To the Editor:

Framing Preferences at the End of Life


The Language of Goals of Care

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We were pleased to learn about the efforts of Gehlbach et al1 in “Code Status Orders and Goals of Care in the Medical ICU.” We applaud the questions posed by this contribution to CHEST (April 2011), and feel the authors’ framing of these issues raises interesting points for further discussion.

One consideration relates to the decision to combine patients and surrogates into a single population, “patients/surrogates.” While we acknowledge the critical care setting frequently necessitates discussion with surrogates rather than patients, we feel it might be problematic to treat these populations as interchangeable in studying patient preferences and how they differ from code status. Code status orders are usually intended to represent patients’ wishes, not those of surrogates, and a large trial demonstrated that patient and surrogate wishes frequently differ.2 We wonder whether the recorded discrepancies between preferences and code status might reflect latent differences between patients and surrogates in addition to confusion and miscommunication.

Another point relates to the discussion surrounding discrepancies in goals of care between physicians and patients. The authors conclude that discrepancies exist in 67.7% of cases, but we are curious as to whether they considered that physicians and patients might use different language to express goals that are closely related or even in agreement from a clinical perspective. For example, the results show that patients are more likely to prioritize achieving life goals, whereas physicians are more likely to prioritize prolonging life. These goals appear to overlap in many clinical scenarios, yet this distinction accounts for the two most significant subsets of discrepancies between physician and patient priorities.

Finally, we are curious about the decision to prompt patients, surrogates, and physicians to identify a single goal of highest priority, particularly in framing the relationship between curative and palliative therapy. While it is true that many physicians view these approaches as mutually exclusive, recent studies have indicated a simultaneous care model may provide substantial benefits, including prolonged life.3-5 Attending to patients’ comfort may actually help them live longer.5 We are concerned that framing goals of care in terms of singular priorities risks propagating a notion of care as either palliative or curative and may impede integration of these approaches to patient care. We thank Gehlbach et al1 for their thoughtful investigation of these issues and their ongoing commitment to the task of improving current practice.

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References

Response

To the Editor:

We thank Mr Allen and Dr Jesus for their efforts to engage some of the issues raised by our study.1 One concern pertains to whether differences between a patient’s code status preference and a surrogate’s understanding of that preference might account for some discrepancies between their expressions of the...