Goals of Care

Development and Use of the Serious Veterinary Illness Conversation Guide

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KEYWORDS

• Palliative care • Goals of care • Serious illness • Serious veterinary illness
• End-of-life communication • Serious illness conversation • Aid in dying • Euthanasia

KEY POINTS

- Goals of care conversations are an essential component of palliative medicine for both human and veterinary patients.
- Goals of care conversations provide formal structure, evidence-based guidance, and dependable support for those involved in serious illness and end-of-life care.
- Serious illness care in veterinary medicine is uniquely positioned to benefit from structured goals of care conversations.
- A goals of care checklist, the Serious Veterinary Illness Conversation Guide, has been modified from human medicine for use in veterinary patients.
- Widespread implementation of high-quality goals of care conversations is a keystone step for quality advancement of palliative care within the veterinary profession.

SETTING THE STAGE: THE UNIQUE NATURE OF SERIOUS VETERINARY ILLNESS AND ITS TREATMENT

In human medicine, end-of-life debates often focus on trying to "die well," being "allowed" to die, and attaining understanding regarding when life-prolonging treatment is no longer in the best interests of patients. This is largely because of the default to treat, which pervades medical intervention for humans. Contemporary medicine in the United States will prolong life at all costs: emotional, financial, and physical, in the name of "doing everything." In the words of oncology nurse Theresa Brown, "Medicine today achieves great things, but too often when patients have no hope of surviving we use technology and drugs simply to keep people alive."[1] Conversations around

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end-of-life care for people consequently tend to focus on upholding the rights of patients to withhold or withdraw life-sustaining treatment, and the many complexities of those rights, including ethical conflicts when patient or family wishes do not match recommendations of the medical team.

In veterinary medicine, where the dominant end-of-life paradigm is euthanasia, the focus is arguably opposite from human medicine. Veterinary end-of-life considerations typically surround questions of life-*ending* versus life-prolonging treatment as well as the “right to live versus right to die,” that is, some say that animals have a right to live rather than be euthanized. Meanwhile, the default recommendation for seriously ill or otherwise suffering animals is euthanasia, and disagreement with this tends to be labeled as “resistance.” This paradox within end-of-life decision making for human and veterinary patients creates rich ethical terrain for the pet-owning public and veterinary profession alike.

Veterinarians are often in the tricky position of weighing client preferences relative to patient best interests. The “veterinary trilemma,” the relationship between the animal, its owner, and the veterinarian, elevates the complexity of these issues,[2] and veterinarians rank resulting ethical conflicts as highly stressful.[3] It is reasonable to wonder when, if ever, euthanasia is a cruelty versus a kindness, and who decides? Within the veterinary profession, there is great interest in preventing suffering in companion animals by euthanizing *before* things get bad (preemptive euthanasia). As a result, those who choose euthanasia later in the disease course, or not at all, are often judged harshly for “letting animals suffer.”

An interesting exception to this resistance to prolong companion animal life seems to exist in veterinary intensive care units (ICU), which increasingly resemble their human counterparts. Along with successful outcomes and life-saving interventions, there exists a surprising amount of suffering in the veterinary ICU. Pain is just one unpleasant experience among many for critically ill animals.[4] However, this reality tends to escape judgment because it exists under the purview of veterinary professionals, with an intent to save life. Conversations regarding withhold/withdraw of life-sustaining treatment have yet to be substantively considered in the professional discourse of veterinary critical care, but the boundary between “heroism" and futility in the veterinary ICU has recently been explored.[2,5] Comparatively, discourse around the ethics of advanced care related to futility and nonbeneficial treatment is prevalent in human medicine.[6–12] It is curious that despite increasing availability and social acceptability of advanced care for animals, bringing with it controversies and ethical conflict similar to human medicine, there has been little attention given to the *limits* of this care by the veterinary profession. Largely absent from the conversation not only consideration of animal welfare issues and medical outcomes associated with advanced care but also what veterinarians are obligated to offer, and what they are not, for patients. In addition, formally structured opportunities for discourse around these issues, such as hospital ethics committees, are largely absent from veterinary settings. Moses[13] points to a “deep lack of ethical literacy” in the veterinary profession as an obstacle to widespread acceptance of ethics consultation services. This is an important area for future research.

