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Serious Illness Conversations

To the Editor: Discussing prognosis is an important but challenging aspect of clinical care with limited evidence to guide best practices. Lu et al.¹ should be commended for their perspective article that proposes a three-stage protocol which may prove useful for providers and trainees who are leading goals of care conversations for patients with highly predictable prognoses, such as those who are hospitalized with irreversible multiorgan failure. However, we are concerned about the blanket application of this protocol to include the many cancer patients with high-risk disease but who may still be early in their clinical course. First, the protocol is built upon the disclosure of the patient’s prognosis. But even when cancer is incurable there are often multiple lines of therapy available with variable chances of attaining a durable response, which makes it difficult even for oncologists to give an early prognosis that is both accurate and meaningfully specific.² Second, there is a significant number of cancer patients (likely 20% to 30%)³,⁴ who are not interested in hearing an estimate of their life expectancy; but this protocol offers no recourse for this when it occurs. Finally, we agree that the protocol’s emphasis on “negotiating” treatment options and requiring that the provider “make a recommendation” for advance care planning may be appropriate for situations where there is a firm short-term prognosis based on severe illness and declining trajectory. However, for patients without a firm short-term prognosis, this approach potentially conflicts with the palliative care guidelines published by the National Comprehensive Cancer Network (v1.2020)⁵ which make a distinction between cancer which has longer versus shorter life expectancy, with only the latter being an indication for the provider to actively recommend de-escalation of code status. For those cancer patients who have serious illness but also a reasonable chance of living with it for many years, it is better to reinforce their sense of control by assisting them in making informed decisions for advanced care planning (ie, naming a health


care power of attorney and considering general values, goals, and preferences), which may or may not include the provider's recommendations for these personal choices.

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In Reply — Serious Illness Conversation

To the Editor: We would like to thank Drs Lycan and Taylor for their thoughtful comments and interest in our recent article describing our Three-Stage protocol.1 Drs. Lycan and Taylor accurately point out the implicit challenges we face in providing prognosis (Stage 1) and recommending treatment options (Stage 3).2 Acknowledging their concerns, we actually find that this protocol is useful because it can be applied to all types of serious illness conversations throughout the illness trajectory.

First, we want to emphasize that “prognosis” is not limited to sharing a concrete time frame. We agree that it is frequently difficult to share the prognosis, and in many cases it may not be appropriate — or possible — to state the life expectancy (eg, early-stage cancer). “It is too early for me to tell you what will happen” could be a prognostic statement in this situation. When cancer advances and becomes incurable, however, we may need to adjust our prognostic statement: “At some point, the cancer will progress and you will become sick,” or “We are hoping we can slow down the progression of cancer, but we are also worried we cannot.” The goal of Stage 1 is to make patients aware that their disease will cause some form of future limitation, whether it is of time, function, and/or unpredictability of the disease. These statements will help patients prepare for possible future negative events. Importantly, we also use invitation statements and elicit the patient’s information-sharing preferences earlier in Stage 1 to avoid disclosing the prognosis in a way that is not compatible with the patient’s wishes.

Secondly, when we emphasize the importance of making recommendations in Stage 3, this does not necessarily mean de-escalation of care intensity or code status. Even with serious illnesses such as incurable cancer, when the patient’s goal is “to prolong life with decent quality of life” and we think this is achievable, we should recommend anti-cancer treatments if available. We agree that it is better to reinforce patients’ sense of control, which is why, in Stage 2 (eliciting goals of care), we should listen to them carefully and fully explore their goals and values. The recommendation we provide must suit the goals of the patient in the context of this particular point in their disease; in fact, for patients with early-stage disease, our recommendation may be to pursue intensive care unit—level care as the next best step in achieving our goal. Additionally, while we make a recommendation, we do not force it. When patients do not like the recommendation, we explore the reasons and correct their misunderstandings, if any. For this reason, we described Stage 3 as “negotiating” treatment options.

Lastly, the take-home point of this three-stage protocol is that we always need to clear Stage 2. Even when you skip sharing the prognosis in Stage 1 altogether because patients are afraid to hear the prognosis, you have to ask Stage 2 questions (“What do you enjoy?” “What makes your life meaningful?”). In a study of heart failure patients who required left ventricular assist devices, the patients who could articulate their unique “unacceptable condition” received less intensive care at the end of life.3 When possible, we should explore patients’ goals, values, and fears surrounding possible negative situations in the future.

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