HHS Public Access

Author manuscript

Patient Educ Couns. Author manuscript; available in PMC 2024 January 16.

Published in final edited form as:

Patient Educ Couns. 2006 October ; 63(1-2): 145–151. doi:10.1016/j.pec.2005.09.010.

Goal setting as a shared decision making strategy among clinicians and their older patients

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Abstract

Objective: Older adults are less likely than other age groups to participate in clinical decision-making. To enhance participation, we sought to understand how older adults think about and discuss their life and health goals during the clinical encounter.

Methods: We conducted six focus groups: four with community-dwelling older persons (n=42), one with geriatricians and internists (n=6), and one with rehabilitation nurses (n=5). Participants were asked to discuss: patients' life and health goals; clinician-patient communication about goals, and perception of agreement about health goals. Group interactions were tape-recorded and transcribed. Data were analyzed using content analysis.

Results: Systemic factors that hindered goal setting included that it was not a priority given limited time, and patients' perceptions that clinicians were more inclined to prescribe medications. Interpersonal factors included patients' perceptions of the clinician as the authority, and the presumption that all patients' goals are the same.

Discussion: Several factors arose from both members in the clinician-patient relationship and hindered discussion of goals in the clinical encounter.

Conclusion: Addressing identified factors may facilitate goal setting for those who desire more participation in shared decision making.

Practice implications: Setting goals initially and reviewing them periodically may be a comprehensive, time-efficient way of integrating patients' goals into their care plans.

Keywords

goal setting; clinical encounter; decision making; aged

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1. Introduction

Patient-centered care is a cornerstone of quality health care,[1] promoting the humanistic, biopsychosocial perspective, emphasizing patients' participation in clinical decision making and encouraging physicians to consider patients' needs and preferences.[2] Despite efforts to increase participation in clinical decision making, patients differ in the extent to which they wish to be involved.[3–7] Age is the most important predictor of this phenomenon,[8] with older patients less likely to participate.[3,7–10] These age-related differences have been attributed to patients' health conditions, and/or to cultural norms where older patients expect a more paternalistic relationship with their physicians.[4,9,10]

Because of the complexity inherent to geriatric care, integration of patients' preferences and goals may be particularly important for this group. Goal setting may be a useful way to encourage older patients to express what they desire from their clinicians and to achieve these aims, thereby promoting shared decision making. Therefore, we sought to better understand how goals are formulated and communicated to design interventions that can improve goal setting and enhance patient-centered care for older adults.

Goal setting, a technique widely used by non-medical disciplines,[11–13] has not been well studied as it relates to clinical medicine. Goal attainment scaling, a method of monitoring patients' progress towards pre-established goals,[14–16] has been found to enhance goal setting in the geriatric population.[17–19] The object of clinical goal setting is to facilitate the process and improve the outcomes of clinical care. Setting goals can: 1) help physicians link care plans to patients' goals; 2) justify diagnostic and therapeutic interventions; 3) clarify the purpose of clinical recommendations; and 4) help resolve disagreements about desired outcomes.[20,21]

This study sought to investigate the willingness of older persons to participate in goal setting. Previous research demonstrating that older persons are less willing to participate in shared decision making mainly use survey methods to determine the attitudes, perceptions, and biases of older persons in non-clinical settings that are generally removed from an active clinical encounter or scenario.[3–7] The present study uses qualitative focus group methodology to offer a more nuanced and comprehensive explanation for why older persons appear less willing to use shared or mutual decision making formats. We wanted to understand how older adults think about their life and health goals and the relationship between them. To gauge willingness to actively participate in the clinical encounter, we wanted to learn how they communicate with clinicians about values and goals, including how these conversations ideally and actually occur. To gain a sense of the perceived utility of these conversations, we sought out their perception of agreement they had with clinicians about their health goals.

2. Methods

2.1 Study design and sample

This qualitative study consisted of six focus groups (n=53) held between May and July 2003. We used focus group methodology to elicit a range of older persons' and clinicians'

ideas about goal setting. Focus groups are recommended to help uncover factors that influence opinions, behavior, or motivation.[22] Four groups were conducted with older adults to gain the patient's perspective on goal setting with clinicians. Older adults were purposively sampled to obtain a range of socioeconomic and functional perspectives. We chose 3 residential sites from which to gather our sample: a high income independent living facility (1 group), a subsidized assisted living facility (2 groups), and a private condominium complex (1 group).