Similarities between human and veterinary medicine include medical teams sometimes continuing to offer interventions even if they do not think them to be in the patient’s best interests, possibly because they think they are obligated to do so. “Resistance” to euthanasia on the part of a veterinary client in the face of veterinarian assessment that it is a reasonable option for her pet is in some ways analogous to “resistance” to discontinuation of life support in the face of physician assessment that it is the most reasonable course of action for a family member. Pressure from

both veterinary clients and human patients (and families) to “keep going” with medical interventions is felt by veterinarians and physicians. The dominant paradigms and default actions of human and veterinary medicine may be distinct, but parallel ethical conflicts arise in both settings. In this author’s view, all humans are impacted by the ways in which advanced care, the limits of such care, and death are navigated across species and circumstances.

Goals of Care (GOC) conversations, the subject of this article, are the means to exploring these increasingly complex issues. They provide formal structure, evidence-based guidance, and dependable support for those involved in serious illness and end-of-life discussions. Involvement in palliative medicine or end-of-life care without GOC conversations is akin to wandering a trailless wilderness without a map.

What is a Goals of Care Conversation?

GOC conversations focus on what is most important to patients and their families as they face serious illness. They do not presume that the only priority is living longer, but rather recognize that medical treatment plans may, and *ought to* be, altered depending on individual goals and preferences. They foster and prioritize “the ask,” the simple yet revolutionary act of asking patients and families what is important to them as their lives are impacted by their illness and its treatment. Although this may sound too simple to warrant scientific inquiry, those who have had a seriously or terminally ill (human) family member know that the impact of these conversations, or lack thereof, is significant. Although GOC conversations have not yet received scholarly attention in the veterinary literature or widespread curricular integration within veterinary teaching institutions, they are established as an essential element of high-quality care in the context of serious illness for people.[14] The structure of, barriers to, and impact of these conversations have all been examined.[14–21] The 2014 article by Bernacki and Block[14] in *Journal of the American Medical Association* “Review and Synthesis of Best Practices” regarding communication of serious illness care goals asserts,

> *Communication about goals of care is a low-risk, high-value intervention for patients with serious and life-threatening illness; these discussions should begin early in the course of life-limiting illnesses… Early discussions about end-of-life care issues are associated with improved patient outcomes, including better quality of life, reduced use of nonbeneficial medical care near death, and care more consistent with patients’ goals. This approach is also associated with improved family outcomes and reduced costs.*[14]

The case for and means of integrating this low-risk, high-value, cost-saving intervention into the veterinary profession are the focus of this article. A complete review of GOC interventions and serious illness communication within human medicine is beyond its scope, but the reader is encouraged to explore the primary source literature cited. Learning from the human medical profession regarding serious illness communication is essential if we are to provide high-quality veterinary care in a goal-concordant way.

Furthermore, rigorous development of palliative medicine within the veterinary profession cannot occur without adequate attention to GOC considerations. Although there have certainly been important contributions to the literature around end-of-life communication,[22,23] the GOC interventions discussed here go beyond the traditional focus on empathic euthanasia decision making and delivery of bad news. It is important to note that frameworks for delivering bad news, which have been evaluated in the literature: SPIKES, PEWTR, ABCDE,[24–26] are only part of a comprehensive GOC

conversation; they address *prognosis*, which is one-eighth of the serious illness conversation framework that is outlined here.[15,19,27]

The Serious (Veterinary) Illness Conversation Guide

A user-friendly, scalable tool for serious illness conversation, the Serious Illness Conversation Guide (SICG), was developed by Ariadne Labs: A Joint Center for Health Systems Innovation, and the Dana-Farber Cancer Institute under the leadership of Drs Susan Block, Rachelle Bernacki, Atul Gawande, and others. The SICG is currently in use and has been the focus of a cluster randomized controlled trial that continues to

Serious Veterinary Illness Conversation Guide

CLINICIAN STEPS

☐ **Set up**

- Thinking in advance
- Is this okay?
- Hope for best, prepare for worst
- Benefit for patient/family
- No decisions necessary today

☐ **Guide** (right column)

☐ **Act**

- Affirm commitment
- Make recommendations about next steps
  - Acknowledge medical realities
  - Summarize key goals/priorities
  - Describe treatment options that reflect both
- Document conversation

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CONVERSATION GUIDE

Understanding

What is your understanding now of where _____ is with his/her illness?
What questions do you have about information your family veterinarian has already shared with you?

