

Trainee Guide

Best Case/Worst Case Communication Framework

Teaching Session Agenda

1st Hour: Focus on graphic aid construction

1. Introduction (15 min)

- a. Watch BC/WC Whiteboard Video
- b. Debrief and time for questions
- c. Review training itinerary including checklist and how to play a 'good' standardized patient

2. Case A: Graphic aid construction (15 min)

- a. Build BC/WC graphic aid individually
- b. Graphic aid construction in small groups
- c. Small group discussion with input from coaches

3. Case A: BC/WC Demo (15 min)

- a. Large group BC/WC conversation demo

4. Graphic aid creation for case B (10 min)

- a. Read assigned case for the 2nd hour and create a graphic aid. Coaches circulate to provide assistance.

2nd Hour: BC/WC small group practice

1. Case B: Practice in pairs (50 min)

- a. Residents take turns playing surgeon, patient/surrogate/evaluator using the checklist (20-30 minutes per rotation)
- b. Coaches use time-outs to give feedback

2. Follow up plan and conclusions (5 min)

- c. Opportunities for additional practice and evaluation

Assessment

1. BC/WC assessment in pairs (30 min per pair)

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Introduction

Have you ever operated on an elderly frail patient who was very sick, who predictably went to the ICU postoperatively with a significant amount of support, only to have the patient's family come see her the next day and tell you to stop all aggressive treatments and allow her to die? We believe that this is a difficult and frustrating problem for surgeons, patients and their families because it can lead to postoperative conflict. Furthermore, providing unwanted care is upsetting for all involved. We have developed an intervention that we think might help with the problem of unwanted care.

We believe the problem in this setting is the language of informed consent, a process we have all been taught to use to make these critical decisions. We are not looking to criticize individuals' current practices nor do we believe that surgeons are poor communicators. Instead, we are concerned that innovation in patient-doctor communication has not kept pace with the vast technical innovations we have witnessed in surgery. Currently we can treat an abdominal aortic aneurysm percutaneously, repair an aortic valve similarly, or take a colon out laparoscopically but we are stuck with 50 year-old communication tools – namely informed consent – for making decisions about whether such operations are valuable to patients. Our goal is to teach surgeons a new communication strategy – a framework – that we believe will help patients and their families make better decisions.

We have developed a communication tool – an intervention to support decision-making – which several clinicians have used at UW to help patients make difficult decisions. Similar to the laparoscope, the success of this tool depends on the surgeon's ability to learn to use it clinically. Notably, the laparoscope was a tremendous innovation; of course it's a great tool, but the success of the intervention depended entirely on surgeons learning to use it. Today, and over the course of the next several months, we will use hands-on learning techniques that we hope will help you and other surgeons to develop comfort and expertise using this innovative communication tool.

Constructing the Best Case/Worst Case Framework

Simple pen and paper diagram

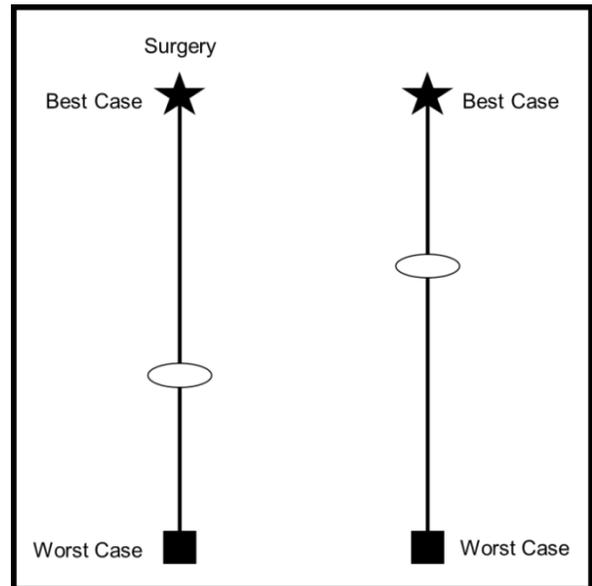
Each vertical line represents a different treatment choice (can be used when there is more than one alternative)

For example:

- Surgery vs. medical management
- Surgery vs. lesser surgery
- Surgery vs. supportive care
- Surgery vs. medical management vs. supportive care

A star at the top ★ of the line represents the “Best Case Scenario,” a box at the bottom ◼

represents the “Worst Case Scenario,” and an oval on the line ○ represents “Most likely.”



Before you start discussing outcomes, it is important to break bad news that this patient has a problem that may be life-threatening. Tell the patient, “I have bad news...”

Tell a story about what the patient’s life would look like in the best case scenario, including the impact of other chronic illnesses and the story about what it takes to get there

- Tangible long-term outcome of proposed treatment
- Short-term implications, including the proposed treatment and short and long term recovery (ICU, SNF, LOS)
- What this looks like in the larger context of the patient's overall health (discuss major chronic illnesses and/or terminal illnesses and the likely course of these illnesses after surgery)

Then tell the story about what you imagine to be the worst case outcome.

- Include the reasonable worst long-term outcome
- Describe what happens between now and the worst long-term outcome
- Death in the operating room is not typically viewed as the worst outcome by most patients, death in the ICU after weeks of complications is considered worse (by most)

Write short notes on the paper describing each case

Process is the same for treatment #2 and/or #3

Incorporate the best information available including the evidence base and your knowledge of the patient’s clinical condition to estimate the most likely outcome

- Circle a point on the line representing where the most likely outcome falls between best and worst case
- Try to avoid using percentages and numbers, instead interpret that information to describe for patients what it means to him/her
- There might not be any outcome between best and worst case, this should be acknowledged, note which is more likely (best or worst case) and acknowledge the possibility that the other could occur
- Language to use: “what I think is most likely...” or “what worries me the most based on your X, Y, Z problems....”

