

EDITORIALS

The Goals of Goals: More Journey, Less Endpoint?

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In their study of goals of care (GOC) discussions and documentation, Wong et al. add to already robust evidence that communication, in this case from physicians caring for hospitalized patients back to long-term care facilities, has room for improvement. They highlight that 37.5% of patients had documented discussions, and for cases in which these discussions resulted in changes to a patient's advance directive, only 1 in 4 were relayed in the discharge summary.¹

As physicians caring for hospitalized patients and concerned with improving care quality and efficiency, many of us are familiar with potential systems solutions to augmenting communication: reminders in the electronic health record, checklists, multidisciplinary teams, scripts, and posthospitalization follow-up phone calls. However, important as they are, these solutions often elide the underlying cognitive elements related to how we, as physicians, think about and engage in the diversity of cases presented to us, and to how we prioritize communication work.

Wong et al. looked at patient characteristics associated with performance of GOC discussions to understand when and why physicians might engage in GOC conversations in the hospital and to generate insights into potential targets for improvement. They found that characteristics of patients prior to hospital admission were not associated with GOC discussions; signs of acuity of illness were.¹ In other words, physicians in the hospital are pretty good at recognizing patients *in extremis*, and prioritize GOC discussions with these patients. What we are not good at, or might not be considering, is assessing the broader context of a patient's health.

Whether we interpret these results as appropriate prioritization, or as a sign that we are waiting too long to broach the subject of care goals, depends on how we conceptualize the hospital stay in the context of a patient's health story, and, by extension, the role of the hospitalist in this story. For some patients, an acute illness requiring hospitalization is unexpected

and readily treated, and the patient rapidly returns to a prior level of health and function. The need for hospitalization represents an outlier state.

For other patients, often older, more debilitated, or with multiple and chronic medical conditions, minor changes in health or declines in mental, social, or physical function precipitate the need for hospitalization. Likewise, iatrogenic harms of hospitalization—sleeplessness, fasting, delirium, immobility—can contribute to enduring decline.^{2,3} For these patients, the need for hospitalization is not so far from, or may be, their norm.⁴

I suspect that Wong et al.'s findings reflect a collective response to the uncertainties of prognostication, and the resultant discomfort in raising questions that are difficult to answer. How do we know it is time to start talking about “the right amount of care?” Some might answer, I think rightly, that it is rarely if ever too early, yet robust discussions are challenging if we are not sure of the relevance or the immediate goal. In the case of the patient who is ill, declining, yet not *in extremis*, many of us might conclude that raising the question would not produce actionable information; it would not change immediate in-hospital management.

This common conclusion leads to a significant missed opportunity, both on an individual level for physicians and patients, and for hospital medicine as a specialty. Health, and the losses that come with declining health, are wrapped up with fundamental aspects of our identities, and take time and consideration to change and evolve. Decisions about our healthcare are statements about who we have been, who we are, and who we will no longer be. Especially for the second group of patients described above, each hospital stay affords a chance to assess, counsel, educate, support, and empower patients to move in the direction of their values, and to ready them for that eventuality when they or their loved ones are faced with decisions about how, and where, they will die. As specialists in hospital-based healthcare, hospitalists have the privilege and professional duty to facilitate this journey.

However, as hospitalists, we are often meeting patients for the first time; how do we assimilate an understanding of that point in time within the context of a patient's life with enough confidence to engage discussions? As Wong et al. show, it appears that in regard to very ill patients, respiratory rate and

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Glasgow Coma Scale inform action.¹ What signs or observations help inform action earlier in the trajectory of decline, to allow for anticipatory guidance and discussion? Increasingly, we see evidence that measures of frailty and functional status, applied in the hospital, are associated with hospital outcomes including readmission and death.^{5–7} Future work might explore if training physicians to systematically assess frailty and functional status leads to greater frequency of, and comfort with, initiating GOC discussions during hospitalization.

Moreover, an emphasis on evaluating frailty and function, and explicitly including this assessment in our clinical decision-making might help shift our thinking toward valuing each hospitalization as an opportunity to both intervene to improve function^{8,9} and to support, educate, and prepare patients under our care for the journey ahead—in other words, to fully engage with our role as specialists in the comprehensive and coordinated treatment of patients who require hospitalization.

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