COMMENTARY

Why do physicians overestimate life expectancy of a person who is terminally ill?

American physicians refer patients to hospice too late. Christakis and Lamont's research shows that physicians are poor prognosticians and tend to overestimate how long a person who is terminally ill will live. Most of the patients (65%) in their study had cancer. This is similar to the proportion (60%) found in hospice patients in a survey carried out in 1995, despite that cancer is not the leading cause of death in the United States.¹ Seven percent of the patients referred to these hospices died within hours of admission. This 11th-hour referral pattern is at least partly due to physicians not recognizing the nearness of death.

A patient is eligible for hospice care if he or she has an estimated life expectancy of 6 months or less. As the authors point out, the actual length of stay is usually less than 6 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 symp-

toms and relieving the family overshadow the need to address the emotional and spiritual issues of remembering, forgiving, and bringing to closure the issues of a person's life. Providing 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 Organization has tried to educate physicians about how to predict appropriate entry points to hospice for various conditions.² These guidelines should be incorporated into the general education of physicians.

The authors' suggestion that prognostication should be done by a "disinterested" experienced physician hits near a common thread of late hospice referrals. Physicians may be reluctant to acknowledge that patients they know well are close to death. This can be compounded by a patient's and family's preference to keep hoping for the patient to

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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 talked to her and her husband and was 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 more than 24 hours before she died. My desire to be optimistic prolonged her dying and added anguish to her husband. Physicians 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

physicians. There is a complex interaction when a physician recognizes and acts on an accurate prognostication, what the physician tells the patient and family, and what the patient and family actually hear. Christakis and Lamont have begun to 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. Physicians should better define landmarks or turning points in prognosis and begin to acknowledge these to themselves and their patients. Only then can physicians adequately guide patients through the dying process.

References

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- 2 Stuart B, Alexander C, Arenella C. *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases*. 2nd ed. Arlington, VA: National Hospice Organization; 1996.

A Book That Informed My Practice

What a Blessing She Had Chloroform by Donald Caton, Yale University Press, 1999, \$30.00

When her eldest daughter gave birth in 1859, Queen Victoria remarked, "What a blessing she had chloroform. Without it I think her strength would have suffered very much." The Queen, an experienced mother, saw no controversy in the use of pain relief in labor. Yet the subject has continually been dogged by controversy (witches were burnt for it). Donald Caton, an eminent chronicler of the history of obstetric analgesia, has written a fascinating account of the social background to its evolution since the introduction of ether, then chloroform, to obstetrics by James Young Simpson in Edinburgh in 1847. The subject is viewed in the wider context of the whole metamorphosis of medicine in the 19th century.

The story began when medicine, religion, and philosophy were intermixed and the balance of earth, air, fire, and water still controlled our bodies, with science a late partner to medicine. Pain had an important role in society: to maintain order and collect information—a purpose still prevalent in some societies today. Its role in childbirth—education, punishment ("She's got to learn"), atonement, redemption, and bonding ("You'll love your baby all the more")—also survives. Writing in the middle of the 19th century, John Stuart Mill pointed out that it was not God but nature that inflicted pain. It was surely permissible to improve on nature. Anesthesia formed part of a new humanitarian movement that aimed "to eliminate suffering from human experience, a tendency that was not particularly apparent before then."

Writing with grace and humor, Caton traces the progress of obstetric anesthesia and analgesia through the bombastic overexuberance of Simpson, the opposition from a cautious medical profession, the diligent and innovative perspicacity that enabled Snow to put the technique on its feet and quell the opposition, the ill-advised enthusiasm for twilight sleep, and the reaction to the overuse of drugs embodied in Grantly Dick Read's natural childbirth campaign.

The need for analgesia in labor was thought to result from the decadent lifestyle (or heightened sensibilities) of modern civilized women. Read resurrected this 19th century belief in asserting, apparently from a personal series of two, that "primitive" people had painless, trouble-free labors but that educated women need feel no pain if fear were eliminated. Would that either of these assertions were true.

Both medical and non-medical readers will enjoy this book but may find the blanket term "anesthesia" confusing. It is used to refer to inhalational analgesia as developed by Snow, true anesthesia (throughout labor) as advocated by Simpson, deep sedation as in twilight sleep, regional (epidural) anesthesia as once used for labor and now reserved for surgery, and the milder regional analgesia. Caton does not mention, perhaps because it still eludes most of humanity, that effective analgesia with mobility and an alert mother and baby can now be provided for labor. Historically, women have demanded analgesia in labor when the medical profession approached it with caution, yet now that it has become vastly safer, many women reject it as dangerous.

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