# Establishing Treatment Goals: Conducting a Family Conference

Medical Resident/Oncology Fellow Competency Assessment Tool  
**Palliative Care Domain: Communication**

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Introduction for the Learner (Resident/Fellow)

Prior to your evaluation of competency:

• Complete the web-based palliative care training program “Medical Resident Training in End-of-Life and Palliative Care” before you undergo this competency assessment. The training program is available on the UMMS Intranet, click on Physicians. The course is listed under “Helpful Links.” It is also available via the internet at http://134.192.120.12/canRes/htdocs/login.asp

• Review Part 1 (Learning Objectives), Part 2 (Teaching Outline) and Part 3 (Evaluation Checklist) of this document THOROUGHLY so that you are aware of what is required of you.

• Review Unit III, Modules 2 (Setting Treatment Goals) and 4 (Conducting a Family Conference) of the Web-based palliative care training program “Medical Residents Training in End-of-Life and Palliative Care.”

• Ask the attending physician to evaluate your competency early in the clinical rotation.

• When you think you are suitably prepared for testing your competency in this area, ask the attending physician on your inpatient clinical rotation to evaluate the selected competency when the appropriate clinical situation arises.

Field evaluation of competency:

• During the course of the clinical rotation it is anticipated that you may have opportunities to demonstrate your competency in ESTABLISHING TREATMENT GOALS: CONDUCTING A FAMILY CONFERENCE with a patient and/or family during morning work rounds with the attending, throughout the day or during times of night call or cross-coverage.

• ASK THE CLINICAL FACULTY MEMBER TO REVIEW THIS COMPETENCY ASSESSMENT TOOL AS SOON AS POSSIBLE SO THAT THEIR MEMORY WILL BE RE-FRESHED AS TO THE DESIRED CHARACTERISTICS OF PERFORMANCE THEY WILL BE EVALUATING.

• At the end of the rotation, the Clinical Faculty Evaluator completes the Evaluation Checklist (Part 3) of this document, and shares it with you.

• You will also complete the self-evaluation portion of the checklist as a measure of competency in practice based learning.

• Evaluation Checklist must be signed by faculty and Resident.

• Return Evaluation Checklist to Dr. Susan Wolfsthal, Internal Medicine Residency Director or Dr. Heather Mannuel, Hematology/Oncology Fellowship Director.

Introduction for the Clinical Faculty Evaluator

How to perform this competency assessment:

A Medical Resident or Oncology Fellow has requested that you assess their competency in a selected palliative care domain during the time you are the attending physician on this service. To assist you with this evaluation, please do the following.

Preparing for field evaluation of competency:

• Review this Competency Assessment Tool thoroughly including the Learning Objectives (Part 1), Teaching Outline (Part 2) and Evaluation Checklist (Part 3) prior to pre-discussion counseling with Resident (required).

• Review Unit III (Communication Techniques) Modules 2 (Setting Treatment Goals) and 4 (Conducting a Family Conference) of the web-based palliative care training program, “Medical Resident Training in End-of-Life and Palliative Care” available on any computer with internet access at http://134.192.120.12/canRes/htdocs/login.asp (optional).

Format of competency evaluation:

Pre-discussion counseling

• Review with the Resident/Fellow the circumstances of the patient situation. Check veracity of patient medical data, diagnostic tests, significance of diagnosis.

• Ask the Resident/Fellow to identify goals of conducting the family conference.

• Ask Resident/Fellow to discuss how the family conference will be conducted.

During the clinical rotation

• Based on the Learning Objectives (Part 1), Teaching Outline (Part 2), and Evaluation Checklist (Part 3) of this document and the content in Unit III, Modules 2 (Setting Treatment Goals) and 4 (Conducting a Family Conference) of the palliative care training website, evaluate whether the Resident or Fellow meets the Learning Objectives during the course of this clinical rotation.

• Provide constructive feedback to Resident/Fellow throughout the rotation regarding this competency.

