COMMENTARY

Physicians, patients, and prognosis

In the terminal stages of a disease, formulating and communicating prognoses are essential and central tasks of the physician. When time is short, it is rarely a matter of making new diagnoses or instituting curative interventions. Instead, the physician's task may involve providing patients and their families with information about what to expect. At this point, it is often not a question of "what do we do?" but "when will it happen?" Because every 1 of our patients will ultimately die, and because, in more than 75% of cases, this will occur after a chronic illness, there is a prima facie case for the clinical importance of understanding how prognoses are formulated and communicated to patients.

For nearly 30 years, studies have appeared showing that physicians are simply not accurate when formulating prognoses. For example, in a classic study, Parkes noted that physicians were systematically biased in their predictions, tending to overestimate how long patients had to live.[1] Another study confirmed this, showing that fewer than 20% of physicians' predictions are accurate and that survival is typically overestimated 5-fold.[2] This inaccuracy contributes to physicians' attitudes toward prognostication: they do not like it. Indeed, their training, their textbooks, and their journals almost universally tend to neglect how to formulate and communicate prognoses.[3,4]

Why should we care that physicians do not feel comfortable with these tasks? The answer is that physicians' discomfort with—and failure at—communicating prog-

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nosis has real and preventable adverse outcomes for patients. Thus, we find that although physicians say they think 3 months is about the right length of time in hospice, patients spend a median of only 30 days receiving hospice services before they die.[5] More generally, the failure to recognize the limits of curative therapy—and attend with our limited resources to dying patients' needs with respect to pain control and quality of life—may substantially contribute to the 40% to 70% of patients who spend their last week of life in pain or have other deficits in their end-of-life care.[6,7] What is more, most patients say that they want to be told their prognoses.[8,9] Patients are often wrong in their perception of the seriousness of their disease and the therapeutic options, whether curative or palliative, that are available. Patients' lack of adequate prognostic information may contribute to their choosing futile curative over feasible palliative care, a choice often counter to their stated interests.[10]

In short, 2 problems need to be addressed. First, we need to advance the science and practice of formulating prognoses. Second, we need to find ways to communicate that information to patients sensitively and effectively, to the extent that they want the information, so that they can make choices near the end of their lives most consistent with their best interests.

This is not solely the responsibility of physicians. What about patients? The and co-workers, in a well-conducted and valuable ethnographic study, look at the physician-patient relationship as it pertains to prognostic communication. In the specific context of a European lung cancer specialty clinic, they explore the way that physicians are willing to ignore the "long-term" (ie, 12 months) prognosis in favor of short-term therapeutic options with limitations known to be profound. Patients, in turn, apparently fail to push their physicians for information about their prognosis or the limits of therapy. The collusion that results means that no one deals with the key issues: that the cancer will almost certainly recur, that it will recur soon, and that these facts have important implications for how patients want to spend their last weeks. Although this has not been expressly examined in the American context, experience suggests that American physicians behave very similarly.

Dr The and associates add much of value by focusing on the dyadic relationship between physician and patient and on the way each reinforces the other's tendencies to avoid these key issues. They suggest that overall goals of honest, forthright communication may get lost in micro-details—in the failure to "get around to" the hard part of the conversation. The hard moral questions that they leave open, appropriately, are these: whose responsibility is it? Is it up to patients to make sure that they extract bad news from physicians? Rather, are physicians failing in their role as advisors whose job it is, in part, to help patients focus on key issues—in this case, facing their impending death in an honest way? Nobody likes to break bad news,[11] but this article highlights the worrisome fact that, when it comes to caring for patients near the end of life, in our rush not to abandon them therapeutically, we abandon them prognostically.

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References

1 Parkes CM. Accuracy of predictions of survival in later stages of cancer. *Br Med J* 1972;2:29-31.
2 Christakis NA, Lamont EB. Extent and Determinants of error in doctors' prognoses in terminally ill patients: prospective cohort study. *BMJ* 2000;320:469-473.
3 Christakis NA, Iwashyna TJ. Attitude and self-reported practice regarding prognostication in a national sample of internists. *Arch Intern Med* 1998;158:2389-2395.
4 Christakis NA. *Death Foretold: Prophecy and Prognosis in Medical Care.* Chicago: University of Chicago Press; 1999.
5 Iwashyna TJ, Christakis NA. Attitude and self-reported practice regarding hospice referral in a national sample of internists. *J Palliat Med* 1998;1:241-248.
6 SUPPORT Principal Investigators. A controlled trial to improve care for seriously ill hospitalized patients: the study to understand prognoses and preferences for outcomes and risks of treatments (SUPPORT). *JAMA* 1995;274:1591-1598.
7 Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA* 2000;284:2476-2482.
8 Kaplowitz SA, Campo S, Chiu WT. Cancer patients' desires for communication of prognosis information. *Health Communication*; in press.
9 Degner LF, Kristjanson LJ, Bowman D, et al. Information needs and decisional preferences in women with breast cancer. *JAMA* 1997;277:1485-1492.
10 Weeks JC, Cook EF, O'Day SJ, et al. Relationship between cancer patients' predictions of prognosis and their treatment preferences. *JAMA* 1998;279:1709-1714.
11 Buckman R. *How to Break Bad News: A Guide for Health Care Professionals.* Baltimore: Johns Hopkins University Press; 1992.

Moments in medical history

The practice of medicine is an art, not a trade, a calling not a business, a calling in which your heart will be exercised equally with your head.

William Osler, 1903
The Master-Word in Medicine