

# The utility of the surprise question: A useful tool for identifying patients nearing the last phase of life? A systematic review and meta-analysis

*Palliative Medicine*  
2022, Vol. 36(7) 1023–1046  
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DOI: 10.1177/02692163221099116  
journals.sagepub.com/home/pmj



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## Abstract

**Background:** The surprise question is widely used to identify patients nearing the last phase of life. Potential differences in accuracy between timeframe, patient subgroups and type of healthcare professionals answering the surprise question have been suggested. Recent studies might give new insights.

**Aim:** To determine the accuracy of the surprise question in predicting death, differentiating by timeframe, patient subgroup and by type of healthcare professional.

**Design:** Systematic review and meta-analysis.

**Data sources:** Electronic databases PubMed, Embase, Cochrane Library, Scopus, Web of Science and CINAHL were searched from inception till 22nd January 2021. Studies were eligible if they used the surprise question prospectively and assessed mortality. Sensitivity, specificity, negative predictive value, positive predictive value and c-statistic were calculated.

**Results:** Fifty-nine studies met the inclusion criteria, including 88,268 assessments. The meta-analysis resulted in an estimated sensitivity of 71.4% (95% CI [66.3–76.4]) and specificity of 74.0% (95% CI [69.3–78.6]). The negative predictive value varied from 98.0% (95% CI [97.7–98.3]) to 88.6% (95% CI [87.1–90.0]) with a mortality rate of 5% and 25% respectively. The positive predictive value varied from 12.6% (95% CI [11.0–14.2]) with a mortality rate of 5% to 47.8% (95% CI [44.2–51.3]) with a mortality rate of 25%. Seven studies provided detailed information on different healthcare professionals answering the surprise question.

**Conclusion:** We found overall reasonable test characteristics for the surprise question. Additionally, this study showed notable differences in performance within patient subgroups. However, we did not find an indication of notable differences between timeframe and healthcare professionals.

## Keywords

Surprise question, advance care planning, palliative care, systematic review, meta-analysis

### What is already known about the topic?

- The surprise question ('Would I be surprised if this patient were to die in the next 12 months?') is widely used to identify patients nearing the last phase of life. Earlier meta-analyses showed a sensitivity of 67.0% and a specificity of 80.2% and a pooled accuracy of 74.8%.
- The surprise question seems to perform better in cancer patients compared to other patient subgroups.
- It is suggested that doctors appear to be more accurate than nurses in recognising people in the last year of life.

### What this paper adds?

- This study is based on 88,268 surprise question assessments and shows that the surprise question has an estimated sensitivity of 71.4% (95% CI [66.3–76.4]) and specificity of 74.0% (95% CI [69.3–78.6]). The negative predictive value of the surprise question remains high with varying mortality rates.

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- Analysis of timeframe subgroups showed similar sensitivity for 6- and 12-month timeframe: 74.5% (95% CI [67.6–81.4]) and 73.4% (95% CI [68.2–78.6]) respectively. Specificity was lower for a 6-month timeframe 64.3% (95% CI [56.8–71.8]) compared to a 12-month timeframe 72.9% (95% CI [67.6–78.1]).
- A sensitivity of 83.8% (95% CI [75.6–92.0]) was observed for patients with cancer and 82.5% (95% CI [60.1–100.0]) for patients with pulmonary disease, whereas the sensitivity for the emergency department was 49.1 (95% CI [35.7–62.5]). Specificity showed less variation with values between 67.3% (95% CI [53.2–81.3]) for cancer patients and 80.0% (95% CI [60.0–99.9]) for primary care patients.
- Seven studies provided detailed information on different healthcare professionals answering the surprise question. Based on these studies we did not find an indication of notable differences between the accuracy of healthcare professionals answering the surprise question.

#### Implications for practice, theory or policy

- The surprise question has a reasonable accuracy and is therefore an appropriate screening tool to identify patients that could benefit from advance care planning.
- The surprise question should not solely be seen as an indicator of prognostication of death but rather as an opportunity for renewed attention for quality of care and shared decision making by timely initiating advance care planning.

## Introduction

Palliative care aims to improve quality of life and end of life care of patients with life-threatening illnesses and to support their families. Improving end of life care is challenging due to the unpredictable course of chronic diseases. In order to benefit from palliative care, the definition of palliative care by the World Health Organisation emphasises timely identification of patients.<sup>1</sup> The surprise question was proposed by Lynn et al.<sup>2</sup> as a screening method to identify patients who might benefit from palliative care. It requires the healthcare professional to answer the question: ‘Would I be surprised if this patient were to die in the next 12 months?’<sup>2</sup> (or a different timeframe other than 12 months).

Two earlier meta-analyses have been performed to study the accuracy of the surprise question.<sup>3,4</sup> Results from Downar et al.<sup>3</sup> showed a sensitivity of 67.0% and specificity of 80.2%. White et al.<sup>4</sup> showed a pooled accuracy of 74.8%. Both meta-analyses included studies with different timeframes, patient subgroups and healthcare professionals. Downar et al. included studies with a 6, 12 and 18 months timeframe but did not differentiate between timeframes in their results. White et al. included studies with timeframes of 7 days, 30 days, 6 months, 6–12 months and 12 months and stated that an increase in timeframe did not impact the diagnostic accuracy. Both meta-analyses concluded that the surprise question performs better in cancer patients compared to other subgroups. White et al. suggested that doctors appear to be more accurate than nurses in recognising people in their last year of life.<sup>4</sup> However, the accuracy of the surprise question by type of healthcare professional is based on one study and more research is needed.

Many studies on the surprise question have been published in recent years, potentially giving new insights, not

only into the overall accuracy of the surprise question, but also into potential differences between timeframes, patient subgroups and healthcare professionals answering the surprise question. Therefore, the aim of this systematic review and meta-analysis is to determine the accuracy of the surprise question in predicting death, investigating potential differences by timeframe, patient subgroup and type of healthcare professional answering the surprise question by answering the following questions: 1. How accurate is the surprise question in identifying patients in the last year of life? 2. Are there differences in accuracy of the surprise question between various timeframes? 3. Are there differences between patient subgroups to identify patients in the last year of life when using the surprise question? 4. Are there differences between healthcare professionals in identifying patients in the last year of life when using the surprise question?

## Methods

### Study design

This study entails a systematic review and meta-analysis of articles studying the accuracy of the surprise question. This study followed the reporting guideline of the Preferred Reporting Items for Systematic Reviews and Meta-analyses (PRISMA).<sup>5,6</sup>

### Data sources and search strategy

A systematic search was performed in six databases from inception till January 22nd 2021: PubMed, Embase, Cochrane Library, Scopus, Web of Science and Cumulative Index to Nursing and Allied Health Literature (CINAHL). The search terms ‘surprise question’, ‘Gold Standards Framework’ and ‘NECPAL’ were combined using the

Boolean operator OR. The latter two are more elaborate tools to predict the need for end of life care that also use the surprise question<sup>7,8</sup> and were added after an initial pilot search. No filters or limits were applied in the search. Details of the search strategy can be found in Appendix 1. Cross-referencing of included studies was performed.

#### Eligibility criteria

*Inclusion criteria.* Studies were included if they met the following criteria:

1. Prospective studies of any design, including non-peer reviewed publications.
2. Using the surprise question as a prognostic indicator.
3. Death as outcome.

*Exclusion criteria.* Studies were excluded if they met the following criteria:

1. Text was not in English.
2. Design was retrospective.
3. Reversed surprise question ('Would I be surprised if this patient were still alive in 12 months?') was used.
4. The results were not obtainable from the text or after contact with the corresponding authors.
5. Timeframe of surprise question and follow-up did not match (e.g. a surprise question timeframe of 6 months and follow-up 'this admission').

#### Study selection

Two reviewers (EvL and LI) independently screened all studies by title and abstract to identify potentially relevant studies. Subsequently full texts of the remaining studies were assessed by the same two reviewers. Screening of the studies was performed using Rayyan.<sup>9</sup> Disagreements were resolved by discussion until consensus was reached. In case of doubt a third reviewer was consulted (JVD). In case of non-peer reviewed publications, databases were searched for full text versions and requested by contacting the corresponding author. In case of incomplete data or if interpretation of data was unclear, the corresponding author of (potentially) relevant studies was contacted to obtain additional data or information.

#### Quality of studies assessment

The Quality in Prognosis Studies (QUIPS) tool<sup>10</sup> was used for risk of bias assessment. Studies were considered of high quality if (1) the size of the eligible population and baseline characteristics were available (2) loss to follow-up was less than mortality rate and reasons for loss to

follow-up were described (3) the setting and person asking the surprise question was described (4) outcome measurement was described and (5) if the risk of confounding was considered low. Studies were considered to have high confounding if decisions on limiting treatment, potentially leading to death, took place in the study setting (e.g. at the Intensive Care or dialysis unit) or when an intervention (consultation of palliative care team or advance care planning conversation) was planned based on surprise question outcome. Articles were critically appraised by two reviewers (EvL and LI). Disagreements were discussed until consensus was reached. Quality assessment did not affect the inclusion of studies.

#### Data extraction and statistical analysis

Two reviewers (EvL and LI) independently extracted the following data: study population, type of healthcare professional answering the surprise question, study setting, total subjects, total surprise question assessments, surprise question timeframe, mean age, gender and mortality. A 'no' answer to the surprise question will be referred to as a positive answer to the surprise question, whereas a 'yes' answer will be referred to as negative answer to the surprise question. In studies where multiple healthcare professionals answered the surprise question, the study's definition was used to determine whether the answer was positive (this could require consensus in case of a multidisciplinary team or require at least one healthcare professional answering 'no'). If multiple healthcare professionals answered the surprise question and the study provided data separately, the physician's response was used for the meta-analysis when possible. In studies where a third option for answering the surprise question besides 'yes' and 'no' was possible (e.g. 'unsure') data extraction was performed conform the study's definition of a positive surprise question answer (e.g. 'unsure' was regarded as 'No, I would not be surprised').

Studies were divided in subgroups based on timeframe and patient group (cancer, cardiac disease, emergency department, kidney disease, primary care and pulmonary disease). The patient groups consisting of too few studies for analysis were combined as various. If a study cohort could potentially be classified into two groups (e.g. cardiac and emergency department), the cohort was classified into the underlying organ specific disease (e.g. cardiac disease). A '6 to 12' month timeframe was considered equivalent to a '12-month' timeframe. In case a study contained a derivation and a validation cohort, these were counted as separate cohorts. When a study investigated two different timeframes of the surprise question, both timeframes were included in the analysis.

