

Divergent Views on Prognosis Between Doctors and Surrogate Decision-Makers



Surrogate decision makers for intensive care patients may misunderstand information given about the patient's prognosis. Commonly, this misperception is attributed to poor understanding of medical information. However, a study from the United States, published in [JAMA](#), has found that such discordance occurred in more than half of their sample, due to misunderstandings by surrogates about physicians' assessments of patients' prognoses and differences in beliefs about patients' prognoses.

The researchers, led by [Douglas B. White](#), MD, MAS, professor in the Pitt School of Medicine's Department of Critical Care Medicine, and director of the department's Program on Ethics and Decision Making, used quantitative surveys and qualitative interviews at 4 ICUs at the University of California, San Francisco Medical Center, where Dr. White previously was a faculty member that involved surrogate decision makers and intensivists over a 4 year period. Discordance about prognosis was defined for the study as a difference of at least 20% between the surrogate decision-maker and physicians's prognostic estimates, misunderstandings by surrogates and differences in belief (any difference between a surrogate's actual estimate and their best guess of the physician's estimate).

See Also: [Shared Decision Making in the ICU - Recommendations](#)

The researchers asked both the surrogates and the doctors to estimate the chances that the patient would survive hospitalization on a scale of 0 (no chance of survival) to 100 (definite survival). They did not know each other's answers. The surrogates were also asked to guess what they thought the patient's doctor answered. Generally, the surrogates would guess somewhere in between their estimate and the doctor's real estimate. That revealed that the surrogates understood they were being more optimistic than what the doctor had been communicating to them.

Findings

- 229 surrogate decision makers (68% women)
- 174 patients (75 died during this period) At enrollment, patients had a median APACHE II score of 28
- 99 physicians
- 53% of prognosis estimates were discordant (122/229)
 - 28% related to misunderstandings by surrogates and differences in belief about the patient's prognosis
 - - 17% related to misunderstandings by surrogates
 - 3% related to differences in belief
- A conversation about prognosis by day 5 of mechanical ventilation was reported by 183 surrogates (80%), 199 physicians (87%), and 213 (93%) of either.
- 157 decision makers said that religion or spiritual beliefs were very or fairly important in everyday life.

Surrogates' prognostic estimates were much more accurate than chance alone, but physicians' prognostic estimates were statistically significantly more accurate than surrogates'. Where 71 surrogates had more optimistic beliefs than the doctor, the most common reasons for optimism were a need to maintain hope to benefit the patient (n = 34), a belief that the patient had unique strengths unknown to the physician (n = 24), and religious belief (n = 19).

Dr. White said: "It isn't a bad thing for a patient's family and friends to have hope that they will recover. However, it is problematic when those overly optimistic expectations result in more invasive treatments in dying patients and delayed integration of palliative care that can alleviate suffering."

See Also: [Do End-of-Life Communication Tools Improve Decision-Making?](#)

Recommendations

The authors recommend that intensivists should routinely communicate with surrogate decision makers about their perceptions of the patient's prognosis and reasons for discordant views before making decisions about goals of care.

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Dr. White, who also holds the UPMC Endowed Chair for Ethics in Critical Care Medicine, added that they are working on interventions to improve the comprehensibility of the prognosis doctors give to surrogates, and to better attend to the emotional and psychological factors that may influence the surrogate's expectations for their loved one's outcome.

In an accompanying editorial, [Prof. Elie Azoulay](#) and colleagues recommend that clinicians don't just deliver information, but also attend to four key tasks:

1. Recognise and respond to the surrogate decision-makers' emotional state;
2. Listen and be receptive to hearing about patient values and family concerns;
3. Communicate about uncertainty about prognosis as a primary communication task;
4. Coordinate the care team to provide a "coherent and unified message."

They conclude: "In these discussions, listening is as important as talking, if not more so, before proceeding to provide the psychological and other support that most families need to process information and share in decisions that honour patients' values, goals, and preferences."

Sources: [JAMA](#); [University of Pittsburgh Schools of the Health Sciences](#)

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