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REMAP: A Framework for Goals of Care Conversations

Julie W. Childers, Anthony L. Back, James A. Tulsky, and Robert M. Arnold

University of Pittsburgh, Pittsburgh, PA; University of Washington, Seattle WA; Dana-Farber Cancer Institute, Boston, MA

Corresponding author: Julie W. Childers, MD, Section of Palliative Care and Medical Ethics, Division of General Internal Medicine, University of Pittsburgh, 200 Lothrop Street, 9S, Pittsburgh, PA 15213; e-mail: childersjw2@upmc.edu.

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QUESTION ASKED: How can oncologists learn the communication skills needed to discuss goals of care with patients with advanced cancer?

SUMMARY ANSWER: The REMAP framework (Reframe, Expect emotion, Map out patient values, Align with values, and Propose a plan) provides a structure for approaching goals of care conversations.

WHAT WE DID: To help learners, from residents to attending oncologists, learn these complex conversational skills, we have developed a framework with a mnemonic, REMAP: Reframe, Expect emotion, Map out patient values, Align with values, and Propose a plan. In the reframe step, the clinician steers the conversation toward the big picture, providing a "headline," which is often the bad news that further cancer treatments are unlikely to be helpful. This is followed by actively attending to the patient's emotional response (expect emotion). Responding to emotion, often more than once, can enable the emotional intensity to decrease enough that discussion can continue. To begin to move toward a plan, the oncologist should intentionally step back to explore the patient's values before discussing therapeutic choices. In mapping the patient's goals, the oncologist asks open-ended questions that are designed to help the patient think about the values that should guide his or her treatment. The oncologist then aligns with those values by reflecting them back to the patient. The clinician should seek to identify at least two separate values that the patient expresses and summarize them, including any ambivalence that is present. The clinician then matches what he or she has heard to devise a patient-specific medical plan. If the patient gives permission, the oncologist will then propose the plan to the patient and assess the patient's reaction.

WHAT WE FOUND: Matching patient values with medical recommendations requires learners to develop listening skills to understand the patient and adjust recommendations in real time on the basis of what they hear. The mnemonic REMAP breaks down a difficult interaction into smaller pieces and helps learners work on particular parts of the conversation.

CONCLUSION: Experts on goals of care recommend a number of strategies when having conversations about goals of care, including discussing prognosis, responding to patient emotion, exploring values and often making a recommendation for medical treatments that fit those values.

The processes underlying REMAP encourage oncologists and other clinicians to seek to understand and remain flexible, adapting their recommendations to what they hear from the patient, with ongoing revision based on the shared decision-making process. REMAP also allows the patient to act as an expert on his or her own life, while requiring the clinician, not the patient, to be the expert in medical treatments. This process will lead to patient-centered decisions that promote better end-of-life care. JOP

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University of Pittsburgh, Pittsburgh, PA; University of Washington, Seattle WA; Dana-Farber Cancer Institute, Boston, MA

Abstract

Conversations regarding goals of care with patients who have advanced cancer still occur too late, and oncologists say they lack the training to have these conversations effectively. Experts recommend a number of strategies when having these discussions, including discussing prognosis, responding to patient emotion, exploring values, and often making a recommendation for medical treatments that fit those values. To help learners, from residents to attending oncologists, learn these complex conversational skills, we have developed a framework with a mnemonic, REMAP: Reframe, Expect emotion, Map out patient goals, Align with goals, and Propose a plan. In the reframe step, the oncologist provides a big picture "headline" that lets the patient know things are in a different place. This is followed by actively attending to the patient's emotional response (expect emotion). Then, to map the patient's goals, the oncologist asks open-ended questions that are designed to help the patient think about the values that should guide his or her treatment. The oncologist then aligns with those values by explicitly reflecting them back to the patient. If the patient gives permission, the oncologist will then use those values to propose a medical plan that matches patient values. The processes underlying REMAP encourage oncologists and other clinicians to seek to understand and remain flexible, adapting their recommendations to what they hear from the patient, with ongoing revision based on the shared decision-making process. This will lead to patient-centered decisions that promote better end-of-life care.

