

Dealing with the difficult family:

Lessons from palliative care

by Geoffrey P. Dunn, MD, FACS

The words “difficult family” can refer to the conduct of a healthy family in an abnormal situation, or a family with maladaptive dynamics under any circumstances. The common denominator is the families’ need for effective and empathic communication by the surgeons caring for them. The issue of communication has recently received long overdue attention from surgeons and nonsurgeons because of the public’s increasing expectations for disclosure, and the mounting evidence of adverse psychological, economic, and legal consequences of communication failure. Life-threatening illness, in particular, has the potential for long-term repercussions, putting family members at risk for emotional turmoil and major psychological disorders.¹ There is evidence that the way bad news is communicated to families has a profound impact on grieving, bereavement, and subsequent psychosocial function.² Despite the rationale for

improved clinical communication with families, several barriers remain for surgeons, including attitudinal barriers, practical barriers, and lack of a well-developed framework for communication with families from multiple cultural backgrounds, in various clinical settings.

Attitudinal barriers

Many surgeons see the doctor-patient relationship as just that: the patient—not the patient’s family—is the focus of attention. Family members may be seen as an unwelcome intrusion into an intimate relationship in which the surgeon has assumed grave responsibilities.³ The “son from out of town” is the familiar shorthand used to describe the scenario in which the surgeon believes he has been challenged unnecessarily by an entitled family member rearing his or her head at the worst possible time, and for the most selfish

of motives. Challenging the traditional model of the physician-patient relationship is the growing social complexity of medical decision making that parallels the growing complexity of illness itself. The capacity to live with multiple comorbidities assumes a socioeconomic context that extends far beyond the needs and perspectives of the individual patient. The trajectory of illness now frequently passes through periods of prolonged dependence, debility, and incompetence of patients that impose financial, social, and legal obligations upon their family members, in addition to an adverse impact on the health of family caregivers.⁴⁻⁶ The focus of health care appears to be evolving from a disease-based model to a more broadly accommodating model that focuses on health and illness as multidimensional experiences for patients and their families. Should this be true, it is inevitable that surgeons will need to acknowledge the importance of family systems theory to better prepare themselves to provide guidance and care.

Practical barriers

Practical barriers also complicate communication with families, as anyone who has attempted to locate a private place for a family discussion on a busy hospital floor will attest. Pauline Chen, MD, FACS, pointed out recently, when commenting on a study that documented a lack of empathic behavior by oncologists and surgeons, that the first thing that she worries about when having to disclose bad news to patients is *time*.⁷ The one-hour family meeting occasionally required for complex decision making is not reimbursable, for even the most trivial procedures, despite the fact that communication of bad news is a highly “invasive procedure” when viewed in the context, for its impact upon trust, compliance, and hope.

The communication sequence

Since the seminal work of Robert Buckman, MD, in clinical communication in the early 1990s,⁸ guidelines for communication with families have been outlined and modified by others with applications in oncology, critical care, and palliative care settings.⁹ The approaches to communication with families are an extension

of the approaches to communication with an individual. The disclosure of bad news is a fundamental component of clinical communication. This component may be modified to accommodate more complicated communication tasks, such as discussing the transition of goals of care in the face of a rapidly changing clinical situation.

The general sequence of maneuvers in all communication situations is the establishment of the appropriate setting (privacy, comfort), eliciting the patient and family’s understanding of the situation (“Tell me what you know about your husband’s illness”), obtaining permission to proceed with the discussion (“Would you like me to tell you what his test results showed?”), imparting knowledge (“I’m afraid I have some bad news...”), the empathic response (“I can see that this news has come as a terrible shock to you”), and summation (“Why don’t I come by later after he has been seen by the other doctors, then we can discuss where to go from here”).

Joseph Weiner, MD, PhD, and Jesse Roth, MD, working with families of patients near end-of-life, have identified common counterproductive behaviors by clinician communicators that have the potential to increase psychosocial distress (see Figure 1, page 18).¹⁰

The communication sequence—which progresses from respect to empathy, and, ultimately, to trust—is designed to protect the patient and family from further harm, by giving them a chance to “take a breath” as they adjust to new realities. Whether imparting bad news or setting new goals, the communication sequence will not be perceived as a supportive one if the empathic response is absent.

