Stephen T. Harvey, M.D., Editor

Flying with a Compass

Goals of Care in the Perioperative Setting

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I met VC in an inpatient progress note. I felt I was standing by the window, watching the attending on rounds come and sit by the bed of this dying retired family doctor. I could almost hear the pleasant, unhurried conversation about VC's life and what he wanted from what remained of it. The note immortalized in the electronic health record was written with poetic brevity and it was the most beautiful, succinct, and thorough description of goals of care I'd ever seen.

"Long discussion with VC about his life, passions, and goals of care," the note started. Autonomy and choice were important to him, as were his family and relationships. He wanted to avoid death in an institutional setting, having spent plenty of time in hospitals during his medical career. His goal was to go home soon, safely, and as comfortably as possible. The note expressed his joy in being a husband, father, physician, and grandfather and in watching the astounding innovations in medicine that had happened during his career.

VC looked tired when I arrived to introduce myself as the anesthesiologist caring for him for his PleurX catheter placement. He paused every word or two to pull oxygen from his nasal cannula. His chart specified he was do not resuscitate/do not intubate. My main goal was to confirm my understanding of his wishes and define what airway and hemodynamic support interventions he would accept if I deemed them appropriate and

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what he would refuse under any circumstances. I wanted to avoid exhausting him with a lengthy conversation. Pausing to speak meant he would need to work to catch up on oxygenation afterward. I described what I had read in the progress note and he was able to nod and interject a few words, communicating that his perioperative care preferences were very consistent with the overarching goals he had conveyed before.

Anesthesiologists frequently care for patients near the end of life. One of the great privileges of my job is assisting in palliative procedures that, as in VC's case, allow the patient to leave the hospital and spend the rest of their time at home or, if unable to leave, then spend it in greater comfort and peace. When the procedure's goals, the patient's wishes, and the acceptable perioperative procedures align, I feel only joy.

My time with most of my patients is brief. I rely on documentation from established therapeutic relationships to help me understand the individuals who are about to entrust me with their lives. The more I know, the better I'm able to care for them and the more trust I'm able to gain in the brief conversation we have in our busy preoperative units.

The primary care provider who had this conversation and wrote this note has my deepest gratitude. The earlier these conversations start, and the more often they start in the setting of an established therapeutic relationship, the more they enrich later acute or subspecialty care. Not only did the note's author engage in this vital conversation and clearly document it, but also placed it in a location which underlined its importance. The electronic health record is very successful in capturing billable care, improving compliance, and producing notes Homerian in length. It is also a powerful and underutilized communication tool. The goals of care were at the top of his progress note, the first thing I saw when I was reviewing VC's chart.

Anesthesiology is often compared with the airline industry—we have preprocedure checklists and do careful equipment checks. We sit in a simulated cockpit, getting constant feedback from our instruments and monitoring equipment. Induction, maintenance, and emergence mirror takeoff, cruising altitude, and landing. Yet all of this is secondary to knowing where you're going. Eliciting and documenting priorities, wishes, and goals of care in the setting of a high-quality primary care relationship gives us a magnetic north to navigate by in these challenging cases.