not clear whether critically ill patients will survive at the time when clinician-family communication should be occurring. Second, although the patient’s death in the ICU is a risk factor for psychological symptoms among family members, even family of patients who survive are at increased risk of these symptoms compared to the general population. Finally, there is evidence that family members of patients who survive are actually less satisfied with communication from ICU clinicians than family of patients who die. If we are to be truly effective in improving clinician-family communication, we must attempt to improve this communication for the family of all critically ill patients.

AN EVIDENCE-BASED APPROACH TO COMMUNICATION DURING THE ICU FAMILY CONFERENCE

Discussions between ICU clinicians and family members about goals of care and medical decision making often take place during ICU family conferences. Conduct of these conferences within 72 h of ICU admission has been associated with reduced days in the ICU for patients that die and with higher ratings of the quality of dying among family members. There are also specific features of these conferences that have been associated with improved family experience or with better assessment of the quality of communication. Improved family outcomes have been associated with having a private place for family communication and with consistent communication by all members of the health-care team. A “preconference” may help meet the latter goal, in which the interdisciplinary team discusses the goals of the family conference and reaches consensus on the prognosis and on what treatments are indicated. During the conference, family members are more satisfied with clinician communication when clinicians spend more time listening and less time talking. Other features of clinician communication that are associated with improved family experiences include assurances that the patient will not be abandoned prior to death; assurances that the patient will be comfortable and will not suffer; and support for a family’s decisions about care, including support for family’s decision to withdraw or not to withdraw life support. In addition, empathic statements by clinicians have also been associated with increased family satisfaction. The three most common types of empathic statements in this setting are statements that explicitly acknowledge the difficulty of having a critically ill loved one, the difficulty of surrogate decision making, and the sadness of having a loved one die. Finally, evaluation by investigators suggest categories of important missed opportunities during ICU family conferences, including the opportunity to listen and respond to family members’ questions, the opportunity to acknowledge and address family emotions, and the opportunity to address basic tenets of palliative care including the exploration of patient preferences, explanation of the principles of surrogate decision making, and assuring nonabandonment by clinicians. Table 2 summarizes the components of clinician-family communication that have been associated with increased quality of care, decreased family psychological symptoms, or improved family ratings of communication.

Several of these findings have been combined into a mnemonic for five features to enhance clinician-family communication: VALUE (value, acknowledge, listen, understand, and elicit) [Fig 2]. This mnemonic has been used as part of an intervention to improve clinician-family communication in the ICU that has been shown to significantly reduce family symptoms of anxiety, depression, and posttraumatic stress disorder 3 months after the patient’s death.
Conduct family conference within 72 h of ICU admission. Identify a private place for communication with family members. Provide consistent communication from different team members. Increase proportion of time spent listening to family rather than talking. Empathic statements. Statements about the difficulty of having a critically ill loved one. Statements about the difficulty of surrogate decision making. Statements about the impending loss of a loved one. Identify commonly missed opportunities. Listen and respond to family members. Acknowledge and address family emotions. Explore and focus on patient values and treatment preferences. Explain the principle of surrogate decision making to the family (the goal of surrogate decision making is to determine what the patient would want if the patient were able to participate). Affirm nonabandonment of patient and family. Assure family that the patient will not suffer. Provide explicit support for decisions made by the family.

**DISCUSSING PROGNOSIS**

Physicians have an important responsibility to share prognoses with patients and their families. However, studies suggest that many physicians do not discuss prognosis directly; and when they do, there is considerable variability in how this is done. There are limited data to guide discussion of prognosis in the ICU, but it is interesting that physicians in ICU family conferences are more likely to discuss prognosis for quality of life than they are to discuss prognosis for survival. This finding suggests that physicians find prognosis for quality of life more relevant to family members and highlights the importance of research to identify prognosis for quality of life.

Expert recommendations can help guide discussions of prognosis and suggest that numeric expressions of risk (eg, "your mother is very unlikely to survive") generally lead to better comprehension than do qualitative expressions of risk (eg, "your mother is very unlikely to survive"). Moreover, since prognostic information applies to outcomes of groups of patients, experts recommend that prognostic information be framed as outcomes for populations rather than as individual outcomes (eg, "out of a group of 100 patients like your mother, I would expect about 90 would not survive this"). Some experts also recommend describing both the probability of death as well as the probability of survival to improve understanding. Patients' willingness to consent to life-sustaining treatment declines substantially as the chances for death or severe functional impairment increase. Therefore, clear, empathic disclosure of prognosis is especially important as the prognosis worsens.

**VALUE: 5-step Approach to Improving Communication in ICU with Families**

- **V**... Value family statements
- **A**... Acknowledge family emotions
- **L**... Listen to the family
- **U**... Understand the patient as a person
- **E**... Elicit family questions

**FIGURE 2.** VALUE mnemonic for improving clinician-family communication in the ICU.

**IMPORTANCE OF INTERDISCIPLINARY INVOLVEMENT IN FAMILY CONFERENCES**

In observational studies, better interdisciplinary communication among nurses and physicians is associated with a number of important outcomes in critical care, including increased patient survival, decreased length of stay, and decreased readmission rates. Better nurse-physician communication has also been associated with higher patient satisfaction and lower rates of ICU nurse and physician burnout. These studies highlight the importance of improving interdisciplinary communication as a mechanism for improving patient outcomes. Improved interdisciplinary collaboration is also associated with decreased symptoms of anxiety and depression among family members and therefore is likely an important component of communication with the family.