End-of-rotation feedback

• Review strengths and weaknesses of competency evaluation with Resident/Fellow.

• Provide constructive feedback to improve Residents/Fellows’ performance and patient outcomes.

Complete Evaluation Checklist (Part 3 of this document)

• Share with learner; allow learner to make his/her own self-assessment of performance.

• Faculty and Resident/Fellow must sign this Evaluation Checklist (Part 3).

• Learner is responsible for returning Evaluation Checklist to Dr. Wolfsthal (Residents) or Dr. Mannuel (Fellows).
Part 1: Learning Objectives

Note to learner and Clinical Faculty Evaluator: The Learning Objectives are listed in terms of fulfilling the six ACGME core competencies, listed below; these are reflected in Evaluation Checklist in Part 3 of this document.

**LEGEND to ACGME core competencies:** [http://www.acgme.org/Outcome](http://www.acgme.org/Outcome)

<table>
<thead>
<tr>
<th>OBJECTIVES – A competent Medical Resident or Oncology Fellow will be able to:</th>
<th>ACGME Competencies</th>
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<tr>
<td>Value the patient and family's role in working with the health care team.</td>
<td>PC MK PBL&amp;I PCS P SBP</td>
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<td>Enhance professional skills in conducting a family conference.</td>
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<td>Respect the patient's autonomy.</td>
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<td>Describe the physical setting where a family conference should be held.</td>
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<td>Identify who should be involved in a family conference.</td>
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<td>Explain the concepts of decision-making capacity and surrogate decision-maker.</td>
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<tr>
<td>Use the key steps in conducting the family conference.</td>
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<tr>
<td>Describe strategies for working with families when there is disagreement or indecision.</td>
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<tr>
<td>Open a family conference appropriately.</td>
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<tr>
<td>Guide the discussion of the patient's medical status.</td>
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<tr>
<td>Moderate a discussion of treatment decision-making.</td>
<td>X</td>
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<tr>
<td>Conclude the family conference appropriately.</td>
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</tr>
<tr>
<td>Document a complete summary of the family conference.</td>
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<tr>
<td>Follow up after the family conference.</td>
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</table>

**LEGEND:**
- PC – Patient Care
- MK – Medical Knowledge
- PBL&I – Practice-Based Learning and Improvement
- PCS – Interpersonal and Communication Skills
- P – Professionalism
- SBP – Systems-Based Practice

Establishing Treatment Goals: Conducting a Family Conference


Establishing goals of care for patients near the end of life is a critical physician skill. Such discussions can occur in the inpatient or outpatient setting, and often occur during a family meeting. Convening a family conference is necessary whenever there is a need for discussion between key members of the health care team, the patient, the patient’s family, and other essential family support people such as a member of the clergy or a close personal friend. A successful family conference is more likely to occur if key steps are completed, in the correct order — a 12 step process is outlined below. These 12 steps are not a cookbook or blue-print which can be followed in a rigid sequence, but a list of principles and tasks that the physician should consider incorporating into the family meeting. Because each patient and family has a unique history and needs, it is important that the physician assess and respond to the family’s needs during the meeting.

1. Pre-Meeting Planning

Determine the reasons for convening a family conference.

- Review medical condition, set treatment goals, decide future level of care/treatments.
- Establish surrogate decision maker.
- Resolve patient, family and/or staff conflicts.

Decide what is medically appropriate

- What tests/procedures/interventions do you believe will improve or worsen function, longevity and quality of life?

Review Medical History

- Review all pertinent medical facts including treatment options, prognosis, with and without treatment, and consultant opinions.

Coordinate opinions

- Contact consultants to coordinate message to patient/family.

Advance Directives

- Review any advance directive documents and bring to the meeting.

Psychosocial data

- Obtain all available information about the patient and family system. psychosocial status/issues.

Attendees

- Determine who you wish to have present from the medical team and invite the family to bring whomever they wish to the meeting. Determine whether there is a need for an interpreter for the patient or family members.

