Chaplain as Reconciler: Guiding Families through End-of-Life Conversations
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Objectives:
• Explore six aspects of the reconciler role: artisan of reconciliation, visionary activist, serious empathic, courageous prophet, patient mediator and compassionate advocate
• Acquire tools to help guide families through crucial end-of-life conversations
• Increase understanding of family dynamics and how they influence a family’s ability to reach a peaceful consensus about end-of-life care for their loved one.

Outline:
I. Definition of Reconciliation
   (proposed by DeYoung p.44-45)
II. Aspects of a Reconciler
   ( proposed by DeYoung p. 137-141)
III. Case Study Proposal
IV. Crucial Conversation Tools
   ( proposed by Patterson, Grenny, McMillan and Switzler)
V. Family Roles and Interactions ( proposed by A. Scott)
VI. Advanced Directives: Pros and Cons

Definition of Reconciliation
• From the Greek: denoted a change from a state of enmity to one of friendship, the healing of a quarrel, a radical change that occurs, in which an intimate and personal relationship is renewed
• Paul uses the language of reconciliation as broader that just between God and humanity.
• Paul’s full definition includes being put into friendship with God and each other, radical change and transformation of a relationship, and restoration of harmony.
• 2 Corinthians 5: 18-20
Aspects of being a reconciler

- What does it mean to be an artisan of reconciliation? Artisans make one of a kind, hand-made items. Artisans are exceptionally accomplished at a skill. Artisans commit their life to developing a craft. Artisans of reconciliation devote their life to becoming more skilled at relational bridge building. Scriptural examples: Jesus relating to Samaritan Woman and to Zaccheus.

- What does it mean to be a visionary activist? Visionary activists devise processes for moving away from how things are and toward the way they should be. Visionary activists believe that conditions can actually improve. Robert F Kennedy “Some people see things as they are, and say why; I dream things that never were, and say why not?” Scriptural examples: Jesus’ promise of the Kingdom of God and Paul’s missionary journeys.

- What does it mean to be a serious empathic? Serious empathics experience the feelings of others and are aware of their own feelings. Serious empathics sense potential conflicts and deeply feel the splits in relationships. Serious empathics are earnest about healing brokenness. Scriptural examples: Jesus reaction to the death of Lazarus and to the woman washing his feet.

- What does it mean to be a courageous prophet? Courageous prophets feel compelled to announce publicly that divisions exist. Courageous prophets speak the truth in an attempt to promote unity. Courageous prophets risk negative consequences of honesty. Scriptural examples: Crucifixion, Prophets and Martyrs.

- What does it mean to be a patient mediator? Patient mediators stand in the middle of chaos proclaiming a message of peace because they know that they cannot build bridges from afar. Patient mediators do not leave the center of chaos too soon because they realize that any slight shift could lead to reconciliation. Patient mediators believe that reconciliation is always possible and celebrate any move toward harmony. Scriptural examples: Jesus and the storm at sea and Jesus on trial.

- What does it mean to be a compassionate advocate? Compassionate advocates take action against injustice and oppression. Compassionate advocates dedicate themselves to mending broken relationships and work toward healing. Compassionate advocates attempt to empower others to do the same. Scriptural examples: Feeding of the 5000 and Matthew 25:35-36, “I was hungry and you gave me food, etc.”
A proposed case study

Dorothy is a 90 year old woman who is currently hospitalized in Critical Care with an ICH (intracranial hemorrhage). She is intubated and receiving medication to maintain her blood pressure. She was found unresponsive by the staff at her assisted living facility. The prognosis is poor. Dorothy had a number of existing medical problems prior to being hospitalized. She has end-stage renal disease. She has dialysis three times a week. She had a left leg amputation due to diabetes. While Dorothy is not brain dead, the chance of her ever returning to her previous level of independence is very small.

Dorothy lives in an assisted living facility. She enjoys visiting with other residents especially at meals provided in the facility dining room. She plays cards almost every night with a group of ladies. She manages her own medications. She does her own laundry and cleaning. She enjoys knitting and crocheting.

Dorothy is a widow with six adult children. Her children and grandchildren visit frequently. Three adult children live in the immediate area. Two live elsewhere in the state and one lives in another state.

Dorothy has no will or advanced directives for healthcare. Despite her health problems, Dorothy has resisted any attempts to talk about end-of-life care. Her response has always been “what will be will be” or “my children know what I want”

It is now time to have a conversation with the family to determine a plan of care for Dorothy.