End-of-life care in most settings is delivered by an interdisciplinary team that includes nurses, physicians, and other clinicians. Patients and families report that interdisciplinary communication is a key component of good end-of-life care. Furthermore, most studies of interventions that improved end-of-life care in the ICU explicitly included an interdisciplinary intervention. In the randomized trial of proactive communication with family members using the VALUE strategy and a bereavement pamphlet, the intervention resulted in more nurses attending ICU family conferences and speaking more during these conferences.

**SPIRITUALITY AND CROSS-CULTURAL COMMUNICATION**

Assessing family members' spiritual needs and offering spiritual care is an important component...
of care for the family of critically ill patients. Family satisfaction with ICU care is higher if the spiritual care needs of family members are assessed and if spiritual care is provided by a spiritual care provider such as a hospital chaplain. Critical care clinicians should not attempt to provide spiritual care, but should routinely assess patient and family desire for spiritual care and refer to spiritual care providers.

Communication with family of critically ill patients is challenging even when clinicians, patients, and family members are from the same culture. When this communication occurs across cultures, there are often more opportunities for miscommunication and mistrust. Recommendations for enhancing cultural competency in health-care communication include exploring cultural beliefs; focusing on building trust rather than decision making about a specific treatment; addressing communication and language barriers to assure good bidirectional understanding between clinicians and family members; explicitly discussing spirituality and religion and the role they play in end-of-life care preferences and decision making; and involving extended family and religious or community leaders.

When cross-cultural communication occurs in the setting of family members who do not speak the same language as clinicians, this adds considerably to the complexity of this communication. Use of professional medical interpreters has been associated with improved outcomes. However, even with professional medical interpreters, errors in communication during ICU family conferences are common and may interfere with understanding, decision making, and emotional support. Family members in interpreted ICU family conferences are less likely to receive basic emotional support from clinicians than family in conferences where all participants speak the same language. A number of suggestions can be made based on a qualitative study examining the perspectives of professional medical interpreters on end-of-life communication. Clinicians should try to meet briefly with the interpreters prior to the family conference to help prepare the interpreter and allow them to provide the clinicians with information about the patient, family or culture. Clinicians could also consider meeting with the interpreter following the conference to allow for debriefing. In addition, interpreters should be asked to explicitly state when they are providing a strict linguistic interpretation and when they are providing cultural mediation or interjecting their own suggestions or comments in an effort to enhance understanding in a cross-cultural setting.

**The Importance of Protocols and Quality Improvement for Improving Communication**

One important feature of the interventions that have been shown to improve clinician-family communication in the ICU is that the interventions were all "proactive" and that a protocol or standardized procedure ensured that communication with family occurred earlier in the ICU course than usual care. Therefore, it is reasonable to conclude that some type of ICU protocol or procedure is likely a necessary component to replicate the successes seen in these studies. At the same time, it is also essential that communication be conducted in a way that is adapted to the needs of individual patients and family members. Communication cannot become protocolized to the point of being robotic and missing the opportunity to respond to individual needs. It is possible to develop protocols or manuals for a communication intervention that allow rigorous evaluation of a standardized intervention but also allow the communication to respond to the needs of the individual. It is also important to allow individual clinicians to use their intuition and individual communication styles to respond in ways that are authentic.

Another area of great potential for improving communication with families in the ICU is the use of local quality improvement efforts focused on communication or palliative care. There have been several efforts to develop chart-based quality measures to assess and guide communication with families, and these have great potential. There has also been a multifaceted quality improvement project that has been associated with a reduction in ICU length of stay for patients who die as well as improved nursing ratings of the quality of dying and a trend toward improved family ratings.

**Billing and Reimbursement for Communication With Family Members in the United States**

If we are to maximize the effectiveness of clinician-family communication in the ICU, it will be important that critical care clinicians be reimbursed for this activity. In the United States, reimbursement for critical care professional services is time-based and current Center for Medicare and Medicaid Services guidelines allow physicians to bill for time spent communicating with family members provided the following criteria are met: first, the patient does not have decision-making capacity and cannot participate in medical decision making; second, the physician is on the floor or unit while communicating with families (by telephone or in person); and third, the focus of the discussion bears directly on patient
management and medical decision making. This discussion can include obtaining a medical history, reviewing the patient's condition or prognosis, and discussing treatments, provided this discussion has a direct bearing on patient management or medical decision making. Since most critically ill patients do not have decisional capacity and since the family of critically ill patients are commonly acting as surrogate decision makers, these criteria are often met during ICU family conferences and other communication with family members. Furthermore, communication with family members that helps to prepare them to participate in shared decision making should also be included. However, these criteria mean that time spent providing emotional support and counseling to family members regarding their own emotions or concerns and that is not directly related to helping families participate in shared decision making cannot be billed under the current critical care codes. Such support for family members should also be easily reimbursable given the proven value of this support for reducing the burden of psychological symptoms among family members, but it is not in the current system. Table 3 outlines the documentation recommended in order to bill for time spent in an ICU family conference.

In practice, because the time-based current procedural terminology code for critical care offers the same reimbursement for any amount of time from 30 to 74 min, time spent communicating with family only adds to the reimbursement if this time pushes the total time > 30 min or > 74 min. However, this feature of time-based reimbursement is true for all components of critical care.

