

## Commentary: Why do doctors overestimate?

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American doctors refer patients to hospice too late. Christakis and Lamont's research shows that doctors are poor prognosticians and tend to overestimate how long a person who is terminally ill will live.

Most of the patients in their study had cancer (65%). This is a similar proportion to that found in hospice patients in a survey carried out in 1995 (60%), despite the fact that cancer is not the leading cause of death in the United States. Seven per cent of the patients referred to these hospices died within hours of admission. This eleventh hour referral pattern is at least partly due to doctors not recognising the nearness of death.

A patient is eligible for hospice care if they have an estimated life expectancy of six months or less. As the authors point out, the actual length of stay is usually less than six weeks. Thus most patients come to hospice during a period of rapid physical change and often in crisis. And they don't live long beyond the crisis.

At times of crisis, the immediate management of symptoms and relieving the family overshadows the need to address the emotional and spiritual issues of remembering, forgiving, and bringing to closure the issues of a person's life. Provision of a physically comfortable death is a worthy goal. It reduces regrets among survivors. Yet more time provides the opportunity for the dying person to participate directly in the process of validating the past and planning for the future and gives the family the chance to relish or repair bonds with the dying person. The National Hospice Organisation has tried to educate doctors on how to predict appropriate entry points to hospice for vari-

ous conditions.<sup>1</sup> These guidelines should be incorporated into the general education of doctors.

The authors' suggestion that prognostication should be done by a "disinterested" experienced doctor hits near one common thread of late hospice referrals. Doctors may be reluctant to acknowledge that patients they know well are close to death. This can be compounded by the patient's and family's preference to keep hoping for the patient to live longer. Those of us who know our patients longer often become attached to them. We, too, hate to admit that death is near. I remember a woman in her 60s I was treating for metastatic breast cancer. She was admitted to the hospital with gastric bleeding that was thought to be unrelated to her cancer. I remember talking to her and her husband and being optimistic about the reversibility of the problem. Because I was trying not to scare her I did not discuss the issues of advanced directives and resuscitation. That night she went into shock, required intubation, and went to the intensive care unit. Her husband was devastated and angry that she had had such treatment. The next day he and I together decided that no additional treatment would be given to prevent her death. He sat with her for over 24 hours before she died. My desire to be optimistic prolonged her dying and added anguish to her husband. Doctors often rail against the denial of patients and their families. Yet we are not immune.

Decisions at the end of life are not just guided by doctors. There is a complex interaction of doctor recognising and acting on accurate prognostication, what the doctor tells the patient and family, and what the patient and family actually hear. Christakis and

Lamont have begun to help tease out the factors involved in end of life predictions. In oncology, the end of chemotherapy usually signals the terminal phase. In other specialties, prognosis is much less demarcated. Doctors should better define landmarks or turning points in prognosis and begin to acknowledge these to ourselves and to our patients. Only then can we

adequately guide our patients through the dying process.

Competing interests: None declared.

- 1 Stuart B, Alexander C, Arenella C. *Medical guidelines for determining prognosis in selected non-cancer diseases*. 2nd ed. Arlington, VA: National Hospice Organization, 1996.

## Commentary: Prognoses should be based on proved indices not intuition

Colin Murray Parkes

The accurate prediction of survival is important for several reasons. Excessive optimism may cause us to wait too long to refer people for palliative care, we may delay the use of narcotic drugs for pain relief, and we may persist in unpleasant and pointless treatments aimed at curing or prolonging life when it would be kinder to stop.

This being the case, it is disappointing to learn from Christakis and Lamont that doctors are still no better at predicting the length of survival of our terminally ill patients than they were 27 years ago.<sup>1</sup> Experienced oncologists may be slightly less starry eyed than the rest of us, but even they are overoptimistic about the likely length of survival of their patients. If all predictions had been divided by two they would have been marginally more accurate.

This failure has to be set against the recent success of research instruments such as Morita's palliative prognostic index<sup>2-4</sup> and Maltoni's palliative prognostic score,<sup>5-6</sup> both of which have been shown to predict short term survival reasonably well. These short and simple instruments make use of a mixture of performance measures and systematic symptom assessments

rather than relying on intuition and clinical judgment alone.

In the long term it may be possible to extract from the research those criteria that will enable us to make more reliable clinical predictions. Until that time arrives we would do better to stop guessing and, when predictions are needed, to make use of these indices.

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### *A memorable patient*

#### The scars of the Jewish holocaust

Although the holocaust of the Jewish people ended officially more than 50 years ago, the scars of that atrocity can be seen to this day. A 72 year old woman, married without children, came to the emergency room with abdominal pain that had worsened throughout that day. It was late in the evening and the two surgeons on call had gone to the operating room, leaving one of us (RP), a young resident, to see the patient. She seemed older than her actual age and was unkempt. She was asked about previous operations and answered in the negative. Abdominal examination revealed a large scar from the navel downwards. Why hadn't she mentioned the surgical procedure that she had obviously undergone? When asked, she looked embarrassed and said, "How do you think I stayed alive? I had a sterilisation done by the Nazis, you see? During the war I lived in a whore house and this is how I survived."

That same night, a few hours later, another woman came to the emergency room complaining of abdominal pain. She was 74 years old and married without children. She seemed young for her age, had blonde hair, and wore heavy makeup. A tattooed number was seen on her arm, typical of the numbers inscribed by the Nazis during the second world war. When asked about previous operations she also answered in the negative. When

asked directly about past gynaecological operations, based on the experience with the earlier case, she hesitantly said, "Yes, I had to have it in order to survive during the holocaust. I was a whore in a Nazi whore house."

This year, when pictures from the yearly memorial day for the holocaust victims in Israel were shown on television together with pictures from the war in Kosovo, we were reminded of the horrendous events of the past that leave their scars, physical and emotional, for years and years to come.

Will the world ever learn the lesson?

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We welcome articles of up to 600 words on topics such as *A memorable patient*, *A paper that changed my practice*, *My most unfortunate mistake*, or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk. Permission is needed from the patient or a relative if an identifiable patient is referred to. We also welcome contributions for "Endpieces," consisting of quotations of up to 80 words (but most are considerably shorter) from any source, ancient or modern, which have appealed to the reader.