

# AFFIDAVIT

I the undersigned, Dr Allan John Donkin state under oath in English that:

I, the undersigned am an adult Male with ID no 8301285098087, and reside at [redacted], Somerset West with a telephone number [redacted]

The facts contained herein are, except where specifically stated, within my personal knowledge and are best of my belief both true and correct.

I am a Medical Doctor and I have a special interest in the subject of euthanasia or physician assisted suicide. I have written two letters on the subject which were published in the British Columbia Medical Journal. My practice number is 0379670. My Health Professions Council of South Africa registration number is MP0661392.

I have attached two letters that I have written to the court in response to Mr Stransham-Ford's Affidavit on the subject of physician assisted suicide.

Date

2015/4/26

Signed

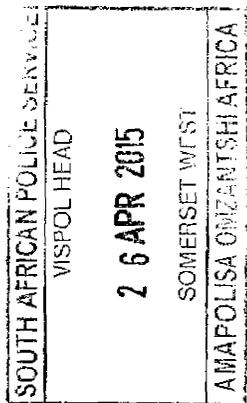
Dr Allan John Donkin

Witness

I, the undersigned, do hereby depose and swear that the contents of the foregoing affidavit are true and correct to the best of my knowledge and belief, and that I am a duly qualified and practicing member of the Health Professions Council of South Africa.  
 I, the undersigned, do hereby depose and swear that the contents of the foregoing affidavit are true and correct to the best of my knowledge and belief, and that I am a duly qualified and practicing member of the Health Professions Council of South Africa.

26/4/15 09:15  
 [Signature]  
 MR BULLOCK  
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SA POLISIED...  
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Degree:  
MBChB(UP) 2006

2014/4/25

To The Court

**Response to Mr Stransham-Ford's affidavit on the subject of physician assisted suicide – should not be for an urgent decision:**

I am a Medical Doctor and I have a special interest in the subject of euthanasia or physician assisted suicide. I have personal experience as a General Practitioner in treating many people in their stages of dying and weakness. I have written two letters on the subject which were published in the British Columbia Medical Journal in 2014.

BCMJ, Vol. 56, No. 1, January, February 2014, page(s) 6 Letters  
BCMJ, Vol. 56, No. 5, June 2014, page(s) 218-219 Letters

I would like time to provide a submission on this matter and request that this process not be rushed or treated as urgent. The decisions made will have far reaching consequences and will have a huge impact on the lives of millions of South Africans. Submissions will take time to prepare adequately on this important issue.

Mr Stransham-Ford states that he has two to four weeks to live (point 46 in his Affidavit) and that this is at best an estimate based solely on the opinion of Dr Bruce (point 47). This is his reason for applying for an urgent decision. I think it would be reckless of the court to hastily make a decision on such a matter with such far reaching



I would suggest an expert objective medical second opinion be obtained as to his possible time remaining.

Signed  
Dr Allan John Donkin

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2014/4/25

To The Court

**Response to Mr Stransham-Ford's affidavit on the subject of physician assisted suicide:**

Though I would like time to provide a more comprehensive submission there are a few points I would like to make initially.

I would like to challenge Mr Stransham-Ford's affidavit in terms of his idea of "dignity".

In his Affidavit he states:

- 34. There is no dignity in:
  - 34.1 having severe pain all over one's body;
  - 34.2 being dulled with opiate medication rendering:
    - 34.2.1 you being unaware of your surroundings and loved ones;
    - 34.2.2 being confused and dissociative;
  - 34.3 being unable to take care of your own hygiene;
  - 34.4 dying in a hospital or hospice away from the familiarity of your own home;
  - 34.5 dying, at any moment, in a dissociative state unaware of your loved ones being there to say goodbye.

He states that there is no dignity in these situations. By this he is stating (perhaps unawares) that he considers people who are in pain, on medication, confused, unaware, unable to care for their own hygiene, people who die in a hospital or hospice away from the familiarity of their own home, to be without dignity and therefore undignified. Would such people be an offence to his sensibilities? Who is he to declare that such people are undignified?



The South African constitution states that everyone has a right to dignity.

Dignity is not dependent on ones function, but rather an innate part of being a human being no matter what state one is in. Our drive in society should be to afford everyone dignity by refusing to snuff them out when we feel our sensibilities are offended by them.

Dignity is something given by the community around an individual. If we love someone and say that they have great worth as a human and we consider them dignified, then they have dignity, no matter what state they are in. Because of the dignity we as a community afford them we will then care for them without resentment.

