



by Pallium Canada

Updates & Innovations in Essential Conversations for the Health Care Team

Session Topic: Goals of Care in the Acute Care Setting: Drawing in the Team

Presenters:

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Dr. Gary Miller, Critical Care Physician

Emily Sullivan, Acute care Speech Language Pathologist

Wednesday March 18th, 2026 12:00pm - 1:00pm

Agenda Item	Discussion
<p>Introduction & Key Themes</p>	<p><u>Overview:</u></p> <ul style="list-style-type: none"> • This lecture focused on goals of care conversations in acute care settings, emphasizing an interprofessional team-based approach. • The session explored how healthcare professionals across disciplines including physicians, nurses, speech-language pathologists, occupational therapists, social workers, and other allied health members can collaborate to elicit, document, and honor patient goals and values throughout their hospital journey. • The presenters shared practical strategies, real-world case examples, and evidence supporting the importance of early, ongoing, and team-centered goals of care discussions that extend beyond end-of-life planning to encompass holistic patient-centered care at every stage of illness. <p><u>Objectives</u></p> <ul style="list-style-type: none"> • To reflect on the value of adopting an interprofessional approach to goals of care conversations in acute. • To consider the factors that encourage or hinder an interprofessional approach to GOC conversations. • To identify strategies that may facilitate GOC training amongst acute care residents and medical staff.
<p>Presentation Key points</p>	<p><u>Defining and Reframing Goals of Care Conversations</u></p> <ul style="list-style-type: none"> • Goals of care conversations were defined as ongoing dialogues between care team members and patients or their support people that get to the heart of what matters most to the patient while establishing shared understanding of their health situation. • These conversations guide care delivery at every stage of a patient's health journey and can inform decisions beyond the current acute care admission, including discharge destinations and degree of intervention. • The presenters emphasized that goals of care conversations are often incorrectly conflated with formal family meetings, difficult news disclosure, prognostic updates, or exclusively end-of-life planning discussions. Instead, they should be viewed as a normal part of care provision sometimes called "the sixth vital sign" that lays groundwork for holistic medical recommendations and interprofessional care planning.

- The session highlighted that these conversations provide a compass for the entire care team, ensuring everyone is "paddling in the same direction" in partnership with patients and families. They often consist of several bite-sized conversations or multiple meetings that address the holistic healthcare needs of patients and their support systems.
- Research presented showed that while 70% of patients would prefer comfort-focused care approaching end of life, very few have documented these preferences. In the absence of proactive goals of care conversations, healthcare systems see increased ICU admissions, disparities in intervention levels, and unnecessary hospitalizations or transfers from community settings. Conversely, team-based approaches to these conversations result in significantly increased rates of family satisfaction with care and improved patient experience.

Q&A

Q: How do we coordinate communication between the care team given varying schedules and capacity barriers? Is there value in having a single point coordinator?

A: While various interventions have been trialed including liaison persons who initiate conversations, everybody at point of care needs conversation tools for organic moments that arise unexpectedly. Having a point person has benefits, but we must continue upskilling all staff across professions. The small hallway conversations and even brief 5-minute gatherings before family meetings can be effective. Time spent upfront in coordination ultimately saves time by reducing need for repeated meetings.

We all document in the same place and are responsible for reading what others say. Before discussions, one can look through the chart for background from previous admissions, OT notes, etc., to incorporate into goals of care conversations. If you recognize something important, either speak to someone or document it, as that's where to look before talking to patients.

