Addressing serious illness conversations during COVID-19

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Effective and empathetic communication skills have always been the foundation of excellent patient care. With the coronavirus disease 2019 (COVID-19) pandemic, these skills have become even more critical considering the potential severity of illness and high mortality rate in vulnerable populations. This is an opportune time to underscore the importance of goals of care conversations (GOC) and advance care planning (ACP). These types of discussions are often referred to under the umbrella of serious illness conversations (SIC). Serious illness conversations outline the "overall priorities and health expectations for care … based on [a patient's] personal values, wishes, beliefs, and perception of quality of life, and what they characterize as meaningful and important."[1] Both GOC and ACP are dialogues between health care providers, patients, and—ideally—patients' substitute decision makers (SDMs). The main difference between ACP and GOC is the context of the decision making. Where ACP is a discussion of future preferences, GOC relates to medical decision making in the moment.[2]

A 2014 review of the literature notes that SIC primarily occur with health care providers who are not familiar with a patient's clinical circumstances.[3] As such, primary care physicians are best positioned to initiate these conversations.[3] Studies have found that early SIC lead to benefits including improved quality of life, reductions in anxiety and depression, and a decreased risk of aggressive medical interventions at the end of life.[3-5] Despite the importance of these conversations, many physicians do not feel prepared to take on discussions of this type, as they were never trained to do so.[3] Evidence supports that communication skills can be learned and improved, just like any medical procedure.[4,6]

Best practices in teaching SIC

The best approach to teaching SIC is interactive case-based sessions with communication skills practice.[3] This more formal, curricular approach to teaching SIC does not preclude learning about SIC in the workplace. Preceptors teaching about SIC from the office to the hospital environment can assist learners through preparation, direct observation, support, and feedback. This is an ideal opportunity to take a flipped classroom approach. The preceptor can provide the learner with helpful resources to review ahead of the patient encounter (**Table 1**).[7,8] Reviewing a selected framework or approach before the conversation, along with relevant clinical details, helps to set the stage for the encounter.

Direct observation of the learner in this setting has multiple benefits, such as facilitating specific feedback to support performance improvement. Direct observation also allows the preceptor to step in if the learner requires assistance or guidance. If the patient or SDM is well known to the preceptor, this helps set a foundation of trust in the clinical encounter, while allowing for the addition of necessary biopsychosocial context. The presence of the preceptor also allows modeling of communication skills for learners who prefer to observe the preceptor facilitating SIC before leading these conversations themselves.

Part of the preceptor's role is to underscore that these conversations are iterative in nature. So often, there is a hidden agenda of confirming a do-not-resuscitate order in SIC. The ultimate goal is to explore how a patient's values and wishes link to medical treatment preferences. It is important for learners to understand that not securing a do-not-resuscitate order is not considered a failure of this process.

Step-by-step approach to SIC

First, it must be emphasized that a high-quality SIC curriculum or teaching experience should begin with communication skills development. These skills include active listening, deciding how to break bad news, and responding empathetically. A key teaching point is to talk less and listen more.

Second, there are several frameworks that standardize SIC, including the Serious Illness Conversation Guide, Vital Talk's REMAP (reframe, expect emotion, map out patient goals, align with goals, and propose a plan) framework, and local adaptations such as the Ontario Palliative Care Network's approach to GOC (**Table 1** and **Figure 1**).[4,6-9] No matter the framework used, they all share the same basic structure.

Substitute decision maker. Ideally, a patient's SDM will be present for the conversation, as it is vital to prepare SDMs for future decision making. Learners must be taught how to identify a patient's SDM using provincial law. If an SDM is identified, this should be documented in the electronic medical record.

Illness understanding. Learners must be taught to explore patients' understanding of their own illnesses before providing any updates or clarifications. It is known that patients retain about 50% or less of medical information, and a further 25% is remembered incorrectly.[10] By allowing the patient to do the talking, the

Table 1. Serious illness conversation resources

RESOURCE NAME	AUTHOR	DESCRIPTION	LINK
Approaches to Goals of Care Discussion[7]	Ontario Palliative Care Network	PDF tool outlining a framework and suggested language to guide GOC	https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/ApproachesToGoalsOfCare.pdf
Improving Your Goals of Care Conversations	Dr Leah Steinberg and Dr Christine Soong, Sinai Health System	Open-source, case-based e-module that guides learners through the steps of GOC	http://www.goalsofcaremodule.com
Serious Illness Conversation Guide (**Figure 1**)[8]	Ariadne Labs	PDF of an evidence-based tool that outlines a framework and suggested language to guide GOC	https://www.ariadnelabs.org/wp-content/uploads/sites/2/2017/05/SI-CG-2017-04-21_FINAL.pdf
Address Goals of Care	Vital Talk	Web-based, evidence-informed tools, suggested language, and videos for GOC	https://www.vitaltalk.org/topics/reset-goals-of-care/
CAPC COVID-19 Response Resources	CAPC	Open-source, COVID-19–specific conversation guides and videos	https://www.capc.org/toolkits/covid-19-response-resources/
COVID-19 Goals of Care Communication Guide for Clinicians	Dr Katie Marchington, Postgraduate Medical Education, University of Toronto	5-min video outlining steps to GOC	https://www.youtube.com/watch?v=FZtBLdsuh_I
Advance Care Planning Resource Library	Speak Up Canada	Resource library of videos, workbooks, and decision aids for ACP; includes links to province-specific resources	https://www.advancecareplanning.ca/resource-library/
Powers of Attorney	Government of Ontario	PDF containing instructions and forms for continuing power of attorney for property and power of attorney for personal care	https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/poa.pdf