REMAP

Although studies show that most patients want to their oncologists to discuss end-of-life plans, these conversations often do not occur.[1-3] One study of patients with stage IV cancer found that oncologists documented discussions about goals of care only 27% of the time.[4] Oncologists also value these conversations but feel they lack the skill to have them.[5] Many patients with advanced cancer are referred to hospice too late, and the majority of patients dying of cancer spend time in the hospital in the last month of life, with 6% percent receiving chemotherapy within 2 weeks of death.[6]

Experts advise oncologists and other clinicians to start conversations regarding goals of care by discussing prognosis, exploring patient values, attending to emotion, and then using this information to develop a plan with the patient.[7-10] This process requires skills that oncologists may not have been taught in their training, and the task of having these conversations can feel overwhelming when viewed as a whole. To help learners, from residents to attending oncologists, learn how to have these discussions, we have developed a mnemonic, REMAP, to guide the conversation: Reframe, Expect emotion, Map out patient goals, Align with goals, and Propose a plan. Mnemonics are frequently used in medical education to teach complex tasks such as creating a differential diagnosis and have been used to teach communication. For example, SPIKES

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(Setting, Permission, Invitation, Knowledge, Emotion, and Support/Summary)[11] has shown success in teaching skills to oncology fellows for delivering bad news.[12] Chunking the conversation into small steps allows the teacher to focus on each section individually, with the learner developing one skill at a time. This decreases the cognitive load for learners and allows them to experience success a piece at a time. The framework also highlights specific behaviors, which allows teachers to provide feedback on what learners are doing well and how they can improve.

Here we describe each step of the framework and provide examples, including signs that will let the clinician know that he or she is done with a particular step and can proceed to the next one (Table 1).

REFRAME

Oncologists and other clinicians initiate conversations on goals of care when current therapies are not working. In this first step, the oncologist seeks to assess the patient's understanding of his illness trajectory and, if necessary, to provide new information. The reframe places the details of the patient's illness into a bigger picture ("the headline") and justifies the need to re-evaluate the goals of care.[13] Using a preamble such as "We think that…" or "I'm worried that…" helps the oncologist give the medical opinion directly without claiming absolute knowledge of the future.

EXAMPLE:

Oncologist: "What have you heard so far about what is going on with the cancer?"

Patient: "Well, I know the scan showed that the cancer has spread, and there are more spots on the liver. And I feel like I'm weaker than I was before."

Oncologist: "So it sounds like you're seeing you are in a different place now than you were a few months ago. I'm wondering—would it be OK to step back a little and talk about the big picture?"

Patient: "Yes, I want to know what's next."

Oncologist: "We've been through a lot of treatments and I'm wondering if it's time to re-evaluate where we are. More treatments might do you more harm than good."

In the example above, the physician engages the patient by asking first what she knows, puts the news into a larger context, and then waits for the patient's reaction. If the patient already knows that things aren't going well, the reframe might be accomplished simply by asking the patient her understanding. However, in situations where the patient is unaware of her clinical status, the reframe may become a conversation about serious news.

Many patients or surrogates doubt physicians' prognostic estimates.[14] A patient's reluctance to engage with an oncologist's prognosis may be the result of an emotional reaction to the information or to the patient's coping style.[15] If a patient does not agree with the oncologist's framing, exploring the patient's view ("Tell me what you are thinking") and empathizing are more helpful than repeating the prognostic information.

