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Establishing Goals of Care at Any Stage of Illness: The PERSON Mnemonic

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Dear Editor:

As a palliative care team members at large, academic hospitals, we are often called to discuss a patient's ''goals of care,'' which we approach in a standardized fashion. Interestingly, despite the fact that ''goals of care'' is oft mentioned in the literature,[1–4] there are very few guidelines on how to approach such a conversation.[1]

We feel compelled to find a structure for goals of care conversations for several reasons: Given the task-oriented nature of medicine and the fact that our team frequently interacts with multidisciplinary learners, we find that we need a way to clarify that goals of care is not just code status and is different from the plan of care. Two, we have not found the SPIKES model[5] to be helpful in early goals of care conversations[6] given that it is specifically focused on sharing news. And three, recommendations for patient-centered goals of care communication go back as far as 1996[7] and yet there is no consensus approach to having these conversations.

To these ends, our team has developed the following approach to having goals of care conversations at any stage of serious illness. It begins like all other important conversations, with consideration for the setting, which should be as personal and quiet as possible. Ideally, all interested parties should be together and in person. Following this, we encourage ourselves and our learners to remember to know the PERSON prior to making important medical decisions.

- Perception: understand the patient and family perception of current health status using open-ended questions and avoiding assumptions (e.g., ''What have the doctors told you?'')
- Explore the patient's life prior to present illness using inquiring and reflection statements and aligning with the patient by acknowledging sources of hope (e.g., ''What was your life like before you got sick?'')
- Relate the patient's story to medical reality and tie medical information to the patient's world (e.g., ''It sounds like before you got sick you liked to…but it's been a long time since you've been able to do that.'')
- Sources of worry: explore the patient's fears using future-oriented statements while sharing your own fears using hope/worry statements (e.g., ''What's important to you now that you know your life will be shorter than you'd hoped?'')
- Outline the plan for going forward using simple, declarative sentences including any time-limited trials
- Notify those who need to know including other family, multidisciplinary team members, and treating teams

We believe this model for goals of care conversations adds to practice in that it is applicable across the spectrum of illness and that it functions as both an inquiry and an advocacy tool. Next steps for the evolution of this tool include hearing from readers of this journal with their thoughts and suggestions. Additionally, we will be studying the PERSON model's effectiveness at improving medical student, resident, and fellow understanding of and comfort with goals of care conversations.

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