ACP—advance care planning, CAPC—Centre for the Advancement of Palliative Care, COVID-19—coronavirus disease 2019, GOC—goals of care conversations.

learner can establish the patient's understanding of previously given medical information and identify any knowledge gaps that might need to be clarified.

Information. It is valuable to instruct learners to first ask if the patient has any questions. This allows the patient to free his or her mind of questions he or she has been waiting to ask, allowing the patient to focus on medical updates. This is also an opportunity to ask the patient how much he or she would like to know about his or her current medical condition. When giving information, learners should be taught to do so in a concise manner that imparts both the information and its meaning.

Values and goals. Patients' values and life experiences drive their decision making. Exploring values often begins with asking "Given the recent changes in your health, what is most important to you?" These values must then be distilled into information that is helpful in the setting of medical decision making. For example, if a patient shares that family is most important to him or her, a follow-up inquiry could be "Tell me about who is important to you and what you enjoy doing with them." The learner might discover that the patient values sharing stories and laughing with family. This information

can then be applied to future decision making. If the patient were to lose the ability to communicate and share stories owing to a medical illness, he or she might not consider that to be a meaningful quality of life. Learners should be instructed to probe deeper to discover what makes life meaningful to patients.

Function or trade-offs. It might be useful to explain this section as an inquiry into what physical or cognitive abilities a patient might be willing to lose for the chance to live longer. As in the example above, the learner could ask "If you were in a situation where you were no longer able to share stories with your family, would that be a meaningful life for you?" Learners should be reminded that these conversations help to determine how a person wants to live and are not meant to focus on death.

Treatment plan (if a conversation regarding goals of care occurs). After establishing illness understanding and identifying a patient's values and acceptable quality of life, a treatment plan should be recommended. Rather than presenting treatment options as a menu, residents should be taught to provide patient-centred recommendations and aim for shared decision making. Using the example above, if the patient were to experience

Figure 1. Serious illness conversation guide

Serious Illness Conversation Guide

CONVERSATION FLOW	PATIENT-TESTED LANGUAGE
1. Set up the conversation · Introduce purpose · Prepare for future decisions · Ask permission	"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?**"
2. Assess understanding and preferences	"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?"
3. Share prognosis · Share prognosis · Frame as a "wish…worry", "hope…worry" statement · Allow silence, explore emotion	"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."
4. Explore key topics · Goals · Fears and worries · Sources of strength · Critical abilities · Tradeoffs · Family	"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?"
5. Close the conversation · Summarize · Make a recommendation · Check in with patient · Affirm commitment	"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."
6. Document your conversation	
7. Communicate with key clinicians	

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a severe stroke with little chance of cognitive recovery, and a decision needed to be made about using a feeding tube, then the learner could say to the SDM "Unfortunately, your loved one has suffered a severe stroke and is unlikely to verbally communicate again. Given that he most valued communicating with family, I do not recommend that we proceed with a feeding tube as it will not help achieve the quality of life that he described as meaningful."

Code status. Code status can best be addressed once a patient's values are known. At that point, a recommendation should be given on whether life-sustaining therapies are likely to allow a patient to meet his or her goals and live a life that he or she has indicated would be meaningful.

Documentation. It is imperative that family medicine learners be trained to document all SIC, ideally using headings and point-form notation, to impart the details of the conversation.

Conclusion

Primary care physicians are well positioned to engage in SIC with patients. Teaching SIC starts with communication skills development, followed by practice in a workplace setting or role-play with a step-by-step framework to clarify patient knowledge gaps and identify their goals and values. 🍁

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Competing interests
None declared

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Teaching tips

‣ Effective teaching of serious illness conversations (SIC) should first focus on communication skills development, including the role of empathy. Use guides, tools, or frameworks to teach learners efficient, thorough, patient-centred communication.

‣ The key components of SIC include establishing illness understanding, identifying a substitute decision maker, providing clinical information, determining values and goals, exploring trade-offs, and making a recommendation for the plan of care.

‣ Values-based SIC put the focus on how patients want to live and not how they want to die.

‣ Learners should be instructed to document all SIC, especially if a substitute decision maker is identified or resuscitation preferences are decided.

‣ Teaching should be practical, with learners having the opportunity to role-play or practise in the workplace.