### Table 3—Recommended Documentation for an ICU Family Conference in Order to Bill as Critical Care Professional Services in the United States*

<table>
<thead>
<tr>
<th>Documentation Element</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying reason that patient unable to participate in</td>
<td>Patient intubated and sedated</td>
</tr>
<tr>
<td>medical decision making</td>
<td>Patient delirious</td>
</tr>
<tr>
<td>Need for discussion</td>
<td>Patient unconscious</td>
</tr>
<tr>
<td>Details of discussion as related to obtaining needed</td>
<td>Need to obtain medical history to inform decision making</td>
</tr>
<tr>
<td>history or making a specific treatment decision or</td>
<td>Need to make a decision about provision of a specific</td>
</tr>
<tr>
<td>decisions</td>
<td>treatment</td>
</tr>
<tr>
<td></td>
<td>Family member provided</td>
</tr>
<tr>
<td></td>
<td>needed medical history</td>
</tr>
<tr>
<td></td>
<td>Prognosis discussed</td>
</tr>
<tr>
<td></td>
<td>Specific treatment options discussed</td>
</tr>
<tr>
<td></td>
<td>Specific treatment decisions made</td>
</tr>
</tbody>
</table>

*From Mulholland.*

### Summary

Critical care is complex, and high-quality critical care requires extensive training, collaboration of a well-functioning interdisciplinary team, implementation of protocols that ensure high levels of adherence to processes of care that are associated with improved outcomes, and adaptation of this care to the needs of the individual. In this way, communication with family members is no different than other aspects of critical care and will require training, interdisciplinary teamwork, and implementation of effective and flexible protocols to achieve the best possible outcomes. We are beginning to identify the best ways to accomplish each of these tasks with the ultimate goal of improving the way we communicate with and care for critically ill patients and their families.

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Conflict Management Strategies in the ICU Differ Between Palliative Care Specialists and Intensivists

Jared Chiarchiaro, MD 1,2; Douglas B. White, MD, MAS 3,4; Natalie C. Ernecoff, MPH 2; Praewpannarai Buddadhumark, MS, RN 2; Rachel A. Schuster, MD, MS 1; Robert M. Arnold, MD 5

Objectives: Conflict is common between physicians and surrogate decision makers around end-of-life care in ICU. Involving experts in conflict management improve outcomes, but little is known about what differences in conflict management styles may explain the benefit. We used simulation to examine potential differences in how palliative care specialists manage conflict with surrogates about end-of-life treatment decisions in ICUs compared with intensivists.

Design: Subjects participated in a high-fidelity simulation of conflict with a surrogate in an ICU. In this simulation, a medical actor portrayed a surrogate decision maker during an ICU family meeting who refuses to follow an advance directive that clearly declines advanced life-sustaining therapies. We audio recorded the simulation encounters and applied a coding framework to quantify conflict management behaviors, which was organized into two categories: task-focused communication and relationship building.

Subsequent digital content is available for this article. Direct URL citations appear in the printed text and are provided in the HTML and PDF versions of this article on the journal’s website (http://journals.lww.com/ccmjournal).

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For information regarding this article, E-mail: chiarchiaroj@upmc.edu

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Conflict Management Strategies in the ICU Differ Between Palliative Care Specialists and Intensivists

We used negative binomial modeling to determine whether there were differences between palliative care specialists’ and intensivists’ use of task-focused communication and relationship building.

Setting: Single academic medical center ICU.

Subjects: Palliative care specialists and intensivists.

Interventions: None.

Measurements and Main Results: We enrolled 11 palliative care specialists and 25 intensivists. The palliative care specialists were all attending physicians. The intensivist group consisted of 11 attending physicians, 9 pulmonary and critical care fellows, and 5 internal medicine residents rotating in the ICU. We excluded five residents from the primary analysis in order to reduce confounding due to training level. Physicians’ mean age was 37 years with a mean of 8 years in practice. Palliative care specialists used 55% fewer task-focused communication statements (incidence rate ratio, 0.55; 95% CI, 0.36–0.83; p = 0.005) and 48% more relationship-building statements (incidence rate ratio, 1.48; 95% CI, 0.89–2.46; p = 0.13) compared with intensivists.

Conclusions: We found that palliative care specialists engage in less task-focused communication when managing conflict with surrogates compared with intensivists. These differences may help explain the benefit of palliative care involvement in conflict and could be the focus of interventions to improve clinicians’ conflict resolution skills. (Crit Care Med 2016; 44:934–942)

Key Words: communication; conflict; critical care; end-of-life care; simulation

Conflict between physicians and surrogate decision makers is common in ICUs (1–3). One study reported that 48% of family members perceive conflict with ICU staff over decisions to limit life-sustaining treatment (4). When conflict is handled poorly, it results in negative psychologic outcomes for surrogates (5, 6) and contributes to low staff morale and burnout (7, 8). When managed well, conflict can be constructive by helping parties better understand the other’s perspective, identifying and correcting misperceptions, and fostering collaboration (9, 10). Involving ethics and palliative care consultants to mediate conflict between ICU physicians and surrogate decision makers improves clinical outcomes (11, 12).
For example, one systematic review showed that palliative care or ethics consultation improved family’s emotional outcomes and reduced ICU length of stay (12).