Interprofessional Approach to Goals of Care

- The presenters distinguished interprofessional approaches from multidisciplinary or interdisciplinary models. In an interprofessional approach, team members view each other as having overlapping expertise while appreciating unique contributions each profession makes to achieve common goals. This requires recognizing that within each profession's scope of practice exists unique perspectives and expertise that better support diverse patient and family needs beyond the physical. The key difference from multidisciplinary approaches is the reliance on one another through mutual trust, increased collaboration, and recognition of shared roles common to multiple professions. In contrast, multidisciplinary teams may work in parallel on the same patient with stricter disciplinary boundaries and potentially different goals without a clear common direction.
- All team members occupational therapists, physiotherapists, social workers, speech-language pathologists, physicians, nurses, and others have roles to play. Many conversations happen organically as natural parts of interactions with patients and families, and patients choose whom they feel safe talking to and how much personal information to share. This person might be the physiotherapist, dietician, care aide, or even housekeeping staff. Therefore, all team members need tools to skillfully handle emerging conversations and listen for trigger statements or natural windows of opportunity.
- Using different interprofessional perspectives allows teams to address spiritual, financial, psychosocial, and vocational concerns that define who patients are and how health conditions impact their daily lives. When teams lean into their areas of expertise and trust each other to practice within full scope, they create a comprehensive picture of the patient.
- The Vancouver Coastal Health Goals of Care Support Team promotes interprofessional approaches by tailoring education to discipline-specific case studies and workflows, collaborating with practice

leads, socializing shared responsibility, encouraging pre-meeting coordination, treating all team members as intelligent and capable, and fostering psychological safety. The team itself comprises multiple professions including three nurses, a social work lead, and an occupational therapy lead, which enriches the education provided. Their infrastructure includes policies, practice guidelines, monthly interprofessional workshops with simulation, quarterly webinars, newsletters, and resources on the Learning Hub accessible to all health authorities.

Discussion from Participants

A participant commented that it's helpful when physicians reinforce conversations about progressive decline, but when physicians avoid these discussions, it makes it harder for families because of the "white lab coat" authority. Having medical staff on board makes conversations easier and helps with proactive planning before situations escalate in acute or ICU settings.

The presenter agreed, further highlighting the importance of all professions being equipped with conversation skills while also having physician engagement to reinforce key messages.

Allied Health Contributions and Case Example

- Emily, a speech-language pathologist, described how looking for opportunities to have goals of care conversations as part of normal routine helps her understand how to best support patients. She routinely uses strategies from the Serious Illness Conversation Guide, particularly the wish, worry, wonder approach, which allows clinicians to show they've been listening to patient hopes, express realistic concerns empathetically, and explore alternatives. For example, when working with someone wishing to communicate verbally but unable to do so effectively, she might express her wish for the same outcome while worrying about others understanding the patient's needs, then wonder if alternative communication methods might help.
- Another key strategy is assessing patients' and families' understanding of health situations, which helps clinicians appreciate whether education has been understood and provides opportunities for further teaching to support decision-making. Using patients' own words when they describe their understanding allows clinicians to meet them where they are. Emily noted that patients and families who have had prior goals of care conversations seem to experience less anguish when making difficult decisions, while those learning information for the first time during medical crises struggle more under emotional stress and time pressure. Early and frequent conversations help guide decision-making processes aligned with specific goals and values, even when families initially defer to clinician expertise.
- Emily presented a detailed case of a frail elderly gentleman with advanced dementia and worsening swallow dysfunction admitted with influenza. Over several weeks, different team members had many goals of care conversations, effectively sharing what they learned. The social worker identified the benefit of interpretation services; Emily learned about the son's concerns regarding aspiration and hopes for oral feeding; the son expressed worry about starvation without tube feeding; the nurse specialist provided education about dementia progression and nutrition needs; and Emily documented the patient's clear nonverbal communication showing desire to eat orally. This collective information gathering allowed the team to center the patient's wish to eat orally when discussing medical options, with each discipline contributing relevant expertise about medical implications, aspiration risk mitigation, and quality of life benefits. The team consensus was that the interdisciplinary approach was key in supporting the family to develop a management plan aligned with their values.

Discussion from Participants

A comment was made that Goals of care information often comes up naturally during night toileting and bedside care in quiet one-on-one moments. Permission from patients to share with the team has always been granted.

Another comment: As a social worker supporting long-term care, I worked with a wife wanting her spouse to continually return to hospital. Digging deeper revealed she needed confirmation she had done everything possible; an emotional rather than medical rationale. Once the MRP confirmed they could provide the same care in the home setting, it alleviated her distress and helped the nursing team shift how they discussed options, demonstrating the value of exploring underlying concerns.

