Options Counseling at the End of Life

Evan Pulvers MD
Catherine S. Forest MD MPH
Heather Paladine MD MEd
Learning Objectives

1) Describe the elements of crucial conversations at the end of life

2) Conduct an end of life options conversation including medical aid in dying

3) Use non-directive questioning to engage patients in patient-centered end of life care
Introductions
What is Options Counseling?

- Communicate non-judgmentally
- Deliver the medical news in a compassionate manner
- Elicit the patient’s description of her emotional reaction
- Acknowledge the options
- Maintain the integrity of patient autonomy through allowing for supported choice
- Non-directive
What is Medical Aid in Dying?

Aid-in-Dying

Term adopted by most laws and professional societies for when a physician prescribes a lethal dose of medication to a mentally competent, terminally ill individual upon the patient’s request, which the patient intends to hasten end of life. Specifically excludes suicide from legal definition in 8 states and Washington DC.

“It is important to remember that the reasoning on which a terminally ill person (whose judgments are not impaired by mental disorders) bases a decision to end his or her life is fundamentally different from the reasoning a clinically depressed person uses to justify suicide.”

American Public Health Association
Medical Aid-in-Dying

➢ AAFP passed engaged neutrality in 2018
➢ In most polls - >80% support option for terminal patients to choose terms of their own death.
➢ Over 25% of Americans live in state where legal
Latest MAID

1) Pre-medications:
   a. Ondansetron 8mg, #1: Take 1 hour before aid-in-dying medications.
   b. Metoclopramide 10mg, #2: Take 1 hour before aid-in-dying medications.

2) Digitalis: 100mg Dispense as powder. Sig: Take 30-45 minutes after nausea medications.

3) Aid-in-Dying medications: Dispense as powder in 120cc glass bottle. Sig: Add liquid to fill bottle and take all in 2 minutes, 30 minutes after taking digitalis.
   a. Morphine sulfate 15gm
   b. Diazepam 1000 mg
   c. Amitriptyline 8gm

For more on current state of MAID: April 28th from 2:30-3:30 in the Huron Room!
North American End of Life Model

adding Medical Aid in Dying

Context of Options

- disclosing serious illness
- goals of care
- code status
- palliative care,
- hospice care
- medical aid-in-dying
- voluntary stopping of eating and drinking

Eligibility

- Adult
- Resident of location
- Terminal disease – expected to cause death within 6 months
- Has capacity
- Able to take medications on own
End of Life counseling

- SPIKES oncology
- The Critical Illness Conversation guide
- Vital Talk
## SPIKES

| Preparation (read chart, room) | x | x |
| Assess Patient Understanding | x | x | x |
| Establish permission to discuss topic | x | x | x |
| Shares medical knowledge | x | x | x |
| Address ambivalence | | | x |
| Respond to emotion | x | | x |
| Elicit patient’s values | | x | x |
| Commit to supporting patient | | x | x |
| Explain next steps | x | x | x |
Outlining the conversation

S (Setting up the interview: space, people, outline the information)

P (patient Perception)

I (obtaining the patient Invitation to talk about the topic)

K (giving Knowledge to the patient)

E (address Emotion with empathy)

