Editor's Note: Authors are invited to respond to Correspondence that cites their previously published work. Those responses appear after the related letter. In cases where there is no response, the author of the original article declined to respond or did not reply to our invitation.

Goals of Care
Role of Physicians in the ICU

To the Editor:

Experts seem to disagree about the meaning of the words "goals of care," as indicated by the point/counterpoint editorial discussion in CHEST (June 2015).1-4 “Goals of care” may mean goals/values of patients to some, to others it is the treatments that achieve the goals, or to some others it means both. Physicians do not know the values/goals of the patients, particularly in the ICU, where the physician is interacting with patient/family for the first time. Physicians should not presume that they do know patients’ values/goals, although sometimes we do assume that a particular level of quality of life is not desirable and think that it is not desired by the patient. It may help if we separate discussion of “goals” from “care” that would achieve the goals and avoid the phrase “goals of care” to clarify the issue better. The distinction between values/goals and treatments that could achieve them should be emphasized, and these (ie, goals and treatments) need to be addressed separately because physicians, particularly trainees, focus on treatments (CPR/do not resuscitate, intubation/mechanical ventilation, and other life-sustaining therapies) rather than identifying goals and offering treatments that achieve the desired goals.

The difficulty in obtaining the goals and uncertainty about prognosis make these discussions difficult, particularly when the surrogate is the decision-maker. Discussions about death and dying are difficult for both patients/families and caregivers.5 A paradigm change with a focus on defining the goals/values, when it can be done, and then a focus on the treatments that could achieve the goals (short-term/long-term) is needed. These discussions need time and coordination between various health-care personnel, and an individual with a focus on coordinating the discussions could help facilitate the process. Finally, we need to reframe the question; we should ask “how do you want to live,” rather than “do you want to live,” which is the question we are actually asking when we discuss CPR and life-sustaining therapies.6

Response

To the Editor:

In her discussion of my counterpoint editorial and rebuttal in CHEST,1,2 Prof Chelluri points out that the words “goals of care” can be confusing. Her problem may be with the word “care.” In normal discourse, it refers to a virtue, a disposition to be a concerned, engaged, compassionate person. But in medicine, it is also a synonym for “treatment.” Hence, a “health-care delivery system” may not always feature “caring.”

If “care” refers to “treatment,” it should be easy to distinguish a treatment from its goals. If that is the meaning of the terms, then I agree with Prof Chelluri that the distinction between a treatment and the goal of the intervention is important. The former is a matter of medical fact; the latter is in the realm of values. Prof Chelluri makes a key point: Physicians should not be expected to know the patient’s goals. Hence, physicians

Lakshmi P. Chelluri, MD, FCCP
Pittsburgh, PA

AFFILIATIONS: From the Department of Critical Care Medicine, University of Pittsburgh School of Medicine.

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CORRESPONDENCE TO: Lakshmi P. Chelluri, MD, FCCP, Department of Critical Care Medicine, University of Pittsburgh School of Medicine, 641 Scaife Hall, 3550 Terrace St, Pittsburgh, PA 15261; e-mail: chelluri@upmc.edu

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are going beyond their expertise in offering advice about the goals of medical intervention.

There is a complication, however. Once patients have stated their goals, it is reasonable for the physician to suggest treatments consistent with those goals. Both patients and physicians may mistakenly believe that the physician is the expert on picking the treatment appropriate for achieving the patient's goals. Typically, however, more than one treatment may, with varying degrees of probability, be expected to achieve various elements of the stated goal. The physician may have to negotiate with the patient to clarify and state the goal more precisely. The patient who says he or she wishes to live at all costs probably does not really mean that. The physician could consider various treatment options, including those, for example, that are extremely expensive, painful, inconvenient, and unaesthetic. In such a case, physicians need to ask patients to formulate their goals more precisely; this makes advising patients problematic.

Prof Chelluri points out that this is made more complicated by the fact that patients are often not competent to respond contemporaneously to such probes. Surrogates may be necessary. We have well-worked-out standards for surrogate decisions. We rely first on the patient's own previously expressed views (as in an advance directive), then on surrogate estimates of what the patient would have wanted based on his or her own values, and finally, on surrogate judgment of what is best for the patient. In any case, there is no reason to assume that physicians' judgments of the proper goals for the patient should be relied on.

Robert M. Veatch, PhD
Washington, DC

AFFILIATIONS: From the Kennedy Institute of Ethics, Georgetown University.

CONFLICT OF INTEREST: None declared.

CORRESPONDENCE TO: Robert M. Veatch, PhD, Kennedy Institute of Ethics, Georgetown University, Healy Hall, 4th Floor, Washington, DC 20057; e-mail: veatchr@georgetown.edu

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