Discussing Goals of Care

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Objectives

- Understand the importance of discussing goals of care with patients
- Discuss 3 steps in discussing goals of care
- Discuss strategies for dealing with conflict at the end of life

Old Model of Medical Care

Hospice
Curative Treatment
Death
TIME
Continuum of care

Dying in the US

- 2/3 of patients want to die at home, only 1/3 do
- Over 50% of patients die without:
  - Doctor knowing their EOL wishes
  - In pain
  - With no discussion of AD
- Hospice referrals coming later and later
- Doctors tend to overestimate prognosis (3:1-5:1)

Part of the Answer:

BETTER COMMUNICATION!!!
Patients with a terminal illness who receive aggressive therapy were NO MORE LIKELY to survive, and had more adverse events (dying on a vent, dying in the ICU, dying in pain, having CPR).

Patients want honest, thoughtful communication with their medical team.

Case 1: Ms. J
- 79 year-old woman w/ metastatic pancreatic cancer
- increased ascites, dyspnea, and fatigue
- Bedbound
- 3rd admission this month
- “I don’t understand why this fluid keeps coming back. Does this mean my cancer is getting worse?” I’m just so tired and, doctor, some days I think I’m dying.”
Case 1: Ms. J

Dr. A: “Ms. J, I don’t want to hear you talking like that. We’re going to send this fluid to the lab. If there’s no infection, I’ll start working on your discharge papers.”

Looking down, Dr. A quickly leaves the room.

Discussing Goals of Care

1) Prognostic Disclosure
2) Establish Patient-Centered Goals
3) Recommend a Plan of Care based on Patient Goals

Step 1: Prognostic Disclosure

- Setting
- Perception
- Invitation
- Knowledge
- Emotion/Empathy
- Summarize/Strategize
Setting
- Prepare
- Ask pt who they would like to attend
- Physical environment
- Limit interruptions

Perception
- What does the patient understand?
- Open-ended questions

Invitation / Information
- What kind of information does the pt want?
Knowledge
- Clear unambiguous information
- Acknowledge limitations
- Use ranges

Emotion / Empathy
- Name
- Understand
- Respect
- Support
- Explore

Summarize / Strategize
- Summarize
- Check for understanding
Step 2: Establishing Patient-Centered Goals

*Goals of Care → Plan of Care

*Hospice discussion = Goals of Care + Needs at Home

Step 3: Recommend a Plan of Care Based on Patient Goals

Any treatment that will not help the stated goals should be discontinued or not started

If patient unable to participate

- Family – “What would the PATIENT want?”
- Be aware of family dynamics
- Appreciate that making decisions for loved one is extremely difficult
Conflict!

- We don’t like it
- We would like to avoid it

Case 2:
Dr. B sat near the bedside of Mr. Smith, a longtime patient with heart failure, diabetes and renal failure. He remained comatose after a stroke, and was actively dying. Yesterday, Dr. B had another family meeting with Mr. Smith’s wife of 40 years and his two daughters to discuss goals of care. Based on previous conversations with the patient as well as guidance from the physician, the family changed the goals to comfort.

Case 2
Mr. Smith’s estranged son, a lawyer from California, bursts in the room and demands that his father be transferred to the ICU for aggressive treatment. “I can’t just stand by while you people kill him!”
Managing Conflict at the End of Life

- Pitfall #1: Poor communication techniques
- Pitfall #2: Not respecting communication preferences of patient/family
- Pitfall #3: Not acknowledging emotion or caregiver stress

Managing Conflict at the End of Life

- Pitfall #4: Ignoring family dynamics
- Pitfall #5: Unintentionally fostering an environment of distrust

When there's no consensus

- Give them some time
- Consider time-limited trial [Ex. “Let’s continue full aggressive support for another 48 hours. If there is no improvement, let’s meet again and discuss treatment options.”]
- Assure non-abandonment
- Consider other resources
Conclusion

- Discussing goals of care is an important for patients with a life-limiting illness
- Goals of care can be discussed using a 3 step process
- Much conflict can be avoided with good communication “up front.”
- Communication about goals of care is a PROCESS and should be individualized

Questions?

Resources
- www.getpalliativecare.org
- www.PalliativeDoctors.org
- www.eperc.mcw.edu