Editorial

Discordant expectations about prognosis in critically ill patients

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Nearly half of all adults in the United States are unable to make medical decisions for themselves about whether to accept life-prolonging interventions near the end of their life (1). Individuals who make medical decisions for critically ill patients unable to make decisions for themselves, termed surrogates, commonly have misperceptions about the prognoses of the patients they are serving as surrogates for. Such misperceptions have been reported to be attributed to poor comprehension or misunderstandings of medical information by patient surrogates and/or inadequate communication between surrogates and physicians (2,3).

In the May 2016 issue of *JAMA*, White and colleagues report on the prevalence of and factors related to discordance of prognosis between physicians and patient surrogates (4). In their original analysis, the authors performed a mixed-methods analysis using both quantitative surveys and qualitative interviews of 229 surrogate decision makers and 99 physicians caring for a large, diverse cohort of 174 critically ill patients at high risk of death across multiple intensive care units within a single health system in California, United States.

Discordance about prognosis, which the investigators defined as a difference of at least 20% between the prognostic estimate of the physician and the surrogate, occurred in 53% of cases. Interestingly, discordance was related both to misunderstandings by surrogates and differences in belief about the patient's prognosis in 28% of cases, with numerous additional cases related only to misunderstandings by surrogates and some additional cases related only to differences in belief. Furthermore, although the prognostic estimates by surrogates were much more accurate than chance alone, the estimates by physicians were significantly more accurate than that of surrogates (P=0.008). Most commonly, surrogates overestimated the prognosis of patients. The prognostic optimism by surrogates was most commonly related to a need to maintain hope to benefit the patient, but it was also attributable to surrogates thinking the patient was unique or had strengths unknown to the physician or to religious beliefs.

The study by White and colleagues is noteworthy and novel since it simultaneously provided quantitative estimates of misperceptions about prognosis and also qualitative provided insights about factors contributing to those misperceptions. Their study highlights the fact that discordant expectations about prognosis is common between physicians and surrogate decision makers among critically ill patients, with much of the discordance related to misunderstandings by surrogates about the physician assessment of the prognosis of patients and also to differences in beliefs about the prognosis of patients.

The fact that surrogate prognosis estimates of critically ill patients were found to be overly optimistic is not novel and has been previously reported (5). Confirmation of this finding is, however, significant since optimistic expectations by surrogates have been shown to correlate with higher rates of electing for invasive treatments in dying patients and delaying the integration of palliative care at the end of life (6). Furthermore, these findings question the validity of true shared decision making, an important tenant of modern medicine and an essential component of initiating palliative care for patients with advanced diseases, since providers and surrogates often do not have an agreement about the likely outcomes of treatment.

From this important study, it is clear that interventions are needed to improve the comprehensibility of prognostic information communicated by healthcare providers to surrogates. Improved comprehension, and thus more accurate expectations by surrogates of patient prognoses, has been shown in both cancer (7) and non-cancer (8) patients with advanced disease to reduce the likelihood of intensive or invasive treatments near the end of life. Providers should regularly discuss with surrogates their perceptions of prognosis of the patient, and these perceptions should be addressed prior to engaging in decision making about goals of care with surrogates. Additionally, attention must be paid to psychosocial and emotional factors that influence the prognostic expectation of surrogates. Interventions to rectify or address discordance about prognosis may certainly be different for surrogates who misunderstand information about patient prognosis compared with surrogates who have differences in beliefs about prognosis.

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Footnote

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