Were the court to grant Mr Stransham-Ford's request they would in fact be taking away peoples right to dignity by declaring that some people in some circumstances are not worthy of dignity and are undignified and therefore can be snuffed out.

Mr Stransham-Ford is not so much making a statement about his own dignity, but rather is revealing that he believes that not all South African's deserve dignity, particularly if they are in a state of dying.

He is asking in fact for the opposite of dignity.

Surely the right to dignity in the Constitution should not be interpreted as the right to feel dignified. We have no control over the feelings of individuals. But we should insist that people have dignity and treat them with dignity even if they feel undignified. Treating people with dignity in spite of their feeling undignified would mean refusing to snuff them out. It would mean insisting on treating them as precious and people who have inherent value as human beings and not treating them as we do animals. We euthanase animals precisely because they are not human beings with unique human value and dignity protected in the Constitution. To euthanase humans like we do animals would be to remove their human uniqueness, value and dignity. It would be to degrade human dignity.

As a General Practitioner I have personal experience in treating many patients in their stages of dying and weakness. I believe that if the court were to affirm Mr Stransham-Ford's interpretation of dignity this would in fact undermine the dignity of many people who are dying and weak.

Furthermore I would like to point out what I believe to be some errors in medical fact in Mr Stransham-Ford's Affidavit.



He states in point 47.5 “there is a risk that my symptoms might not be adequately addressed due to poor renal function”. I note that Dr Bruce also states this in his report (Point 8 of Dr Bruce's report on page 59 of the Affidavit). However no reason for this statement is given by Dr Bruce. Dr Bruce should be required to prove this statement as he provides no evidence for it.

Just before this in point 47.4 of Mr Stransham-Ford's Affidavit he reports the following, “as a result of my poor kidney function, many of the pain medications are contraindicated and not as effective as my kidneys are unable to properly metabolise medication;”

This statement by Mr Stransham-Ford is at the core of his argument for medical urgency; However this information is not stated in Dr Bruce's report. The onus is on Mr Stransham-Ford to prove this as he has not produced any evidence to substantiate it. It may be a result of his misunderstanding of what he was verbally told by Dr Bruce.

There are sufficient medicines to treat pain in renal failure safely, and what is more, in palliative care we are no longer concerned about possible toxic effects of medicines when a person is in their final stages of dying as symptom control becomes of paramount importance in the last few days.

Please see the following attachment for evidence:

Opiate toxicity in patients with renal failure

*BMJ* 2006; 332 doi: <http://dx.doi.org/10.1136/bmj.332.7537.345> (Published 09 February 2006) Cite this as: *BMJ* 2006;332:345

He states in point 24 “If any other treatment other than Morphine is required, I'll have to receive same at hospital away from home”. This is not stated in Dr Bruce's report. The onus is on Mr Stransham-Ford to prove this as he has not produced any evidence to substantiate it.

In my experience working with hospice, patients are able to receive all manner of treatments from hospice nurses and doctors in their homes including palliative sedation with a variety of medications.

He states in point 29 “I am bed ridden and have injections and drips.” As a medical doctor I know that he already has a right to decline any medical intervention he wishes and physician assisted suicide will have no impact on this.

He states in point 30 “I will be confused and scared... until I breathe my last, which may even be with a machine.” As a medical doctor I know that he already has the right to make his wishes known to his doctors if he would not like to be put on a machine to help him breathe. Physician assisted suicide will have no impact on this. In fact doctors



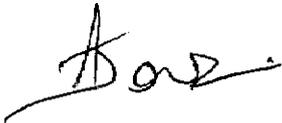
would be very unlikely to put him on a ventilator even if he wished it as he is known to have a terminal illness.

These comments of Mr Stransham-Ford reveal that he does not have a good understanding of the process that lies ahead of him, and that his doctors have not yet adequately explained what he can choose about what he will go through. His request for physician assisted suicide is unnecessary as there are already solutions to many of his fears. His lack of accurate information makes his request for physician assisted suicide to be without credibility.

Lastly, Mr Stransham-Ford's request for physician assisted suicide would add nothing to his situation. He is already capable of committing suicide if he so wishes, and it would be an easy task for him to overdose on the pain medication that he would be taking. As physician assisted suicide would not change anything about his ability to commit suicide, I must conclude that the reason he is making this request is not that he would like a change in his circumstances, but rather that he would like the Court and the Medical Profession to agree with his world view that human beings are undignified and lack no inherent dignity when they are in certain states of being, and so can be snuffed out. I believe by disagreeing with him we as a community will be continuing to afford dignity to all who are weak and dying (in accordance with the Constitution), including to Mr Stransham-Ford.