An important knowledge gap is in understanding why involvement of palliative care consultants in cases of physician-surrogate conflict in the ICU results in better outcomes. Understanding how these experts handle conflict can inform communication interventions for other clinicians. However, existing methodologies to study how experts manage conflict have important limitations. Self-report of conflict management from physicians is subjected to social desirability bias. Audio-recording family conferences is time consuming, logistically challenging, may add emotional burdens on family members and clinicians during already difficult conversations, and raises ethical issues regarding privacy and confidentiality protection (13).

Medical simulation offers a safe and feasible way to study high-stakes communication encounters such as conflict between clinicians and surrogates (14, 15). Simulation creates a controlled laboratory in which to study variations in behavior. For example, simulation has been used to evaluate trauma team performance (16) and train residents in the ICU (17). We have previously shown that a conflict simulation is viewed by ICU clinicians as a realistic model of what happens in their day-to-day practice related to family communication (18).

Therefore, we used a validated simulation (18) to identify differences between how palliative care specialists and intensivists manage conflict with surrogate decision makers about end-of-life treatment decisions in ICUs.

**MATERIALS AND METHODS**

**Description of Simulated Case**

We previously developed a simulated case using evidence-based guidelines for simulation in healthcare (19–22) that we have shown to reliably produce conflict (18). The case is of a patient with an underlying metastatic malignancy who suffered an acute event resulting in critical illness. The patient had a recent advance directive declining the use of advanced life-sustaining therapies. The conflict centered on the refusal of the patient’s surrogate decision maker to follow the patient’s preferences, instead opting to continue life support with the hope of recovery and return to home. We hired an experienced professional actor to portray the patient’s daughter. We trained the actor using rehearsals in a controlled laboratory in which to study variations in behavior. For example, clarification of surrogate’s understanding of the clinical and prognostic information and educating about principles of surrogate decision making. We then deductively identified other conflict management statements that physicians used in the simulated conferences through a qualitative analysis of five conferences using the modified ground theory approach as described by Crabtree and Miller (27). We then combined all the conflict management themes into a comprehensive codebook through an iterative process using constant comparisons (28). We reached thematic saturation where all new data could be easily assigned to existing themes. Once thematic saturation was reached, we applied the coding framework to all interview transcripts. Table 1 contains all of the themes included in the codebook.

**Coding Procedures and Inter-Rater Reliability.** Two raters independently coded all transcripts (R.A.S. coded all transcripts; J.C. served as second coder for 22 transcripts; and N.C.E. served as second coder for 14 transcripts). The raters were blinded to whether the physicians were palliative care specialists or intensivists. First, two investigators independently read the entire transcribed encounter to identify the beginning of conflict with the surrogate; next, investigators applied the codes described above to identify the conflict management strategies used in the conference. In order to ensure reliability of our coding, any discrepancies were resolved via discussion and adjudication, and only consensus codes were included in the final codebook. We tested coders’ inter-rater reliability with a subset of key passages, with $\kappa = 0.93$ for R.A.S. and J.C., and $\kappa = 0.86$ for R.A.S. and N.E. We used Atlas.ti for code management (Scientific Software, Berlin, Germany).

**Organization of Themes into a Framework.** In order to evaluate the potential differences between the conflict management statements made by palliative care specialists and intensivists, we organized the coded themes according to a variant of the widely used “three-function model” of medical interviewing as described by Lipkin et al (29) and Cole and Bird (30). This model includes three interview functions: 1) “gathering data” to understand the problem, 2) “educating
# TABLE 1. Themes of Conflict Management Statements With Exemplars