The accuracy of the surprise question was analysed by constructing 2 × 2 tables of the surprise question response and mortality for each study. A true positive was considered as 'No, I would not be surprised' and deceased within the predetermined timeframe and a true negative was

considered as 'Yes, I would be surprised' and alive. Sensitivity, specificity, negative predictive value (NPV), positive predictive value (PPV) and confidence intervals (CI's) were calculated for each study. CI's were calculated with Wilson's method.<sup>11</sup> We considered for sensitivity a correct outcome corresponding to a positive surprise question answer ('No, I would not be surprised') patients that died during the specified timeframe, and for specificity a correct outcome corresponding to patients with a negative surprise question answer ('Yes, I would be surprised') that did not die during the specified timeframe. NPV represents the percentage of patients surviving when the healthcare professionals predicted survival and PPV represents the percentage of patients dying when healthcare professionals predicted death within the specified timeframe. A bivariate random effects logistic regression model was used to pool sensitivity and specificity.<sup>12</sup> This model analyses the combination of sensitivity and specificity, estimates heterogeneity of sensitivity and specificity between studies and the correlation between these measures. Results from the analyses are presented as pooled sensitivity and specificity. PPV and NPV depend on prevalence of disease or mortality rate. Hence, pooled sensitivity and specificity were used to estimate pooled PPV and NPV with 95% CI for various mortality rates: 5%, 10% and 25%. From the results from this analysis, the summary c-statistic (area under the summary receiver operating characteristic curve) was estimated with formulas described by Walter.<sup>13</sup> The corresponding standard error (SE) was estimated with the Delta method.<sup>14</sup> The heterogeneity measure ( $\tau^2$ ), differences between studies beyond the uncertainty captured by confidence intervals, was used to estimate the  $I^2$  statistic.<sup>15</sup>

In a second step, we assessed the impact of timeframe, patient group and peer reviewed versus non-peer reviewed studies by including these characteristics in the model. Reporting the results from the analysis with timeframe was limited to 6 and 12 months, as these were considered most relevant. We performed a likelihood ratio test to assess the influence of non-peer reviewed publications. For each subgroup we estimated pooled sensitivity, specificity, NPV, PPV and the c-statistic with CI's. For the subgroups cardiac, emergency department and pulmonary disease, the analysis showed convergence difficulties, as the correlation between sensitivity and specificity over studies was estimated close to zero. For these analyses, we removed the correlation to obtain reliable results. Statistical analysis was performed with SAS version 9.4.<sup>16</sup> Forest plots were made using Microsoft Excel version 2016.<sup>17</sup>

According to Dutch law, ethics approval was not required for this study.

## Results

### Study selection

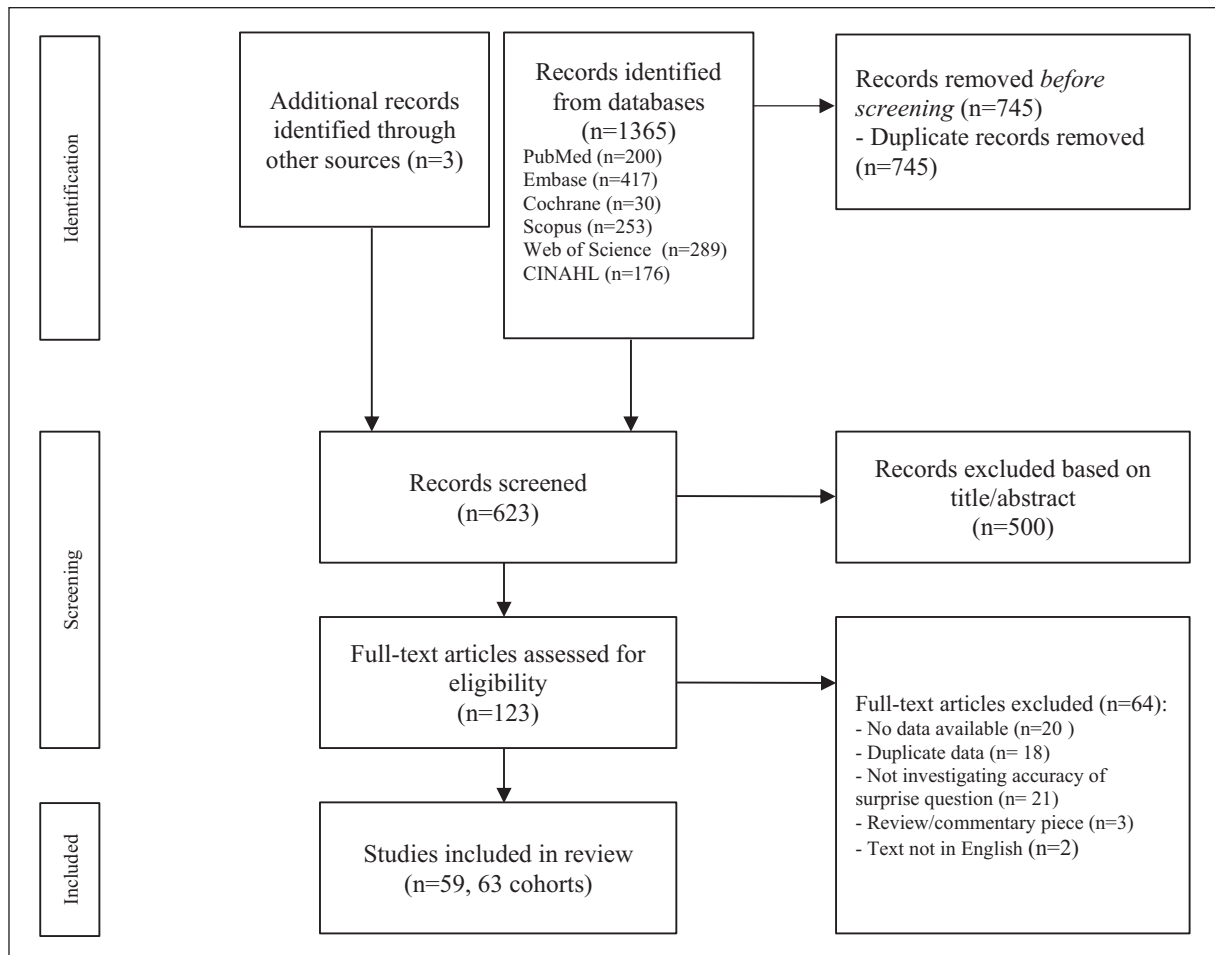
The systematic search identified 1365 studies, of which 745 were duplicates. Cross-referencing resulted in the

inclusion of three extra studies.<sup>18–20</sup> Of the remaining 623 studies, 500 articles were excluded based on title/abstract screening. Full texts were assessed of 123 studies. Based on full text, 64 articles were excluded. In total 59 studies were included in the meta-analysis.<sup>18,19,21–77</sup> The flowchart of the included studies can be found in Figure 1. Four studies consisted of multiple cohorts: three studies consisted of a derivation and a validation cohort<sup>22,38,51</sup> and one study consisted of two different patient subgroups.<sup>69</sup> In total 63 cohorts were included in our analysis. Four studies used two variants of the surprise question with varying timeframes.<sup>31,44,63,73</sup>

Corresponding authors of 35 potentially relevant studies were contacted in order to obtain full text or additional data in order to construct the  $2 \times 2$  table. 18 studies were included after the authors provided additional data.<sup>19,22,23,36,38,39,42,43,46,51,52,54,58–60,69,71,74</sup> Of the remaining 17 articles, two studies were excluded since they did not use the surprise question to predict death.<sup>78,79</sup> Eight studies were excluded since the author was not able to not provide extra data.<sup>80–87</sup> Seven studies were excluded since the corresponding author did not respond after various attempts.<sup>88–94</sup> For eight other potential relevant studies (all non-peer reviewed), no contact details were available nor could these be obtained after extensive searching.<sup>95–102</sup>

### Study characteristics

Characteristics of included studies can be found in Appendix 2. Studies were heterogeneous in timeframe, population, setting and healthcare professional answering the surprise question (e.g. nurse v medical specialist). Most studies originated in the United States (20 studies), United Kingdom (9 studies) and The Netherlands (six studies). Forty-five studies took place in the hospital. Of these, 12 studies were performed at haemodialysis units and eight in outpatient clinics. Of the remaining 14 studies, eight took place in general practice/primary care, three in hospice care settings, one in a nursing home and one in a neurorehabilitation centre. One study took place at multiple settings (three primary care centres, one general hospital, one intermediate care centre and four nursing homes).<sup>37</sup> Most studies investigated a 12-month timeframe of the surprise question (48 cohorts). Other timeframes were 3 days,<sup>66</sup> 1 week,<sup>31</sup> 1 month,<sup>31,36,43,50,55,73</sup> 3 months,<sup>44</sup> 6 months<sup>19,22,38,42,46,52,63</sup> and 24 months.<sup>56</sup> Four studies used two variants of the surprise question with varying timeframes.<sup>31,44,63,73</sup> In general, patients included were adults (>18 years), except for one study performed in children.<sup>44</sup> Eighteen studies included patients with kidney disease, 12 patients with cancer, seven with cardiac disease, seven included a diverse group of patients in general practice/primary care, six studies included patients with pulmonary disease and five studies included patients from the emergency department. In seven studies the surprise question was answered



**Figure 1.** PRISMA flow diagram of screening process.<sup>6</sup>

by various healthcare professionals.<sup>26,45,49,56,59,70,74</sup> In two studies answering the surprise question was based on consensus of a multidisciplinary team.<sup>30,44</sup> Mortality rate of all studies was on average 11.85% and varied between studies from 0.99% (primary care)<sup>75</sup> to 78.78% (advanced cancer patients at the emergency department).<sup>62</sup>

In total five of the included studies added a third option for answering the surprise question besides 'yes' and 'no', including 'don't know this patient well enough',<sup>26</sup> 'don't know',<sup>65</sup> 'unsure',<sup>47</sup> 'uncertain'<sup>48</sup> and 'defer'.<sup>70</sup> In total these answers represent 61 of 88.268 surprise question assessments, varying from 6%<sup>47</sup> to 9%<sup>70</sup> per study. In two studies this percentage could not be retrieved.<sup>26,48</sup>

### Quality assessment: Risk of bias

A detailed overview of the risk of bias assessment is presented in Appendix 3. Three studies had a high risk of bias (two non-peer reviewed), 13 studies (eight non-peer reviewed) had a moderate risk of bias and 43 studies (six non-peer reviewed) had a low risk of bias. Most methodological issues were in study population (domain 1: eight

high and 30 intermediate risk of bias) and study confounding (domain 5: two high and 17 intermediate risk of bias). A risk of selection bias was in many studies caused by not specifying the eligible population. An intermediate or high-risk assessment in study confounding was in most studies due to the setting and patient population (e.g. haemodialysis patients) or caused by planning an intervention based on the outcome of the surprise question.