Crucial Conversation Tools

Preparing for the conversation
- Right mind set
- Right heart set
- Right skill set

Defining a crucial conversation
- Two or more people are involved
- Opinions vary
- Stakes are high
- Emotions run strong
- Results can have a huge impact on the quality of life

How do we handle crucial conversations?
- We avoid
- We face them and handle them poorly
- We face them and handle them well
How can we handle these conversations well?

- Focus on what you really want; clarify what you do not want
  *What do we want for Dorothy? What do we want for her family?*
  *What are we trying to avoid for Dorothy or her family?*

- Avoid the “sucker’s choice” There are always more than two outcomes. It is not an either/or. Look for the “and”
  *Are there more choices for Dorothy other than discontinuing aggressive treatment or continuing it? Could we continue treatment but make Dorothy DNR? Could we agree on a timeline? If there is no meaningful progress in 48 hours then we will discontinue aggressive treatment. Can we define meaningful progress and aggressive treatment?*

- Create an environment where all can feel safe
  *Can we find a time and a place where Dorothy’s family will feel safe and comfortable? How can we include the staff that the family is most familiar with? Can we find a room that will accommodate all the family who want to be present? Can we arrange conference call, speakerphone or Skype for those who cannot be physically present?*

### Consequences of people not feeling safe

- **SILENCE**- purposely withholding information, feelings, etc)

  **Masking:** understating or selectively showing true opinions. (sarcasm, sugarcoating, couching)
  *“Mom has always recovered from every setback before. She’s a tough old bird.”*
  *“Are you people saying you don’t want to treat our mother and just give up on her?”*
  *“There is always the hope of a miracle.”*
  *“My sister-in-law’s uncle’s cousin has recovered from a head bleed when the MDs said he wouldn’t, so it is always possible.”*

- **Avoiding:** steering completely away from sensitive subjects.
  Talking but not addressing the real issues.
  *“I think it is way too soon to talk about this stuff”*
  *“I want to know what mom’s creatinine level is?”*
  *“I talked with the people at the assisted living and they will hold mom’s room for 30 days. Does everyone agree with that?*
  *“When we were growing up, Mom was always there for us.”*

- **Withdrawing:** Pulling out of the conversation, either by not speaking or by exiting the room
  *“I’m just here to listen. I’m the youngest and no one cares what I think anyway”*
  *“I need some fresh air (translated- I need a smoke)”*
• **VIOLENCE**—any verbal strategy that attempts to convince, control or compel others to your point of view. Can include name-calling, monologuing or making threats

**Controlling:** forcing your views on others or dominating the conversation. Methods include cutting others off, overstating your facts, speaking in absolutes, changing subjects or using directive questions to control the conversation.

“*I’m the one who has been caring for mom, taking her shopping and to MD appointments and such. I know what’s best for her.*”

“*It’s nice that everyone could find the time to be here today. No one ever had time for mom before!*”

“*Before you say anymore, I want my questions answered*”

**Labeling:** putting a label on people or ideas so that we can dismiss them

“*If you think mom would want to be lying in a nursing home not knowing who she is or where she is, you are just ignorant*”

“*I think we should move mom to ______ Hospital. They will know how to save her. You people are giving up on her*”

**Attacking:** movement from winning the argument to making the person suffer. Tactics include belittling and threatening.

“*I’m not surprised you would say that. You’ve always had to have your way since we were kids.*”

“*I think if my mother had been treated correctly from the beginning we wouldn’t be in this situation. I contacted a lawyer yesterday.*”

“*One MD tells me one thing and another tells me different. You people don’t know what you’re doing*”

**Creating Safety**

When others move to silence or violence a reconciler needs to step out and not engage.

Reconciler needs to establish mutual purpose:

• I care about your interests
• My motives are to help you
• I respect you

Steps to establishing mutual purpose:

• **C** Commit to seek mutual purpose, family, staff and reconciler
• **R** Recognize the “why” behind what each party wants
• **I** Invent a mutual purpose with compatible goals
• **B** Brainstorm new strategies
Telling Stories

When people feel safe and commit to a mutual purpose they are in a position to tell their stories and hear others’ stories. The family members have stories of how they perceive the events. The medical staff has stories of how they perceive events. Social workers, chaplains and family clergy have stories of how they perceive events. In a safe environment all can share.

