Module: Goals of Care Discussion

Learning Objectives

Attitudes	• Identify with whom to have GoC discussions and when to have them.
Knowledge	• Understand key principles of goals of care discussions, including aligning medical interventions/conversations with patient values and quality of life expectations.
Skills	• Understand not all GoC discussions end with decisions as patients need time to digest information.

Module Content
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Teaching Outline

Despite their importance, goals of care discussions are often challenging due to the emotional, ethical, and communication complexities involved. Surgeons must balance technical expertise with empathy and sensitivity, navigating conversations that encompass prognosis, potential outcomes, and the patient's quality of life. Effective communication strategies are therefore essential in facilitating these discussions, ensuring that patients receive treatment that aligns with their goals.

With Whom to Have Discussions

Goals of care (GoC) discussions should occur with all patients. Normalizing the process of discussing why a patient wants to pursue a specific treatment plan will help surgeons connect with their patient. Discussions with patients help manage patient expectations for outcomes and for the trajectory of illness and treatment and ensure that the treatment plan best fits their goals and that future treatments align with their wishes. GoC discussions have been noted in the literature to be completed less often with patients from structurally marginalized groups. By conducting a GoC discussion with every patient, surgeons will help mitigate that difference. Establishing rapport with a patient early in their clinical course may facilitate difficult conversations in the future. Extra attention should be paid to those who are undergoing complex operations, those with an expected prolonged hospitalization or need for postoperative rehabilitation, those with a high fragility index, and those with high likelihood of mortality and morbidity.

When to Have Discussions

Clinical/elective setting: Perioperative decision-making programs may improve mortality, symptom control, quality of life, communication, and healthcare utilization. In the elective setting, surgeons should engage in GoC discussions with patients to align surgical interventions with the patient's values and preferences, ensuring that the procedures performed are in harmony with the patient's overall health goals and quality of life. This proactive approach allows for a more thorough informed consent process and helps prevent potential conflicts between the patient's desires and the clinical realities of the surgical process. By integrating these discussions into their practice, surgeons can enhance the alignment between surgical outcomes and patient expectations, leading to satisfactory and ethically sound healthcare experiences. Detailed pre-operative discussions also allows the patient ample time to prepare an Advanced Care Directive and Medical Power of Attorney (MPOA) for high-risk operations.

Emergent setting: Ideally, GoC discussions should occur during the initial encounter. Initiating these conversations at the time of diagnosis, or when surgical options are first being considered, allows for a thorough exploration of the patient's values, goals, and preferences. Pre-operative discussions provide the opportunity for the surgeon to discuss potential risks, benefits, and alternatives, ensuring that the patient's choices are well-informed and aligned with their overall health goals. By prioritizing these conversations early in the emergency setting, surgeons can set expectations and assess patients' wishes. Recognizing the emergent/emergency need of some high-risk operative interventions and the limited time for conversation,

a brief discussion managing expectations and likely outcomes should be included in the informed consent process. A more detailed discussion should happen postoperatively, including discussion of overall trajectory of illness, rehabilitation, and post-surgical care.

Intensive care setting: In the ICU, GoC conversations should be initiated as soon as possible, particularly if the patients' conditions are critical or are expected to have an unstable trajectory. The intensity and complexity of ICU care often involves life-threatening conditions where the risks of surgery are heightened, making it essential to clarify the patient's values, priorities, and preferences early in their ICU stay. Ideally these discussions should be started when the patient is admitted to the ICU. If they are unconscious or unable to communicate, this conversation will take place as a family conference (Please see Conducting a Family Conference module). Additionally, if the patient's condition deteriorates or if there are significant changes in their prognosis, their GoC should be revisited to reassess and confirm the alignment of ongoing or proposed treatments with the patient's desires. Engaging in these conversations promptly within the ICU setting not only aids in shared decision-making but also helps to alleviate the emotional burden on families, ensures that care remains patient-centered, and prevents unnecessary or unwanted interventions that may not align with the patient's best interests.

Explore Patients' Values and Preferences

In exploring a patient's values and preferences during a GoC discussion, one should begin by creating a comfortable and open environment where the patient feels safe to express their thoughts and concerns. This involves actively listening to the patient's narrative, understanding their life story relevant to their medical issues, and identifying what matters most to them in terms of quality of life and health outcomes. By asking open-ended questions such as, "What are your biggest concerns about your health?" or "What would make a treatment worthwhile for you?" one can gain insight into the patient's priorities and how they define a meaningful life. This initial step is crucial as it helps to establish trust and ensures that the conversation is centered around the patient's individual perspective.