Physician Training and Team Culture Transformation

- Dara described various formats for engaging residents and acute care physicians at Vancouver Coastal Health, including longer workshops with conversation guides and simulation, and shorter discussion-based sessions where learners share strategies with each other.
- Common topics requested by ICU residents include differentiating goals of care from code status or MOST levels, handling family disagreements, managing unrealistic expectations, navigating cultural and language barriers, and dealing with moral distress. She has residents reflect on patients from handover, considering five key questions: When was the last time we learned the patient's or substitute decision maker's understanding in their own words? What are they hoping for? What are their worries? How have they defined quality of life? What falls into acceptable versus unacceptable outcome categories? Physician attending training has been adapted in various ways, supported by SSC funding, CME and CPD credits, development of champions like Gary to role model and mentor others, flexibility in delivery timing, and tailoring case studies to specific specialties in collaboration with Providence Healthcare. The Goals of Care Support Team also provides real-time support for preparing, debriefing, or being present during conversations to help medical staff gain comfort.
- Gary shared personal lessons learned throughout his career, emphasizing starting conversations before crises happen, ideally in outpatient settings for elderly or deteriorating patients. He stressed the importance of listening more than talking, as physicians tend to over-explain prognosis while underexploring what patients value. Simple questions like "What does a good day look like for you?" or "What are you most afraid of?" reveal more than quality of life checklists. He noted that prognosis differs from goals; patients organize lives around meaning, relationships, and function rather than survival statistics. Family dynamics must be acknowledged explicitly without pitting members against each other or the team. When patients say "do everything," it usually expresses love and fear rather than specific treatment directives, often meaning "don't give up on me."
- Gary emphasized that hope and honesty coexist, with patients reporting less anxiety and better outcomes when given honest information. Uncertainty should be admitted to build trust. Documentation and revisiting goals as illness progresses is vital. He shared a story of a cleaning woman who discovered a patient crying because no one had explained her situation, illustrating that input can come from any team member. He presented research showing transformation from physician-dominated toxic cultures to constructive ones through shared reasoning, valuing all team members' knowledge, and thanking people for speaking up.

Q&A

Q: Would it make sense to have a unified person dedicated to advanced care planning discussions within the healthcare system, similar to a productive Australian project from about a decade ago?

A: Various interventions have been trialed, including liaison persons who initiate conversations, and there are definitely benefits. However, everybody at point of care still needs conversation tools for organic

moments that arise unexpectedly during routine care activities. We need both dedicated support and ongoing upskilling of all staff across professions.

Practical Strategies and Resources

- Timing recommendations for goals of care conversations include: on admission as a normal part of care; when there are important developments such as new diagnoses or significant treatment complications; when patients have been hospitalized for extended periods as goals and needs change over time; and before discharge, especially for vulnerable or frail patients where instability is expected. The presenters emphasized that hindsight is 20-20, making post-treatment reflection an opportune time for these conversations.
- Key strategies for team coordination include: documenting goals of care information in centralized locations accessible across disciplines; brief pre-meeting gatherings to coordinate approach and identify who will lead and what each member wishes to explore; treating all team members as intelligent, capable, and caring; and fostering psychological safety so team members feel safe bringing information forward. The response to information sharing either encourages or discourages future contributions. Including nursing and allied health in family meetings when appropriate, being mindful of topics and availability, strengthens the interprofessional approach.
- The presenters emphasized that silence has consequences when patient wishes change from full treatment to comfort-focused care, the default will be more aggressive intervention without communication. All team members are encouraged to speak up, raise concerns again through different channels if dismissed, and trigger reviews when gaps exist between documented plans and patient-expressed wishes. This advocacy protects something irreplaceable, as families often regret not having earlier conversations to reflect patient wishes.

Next Steps & Resources

- Serious Illness Conversation Guide (original and adapted version from FNHA and [BC Centre for Palliative Care](#) and [this](#))
- Multiple adapted conversation guides available on Vancouver Coastal Health Goals of Care Support Team webpage: [link](#)
- Patient and family worksheet available in 5-6 languages at [vch.eduhealth.ca](#) for reflecting on goals of care questions before family meetings: [link](#)
- Ariadne Labs social work-specific guide for serious illness conversations: [link](#)

Resources

- [Video link](#)