

**FAST FACTS AND CONCEPTS #227**  
**THE FAMILY MEETING: END OF LIFE GOAL SETTING AND FUTURE PLANNING**

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**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

1. Clinical Tools. Center to Advance Palliative Care. Available at: <http://www.capc.org/tools-for-palliative-care-programs/clinical-tools/>. Accessed August 4, 2009. Free registration required.
2. Back A, Arnold R, Tulsky J. *Mastering communication with seriously ill patients: balancing honesty with empathy and hope*. New York, NY: Cambridge University Press; 2009.

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