### Meta-analysis

In total 88.268 assessments were included from 59 different studies and 63 different cohorts. Sensitivity between individual studies varied from 12.5%<sup>73</sup> to 100%,<sup>28</sup> specificity varied from 26.3%<sup>66</sup> to 98.6%,<sup>75</sup> NPV from 35.1%<sup>52</sup> to 100%<sup>28</sup> and PPV from 5.4%<sup>43,55</sup> to 84.7%.<sup>62</sup> Individual study results and forest plots of the sensitivity and specificity can be found in Appendices 4–6. A likelihood ratio test showed that inclusion of non-peer reviewed publications did not significantly change the results ( $p$  value 0.84). Non-peer reviewed publications were therefore retained in all analyses.

The meta-analysis resulted in an estimated sensitivity of 71.4% (95% CI [66.3–76.4]), an estimated specificity of 74.0% (95% CI [69.3–78.6]) (Table 1, Figures 2 and 3). The estimated NPV varied from 98.0% (95% CI [97.7–98.3]) to 88.6% (95% CI [87.1–90.0]) with a mortality rate of 5% and 25% respectively (Table 1, Figures 4 and 5). The estimated PPV varied from 12.6% (95% CI [11.0–14.2]) with a mortality rate of 5%–47.8% (95% CI [44.2–51.3]) with a mortality rate of 25%. The c-statistic value was 0.79 (95% CI [0.77–0.81]) in the overall analysis. Heterogeneity ( $I^2$ ) in the overall analysis was 98.2% and 98.4% for sensitivity and specificity respectively.

Results from the subgroup analysis including timeframe subgroups (6- and 12-months), patient subgroups and peer reviewed versus non-peer reviewed subgroups can be found in Table 1 and Figures 2 to 5. Analysis of timeframe subgroups showed similar sensitivity for 6- and 12-month timeframe: 74.5% (95% CI [67.6–81.4]) and 73.4% (95% CI [68.2–78.6]) respectively. Specificity was lower for a 6-month timeframe 64.3% (95% CI [56.8–71.8]) compared to a 12-month timeframe 72.9% (95% CI [67.6–78.1]).

Subgroup analysis of patient subgroups showed a lower sensitivity for the surprise question at the emergency department (49.1%; 95% CI [35.7–62.5]) compared to higher sensitivities for cancer patients (83.8%; 95% CI [75.6–92.0]) and patients with pulmonary disease (82.5%; 95% CI [60.1–100]). Specificity varied from 67.3% (95% CI [53.2–81.3]) in cancer patients to 80.0% (95% CI [60.0–99.9]) in primary care patients. NPV was the lowest in the emergency department with a NPV of 96.6% (95% CI [95.8–97.6]) and the highest in pulmonary patients with a NPV of 98.8% (95% CI [97.1–100.0]) at a mortality rate of 5%. NPV varied from 81.9% (95% CI [77.7–86.1]) in patients at the emergency department to 92.6% (95% CI [83.6–100]) in patients with pulmonary disease and 92.6% (95% CI [89.9–95.2]) in patients with cancer at a mortality rate of 25%.

In seven studies multiple healthcare professionals answered the surprise question. Due to the heterogeneity of the results (different patient subgroups, different healthcare professionals answering the surprise question with different seniority and different intensity in care provision to the patient) we could not perform a meta-analysis on this subgroup. An overview of the accuracy of the surprise question by different healthcare professionals can be found in Table 2. The study by Da Silva Gane et al.<sup>26</sup> investigated the variability between nephrologists and nurses of different levels of seniority (referred to as 'bands'). They conclude that nephrologists perform better compared to nurses based on a higher sensitivity and similar specificity. The study of Lakin et al.<sup>56</sup> also show that primary care physicians have a higher sensitivity compared to nurse care coordinators. On the contrary, the results of Valerio and Farinha<sup>74</sup> show that nurses have a higher sensitivity and lower specificity compared to nephrologists and the results of Straw et al.<sup>59</sup> show that heart failure nurses have a higher

sensitivity compared to cardiologists, trainee-grade doctors and non-specialist nurses. Similar performances between healthcare professionals are seen in the study by Mudge et al.<sup>49</sup> when comparing doctors and senior nurses and by Rauh et al.<sup>70</sup> when comparing doctors, nurses and advanced practice providers. Ebke et al.<sup>45</sup> compare the accuracy of answering the surprise question by neurorehabilitation physicians and palliative care physicians, with palliative care physicians having a higher sensitivity and lower specificity. In five other studies multiple healthcare professionals answered the surprise question, however, no separate data was reported.<sup>40,51,54,67,73</sup>

## Discussion

### Main findings

This meta-analysis evaluated the accuracy of the surprise question in predicting death, differentiating by timeframe, patient subgroup and by type of healthcare professional answering the surprise question. In total, 59 studies encompassing 63 cohorts were identified including 88,268 surprise question assessments. The pooled sensitivity was 71.4% (95% CI [66.3–76.4]) and the pooled specificity 74.0% (95% CI [69.3–78.6]). The c-statistic value was 0.79 (95% CI [0.77–0.81]) in the overall analysis. Analysis of timeframe subgroups showed similar sensitivity for 6- and 12-month timeframe (74.5% (95% CI [67.6–81.4]) and 73.4% (95% CI [68.2–78.6]) respectively) and lower specificity for 6-month timeframe compared to a 12-month timeframe (64.3% (95% CI [56.8–71.8]) and 72.9% (95% CI [67.6–78.1]) respectively). Pooled estimates showed variation between patient groups. A sensitivity of 83.8% (95% CI [75.6–92.0]) was observed for patients with cancer and 82.5% (95% CI [60.1–100]) for patients with pulmonary disease, whereas the sensitivity for the emergency department was 49.1% (95% CI [35.7–62.5]). Specificity showed less variation with values between 67.3% (95% CI [53.2 and 81.3]) for cancer patients and 80.0% (95% CI [60.0–99.9]) for primary care patients. The estimated NPV varied from 98.0% (95% CI [97.7–98.3]) to 88.6% (95% CI [87.1–90.0]) with a mortality rate of 5% and 25% respectively. The estimated PPV varied from 12.6% (95% CI [11.0 to 14.2]) with a mortality rate of 5% to 47.8% (95% CI [44.2–51.3]) with a mortality rate of 25%. The NPV remains high with increasing mortality rate in all subgroups. Seven studies provided detailed information on different healthcare professionals answering the surprise question. Based on these studies we did not find clear evidence for a difference between the accuracy of healthcare professionals answering the surprise question.

### Strengths and limitations

This study has a number of strengths. First of all, each part of the review process was independently undertaken by

**Table 1.** Diagnostic accuracy of the surprise question.

Patient subgroup	No. of cohorts	Sensitivity [95% CI]	<i>I</i> <sup>2</sup> , %	Specificity [95% CI]	<i>I</i> <sup>2</sup> , %	AUC [95% CI]	PPV – mortality rate 5% [95% CI]	NPV – mortality rate 5% [95% CI]	PPV – mortality rate 10% [95% CI]	NPV – mortality rate 10% [95% CI]	PPV – mortality rate 25% [95% CI]	NPV – mortality rate 25% [95% CI]
Total	63	71.4 [66.3–76.4]	98.2	74.0 [69.3–78.6]	98.4	0.79 [0.77–0.81]	12.6 [11.0–14.2]	98.0 [97.7–98.3]	23.4 [20.8–25.9]	95.9 [95.3–96.4]	47.8 [44.2–51.3]	88.6 [87.1–90.0]
Timeframe												
6 months	7	74.5 [67.6–81.4]	96.4	64.3 [56.8–71.8]	97.4	0.75 [0.71–0.80]	9.9 [8.3–11.6]	98.0 [97.5–98.4]	18.8 [16.0–21.7]	95.8 [94.8–96.7]	41.0 [36.5–45.5]	88.3 [85.9–90.8]
12 months	48	73.4 [68.2–78.6]	98.0	72.9 [67.6–78.1]	98.3	0.80 [0.77–0.82]	12.5 [10.8–14.2]	98.1 [97.8–98.4]	23.1 [20.4–25.9]	96.1 [95.5–96.7]	47.5 [43.6–51.3]	89.2 [87.7–90.7]
Subgroups												
Cancer <sup>a</sup>	12 <sup>a</sup>	83.8 [75.6–92.0]	90.4	67.3 [53.2–81.3]	90.7	0.83 [0.79–0.88]	11.9 [8.0–15.7]	98.8 [98.3–99.2]	22.2 [15.8–28.5]	97.4 [96.4–98.4]	46.1 [37.0–55.1]	92.6 [89.9–95.2]
Cardiac	7	71.0 [60.5–81.5]	82.4	73.4 [62.2–84.6]	86.9	0.78 [0.69–0.87]	12.3 [7.5–17.1]	98.0 [97.2–98.8]	22.9 [15.0–30.8]	95.8 [94.2–97.4]	47.1 [36.0–58.2]	88.4 [84.3–92.4]
ED	5	49.1 [35.7–62.5]	80.9	76.5 [68.5–84.6]	82.8	0.68 [0.58–0.79]	9.9 [6.0–13.8]	96.6 [95.7–97.6]	18.9 [12.2–25.6]	93.1 [91.3–94.9]	41.1 [30.5–51.7]	81.9 [77.7–86.1]
Kidney	18	62.1 [55.9–68.3]	91.4	76.7 [70.5–83.0]	94.4	0.76 [0.70–0.81]	12.3 [9.3–15.3]	97.5 [97.0–97.9]	22.9 [18.0–27.8]	94.8 [93.9–95.7]	47.1 [40.1–54.0]	85.9 [83.7–88.0]
Primary care	7	68.8 [47.3–90.3]	86.8	80.0 [60.0–99.9]	87.5	0.81 [0.74–0.89]	15.3 [5.5–25.1]	98.0 [97.0–99.0]	27.6 [12.5–42.7]	95.8 [93.9–97.8]	53.4 [34.5–72.2]	88.5 [83.4–93.6]
Pulmonary <sup>b</sup>	6 <sup>b</sup>	82.5 [60.1–100.0]	79.1	72.8 [54.3–91.3]	82.8	0.85 [0.68–1.00]	13.8 [5.1–22.5]	98.8 [97.1–100.0]	25.2 [11.4–39.0]	97.4 [94.1–100.0]	50.3 [32.0–68.6]	92.6 [83.6–100.0]
Various	12 <sup>c</sup>	75.9 [69.2–82.7]	89.9	70.8 [62.5–79.2]	91.3	0.80 [0.76–0.83]	12.1 [9.6–14.5]	98.2 [97.9–98.6]	22.4 [18.4–26.5]	96.4 [95.6–97.1]	46.5 [40.7–52.2]	89.8 [87.8–91.8]
Type of publication												
Peer reviewed	47 <sup>d</sup>	72.0 [66.4–77.6]	97.7	73.9 [68.6–79.3]	97.9	0.79 [0.77–0.82]	12.7 [10.9–14.5]	98.1 [97.7–98.4]	23.5 [20.5–26.4]	96.0 [95.3–96.6]	47.9 [43.8–52.1]	88.8 [87.2–90.4]
Non-peer reviewed	16 <sup>e</sup>	69.1 [58.4–79.8]	93.0	74.1 [64.9–83.3]	93.9	0.78 [0.73–0.83]	12.3 [9.2–15.4]	97.9 [97.3–98.5]	22.9 [17.9–27.9]	95.6 [94.4–96.8]	47.1 [40.0–54.2]	87.8 [84.8–90.8]

ED: emergency department; AUC: area under the curve; *I*<sup>2</sup>: Heterogeneity; CI: confidence interval; PPV: positive predictive value; NPV: negative predictive value.