Signed

Dr Allan John Donkin



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**Practice** Lesson of the week

## Opiate toxicity in patients with renal failure

BMJ 2006; 332 doi: <http://dx.doi.org/10.1136/bmj.332.7537.345> (Published 09 February 2006) Cite this as: BMJ 2006;332:345

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### Pain Management in Renal Failure - Choice of opioid

Editor – Conway has highlighted the difficulties in managing painful conditions in patients with renal failure (1). However, the suggestion that opioids should be avoided in this group of patients may encourage undertreatment of pain in individuals with renal failure. Patients with chronic kidney disease frequently report pain (2) and patients with cancer often develop severe renal impairment (3).

Whilst patients on opioids should be monitored for adverse effects, particular opioids are likely to cause toxicity in renal patients. These include morphine, diamorphine and codeine derivatives which produce toxic metabolites which accumulate in renal failure. Studies report profound respiratory depression and narcosis when renal patients are given these opioids (4)(5).

We agree with the suggestion that opioids which accumulate in renal failure should be avoided. However, suggesting buprenorphine for mild to moderate pain and alfentanil for severe pain requires further discussion.

Buprenorphine is metabolised in the liver to norbuprenorphine and buprenorphine-3-glucuronide. The parent drug is excreted unchanged via the biliary system but the metabolites are excreted by the kidneys. Although the metabolites have little analgesic action in humans, they do accumulate in renal failure (6). B-3-G is a potent respiratory depressant in rats and its action in humans as yet, is unclear (7). Buprenorphine has not been adequately studied in humans with renal failure and therefore it cannot be recommended as first choice for mild to moderate pain in renal failure.

We have successfully used immediate-release tramadol on an 8-12hrly basis in renal patients. Tramadol is metabolised in the liver to one active metabolite, O-demethyl-tramadol and 90% of the parent drug and its metabolites are excreted by the kidneys. In comparison with codeine,



tramadol causes less adverse effects and does not cause significant respiratory depression for a given level of analgesia (8). Although limited, the evidence for the cautious use of tramadol in renal patients is greater than it is for buprenorphine (9). Thus, immediate-release tramadol would be our first choice analgesic for patients with renal failure with mild to moderate pain.

Conway suggests alfentanil for severe pain in renal failure.

Alfentanil is metabolised in the liver to non-toxic metabolites which are renally excreted. Only 1% of the parent drug is excreted unchanged by the kidneys. However, it can only be given parentally. This is not convenient for the majority of people with chronic painful conditions and renal failure, who are not in the terminal phase of their illness.

In general, the evidence for the safe use of opioids in patients with renal failure and severe pain is limited. However, the literature suggests that both Hydromorphone and Oxycodone are safer than morphine or diamorphine and our clinical experience supports this. Furthermore, they can be given in the oral form and are more suitable for managing chronic painful conditions.

Hydromorphone is metabolised in the liver to Hydromorphone-3-Glucoronide, which is excreted in the urine and accumulates in renal failure. None the less, patients with renal impairment in a palliative care unit had an improved side-effect profile when switched from morphine to Hydromorphone (10).

Oxycodone is metabolised in the liver, principally to noroxycodone and also to oxymorphone. 10% of the parent drug is excreted unchanged by the kidneys. Although the metabolites are excreted in the urine and studies show that accumulation occurs in renal failure, there have been few adverse effects reported (11). In our experience, when creatinine clearance <10ml/minute, pain can be managed effectively using 50% of the normal dose, as suggested by Broadbent (12).

The evidence does not support the use of codeine, morphine, pethidine or diamorphine for people with renal failure and severe pain. Given the evidence from the literature and our own clinical experience, we would recommend tramadol for mild to moderate pain. For those renal patients with severe pain, alfentanil is recommended if the parental route is appropriate and hydromorphone or oxycodone where the oral route is preferred.

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Competing interests:

None declared

**Competing interests:** No competing interests

**04 March 2006**



4/25/2015

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## Extent and determinants of error in physicians' prognoses in terminally ill patients

### prospective cohort study

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See "Why do physicians overestimate life expectancy of a person who is terminally ill?" on page 313.

