A "Three-Stage Protocol" for Serious Illness Conversations: Reframing Communication in Real Time

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As trainees in nephrology and general surgery navigating serious illness conversations, we understood that our words carried lasting consequences. Although we intended to choose our words carefully — using the mnemonics we had learned to deliver "bad news" and rehearsing planned phrases — in practice, our conversations seldom went as smoothly as we hoped. Instead, we might forget what to say next, or our statements might be met with blank stares. Why did this happen? What could we do?

Simply, without formal communication training, we were lost in the gap between clear intentions and murky execution. In nephrology, for example, trainees and clinicians consistently indicate need for communication education but may have limited access to structured communication teaching.[1-3]

In response to this, we propose a "Three-Stage Protocol" for serious illness conversations, designed specifically for trainees and/or specialists — all learners — who may not have previously received formal communication training (Figure). Like others, we define "serious illness conversations" as communication regarding goals of care (GOC), patient values and priorities, treatment planning and decision-making, advance care planning, and end-of-life discussions for patients with serious illness.[4]

Although there are existing communication strategies available (eg, Reframe, Expect emotion, Map out patient goals, Align with patient goals, Propose a plan [REMAP], Serious Illness Conversation Guide, and 2017 ASCO Guideline),[4-6] our approach highlights eliciting GOC — the crucial step often overlooked in communication. The Three-Stage Protocol is not intended to convey novel information or content that other communication strategies do not; rather, its purpose is to offer clinicians a more easily memorable and adaptable communication framework by anchoring the GOC in the conversation.

Jacobsen et al[7] described a similar strategy, but it focused on how to eventually formulate the conversation's resulting recommendation. Although we acknowledge this importance, we frequently observe that by emphasizing the treatment recommendation as the objective of the conversation, learners may skip the fundamental process of identifying patients' goals and values, thereby precluding truly goal-concordant care. Likewise, although REMAP's "M" (map out what's important) and "A" (align with goals) indicate the discussion of GOC, its "R" (reframe why the status quo isn't working, eg, "we're in a different place") does not provide explicit guidance for the learner to discuss prognosis, which is essential to how patients contextualize their "big picture" goals.[5]

In contrast, the Three-Stage Protocol is conceptually and practically distinguished by several key features: (1) a simple, sequential structure, which allows learners to recall and apply these concepts more readily in real time; (2) emphasis on defining GOC before formulating a clinical plan; and (3) generalizability to all types of communication throughout the illness trajectory.

STAGE 1: SHARING KNOWLEDGE

In stage 1, we establish a shared foundation of medical information and prognostic

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Stage 1: Sharing knowledge

- Set the stage
  - Communicate in advance with other team members regarding the medical condition to be conveyed
  - Determine an appropriate setting for the conversation to occur
- Invitation statement
- Summarize and explain the medical condition
  - "Two-minute rule"; "50% rule"
- **Share the prognosis**
  - Approximate time frame, anticipated functional status, and/or unpredictability of disease trajectory
- Expect and respond to emotions

Stage 2: Clarifying GOC

- "Knowing this condition, …"
  - What is most important? What makes your (his/her) life meaningful?
  - What are you most worried/concerned about?
  - What would he/she say if he/she were here and heard what we just discussed?
- **Identify patient goals—i.e. values, wishes, preferences, and priorities**
  - Example: "It sounds like xxxxx is most important to you. How does this sound?"

Stage 3: Negotiating treatment options

- Weigh possible benefits and burdens of each intervention
- Do not ask yes/no questions to each intervention
  - AVOID: "Do you want to be DNR?" "Do you want chemotherapy?"
- **Make a recommendation based on the agreed-upon goal**
  - INSTEAD: "In order to achieve your goal xxxxx, I would not recommend resuscitation or chemotherapy"

DNR = Do Not Resuscitate; GOC = Goals of Care.

FIGURE. Three-Stage Protocol for decision-making conversations in serious illness. DNR = do not resuscitate; GOC = goals of care.

awareness. Using similar strategies to those described in others' work for "breaking bad news" (eg, SPIKES), our goal in stage 1 is ultimately to share the prognosis, based on knowledge of the clinical situation.[8] We also devote attention to the concept of prognostication as a multidimensional process involving elements including time, function, and unpredictability.[9]

In the hours to days before the conversation, we set the stage by ensuring communication among the medical team about collective perspectives and aims. To attain a thorough understanding of the patient's medical history and clinical course, we invite discussion between the key stakeholders (eg, primary care physician, cardiologist, and/or oncologist), addressing any questions, identifying participants (eg, surrogate decision-makers and/or family members), and clarifying our own role (as primary team or consultant, with or without authority to direct care plans).

