ACP releases High Value Care advice for communicating about end-of-life care goals

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Physician-patient communication about goals of care is a low risk, high value intervention for patients with a life threatening illness, the American College of Physicians (ACP) advises in a paper published in *JAMA Internal Medicine*.

"Discussions about end-of-life care, especially early in the course of a life-limiting illness, are associated with care more consistent with patient goals and improved patient outcomes, including longer survival rates and better quality of life," said Dr. David Fleming, president, ACP. "This approach is also associated with improved bereavement outcomes for family members."

Co-authored for ACP's High Value Care Task Force by Dr. Rachelle Bernacki and Dr. Susan Block from the Center for Palliative Care at Harvard Medical School, "Communication about Serious Illness Care Goals: A Review and Synthesis of Best Practices" notes that a consistent and large body of mostly observational research shows that patient, physician, and system factors all contribute to deficiencies in serious illness care communication.

The paper reviews current literature and describes best practices in conversations about serious illness care goals. The paper also offers practical advice for clinicians and health care systems about developing a systematic approach to the quality and timing of such communication to assure that each patient has a personalized serious illness care plan.

"It is important for physicians, patients, and their families to know that the evidence does not support the commonly-held belief that communication about end-of-life issues increases depression, anxiety, or loss of hope among patients," Dr. Fleming said.

Effective communication about end-of-life care may also reduce costs. Best practices in discussing goals of care include sharing prognostic information, eliciting decision-making preferences, understanding fears and goals, exploring views on tradeoffs and impaired function, and wishes for family involvement, the authors write.

ACP advises that communication about serious illness care goals should come from the patient's primary clinician even when a team of clinicians is involved with the patient's care. Key elements of a system to help assure that every patient has a personalized serious illness care plan include training clinicians, identifying patients at risk of dying, preparing and educating patients, "triggering" physicians to conduct discussions at the appropriate time, a structured communication format for goals of care discussions, a system to assure documentation of these discussions, and metrics to gauge performance.

ACP supports the need for improving the approach to serious illness and end-of-life care, as well as the system changes needed to assure thoughtful and timely communication with patients and their family members across all health care settings.

The most common clinical conditions relevant to the paper include cancer, congestive heart failure, chronic obstructive pulmonary disease, and chronic kidney disease / end stage renal disease.

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