Goals of Care Conversations

Ask before you tell · Recommend, do not present a menu of options

SILENCE IS A TOOL
use it deliberately

PREPARE BEFORE YOU WALK IN *five minutes of preparation changes the whole conversation*

KNOW THE FACTS

Be clear on the diagnosis, prognosis and realistic options before entering. Speak to the consultant and the specialty teams first so you are not contradicted mid-conversation — conflicting messages from different clinicians is the commonest source of family distress and mistrust.

SET IT UP

A private room, everyone sitting, phones silenced, enough chairs. Ask **who should be present** and whether an **interpreter** is needed — use a professional interpreter, never a family member, for these conversations. Allow enough time and hand over the page.

KNOW WHO DECIDES

Establish **capacity**, and identify any **advance directive, living will or appointed surrogate**. If the patient lacks capacity, the surrogate's task is **substituted judgement** — what the patient would have wanted — not what the surrogate wants.

RUN THE CONVERSATION *SPIKES for breaking news, REMAP for deciding what to do next*

Step	What it means in practice
R — Reframe	Establish that the situation has changed. **"I wish things were different, but the treatments are no longer controlling the cancer."** Use a **warning shot** first, then stop.
E — Expect emotion	**Stop talking and respond to the emotion before adding information.** Nobody absorbs facts while distressed. Use **NURSE** statements: Name, Understand, Respect, Support, Explore.
M — Map the values	**"Given this, what is most important to you?"** Ask what a good day looks like, what they would not want to lose, and what they are hoping for — then what they are worried about.
A — Align	Reflect their values back explicitly. **"So being at home and comfortable, and not being in hospital again, matter most to you."** This confirms you heard correctly.
P — Plan and propose	**Make a recommendation based on their values.** "Based on what you have told me, I would recommend focusing on comfort and avoiding readmission." **Do not present a menu and ask them to choose** — that abdicates clinical responsibility onto a grieving family.

SAY IT PROPERLY *the specific phrases that help and the ones that harm*

AVOID THESE

"Do you want us to do everything?" — nobody says no, and it implies comfort care is nothing. **"There is nothing more we can do."** — untrue and abandoning; there is always symptom control and presence. **"Withdrawing care."** — you withdraw an intervention, never care. Also avoid euphemisms like "passed" and "let go", and avoid jargon such as pressors, intubation and DNR without explanation.

USE THESE INSTEAD

"I wish... " aligns you with their hope while being honest. **"We will focus on making sure she is comfortable and not in pain." "Tell me what you understand about what is happening."** — ask before telling. **"What would he say if he were sitting here with us?"** for surrogates. And when you do not know: **"I do not know exactly how long, but I am worried it may be short."**

RESUSCITATION AND ESCALATION *a clinical recommendation, framed by values*

Element	Approach
Frame it as a recommendation	"Given how unwell his heart and lungs are, **CPR would not bring him back**, and I would recommend we do not attempt it. We will continue everything else." **Do not offer it as a choice when it will not work**, but do explain the decision.
Separate the decisions	**A resuscitation decision is not a ceiling of care.** Make antibiotics, ICU admission, transfusion and readmission explicit and separate — patients are harmed when "not for CPR" is silently read as "not for treatment".
Document specifically	Record **who was present, what was discussed, the values expressed, and the agreed plan** — not just the outcome. Write what to do, not only what not to do.
Time-limited trials	Where prognosis is genuinely uncertain, **agree a defined trial with a review point and explicit criteria**: "Let us continue for 72 hours, and if the kidneys and blood pressure are not improving, that tells us this is not reversible." This resolves many impasses.

THE DIFFICULT SCENARIOS *what to do when it does not go smoothly*

Situation	Approach
"Do everything, doctor"	**Explore what "everything" means to them** rather than accepting or refusing it. Usually it expresses **fear of abandonment**, not a request for specific interventions. "I want you to know we will not stop caring for him — tell me what you are most worried about."
Family conflict	Return everyone to **substituted judgement**: "What would *she* say if she could tell us?" This shifts the question from what each family member wants to what the patient would have wanted, and defuses guilt. Offer a further meeting rather than forcing resolution in one sitting.
Requests for non-beneficial treatment	Do not offer interventions that **cannot achieve the stated goal**. Explain why, offer what you can do, and use **time-limited trials** where there is genuine uncertainty. Escalate to a second opinion, ethics or the palliative team rather than into confrontation.
Cultural and religious factors	**Ask rather than assume.** Norms around disclosure, family-centerd decision-making and end-of-life practice vary widely. "Some people want all the details, others prefer we speak mainly with family — what would you prefer?" Offer chaplaincy and use professional interpreters.
The patient who will not engage	Respect it, and **leave the door open**. "That is completely fine. Can I check back with you another day?" Coerced conversations produce worse decisions and damage trust.

PEARLS & PITFALLS

- **Ask before you tell.** Start with what they already understand, and you will discover the conversation is often further along, or much further behind, than you assumed.
- **Respond to emotion before giving more information.** Continuing to talk through tears is the commonest error and guarantees nothing is retained.
- **Make a recommendation.** Offering a menu of options to a distressed family is not respecting autonomy, it is abandoning them.
- **Never say "there is nothing more we can do."** Reframe to what you *will* do — comfort, presence, symptom control.
- **Separate resuscitation status from the ceiling of care**, explicitly and in the notes.
- **Use silence.** After a warning shot or bad news, stop talking. The pause does more work than the next sentence.

References: VitalTalk REMAP and NURSE frameworks · SPIKES protocol for breaking bad news · Serious Illness Conversation Guide (Ariadne Labs) · national guidance on treatment escalation and resuscitation decision-making.

Educational aid; adapt to local law, capacity legislation and institutional policy.

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