<table>
<thead>
<tr>
<th>Theme</th>
<th>Exemplars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Understanding of medical facts and prognosis</strong></td>
<td></td>
</tr>
<tr>
<td>Prognosticating(^a)</td>
<td>“His overall prognosis is very bad. He [has] a high chance of not making it.”</td>
</tr>
<tr>
<td>Hanging crepe</td>
<td>“And he's very, very sick. And then you add the very advanced lung cancer on top of this… those are things we can't fix.”</td>
</tr>
<tr>
<td>Repeating information(^a)</td>
<td>“Like I mentioned already, I, I doubt that he'll be able to leave the hospital. People don't just don't do well with the type of illness that he has.”</td>
</tr>
<tr>
<td>Acknowledging uncertainty</td>
<td>You know, no one can predict the future and I would be remiss if I made any promises one way or the other.</td>
</tr>
<tr>
<td>Correcting misperceptions(^a)</td>
<td>So, I hear what you're saying that before there was a full recovery, but at this time it seems like there might be a little more going on.</td>
</tr>
<tr>
<td>Checking understanding</td>
<td>“What do you understand? What were the conversations you had with him?”</td>
</tr>
<tr>
<td><strong>Sharing an understanding of patient values</strong></td>
<td></td>
</tr>
<tr>
<td>Naming shared interests(^a)</td>
<td>“We're hoping for the same thing, we're going to try to work toward that same goal… we just want to make sure that we have the same expectations for where we're headed.”</td>
</tr>
<tr>
<td>Exploring patient values(^b)</td>
<td>“Do you mind just walking him through some of his Five Wishes here and telling me, you know, what was going on with him and what might have caused him to make the answers that, that he made?”</td>
</tr>
<tr>
<td><strong>Discussing patient as a person(^b)</strong></td>
<td>“So let's talk about him more. What, what kind of things did he enjoy?”</td>
</tr>
<tr>
<td><strong>Educating about the surrogate's role</strong></td>
<td></td>
</tr>
<tr>
<td>Highlighting the applicability of the advance directive(^a)</td>
<td>“And it looks like he wrote 'no life support for any reason,' and right now he's definitely on life support.”</td>
</tr>
<tr>
<td>Discussing principles of surrogate decision making(^a)</td>
<td>“You are the person that he has chosen to help make decisions … as that person, it's your responsibility to act out of what he would want.”</td>
</tr>
<tr>
<td><strong>Supporting the surrogate</strong></td>
<td></td>
</tr>
<tr>
<td>Understanding emotion(^b)</td>
<td>“Because I understand where you're coming from, I understand your love, very, very, very big love for him, and that you would love to have a chance to just say a few words and have him respond.”</td>
</tr>
<tr>
<td>Exploring the surrogate's point of view</td>
<td>“Now, what's your hope? What do you think, what do you hope will happen?”</td>
</tr>
<tr>
<td>Offering support services(^b)</td>
<td>“if you have any social problems, you know, dealing with all this, we also have a social worker that can help you through this”</td>
</tr>
<tr>
<td>Offering personal availability</td>
<td>“I'm here all day, and somebody can reach me all night, so if you have any questions or concerns at any time”</td>
</tr>
<tr>
<td>Respecting/praising(^b)</td>
<td>“It sounds like you've done an incredible job, sticking with his, at his bedside, and being there with him and constantly visiting him.”</td>
</tr>
<tr>
<td>Supporting emotionally(^b)</td>
<td>“No matter what you choose, we'll be there to support you”</td>
</tr>
<tr>
<td>Naming the emotion(^b)</td>
<td>“I hear what you're saying and your concern about feeling like you were giving up on him”</td>
</tr>
<tr>
<td>Exploring emotions(^b)</td>
<td>“How do you feel about everything in our discussion?”</td>
</tr>
<tr>
<td><strong>Attempts to resolve conflict</strong></td>
<td></td>
</tr>
<tr>
<td>Delay decision making</td>
<td>“No decisions need to be made right now, OK?”</td>
</tr>
<tr>
<td>Stay the course</td>
<td>“We're going to continue, we're going to continue the treatment that we're doing, OK. That's not going to change.”</td>
</tr>
<tr>
<td>Make a treatment recommendation</td>
<td>“If his heart were to give out, we wouldn't recommend doing chest compressions for him, pounding on his chest and doing cardiopulmonary resuscitation.”</td>
</tr>
<tr>
<td>Generate options</td>
<td>“Maybe it would help if I tell you a little bit about sort of what our options are at this stage, OK?”</td>
</tr>
<tr>
<td>Defer to the surrogate</td>
<td>“So, even though he has the directive, because you're his power of attorney, your decisions are what we'll follow.”</td>
</tr>
</tbody>
</table>

\(^a\)Task-focused themes.

\(^b\)Relationship-building themes (naming the emotion, understanding the emotion, respecting/praising, supporting emotionally, and exploring emotions were combined to form "expressing empathy").
and counseling” to provide information, and 3) “relationship building” through rapport and responsiveness to emotions. In this variant, functions 1 and 2 are combined into “task-focused communication.” We created one outcome measure for task-focused communication (functions 1 and 2) and one outcome for relationship-building communication (function 3).

The task-focused communication outcome contains the following themes: 1) giving information about prognosis, 2) telling the family how the advance directive should be applied, 3) explaining the principles of surrogate decision making, 4) correcting misperceptions about the patient’s clinical situation, and 5) repeating information. The relationship-building outcome contains the following themes: 1) expressing empathy, 2) asking about the patient as a person, 3) asking about the patient’s values, 4) offering support services, and 5) naming shared interests. We chose these themes to include in the outcome measure because they are the themes that mostly clearly fit into this existing framework of task-focused and relationship-building communication.

Statistical Analysis
To make initial comparisons of communication statements used by palliative care specialists and intensivists, we used t tests (using unequal variance as appropriate). We used negative binomial modeling to assess for an association between the use of task-focused or relationship-building communication and whether the physician was a palliative care specialist. We chose this method over Poisson due to overdispersion—a phenomenon when the variance is much larger than the mean (31). We excluded the medical residents from the primary analysis in order to reduce confounding due to training level.

To assess for confounding variables that may affect the relationship between communication strategy and palliative specialty, we used the change-in-estimate approach (32, 33). This method of model selection is advocated by some methodologists because it has shown potential gains in precision (34). In this approach, we fit bivariate models, each with palliative care specialty as the primary predictor and a potential confounding variable as the covariate. We considered a variable as a confounder if it changed the effect size of the relationship between the main predictor (palliative care specialty) on the outcome measure (task-focused or relationship-building communication) by at least 10% when that variable was added to the model.

We tested the following variables as potential confounders in this manner: clinician age, gender, ethnicity, years in practice, and medical training level (attending vs fellow). Supplemental Tables 1 and 2 (Supplemental Digital Content 1, http://links.lww.com/CCM/B631) contain the results from this testing. The variables that changed the effect size by at least 10% and were included in the final multivariate model were clinician age, years in practice, ethnicity, and medical training level (attending vs fellow). Because clinician age and years in practice are collinear, we only included years in practice in the model. We also included gender in the model because we found it to be an independent predictor of task-focused communication in univariate modeling.

