



The Role of the Family Meeting

By William Eaton, MD, CCFP, FCFP

I'm old enough to remember when we stopped being called GPs and nowhere does the term family physician live up to its name more than at a family meeting. The bringing together of this complex network of (usually) biologically related, interconnected, interdependent, interlocking, interactive individuals evokes, in the physician, emotions ranging from awe and mystification to despair and exasperation. In serious illness, where family members provide long-term care to a progressively fading member, the family meeting opens the physician's eyes as to what's actually going on.

When a person becomes ill, each relative and friend may feel a strong need to hear about the condition from the doctor and health-care team. The doctor saves time and effort by arranging for all those involved to get together and talk as a group about the patient's illness and future. The family meeting is also the venue to offer support and to inform the family about such housekeeping issues as how and when to contact members of the health-care team, visiting times for friends, and hospitalisation procedures.

We bring the family together whenever there is a pressing need in order to learn how best to help

Table 1

Indications for a Family Meeting

- Recent diagnosis of serious illness
- Onset of complications: metastases in cancer
- Admission to hospital
- Discharge from hospital
- Sudden worsening of illness
- Change in structure of family caregivers

Table 2

Health-Care Team Goals for the Family Meeting

- Identify primary caregiver(s)
- Assess family dynamics
- Assess family members' needs for information
- Provide information efficiently
- Answer questions
- Discuss housekeeping issues
- Offer emotional and educational support

both the sick person and the family caregivers. (Table 1) Table 2 catalogues some of the more

Family Meeting

Table 3

Family Members' Needs during Terminal Illness

- Be with the dying person.
- Be assured of comfort for the dying person.
- Be informed of the patient's condition.
- Ventilate emotions.
- Be informed of impending death.
- Receive support and comfort from family members.
- Receive acceptance, support and comfort from the health-care team.

common assessment and therapeutic goals of the family meeting from the doctor's perspective, while Table 3 lists the parallel family goals .

Family dynamics are always unique to the particular family in question but family structure has a pattern. Families behave at a family meeting much like they do elsewhere, allowing the doctor to assess communication styles and family bonding. Arbitrary rules, inflexible roles, chronic dependence, scapegoating, and power struggles are all part of dysfunctional family structures. As the family is always stronger than the doctor or a room full of health-care professionals, the dual strategies of these meetings are



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assessment and support, rather than family therapy.

Our assessment of the care-giving assemblage includes, but is not limited to, the following questions:

- Who is the primary caregiver (the squeaky wheel doesn't always run the cart)?
- Who is at the family meeting (the busy daughter in town for the weekend)?
- Who is not (the son who too emotional to visit)?
- Who will be at the bedside as the patient's illness advances?
- Who do you, the doctor, feel will be able to help when trouble arises?
- Who will not?
- What are the family dynamics?

As we make this assessment, a corresponding objective is to assist the family in dealing with bad news. In this regard, I find it helpful to keep the following in focus: facts, feelings and the future. We offer the family the facts of the case in words they can understand and answer their questions with both honesty and interpretation divined from our medical experience. We encourage the discussion of feelings, even though such discussions may be uncomfortable all around. The family meeting is usually a good place to bring up at least the existence of such feelings, but counseling around these emotional responses is better done one-to-one.

We need to finish up the family meeting with a solid plan for the future. Families, as well as individuals, are comforted by a doctor who has a clear plan and expresses same out loud. Once the blueprint of care is out in the open, the family can debate it, refine it and set it motion. Some families will, aggressively or passively, or both, block any externally imposed plans and it's helpful to be aware of this earlier than later.

Problem areas

Family Meeting

Denial

Denial occurs in about 10% to 15% of people and, in my experience, denial can run in families — so beware. Phrases like “I never heard about any of this until today” or “Nobody told me” might ring true in the extremely early phases of a person’s illness. However, by the later stages, all family members should have been exposed to the bad news. The ability to block such bad news, despite numerous discussions, can be impressive. Denial cannot be “overcome” by volume or repetition at a family meeting; one-to-one discussions work better.

Intellectualization is denial that went to university; spiritualization is denial that goes to church.