<sup>a</sup>2/12 cohorts were analysed with two separate timeframes.

<sup>b</sup>1/6 cohort was analysed with two separate timeframes.

<sup>c</sup>1/12 cohort was analysed with two separate timeframes.

<sup>d</sup>3/47 cohorts were analysed with two separate timeframes.

<sup>e</sup>1/16 cohort was analysed with two separate timeframes.

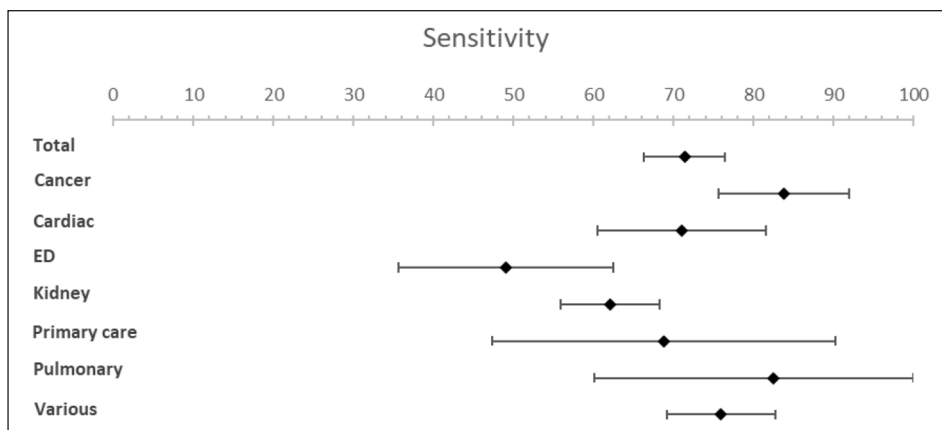


Figure 2. Forest plots for sensitivity.

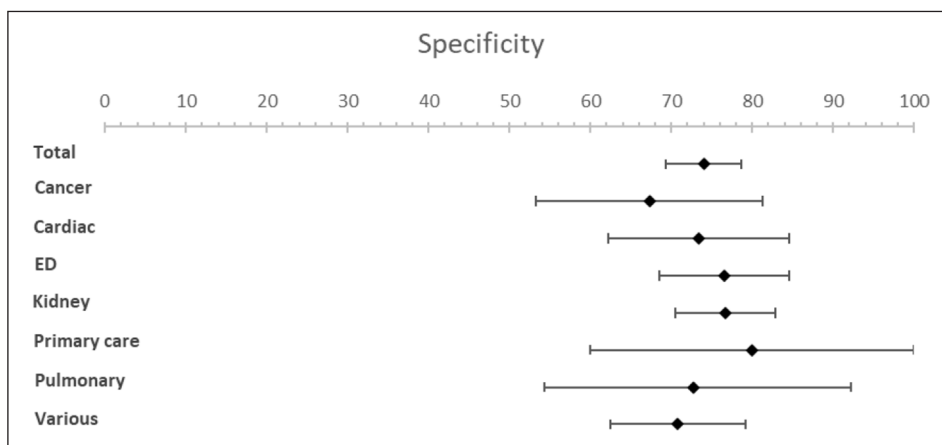


Figure 3. Forest plots for specificity.

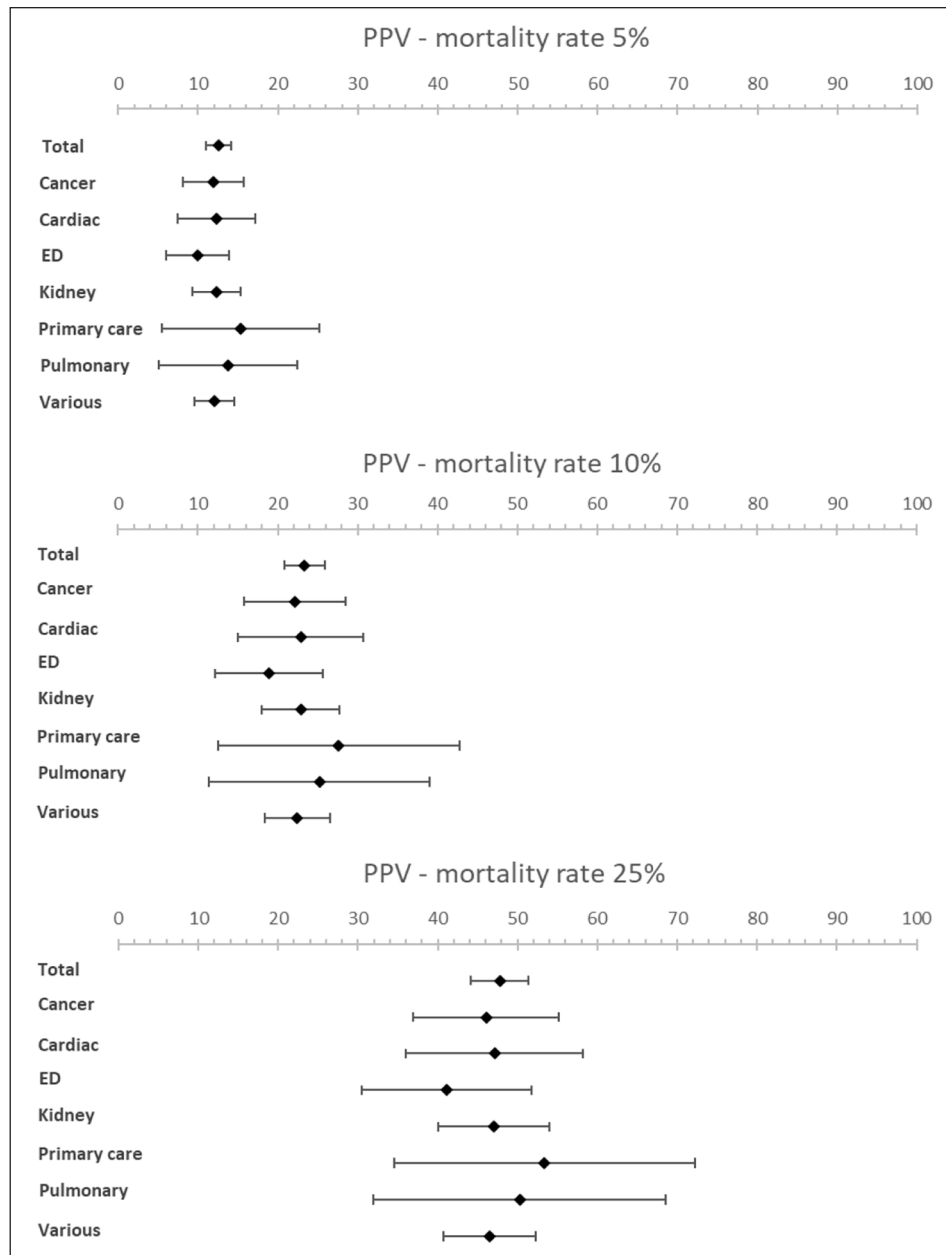
two reviewers. Furthermore, a high number of studies have been included. This can be explained by (1) the increased attention for palliative care and the surprise question, resulting in a high amount of recently published studies (2) the effort made to obtain additional data by contacting authors and (3) including non-peer reviewed studies: 16 of the 59 included studies were non-peer reviewed studies, mostly conference abstracts. We also included the non-peer reviewed studies in an effort to avoid publication bias of favourable outcomes.<sup>103</sup> A limitation of including non-peer reviewed studies is that they did not provide sufficient information for a comprehensive quality assessment, which could have led to a relatively negative quality assessment. Furthermore, we observed a high degree of heterogeneity, with an overall  $I^2$  of 98.2% and 98.4% for sensitivity and specificity respectively. The analysis with subgroups (i.e. timeframe, patient subgroups and type of publication) still showed a high degree of heterogeneity. This can be explained by the enormous diversity in included studies, reflecting the different real-life circumstances in which the surprise question is used, and

its versatile nature. Furthermore, the accuracy of the surprise question may be overestimated due to a possible self-fulfilling prophecy: a positive answer to the surprise question ('No, I would not be surprised') could lead to, consciously or subconsciously, discussing goals of care, thereby potentially influencing outcome. Finally, c-statistics were estimated with an easy to apply formula, which may result in a slight over-estimation.<sup>13</sup>

### Comparison to other literature

As described earlier, two meta-analyses were performed on the accuracy of the surprise question by Downar et al.<sup>3</sup> and White et al.<sup>4</sup> Despite this, the subjectiveness and accuracy of using the surprise question are still debated.<sup>104,105</sup> The previous meta-analyses included 17 and 22 cohorts, with 11.621 and 25.718 surprise question assessments respectively, compared to 63 cohorts and 88.268 SQ assessments in this study. Moreover, Downar et al. did not include 'Gold Standards Framework' in the search, therefore missing studies that did not mention the





