The Goals of Care Loop: How Teams Get Stuck and Oncology Social Workers Restore Alignment

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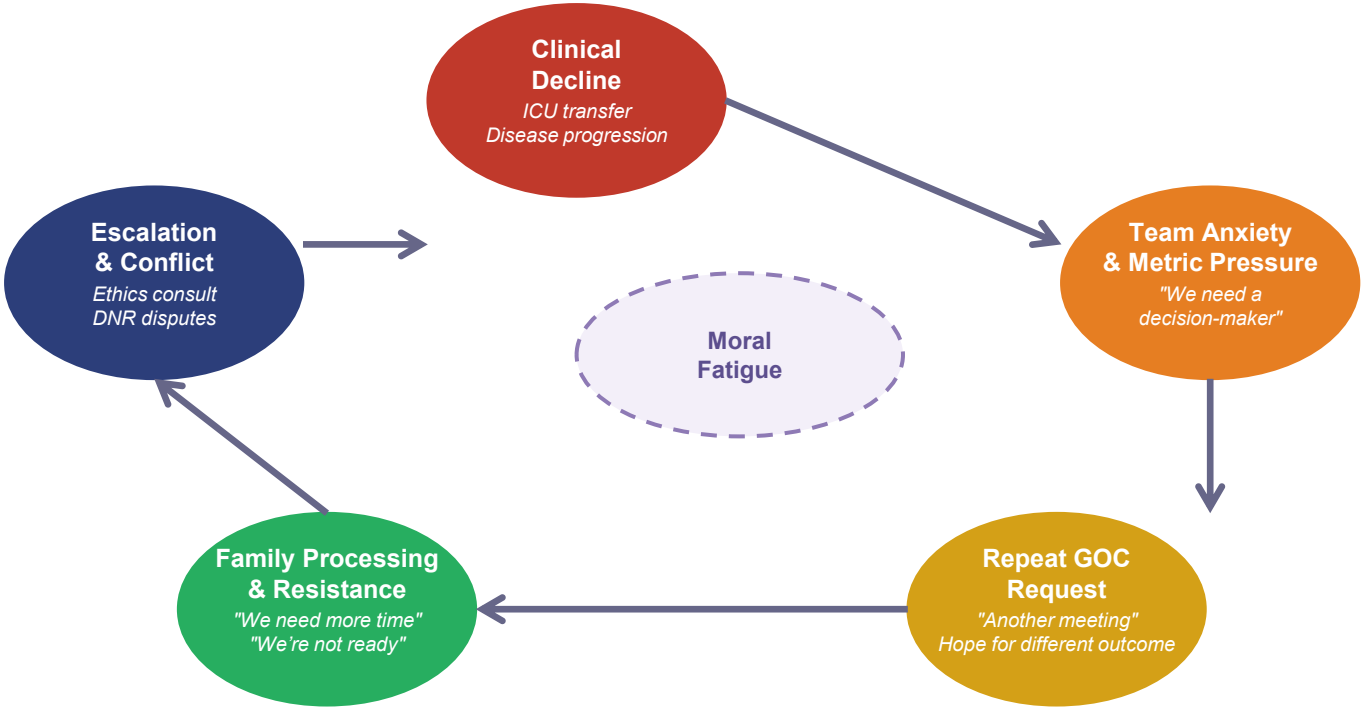
“We need another Goals of Care meeting.”

Does this feel familiar?

The GOC Loop: What's Actually Happening

Reframing communication failure as predictable system behavior

The Reactive GOC Loop



Predictable Reflexes — Not Bad Practice

When teams are anxious and accountability is high, these responses are almost automatic:

- 🔍 Identify MPOA / Legal Next of Kin
- 📋 "The patient needs to be DNR"
- ⚖️ Ethics Consult
- 📝 Document "barriers to discharge"

"These aren't wrong — they're reflexes. But they often increase adversarial dynamics and mistrust, especially in oncology."

GOC Loop Off-Ramps

Upstream Interventions

- Early ACP (in clinic!)
- Values-based conversations (e.g., what is most important? What life experiences may be impacting views about death and dying?)
- Reframing the narrative that comfort care = "giving up".

Goal Reframing/Parallel Discharge Planning

- Plan A rejected --> define Plan B
  - Time-limited trial
  - Function-focused DCP; take value judgements out of it
- Disposition Pathways: SNF, Home with home health, LTAC, nursing home
  - Understand these may be suboptimal

Off-ramps allow for pressure release by removing EOL decisions from the equation.

What the Literature Tells Us—and What It Doesn’t

The Evidence Gap

What the literature acknowledges

- Emotional and relational complexity in family decision-making
- Collaborative, culturally-informed family process
- Importance of prognostic communication

What's largely missing

- Why teams get stuck — not just families
- Risk-averse, liability-driven escalation patterns
- Hospital throughput pressure as a variable
- How to move forward without forcing agreement

The gap isn't in understanding families. It's in understanding what the system does under pressure.