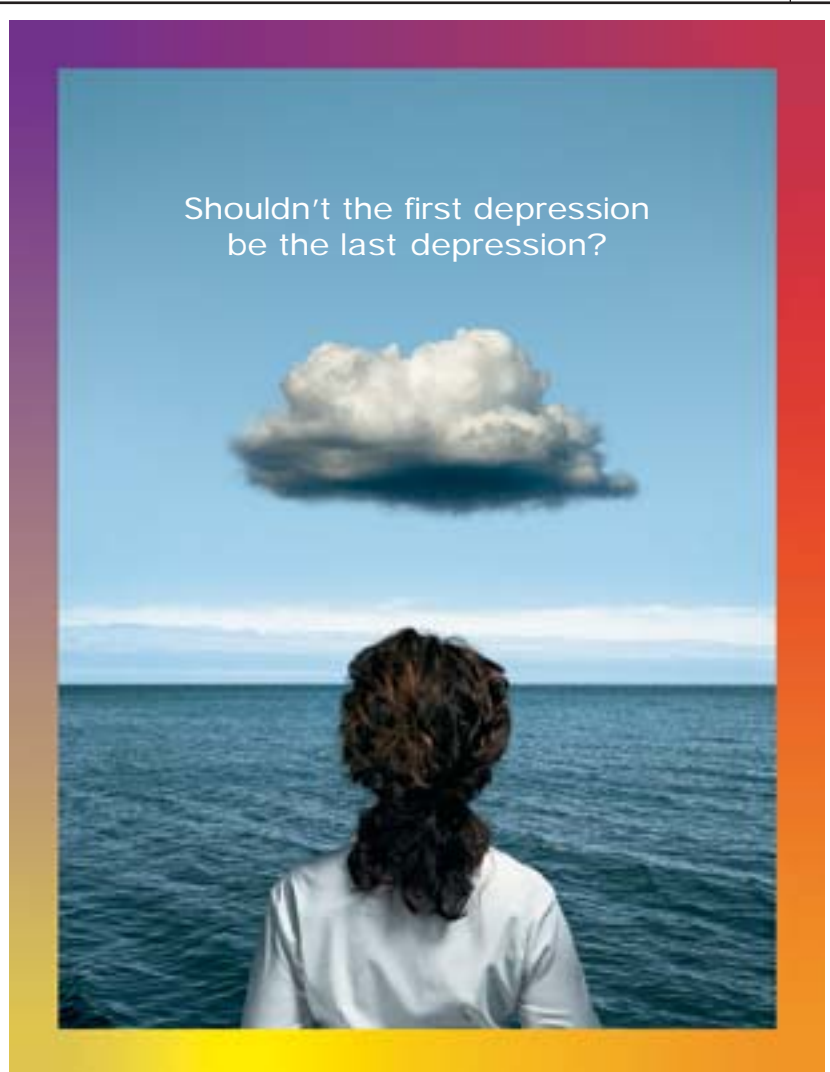
Anger

Although anger’s worst display usually involves someone storming out of the room, family members who have been caring for a sick loved one can become frustrated, tired, and confused. Quite frankly, by the time a person approaches death, the family usually has much to be angry about. Many people today are poorly equipped to deal effectively with anger and they leave the meeting or lash out, usually creating more unpleasantness. The doctor should acknowledge the cause of the frustration and encourage discussion because, too often, the family has not been offered a safe forum within which to discuss such unpleasant emotions.

Silence

Silence may be golden, but it doesn’t give the doctor much to work with. All the open-ended questions in the book won’t encourage mutual understanding if the family members won’t talk. When the whole family keeps mum en masse, it makes for a very short meeting. More often, one or two members remain verbally repressed, demonstrating their lifetime family roles or expressing their frustration and despair through passive aggressiveness. If the silent one turns out to be the primary caregiver, the doctor should avoid coming up with a plan of care at that particular meeting. If the primary caregiver doesn’t buy into the plan, it won’t work. Again, one-to-one discussions work best here.

Rudeness



Family Meeting

Table 5

Step Guide to the Family Meeting

- 1) Set up the meeting.
- 2) Start with introductions.
- 3) Assess the family's understanding of the medical problem.
- 4) Provide a short summary of the patient's condition.
- 5) Ask what the patient would want in this situation.
- 6) Determine who is the surrogate and decision-maker.
- 7) Summarize and make recommendations.

The family that can't show enough respect for each other to be quiet while others speak can be equally difficult. Interruptions, whispering side conversations, and sarcastic words or body language indicate a lack of self-confidence. The meeting leader can have considerable trouble keeping order. The family may not be aware what they are communicating through these behaviors and may misinterpret this impoliteness as normal.

Mechanics of the Family Meeting

I have held family meetings at home, in the clinic and in hospital. For the first two, I am often alone with the family and the issues often involve breaking bad news, for example, diagnosis of cancer or dementia, progression of the disease, or looming institutionalization. In hospitals, the health-care team is fuller and a meeting leader is needed. Usually the social worker contacts the family members, sets up individual support strategies and, subsequently, chairs the meeting. One person needs to be in charge of the meeting and all members of the health-care team need to respect this often-challenging role. In some systems, the doctor, nurse or pastoral-care worker acts as chair, but in my experience social workers function best in this role.

At the beginning of the meeting, once

introductions are over, I find it helpful for the family spokesperson to present the family's version of what is going on. Next, the medical facts are laid out by the doctor clearly and in plain English. After each member of the health-care team has had their say, the family members are asked to give an interpretation of their situation and to speak about what the patient would have wanted or expressed a desire for in the past.

As the meeting winds down I try to focus on the primary caregiver as the plan of care is debated and future activities are organized. In my experience, most family meetings take more than half an hour and less than an hour. Less than half an hour is too short to bring out serious issues, while fatigue sets in after one hour in a crowded room.

Even when family meetings go wrong (*i.e.*, with silence, storming off, aggressive denial, passivity, uncontrolled sentimentality), I always know more about how to care for the patient, once I've met the family and observed first-hand their dynamics and coping abilities. To know all, is to understand all, is to forgive all. Remember, the main aim of the family meeting is to find out how to support the group, while doing good for the patient.

CME

Suggested Readings

1. Furukawa M: Meeting the Needs of the Dying Patient's Family. *Critical Care Nurse* 1996;16(1):51-7
2. Brenner PR: Hospice Applications of Family Systems Theory. *Am J Hosp Care* 1985;13-6
3. Dyer KA: Presentation at AMSA Convention, March 30, 2001, www.journeyofhearts.org.