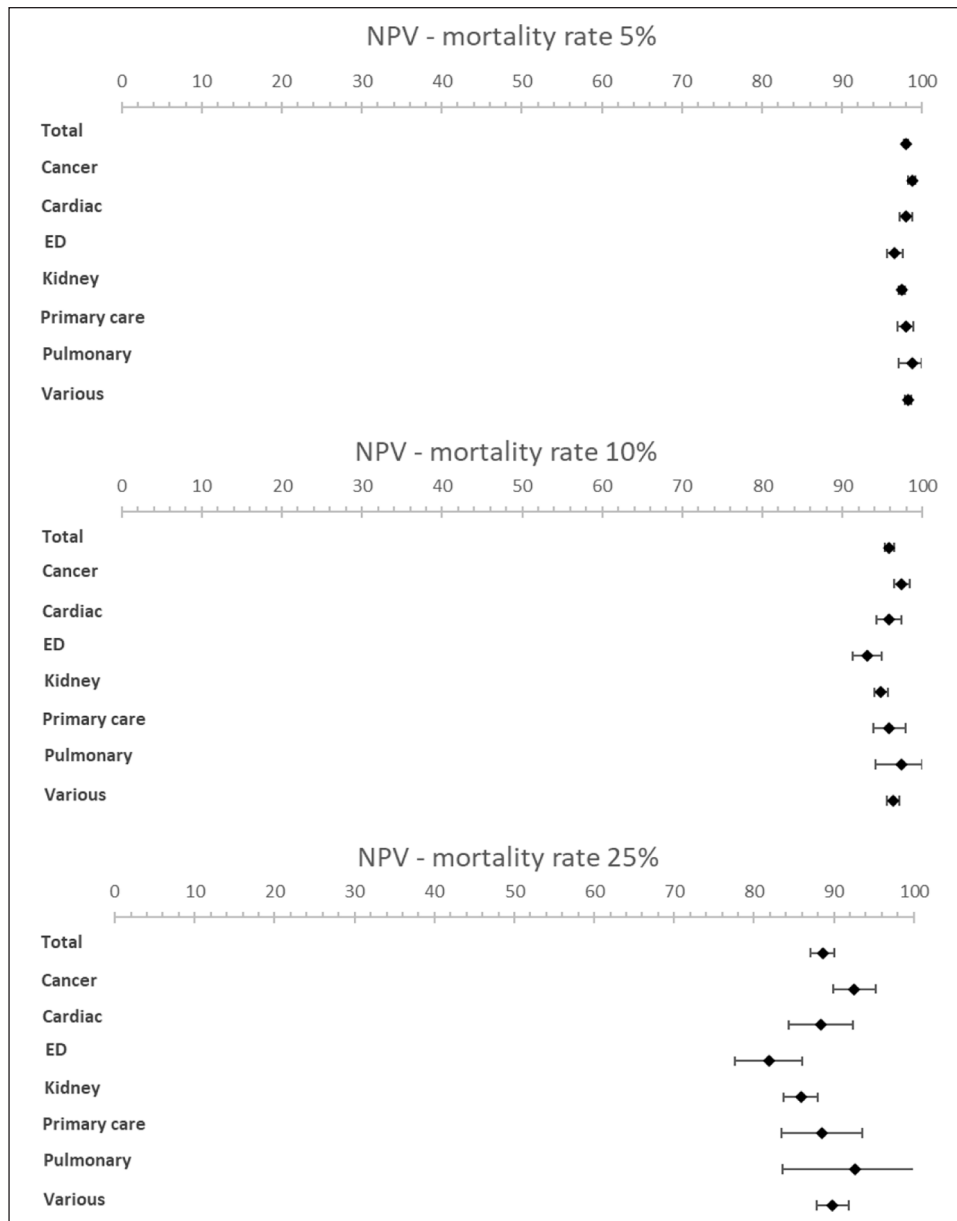
**Figure 4.** Forest plots showing PPV for various mortality rates (5%, 10% and 25%).

surprise question in title or abstract. Furthermore, both meta-analyses report a substantial risk of bias in their included studies. Indeed, in our assessment, most pre-2017 studies have an increased risk of bias whereas more recent studies seem to be of better methodological quality. Hence, our results may be more reliable due to the increase of surprise question assessments included and improved methodological quality of included studies.

This study shows similar results in overall accuracy in predicting death compared to the previous meta-analyses. Downar et al. reported a sensitivity of 67.0% and a specificity of 80.2% compared to 71.4% and 74.0% respectively in our study. The c-statistic (area under the

curve) of Downar et al.<sup>3</sup> was 0.81 [0.78–0.84] compared to 0.79 [0.77–0.81] in our meta-analysis. De Bock et al.<sup>106</sup> studied the accuracy of the Supportive and Palliative Care Indicators Tool (SPICT) in a geriatric population and report a higher sensitivity of 84.1% and a lower specificity of 57.9% compared to our results of the surprise question.

White et al. stated that an increase in timeframe did not impact the diagnostic accuracy. Our study showed similar sensitivity for 6- and 12-month timeframe. However we found a lower specificity for 6-month timeframe compared to a 12-month timeframe. Our study confirms the previous conclusions that the surprise



**Figure 5.** Forest plots showing NPV for various mortality rates (5%, 10% and 25%).

question performs better in cancer patients compared to other subgroups. We did not find clear evidence for a difference between the accuracy of healthcare professionals answering the surprise question, in contrast to an earlier suggestion by White et al.<sup>4</sup> that doctors seem to be more accurate than nurses in recognising people in the last year of life.

### *Implications for practice*

A systematic review by Cardona-Morrell et al.<sup>107</sup> indicated that on average 33%–38% of patients nearing their end of life receive non-beneficial treatments in the last 6 months of their life. Advance care planning can have a

positive effect on end of life care, decrease life-sustaining treatment, increase use of hospice and palliative care, prevent hospital admissions and improve goal-concordant care.<sup>108</sup> Timely identification of patients who could potentially benefit from advance care planning is important.<sup>109</sup> The importance of advance care planning increases when nearing the end of life. Hence, prognostication of mortality can be used as a proxy for initiating advance care planning. The surprise question is an easy to use tool<sup>2</sup> and does not require large amounts of clinical data compared to other available screening tools.<sup>110</sup> These characteristics and the reasonable accuracy in predicting death with fairly high NPV with various mortality rates make the surprise question an appropriate

**Table 2.** Accuracy of the surprise question by type of healthcare professional.

Study	Type of healthcare professional	Sensitivity, % [95% CI]**	Specificity, % [95% CI]**	PPV, % [95% CI]**	NPV, % [95% CI]**
Da Silva Gane et al. <sup>26</sup>	Nephrologists	73.7 [64.6–82.8]	73.9 [66.3–81.5]	33.5 [27.3–39.7]	94.3 [90.9–97.7]
	Nurse band 5*	35.6 [21.3–49.9]	85.4 [77.8–93.0]	32.4 [21.7–43.1]	88.3 [86.5–90.1]
	Nurse band 6*	51.1 [31.5–70.7]	78.5 [69.1–87.9]	31.1 [24.4–37.8]	90.1 [87.3–92.9]
	Nurse band 7/8*	51.4 [18.1–33.1]	79.1 [72.4–85.8]	30.0 [20.7–39.3]	90.3 [87.8–92.8]
Ebke et al. <sup>45</sup>	Neurorehabilitation physicians	50.0 [32–67]	86.1 [81–91]	37.8 [27–50]	91.1 [88–94]
	Palliative care physicians	67.7 [50–83]	70.3 [64–77]	27.7 [22–34]	92.8 [89–96]
	At least one clinician	76.5	64.9	26.8	94.2
Mudge et al. <sup>49</sup>	Doctors	81	70	38	94
	Senior nurses	80	68	36	93
	Either discipline	90	56	31	96
Straw et al. <sup>59</sup>	Cardiologists	85	59	52	88
	Trainee-grade doctor	75	62	51	83
	Heart failure nurse	90	44	45	90
	Non-specialist nurse	66	73	58	79
Lakin et al. <sup>56</sup>	Primary care physician	79.4	68.6	31.6	94.8
	Nurse care coordinators	52.6	80.6	31.8	90.8
	Either healthcare professional says ‘no’	82.6	62.7	28.1	95.3
	Both healthcare professionals say ‘no’	50.3	86.7	40	90.8
Valerio and Farinha <sup>74</sup>	Nephrologists	68.2	77.3	27.8	95
	Nurses	81.8	64.5	22.8	96.5
Rauh et al. <sup>70</sup>	Medical doctor	75	69	43	90
	Nurses	71	61	42	84
	Advanced practice providers	83	67	44	93
	Combined	75	66	43	89

PPV: positive predictive value; NPV: negative predictive value.

\*Band 5 nurses are less senior nurses. Band 6 nurses are of intermediate seniority and band 7/8 are senior nurses.

\*\*CI's are only provided when presented in the original study.

screening tool for initiating advance care planning. Additionally, patients with a positive answer to the surprise question ('No, I would not be surprised') are likely to be vulnerable and may therefore benefit from advance care planning regardless of whether they die exactly within the specified timeframe. Furthermore, initiating advance care planning 'too early' does not seem to cause damage.<sup>108</sup> The results of this systematic review and meta-analysis encourage the use of the surprise question as screening tool by various healthcare professionals, not exclusively by doctors. We think the surprise question should not solely be seen as an indicator of prognostication of death but rather as an opportunity for renewed attention for quality of care and shared decision making by timely initiating advance care planning.

## Conclusion

We found overall reasonable test characteristics for the surprise question. Additionally, this study showed notable differences in performance within patient subgroups.

However, we did not find an indication of notable differences between timeframe and healthcare professionals. We submit that the surprise question is an appropriate tool for initiating advance care planning.

## Acknowledgements

We would like to thank all of the corresponding authors of the studies listed in this meta-analysis for providing us with additional data and/or information.

## Authorship

EvL, LI and JvD conceived and designed the study. EvL and LI collected the data, critically appraised the articles and drafted the manuscript. NZ performed the statistical analyses. All authors critically revised the manuscript and approved the final version to be published.

## Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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#### Appendix 1. Search strategy.

Source	Date of search	Search strategy
PubMed	22-01-2021	((surprise question*[Title/Abstract]) OR “gold standards framework”[Title/Abstract]) OR NECPAL[Title/Abstract]
Embase	22-01-2021	‘surprise question*’:ti,ab,kw OR ‘gold standards framework’:ti,ab,kw OR necpal:ti,ab,kw
Cochrane	22-01-2021	(‘Gold Standards Framework’):ti,ab,kw OR (‘surprise question’):ti,ab,kw OR (NECPAL):ti,ab,kw
Scopus	22-01-2021	TITLE-ABS-KEY (‘surprise question*’) OR TITLE-ABS-KEY ( ‘gold standards framework’ ) OR TITLE-ABS-KEY
Web of Science	22-01-2021	TOPIC:(‘surprise question*’) OR TOPIC:(‘gold standards framework’) OR TOPIC: (NECPAL)
CINAHL	22-01-2021	TI ‘surprise question*’ OR AB ‘surprise question*’ OR MH ‘surprise question*’ OR TI ‘gold standards framework’ OR AB ‘gold standards framework*’ OR MH ‘gold standards framework*’ OR TI ‘necpal*’ OR AB ‘necpal*’ OR MH ‘necpal*’

No filters/limits were applied in the searches.

Appendix 2. Characteristics of included studies.