S (Strategize and Summarize)
### Serious Illness Conversation Guide

<table>
<thead>
<tr>
<th>CONVERSATION FLOW</th>
<th>PATIENT-TESTED LANGUAGE</th>
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<tbody>
<tr>
<td>1. Set up the conversation</td>
<td>“I’d like to talk about what is ahead with your illness and do some thinking in advance about what is important to you so that I can make sure we provide you with the care you want — is this okay?”</td>
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<tr>
<td>- Introduce purpose</td>
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<tr>
<td>- Prepare for future decisions</td>
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<td>- Ask permission</td>
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<tr>
<td>2. Assess understanding and preferences</td>
<td>“What is your understanding now of where you are with your illness?” “How much information about what is likely to be ahead with your illness would you like from me?”</td>
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<td>3. Share prognosis</td>
<td>“I want to share with you my understanding of where things are with your illness...” Uncertain: “It can be difficult to predict what will happen with your illness. I hope you will continue to live well for a long time but I’m worried that you could get sick quickly, and I think it is important to prepare for that possibility.” OR Time: “I wish we were not in this situation, but I am worried that time may be as short as ___ (express as a range, e.g. days to weeks, weeks to months, months to a year).” OR Function: “I hope that this is not the case, but I’m worried that this may be as strong as you will feel, and things are likely to get more difficult.”</td>
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<tr>
<td>- Share prognosis</td>
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<td>- Frame as a “wish...worry”, “hope...worry” statement</td>
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<td>- Allow silence, explore emotion</td>
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<td>4. Explore key topics</td>
<td>“What are your most important goals if your health situation worsens?” “What are your biggest fears and worries about the future with your health?” “What gives you strength as you think about the future with your illness?” “What abilities are so critical to your life that you can’t imagine living without them?” “If you become sicker, how much are you willing to go through for the possibility of gaining more time?” “How much does your family know about your priorities and wishes?”</td>
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<tr>
<td>- Goals</td>
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<td>- Fears and worries</td>
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<td>- Sources of strength</td>
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<td>- Critical abilities</td>
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<td>- Tradeoffs</td>
<td></td>
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<td>- Family</td>
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<td>5. Close the conversation</td>
<td>“I’ve heard you say that ___ is really important to you. Keeping that in mind, and what we know about your illness, I recommend that we ___ This will help us make sure that your treatment plans reflect what’s important to you.” “How does this plan seem to you?” “I will do everything I can to help you through this.”</td>
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<tr>
<td>- Summarize</td>
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<td>- Make a recommendation</td>
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<td>- Check in with patient</td>
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<td>- Affirm commitment</td>
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<td>6. Document your conversation</td>
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<td>7. Communicate with key clinicians</td>
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Vital Talk app/trainings

GOC - REMAP (vitaltalk)
R (Reframe why status quo isn’t working)
E (Expect emotion)
M (Map the future)
A (Align with patient values)
P (Plan medical treatment)

Prognosis - ADAPT (vitaltalk)
A (Ask what patient knows and what they want to know)
D (Discover what information will be useful)
A (Anticipate ambivalence)
P (Provide information that the patient wants)
T (Track emotion)
● Step AWAY from the tool box...

Until you’ve decided what you want to build.
Patient inquires about aid-in-dying...

ASK

Patient-centered plan

TELL

ASK again (goals of care)
Work in groups of three

- Draft an outline script of a standardized medical aid in dying counseling conversation
- Use parts of the palliative care conversation frameworks and non-directive options counseling.
- Consider how this could be used to teach learners
Regroup and Debrief
more information

Feel free to contact any of us:

Evan Pulvers  evan.pulvers@gmail.com
Catherine Forest  dr.catherineforest@gmail.com
Heather Paladine  hlp222@gmail.com

Follow up on the Current State of MAID in USA and Canada April 28 at 2:30-3:30 in the Huron Room
Examples of Words That Work
drawn from work of Rachel Bernacki MD and Atul Gawande MD at Ariadne Labs

★ set up conversation

★ assess

understanding

★ share prognosis

- “I’m hoping we can talk about your illness and where it’s going--is that ok?”
- “What is your understanding of where you are with your illness?”
- “I’m worried that time might be short.”
Explore Key Topics

★ “What are your most important life goals if your health worsens?”

★ “What are your biggest fears and worries for the future with your health?”

★ “What gives you strength as you think about the future with your illness?”

★ “What are some abilities that you cannot imagine living without them?”

★ “If you become sicker, how much are you willing to go through for the possibility of having more time?”
Words That Work
continued
★ “How much does your family know about your priorities and wishes?”

★ “It sounds like it is very important to you.”

★ Given your goals and priorities and what we know about your illness at this stage, I recommend…

★ “We’re in this together.”