How to use the
Best Case/Worst Case
Communication Tool

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Overview

• What is BCWC?
• Where does shared decision making fit in a conversation and how is it different than informed consent?
• How to use BCWC
• Practice
The Tool
How Best Case/Worst Case works in practice
Doctor: The next question then becomes is, do we take out your gall bladder or should we take out your gall bladder? And what I like to tell patients is that if we turn to the page in the surgical textbook on cholangitis from a gall stone, the answer is simple. Take out the gall bladder because that’s the source of the gall stones. We don’t want any more gall stones coming down there. So you may ask, “What’s the problem then?” Of course we do that. Well, to take out the gall bladder means having a surgery. And we want to make sure when we do surgery on people that it’s the right thing to do and that we don’t hurt you more. So the reason we take out the gall bladder is to prevent this problem from happening again. This, this problem has now been solved for this episode, okay? But we sure wouldn’t want to do something that would give you a bigger problem, or hurt you in some way. So in general with gall bladder surgery, everyone who gets a gall bladder taken out for any reason has some of, shares some risk. And those risks are bleeding, um, infection in the area we operate, damaging the liver, damaging that vein drainage duct which we call the common bile duct, damaging intestines around in the area. So lots of things could go wrong. And that’s for everybody. Um, but if you’re someone who has other medical problems, any one of those problems which would be a big deal in someone that’s otherwise healthy turns into an even bigger deal and potentially a life-threatening deal. And so we just take a little bit of pause and make sure that everyone is able to undergo surgery. So when I started to look at your information, a couple things made me take a little bit longer pause. One was the heart problem that you’ve had in the past. You had a heart attack.
“So, so if we think about um care for someone like him at this place there’s there’s probably a best case scenario that we can lay out for you is one option if we do the surgical procedure and then the other option is to take him home and make him comfortable and not to have surgical procedure.”
Patients really like it!

• And then you’re onto the whole denial thing of what’s happening you know. So when you have it in black and white, on a piece of paper, you can re-reference it... When you’re more able to take in the information.

• What the particular risks were for you and he had a very nice little piece of paper which we still have that explained the worst case scenario, the best case scenario. And that’s nice to refer back to now at this point.

• ...it actually helps me, now when I’m with my dad at his doctor’s appointments to, to ask more questions when I’m there. If, if anything um, I, I kinda think sometimes his doctor’s office could use something like this
Providers Like it (N=22)

- **Saves time**: Score 4-5
- **More benefit than harm**: Score 4-5
- **Reliable method**: Score 4-5
- **Better than what I usually do**: Score 4-5
- **Easy to use**: Score 4-5
Death: the D-Word

• Avoid Euphemisms:
  – The end of the road, hospice, nothing more we can do, comfort care, palliative care, out of options, may not make it, change our focus, quality of life, think about our goals, can’t change the course, make comfortable

• The most terrible outcome is usually not dying in the OR but a prolonged course ultimately leading to death.

• Work on stating this reality empathically and in a way which cannot be misinterpreted.
  – Ultimately ending in his death, in the worst case it results in his death in the ICU, he gets home before he dies
Decision Talk

• Phrases for Deliberation
  – “How are you thinking about this?”
  – “What are you thinking?”
  – “What’s the most important thing for you?”

• The Trouble with “Want”
  – Use think and say and tell us
Make a Recommendation

• Take into account the goals and preferences elicited from the deliberation
BEST CASE/WORST CASE

BREAK BAD NEWS

STORYTELLING
INCLUDE OTHER MEDICAL PROBLEMS

MAKE A RECOMMENDATION

TREATMENT A
TREATMENT B

WHAT IS IMPORTANT TO YOU NOW?
Described a BEST CASE outcome
No □ Yes □

Described a MOST LIKELY outcome
No □ Yes □

Described a WORST CASE outcome
No □ Yes □

Graphic aid shows at least 2 possible treatments, clearly named, and for each treatment there is a vertical line with a box, star, and oval/mark to indicate most likely
No □ Yes □

Written diagram includes written Best Case, Worst Case and Most Likely outcomes for each treatment offered
No □ Yes □

Uses patient-friendly terminology in the written diagram
No □ Yes □

Wrote “what is important to you now?” or equivalent phrase on the graphic aid
No □ Yes □

Broke bad news (e.g. “I have bad news...”)
No □ Yes □

Used narrative/ told a story when describing outcomes
No □ Yes □

Included patient’s chronic medical conditions in discussion about treatment outcomes
No □ Yes □

Used questions or phrases to encourage deliberation
No □ Yes □

Made a recommendation linked to patient preferences
No □ Yes □

TOTAL SCORED POINTS:
________ / 15
Practice Overview

• Create a BC/WC graphic aid individually and then as a small group
• Observe a BC/WC demonstration
• Practice using BC/WC in small groups using role play. Use the checklist to follow along and provide feedback.
• Make a graphic aid for case 2
• Practice in small groups
Case 1:

- Mrs. Rodgers is an 83 yo woman with multiple co-morbidities previous stroke, pulmonary embolism 6 months ago on warfarin, and S/P CABG 5 years ago. Lives at retirement home and somewhat dependent on family and visiting nurses because of weakness related to stroke.

- She underwent left hemicolecctionomy for ischemic colitis 8 years ago then developed a large midline incisional hernia which was repaired with mesh 2 years ago. Two days ago she presented with nausea, and abdominal pain at a recurrent ventral hernia site and was found to have partial SBO with a transition point at the hernia on CT scan.

- She has had conservative management of SBO for 3-4 days without return of bowel function.

- Exam: distended, hernia larger than usual per patient, not reducible, tender around hernia site. HR: 80, BP: 145/60. WBC 11.5.
Case 2

- Mr. Starr is a 75 yo man with critical limb ischemia and wet gangrene on left D1-5. Previous BKA on right leg, left sided hemiparesis from stroke, current smoker, lives at home with his daughter, but is fully dependent on her for all ADLs currently. Developed waxing and waning delirium in hospital
- **Exam:** Elderly man, frail appearing, alert but not oriented.
- Large, tender left D1 ulceration with smaller ulcerations between each toe, malodorous, has only palpable femoral pulse
- **Imaging:** CTA: long segment occlusion from distal SFA to peroneal artery as the only runoff
- **Previous hospital Course:** Revascularization attempted percutaneously, unsuccessful, no other endovascular options. Vascular tells you AKA is the best surgical option.
- **Physician Instructions:** Meet with Mr. Starr’s son/daughter to discuss treatment options, the POA. You have met with her daily since her father’s admission and she is aware of the situation. You set up this meeting to discuss treatment options and the decision-making process.