We also performed a sensitivity analysis to determine whether the modeling results are robust to small changes in how the outcome measures are constructed. We changed the outcome measures by adding fewer task-focused or relationship-building communication themes. For example, in addition to using the five themes as listed above to create the task-focused communication outcome, we also completed the same analysis with the task-focused communication outcome containing four of these themes. We then completed the same analysis using only three themes for this outcome. We followed the same procedure for the relationship-building communication outcome. Supplemental Table 3 (Supplemental Digital Content 1, http://links.lww.com/CCM/B631) contains this sensitivity analysis.

Supplemental Table 4 (Supplemental Digital Content 1, http://links.lww.com/CCM/B631) contains the results of this same analysis but including the residents. The main results are not different from that in the primary analysis where residents were excluded.

We used STATA 13.1 (StataCorp, College Station, TX) for all analyses.

RESULTS
Characteristics of Study Participants
Table 2 shows the demographic characteristics of the physicians who participated in the study. The sample consists of 36 physicians: 22 attending physicians (61%), 9 pulmonary and critical care fellows (25%), and 5 internal medicine residents (14%). The palliative care specialist group consists of 11 attending physicians who are board certified in hospice and palliative medicine. The intensivist group consists of 10 attending physicians who are board certified in other specialties including pulmonary and critical care medicine, anesthesia, and emergency medicine as well as 9 pulmonary and critical care fellows who are board certified in internal medicine and 5 internal medicine residents who were rotating through the ICU and are not board certified. We excluded the medicine residents’ data from the primary analysis in order to reduce confounding due to training level. All pulmonary and critical care fellows receive training in conflict resolution as part of their fellowship training. Physicians’ mean age was 37 years old with a mean of 8 years in practice. The sample was diverse in terms of gender and race.

There was no difference in the duration of conferences between palliative care specialists and intensivists (mean 22.5 ± 5.9 min vs 21.3 ± 6.1 min, respectively).

Main Themes of Conflict Management
Table 1 contains the main themes of conflict management statements demonstrated during the simulated conferences and corresponding exemplars. These main themes include understanding of medical facts and prognosis, sharing and understanding of patient values, educating about the surrogate’s role, supporting the surrogate, and attempts to resolve conflict.
# TABLE 2. Characteristics of Participants by Intensivists and Palliative Care Physicians

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Intensivists (n = 20)</th>
<th>Intensivists Including Residents (n = 25)</th>
<th>Palliative Specialists (n = 11)</th>
<th>Total (n = 36)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>9 (45)</td>
<td>12 (48)</td>
<td>4 (36)</td>
<td>16 (44)</td>
</tr>
<tr>
<td>Female</td>
<td>11 (55)</td>
<td>13 (52)</td>
<td>7 (64)</td>
<td>20 (56)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>9 (45)</td>
<td>13 (52)</td>
<td>8 (73)</td>
<td>21 (58)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>6 (30)</td>
<td>7 (28)</td>
<td>3 (27)</td>
<td>10 (28)</td>
</tr>
<tr>
<td>Black/African-American</td>
<td>2 (10)</td>
<td>2 (8)</td>
<td>0</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Declined to answer</td>
<td>2 (10)</td>
<td>2 (8)</td>
<td>0</td>
<td>2 (6)</td>
</tr>
<tr>
<td><strong>Training level</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending</td>
<td>11 (55)</td>
<td>11 (44)</td>
<td>11 (100)</td>
<td>22 (61)</td>
</tr>
<tr>
<td>Fellow</td>
<td>9 (45)</td>
<td>9 (36)</td>
<td>0</td>
<td>9 (25)</td>
</tr>
<tr>
<td>Resident</td>
<td>0</td>
<td>5 (20)</td>
<td>0</td>
<td>5 (14)</td>
</tr>
<tr>
<td><strong>Primary specialty</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal medicine</td>
<td>15 (75)</td>
<td>15 (60)</td>
<td>9 (82)</td>
<td>24 (67)</td>
</tr>
<tr>
<td>Emergency medicine</td>
<td>5 (25)</td>
<td>5 (20)</td>
<td>0</td>
<td>5 (14)</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>2 (10)</td>
<td>2 (8)</td>
<td>0</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Neurology</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Family medicine</td>
<td>0</td>
<td>0</td>
<td>2 (18)</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Not applicable (residents)</td>
<td>–</td>
<td>5 (20)</td>
<td></td>
<td>5 (14)</td>
</tr>
<tr>
<td><strong>Subspecialty</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulmonary and critical care medicine</td>
<td>5 (25)</td>
<td>5 (20)</td>
<td>0</td>
<td>5 (14)</td>
</tr>
<tr>
<td>Critical care medicine</td>
<td>5 (25)</td>
<td>5 (20)</td>
<td>0</td>
<td>5 (14)</td>
</tr>
<tr>
<td>Hospice and palliative medicine</td>
<td>0</td>
<td>0</td>
<td>11 (100)</td>
<td>11 (31)</td>
</tr>
<tr>
<td>Infectious diseases</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Geriatrics</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>1 (9)</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Nephrology</td>
<td>1 (5)</td>
<td>1 (4)</td>
<td>0</td>
<td>1 (3)</td>
</tr>
<tr>
<td>None</td>
<td>8 (40)</td>
<td>8 (32)</td>
<td>0</td>
<td>8 (22)</td>
</tr>
<tr>
<td>Not applicable (residents)</td>
<td>–</td>
<td>5 (20)</td>
<td></td>
<td>5 (14)</td>
</tr>
</tbody>
</table>

| **Mean (SD)**                        |                       |                                          |                                |                |
| Age (yr)                             | 36.3 (7.0)            | 34.5 (7.2)                               | 44.1 (9.9)                    | 37.4 (9.2)     |
| Years in practice                    | 7.2 (6.3)             | 5.7 (6.4)                                | 13.3 (10.2)                   | 8.0 (8.4)      |
| Self-rated skill in handling difficult conversation (0 worst–10 best) | 7.2 (1.6) | 7.2 (1.5) | 8.1 (1.1) | 7.5 (1.5) |