Potential participants were initially identified by a contact person at each site. To be eligible for inclusion, participants had to be age 60 years or older, English-speaking, and cognitively intact. Once the study was explained to potential participants by the site contact, a member of the research team obtained consent and demographic data. Measures included the telephone mini-mental state exam,[23] a 14-item scale of Activities of Daily Living (ADLs and IADLs),[24] an assessment scale of 11 common chronic illnesses, and a measure of self-rated health. Participants were then notified of the date of the focus group to be held at their residential site.

Two focus groups were held with clinicians: one with geriatricians and internists, and another with geriatric rehabilitation nurses. All clinicians were affiliated with the same northeastern teaching hospital. Clinicians in these specialties were chosen based on their routine practice with older patients. Clinicians were approached by a member of the research team who explained the study. Demographic data were collected at the focus groups. This study was approved by the Institutional Review Board at the Yale School of Medicine.

2.2. Data collection and analysis

Semi-structured interview guides were used for patient and clinician groups. Participants were asked to discuss: 1) their (or their patients') life and health goals, how they arrived at these goals, and the relationship between them; 2) communication about goals, including how conversations ideally and actually occur; and 3) their perception concerning agreement with clinicians/patients about patients' health goals. The interview guides appear in Tables 1 and 2.

Focus groups lasted approximately one hour and were audiotaped. Following transcription, 3 researchers (STB, ADN, DSG) independently identified content areas in the first 2-3 transcripts using content analysis. This analytic process involved line-by-line scrutiny of text to identify and sort segments of data.[25] The sorted categories evolved into a coding system, which the team applied independently to transcripts. The team then convened to review coded data and negotiate discrepancies. With the coding of successive transcripts, the coding system was expanded, refined, and applied to previously coded data. When all focus groups were completed, the final coding system was applied to each transcript. We identified themes by noting regularities and patterns in the data using the process of "conclusion drawing."[26,27] Atlas/ti software assisted with data coding and analysis.

3. Results

3.1 Characteristics of the sample

Patient participants (n=42) were primarily older (82yrs ± 7), female (66%), well-educated, lived alone (66%), had an average of 2 chronic illnesses, and minimal to moderate functional impairments (mean=25.6 ± 2.5, range 0-28). While focus groups were not conducted at a clinician's office, most participants had active, chronic conditions for which they were receiving ongoing medical care. All participants were asked to share perspectives based on their recent clinical encounters. Clinician participants (n=11) averaged 42.2 years of age, and most were female (82%). There were 6 physicians: 3 in Internal Medicine and 3 in Geriatric Medicine, and 5 nurses, 4 of whom were in Geriatric Rehabilitation and 1 of whom was a Nurse Case Manager in Geriatrics. Participants are described in Table 3.

3.2 Patient participants' views of life and health goals

Patient participants identified specific goals for their life and their health. Goals for life included being productive, socially active, employed or volunteering, and reaching "life milestones." Goals for health included reducing anxiety and choosing a good clinician. The most often mentioned goals-- maintaining general health, remaining mentally and physically active, and being independent-- were identified as both life and health goals.

Patient participants reported that they did not always discuss their life and health goals with their clinicians. Some were taken aback at the idea of doing so. Discussion of goals was not seen as part of the medical encounter; rather, discussion of symptoms was seen as the main purpose of the visit:

> One doesn't do that very well. One doesn't do that. I don't think anyone in this room goes to their physician and sits down with the physician and tells them what their lifetime goals are. I go there because I have a sore throat or a broken leg. That's the reason [I] go.

Another participant agreed,

> Discussing life goals… I don't think people talk in those terms.I certainly never talk to a physician about my life goals. I say, 'I can't move my right arm.' He gets the point. But we don't talk life goals, we talk symptoms.

Others reported that they would like to discuss life and health goals, but that clinicians were not interested or able to do so, and preferred to focus on symptoms:

> They don't have time for that. I've heard a doctor say when you try to give them a list of some things, well, he'll say, 'Well, what troubles you today?' Not a general thing, but what today. Which toe hurts today?

One respondent said simply:

> I don't think my doctors think about my health goals.

Others felt that goals are part of the medical encounter, but not explicitly communicated:

> I'm sure [the doctor] has it in his head somewhere. It's just that [goals] haven't been brought down so it becomes a discussion between patient and doctor. That's the issue.