When stepping into a room with a large, hostile family, the immediate first step is to acknowledge the emotion in the room. Not doing so would be the same as starting a major elective operative procedure without being aware that the patient is profoundly hypotensive. The safe conduct of an operation is a useful metaphor. For both a successful operation and effective communication, the setting and good support staff are key; consent is required; there is a “point of no return”; awareness of the immediate impact of an operative maneuver is critical; and closure is desirable, though not always possible. Like surgery, effective communication with the difficult

family is a learnable skill that is best taught through mentoring.

The palliative care setting

Further refinement in working with difficult families—beyond the basic communication strategies outlined in this article—will require customized approaches that are adaptable to each family’s unique characteristics. This will require increased training and instruction for surgeons regarding family systems concepts. Several

models of family systems theory, which have not previously been taught in formal medical curricula, can be applied to end-of-life scenarios—and may provide a useful framework for communication with families of all degrees of psychological health and cohesion.

Recognizing the value of family systems theory, Deborah King, PhD, and Timothy Quill, MD, at the University of Rochester School of Medicine and Dentistry, Rochester, NY,¹¹ applied a theoretical model proposed by Wynne¹² in their work with families in the palliative care setting. This

model conceptualizes family relational processes as a progressively developing capacity that builds upon previously acquired competencies and experiences. In this model, the most basic level of relating consists of attachments formed between individual members. The more stable these bonds become over time, the better the foundation is for subsequent higher order processes—such as open communication and a willingness to see from another’s perspective—that are prerequisites for collaborative complex decision making. This model predicts that the stronger the underlying attachment bonds within the family system, the more resilient the family will be under duress. Within this framework, the Rochester group was able to identify warning signs of families with seriously disrupted relational abilities, and make recommendations for how to proceed, specifically during the conduct of a family meeting (see Figure 2, this page).

Clinical experience with patients and families receiving palliative care and hospice experience has provided us a rich source of insight into family dynamics and adaptive patterns occurring in the frequently

Figure 1

Avoiding iatrogenic harm while discussing goals of care in the context of serious illness

- Prior to discussion of goals of care with family/patient, assess readiness to acknowledge possibility of serious or life-limiting illness or complications
- Do not make the relief of suffering conditional upon acceptance of a limited or potentially limited life-span
- Do not confuse “denial” with avoidance and normal grieving when characterizing a family that seems reluctant to address goals of care or overly reliant on treatments that yield little benefit
- Do not debate with patient and family about the reality of a serious medical situation
- Avoid presenting medical decisions in a hypothetical, impersonal, and binary manner

Source: Weiner JS, Roth J. Avoiding iatrogenic harm to patient and family while discussing goals of care near the end of life. *J Pall Med.* 2006;9(2):451-463.


Figure 2

Recommendations for working with families with seriously impaired relational abilities

- Recognize the warning signs of deep relational dysfunction in the family
- Be prepared to address high levels of family disorganization, conflict, or instability
- Increase the level of structure in family meetings to minimize conflict

Source: King DA, Quill T. Working with families in palliative care: One size does not fit all. *J Pall Med.* 2006;6(3):704-715.

harsh light of life-threatening and terminal illness. The application of these models should not be arbitrarily confined to palliative care venues, because the need for effective communication is a clinical constant—its value is not correlated with the patient’s prognosis, but rather, with its capacity to sustain or restore the patient and his or her family’s homeostasis.

Illness is no longer simply a personal experience—recognition of the importance of working effectively with the difficult family is a sign of how far medicine has evolved during the past quarter-century. Much of the clinical experience and evidence regarding how to go about this has come from a specialty—hospice and palliative medicine—that did not even exist a few years ago. Future psychosocial research should identify family system models adapted to surgical settings not limited to end-of-life, and the best way to introduce these models to surgeons in training. Through effective communication, the encounter with the difficult family, previously dreaded, can result in a rewarding experience, with positive long-term repercussions for all parties involved. 

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