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### Abstract

Go to:

**Objectives** To describe physicians' prognostic accuracy in terminally ill patients and to evaluate the determinants of that accuracy. **Design** Prospective cohort study. **Setting** Five outpatient hospice programs in Chicago. **Participants** A total of 343 physicians provided survival estimates for 468 terminally ill patients at the time of hospice referral. **Main outcome measures** Patients' estimated and actual survival. **Results** Median survival was 24 days. Of 468 predictions, only 92 (20%) were accurate (within 33% of actual survival); 295 (63%) were overoptimistic, and 81 (17%) were overpessimistic. Overall, physicians overestimated survival by a factor of 5.3. Few patient or physician characteristics were associated with prognostic accuracy. Male patients were 58% less likely to have overpessimistic predictions. Medical specialists excluding oncologists were 326% more likely than general internists to make overpessimistic predictions. Physicians in the upper quartile of practice experience were the most accurate. As the duration of the doctor-patient relationship increased and time since last contact decreased, prognostic accuracy decreased. **Conclusions** Physicians are inaccurate in their prognoses for terminally ill patients, and the error is systematically optimistic. The inaccuracy is, in general, not restricted to certain kinds of physicians or patients. These phenomena may be adversely affecting the quality of care given to patients near the end of life.

### INTRODUCTION

Go to:

Although physicians commonly have to prognosticate, most feel uncomfortable doing so.<sup>1</sup> Neither medical training<sup>1,2</sup> nor published literature<sup>3,4</sup> treat prognostication as important, and prognostic error is widespread.<sup>2</sup> Unfortunately, prognostic error may have untoward effects on both patient care and social policy.

Parkes showed that physicians' predictions of survival in 168 cancer patients were often erroneous and optimistic,<sup>5</sup> and these findings were confirmed by subsequent studies.<sup>6,7,8,9,10</sup> However, previous work has been limited by the use of small samples of patients and of prognosticators (typically <4), failure to examine whether certain types of physicians are more likely to err in certain types of patients, and neglect of the possibility of different determinants of optimistic and pessimistic error. We conducted a large, prospective cohort study of terminally ill patients to evaluate the extent and determinants of prognostic error.

### PARTICIPANTS AND METHODS

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Our cohort consisted of all patients admitted to 5 outpatient hospice programs in Chicago during 130 consecutive days in 1996. Participating hospices notified us about patients on admission, and we immediately contacted the referring physicians to administer a 4-minute telephone survey. Of the 767 patients (referred by 502 physicians), 65 did not meet the entry criteria (they were children, were denied hospice admission, or refused to give consent), and 51 died before we were notified (survival predictions would be meaningless). Of the remaining 651 patients, for 66 (10.1%) we contacted the physician only after the patient's death (and so could not get meaningful prognoses), for 14 (2.2%) the physician refused to participate, and for 67 (10.3%) the physician could not be contacted. We, thus, completed surveys with 365 physicians caring for 504 patients (77.4%). Comparison of these 504 patients with the 147 excluded patients showed no important differences in patient or physician characteristics. On June 30, 1999, we had dates of death for 486 (96.4%) of the 504 patients. Because data were occasionally missing, not all totals in the analyses are equivalent.

We obtained the patients' age, sex, race, religion, marital status, diagnosis, and comorbidities from the hospice. From the survey, we obtained an estimate of how long the patient had to live; information about the patient, including Eastern Cooperative Oncology Group performance status<sup>11</sup> and duration of illness; information about the physician, including experience with similar patients and self-rated dispositional optimism; and information about the doctor-patient relationship, including the duration, recentness, and frequency of contact. From public records, we obtained other data on the physicians, such as specialty, years in practice, and board certification. Dates of patients' deaths were obtained from public death registries or the hospices.

We divided the observed by the predicted survival and deemed prognoses accurate if this quotient was between 0.67 and 1.33. Values less than 0.67 were optimistic prognostic errors, and those greater than 1.33 were pessimistic. We conducted analyses using different cutoff points or more categories, as well as analyses that treated this quotient as a continuous measure, but these analyses did not contravene the results presented. To evaluate associations between categorical and continuous variables and the trichotomous prognostic accuracy variable, we used  $\chi^2$  tests and analysis of variance, respectively. We used multinomial logistic regression to assess the multivariate effect of patient and physician variables on prognostic accuracy.