Discussion of goals was seen as important to some who felt that clinicians could facilitate achievement of life and health goals:

> I'm trying to stay with it, trying to enjoy as much of life as I can.
>
> I like music and things like that. If I don't enjoy life, well, I hope
>
> I have many years left. I have grandchildren and great grandchildren, two of ours will finish college and two others are in there now…
>
> I'd like to see the young people accomplish their goals in life, and we'll enjoy it with them. Everything seems to fit together. Your doctors get you on the right track.

3.3 Clinicians' views of life and health goals

When clinicians were asked what they thought their patients' life and health goals were, they responded similarly to patient participants. They identified maintaining general health and independence, mental, physical and social activity, employment/volunteer work, and reaching life's milestones. Differently than patient participants, they spoke about improving quality of life, optimizing safety, symptom relief, and prevention of disease and illness.

Clinicians gave mixed responses as to whether or not they brought up goals with patients. Some reported that they do not engage in goals discussions because they are not trained to consider patients' goals, and because patients do not seem to be interested:

> It seems to me like when we talk about goals there are many different domains of goals, and that medical training… [focuses] on what the physicians' goals should be. For example, with diabetes, we want a hemoglobin and such and such and there hasn't been much focus on having that conversation of what the patient's goals are. Or when you actually do have that conversation on what the patient's goals are often you get a blank stare back. Well, if you're the doctor, you know what is best, so I think in many ways having the awareness to bring up the topic is difficult, and then once you bring it up it's not necessarily a dialogue.

Some clinicians felt that the focus of the clinical encounter was on symptom relief itself rather than on symptom relief as a life or health goal. One physician explained why he does not use a goals approach:

> In conversations I have I would agree I don't ask patients' overall goals. I never ask. And I'm an internist, so maybe there's a little bit of a difference, but in terms of what my goals were, again, I would concur that it lies with function and more with relieving symptoms. So if I have someone with a painful condition, my goal is to get them feeling well again. It has to do with function, but it is not something I explicitly think about as much.

Some clinicians were goal-oriented, but did not conduct explicit goals discussions. These clinicians worked under the assumption that they and their patients know the patients' goals implicitly:

> I would just assume that everyone wants as much function as possible, no matter where they are in their life, no matter what their prognosis is.

A second physician stated:

> My goal for them is functioning as well as they can in the community and that's what I'm always thinking about. I don't think, "I think that's what my patients want." They don't expressly say that they want to be independent, but I think that's what they want.

Other clinicians favored having an explicit discussion of goals:

> It seems like it would be easier to have that conversation so they can volunteer more easily, "I want to get to my grandson's graduation and be independent and not be a burden on my family."

Some physicians felt it was their role to make the association between life and health goals for patients:

> It's up to you to actually make that connection as their doctor.

These clinicians related life and health goals to each other, and asked patients very specifically about their goals:

> I talk to my patients in the geriatric clinic like, "What do you do in an average day? Do you go grocery shopping? Do you go to Walmart? What things do you like to do? What can we do to maintain you at that level? Is there something else you'd like to be able to do? Let's try working towards that.

Goal-oriented clinicians reported that goals discussions are most helpful during a first contact with patients to get to know them better, or when there is a "gray zone" and a concrete plan would be helpful. Goals discussions were also favored as part of preventative discussions, to help prioritize and focus treatment goals, and to support patients:

> [Cancer patients] are a really good example. They're coming in for chemo, for radiation. They're losing their hair, all these physical changes are happening to them, but if you can keep them focused on the greater goal of getting better-- your hair will grow back, things like that— it… makes them a lot stronger in will to succeed.

Nurses also used goals as a means of supporting patients, and added that they see goal setting as ongoing instead of a one-time conversation:

> I think as the patients move through the program and they'll start with a walker and then they do well and then they'll graduate to a cane, so you say, "You mastered that, now your next goal is to master the cane and be safe and then move on." I think we do it ongoing.

In this way, clinicians distinguished between short and long-term goals:

> We look a lot initially at short-term goals, like if they had a stroke they need to focus on a safe transfer so that down the line they could go home and be safe to do things at home on their own. So my idea is I look at it as short-term and then bring that in play for a longer term success.

Some nurses felt there was a difference between the medical and nursing approach to goals:

> I think the doctors have specific things more or less. If someone comes in with a cardiac problem, that's what they're going to concentrate on. They're not going to concentrate on a bowel movement or do they have money to buy meds. There are like a thousand other things that go with it. That's not really their focal point. Their focal point is more directed. It's in what they're here for. Whereas nursing gets involved and they get more global. They look at the whole patient and the whole patient situation.

