The "Wish/Worry/Wonder" framework

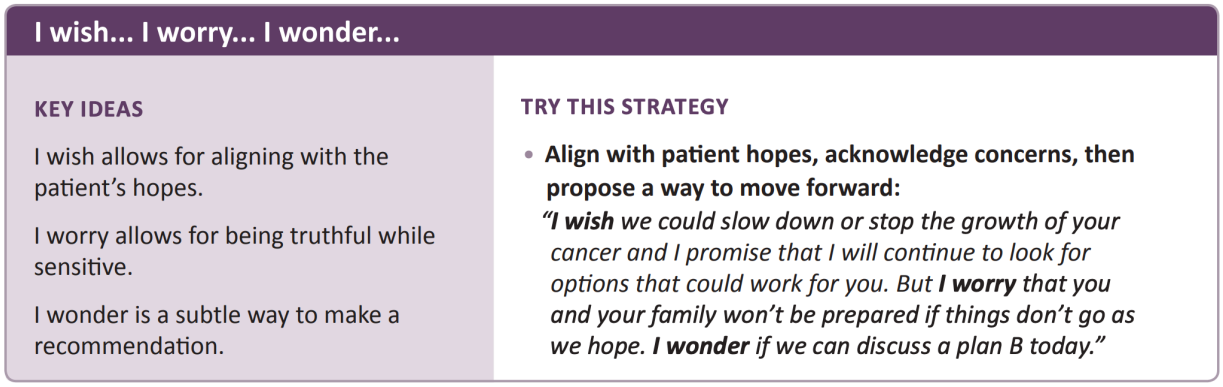

FIGURE 4: I WISH, I WORRY, I WONDER FRAMEWORK
https://www.divisionsbc.ca/sites/default/files/Divisions/Powell%20River/ClinicianReferenceGuide.pdf

Pertaining to COVID19 (or other serious respiratory illness), the clinician might consider stating the following (if consistent with patient values and context),

-I ***wish*** your mom/dad (or other) weren't struggling with this viral infection/ COVID19 infection/ chest infection, our home takes every possible measure to protect our residents
-I ***worry*** that given mom/dad's age and their co-existing illnesses, things are likely to get worse and mom/dad might go on to have respiratory failure. I also ***worry*** that pursuing invasive measures such as intubation or ventilation would not be helpful or considered if we send mom/dad to the hospital
-I ***wonder*** if we can talk about what mom/dad would have wanted in this scenario and discuss plan B to ensure they are comfortable and receive the best possible care with us

The clinician discusses next any goals and fears the SDM might have, which could bring up strong feelings such as guilt, commonly seen in caregivers. The topic of CPR might come up and the clinician may need to explain the known futility of CPR as an intervention overall and particularly in the critical ill elderly. The following is borrowed from the source shared earlier, https://www.divisionsbc.ca/sites/default/files/Divisions/Powell%20River/ClinicianReferenceGuide.pdf.

"CPR is a procedure for patients who have died in which we use machines to try to restart the heart or breathing. In patients with metastatic cancer, its effectiveness is extremely low — between 2% and 6% — and even those who can be brought back initially have to be kept alive on breathing machines and almost never leave the hospital."

Family might be reminded that the physician may withhold CPR if he/she does not deem it to be indicated, which is likely in this anticipated scenario. https://www.cmaj.ca/content/191/47/E1289 .

One consideration for providing recommendations, step 6, is to keep in mind that SDMs and family of LTC residents often develop a trusting working relationship not only with the clinician but the entire interdisciplinary team in the home. They come to feel 'part of a bigger family' and being direct and honest about our recommendations as clinicians alleviates the burden of guilt and uncertainty and enhances the security in their decision 'to do what's right' for their loved one.

While this document may seem tedious, the principles are largely simple and centred around the best possible narrative of the patient's life story. When exercised regularly, they become second nature in clinical practice and provide excellent patient centred outcomes and family satisfaction with care. One recommendation to consider is to print a few copies of the serious illness conversation guide easily accessible through the link provided above, and use it as a template to start the first few serious illness conversations. With time, the vocabulary used becomes part of our language and communications with SDMs/ family and we begin to feel more comfortable having these dialogues earlier and more frequently.

Finally, please use own clinical judgement in applying these principles. While most LTC residents tend to be elderly and present with similar co-morbidities, a small precent of younger individuals as well as persons with a public trustee and guardian also reside in LTC. Tailoring the conversation to the individual's needs in a medico-legally sound manner will optimize trust and outcomes for all involved.

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