Information Preferences

How much information about _____'s illness would you like from me? How much additional information do you feel you need to help make decisions?

FOR EXAMPLE:
Some families like to have lots of information about what to expect, others do not. Some people are very comforted by lots of diagnostic information and some people find this stressful.

Prognosis

Share prognosis as a range, tailored to information preferences. Understand that euthanasia as end point for most patients has tremendous impact on "prognosis". What is acceptable for one family may not be for another.

Goals

If _____'s situation worsens, what are your most important goals?

Fears / Worries

What are your biggest fears and worries about _____'s health?

Function

What abilities or activities are so critical to _____'s life that you can't imagine him/her living without them?

Trade-offs

If _____ becomes sicker, how much are you willing to go through for the possibility of gaining more time together?

Aid in Dying

What are your beliefs surrounding euthanasia?

Fig. 1. The SVICG. (*Courtesy of* Katherine Goldberg, DVM, LMSW.)[27]

evaluate several research questions.[14,15,28–32] It has also been modified for veterinary use.[27] Curated from its human counterpart following the 2015 Communication in Serious Illness Course in Boston, Massachusetts, the Serious Veterinary Illness Conversation Guide (SVICG) provides veterinarians and their teams with a guide to help conduct comprehensive GOC conversations. It provides a basic framework that may be used in a variety of settings for veterinary patients. Given substantial and compelling evidence for the use of checklists in medicine,[20,33–37] use of a structured communication format for serious illness care is an empirically supported strategy.

> *They [checklists] ensure completion of necessary tasks during complex, stressful situations in which memory alone may not be sufficient, or when stress and discomfort felt by those participating in the scenarios may cloud clear thought processes, interfere with effective communication, and prevent accomplishment of desired outcomes.*[20]

Certainly, serious illness and end-of-life conversations are “complex, stressful situations.” Physicians also report discomfort with them, identifying more barriers to having the discussions than patients do.[38] For all these reasons, the checklist structure functions to optimize the likelihood of a quality conversation even when emotions are high. In addition, although the questions explored in the SICG/SVICG are standard topics of GOC conversations, the structure of the checklist provides a systematic approach to developing an individualized treatment plan for each patient.[20] Considering that most veterinarians are less familiar with formal GOC conversations than physicians, using a systematic approach is likely to be beneficial for the introduction of this intervention into veterinary medicine (**Fig. 1**).

Conversation Guide Focus Areas

Understanding

The importance of assessing clients’ understanding of where their animal is with his or her disease cannot be overstated. Particularly in a referral setting, where multiple clinicians have seen the patient, much of what has been communicated to the client is often lost. In addition, emotions are frequently high, and clients may be confused or entirely mistaken about what is wrong with their pet. Starting with an open-ended solicitation of the client’s understanding of what’s going on is invaluable and should not be skipped.

Information preferences

Similarly, gaining an understanding of how much information a client *wants* to receive will proactively establish rapport and help to avoid conflict around communication styles and preferences between clients and veterinarians. The “some people” is a useful tool here: *“Some people like to have a lot of medical information, and some people don’t”*; it helps normalize the client’s perspective, whatever it may be. The veterinarian is also demonstrating that she or he will support the client, no matter what their information preferences are.

