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

Dena J. Schulman-Green [a,*], Aanand D. Naik [b], Elizabeth H. Bradley [c], Ruth McCorkle [a], Sidney T. Bogardus [c]

[a] *Yale University School of Nursing, 100 Church Street South, P.O. Box 9740, New Haven, CT 06536, USA*
[b] *M.E.D. VA Medical Center, Baylor College of Medicine, USA*
[c] *Yale University School of Medicine, USA*

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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 consider 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; communication about goals, and perception of agreement about health goals. Group interactions were tape-recorded, transcribed, and analyzed using content analysis.
Results: All participants were willing to discuss goals, but varied in the degree to which they did so. Reasons for non-discussion included that goal setting was not a priority given limited time, visits focused on symptoms, mutual perception of disinterest, and the presumption that all patients' goals were the same.
Conclusion: Interventions to enhance goal setting need to address key barriers to promoting goals discussions. Participants recognized the benefits of goal setting, however, training and instruments are needed to integrate goal setting into medicine.
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

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], with older patients less likely to participate [3,7–10]. However, because of the complexity inherent to geriatric care, integration of patients' preferences and goals may be particularly important for this group.

Goal-setting approaches have been shown to increase patients' progress toward mutually agreed upon goals [11–13] and to foster adherence to physicians' recommendations [14]. Despite evidence that goal setting can improve patient care, little is known about what factors may enhance or impede goal setting within the context of geriatric care. Previous studies of shared decision making within the context of geriatric care mainly use survey methods to determine the attitudes and perceptions 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

* Corresponding author. Tel.: +1 203 737 1564; fax: +1 203 737 2414.
E-mail address: dena.schulman-green@yale.edu (D.J. Schulman-Green).

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persons appear less willing to use shared or mutual decision making formats.

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 chose focus group methodology to understand differences in perspectives between patient and clinician participants and to allow ideas on specific goal-setting techniques to emerge from the group. Unlike in-depth individual interviews, focus groups have the capacity to elicit a synergy that individuals alone do not possess [15]. 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 three residential sites from which to gather our sample: a high income independent living facility (one group), a subsidized assisted living facility (two groups), and a private condominium complex (one 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 [16], a 14-item scale of Activities of Daily Living (ADLs and IADLs) [17], 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.

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?

Focus groups lasted approximately one hour and were audiotaped. Following transcription, three researchers (STB, ADN, DSG) independently identified content areas in the first two to three transcripts using content analysis. This analytic process involved line-by-line scrutiny of text to identify and sort segments of data [18]. 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 [19–20].'' Atlas/ti software assisted with data coding and analysis.

3. Results

3.1. Characteristics of the sample

Patient participants ($n = 42$) were primarily older (82 years ± 7), female (66%), well-educated, lived alone (66%), had an average of two 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 patient participants had active, chronic conditions for which they were