Then, in an appropriate physical setting, we open the conversation with an invitation statement, which allows us to concurrently gauge the patient and family's understanding of the disease and level of health literacy, as well as the patient's willingness to discuss his/her medical condition: "I'd like to tell you more about how your cancer is doing, share with you what we doctors are concerned about regarding your cancer, and then hear from you about your goals and values so that we can help make the best decision for you. How does that sound? Could you share with us what the doctors have told you so far about your cancer?"

Using this compiled knowledge, we summarize the medical condition, adhering to

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the "two-minute rule"; that is, a patient's medical condition, regardless of its complexity, should be presented in a chronologically and contextually succinct manner within 2 minutes. By beginning with the underlying disease (eg, cancer) and explaining that recent conditions (fatigue, infection, etc) are manifestations of disease progression — not vice versa — we avoid losing sight of the originating problem. We also follow the "50% rule," which cautions that the individual conducting the conversation should not be speaking for more than half of the total time.[10] Successfully conveying this medical condition requires practice, and should be rehearsed in advance of the conversation. [13]

The goal of stage 1 is to share the prognosis, that is, what is likely to happen in the future, stemming from this 2-minute summary. Since some patients may not wish to receive prognostic information, we offer another invitation ("Is it ok to share with you what we are worried about?") before that. The prognostic statement may be multifold, suggesting limitations on time, function, and/or inherent uncertainty regarding illness trajectory and possible future illness states[9]: "I'm worried that we are no longer able to continue cancer treatment; and because of that, it is fair to say that your time may be getting shorter." Or "It can be difficult to predict how quickly your cancer might progress, but you could get much sicker very quickly and it is important for us to prepare for that possibility."[9] By sharing a more general prognosis ("weeks to months") rather than a specific timeframe ("6 months"), we focus on conveying limited survival rather than exact calculations. This prognostic statement of stage 1 is crucial to advance to the next stage, and it is expected that tremendous emotional responses may be encountered. We thus pause to address any patient and family emotions before continuing the conversation.[5,6]

Having delivered the prognosis, only then we may then proceed to stage 2.

STAGE 2: CLARIFYING GOC

In our opinion, stage 2 is the most important step in all forms of serious illness communication, yet it is frequently missed. This may appear conceptually simplistic but actually highlights for the learner the critical importance of eliciting patient and family goals, preferences, and values before discussing treatment options. Here, we craft questions to explore GOC based on the prognosis presented in stage 1. We suggest questions such as, "What are you most worried about?", "What is most important?", or "What are you hoping for?" If patients initially have difficulty providing concrete answers, other questions such as, "Tell me about yourself. What do you enjoy?" or "What makes your life meaningful?" may provide additional insight.

Each patient has unique goals and values; there are no right or wrong answers. Here, we need to listen carefully and allow patients to fully explore and express their wishes. By helping patients share and verbalize their GOC, we offer acknowledgment and validation of their individual preferences. Given patients' potentially multiple and/or competing wishes, the aim of stage 2 is to prioritize patients' goals based on the prognosis conveyed in stage 1. We may also ask questions such as, "What is the condition(s) you would find unacceptable?" or "How much more are you willing to go through for the possibility of more time?" to help patients explore the potential trade-offs required to achieve their goals. The patient's words are then summarized, clarified, and reflected back: "It sounds like you want to be pain-free and if possible, spend time at home. Does that sound right? Let's talk about how we can achieve this goal."

STAGE 3: NEGOTIATING TREATMENT OPTIONS

Building directly upon stages 1 and 2, stage 3 allows us to offer a goal-concordant recommendation.[7] In stage 3, clinicians help patients and families reframe their goals and wishes into compatible plans. This involves a careful synthesis of the prognosis shared in stage 1 and the patient's goals and priorities revealed in stage 2, taking into account not only the potential risks and benefits of any medical

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interventions offered in the current time, but also their relative impacts in the context of multiple — yet unknown — possible illness trajectories in the future (eg, steady decline versus acute illness episodes).