Unhelpful Stories
- **Victim**: It’s all my fault
- **Villain**: It’s all your fault
- **Helplessness**: There’s nothing else I can do

Sharing Your Story
- **S** Share your facts. Start with the least controversial
- **T** Tell your story. Explain how you see things.
- **A** Ask others for their stories. How do others see things?
- **T** Talk tentatively. Recognize that the way you see things may not be the only way to see them
- **E** Encourage testing. Make it easy for others to have different or opposing views.

Use Your Listening Skills
- **Ask**: Start by simply expressing interest in the other person’s views
- **Mirror**: Increase safety by respectfully acknowledging the emotions people appear to be feeling
- **Paraphrase**: As others, begin to share part of their story, restate what you’ve heard to show not just that you understand, but also that it’s safe for them to share what they’re thinking.
- **Prime**: If others are reluctant to share, prime. Take your best guess at what they may be thinking

Share Your Views
- **A** Agree when you do
- **B** Build. If others leave something out, agree where you do and build from there
- **C** Compare. When you do differ significantly, don’t suggest someone is wrong. Compare two views
Moving to Action

It takes time and attention to come to consensus. In decisions about end-of-life patient care, consensus is always the goal. Everyone comes to an agreement and then supports the final decision. We need to be realistic about consensus.

- Don’t pretend that everyone will get their first choice
- No martyrs, please
- Don’t take turns
- Don’t engage in post-discussion lobbying
- Don’t say I told you so.

Revisiting the case study

Family Roles and Interactions

End-of-life decisions are made in the context of family. Family roles and patterns of behavior, communication styles and ways of handling conflict affect these decisions. Despite different roles, patterns, communication and conflict handling there are four messages that hold particular importance for all families.

Family Roles and Patterns of Behavior: Family patterns of decision making typically remain unchanged once established. When roles change, as they do at end-of-life, the pattern changes.

- Child may become caregiver, possibly employee if compensated for care-giving. Child may become decision-maker for an incapacitated parent. Parent may feel loss of the valued role of decision-maker and be resentful of role reversal.
- Sibling conflicts and rivalries resurrect.
- Gender roles established in childhood can resurface.

Family Communication: Families use either implicit or explicit communication. Families use positive influence strategies or negative influence strategies.

- Explicit communication is marked by open expression, active problem solving and direct verbal agreements.
- Implicit communication tends to avoid open conflict and rely on silent agreements in which decisions evolve incrementally over time.
- Positive influence strategies such as showing interest in others ideas during decision-making creates greater intimacy
- Negative influence strategies such as getting angry and demanding during decision-making results in less intimacy

Handling Conflict: End-of-life decisions are often intergenerational and ripe for conflict even in well-functioning families. The danger is that end-of-life decisions when made in the context of conflict may not be the best. The goal may become managing the conflict rather than the patient’s end-of-life wishes.
• Generational conflicts: Older adults tend to rate conflict as less problematic than do younger persons and they tend to be more noncommittal during conflict. Older adults tend avoid conflict because they believe that disputes can be stressful on their health.
• Value conflicts: People may have trouble articulating their ethical positions and respond emotionally when discussing values.

Important messages:
• Messages of love tend to create a sense of connectedness
• Messages about personal identity can affirm individuals’ positive qualities
• Discussion of spirituality validates the importance of faith
• Acknowledging difficult relationship issues provides an opportunity for reconciliation

Conclusion and Discussion
Pros and Cons of Advanced Directives
Advance care planning is one of the ripest areas for improvement.

Pro
* can improve end-of-life care
* can reduce stress, written helps more than verbal
* document opens the door for communication
* when done before death is imminent, it reduces pressure
* provides a way of communicating with healthcare professionals
* way to make decisions about treatment preferences
* can make pain management desires known
* can ensure patient will be treated as a whole person
* can create a sense of relational completion and help prepare for death

Con
* simply talking about end-of-life does not necessarily improve understanding
* quality of communication matters How do we define effective communication?
* discussion can be physically, psychologically and relationally taxing
* less than one in three people formalize their wishes
* document is not a guarantee that wishes will be followed
* end-of-life wishes change over time
* written documents can be misplaced, invalid or too general
* family members may not know the document exists
* person may have cognitive and psychological changes that impair how they make decisions

Sources

Crucial Conversations: Tools for talking when stakes are high by Kerry Patterson, Joseph Grenny, Ron McMillan and Al Switzler, McGraw-Hill, 2002

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Reconciliation: Our Greatest Challenge-Our Only Hope by Curtiss Paul DeYoung, Judson Press, 1997