*Sums add to > 100% because some answered more than one specialty. Dashes indicate data is not applicable.*
Comparing the Conflict Management Styles of Palliative Care Specialists and Intensivists

**Figure 1** shows that palliative care specialists perform more relationship-building communication and less task-focused communication per family conference compared with the intensivists. Table 3 shows the results from the negative binomial modeling. This modeling shows that, after adjusting for confounders, palliative care specialists perform significantly less task-focused and a trend toward more relationship-building communication compared with intensivists.

**Palliative Care Specialists’ Use of Task-Focused Communication**

Palliative care specialists used 45% less task-focused communication statements compared with intensivists (incidence rate ratio [IRR], 0.51; 95% CI, 0.34–0.78; \( p = 0.002 \)), as detailed in Table 3. This relationship remained statistically significant when adjusting for clinician years in practice, gender, ethnicity, and attending versus fellow status. Table 4 contains the mean frequencies and \( p \) values of task-based communication statements used including 1) giving information about prognosis (mean 1.6 times per conference vs 3.9 times per conference by intensivists; \( p = 0.007 \)), 2) telling the family how the advance directive should be applied (1.5 vs 2.9 times per conference; \( p = 0.07 \)), 3) explaining the principles of surrogate decision making (1.8 vs 2.5 times per conference; \( p = 0.30 \)), 4) correcting misperceptions about the patient’s clinical situation (0.4 vs 0.6; \( p = 0.52 \)), and 5) repeating information (0.3 vs 1.1; \( p = 0.03 \)).

**Palliative Care Specialists’ Use of Relationship-Building Communication**

Palliative care specialists used 54% more relationship-building communication statements compared with intensivists (IRR, 1.54; 95% CI, 0.93–2.56; \( p = 0.095 \)), as detailed in Table 3. This relationship was not statistically significant in the unadjusted model or in the model adjusted for clinician years in practice, gender, ethnicity, and attending versus fellow/resident status. Table 4 contains the mean frequencies and \( p \) values of relationship-building communication statements including 1) expressing empathy (mean 7.1 times per conference vs 4.6 times per conference by intensivists; \( p = 0.15 \)), 2) asking about the patient as a person (1.5 vs 0.8 times per conference; \( p = 0.17 \)), 3) asking about the patient’s values (0.9 vs 0.6 times per conference; \( p = 0.23 \)), 4) offering support services (0.5 vs 0.6; \( p = 0.80 \)), and 5) naming shared interests (1.1 vs 0.7; \( p = 0.29 \)).

Supplemental Table 3 (Supplemental Digital Content 1, http://links.lww.com/CCM/B631) contains the sensitivity analysis that shows our modeling results are robust to small changes in how the outcome variables are constructed as described above in the Statistical Analysis section. Supplemental Table 4 (Supplemental Digital Content 1, http://links.lww.com/CCM/B631) contains the analysis including medical residents and produces similar results to the main analysis.

**DISCUSSION**

We used a novel simulation methodology to study surrogate-physician conflict over appropriate end-of-life care in the ICU. We found that palliative care physicians differed from intensivists in how they communicated when there was a conflict with surrogates over appropriate care. First, they engaged in less task-focused communication compared with intensivists (e.g., conveying biomedical information). Second, there was a trend toward engaging in more relationship-building communication (e.g., making efforts to understand the patient as a person).

This study provides new information about the differences between how palliative care specialists and intensivists approach end-of-life communication. We are aware of no other studies addressing this topic in the ICU environment.
outpatient setting, Roter et al (35) audiotaped experts in ethics and patient-physician communication talking to patients about advance care planning and found that the experts spent more time listening compared with other internists. The similarities in results suggest that experts have a unique skill set for managing difficult conversations regardless of setting. These skills differ from what nonexperts do.

Physicians’ communication behavior has important clinical implications (36, 37). Competence in end-of-life conversation is associated with increased patient satisfaction and lower rates of liability litigation (38–40). Communication style also may affect psychologic outcomes. For example, more compassionate physician behavior during communication is associated with less patient anxiety (41).