Prognosis

This section tends to dominate “delivering bad news” education, but in fact it is only a fraction of the complete GOC conversation. Still, it is extremely important, and research suggests that targeted approaches are necessary for improvement. For example, one study gathering baseline information about surgeons’ experiences and attitudes when delivering bad news was performed at a (human) medical teaching institution.[25]

Ninety-three percent of respondents perceived delivering bad news to be a very important skill, and 7% perceived delivering bad news to be a somewhat important skill; however, only 43% of respondents thought they had the training to effectively deliver such news.[25] In addition, 85% thought they needed additional training to be effective when delivering bad news.[25] Of the 85% of participants who thought they needed additional training, 59% were residents and 26% were attendings.[25] This and other data show that there is an unmet need in educating physicians to empathically and effectively deliver bad news. Corresponding research in the veterinary profession has been limited. One recent study uses the COMFORT model as a framework to organize the communication of "breaking bad news" in veterinary medicine.[39]

As indicated by the SVICG, an important feature of prognosis and delivery of bad news for veterinary patients is the availability of euthanasia. "Prognosis" and survival times, even within the scholarly veterinary literature, are adulterated by euthanasia as the endpoint for most patients. Criteria for euthanasia of client-owned animals are inherently subjective and nonuniform. The importance of this reality relative to GOC conversations is to recognize, and help clients recognize, the profound subjectivity of prognosis. Research methods and limitations within the veterinary profession are beyond the scope of this article; however, randomized clinical trials (RCT) in veterinary research have recently been discussed.[40] Strikingly, mode of death was not mentioned as a factor in interpreting veterinary RCT data. Weighing the relative value of evidence- versus experience-based assessments of prognosis may prove to be an important task for veterinarians and the pet-owning public. The question, *"How much time does he have?"* in the context of euthanasia as an option at any time, often in the absence of a definitive diagnosis, may not be a particularly useful question. The unspoken, yet brutally honest question, *"How much time are you going to give him?,"* is what gets to the heart of "survival times" in veterinary medicine. This reality can be profoundly uncomfortable to recognize, and navigating GOC in this unique context is precisely what makes serious illness communication an essential skill for veterinarians. The burden of responsibility around deciding when to end a pet's life cannot be overstated. Prognosis may be viewed as a 2-part process: first, what do we know about the disease trajectory, and second, what are the client's limits, in terms of seeing the trajectory through?

Goals

Multiple studies in human medicine have shown that people have priorities other than just living longer. Although corresponding research does not exist in veterinary medicine regarding client goals and priorities for their pets, it is reasonable to expect that outcomes could be similar. The goals section of the conversation guide asks what clients want as their pet's disease progresses. What are their goals as time runs short? Goals may be related to the disease and its treatment, for example, maintaining normal behavior patterns and mentation, keeping a pet at home rather than traveling for treatment, avoiding oral medications, or related to shared activities and other "nonmedical" plans, for example, going on a trip to a meaningful place, visiting with now-grown children or others, continuing to go hiking/swimming/another valued activity, being alive for the upcoming birth of a baby, and so on. Open-ended solicitation of client goals is invaluable in its ability to inform treatment planning. It is then the veterinarian's job to assess the feasibility of client goals relative to patient welfare and communicate if alternative planning is indicated.

Fears/worries

Similarly, asking what clients' biggest fears or worries are about their pet's health can be a game-changer. Often, clients are worried about things that veterinarians might

not consider, for example, *"I'm worried that her hair won't grow back (after the ultrasound) before she dies,"* or *"I'm worried that my friends think I'm doing the wrong thing,"* or *"My biggest fear is that I will find him dead in the house,"* or *"I'm worried that he will be scared during the euthanasia."* Medical concerns are also pervasive for clients, that is, fear of pain/not recognizing pain, losing control of bladder/bowels, declining mentation, and so on. Assessing what clients are afraid of/worried about establishes rapport and enables the veterinary care team to address individualized concerns. Client anxiety and distress around unaddressed fears can be considerable and lead to impaired caregiving, which then negatively impacts patient welfare. Proactive communication is an important tool for mitigating this.

