

merely the natural time course of the disorder is still unclear. Our study was the first trial of radiofrequency ablation in patients with atrial fibrillation with 2 years of follow-up. We are currently planning to coordinate a supplementary 5-year follow-up that will include data from Holter monitoring and recording of intercurrent radiofrequency ablation procedures after the 2-year follow-up and the ongoing use of antiarrhythmic medications. We are also analyzing the cost-effectiveness of the two strategies.

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Talking with Patients about Dying

TO THE EDITOR: Weeks et al. (Oct. 25 issue)¹ raise an important concern that patients with advanced cancers may not understand that chemotherapy is not curative. However, as the authors acknowledge, there are challenges in interpreting patients' expectations on the basis of responses to a single, closed-ended interview item.

Our study on informed consent in early-phase oncology trials may shed light on the extent of these challenges. We found that patients express higher expectations of benefit when the query is framed in terms of personal benefit rather than in terms of a population frequency of a particular benefit.^{2,3} Furthermore, patients with the greatest optimism regarding the benefit of experimental therapy commonly explain their answer in terms of the importance of expressing a positive attitude, not in terms of their assessment of their actual prognosis.² Thus, interpretation of patient-survey items must account for the fact that what we think we are asking patients may be different than what patients mean by their responses.

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TO THE EDITOR: The study by Weeks et al. provides intriguing insight into the uncertainty surrounding patient satisfaction. In this study, patients who had a falsely optimistic view of their treatment aims were more likely to rate their physician's communication highly. Ratings of physician communication by patients are key elements of the Hospital Consumer Assessment of Healthcare Providers and Systems survey.¹ Since October 2012, these ratings have determined Medicare reimbursement to hospitals. Patient-satisfaction scores are publicly reported and used by many commercial websites as the sole criterion for comparing physicians and health care facilities.

However, recently published data show that high patient-satisfaction ratings are associated with poor patient outcomes and increased cost of care.² Although we cannot assume causality, these findings arouse concern. Reported associations between patient satisfaction and quality of care have been weak and contradictory.^{3,4}

Accumulating data suggest that our understanding of determinants and outcomes of patient satisfaction is extremely poor. Much more investigation is required before patient satisfac-

tion can be considered a valid measure of comparison in the assessment of physicians and health care facilities.

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TO THE EDITOR: Weeks et al. rightly believe that “chemotherapy may offer palliation and some prolongation of life.” So, perhaps, may hope. It would be interesting to know the relative survival among the patients who did and those who did not think cure possible.

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Dr. Hughes-Davies reports holding shares in AstraZeneca. No other potential conflict of interest relevant to this letter was reported.

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TO THE EDITOR: In their editorial, Smith and Longo¹ respond to the study by Weeks et al. that examined patients' unrealistic expectations of the curative outcome of chemotherapy treatment for metastatic lung or colorectal cancer. Adolescents and young adults also often have inaccurate expectations of the curative potential of cancer treatments. This is partly due to the wide range of ages in this group (16 to 30 years), to the differences in physical, psychological, cognitive, and spiritual development, and to the fact that phase 1–2 clinical trials are often couched in

terms of further “treatment” options. Adolescents and young adults listen to what physicians may or may not have told them and are concerned about their parents' perspective on outcome, while thoughts of treatment futility may be kept to themselves out of fear of upsetting their parents or staff. As clinicians, we must consider our role in perpetuating flawed expectations and help adolescents and young adults voice their preferences.² They have the same desires as older adults to find meaning and closure as the end of their life nears.

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THE AUTHORS REPLY: We appreciate these suggestions for future research that builds on our observations. We recognize that although our results provide population-based data on the prevalence of misconceptions about the effectiveness of chemotherapy for advanced cancer, a better understanding of the genesis of these misconceptions could help inform the design and implementation of interventions to address the problem. Qualitative studies, as suggested by Weinfurt et al., would be helpful, especially if they were conducted in parallel with assessments of the nature of doctor–patient communication about the effectiveness of chemotherapy. We also agree with Hughes-Davies that more information about the effect of this misunderstanding on outcomes is needed, and we are currently conducting additional analyses examining the association of patient beliefs about the likelihood of cure with subsequent patterns of care and patient outcomes, including survival.

Singh brings attention to the inverse relationship between patients' ratings of physician communication and their understanding that chemotherapy is not curative. As noted in our article, we agree that this finding should arouse concern about the unquestioning use of these ratings as accountability measures. The best physicians communicate with both honesty and compassion; we should be sure that any accountability measure is able to reliably identify that combination of skills.

As Pao et al. note, adolescents and young adults with incurable cancer may face particular challenges, though the literature on decision making and doctor-patient communication with respect to adolescents and young adults and their families is relatively limited. Targeted studies in this group as well as other subgroups defined according to patient characteristics could be informative.

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THE EDITORIALISTS REPLY: All patients, regardless of age, need to plan and to be able to live their lives to the fullest knowing what is going to happen to them.

Singh notes that there is not a simple relationship among high patient-satisfaction ratings, patient outcomes, and the cost of care. As health care systems integrate patient-satisfaction ratings into their compensation models, the risk is real that efforts to make the patient happy may trump the need to have a frank factual discussion of prognosis, if the data in the study by Weeks et al. are correct. Whether honesty and dissatisfaction with the care are actually related requires more study. In our experience, patients rarely leave a practice to find a physician who is less truthful with them.

Hughes-Davies suggests that "hope" may offer palliation and some prolongation of life. We caution that hope should not be confused with

overly optimistic projections. In another study, Weeks et al. examined the relationship between the expectation of survival and actual survival, and they found that patients who overestimated their survival lived no longer than patients who had a more realistic appraisal. These patients did, however, have more difficult deaths with more aggressive end-of-life intubations and resuscitation, and they were more likely to die in the hospital.¹ Similarly, Lee et al. found that survival among patients who overestimated their prognosis after bone marrow transplantation was no longer than among those who had a more realistic appraisal.² Patients with the worst prognosis received the least helpful prognostic information.³ Of note, after bone marrow transplantation, patients who had completed an advance directive actually had substantially improved survival as compared with those who did not.⁴ We do not think that the advance directive acts as a talisman to ward off death, but that planning for all potentialities ("hope for the best but plan for the worst") is possibly associated with better survival, not worse. In fact, patients remain just as hopeful after their doctor is honest with them.⁵ Samuel Taylor Coleridge wrote, "He is the best physician who is the most ingenious inspirer of hope." This adage is untrue when "false" is added as the penultimate word.

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