

# Talking about death: Now that it pays, how to do it well

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Medicare recently began paying for advance care planning (ACP) conversations. Many physicians, however, may have a shortage of the training needed to excel with these encounters, which involve exploring a patient's end-of-life health values, discussing relevant treatment options and then developing a plan and communicating it to loved ones and care teams. Physician experts recommend ways to incorporate this essential component of end-of-life care into standard practice.

The *AMA Code of Medical Ethics* provides guidance on end-of-life care, such as chapter 5, "Opinions on Caring for Patients at the End of Life," which covers topics such as advance care planning, advance directives and orders not to attempt resuscitation.

Following are highlights from an article in *AMA Journal of Ethics*® (@JournalofEthics) by Carin van Zyl, MD, a palliative care specialist at the University of Southern California Keck School of Medicine and the Los Angeles County + USC Medical Center, and Dawn M. Gross, MD, PhD, host of the radio show "Dying to Talk." The article explores the challenges and opportunities in developing formalized outcomes, measurement methods and training for ACP conversation procedures.

In the broadest sense, ACP begins with asking patients to identify what makes life meaningful to them. More specifically, it might involve asking them to determine the minimum acceptable quality of life or function with which they would be willing to live.

The conversation is important "because of the ever-growing number of medical interventions available, it is increasingly difficult to discern when death is approaching," the authors wrote. "As a result, people living with life-limiting illnesses often face choices between treatments that might extend time or improve quality of life but that can rarely achieve both."

They recommend the following advice for talking with patients about advance care planning.

**Focus on quality over quantity.** Rather than assuming that the patient's goal is always to have more time, try to uncover what defines quality of life for the patient and then make relevant

recommendations regarding treatment options. If more time is a goal, try to determine what specific date or experience the patient is looking forward to, such as the birth of a child. That may enable care teams to tailor medical care to support that goal.

**Help the patient select a surrogate decision-maker.** Also known as the durable power of attorney for medical decisions, the surrogate health care decision-maker advocates the patient's wishes in the event that the patient is unable to do so herself. This need not be her legal partner or a family member. In fact, close family members may, under the stress of an end-of-life situation, fail to distinguish their own wishes from the patient's.

**Document the patient's wishes in an advance directive.** A formal record of the patient's wishes can be valuable, especially when a surrogate cannot be identified. Note, however, that there is not yet a universal advance directive form or a portability platform to enable care teams to access advance directives across settings.

**Develop your skills.** By accepting Current Procedural Terminology (CPT®) codes that have been developed, the Centers for Medicare & Medicaid Services acknowledged that ACP conversations involve skills that require instruction and practice to master. Seek opportunities to actively observe experienced physicians holding ACP conversations, engage in coached practice of managing complex conversations, and request structured feedback from teachers, patients and families.

It might seem that some physicians are naturals at end-of-life conversations, but empathic communication can be learned like any other clinical skill. *AMA Journal of Ethics* has produced several "Ethics Talk" podcasts on this topic, including "Healthy Dying and How It Can Happen" and "Facilitating End-of-Life Care Discussions through the Conversation Project."

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