Meeting leadership

- Designate one person from the medical team to serve as meeting leader.
- Determine if the patient has decision-making capacity.
  - Decision-making capacity refers to the capacity to make medical decisions and to provide informed consent to treatment. This is different from competence, a legal term; competence is determined by a court, not by a physician.

- Key elements of decision making capacity. A patient must meet three criteria to demonstrate decision-making capacity:
  - Ability to Understand information about diagnosis and treatment.
  - Ability to Evaluate deliberate, weigh alternatives, compare risks and benefits.
  - Ability to Communicate a Choice verbally, in writing, or with a nod or gesture.

2. Environment

- Find a quiet, private room.
- Arrange chairs in a circle so each participant has a “front-row” seat.
- Make sure the patient, if participating, will be as comfortable as possible.

3. Introductions

- Ask all participants to introduce themselves and their relationship to the patient.
- For large groups, set ground rules - everyone can speak; no interruptions.
- Identify the legal surrogate decision maker if available.
- Review your goals and purpose of the meeting.
- Ask participants for their goals.
- Write names down if this is helpful to you.

4. Determine what the patient/family already knows.

- “What is your understanding of _____’s present condition” or “What have you been told about ______’s condition.”
- For patients with chronic diseases, ask about function and quality over the preceding 3-6 months and any changes or trends.
- Invite all participants to share their impressions.

5. Medical Review.

- Provide a short synopsis of the current medical condition and how the current condition fits within the larger illness trajectory (for chronic disease patients). The synopsis should be very brief, focusing on the large overall condition (“your father has pneumonia and kidney failure; despite 3 days of antibiotics, his condition is getting worse”).
- Avoid medical jargon. Use the word “dying” if appropriate to the situation; “Despite the chemotherapy, the cancer is growing, I believe your mother is dying.”

6. Allow silence

- Respond to questions and emotional reactions.
- When the medical review has indicated that no further treatments are likely to reverse the disease process/the patient is dying, there are two common reactions:
  - Acceptance - Patients and families who understand and ac-
except that death is approaching will typically ask or be thinking of the following questions and emotional reactions.

- How much time?
- What will happen?
- What do we do now?
- Non-Acceptance - When patients or families are not ready to accept that death is coming, common questions include (see step 10 — Managing Conflicts).
- How can you be sure?
- He was fine last week.
- We want a second opinion.
- There must be some mistake.
- Shifting focus by asking questions about a relatively minor aspect of care.
- Common Emotional Responses - during this phase of the meeting, emotional reactions are common.
  - Sadness
  - Grief, tears, crying, wailing
  - Guilt
  - Anger
  - Regret

7. Present Broad Care Options

- You will need to discuss prognosis to help patients/families decide among care options. A good entry to such a discussion is: “Has anyone talked to you about time?”
- Guidelines on providing prognosis include: a) always ask if such a discussion is desired before providing data, b) provide data in a range (a few weeks to a few months), c) stop and allow silence after providing data to gauge any emotional reaction.
- Options usually breakdown into two major domains
  - Continuing or expanding life-prolonging treatments with a goal of improved function, lengthened life, and/or improved quality, versus…
  - Continuing comfort care, but discontinuation of life-prolonging treatments with expected death.

8. Decision-making

- When the patient can speak for themselves
  - Ask patient what treatment he/she is considering.
  - Ask patient what type of support he/she would like from family members and health care team.
  - Invite discussion from other family members about supporting the patient’s decision.
- When the patient can not speak for themselves
  - Describe the goal of substituted decision making - to speak on behalf of the patient by making those choices we believe the patient would make if they could speak.
  - Ask each family member what they believe the patient would choose if he/she were able to speak on their own behalf.
- Ask each family member what their own wishes are for the patient.
- At this point some families want time alone (10 or 15 minutes) to talk before making a decision.