It is not necessary for the patient to accept the medical view of their prognosis to continue the conversation. To encourage the patient to hold to hope for the best and come up with an alternative plan if things get worse, the clinician might say,

Table 1. Examples of Clinician Statements to Guide Conversations Regarding Goals of Care

REMAP	Physician Statement
Reframe	"You've worked very hard with all the treatments over the years, and I hear that now you're feeling more tired and it's harder for you to do the things you enjoy. I'm seeing that you're in a different place now. Further treatments may be too hard on you."
Emotion	"What worries you most about this?" "It's understandable that you would feel sad when thinking about these things." "This is hard to talk about." "Is it OK to talk about what this all means for the future?"
Map	"Tell me about some of the things you enjoy doing." "What's most important to you given that time is limited?"
Align	"From what I'm hearing from you, the most important thing for you is to have time at home, sitting on the porch with your family. You feel like at this point you've spent too much time in the hospital, and you wouldn't want to come back if it could only extend your life a few days or weeks."
Propose a Plan	"Given what you've told me, I'd propose that we do everything to help you spend time at home with your family. I don't think more cancer treatment is likely to help with that. I think getting hospice involved would help you do what you want to do with the time you have. What do you think?"

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"I understand that you feel it's important to maintain a sense of optimism. I'll do everything I can to help you stay as healthy as possible. I'm wondering if you could also think about the possibility that things might not work out as we hope." In such cases, patients may try advanced therapies about which the oncologist is skeptical and also begin to plan for what to do if things do not get better.[16]

Proceeding to the Next Step

One way to be sure the patient has heard the reframe is to use a "teach back," asking the patient a question such as "Just so I can be sure I'm being clear, could you tell me what you will tell your son about our conversation today?" Otherwise, the Reframe step is integrated with the next step, Expect emotion, because emotion often usually follows the reframe.

EXPECT EMOTION

Most patients will have an emotional reaction to thinking about disease progression and the likelihood of further losses in the future. In some cases, emotional cues from patients may be verbally explicit, whereas in other cases, they may be apparent through nonverbal reactions such as crying. Reflective statements that name or acknowledge the presence of emotion help the patient feel heard.[17]

EXAMPLE:

Oncologist: "You've worked very hard with all the treatments over the years, and I hear that now you're feeling more tired and it's harder for you to do the things you enjoy. I'm seeing we're at a point where further treatments may be too hard on you."

Patient: "What would I do if I didn't get more treatment?" (sounding anxious)

Oncologist: "I know this is not something that you wanted to hear."

Patient: "Yes I've been afraid this day would come. I don't know what I'll do."

Oncologist: "What are you most worried about?

As in the example above, questions patients ask right after the reframe are often expressions of emotion rather than cognitive requests for information.

Proceeding to the Next Step

Responding to emotion, often more than once, can enable the emotional intensity to decrease enough that discussion can continue. One can also ask permission to move forward, with a question such as "Would it be OK to talk about what this means for the future?" If the patient responds to this question with another emotional cue, or if the emotion does not dissipate after several turns of attending to it, the patient needs more time, and the rest of the conversation may need to wait until another day.

MAP OUT PATIENT VALUES

To begin to move toward a plan, the oncologist should intentionally step back to explore the patient's values before discussing therapeutic choices, with a statement such as "In order to figure out the best plan for you, let's talk for a couple of minutes about what is most important to you at this point."

The conversation that follows does not immediately focus on treatments. Instead, the oncologist explores what matters most to the patient and her concerns about the future. Information about the patient's values allows the oncologist to develop a patient-centered treatment plan that is most likely to achieve the patient's goals given the new biomedical situation.

To map the patient's values, the oncologist uses evocative, open-ended questions that are designed to help the patient think about the values that should guide her treatment.

EXAMPLE:

Oncologist: "What's most important to you given where things are with your cancer?" (evocative question)

Patient: "I want to make sure that my kids are taken care of. I need to do my will and figure out who's going to look after them."

Oncologist: "So your kids' well-being is important to you, and you're thinking about getting things in order so that they are supported when you're not around. What else is important now?" (evocative question)

Patient: "Well…I don't want to be in pain."