Function

Attunement to patient function is essential and often missed in standard "quality-of-life" assessments. For example, despite its title, the popular "HHHHHM Quality of Life Scale" originally developed in 2004 by Villalobos, revised and published in 2007 and 2011, functions as a euthanasia decision tree rather than a quality-of-life assessment tool. Furthermore, it paints with a broad brush functions that are surely experienced differently by individual patients. What is the impact of poor mobility in a Yorkie versus a Newfoundland, for example? Finally, a numerical score determines "acceptable life quality to continue with pet hospice."[41] As is evident from this article, and throughout this issue, such a conclusion is deceptively simplistic, and depending on the level of medical supervision, potentially harmful to patients. In contrast, ascertaining which abilities or activities are so critical to a pet's life that the client cannot imagine him or her living without them enables veterinarians to understand the client's functional "deal-breakers" so to speak, in a nonjudgmental context. Client tolerance and intolerance for immobility, incontinence, and other aspects of illness cannot be assumed. Similarly, for some animals, playing with toys or going on long hikes is essential for their very happiness; others are content to lounge, so long as basic needs are attended to. Patient preferences and individual personalities are relevant, even in nonhuman animals. Humans, caregiver and veterinarian, are responsible for interpreting the animal's behaviors so that individualized treatment planning is optimized. It is here where overlap often occurs between a GOC conversation and palliative-oriented history taking.

Critical to palliative care evaluation, specifically the history or "subjective" part of a Subjective, Objective, Assessment, Plan note, is assessment of activities of daily living (ADLs); for humans this includes things like bathing, dressing, eating, and getting in and out of a car. Extrapolated to animals, ADLs relate to the things that patients need to do to be themselves and move through their day: get in and out of a litter box, go for a walk, ambulate (and/or jump) to a food bowl, eat, groom, play, and interact with people and other animals. Depending on the patient's "job," a list of ADLs may be more involved, service and working animals, for example. A seriously ill working farm dog may require more cognitive stimulation than the average companion dog once their illness prevents them from being able to work. Completion of a GOC conversation using the SVICG will draw on this information in the "Function" section if ADLs have already been assessed, or the ADL assessment may be informed by the SVICG if this has been done first.

Tradeoffs

Tradeoffs are particularly hard to assess by proxy. In human medicine, this is when the patient would be asked, *"How much are you willing to go through for the possibility of gaining more time?"* The question is one of balancing suffering now for possible time

later, a complex consideration even for mentally competent humans. Health Care Proxies (HCPs), who speak for patients once they are no longer able to speak for themselves, are charged with best estimating *what the patient would want* and advocating for that preference. In many ways, companion animal owners are HCPs throughout the life of the animal; the veterinary patient never gets to have a choice, although clients may believe they are acting on the patient's behalf. "*I'm asking myself, what would this cat want? I don't want this to be about me.*" This point bears further development in future work, because the issue of boundaries between client needs and patient needs is very poorly explored in the veterinary profession (Lisa Moses, personal communication, 2018). It is unfortunately the case that patient suffering occurs, despite client wishes to the contrary, when veterinarians and clients do not examine the rationale behind decision making as closely as is likely warranted.

HCP assessment of tradeoffs becomes particularly challenging when decisions are made that subject the patient to harm with potential (or inevitable) suffering: invasive interventions, surgical recovery time, isolation during hospitalization, and so forth. For veterinary patients and caregivers, consideration of tradeoffs is a complex yet necessary part of the SVICG that assesses information not otherwise obtained via broad questions about goals and priorities. In part, this is because client preferences and limits are also being solicited. How much are *you* (the client) willing to go through for the possibility of more time? Factors to consider here include things like driving long distances to seek specialty care, taking time off from work to care for pets at home, ability/willingness to administer medications, financial budget, environmental modifications of the home, alterations in family schedule, and so on. These factors put the legal status of animal patients (and realities of pet ownership) front and center; although clients may prefer that their own needs not be considered above the animal's, this can hardly be reasonable or possible all the time.

Aid in dying

This final question of the SVICG is what most clearly sets it apart from its human counterpart. The term "Aid In Dying" is intentionally used by the author rather than "Euthanasia" to most appropriately and accurately frame the conversation in the context of GOC. Euthanasia for animals is, in fact, just assisted dying. It is a procedure, the benefits and burdens of which must be considered just as they are for any other medical intervention (inserting a chest tube, obtaining a blood sample, performing pericardiocentesis). In the context of serious illness conversation, which involves patients who are going to die and likely imminently no matter what communication takes place, the question is not about binary modes of death (euthanasia vs not) or language ("natural death," "active euthanasia," "physician aid in dying," "medical aid in dying," "death with dignity") per se, but rather the *intentionality* of the act. What are client beliefs around purposefully choosing to end their pet's life (euthanasia), and what qualifications surround these beliefs? There may be a *preference* for unaided death, for example, but euthanasia is acceptable under certain circumstances. It is then the veterinarian's job to facilitate a conversation about these circumstances and guide treatment planning accordingly. A complete discussion of euthanasia within the veterinary profession, associated ethical conflicts, considerations for clients, and implications for veterinarian well-being is beyond the scope of this article. However, it is important to recognize the depth and complexity of these issues in the context of GOC conversations. The availability of legal euthanasia for companion animal patients alters the landscape of serious illness care, decision making, and treatment planning within the veterinary profession in every possible way. The impact of euthanasia within the veterinary profession cannot be overstated.

