Starting a Goals of Care Conversation with patients

Starting a Goals of Care conversation with your patient is part of the Advance Care Planning (ACP) process, which includes choosing a surrogate or alternate decision-maker and communicating values or wishes for medical care.

Advance Care Planning is appropriate for healthy adults and patients with their family and healthcare providers, early, recurrently, and as circumstances change.

Evidence shows that ACP conversations improve patient and family satisfaction with care and concordance between patients' and families' wishes, increase the completion of ACP documents, reduce the likelihood of patients receiving hospital care and the number of days spent in hospital, and increase the likelihood of receiving hospice care.

Triggers for reviewing goals of care

Annual visit	Disease worsening/ progression
Repeated or severe hospitalization(s)	Considering major procedures or interventions
Change in functional or health status	Change in social support system, death of a spouse
Change in living situation (independent to assisted or long-term care facility)	Clinician response of "no" to "Would you be surprised if this patient died in the next year?"

Key elements of goals of care discussions

Review previous discussions and documented wishes for care	"What conversations have you had with other doctors and your family about the care you would want to receive
Assess the patient's willingness to receive information and their preferred role in decision making	"How much do you want to know about your condition?" "Do you make your own decisions about your care, or do you prefer someone else makes those decisions?"
Discuss prognosis and anticipated outcomes for current treatment. Assess for patient understanding	"In order to plan for the future, I think it is important to discuss what the expected course of your [condition] may be."
Ask the patient about their values, goals, and fears for the future	"What makes life worth living for you?" "Given the severity of your illness, what is most important for you to achieve?" "What are your biggest worries as we discuss these issues?"
Discuss health states the patient would find unacceptable	"Would there be any circumstances under which life would not be worth living?"
Discuss specific preferences for life-sustaining treatments and interventions being considered	"Have you thought about what treatments you would want and not want if your health got worse?"
Summarize and make a plan	
Complete/update advance directives and document conversation in medical record	

Dos and Don'ts of Goals of Care Discussions

Do	Don't
Listen and let the patient do most of the talking	Wait until death is imminent
Break information into small chunks	Qualify treatment as
Check frequently for understanding	Ask patients if they want
Provide empathy and support	Tell patients there is
Emphasize what can be done	Focus solely on preferences for procedures
Offer your recommendation(s) based on their goals and values	Exclude surrogate decision-makers from the discussion

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https://www.advancecareplanning.ca/ Tools & resources