Author	Country	Population	Healthcare professional answering the surprise question	Setting	Total subjects (n)	Total surprise question assessments (n)	Surprise question timeframe	Subject age mean (SD)	Gender M:F
Barnes et al. <sup>18</sup>	United Kingdom	Heart failure, 60 years or older	General practitioners	General practice	542	231	12 months	77 (71–82)**	121:110****
Moss et al. <sup>21</sup>	United States	Haemodialysis	Nurse practitioners	3 haemodialysis units	147	147	12 months	66.4 (14.8)	81:66
Cohen et al. <sup>22</sup>	United States	Haemodialysis	Nephrologists	Haemodialysis unit	512 (d) 514 (v)	447 (d) 427 (v)	6 months	60 (17) (d) 63 (16) (v)	254:195 (d) 245:182 (v)
Moss et al. <sup>23</sup>	United States	Breast, lung or colon cancer	Oncologists	Outpatient clinic	853	826	12 months	60 (13)	126:727
South et al. <sup>24</sup> (a)	United Kingdom	Acute exacerbation COPD	NR	COPD unit	199	199	6–12 months	70 (NR)	92:107
Fenning et al. <sup>25</sup>	United Kingdom	Acute coronary artery disease	Medical staff	Cardiology ward	172	172	6–12 months	66 (14)	105:67
Da Silva Gane et al. <sup>26</sup>	United Kingdom	Haemodialysis	Nephrologists and nurses	3 haemodialysis units	344	344	12 months	71.9 (11.0) (died) 62.2 (15.8) (alive)	221:123
Pang et al. <sup>27</sup>	Hong Kong	Peritoneal dialysis patients	Nephrologists	Dialysis centre	367	367	12 months	60.2 (12.3)	205:162
Reilly et al. <sup>28</sup> (a)	United Kingdom	Non-cancer respiratory patients	Pulmonologists	Ward of general hospital	85	85	12 months	68 (NR)	36:49
Moroni et al. <sup>29</sup>	Italy	Stage IV cancer	General practitioners	General practice	231	231	12 months	70.2 (SE 0.9)	117:114
Feyi et al. <sup>30</sup>	United Kingdom	End-stage renal disease	Multidisciplinary	1 dialysis unit	178	178	12 months	NR	NR
Hamano et al. <sup>31</sup>	Japan	Advanced cancer	Palliative care physicians	58 palliative care services	2361	2361	7 and 30 days	69.1 (12.8)	1358:1003
Amro et al. <sup>32</sup>	United States	Haemodialysis	Nephrologists	Dialysis centre	201	201	12 months	71 (65–77)**	105:96
Maria Carmen et al. <sup>33</sup> (a)	Spain	Haemodialysis	Medical staff	Haemodialysis unit	49	49	12 months	NR	NR
Gerlach et al. <sup>34</sup> (a)	Germany	Cancer (haemato-oncology)	Physicians	Hemato-oncology outpatient clinic Stem cell transplantation unit	828	672	12 months	NR	NR
Lakin et al. <sup>35</sup> (a)	United States	High risk patients	General practitioners	Academic primary care centre	1737	1737	12 months	65 (NR)	696:1041
Strout et al. <sup>36</sup> (a)	United States	Emergency department patients with sepsis	Emergency physicians	Emergency department	330	330	30 days	71 (0–97)***	182:148

(Continued)



## Appendix 2. (Continued)

Author	Country	Population	Healthcare professional answering the surprise question	Setting	Total subjects (n)	Total surprise question assessments (n)	Surprise question timeframe	Subject age mean (SD)	Gender M:F
Gómez-Batiste et al. <sup>37</sup>	Spain	Advanced chronic disease	Healthcare professional	Three primary care centres, one general hospital, one intermediate care centre, four nursing homes	1064	1059	12 months	81.3 (11.8)	378:686
Hadique et al. <sup>38</sup>	United States	Medical ICU patients	ICU physicians	Medical ICU	500 (d)	500 (d)	6 months	61.1 (17.7) (d)	257:243
Lilley et al. <sup>39</sup>	United States	Acute surgical conditions, 65 years or older	Surgical residents and attendings	Emergency general surgery service	549 (v)	543 (v)	12 months	61.1 (16.2) (v)	296:253
Moretti et al. <sup>40</sup>	United Kingdom; Italy	Acute coronary artery disease	Medical and nursing staff	Cardiology ward	119	163*	6–12 months	79.3 (7.9) (SQ+)	78:85
Salat et al. <sup>41</sup>	United States	Advanced chronic kidney disease (no dialysis) >60 years	Nephrologists	Outpatient clinic	629	470	12 months	73.5 (7.0) (SQ-)	432:197
Santos Lascasas et al. <sup>42</sup> (a)	Portugal	Dialysis patients, 65 years or older	NR	Dialysis unit	488	488	12 months	67.5 (12.7)	239:249
Strout et al. <sup>43</sup> (a)	United States	Admitted adult emergency department patients	Emergency physician and inpatient physician	Hospital wards	360	360	6 months	71 (65–77)*	169:191
Burke et al. <sup>44</sup>	United Kingdom	Children (0–21 years) with life-threatening disease	Multidisciplinary team	Children's hospice	327	325 (3 m) 306 (12 m)	30 days	67 (18–103)***	50.3% female
Ebke et al. <sup>45</sup>	Germany	Neurorehabilitation	Neurologists and palliative care physicians	Neurorehabilitation centre	279	236	12 months	7.7 (5.3)	185:142
Faria de Sousa et al. <sup>49</sup> (a)	Portugal	Advanced stages of: cancer, heart failure, kidney disease, COPD	General practitioners	General practice	209	201	6 months	63 (14)	161:118
Faria et al. <sup>46</sup>	Canada	Haemodialysis	Nephrologists	Haemodialysis unit	374	374	6 months	72.6 (12.6)	113:96
Liyanaige et al. <sup>47</sup>	Australia	Nursing home residents	Director of Nursing	Nursing home	187	187	12 months	68 (15)	221:153
Mitchell et al. <sup>48</sup>	Australia	Patients, 70 years or older	General practitioners	19 general practices	4375	1525	12 months	82.4 (9.09)	83:104
Mudge et al. <sup>49</sup>	Australia	Hospital inpatients	Senior nurses and medical staff	Teaching hospital	524	513	12 months	79.1 (6.9)**	1013:512****
								60.2 (18.9)	276:237****

(Continued)

## Appendix 2. (Continued)

Author	Country	Population	Healthcare professional answering the surprise question	Setting	Total subjects (n)	Total surprise question assessments (n)	Surprise question timeframe	Subject age mean (SD)	Gender M:F
Ouchi et al. <sup>50</sup>	United States	Emergency department patients, 65 years or older	Emergency physicians	Emergency department	207	207	12 months	75 (7.5)	NR
Schmidt et al. <sup>51</sup>	United States	Advanced chronic kidney disease (no dialysis)	Clinicians and nurse practitioners	Outpatient clinics	749 (d) 437 (v)	749 (d) 437 (v)	12 months	69.3 (14.6) (d) 70.0 (13.3) (v)	381:368 (d) 166:271 (v)
Tanasychuk et al. <sup>52</sup>	Israel	Acute kidney injury with unscheduled dialysis	Nephrologists	Hospital	475	475	6 months	72.8 (12.2)	238:192
Aaronson et al. <sup>53</sup>	United States	Heart failure	Emergency physicians	Emergency department	193	193	12 months	74.5 (12.6)	NR
Gastelurrutia et al. <sup>54</sup> (a)	Spain	Heart failure	Physicians and nurses	3 outpatient heart failure clinics	922	922	12 months	69.3 (12.2)	648:274
Haydar et al. <sup>55</sup>	United States	Emergency department patients, 18 years or older	Emergency physicians	Emergency department	6122	6089	30 days	66 (51–79)**	3168:2954
Lakin et al. <sup>56</sup>	United States	Chronically ill primary care patients	Primary care physician and nurse care coordinators	Primary care	1163	1163*	24 months	70.1 (14.8)	500:663
Ouchi et al. <sup>57</sup>	United States	Admitted Emergency department patients, 65 years or older	Attending physicians	Emergency department	10,737	16,223*	30 days	75.9 (8.8)	5205:5532
Raubenheimer et al. <sup>58</sup>	South Africa	Admitted to acute medical services	Two trained clinicians	Acute medical services	822	822	12 months	52 (37–67)**	378:444
Straw et al. <sup>59</sup>	United Kingdom	Decompensated heart failure	Cardiologists. Trainee-grade doctors and heart failure nurses	Cardiology ward	129	114	12 months	71 (14)	73:41
Tripodoro et al. <sup>60</sup>	Argentina	Cancer	Treating physicians	All patients in 1 centre	317	313	12 months	77 (21–99)***	106:211
Veldhoven et al. <sup>61</sup>	The Netherlands	Primary care patients, 75 years or older	Two general practitioners	General practice	292	292	12 months	84 (5.46)	117:175
Verhoef et al. <sup>62</sup>	The Netherlands	Advanced cancer at emergency department	Attending physicians	Emergency department	245	245	12 months	62 (45–79)**	118:127
Edge et al. <sup>63</sup> (a)	United States	Metastatic cancer	Oncologists	Outpatient clinic	1276 (6 m) 655 (12 m)	1276 (6 m) 655 (12 m)	6 and 12 months	NR	NR
Ernecoff et al. <sup>64</sup> (a)	United States	Advance chronic kidney patients, 60 years or older	Physicians	Outpatient nephrology clinic	510	95	12 months	NR	NR

(Continued)

**Appendix 2. (Continued)**

Author	Country	Population	Healthcare professional answering the surprise question	Setting	Total subjects (n)	Total surprise question assessments (n)	Surprise question timeframe	Subject age mean (SD)	Gender M:F
Flierman et al. <sup>65</sup>	The Netherlands	Hospital inpatients, 70 years or older	Nurses	Ward of general hospital	252	252	12 months	81.2 (6.56)	122:130
Ikari et al. <sup>66</sup>	Japan	Metastatic cancer	Physicians	Palliative care unit	1411	1411	3 days	72.6 (12.2)	716:659
Estifan Kasabji et al. <sup>67</sup> (a)	Spain	Haemodialysis	Nephrologists and nurses	Haemodialysis unit	180	178	6–12 months	69 (14.1)	124:56
Lai et al. <sup>68</sup>	Taiwan	Peritoneal dialysis patients	Nurses	Haemodialysis unit	401	401	12 months	56.2 (14)	214:213
Maes et al. <sup>69</sup>	Belgium	Hospital inpatients, 75 years or older: first cohort acute geriatric ward; second cohort cardiac patients	Physicians	Geriatric ward and cardiology ward	458	368	6–12 months	NR	184:195
Rauh et al. <sup>70</sup>	United States	Gynaecological oncology	Attending physicians, 'physician assistants, nurses'	Two tertiary centres	358	341	12 months	NR	0:358
Tabernero Huguet et al. <sup>71</sup> (a)	Spain	Patients on respiratory ward	NR	Respiratory ward of hospital	363	361	12 months	NR	NR
Tak et al. <sup>72</sup> (a)	The Netherlands	Idiopathic pulmonary fibrosis	Health care providers	Outpatient clinic	123	123	12 months	74 (63)	108:15
Valerio and Farinha <sup>73</sup> (a)	Portugal	Haemodialysis	Nephrologists and nurses	Haemodialysis unit	194	194	12 months	69.9	NR
van Wijmen et al. <sup>75</sup>	The Netherlands	General population	General practitioners	General practice	3640	3640	12 months	NR	NR
Yen et al. <sup>76</sup>	Taiwan	Hospital inpatients	Nurses	Hospital	23,444	21,098	6–12 months	62.8	11,230:9879
Ermers et al. <sup>77</sup>	The Netherlands	Cancer	Oncologists	Outpatient clinic	382	379	12 months	59.4	211:168
Tripp et al. <sup>73</sup>	United States	COPD patients	Physicians and advanced practice providers	Emergency department (30 days) and general ward of hospital (12 months)	428	381 (30 days) 365 (12 months)	30 days and 12 months	NR	210:218

(a): abstract or other non-peer reviewed publication; NR: not reported; (d): derivation cohort; (v): validation cohort; SQ+: surprise question answered with 'no'; SQ-: surprise question answered with 'yes'. \*Multiple assessments per patient possible. \*\*Median (IQR). \*\*\*Median (range). \*\*\*\*SQ group only.