Use of the Serious Veterinary Illness Conversation Guide

Ideally, GOC conversations would be implemented for all geriatric, chronically or seriously ill patients, and all clients who are struggling with decisions, but realistically this is unlikely to happen. Case selection, then, is an important consideration and is briefly outlined here. A complete review of triggers and criteria for GOC interventions in human medicine is beyond the scope of this article, but several different approaches have been evaluated in various study populations.[14,30,32,42–46] There are currently no corresponding data in the veterinary literature. The "surprise question" (SQ) has been evaluated extensively in human medicine. It is most appropriately used as a screening tool for palliative interventions (such as GOC conversations) rather than a predictor of death, and studies demonstrate significant utility in several patient populations.[47–55] The SQ simply asks physicians, *"Would you be surprised if this patient died in the next 12 months?"* Physician response of "no" is a trigger for palliative care intervention. Use of the SQ as a screening tool assumes that patients in their last year of life may have unmet palliative care needs; therefore, identifying patients in the last year of life is critical for palliative care provision. Evaluation and validation of the SQ within veterinary medicine, likely with an adjusted timeframe, could prove to be a useful area for future study.

In veterinary medicine, overall outcome data are limited across treatment settings, academic versus private practice ICU, primary care clinic, and so forth. Therefore, it is currently difficult to stratify patients into high/low risk of death (which could be one criterion for a GOC conversation). Although individual institutions may know their own survival-to-discharge rate,[56] these data are not widely known across institutions within the veterinary profession, which further complicates estimates of survival, disease severity, and likelihood of discharge and/or return to function. As a result, it is not easy to determine selection criteria for implementation of serious illness conversation. It is here where GOC interventions and prognostication within veterinary settings (primarily ICU) overlap. Although attention to prognostic stratification in veterinary medicine has been limited, a severity of illness stratification system has been evaluated in a veterinary teaching hospital.[57] Prognosis for neonatal foals in an ICU has also been assessed, with the goal of predicting patient outcomes.[58]

Taking all of this information into consideration, it is this author's recommendation to implement GOC conversations early and often. Certainly, research to evaluate whether GOC outcomes from human medicine hold true in veterinary contexts is warranted. However, given repeated evidence from human studies of significant benefit and no documented harm,[14,16,20,29,32,43,59] there is much to gain from conducting structured GOC conversations with veterinary clients. Few interventions have demonstrated such high value and low risk in either human or veterinary medicine. As Dr Atul Gawande said in his 2015 keynote address at the American Academy of Hospice and Palliative Medicine annual assembly, *"If you (palliative care providers) were a drug, the FDA would approve you!"*

Goals of Care, Veterinary Clients, Pet Death, and Caregiver Burden

Goal-concordant care is vital in veterinary medicine, specifically as relates to end-of-life choices, because it has been shown that reactions, both healthy and potentially harmful, to pet death are more likely to be associated with factors related to the client than the pet.[60] For example, client attitudes toward euthanasia, societal attitudes toward pet death, and level of support received from the attending veterinarian have been shown to be more important modifiers of client grief reactions than the age of pet at the time of death. In addition, these factors more broadly impact client

experiences of their pet's death and impressions of their veterinarian's role in that death. Other factors found to increase the intensity of both uncomplicated and complicated grief reactions following pet loss include attachment to pet, level of social support, and preferences regarding means of death/euthanasia.[61] These factors are all explored in GOC conversations, which then function as a modifier of grief reactions following pet loss. Support after the death of a pet is important, but it is not the only opportunity for veterinary professionals to help clients as they face the final phase of their pets' lives.