Once the framework is mapped out: Encourage Deliberation

- “How are you thinking about this?”
- “What are you thinking?”
- “What’s the most important thing for you?”

Write on the bottom of the graphic aid, “What is important to you now?”

Make a recommendation based on feedback from patient/family

Leave the paper diagram with patient and family

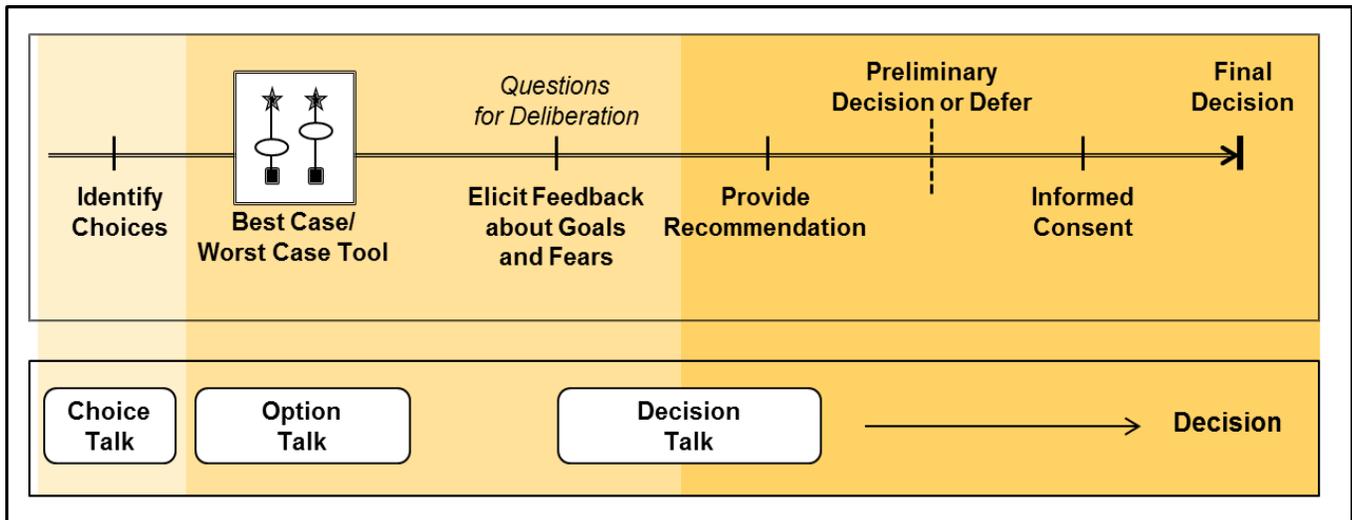
- Our focus groups of older adults liked the idea of sharing this information with family, nurses and other physicians using the diagram
- This may allow other consultants to contribute to the decision-making or understand the rationale, adjust best case/worst case scenario using their expertise

If patient chooses surgery, you will still need to obtain formal informed consent

Important notes to remember when thinking about Best Case/Worst Case:

- *Tangible long-term outcome:* try to avoid the term “nursing home” without describing what that means. Instead, “You will be dependent on others; for example dependent on your family, or need to live in a nursing home.”
- *Larger context of patient’s overall health:* You can begin the conversation with: “I have bad news” or “I’m concerned that... (e.g. you’ve been in and out of the hospital, you are frailer, more vulnerable, you have all these other problems etc.)
- *If supportive care is an option:* “By choosing this option, it is an acknowledgement that this problem will take your life.”

Theory-Driven Tool Development *(see included papers for reference)*



To make decisions consistent with their preferences, older adults need information about possible interventions contextualized into a personal framework.¹⁻³ Shared decision making, in contrast to informed consent, allows patients to express values and outcome preferences so physicians can, in turn, enable patients to make decisions that reflect these values.⁴ For medical decisions involving high-risk treatments and uncertain outcomes, engaging patients through shared decision making can ensure the optimal clinical choice.⁵

Decision support interventions, such as patient decision aids for prostate cancer screening,⁶ increase shared decision making in clinical practice, and are well described.^{7,8} However, some decision aids may actually inhibit *shared* decision making, as they contain comprehensive information and are designed for independent use outside of a clinical interaction.⁹ Building on the conceptual model proposed by Elwyn,^{10,11} we have developed a decision support intervention specifically for face-to-face clinical interactions that promotes dialogue and patient deliberation, and supports shared decision making in the context of life-threatening illness. It is designed “to engage patients in a discussion about preferences” and to “assist them with the emotional work of considering future prospects.”¹⁰

From a conceptual perspective, our intervention specifically supports shared decision making between surgeons and older adults facing life-threatening illness. In contrast to standard decision aids that are designed to be used independently, our intervention answers the call for in-the-moment, face-to-face decision support interventions used during a clinical encounter.¹⁰ It provides a structured framework that promotes dialogue and deliberation between patients and surgeons about the value of surgery. It shows a confined range of possible outcomes, illustrates that some outcomes are more likely than others, and conveys a choice between two (or more) strategies, rather than one dominant plan with a secondary “alternative.” Because it uses narrative to explain how patients might experience the

range of possible outcomes, not just the isolated risk-disclosure language of informed consent, it helps patients visualize outcomes in a way that they can align with their values and preferences.

Investing in Deliberation: A Definition and Classification of Decision Support Interventions for People Facing Difficult Health Decisions

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JGIM

PERSPECTIVE

Shared Decision Making: A Model for Clinical Practice

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