

The importance of establishing goals of care for hospital patients

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With an increasing number of technologies and therapies, we are charged, as intensivists, with the task of providing the most beneficial and least burdensome treatments to the most appropriate patients. As laden as these determinations are with subjectivity, what is undeniable is that they require us to know something of what our patients hold to be meaningful and acceptable. Additionally, our patients (or their substitute decision makers) need to know something of what the intensive care unit can offer them and what it cannot. This sharing of information requires an experienced and expert communicator, and time, both of which may not be available in the tension and urgency of an acute medical crisis.

In this issue of the Journal, Orford and colleagues provide us with a profile of patients referred for admission to a tertiary hospital ICU over a 5-month period.¹ The casemix is broad, comprising acute medical and elective and emergency surgical indications. The authors used modified trigger tools originally designed to identify patients with life-limiting illnesses (LLIs) in primary and secondary care settings^{2,3} in the United Kingdom (and more recently validated at their own institution⁴) to stratify patients. Most (two-thirds) of the referred patients fell into the group with at least one LLI. These patients were much more likely to die either in hospital or within the first year when compared with the group with no LLIs. This finding may not be surprising, but the use of these tools in a critically ill cohort is new.

Next, the authors looked at evidence of documentation of goals of care (GOC) discussions in the groups. The proportion of patients who had had GOC discussions was higher in the patients with LLIs, but even in this group, only one-quarter had full documentation of the conversation, including details of the content and outcome. It is possible, of course, that conversations were being held and not documented, which would be problematic in itself. Whether these findings reflect the norm for ICU referrals in Australia and New Zealand is uncertain. A previous report using information from the Australian and New Zealand Intensive Care Society Adult Patient Database showed that only a small minority (3.2%) of patients admitted to the ICU had pre-existing limitation of medical treatment (LOMT) orders in place,⁵ but data on referrals were not available. The literature on medical emergency teams (METs) certainly suggests a key role in instituting LOMT at MET calls.⁶ It seems possible (or perhaps even probable) that the pattern described by the authors is common.

If so, it is tempting to merely decry the situation as a failure of the system, or even as a deficiency in the action of our colleagues in primary and acute care settings. The challenge, however, is to move away from criticising and blaming and to try instead to identify solutions. Barriers to initiating GOC conversations need to be acknowledged and understood. For example, a recent survey of doctors and nurses in medical inpatient settings in Canada⁷ cited patient and family barriers (eg, perceived difficulty coming to terms with a poor prognosis) as predominant, as opposed to clinician barriers (eg, lack of training in GOC conversation) or systemic issues. Importantly, participants expressed willingness for collaboration with other health care practitioners (including non-doctors) in planning and initiating these discussions. There are undoubtedly other factors at play in hospitals too — diagnostic paralysis, limited knowledge of critical care support risks and limitations, and lack of time — which need to be uncovered and explored. It may be that the context of the conversation requires reframing, with a GOC framework replacing the currently common LOMT order.

Requiring the determination of a GOC category for *all* admitted patients (not just those at greater risk of dying) was successfully implemented and evaluated at two Australian health services.⁸ Such a framework is now being adopted more widely. By normalising GOC considerations into the admission process, we may achieve more timely conversations with patients or substitute decision makers. Effective communication is vital: in a Canadian cohort of elderly unwell patients, the rate of mismatch between medical orders for cardiopulmonary resuscitation and patient (or family) preferences was high (predominantly overtreatment).⁹ The authors rightly classed these as medical errors.

If the problems are complex, and the solutions still controversial and perhaps elusive, one thing that is certain is that our specialty is in a unique position to provide leadership and advocacy in this area. Our broad clinical and administrative position provides an interface with all specialties within the hospital, and our strong culture of multidisciplinary care and expertise in communication training should be harnessed to further investigate, evaluate and enhance processes. The questions raised by the data in the study are compelling, and it is imperative we answer them with collaboration, collegiality and humility.

Competing interests

None declared.

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