9. Making a Recommendation

- When patients/families struggle to make a decision, or you believe there is one preferred medical decision based on the facts, and/or your knowledge of the patient’s wishes, make a clear recommendation.
- Avoid statements such as: “what would you like us to do?” This type of statement only tends to worsen a families sense of guilt about “pulling the plug.”

10. Managing Conflict

- This is the point in the conference when conflicts between the family and the health care team, or conflicts between family members, typically surface. This is especially true when the questions listed above (non-acceptance) are verbalized. Common reasons for such conflicts include the following:
  - Grief/Time - family members have not had sufficient time to psychologically adjust to imagining their life without the dying person.
  - Information - incorrect, misleading, or conflicting information has been provided to the family by other health care providers.
  - Anger/Guilt - long lasting intra-family issues may disrupt or preclude logical decision making; in severe cases, the struggle you observe may be the result of long-standing serious family dysfunction—issues of past or current drug or alcohol dependence and/or physical, verbal or sexual abuse are common.
  - Trust - if a patient or family does not have trust in the medical team, it is impossible to work together to develop a treatment plan.
  - Culture - differences in culture, religion, socioeconomic status, etc. may all impede decision making. See the CAT 4D on Cultural Issues, of the FPCER or Unit IV, Module 3 of the web-based training course “Medical Resident Training in Palliative and End-of-Life Care” on Cross-Cultural Awareness for strategies.
- Key points in managing conflict
  - Active listening - strive to maintain a civil discourse; ensure that your body language is open, conveying concern and empathy, re-state or paraphrase what people are saying to make sure you and others understand.
  - Correct any factual misunderstandings.
  - Provide an empathetic statement “I can’t imagine how hard this must be.”
  - Keep the focus of the discussion on the patient’s well-being.
  - Recognize that more time may be necessary; schedule a follow-up meeting.
  - Establish a time-limited trial of continued life-sustaining
treatments - establish clear goals and a time line (e.g., improved cognition, improved LFTs).
- Recognize that other resources may help the family: psychologist, spiritual counselor, palliative care team, ethics consultation.
- State directly that you (and health care team) will not abandon the patient and family, and will assure the patient remains as comfortable as possible.
  - Continued conflict
    - If patient/proxy/health care agent still requests treatment that you consider medically ineffective, see CAT 3D. Addressing requests for medically ineffective treatment is beyond the scope of this CAT.

11. Translate goals into a care plan

- When a decision has been made to limit further life-sustaining treatments, it is time to refocus the goals of care. Ask: “Knowing that time is short, what is important, what do you want/need to do in the time you have left”. Typical responses are home, comfort, being with family, living until a particular life event. Treatment goals drive our choice of diagnostic and therapeutic methods. When treatment goals change it is natural that diagnostic and therapeutic methods will also change—some will be discontinued and others started. The phrase “withdrawing treatment” can have a powerful emotional impact upon a patient and family because it may suggest abandonment. For this reason the physician should not use this term, but should instead speak about changing the goal of treatment from cure to maintaining the patient’s comfort. In addition, the provision or discontinuation of certain treatments such as non-oral hydration and nutrition can have strong emotional meaning. Therefore the physician should facilitate discussion of these decisions and explore their meaning with patients and families.

- Review the current medical tests, procedures, medications - decide which are helping to meet the patient’s goals; which are providing no benefit. Key items for discussion at this time include
  - Future hospitalizations or ICU admissions
  - DNR status
  - Use of artificial hydration/nutrition, blood products or antibiotics
  - Home support, Hospice

- Explore the meaning of changing treatment goals (and discontinuing some treatments) with the patient/family — some issues are inherently more difficult to others to consider (hydration and feeding withdrawal are typically the hardest decision for families). Be aware of cultural beliefs and attitudes that will influence decision-making.

- Develop a care plan that matches the patient/families goals, verbally summarize the care plan to ensure understanding and agreement. Caution against unexpected outcomes (e.g., if a dying patient does not die, as expected following discontinuation of treatment).

