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| Clinician: You will conduct a goals of care conversation with a 67 year-old patient with ESRD on maintenance hemodialysis for the past three years. Although adherent to medications and dialysis treatments, the patient experiences significant disability and has been hospitalized three times in the last year. You know this patient well. Patient: You have been on hemodialysis for three years. You have been in the hospital three times in the last year, most recently for a heart attack last month. You understand that your illness is getting worse, and you’re hoping that things will turn around. You value your independence and don’t want to depend on your family for personal care. You are especially close to your daughter, who has been a big help to you and your spouse. |

PRACTICE SEGMENT 1: Begin / Discuss the patient’s surrogate

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| Task | Clinician ClipartClinican | outline of a male patient's head and shoulders Patient |
| Introduce the conversation and ask permission to proceed | I was hoping we could spend this visit talking about your health and what matters to you, and discussing the kind of medical care you would or wouldn’t want in the future. This will help us make sure you get the care that matches your goals. Can we spend a little time talking about this?  | Sounds like a good idea. |
| Identify patient’s desired surrogate | To start off, it’s helpful to know who would be the best person to speak for you if you were ever too sick to communicate your health care decisions yourself. Have you thought about who you’d like this to be? | Yes. I want my daughter to do that. She knows what I want. |

Page 1

PRACTICE SEGMENT 1, continued

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|  Task | Clinican | Patient |
| Find out if desired surrogate would be authorized | She sounds like a good choice. Have you completed an advance directive to name your daughter as the person who would be authorized to speak for you? | No. Do I have to do that? |
| Inform patient who would be the authorized surrogate | Yes. As your next-of-kin, your wife would be your official health care decision maker, unless you name someone else in an advance directive. | Really? I don’t want to put my wife through that. She has her own health problems. It’s best if it’s my daughter. |
| Tell the patient how to name a surrogate and offer help | OK. Would you like our social worker to help you put that in an advance directive? | Yes, I would. |

Page 2

 PRACTICE SEGMENT 2: REMAP – Reframe, Emotion, Map, Align, Plan

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| Task | Clinician ClipartClinican | outline of a male patient's head and shoulders Patient |
| Assess understanding of illness and prognosis | Is it OK if we spend some time talking about how you’re doing with your kidney failure and dialysis treatments? | Yeah. I’ve been feeling more and more exhausted, and I’ve been spending more time in the hospital. It’s been tough. |
| It has been tough. [pause] What do you think the future might look like with your kidney failure? | Well, I know it gets bad, but I always bounce back.  |
| Reframe | I’m worried that we are in a different place now, and it’s going to be harder for you to bounce back. | [Sad] So, what are you saying – that I’m supposed to give up? |
| Respond to emotion | I don’t want you to give up. We’re here to help you in every way we can.  | I’m a fighter. I know I can still beat this thing. |
| You are a fighter. I really admire that about you. It must be frustrating that you continue to have more problems related to your kidney failure. | [Sad] I’ve just kept hoping that I’d get better. |
| Respond to emotionAsk permission before moving on | I can see how disappointing this is. [pause] Would it be OK if we talked about where we go from here? | That would be OK. |
| Map out what’s important – thoroughly explore values and goals | Given this situation, what’s most important to you?Page 3 | I want to be able to take care of myself. I don’t want to feel so sick all the time, and I don’t want to be in pain.  |

PRACTICE SEGMENT 2, continued

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| Task | Clinican | Patient |
| Continue exploring values and goals | Those sound like good goals. What else? | I’d like to be at home for as long as I can. Spending time with my kids and my grandkids without feeling so tired is important. My grandkids help take my mind off my troubles. |
| Ok. What else? | That’s about it, I guess. |
| As you think about the future, is there anything you want to avoid? | I want to live, and I’m not getting better. It’s so frustrating. |
| Respond to emotion | It is frustrating. I wish it was easier. | Me, too. |
| Align with patient’s values | It sounds like what really matters to you is [summarize]. | [Agree] |
| Ask permission tomake recommendation | Would it be OK if I offered a recommendation? | Sure. |
| Make a recommendation | Given what you’ve told me is most important, there’s a lot we can do to help. We’ll focus on managing your symptoms as well as we can. We’ll also look into getting you some help at home so you can stay more independent and can put your energy toward spending time with your family. |  |
| Ask if the patient agrees | Does that sound right? | Yes, that sounds good. |

Page 4

PRACTICE SEGMENT 3: Discussion life-sustaining treatment and summarize plan/next steps

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| Task | Clinician ClipartClinican | outline of a male patient's head and shoulders Patient |
| Explore dialysis options | Dialysis can help you live longer, but there are trade-offs. Some people decide that dialysis is not helping them live the life they want. What about you? | I really don’t like coming in for dialysis, or the way it makes me feel, but it gives me my best shot at living longer, and that’s important to me. |
| Assess knowledge of CPR | Another treatment I’d like to talk about is CPR. Can you tell me what you know about CPR? | I’ve seen it on TV, but I don’t know much about it. |
| Provide basic information  | CPR is used only when someone’s heart and breathing stop. It involves forcefully pushing on the chest, and can also include shocking the heart and putting a tube down the throat to try to get the heart and breathing to start again.  | If it brings you back alive, why wouldn’t everyone want it? |
| Provide desired informationGeneral Outcomes 🡪Probabilities 🡪 | Most adults who receive CPR don’t survive. Young and otherwise healthy people have better chances of surviving, and people with serious health problems have lower chances.  | What do you think my chances are? What’s the likelihood it would work? |
| About 22 of 100 people on dialysis survive after receiving CPR in the hospital, which means that 82 out of 100 die. One year after receiving CPR, 7 of 100 people are still alive, and 93 are not.  | Wow, that’s a lot different than I expected. |

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PRACTICE SEGMENT 3, continued

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| Task | Clinican | Patient |
| Respond to emotion | It can be surprising. | If I survived after CPR, would it affect my ability to do the things I want?  |
| Provide desired information Outcomes linked with goals 🡪 | There is a high risk of broken ribs, and a [large chance] that you would need more help. You might not be able to go back home to live by yourself, and you might need machines afterward to help keep you alive. There’s a [small chance] that you wouldn’t be able to recognize your family if you survived after CPR.  | I guess that’s important to know. Even so, I think I’d want to give CPR a try. |
| Explore possible inconsistencies between goals and treatment decisions | I worry that CPR wouldn’t help you reach your goals of staying independent and living at home. | It might not, and I know I might end up worse off – in the hospital, on machines, in pain… But I might be that rare person who does better than everybody expects, and it’s worth a shot if it might give me one more day with my family. |
| Explore circumstances when treatment may not be wanted | You have a strong bond with your family, and I respect that. Can you think of a situation when you wouldn’t want CPR? | If my health gets so bad that I can’t recognize my family or make decisions for myself, at that point I wouldn’t want CPR. |

Page 6

PRACTICE SEGMENT 3, continued

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| Task | Clinican | Patient |
| Summarize and confirm | At this point, you would want CPR if your heart and breathing stop. If your health got so bad that you couldn’t recognize your family or make decisions for yourself, then you wouldn’t want CPR. Do I have that right? | Yes, that’s right. |
| Next steps | Ok, I’ll put that in your health record. Let’s talk with your wife and your daughter together to make sure they know what you want. Would that be ok? | That sounds good. |
| Close | [Improvise other next steps, e.g., advance directive follow-up, and close the conversation.] | [Improvise] |

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