There are a variety of types of evocative questions that may elicit the patient's values. A simple opening can be to ask about the existence of a living will or if the patient has ever thought about what would be important if he got sicker. However, many patients do not have a living will and cannot readily present an answer to an abstract question about values. In those cases, the oncologist must take an active role in guiding the patient to uncover and interpret his values, listening for cues about what is important to the patient and asking further questions to explore those areas.[17] Talking about what the

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patient wants to avoid (or is concerned about) allows the patient to explore how she views medical treatments as she gets sicker. Sometimes the patient's expression of emotion will lead to a discussion of what's important.[18] Another way to lead into this discussion is to ask the patient directly about what his life is like outside the hospital and about his hobbies and activities. This can begin a discussion of meaningful and unfinished goals. Other strategies are listed with examples in Table 2.

A common pitfall is for the clinician to prematurely close this values step. The fact that a patient likes being active does not mean she would not be willing to have a short stay in the intensive care unit. Most people have a complex set of values, some of which are in conflict with each other. The task here is to explore these values, to feed them back to the patient and help her prioritize them. For example, one might point out that "I hear you want to stay active and you want to be around for your daughter as long as possible. If we can't achieve both of these, which is most important?" Similarly, if for example, a patient expresses a preference about a specific treatment ("I don't want to be on machines again"), the physician should take that "no" response as an opportunity to explore the patient's priorities regarding life extension versus quality rather than making a final decision.

Proceeding to the Next Step

The oncologist can begin moving into the aligning step when she has a thorough understanding of the patient's unique values and any ambivalence that is present. Clinicians who are beginning to have mapping conversations should, at minimum, seek to find out enough about values so they can apply more than one patient value to a medical decision.

ALIGN WITH VALUES

In aligning, the physician verbally reflects back what she has heard from the patient, including any ambivalence. In moving to this phase, the clinician transitions from evocative questions to more reflections and summaries. In a reflection, the clinician makes a hypothesis about what the patient means, and a summary is a collection of reflections that demonstrates an understanding of several aspects of the patient's values and priorities. The summary may then lead to further mapping as the patient clarifies, expands, or qualifies what's important.

EXAMPLE:

Oncologist: "From what I hear you saying, you're tired of all these different treatments we've been doing and coming back and forth to the hospital. The main priority right now is to be at home spending time with your family and feeling as good as you can. You'd be willing to come to the hospital if there is something they could do to help you get home and be with your family, but if it's not going to help you get stronger, you'd rather not."

Patient: "Yes that's right. The chemotherapy has been the hardest part."
Oncologist: "So you wouldn't want to put up with more side effects, especially if a treatment has a low chance of helping you live longer."

Table 2. Strategies for Mapping Values

Strategy	Example
Asking about advance directives	"Have you ever completed a living will?"
Asking about values directly	"What's most important to you now, with what you know about your illness?" "What else?"
Reflecting on emotion	"You feel sad thinking about the possibility that you won't see your children grow up. It sounds like time with your children is one of the most important things for you now."
Exploring worries	"As you think about the future, what concerns you?" "What do you want to avoid?"
Exploring life outside the hospital or clinic	"What kind of things do you like to do when you're feeling stronger?"
Personal experience with medical interventions	"What has chemotherapy been like for you?"
Family/friend experience with medical interventions	"Has anyone close to you been in the intensive care unit or on a breathing tube? What was that like?"
Exploring recent quality of life	"How has your life been for the past year since you've had more health problems?"

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Proceeding to the Next Step

The clinician will know that alignment has occurred when the patient responds something like "That is exactly right—that's what most important." This signals that the patient is ready to move to the planning phase. If the patient continues to explore and clarify further after the aligning summary, the clinician will move back into mapping to better understand the patient's values. A patient may ask for a plan; if he or she does not, a question such as "Would it be OK if I give a recommendation?" will also demarcate a transition to planning and confirm the patient's willingness to hear the clinician's recommendation.

PROPOSE A PLAN

If the patient is willing to hear it, the oncologist proposes a medical plan that he believes has the best chance of maximizing the patient's values and goals, using both information about her values and his knowledge of the feasibility of medical treatments that would help her achieve her goals.