Reframing Progress: From Agreement to Alignment

The Key Reframe

Progress ≠ Agreement

Getting a family to say “hospice”
is not the goal.

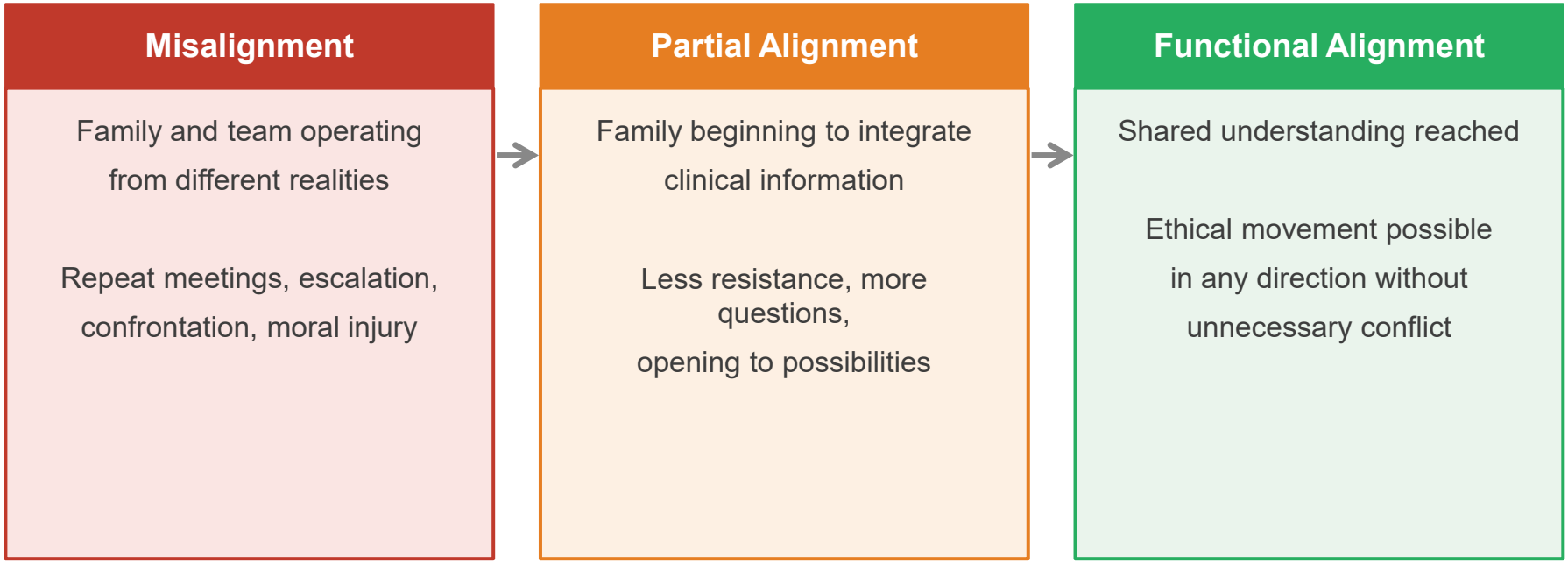
Progress = Alignment

Reduced resistance +
shared clinical understanding.

Alignment: reduced emotional resistance + shared understanding of clinical reality.
Alignment allows ethical movement in any direction — hospice, continued treatment, ICU transfer — without unnecessary conflict.

“This is where social work has unique leverage.”

The Alignment Spectrum



SW intervention creates movement along this spectrum — without forcing any particular outcome.

The Practical Model: Reduce Pressure, Increase Clarity

Two Simultaneous Tracks

Reduce Pressure	
SW	Build rapport with family unrelated to GOC — parking, lodging, support
SW	Be a psychologically safe presence; do not initiate GOC conversations
Team	Allow space for family to witness clinical decline without pressure to decide
Team	Resist reflexive escalation — disagreement ≠ ethical dilemma

Increase Clarity	
MD	Ensure patient/family have accurate, current clinical information
MD	Deliver medical guidance without embedded pressure for a specific decision
SW	Process the emotional weight of medical reality alongside family
SW	Distinguish intellectual understanding from emotional readiness

Case Examples

Alignment achieved · Escalation backfires

Mr. Smith— Background

75-year-old African American male

Metastatic SCLC — traveled from Arkansas to MDA for second opinion with his daughter

Admitted from clinic; prolonged admission complicated by respiratory failure on high-flow O_2 — unable to wean consistently

Thoracic med onc and hospitalist teams had multiple GOC conversations recommending best supportive care / hospice / DNR

After the third conversation, daughter told the team: ***"Stop coming to me about hospice. I don't want to hear that word."***