3.4 Themes: Systemic and Interpersonal Factors

Analysis revealed several themes that influence goal setting. These factors could be grouped into two areas: systemic factors and interpersonal factors. Themes and subthemes are described in Table 4.

3.4.1 Systemic factors—A common theme that emerged as participants described the way they discuss health goals with their clinicians involved systemic factors. Systemic factors included characteristics of the health care system that influence the time, manner, or content of goals discussions. Systemic factors reported included: 1) that goal setting was not a priority given limited time, and 2) patients' perceptions that clinicians were more inclined to prescribe medications.

Not a priority given limited time.: Lack of time during the medical encounter was widely reported by both patient and clinician participants as a major impediment to their ability to fully discuss goals. Patient participants described the blur of rushed visits:

> They don't have enough time to talk to us. Always the consultations are very brief. Something you could hurry up and your 10 minutes are up.

Another said,

> He doesn't say so, but I know he has to get rid of me as soon as possible so that another patient will come in.

Patient participants felt that the brevity of the visits affected what could be discussed. They reported visits to be routine, addressing only specific complaints rather than broader health issues. This situation discouraged patient participants from bringing up their health care goals:

> I know it's difficult for a doctor to take a personal interest in every patient, but they give you short sessions. You just go in and it's all routine and you're reluctant.

Another said,

> I'd like the doctor to know me, but you can't do that now. You don't have the chance of a snowball in hell. You go to see a doctor, you're out in 10 or 15 minutes. He's reaching for his prescription pad or something.

Visits seemed to be a struggle against time to have their concerns heard, goals discussed, and questions asked and answered. Patient participants reported this to be a very frustrating experience, although some understood the pressures of today's health care system. Nonetheless, they felt their health goals warranted time for discussion and wanted more out of the clinical encounter:

> They're busy and they want you in and out and so forth. The question is, how do we all get this over to them that these are things that need attention?

Patients' perceptions that clinicians were more inclined to prescribe medications.: Many patient participants reported the feeling that physicians preferred to prescribe medications instead of having a goals discussion. Some felt that, with the increased availability of information, clinicians assume they should utilize available interventions, but that these interventions may not further patients'goals, or may preclude discussion of goals.

> He is quick with the medication, so you can't talk it out with the doctor.

Another patient participant discussed his dissatisfaction:

> In fact, I did get prescriptions. Most of them don't agree with me either. They make me dizzy. They make me listless. I have hypertension like up to there and everything I get isn't cross-tested, so… those are my two qualms.

3.4.2 Interpersonal factors—

Interpersonal factors include features of the clinical encounter. Interpersonal factors included: 1) patients' perception of the clinician as the authority in the relationship, and 2) the presumption that all patients' goals are the same.

Patients' perception of the clinician as the authority in the relationship.: Patient participants reported feeling that their clinician was the authority in the clinical encounter, meaning that the clinician provides technological expertise and orchestrates the appointment. Patient participants were comfortable and expected clinicians to provide technical information:

> He knows about the medication. He's the one that has to tell you.

Patient participants respected clinicians' advice and in many cases stated that they followed the clinician's instructions unquestioningly:

> I will always do what they recommend. I have great faith in them.

> I believe in them and I do what I'm told to do.

Others preferred to be more involved in the formulation of a treatment plan, but left the ultimate decision to their clinician:

> I go to my doctor and have a discussion with him with respect to my illness, and he discusses it with me and he decides on what I should be taking, and I take it. Period.

One patient participant described his perception of his clinician:

> The doctor I had before was very communicative. He would answer all your questions. He was somewhat of a teacher because he explained how my insides worked so I understood everything.

Patient participants felt that discussion of goals was personal or even embarrassing, and that trusting their clinician was important to facilitate conversation about goals.

> Once you get your rapport with them, it's easier… but when you're new, you're in trouble.

Presumption that all patients' goals are the same.: Upon initial questioning, participants reported that they thought everyone's goals were the same, e.g., to be healthy:

> If you ask a question of what are lifetime goals for health, I'll tell you everyone feels the same way. A person would like to be healthy.

Some felt that they had already achieved a goal of long life, so achievement of any additional goals was "icing."

> …what other goals could there be other than to survive?

Upon further prompting, however, participants reported very specific, individual goals, such as being able to walk stairs, or improving hearing to enjoy concerts. Patient participants said they were not prompted to think about goals, which discouraged discussion of goals. Some reported that they thought their clinicians could assume what their goals would be:

> Don't you think a doctor would know? We have the same goals as he or she has.