## Appendix 3. Critical appraisal.

Article	1. Study participation	2. Study attrition	3. Prognostic factor measurement	4. Outcome measurement	5. Study confounding	6. Statistical analysis and reporting	Total
Barnes et al. <sup>18</sup>	High	Low	Low	Low	Low	Low	Low
Moss et al. <sup>21</sup>	Low	Low	Low	Low	Moderate	Low	Low
Cohen et al. <sup>22</sup>	Moderate	Low	Low	Low	Moderate	Low	Low
Moss et al. <sup>23</sup>	Low	Low	Low	Low	Low	Low	Low
South et al. <sup>24</sup> (a)	High	Low	Moderate	High	Moderate	Low	High
Fenning et al. <sup>25</sup>	Moderate	Low	Low	Low	Low	Low	Low
Da Silva Gane et al. <sup>26</sup>	Low	Low	Low	Low	Moderate	Low	Low
Pang et al. <sup>27</sup>	Low	Low	Low	Low	Low	Low	Low
Reilly et al. <sup>28</sup> (a)	High	Low	Moderate	Moderate	Moderate	Low	Moderate
Moroni et al. <sup>29</sup>	Moderate	Low	Low	Low	Low	Low	Low
Feyi et al. <sup>30</sup>	High	Low	High	High	High	Low	High
Hamano et al. <sup>31</sup>	Moderate	Moderate	Low	Low	Low	Low	Low
Amro et al. <sup>32</sup>	Low	Low	Low	Low	High	Low	Moderate
Maria Carmen et al. <sup>33</sup> (a)	Moderate	Low	High	Low	Moderate	Low	Moderate
Gerlach et al. <sup>34</sup> (a)	Moderate	Low	Moderate	Moderate	Low	Low	Moderate
Lakin et al. <sup>35</sup> (a)	High	Low	Moderate	Low	Low	Low	Low
Strout et al. <sup>36</sup> (a)	Moderate	Low	Low	Moderate	Low	Low	Moderate
Gómez-Batiste et al. <sup>37</sup>	Low	Low	Low	Low	Low	Low	Low
Hadique et al. <sup>38</sup>	Low	Low	Low	Low	Low	Low	Low
Lilley et al. <sup>39</sup>	Moderate	Low	Low	Low	Low	Low	Low
Moretti et al. <sup>40</sup>	Moderate	Low	Low	Moderate	Low	Low	Low
Salat et al. <sup>41</sup>	Moderate	Low	Low	Low	Low	Low	Low
Santos Lascasas et al. <sup>42</sup> (a)	Moderate	Low	Low	Low	Moderate	Low	Low
Strout et al. <sup>43</sup> (a)	Moderate	High	Low	Moderate	Low	Low	High
Burke et al. <sup>44</sup>	Moderate	Low	Low	Low	Low	Low	Low
Ebke et al. <sup>45</sup>	Low	High	Low	Low	Low	Low	Moderate
Faria de Sousa et al. <sup>19</sup> (a)	Moderate	Low	Low	Low	Low	Low	Low
Forzley et al. <sup>46</sup>	Low	Low	Low	Low	Moderate	Low	Low
Liyanage et al. <sup>47</sup>	Low	Low	Low	Low	Low	Low	Low
Mitchell et al. <sup>48</sup>	Moderate	High	Moderate	Low	Low	Low	Moderate
Mudge et al. <sup>49</sup>	Low	Low	Low	Low	Low	Low	Low
Ouchi et al. <sup>50</sup>	Moderate	Low	Low	Low	Low	Low	Low
Schmidt et al. <sup>51</sup>	Moderate	Low	Low	Low	Moderate	Low	Low
Tanasychuk et al. <sup>52</sup>	Moderate	Low	Low	Low	Moderate	Low	Moderate
Aaronson et al. <sup>53</sup>	Moderate	Low	Low	Low	Low	Low	Low
Gastelurrutia et al. <sup>54</sup> (a)	Low	Low	Low	Low	Low	Low	Low
Haydar et al. <sup>55</sup>	Low	Low	Low	Low	Low	Low	Low
Lakin et al. <sup>56</sup>	Moderate	Low	Low	Low	Low	Low	Low
Ouchi et al. <sup>57</sup>	Low	Low	Low	Low	Low	Low	Low
Raubenheimer et al. <sup>58</sup>	Moderate	Low	Low	Low	Low	Low	Low
Straw et al. <sup>59</sup>	Moderate	Low	Low	Low	Low	Low	Low
Tripodoro et al. <sup>60</sup>	Low	Low	Low	Low	Low	Low	Low
Veldhoven et al. <sup>61</sup>	Low	Low	Low	Low	Low	Low	Low
Verhoef et al. <sup>62</sup>	Moderate	Low	Low	Low	Low	Low	Low
Edge et al. <sup>63</sup> (a)	Moderate	Low	Low	Low	Low	Low	Low
Ernecoff et al. <sup>64</sup> (a)	High	Low	Low	Low	Low	Low	Moderate
Flierman et al. <sup>65</sup>	Moderate	Low	Low	Low	Low	Low	Low
Ikari et al. <sup>66</sup>	Moderate	Low	Low	Low	Low	Low	Low
Estifan Kasabji et al. <sup>67</sup> (a)	High	Low	Moderate	Low	Moderate	Low	Moderate
Lai et al. <sup>68</sup>	Low	Low	Low	Low	Moderate	Low	Low
Maes et al. <sup>69</sup>	High	Moderate	Low	Moderate	Low	Low	Moderate
Rauh et al. <sup>70</sup>	Moderate	Low	Low	Low	Low	Low	Low
Taberner Huguet et al. <sup>71</sup> (a)	Moderate	Low	Low	Low	Moderate	Low	Moderate
Tak et al. <sup>72</sup> (a)	Moderate	Low	Low	Low	Low	Low	Low

(Continued)

**Appendix 3.** (Continued)

Article	1. Study participation	2. Study attrition	3. Prognostic factor measurement	4. Outcome measurement	5. Study confounding	6. Statistical analysis and reporting	Total
Valerio and Farinha <sup>74</sup> (a)	Moderate	Low	Low	Low	Moderate	Low	Moderate
Van Wijmen et al. <sup>75</sup>	Low	Low	Low	Low	Low	Low	Low
Yen et al. <sup>76</sup>	Low	Low	Low	Low	Moderate	Low	Low
Ermers et al. <sup>77</sup>	Low	Low	Low	Low	Moderate	Low	Low
Tripp et al. <sup>73</sup>	Low	Low	Low	Low	Moderate	Low	Low

Note: (a): abstract or other non-peer reviewed publication.