This may be best described in the following example: For a patient with widely metastatic cancer admitted to the hospital with recurrent sepsis and renal failure, by the time the clinician reaches stage 3 in the conversation, he/she will have already traversed stage 1 by sharing the patient's prognosis (eg, anticipated survival of weeks to months; mostly bedbound, nonambulatory physical functional status; decreased mental acuity but still able to recognize and converse with family members). The clinician will also have explored the patient's GOC in stage 2 (eg, finding that the patient's goals were to avoid pain or discomfort and spend as much time at home as possible with family). In stage 3, the clinician will need to synthesize the possible interventions, expected consequences of each treatment pathway, and likelihood of achieving the patient's stated goals. It is also important to avoid "yes/no" questions to each medical intervention, which fail to take into account the GOC and do not actually provide a recommendation. In this way, we may more easily arrive at a goal-concordant treatment plan, such as: "The best way to achieve your goal is hospice care and, when you get sick, we would focus on comfort, instead of trying resuscitation. How does that sound to you?"

Applying the Three-Stage Protocol

In contrast to other communication strategies, the Three-Stage Protocol's brief framework is comparatively easy to recall, allowing learners to synthesize information and respond more easily during real-life conversations. To ensure that GOC are integrated into the recommendation, the learner needs only to remember that he/she must "clear stage 2" (elicit GOC) before proceeding further; with this anchoring principle in place, knowledge-sharing and treatment decision-making must fall before and after in a largely linear fashion, regardless of what unforeseen obstacles arise during the conversation.

We believe that completing stage 2 of the three-stage protocol is the key to making a successful, goal-concordant recommendation in stage 3. Although stage 3 can be challenging and may require a higher level of communication skills (eg, with the assistance of a palliative care specialist), all learners — regardless of level of communication training — should be able to begin to formulating a goal-concordant treatment recommendation after eliciting GOC in stage 2. Interestingly, while the discussions in stage 1 and stage 3 require a certain level of medical expertise, this crucial discussion in stage 2 does not. Stage 2 questions can also be asked by non-physicians (eg, nurses, social workers, etc), even in advance. The collected information can then be used during the actual serious illness conversations.

The Three-Stage Protocol is also uniquely applicable to all forms of serious illness conversations and to any specialty. Unlike other pedagogic tools intended for specific periods in the disease course (eg, late GOC),[11] the three-stage protocol can be tailored to (1) advance care planning for new or early-stage disease; (2) early GOC, for example, when dialysis is initiated or before high-risk surgery (eg, left ventricular assist device implantation) is considered; and (3) end-of-life discussions in end-stage disease. In (1), since it may not be possible yet to provide a clear prognosis (stage 1), the conversation may focus more on what the patient enjoys (stage 2) to inform future guiding goals and values. In (2), the prognosis may still be affected by many factors, but the disease severity portends increased mortality; thus, we might concentrate on exploring whether there are any "unacceptable conditions" (again, stage 2) that would affect subsequent treatment options offered (stage 3).[12] In (3), the prognosis is clearer; the most pressing concern is to reach a shared decision about the treatment plan. Again, in each scenario, stage 2 is the crucial step. By following the stages sequentially, the clinician can navigate this challenging process with greater confidence.

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Troubleshooting: Return to Stage 2

But what if the learner "gets stuck" in the conversation? Perhaps the most common pitfall in serious illness conversations is to leap from stage 1 ("Unfortunately, chemotherapy is no longer an option") directly to stage 3 ("Do you want resuscitation?") — without completing stage 2. In this situation, the larger context of the patient's overall GOC is missing, and instead of offering a complete recommendation, the clinician must continue to ask many "yes/no" questions (Dialysis? Antibiotics? Vasopressors in intensive care unit?, etc), to which the patient is unlikely to provide ready answers. Another frequent pitfall we have observed is that, in an attempt to explore GOC (stage 2), clinicians may ask the question "What would you/he/she want?". The word "want" becomes problematic here, because to answer to that question, we would need to begin offering treatment options (stage 3); as a result, stage 2 is skipped automatically. To avoid that mistake — that is, to clear stage 2 — the question "What are you (is he/she) hoping for?" can be used instead. Thus, using the step-wise Three-Stage Protocol provides a safety net against these potential hazards.

CONCLUSION

The aim of the Three-Stage Protocol is not to suddenly transform an individual into a master communicator; communication, as with any other procedure, requires practice.[13] Instead, our goal is to provide a communication strategy that can be readily accessed by clinicians at all levels of training and applied throughout any disease course.

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