CASE 1 — The Repeating GOC Case

System Response

- Team anxiety escalated — fixated on daughter as “delaying care”
- Push to consult ethics
- Repeated GOC conversations with same framing
- SW noted: disagreement ≠ ethical dilemma

SW Intervention

- Built rapport on non-GOC needs: parking voucher, local lodging
- Greeted daughter consistently — became a safe, familiar presence
- Did not initiate GOC conversations
- Continued follow after ICU transfer; collaborated with ICU SW

The Shift

- Daughter asked to speak with SW alone
- “Is my dad dying? Tell me your honest opinion — I won’t get mad.”
- Organic opening — not manufactured by the team
- Code status changed to DNR; patient passed peacefully on comfort measures

What Alignment Looked Like

> **“Is my dad dying? Tell me your honest opinion — I won’t get mad.”**
> *— Daughter, unprompted, asking SW for truth after weeks of team pressure*

→ Alignment was NOT the team convincing her of anything

→ Alignment happened when she felt safe enough to ask the question herself

→ Outcome: DNR, transfer to comfort measures, peaceful death — on her timeline

→ Ethics consult was never needed. Pressure would have made this worse.

Mrs. Jones — Background

- 54-year-old African American female with a history of progressive stage IV SCC of the cervix and other co morbidities causing prolong admissions over the course of two years. Treatment naïve and declines medical treatment.
- Admitted for upper GI bleed and recent onset of neuropathy/numbness of bilateral lower extremity with concern for port infection
- Family was not ready for hospice and multiple GOC were arranged however family avoided meetings. As a result, teams' concerns would escalate causing more GOC referrals and family getting upset.
- Patient and family continued to deny care during hospitalization. Family did not want the medical team talking to the patient unless someone in the family was present.

CASE 2 — When Escalation Backfires

System Response

- Team becoming frustrated with patient and the family's refusal of care and making it difficult to communicate with patient and family.
- Daughter were suspicious of medical team's interventions
- Repeated GOC conversations.
- SW noted: No clear goal from the family. Resulting in conflict between medical team and family.

SW Intervention

- Built rapport with patients' daughter. When possible.
- Trying to get the team to understand that escalating pressure with the family was not going get the outcome they wanted.

Outcome

- No shift with the family. Patient had a stroke and was transferred to the ICU where she passed away.
- Code status was never changed to DNR.

Quality Improvement: Goals of Care Workflow Initiative

Early data + baseline survey domains

Why a Structured Workflow?

The Problem We're Trying to Interrupt:

- GOC conversations were happening reactively — triggered by crises and institutional throughput pressures, not family readiness.
- Social workers relegated to doing secretarial work without clinical depth; scheduling, setting up a zoom meeting, etc.
- Escalation (ethics, palliative, MPOA pursuit) was the de facto next step
- Staff moral fatigue was accumulating without a named intervention pathway

Baseline Survey Domains
Family perception of communication and alignment
Healthcare team perception of communication effectiveness
Family and healthcare team ideas for improvement

Note: This is baseline / early data. We are not presenting outcomes.

What Ad Hoc Looks Like: Pre-Intervention Baseline

Baseline survey of current, unstructured practice — themes are what the workflow is designed to address.

Pre-Meeting Is Critical — And Noticed When Missing

Providers across disciplines flagged absent or rushed pre-meetings as a direct cause of disorganized family communication and misaligned team messaging.

Social Work Role Not Consistently Respected

In several cases SW was excluded mid-meeting or reduced to logistics coordination — despite being the named clinical lead. Role clarity is unresolved across teams.

Earlier SW Involvement Is Being Requested

Providers and nurses noted SW was engaged too late — after team-family dynamics had already deteriorated. Earlier, proactive SW presence was explicitly requested.

Provider Attendance and Accountability Gaps

No-shows, non-responses, and “I don’t have time” were documented across cases, with no current mechanism for follow-up or shared accountability.

Pre-intervention baseline only. These themes define what a structured workflow is designed to change.

Discussion

Your experience with the GOC loop

Turn and Talk — Pick One

1

Where do you see GOC looping on your service?

What does the repetition look like? Who initiates it?

2

What signals tell you a family isn't emotionally ready yet — even when they understand the prognosis?

What do you look for? What does it feel like in the room?

3

Where do you feel pressured to escalate before alignment actually exists?

What drives that pressure? From whom?

5 minutes in pairs → 2–3 comments to the group

Why This Is Social Work's Lane

This Is Systems Work

Not “soft skills”

Navigating system pressure, team dynamics, and institutional reflexes is structural intervention.

Trained for complexity

Social workers hold the relational, cultural, and systemic knowledge that medicine often lacks in these moments.

Unique leverage

SW can interrupt harm without forcing outcomes — that’s the lane. Not a soft add-on. A clinical necessity.

Alignment creates movement.

Pressure creates resistance.

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Citations

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