### RESULTS

Go to:

The patients had a mean (SD) age of 68.6 (17.4) years, and 225 (44.6%) were men. The diagnosis in 326 patients (64.7%) was cancer, in 62 patients (12.3%) it was acquired immunodeficiency syndrome (AIDS), and 116 patients (23.0%) had other conditions. The mean duration of disease was 83.5 (135.8) weeks, and the median performance status was 3 (corresponding to >50% of the day spent bedridden). The physicians had a median duration of medical practice of 16 years; of 363 physicians, 291 (80.2%) were men; of 365 physicians, 293 (80.3%) were board certified; and of 345 physicians, 255 (73.9%) rated themselves optimistic. Of

Two handwritten signatures in black ink are located in the bottom right corner of the page. The first signature is a stylized 'S' followed by a flourish, and the second is a more complex, cursive signature.

4/25/2015

## Extent and determinants of error in physicians' prognoses in terminally ill patients

358 physicians who listed their specialty, 114 (31.8%) specialized in general internal medicine, 71 (19.8%) in internal medicine subspecialties excluding oncology, 61 (17.0%) in oncology, 55 (15.4%) in family or general practice, 27 (7.5%) in geriatrics, and 30 (8.4%) were surgeons or practiced other specialties. In the past year, the physicians had cared for a median of 5 patients with the same diagnosis and had referred a median of 8 patients to a hospice. They had known the patient a mean of 159.2 (307.7) weeks, had 11.1 (13.9) contacts in the previous 3 months, and had examined the patient 14 (29) days before.

## Physicians' prognostic estimates

In only 18 of 504 patients did the physician refuse to predict survival to us. Of the remaining 486 patients, 18 had missing dates of death, leaving 468 patients referred by 343 physicians for analysis of prognostic accuracy. The figure illustrates the extent of the error. The median observed patient survival was 24 days. The mean ratio of predicted to observed survival was 5.3. The correlation between predicted and observed survival was 0.28 ( $P < 0.01$ ). When an accurate prediction was defined as between 0.67 and 1.33 times the actual survival, 92 (19.7%) of 468 predictions were accurate, 295 (63.0%) were optimistic, and 81 (17.3%) were pessimistic. When an accurate prediction was defined as between 0.50 and 2.0 times the actual survival, 159 (34.0%) of 468 predictions were accurate, 256 (54.7%) were optimistic, and 53 (11.3%) were pessimistic. Death occurred within 1 month of the predicted date for 195 patients (41.7%), at least 1 month before the predicted date in 214 patients (45.7%), and at least 1 month after the predicted date in 59 patients (12.6%).



Figure 1

Predicted vs observed survival in 468 terminally ill hospice patients. Diagonal line represents perfect prediction. Circles above diagonal line represent patients in whom survival was overestimated; those below line are patients in whom survival was underestimated. ...

The extent of prognostic error varied depending on both observed and predicted survival (table). The longer the observed survival (that is, the less ill the patient), the lower the error; conversely, the longer the predicted survival, the greater the error.

Table 1

Doctors' overestimates of patient survival by observed and predicted survival

## Factors associated with prognostic accuracy

Bivariate analyses of the trichotomous accuracy variable and patient attributes showed no important differences in patients' age, sex, race, religion, or marital status. However, patients with cancer were the most likely to have overoptimistic predictions (202 [67.1%] of 301 patients with cancer vs 37 [63.8%] of 58 patients with AIDS and 56 [51.4%] of 109 other patients) and the least likely to have overpessimistic predictions (39 [13.0%] of 301 patients with cancer vs 13 [22.4%] of 58 AIDS patients and 29 [26.6%] of 109 other patients); AIDS patients were the least likely to have correct predictions (8 [13.8%] of 58 patients vs 60 [19.9%] of 301 patients with cancer and 24 [22.0%] of 109 patients with other conditions). All comparisons were significant ( $P < 0.01$ ).

Bivariate analyses of the physician attributes showed no important differences in sex, years in medical practice, board certification, self-rated optimism, number of hospice referrals in the past year, or number of medically similar patients in the past year. However, physicians in medical subspecialties excluding oncology were the least likely to give correct estimates (8 [10.1%] of 79 physicians vs 11 [36.7%] of 30 physicians in surgery or other, 18 [26.9%] of 67 physicians in family or general practice, 24 [22.9%] of 105 physicians in oncology, and 30 [16.7%] of 180 physicians in geriatric or general internal medicine), and oncologists were the least likely to be overpessimistic in their estimates (10 [9.5%] of 105 oncologists vs 21 [26.6%] of 79 physicians in other internal medicine subspecialties, 13 [19.4%] of 67 physicians in family or general practice, 31 [17.2%] of 180 physicians in geriatric or general internal medicine, and 4 [13.3%] of 30 physicians in surgery or other). All comparisons were significant ( $P < 0.01$ ).