Of significant importance, and discussed in Mary Beth Spitznagel's article, "Caregiver Burden and Veterinary Client Wellbeing," in this issue, is the issue of caregiver burden related to seriously ill pets. This phenomenon was initially explored by Spitznagel and colleagues[62] and further discussed in an accompanying editorial[63] by this author. GOC conversations are related to caregiver burden insofar as they solicit client goals, preferences, and limits as treatment planning occurs on behalf of a seriously ill pet. Given the intimate involvement of veterinary clients in the care of their ill pets, arguably more than in human medicine, due to fewer established resources, client understanding of, and willingness to participate in, caregiving is critical. Shared decision making is currently promoted as the dominant model and best practice for communication in serious illness for people[46] with goal-concordant care as its aim. It is this author's belief that goal-concordant care is a protective factor against caregiver burden for seriously ill pets and may even mitigate it. Further research is necessary to support this hypothesis. Studies in human medicine have evaluated the bereaved caregiver experience, and it has been suggested that poor quality end-of-life communication may result in bereaved caregivers feeling more anxious, depressed, traumatized, or regretful.[46,64,65]

Serious Illness Conflicts in Veterinary Medicine

By now it is apparent that serious illness care for companion animals is complicated territory. Each experience is unique; however, there are some situations that arise predictably. Some common conflicts for which use of the SVICG may be an effective intervention are now outlined.

Disagreement in family

Family disagreement is a common issue in end-of-life care for people as well as for animals.[66–68] In veterinary practice, differing opinions on everything from whether the pet is eating, happy, or in pain, to fundamental beliefs regarding euthanasia or how much money to spend on a pet's care, often coexist within one family unit. Strategies for dealing with this include recommending that family members assess quality of life as well as answer GOC questions such as those in the SVICG, independently. The process of then coming together to discuss these preferences is often quite useful and aids in communication around difficult decisions. Major family conflicts typically have a long history that will not be resolved before decisions need to be made on behalf of a pet. When this is the case, exemplary symptom management for the animal is critical while the human issues are being worked out.

Traumatic prior experience with animal death/loss

Many clients have unfortunately had negative experiences with animal death and loss. The impact of this on their ability to make decisions on behalf of a current pet cannot be overestimated. Open-ended inquiry regarding past experiences with pets should be part of basic history taking in serious illness contexts, but is certainly essential for GOC conversations. Past experiences with animal death usually come up in the

"Aid in Dying" section of the SVICG, when clients will often share what happened "last time" and how/if they would like things to be different with the current pet. Most people are very willing to share their experiences, and often much useful information can be gained by listening. Relationships with mental health professionals are also important; veterinarians are not trained to recognize or address posttraumatic stress symptoms or concerning features of other disorders. If a veterinarian suspects that a client cannot cope with a previous loss based on comments from the client related to disruptions in ADLs, sleep disturbance, difficulty eating, increased use of alcohol or other substances, physical symptoms, missing work, or thoughts of self-harm, referral to a mental health professional is appropriate. Additional information regarding mental health professionals in veterinary end-of-life care is found in Sandra Brackenridge's article, "The Social Worker: An Essential Hospice and Palliative Team Member," in this issue.

Traumatic prior experience with human death/loss or medical care

Traumatic stress is now thought to occur following several medical experiences, including pediatric injury and illness, chronic disease, and ICU stays.[69–76] This means that a subset of veterinary clients will have experienced trauma from medical intervention, either directly or indirectly. The impact of this on veterinary decision making has not been evaluated. However, clients routinely mention their past negative experiences with human health care over the course of veterinary visits. For example, discussion regarding chemotherapy in a dog turns to the client's mother, currently battling side effects from her own cancer treatment. The statement, "I would never subject my cat to treatment X," is often based on bad experiences with treatment X in people, not pets. These issues typically come up in the "Tradeoffs" and "Function" sections of the SVICG. Veterinarians should be prepared for this information; navigating it can be tricky, but it is important for achieving goal-concordant care for the current patient.