Next, one should delve into the patient's goals and expectations for their care. This involves discussing the potential outcomes of the proposed surgical intervention, including the best-case and worst-case scenarios, and how these align with the patient's personal goals. For example, if a patient values independence and fears being dependent on others, one should discuss how different treatment options might impact their ability to maintain this independence. The discussion should explore any fears or misconceptions the patient may have about surgery and post-operative recovery, and provide clear, compassionate explanations. Managing expectations regarding outcomes, rehabilitation, expected functional status, post-operative medical needs and intensity are all critical in communication with the patient. By aligning the medical facts with the patient's values, one can help the patient make informed decisions consistent with their overall life goals. The surgeon should also be prepared to revisit this conversation as the patient's condition evolves, as goals and preferences may change over time. By maintaining ongoing communication, the surgeon can continue to support the patient in making decisions that reflect their values, ensuring that care remains patient-centered and aligned with what the patient considers most important in their life.

Content

A GoC discussion will look different from patient to patient and in various settings. If complex, it can be difficult to complete these conversations in one sitting. When having a GoC discussion with a patient, a surgeon should begin by thoroughly explaining the patient's current medical condition and the proposed surgical intervention. This includes outlining the diagnosis, the nature of the surgery, and what treatment plans are being offered. The surgeon should discuss the potential benefits of the surgery, such as the improvement in symptoms, prolongation of life, or enhancement of quality of life. It is equally important to clearly explain the risks, including complications, the likelihood of success, and the potential impact on the patient's overall health. This balanced presentation allows the patient to have a realistic understanding of what the surgery entails and sets the foundation for an informed decision-making process.

Next, the surgeon should address the patient's goals, values, and preferences by exploring what outcomes the patient hopes to achieve through the surgery and what trade-offs they are willing to accept. If there are alternative treatments or the option to forgo surgery, these should also be discussed, highlighting how each option aligns with or deviates from the patient's goals.

Finally, the surgeon should cover the logistical and ethical aspects of the patient's care, ensuring that the patient's wishes are respected throughout the surgical and recovery process. This includes discussing advance directives, do-not-resuscitate (DNR) orders, surrogate decision maker if needed, and any other specific instructions the patient may have for their care should complications arise. The surgeon should also talk about the importance of clear communication with the patient's family and other healthcare professionals, ensuring that everyone involved in the patient's care is aware of and respects the patient's preferences. Additionally, the surgeon should reassure the patient that their care plan will be revisited and adjusted as needed, depending on how their condition evolves during the treatment course. By covering these critical content areas, the surgeon ensures that the patient is fully informed, supported, and empowered to make decisions that reflect their values and priorities. Although these discussions may seem like they would take up most of the time of a clinic visit, they can all be seamlessly integrated into the visit, not adding more than a few extra minutes. A GoC conversation may not contain all these segments at one time, as it is a process, and patients may need time to think about their goals and how treatment plans aligns with their options. GoC discussions should be revisited often.

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Pre/Post Test

Questions

1. What is the primary goal of a goals of care discussion?

   a) To convince the patient to accept the recommended treatment
   b) To inform the patient about all possible medical interventions
   c) To align medical treatment with the patient's values and preferences
   d) To discuss only life-prolonging interventions

2. Who can fill out an advance care directive?

   a) Only a healthcare provider
   b) Any adult who has capacity
   c) A family member on behalf of a patient with capacity
   d) Only individuals with a terminal illness

Answers

1. C) To align medical treatment with the patient's values and preferences
2. B) Any adult who has capacity

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Case Scenario

Mr. Stevens is an 88-year-old male with a history of diabetes, hypertension, and newly diagnosed resectable pancreatic cancer. Pre-op discussions include risks, benefits, and filling out an advance care directive where he indicated full treatment. He was scheduled for an elective Whipple procedure, but intra-op metastatic disease was noted on his liver and the procedure aborted. After the surgery, Mr. Stevens was informed of the findings, and his surgical team discussed the need for a goal of care (GoC) conversation. The discussion focused on the transition from curative surgery to potential palliative care options; however, the patient needed more time to process this update. The next day the patient had an aspiration event, and he was emergently intubated and admitted to the ICU for respiratory support. His condition stabilized, but he remained on mechanical ventilation and failed extubation. Given his frail state and the recent metastatic diagnosis, the ICU team approached his surrogate decision maker for another goal of care (GoC) discussion. The team needed to reassess Mr. Stevens' preferences considering his critical condition, including whether he would want to pursue ongoing life-sustaining treatments as his advance care plan indicated. The family faced complex decisions as they grappled with Mr. Stevens' previous goals and his sudden deterioration. After discussing what the patient values in life a decision was made that due to his complications and frail state, he may never live independently, something that he valued deeply, and the surrogate decision maker decided to pursue comfort focused care.