### TABLE 3. Incidence Rate Ratio for Physician Behaviors During Interviews Excluding Five Residents ($n = 31$)

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Incidence Rate Ratio (95% CI)</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task-focused communicative behaviors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized in palliative care (vs not) unadjusted</td>
<td>0.51 (0.34–0.78)</td>
<td>0.002</td>
</tr>
<tr>
<td>Specialized in palliative care (vs not) adjusted</td>
<td>0.55 (0.36–0.83)</td>
<td>0.005</td>
</tr>
<tr>
<td>Years in practice</td>
<td>1.01 (0.98–1.04)</td>
<td>0.590</td>
</tr>
<tr>
<td>Female (vs male)</td>
<td>0.59 (0.40–0.86)</td>
<td>0.007</td>
</tr>
<tr>
<td>Racial minority (vs non-Hispanic white)</td>
<td>0.78 (0.52–1.19)</td>
<td>0.257</td>
</tr>
<tr>
<td>Attending (vs fellow)</td>
<td>0.81 (0.50–1.31)</td>
<td>0.387</td>
</tr>
<tr>
<td><strong>Relationship-building communicative behaviors</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialized in palliative care (vs not) unadjusted</td>
<td>1.54 (0.93–2.56)</td>
<td>0.095</td>
</tr>
<tr>
<td>Specialized in palliative care (vs not) adjusted</td>
<td>1.48 (0.89–2.46)</td>
<td>0.128</td>
</tr>
<tr>
<td>Years in practice</td>
<td>1.00 (0.96–1.04)</td>
<td>0.963</td>
</tr>
<tr>
<td>Female (vs male)</td>
<td>1.15 (0.68–1.95)</td>
<td>0.604</td>
</tr>
<tr>
<td>Racial minority (vs non-Hispanic white)</td>
<td>0.66 (0.40–1.10)</td>
<td>0.108</td>
</tr>
<tr>
<td>Attending (vs fellow)</td>
<td>0.67 (0.35–1.27)</td>
<td>0.219</td>
</tr>
</tbody>
</table>

### TABLE 4. Mean Frequencies and $p$ Values for Task-Focused and Relationship-Building Communication Statements

<table>
<thead>
<tr>
<th>Communication Statement</th>
<th>Palliative Specialists’ Mean Frequency (SD) per Conference</th>
<th>Intensivists’ Mean Frequency (SD) per Conference</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task-focused communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide prognostic information</td>
<td>1.6 (1.7)</td>
<td>3.9 (2.3)</td>
<td>0.007</td>
</tr>
<tr>
<td>Highlight the applicability of the advance directive</td>
<td>1.5 (1.2)</td>
<td>2.9 (2.2)</td>
<td>0.07</td>
</tr>
<tr>
<td>Explain the principles of surrogate decision making</td>
<td>1.8 (1.5)</td>
<td>2.5 (1.8)</td>
<td>0.30</td>
</tr>
<tr>
<td>Correct misperceptions</td>
<td>0.4 (0.8)</td>
<td>0.6 (1.0)</td>
<td>0.52</td>
</tr>
<tr>
<td>Repeat information</td>
<td>0.3 (0.5)</td>
<td>1.1 (1.4)</td>
<td>0.03</td>
</tr>
<tr>
<td><strong>Relationship-building communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use empathy</td>
<td>7.1 (4.5)</td>
<td>4.6 (4.4)</td>
<td>0.03</td>
</tr>
<tr>
<td>Explore the patient as a person</td>
<td>1.5 (1.4)</td>
<td>0.8 (1.3)</td>
<td>0.17</td>
</tr>
<tr>
<td>Explore the patient’s values</td>
<td>0.9 (0.7)</td>
<td>0.6 (0.8)</td>
<td>0.23</td>
</tr>
<tr>
<td>Provide support services</td>
<td>0.5 (0.5)</td>
<td>0.6 (0.6)</td>
<td>0.80</td>
</tr>
<tr>
<td>Name shared interests</td>
<td>1.1 (0.7)</td>
<td>0.7 (1.1)</td>
<td>0.29</td>
</tr>
</tbody>
</table>
When managing conflict, decreasing the emphasis on information transfer and focusing on a relationship-building strategy may be more effective.

Understanding how experts manage conflict may help us build an educational program that teaches clinicians conflict management skills. Exercises that simulate difficult situations such as conflict are a safe and efficient method to train nonexperts in a way that mitigates the risk of emotional distress when practicing underdeveloped communication skills (14, 15). For example, a 3-day course using simulated patients and immediate feedback increases critical care fellows’ self-reported family meeting communication skills (42).

Our study has several limitations. First, because of the small sample size, we were unable to detect a statistically significant difference in the use of relationship-building communication statements. This could also be because palliative care specialists use a larger toolbox of communication skills consisting of both task-based and relationship-building communication. Also, some intensivists may be more like experts in their use of relationship-building communication and this would bias toward the null. Second, because this was a simulation, we were unable to determine whether these different approaches to conflict management result in different outcomes for families. Future study is needed to examine the impact of the different approaches on conflict resolution, decision making, and surrogate decision makers’ outcomes. Third, the intensivist group included physicians at different levels of training and the palliative care specialist group included only attending physicians. Inclusion of palliative care fellows would have created more balanced groups in terms of experience level. To reduce confounding due to training level, we excluded residents from the primary analysis and adjusted for attending versus fellow status in the model. Finally, the conflict management statements described are in response to one type of conflict—whether to continue life-sustaining therapy for a critically ill patient with end-stage illness. There are many other types of conflict, and further study is needed to simulate other scenarios.

CONCLUSIONS

We found that palliative care specialists engage in less task-focused communication and a trend toward more relationship-building compared with intensivists. These findings may help explain some of the mechanism of benefit behind palliative care consultation in cases of conflict in ICUs. These expert conflict management strategies could be incorporated in future exercises to train intensivists in high-quality communication skills.

REFERENCES

Chiarchiaro et al