4. Discussion and Conclusion

4.1 Discussion

This study suggested several factors that affect goal setting between patient participants and their clinicians, including the systemic factors that goal setting was not a priority given limited time and patients' perceptions that clinicians were more inclined to prescribe medications, and the interpersonal factors of patients' perception of the clinician as the authority in the relationship, and the presumption that all patients' goals are the same. These factors impeded efforts to discuss patients' goals within the clinical encounter.

Patient participants expressed concerns about discussing goals with their clinicians, which they felt was personal, and that they do not often know their clinicians well enough to have this intimate discussion. Thus, although the systemic factor of limited time is a hindrance to goals discussion, perhaps the greater obstacle is the interpersonal factor that "one doesn't do it"—one doesn't talk about goals with one's clinicians. Yet many participants did not even grasp the concept of goal setting until a discussion among focus group participants was started. The vague goals mentioned, e.g. "to be healthy," may represent the fact that goal

setting was a foreign concept to patient participants, and that they therefore had not had the opportunity to develop their concept of goals in greater depth. In some cases, despite multiple probes to elicit more detailed goals, patient participants were unable or unwilling to expand upon their health goals; however, because life goals and health goals were identified similarly among patient participants, we believe they are the subject of shared decision making with clinicians.

As the other member of the patient-physician dyad, physicians are not trained to have weighty discussions about health and life goals with patients. Facilitating achievement of goals is different from eliciting goals. To do both requires both medical and psychological skill sets. Clinicians in our study varied in their skill sets and willingness to incorporate goals into their clinical interactions. The issue of goal setting has largely been avoided in clinical encounters because historically patients presented with acute problems and the assumption was that the physician made the acute problem go away. Treatments were deemed effective if the patient returned to their normal health and function. Nowadays, the same interaction occurs around symptom control for acute exacerbations of chronic conditions. Acute symptoms can be controlled, at least temporarily, but the patient is often not “back to normal” or cured. The importance and impact of this distinction has not really penetrated contemporary clinical encounters and patient-physician communication. Clinical goal-setting, therefore, remains an abstract, foreign, or disparaged concept, even when it has been shown to be an efficient and effective method of clinical care.[28–35] Therefore, obstacles to goal setting arise from both members in the clinician-patient relationship.

Goal setting is clinically relevant for two main reasons. First, goal setting facilitates shared decision making through various direct interventions within the doctor-patient relationship (e.g. enhanced communication, discussion of preferences for care, and development of physician-patient agreement regarding treatment goals.[35] Second, goal setting may improve the outcomes of clinical interventions (e.g. increased use of preventative services, enhanced attainment of chronic disease management endpoints, improved function after rehabilitation, etc.).

For example, a study of older patients with Type 2 diabetes[28] found that patients framed their goals for their diabetes care in terms of functional outcomes (e.g. maintaining independence) rather than traditional diabetes outcomes (e.g. glucose control). Another study[29] on perceptions of health maintenance behaviors among rural older adults likewise reported that the lay definition of health overlaps with, but is not synonymous with a biomedical model. These findings, like our own, suggest that use of goal setting in the clinical setting can help improve physician-patient communication, capture patients’ specific values and circumstances, and assist in the development of successful individualized care plans.

A few points must be considered when interpreting our findings. Our patient participants were generally well-educated and functionally in good health, both of which may reflect greater desire for participation in goal setting. Additionally, our patient participants also had a mean age of 81 years. Attitudes towards goal setting may differ between the young-old and oldest-old, and these findings may be confined to only members of the current generational

cohort. Younger cohorts (e.g., baby-boomers) may have significantly different perceptions of goal setting and shared decision making.[7] Our clinician participants worked in specialties in which contact with older patients is routine. Therefore, they may be have been more attuned to goal setting than clinicians who have less contact with the older population. Finally, since all participants were from Connecticut, generalizability is limited.

4.2 Conclusion

Patients and clinicians expressed differences in their willingness to use a goal setting approach. Setting goals is a standard management procedure and a common start to any project. Yet while goal setting is a staple practice in other fields,[11] medicine seems to be an exception. Medicine, for many of our participants, was not about goals. Most of the participants thought goal setting was a good idea in theory, but not possible in practice because of systemic and interpersonal obstacles.