12. Document and Discuss

- Discuss the meeting with health care providers who were unable to attend (e.g., the patient’s evening nurse).
- Provide concise written documentation of the meeting.
  - Who was present?
  - What was discussed?
  - What was decided?
  - What decisions were deferred?
  - Plan of care?
  - Next steps?

References


Tattersall MHN – Truth-telling and consent, pp. 290-295

Fallowfield L – Communication with the patient and family in palliative medicine, pp. 333-341.

Jeffrey D. – Communication between professionals, pp. 348-353.


### Part 3: Evaluation Checklist

**Learner name:** ________________________________  
**Evaluator/Attending:** _________________________

- [ ] Resident PGY Level: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5  
- [ ] Fellowship Year: [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5  

**Rotation Site:** [ ] Inpatient Cancer Center [ ] Inpatient GIM [ ] Oncology Clinic [ ] Continuity GIM clinic [ ] Other

Please rate the trainee's competency/skills/knowledge/attitude using the following scales:

<table>
<thead>
<tr>
<th>For competency/skills</th>
<th>For knowledge and attitudes (e.g., Medical Knowledge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 = Competent to perform independently</td>
<td>4 = Superior</td>
</tr>
<tr>
<td>3 = Competent to perform with minimal supervision</td>
<td>3 = Satisfactory</td>
</tr>
<tr>
<td>2 = Competent to perform with close supervision / coaching</td>
<td>2 = Below average</td>
</tr>
<tr>
<td>1 = Needs further basic instruction</td>
<td>1 = Insufficient – needs further learning</td>
</tr>
<tr>
<td>n/o = not observed</td>
<td>n/o = not observed</td>
</tr>
</tbody>
</table>

### OBJECTIVES

#### Patient Care

**Overall Performance:**

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
<th>1 to 3 Unsatisfactory</th>
<th>4 to 6 Satisfactory</th>
<th>7 to 9 Superior</th>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>

**Medical Knowledge**

- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] The physical setting where a family conference should be held was appropriate.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Identified who should be involved in a family conference.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Explained the concepts of decision-making capacity and surrogate decision-maker.

**Interpersonal and Communication Skills**

- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Used the key steps in conducting the family conference.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Described strategies for working with families when there is disagreement or indecision.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Opened a family conference appropriately.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Guided the discussion of the patient's medical status.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Moderated a discussion of treatment decision-making.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Concluded the family conference appropriately.
- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Followed up after the family conference.

**Systems Based Practice**

- 4 [ ] 3[ ] 2[ ] 1[ ] n/o[ ] Documented a complete summary of the family conference.

**Overall Performance:**

<table>
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<tr>
<th>Cannot Evaluate</th>
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Part 3: Evaluation Checklist (Continued)

**OBJECTIVES (Continued)**

**Professionalism**
- 4 o 3 □ 2 □ 1 □ o □ n/o □ Valued the physician’s role in convening a family conference.
- 4 o 3 □ 2 □ 1 □ o □ n/o □ Valued the patient and family’s role in working with the health care team.
- 4 o 3 □ 2 □ 1 □ o □ n/o □ Enhanced professional skills in conducting a family conference.
- 4 o 3 □ 2 □ 1 □ o □ n/o □ Respected the patient’s autonomy.

**Overall Performance:**

<table>
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**Resident/Fellow strengths:**

**Resident/Fellow areas for improvement:**

**Overall impression:** Did the Resident/Fellow demonstrate competency in a manner so as to do no harm?

<table>
<thead>
<tr>
<th>Cannot Evaluate</th>
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**Resident/Fellow self-evaluation of performance:** May comment on any of the above checklist items or other reflections on performance; perceived strengths, and need for improvement and learning.

Clinical Faculty Evaluator/Attending

Resident/Fellow

Clinical Faculty Evaluator/Attending – PRINTED NAME/DATE

Resident/Fellow – PRINTED NAME/DATE