

Palliative Care

Goals of care: The Bridge to Hospice

Assessing "Goals of Care" is an essential aspect of *hospital-based non-hospice palliative care*. Patients who are gravely ill have an average of 5 admissions to the hospital in the year before death. The patient and family are usually aware that the patient has declining health and is approaching the end of life. Patients make several transitions of care to various levels, including to hospitals, skilled nursing facilities, rehab facilities, long term care hospitals, home health care, and nursing homes. Hospitalists, primary care physicians, advanced practice practitioners, home health nurses, and therapists spend time with this patient group in their last year of life. All providers, not just physicians, need to exercise their unique social skills to enhance the lives of patients who are experiencing end-of-life changes.

Goals of care conversations start the process of grief management. Anyone who ever experienced loss know that it is better to experience grief in stages rather than all at once. Since humans can predict the future, grief often begins at diagnosis of a fatal illness, rather than at death. As a system and as a team, physicians and providers can manage end-of-life moments so that they minimize the patient's emotional pain and suffering. A culture that promotes a more comfortable grieving process for our patient population is beneficial to patients who must face the end of life. All providers who encounter patients who are declining in functional status and transitioning toward hospice need to be able to initiate conversations about goals of care.

Goals of care conversations help in the grieving process. They allow patients time to think about their situation and understand their capabilities while they are relatively well. A simple conversation will help them make decisions and grieve at their own pace. Often the patient and his family will do this once they are home, long after the conversation has taken place, and they will recruit input from extended family and trusted advisers. By connecting the patient with his family and community, patients can be comforted by them psychologically and spiritually.

Even if the "Goals of Care" conversation does not lead to a change in care or code status, it still benefits the patients mentally as they gradually accept their condition. It also helps prepare the patient to accept the correct level of care before a tragedy occurs. Nearly everyone wants to avoid unnecessary suffering when options for cure are few or non-existent. By touching the "Goals of Care" conversation from multiple trusted providers over a year or two as patients make transitions, the patient will gain confidence that he/she is making correct decisions.

The Components of a Goals of Care Conversation

Hospitalists, specialists, and all providers who admit patients into a health care facility ought to be discussing goals of care as part of their history and physical or before significant procedures. This endeavor aligns the patient's values with the course of treatment before making clinical decisions. Goals of care conversations assure the patient's autonomy is respected and are consistent with the medical ethic, *Primum non nocere* – first do no harm.

There are several essential components to a "Goals of Care" conversation, which need to be documented in the medical record.

1. Begin by assessing the patient's *capacity* to make decisions. Does the patient have the ability to understand relevant information, appreciate the situation, reason, and manipulate information rationally, and communicate a choice effectively? If the answer is "yes," then the patient has capacity. Identify the *power of attorney* or surrogate decision-makers and include them in the conversation.
2. Next, ask the patient about *expectations and wishes*. The answer might surprise you. Understanding preconceived notions and cultural differences are important to understand the patient's perspective and religious beliefs that may affect medical decisions. Discussions about wishes naturally would lead to further conversation about *code status* and *prognostication*.
3. This point in the conversation is an excellent opportunity to align the patient's and family's expectations with the reality of what the health care system can accomplish. Treatments need to be offered and discussed. After making treatment decisions, *pain management* concerns should be assessed and documented.

Documenting *discussions with family members* in today's health care environment is extremely important for care management. Providers change shifts frequently, and care occurs at a more rapid pace. A change in health status can be swift. It is essential that the next provider can build upon former patient and family conversations. When a patient or family member's expectations are not in alignment with the provider's understanding of prognosis, as is common with the denial of grief, it is also important to document the response. This situation might influence a provider to obtain another opinion by consulting the patient's regular provider or a palliative care specialist. It may be appropriate to continue managing the patient's medical condition, to provide more time for the grieving process.

Sometimes, it is necessary to reach out to the family by phone or have preset expectations when discussions should take place so that providers, case managers, and nurses can all participate and contribute.