It is important to consider what makes medicine different from other fields where goal setting is basic. Until recently, it has not been part of the culture of medicine to talk about goals. The addition of financial and time constraints create an environment where goal setting is even more difficult. What may be useful to facilitate goal setting within the current medical system is a method. A specific goal-setting method could: 1) serve as a rapport builder; 2) give structure to goal setting conversations, 3) make goal setting a fixture within the medical encounter as part of routine paperwork (or in place of existing paperwork, e.g., SOAP note); and 4) improve the quality of health care because information could be shared with other providers, thereby reducing fragmentation in care. A framework based on patients' values and preferences has been developed to guide decision making about cancer screening among older patients.[30] Developing a goal-setting instrument and training medical practitioners in its use is likely to diminish impediments to shared decision making among elderly patients.[35] Efforts can be made to encourage patients to participate in setting treatment goals. However, a procedure that puts the onus entirely on practitioners has limited value. For decision making to be truly shared, patient and practitioner alike must be willing and able to contribute.

4.2.1 Practice Implications—This study identified key factors that affect goal setting within the clinical encounter. Improving clinician-patient interactions by addressing these factors may facilitate shared decision making with older persons. Innovations to improve goal setting must be time-efficient and well-integrated with the technological advances in medicine. There may be certain times over the course of care when goals are more relevant; e.g., at the outset of the clinician-patient relationship, or after a major health event. Future research might test the hypothesis that setting goals initially and reviewing them periodically using a goal-setting instrument may be a comprehensive, yet time-efficient way of integrating patients' goals into their care plans, thereby promoting shared decision making.

Acknowledgements

The authors would like to thank Shirley Hannon, RN, for her assistance with identifying participants and performing initial data collection for this study.

This research was supported by the Hartford/RAND Foundation. This paper was presented at the Annual Meeting of the American Geriatrics Society held in Las Vegas, Nevada in May 2004 under the title, “What hinders shared goal setting between older adults and their clinicians?”

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Table 1.

Patient interview guide

(1) What do you think of as goals for your life? (goals = expectations, desired outcomes, motivations, or what would you like to achieve …) (a) What is the relationship between life goals and your goals for your health or health care? (b) Do you ever relate your goals for health and health care to what you want to have happen when you visit the doctor or nurse?
(2) Thinking about the goals you have for your health care, how did you decide on these goals? What or who influenced your choices?
(3) How do you talk about goals with doctors? With nurses? (a) How might you like to talk about goals? (b) What would you say? (c) What would you like the doctor to say or ask?
(4) How well do you think you and your clinicians agree on what your health care goals are? (a) What works well for you when talking to your clinicians about your health care goals? (b) What does not work well? (c) How do you wish you and your clinicians would talk about health goals?
(5) Our objective was to understand how patients think about health care goals. Is there anything else I should have asked you to help us better understand this issue?

Table 2

Clinician interview guide

(1) How would you define goals for health or health care?
(2) How would you differentiate between “medical/health care” goals and “life” goals? (a) What is the relationship between goals for health and the outcomes of medical care?
(3) How do you generally talk to your patients about their health care goals? (a) How do you or your patients differentiate between health care and life goals? (b) How do you or your patients differentiate between general and specific goals? (c) How do you or your patients differentiate between short-term and long-term goals?
(4) How well do you think you and your patients agree on their health care goals? (a) What works well for you when talking to your patients about their health care goals? (b) What does not work well for you when talking to your patients about their health care goals? (c) How do you wish you and your patients would talk about their health care goals? (d) What are causes or sources of disagreement with patients and their families regarding goals? How are they resolved? (e) What problems seem to arise routinely when talking to patients about their health care goals? (f) What do you think your patients consider as goals and how do they discuss them with you?
(5) What would help you to capture patient goals?
(6) Our objective was to understand how clinicians think about health care goals. Is there anything else I should have asked you to help us better understand this issue?

Table 3.

Characteristics of study population

Characteristics	Value
Patient groups, n	42
Age, mean ± S.D.	81.1 ± 7.1
Female, n (%)	27 (65.9)
Education in years, mean ± S.D.	15.3 ± 2.9
Lives alone, n (%)	27 (65.9)
Self-rated health (0–4), mean S.D.[a]	3.4 ± 0.9
Chronic conditions, mean ± S.D.	2.1 ± 1.1
Functional status (0–28), mean S.D.[a]	25.6 ± 2.5
Clinician groups, n	11
Age, mean S.D.	42.2 ± 11
Female, n (%)	9 (81.8)
Physician, Internal Medicine	3
Physician, Geriatric Medicine	3
Nurse, Geriatric Rehabilitation	4
Nurse Case Manager, Geriatrics	1

[a]Higher scores reflect better values