Among the doctor-patient relationship variables (such as length of professional relationship, number of recent contacts, and time since last examination), the interval since last examination was important: overpessimistic predictions were associated with the most recent examinations (7.5 days), overoptimistic predictions with the next most recent examinations (13.8 days), and the correct predictions with the longest interval since physical examination (19.5 days;  $P < 0.05$  for these comparisons).

The trichotomous prognosis variable was regressed on patients' age, sex, race, diagnosis, duration of disease, and performance status and on physicians' experience, sex, optimism, board certification, specialty, related practical experience, duration of relationship, number of contacts, and interval since last examination (full results are available on the *BMJ* website). The model showed that physicians' prognostic accuracy was independent of most patient and physician attributes. After other attributes were adjusted for, however, male patients were 58% less likely to have overpessimistic than correct predictions (odds ratio [OR], 0.42; 95% confidence interval [CI], 0.18-0.99). Physicians in the upper quartile of practice experience were 63% less likely to make optimistic rather than correct predictions (OR, 0.37; CI, 0.19-0.74) and 78% less likely to make pessimistic rather than correct predictions (OR, 0.22; CI, 0.08-0.61). Physicians with medical subspecialty training (excluding oncologists) were less than 6 times more likely than geriatricians and general internists to make pessimistic rather than correct predictions (OR, 3.26; CI, 1.01-10.67). As the duration of the doctor-patient relationship increased, so, too, did the physician's odds of making an erroneous prediction. For example, each 1 year longer that the physician had known the patient resulted in a 12% increase in the odds of an overpessimistic prediction (OR, 1.12; CI, 1.02-1.22). Also, as the interval since the last physical examination increased, the odds of a physician making a pessimistic rather than a correct prediction decreased; each day longer resulted in a 3% decrease in the odds (OR, 0.97; CI, 0.94-0.99).

## DISCUSSION

Go to:

Our study of 365 physicians and 504 hospice outpatients found that only 19.7% of prognoses were accurate. Most predictions (63.0%) were overestimates, and physicians overall overestimated survival by a factor of about 5. These prognoses were physicians' best guesses about their patients' survival prospects, objectively communicated to the investigators and not to patients themselves. Close multivariate examination showed that most physician and patient attributes were not associated with prognostic error. The tendency of physicians to make prognostic errors, however, was lower among experienced physicians. Moreover, the better the physician knew the patient—as measured, for example, by the length and recentness of their contact—the more likely the physician was to err.

These findings have several implications. First, undue optimism about survival prospects may contribute to late referral for hospice care, with adverse implications for patients.<sup>12,13</sup> Indeed, although physicians state that patients should ideally receive hospice care for 3 months before death,<sup>14</sup> patients typically receive only 1

4/25/2015

## Extent and determinants of error in physicians' prognoses in terminally ill patients

month of such care.<sup>15</sup> The fact that physicians have unduly optimistic ideas about how long patients have to live may partly explain this discrepancy. Physicians who do not realize how little time is left may miss the chance to devote more of it to improving the quality of patients' remaining life. Second, to the extent that physicians' implicit or explicit communication of prognostic information affects patients' own conceptions of their future, physicians may contribute to patients making choices that are counterproductive. Indeed, in 1 study, it was found that terminally ill cancer patients who hold unduly optimistic assessments of their survival prospects often request futile, aggressive care rather than perhaps more beneficial palliative care.<sup>16</sup> Third, our work hints at corrective techniques that might be used to counteract prognostic error. Disinterested physicians, with less contact with the patient, may give more accurate prognoses, perhaps because they have less personal investment in the outcome.<sup>17</sup> Clinicians, therefore, may wish to seek second opinions regarding prognoses, and our work suggests that experienced physicians may be a particularly good source of opinion. Finally, our work suggests that prognostic error in terminally ill patients is uniformly distributed. This has implications for physicians' training and self-assessment because it suggests that there is not one type of physician who is prone to error, nor is there one type of patient in whom physicians are likely to err.

Obtaining prognostic information is often the highest priority for seriously ill patients, eclipsing their interest in treatment options or diagnostic details.<sup>18,19</sup> Reliable prognostic information is a key determinant of both physicians' and patients' decision making.<sup>16,20,21</sup> Although some error is unavoidable in prognostication, the type of systematic bias toward optimism that we have found in physicians' objective prognostic assessments may be adversely affecting patient care.

## Notes

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4/25/2015

Extent and determinants of error in physicians' prognoses in terminally ill patients

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