
GUEST EDITORIAL

A Need for Better Predictors of Death

There is widespread agreement that one of the most destructive political torpedoes fired during the health care debate was Sarah Palin's Death Panel calumny, which managed to scuttle any opportunity to entertain constructive measures to improve end-of-life care by reimbursing advance care planning conversations. I would like to articulate a heresy — that even if Palin had not poisoned the initiative, conversations about terminal care preferences would have been hobbled by the current dearth of practical prognostic tools.

A decade after Nicholas Christakis wrote about why physicians are reluctant to predict the future there continues to be a crucial failure on the part of medicine to ascertain and communicate with patients and families about dire prognostic situations. In my book on murder accusations following the provision of palliative care (Cohen, 2010), one of the nurse protagonists describes how she informed a patient and her family that death was imminent. The nurse explains: "This sort of thing has become a nursing role. I am convinced we have made it one, because nobody else does it. If the doctors are not going to do it, then I think we need to."

Research is clear that the overwhelming majority of Americans would want to know if they were severely ill and likely to die. Surveys have consistently demonstrated that patients and families want their physicians to give them the bad news. This is not because we are a particularly morbid nation, but because we value the right to know the truth and recognize that there are choices to be made when confronting our demise. As a people, we cherish the freedom to maximally determine our actions, and if death is rapidly approaching many individuals want to be able to expeditiously wrap up their lives in an orderly fashion. They may or may not want to draw a line about future hospitalizations or surgeries or intensive care admissions or cardiopulmonary resuscita-

tion attempts. People may or may not wish to express preferences about how to manage funerals or other related arrangements or how to distribute their material possessions and to tie up financial loose ends. They may or may not want to explore the options of remaining in their own domiciles with the assistance of hospice services or dying in medical facilities or nursing homes or a residential hospices.

My experience with chronic kidney disease has been that medical research is easily capable of investigating and providing clinicians with formulas to predict high-mortality groups of patients. Our investigatory group recently published and placed online an instrument that allows nephrologists to enter actuarial variables along with their subjective assessment of a dialysis patient's chances of dying within six months. The tool then calculates a statistically accurate prognosis. While statistics are certainly not guarantees, they can serve to at least alert people whether they fall within a high-risk category, e.g., are they among the one-fifth of a dialysis clinic population who are most likely to die within the next six-months? The same approach can be used with chronic obstructive pulmonary disease, congestive heart failure, Alzheimer's disease, diabetes, or any number of other disorders or combinations of disorders. Such predictive models are especially relevant for people whose lives have been artificially prolonged by arduous life-support treatments, such as renal dialysis or ventilators. The field of oncology is praiseworthy for tracking one-year and five-year mortality rates of different cancers, but I would think a shorter predictive time, such as six-months or a week is preferable. The same research techniques could be applied not only for predicting mortality but also for estimating the likelihood of improved or deteriorating bodily function — many patients would like to know, e.g., "Will the machine keep me

alive, but I will never be able to resume work?” “Will I have to leave my home for a nursing facility?” And so on. . .

Before we blame Palin for obstructing end-of-life care, we need to honestly confront and address the limitations in our knowledge. Systematic research on short-term prognosis is essential before we will truly be prepared to have those crucial discussions.

REFERENCE

Cohen, L.M. (2010). *No Good Deed: A Story of Medicine, Murder Accusations, and the Debate over How We Die*. New York: HarperCollins.

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