Spiritual conflict

The role of religion in veterinary care has received minimal attention in the scholarly literature. Nevertheless, clients' spiritual or religious beliefs may impact treatment decisions for their pets. This should not come as a surprise, considering that religion is considered standard demographic information in human hospitals, even when the stated religion is "none." Davis and colleagues found that "the religious and spiritual schemata that people use to conceptualize human life and death are applied to companion animals relatively commonly, even among nonreligious people.[77]" In their study, 56% of participants believed in an afterlife for their pet and generally found this belief comforting. Belief in an afterlife for animals has also been related to stronger attachment to a pet and a greater grief response to its death.[77] The Davis and colleagues study did not find that euthanasia raised any religious issues for clients, nor did religious belief impact aftercare choices; however, this is in stark contrast with this author's practical experience, whereby these issues arise commonly and can be quite distressing. One client severed ties with the church that had been central to her life for many decades after the priest said that her ailing dog did not have a soul. Another struggled with pain management recommendations because "suffering is important for enlightenment." Asking, "Is there a spiritual or faith tradition that helps inform decision making for your pet," can help facilitate communication around these issues. Spiritual/religious concerns may come up in any section of the SVICG, but most commonly when discussing "goals/values," "fears/worries," and "Aid in Dying." Patient-tested language from the initial clinical trial with the conversation guide

(in human patients) includes *"What gives you strength as you face your illness?"* It is here where people typically mention faith, God, or religion, if these things are important to them. This question is important for veterinary clients as well.

Mental and other illness affecting decision making capacity

This is something of increasing significance that veterinarians have no formal training in. The legal nuances between "competency" and "capacity" are beyond the scope of this brief discussion; concern regarding clients' ability to reasonably make medical decisions on behalf of their pets is the broader issue. Given the legal status of animals, and veterinarians' professional identification as "animal helping" rather than "human helping" professionals, it is not surprising that this issue has received little attention to date. In human medicine, however, it is an area of ongoing engagement.[78–84] The 4 domains in assessment of decision-making capacity are (1) communicating a choice, (2) understanding, (3) appreciation, and (4) rationalization/reasoning. These domains may be affected by anything from memory, attention span, and intelligence, to depression, anxiety, phobias, dementia, and psychosis.[81] Certainly, these factors will be present in the pet-owning public and have the potential to impact veterinary care provision. Again, the reader is referred to Sandra Brackenridge's article "Caregiver Burden and Veterinary Client Wellbeing," in this issue for further discussion of the role of mental health professionals.

Goals of Care Conversation Deficits and Application to Veterinary Medicine

Finally, it is important to note that although research in human medicine consistently demonstrates positive outcomes from early GOC discussions,[14,16,20] deficits in the conversations themselves have been identified. Primarily, these have been related to content and timing.[15] Deficits relevant to veterinary practice include conversations occurring too late in the disease course, occurring when patients are in crisis, or occurring when clinicians who know the patient are not available. In addition, physicians tend to focus on choices regarding procedures and treatments rather than on goals and values.[15] Research also shows that "clinicians are underprepared and undertrained" to conduct high-quality conversations and "tend to avoid them."[15,85,86] The structured, checklist format of the SVICG is designed to address these challenges, and research in human medicine has certainly shown promising results related to addressing deficits in, and barriers to, effective GOC conversations. Even still, awareness of these deficits is essential if the veterinary profession is to effectively integrate serious illness communication into the care of its most vulnerable patients.

SUMMARY

Serious illness communication and GOC conversations are at the heart of palliative medicine, insofar as they hold goal-concordant care as their primary objective. These conversations, in combination with exemplary palliation of physical symptoms, have the power to transform serious illness care for veterinary patients and their caregivers. Despite repeated evidence that GOC conversations offer significant benefit and minimal harm to human patients, barriers to widespread and high-quality implementation persist. The veterinary profession can benefit from the experiences of palliative care implementation in human medicine and learn from its challenges. One strategy to overcoming barriers has been utilization of a structured checklist format for serious illness conversations. The SVICG promotes individualized, goal-concordant care planning even when conflict and emotional demands are high. It is this author's sincerest hope that mindful implementation of high-quality GOC conversations will

elevate the level of medical care that seriously ill veterinary patients receive and provide much-needed clarity and support for their caregivers.

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