THE GOAL SETTING CONFERENCE

BEFORE THE MEETING

- Review chart-know all medical issues: history, prognosis, treatment options
- Coordinate medical opinions among consultant physicians
- Decide what tests/treatments are medically appropriate (i.e., likely to benefit the patient)
- Review Advance Care Planning documents
- Review/obtain family psychosocial information
- Decide who you want to be present from the medical team
- Clarify your goals for the meeting-what decisions are you hoping to achieve?

10 STEP GUIDE	HELPFUL LANGUAGE
1. ESTABLISH PROPER SETTING Private, comfortable; Everyone seated, Turn off/forward pager	
2. INTRODUCTIONS • Allow everyone to state name and relationship to patient • Build relationship: ask non-medical question about patient	*"Can you tell me something about your father? What kind of person is he?"*
3. ASSESS PATIENT/FAMILY UNDERSTANDING • Encourage all present to respond • Ask for a description of changes in function over course of illness/hospitalization	*"What have the doctors told you about your wife's condition at this point?"* *"What is your assessment of the current medical situation?"*
4. MEDICAL REVIEW/SUMMARY • Summarize "big picture" in few sentences- use "dying" if appropriate; avoid organ-by-organ medical review • Avoid jargon • Answer questions	*"I'm afraid I have some bad news. I wish things were different. Based on what you have told me, and what I see, I believe your mother is dying"*
5. SILENCE/REACTIONS • Respond to emotional reactions (have tissues available) • Prepare for common reactions: acceptance, conflict/denial, grief/despair; respond empathically	*"This must be very hard"* *"I can only imagine how scary/difficult/overwhelming this must be"* *"You appear angry, can you tell me what is upsetting you?"*
6. DISCUSS PROGNOSIS • Assess how much patient and family want to know • Provide prognostic data using a range • Respond to emotion	*"Some people like to know every detail about their illness, others prefer a more general outline. What kind of person are you?"* *"Although I can't give you an exact time, given your illness and condition, I believe you have (*hours to days*) (*weeks to months). *This is an average, some live longer and some live shorter"*

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7. ASSESS PATIENT/FAMILY GOALS Possible goals: • prolong life • improve function • return home • see a family milestone • relief of suffering • staying in control	*"What do you wish to accomplish?"* *"Are there any important goals or tasks left undone?"* *"What is most important to you at this time?"* *"Knowing that time is short, what goals do you have?"* *"How do you picture your death?"* *"Where do you want to be when you die?"*
8. PRESENT BROAD CARE OPTIONS • Stress priority of comfort, no matter the goal • Make a recommendation based on knowledge/experience	*"Given what you have told me, about your mother and her goals, I would recommend . . ."* *"These decisions are very hard; if (patients name) were sitting with us today, what do you think he/she would say?"* *"How will the decision affect you and other family members?"*
9. TRANSLATE GOALS INTO CARE PLAN • Review current and planned interventions-make recommendations to continue or stop based on goals • Discuss DNR, Hospice/Home Care, Artificial Nutrition/Hydration, future hospitalizations • Summarize all decisions made CONFIRM YOUR CONTINUED AVAILABILITY REGARDLESS OF DECISIONS	*"You have told me your goals are ____ With this in mind, I do not recommend the use of artificial or heroic means to prolong your dying process. If you agree with this, I will write an order in the chart that when you die, no attempt to resuscitate you will be made, is this acceptable (ok)?"* *"All dying patients lose their interest in eating in the days to weeks leading up to death; this is the body's signal that death is coming."* *"I am recommending that the* (tube feedings, IVF) *be discontinued (*or not started*) as these will not improve her living and may only prolong her dying."*
10. DOCUMENT AND DISCUSS • Write a note: who was present, what decisions were made, follow-up plan • Discuss with team members (consultants, nurse, etc.) • Check your emotions	**Team debriefing = Opportunity for Teaching and Reflection** Ask team members: *"How do you think the meeting went?" "What went well?" What could have gone more smoothly? "What will you do differently in the future?"*

MANAGING CONFLICT

- Listen and make empathic statements
- Determine source of conflict: guilt, grief, culture, family, dysfunction, trust in med team, etc.
- Clarify misconceptions
- Explore values behind decisions
- Set time-limited goals with specific benchmarks (e.g. improved cognition, oxygenation, mobility)

WHEN YOU NEED ADDITIONAL ASSISTANCE OR SUPPORT CONSIDER A PALLIATIVE CARE CONSULT

Palliative Care Service consult pager: (917) 632-6906 or 9399

Adapted from Weissman, DE "The Family Goal Setting Conference" and "Communication Phrases Near the End of Life" pocket cards from Medical College of Wisconsin