> EXAMPLE:
>
> Oncologist (after receiving permission to propose a plan): "Given what you've told me about your goal to be at home as much as possible and also to make it to your granddaughter's birthday if possible, I'd propose that we do everything to maintain your health to help you do that, with some limitations. I think we should try this new clinical trial, but if you find yourself having a lot of side effects, we should stop it and just focus on treating your pain and keeping you at home. In the meantime, if you have an infection that can be treated with antibiotics, we would bring you back to the hospital, but we wouldn't put you on machines like a breathing tube. What do you think?"

The plan depends on the values heard in the mapping phase. If the patient says that medical treatments and hospitalizations have been too burdensome and her main priority is to be at home and enjoy her life, the oncologist's recommendation might be to not pursue more treatment or clinical trials right now. The oncologist makes a recommendation that has the best chance of achieving the patient's goals, taking into account what degree of burden and risk she is willing to accept. The proposed plan should be explicitly linked to the patient's values ("Given what you've told me about your goal to maximize your time as much as possible…"). In other words, much as when solving a complicated math problem, clinicians should show their work.

The plan should start with what will be done to achieve the patient's goals. The oncologist may need to discuss the fact that some goals will be easy to achieve; others may be more of a stretch ("We can get you home and keep you comfortable. I think getting you well enough to go to Los Angeles will be tough. Can we talk about other alternatives that will let you see your grandchildren?") After focusing on what can be done ("We'll do everything we can to help you be at home and enjoy time with your family."), the clinician can note what she does not think will achieve the patient's goals ("When your heart stops and you are near the end of life, we won't use machines to try to keep you going; instead we'll let you pass naturally and use medications to make sure you are comfortable.")

The proposal of a plan is followed by an open-ended question assessing the patient's reaction ("What do you think?"). If the patient does not accept the plan, there is more for the clinician to explore, either in terms of patient emotion or underlying values. An attitude of curiosity helps the dialogue remain open.

Some patients or surrogates feel that it is their responsibility to decide what the next steps are, without the doctor's input.[18] For patients or families who do not want a recommendation, the physician should ask open-ended questions to explore how they can best assist with decision-making: "Tell me what you are thinking about the next steps" and "How can I be most helpful to you?"

Completing This Step

If there seems to be agreement on a proposed plan, asking "What questions do you have?" will encourage the patient and family to explore all aspects of the plan. The teach-back technique mentioned above also ensures a common understanding.

CONCLUSION

In conclusion, matching patient values with medical recommendations requires us to develop listening skills to understand the patient and adjust our recommendations in real time on the basis of what we hear. There is no one-size-fits-all plan for a specific clinical scenario, and this flexibility takes some practice. Structured practice using the REMAP protocol will help oncologists and other clinicians pause and take time to understand the patient, whether through simulated patient scenarios or co-led family meetings with feedback from a more experienced clinician.

REMAP is presented as a stepwise process to prompt clinicians who are working on improving their skills in these

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conversations regarding goals of care. As clinicians become more expert in this framework, they will find themselves varying and blending the steps of REMAP. Responding to emotion, for example, is often appropriate at every stage of these difficult conversations, not just after the reframing step.

The processes underlying REMAP align oncologists and other clinicians with patients and their families. Clinicians seek to understand and remain flexible, adapting their recommendations to what they hear from the patient, with ongoing revision based on the shared decision-making process. This will lead to patient-centered decisions that promote better end-of-life care. JOP

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Author Contributions
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Manuscript writing: All authors
Final approval of manuscript: All authors
Accountable for all aspects of the work: All authors

Corresponding author: Julie W. Childers, MD, Section of Palliative Care and Medical Ethics, Division of General Internal Medicine, University of Pittsburgh, 200 Lothrop Street, 9S, Pittsburgh, PA 15213; e-mail: childersjw2@upmc.edu.

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AUTHORS' DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

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