**Appendix 4.** Individual study results.

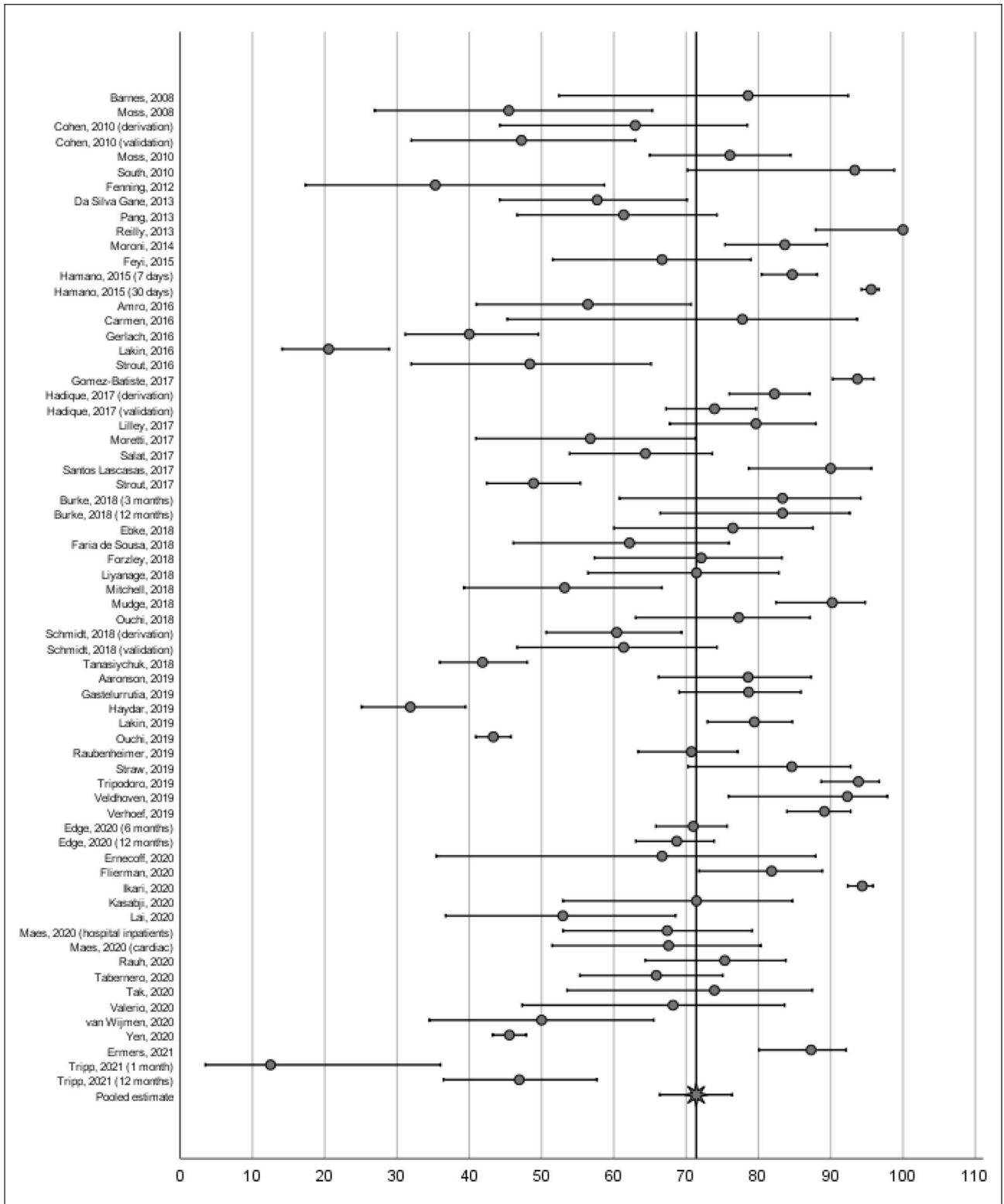
Study (authors)	Patient group	Timeframe (months)	Abstract (Yes/No)	Total SQ responses (n)	Mortality rate (%)	Sensitivity (95% CI)*	Specificity (95% CI)*
Barnes et al. <sup>18</sup>	Cardiac disease	12	No	231	6.1	78.6 [52.4–92.4]	61.3 [54.7–67.5]
Moss et al. <sup>21</sup>	Kidney disease	12	No	147	15.0	45.5 [26.9–65.3]	80.8 [73.0–86.7]
Cohen et al. <sup>22</sup> (derivation cohort)	Kidney disease	6	No	447	6.0	63.0 [44.2–78.5]	87.4 [83.9–90.2]
Cohen et al. <sup>22</sup> (validation cohort)	Kidney disease	6	No	427	8.4	47.2 [32.0–63.0]	89.8 [86.4–92.4]
Moss et al. <sup>23</sup>	Cancer	12	No	826	8.6	76.1 [65.0–84.5]	89.8 [87.4–91.8]
South et al. <sup>24</sup>	Pulmonary disease	12	Yes	199	7.5	93.3 [70.2–98.8]	55.4 [48.2–62.4]
Fenning et al. <sup>25</sup>	Cardiac disease	12	No	172	9.9	35.3 [17.3–58.7]	79.4 [72.3–85.0]
Da Silva Gane et al. <sup>26</sup>	Kidney disease	12	No	344	15.1	57.7 [44.2–70.1]	74.7 [69.4–79.3]
Pang et al. <sup>27</sup>	Kidney disease	12	No	367	12.0	61.4 [46.6–74.3]	74.6 [69.6–79.1]
Reilly et al. <sup>28</sup>	Pulmonary disease	12	Yes	85	32.9	100 [87.9–100]	31.6 [21.0–44.5]
Moroni et al. <sup>29</sup>	Cancer	12	No	231	45.0	83.7 [75.4–89.5]	69.3 [60.8–76.6]
Feyi et al. <sup>30</sup>	Kidney disease	12	No	178	23.6	66.7 [51.6–79.0]	77.9 [70.3–84.1]
Hamano et al. <sup>31</sup> – 7 day timeframe	Cancer	0.25	No	2361	14.1	84.7 [80.4–88.2]	68.0 [65.9–70.0]
Hamano et al. <sup>31</sup> – 1 month timeframe	Cancer	1	No	2361	47.2	95.6 [94.2–96.7]	37.0 [34.4–39.7]
Amro et al. <sup>32</sup>	Kidney disease	12	No	201	19.4	56.4 [41–70.7]	82.7 [76.2–87.8]
Maria Carmen et al. <sup>33</sup>	Kidney disease	12	Yes	49	18.4	77.8 [45.3–93.7]	67.5 [52.0–79.9]
Gerlach et al. <sup>34</sup>	Cancer	12	Yes	672	15.6	40.0 [31.1–49.6]	93.1 [90.7–94.9]
Lakin et al. <sup>35</sup>	Primary care	12	Yes	1737	6.4	20.5 [14.1–28.9]	94.4 [93.2–95.4]
Strout et al. <sup>36</sup>	Emergency department	1	Yes	330	9.4	48.4 [32.0–65.2]	68.9 [63.4–73.9]
Gomez-Batiste, 2017 <sup>37</sup>	Primary care	12	No	1059	27.0	93.7 [90.3–96.0]	26.4 [23.4–29.6]
Hadique et al. <sup>38</sup> (derivation cohort)	Intensive care	6	No	500	36.0	82.2 [76.0–87.1]	71.9 [66.7–76.5]
Hadique et al. <sup>38</sup> (validation cohort)	Intensive care	6	No	543	34.6	73.9 [67.2–79.7]	81.7 [77.3–85.4]
Lilley et al. <sup>39</sup>	Acute surgical conditions	12	No	163	36.2	79.7 [67.7–88.0]	51.0 [41.5–60.4]
Moretti et al. <sup>40</sup>	Cardiac disease	12	No	470	7.9	56.8 [40.9–71.3]	93.5 [90.8–95.5]
Salat et al. <sup>41</sup>	Kidney disease	12	No	488	17.8	64.4 [53.9–73.6]	71.3 [66.7–75.5]
Santos Lascasas et al. <sup>42</sup>	Kidney disease	6	Yes	360	13.9	90.0 [78.6–95.7]	67.1 [61.7–72.1]
Strout et al. <sup>43</sup>	Emergency department	1	Yes	9923	2.3	48.9 [42.4–55.4]	80.3 [79.5–81.1]
Burke et al. <sup>44</sup> – 3 month timeframe	Children	3	No	325	5.5	83.3 [60.8–94.2]	93.2 [89.8–95.5]
Burke et al. <sup>44</sup> – 12 month timeframe	Children	12	No	306	9.8	83.3 [66.4–92.7]	70.7 [65.0–75.7]

(Continued)

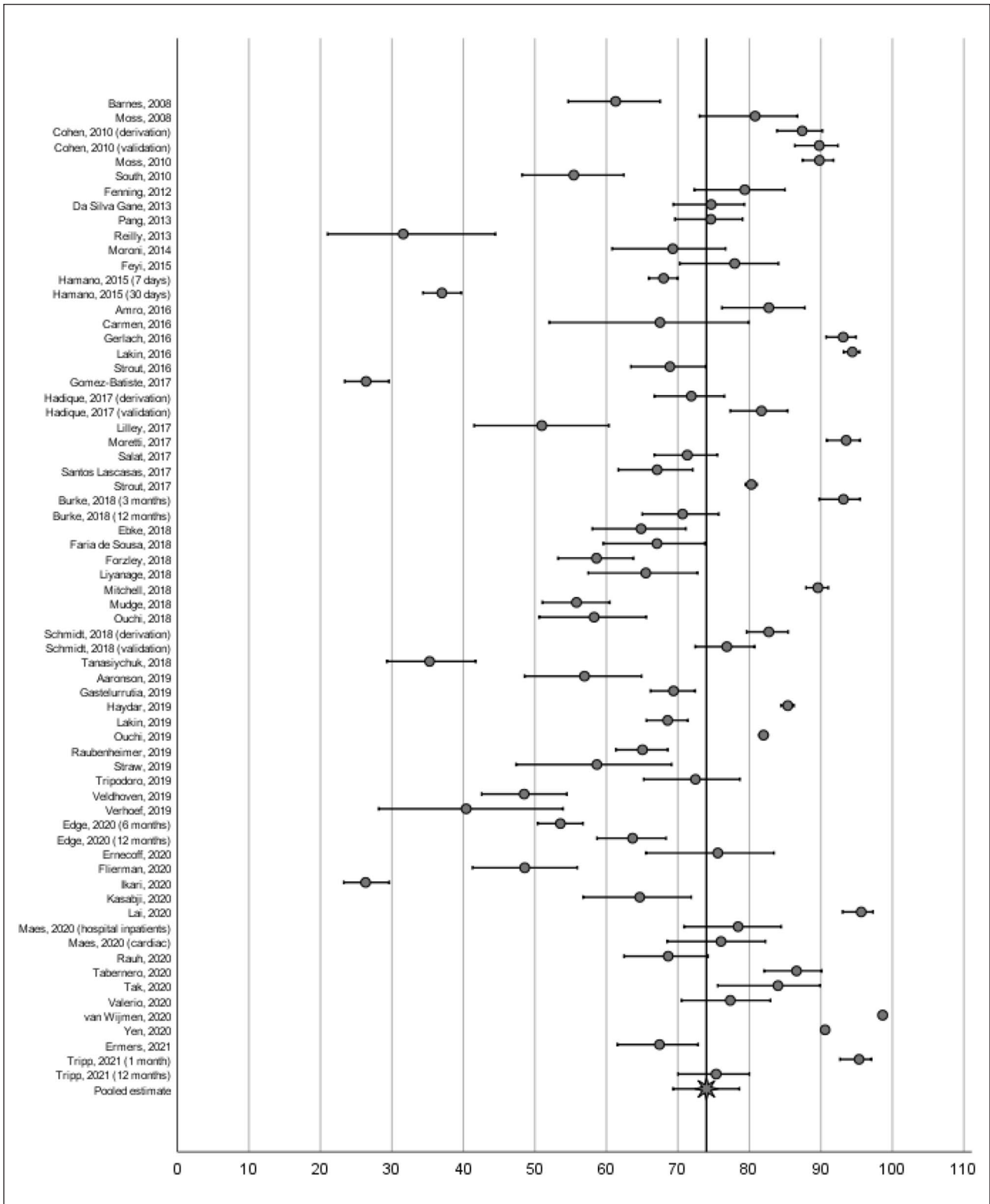
## Appendix 4. (Continued)

Study (authors)	Patient group	Timeframe (months)	Abstract (Yes/No)	Total SQ responses (n)	Mortality rate (%)	Sensitivity (95% CI)*	Specificity (95% CI)*
Ebke et al. <sup>45</sup>	Neurorehabilitation	12	No	236	14.4	76.5 [60.0–87.6]	64.9 [58.0–71.1]
Faria de Sousa et al. <sup>19</sup>	Primary care	6	Yes	201	18.4	62.2 [46.1–75.9]	67.1 [59.6–73.8]
Faria et al. <sup>46</sup>	Kidney disease	6	No	374	11.5	72.1 [57.3–83.3]	58.6 [53.2–63.8]
Liyanage et al. <sup>47</sup>	Nursing home	12	No	187	22.5	71.4 [56.4–82.8]	65.5 [57.5–72.8]
Mitchell et al. <sup>48</sup>	Primary care	12	No	1525	3.1	53.2 [39.2–66.7]	89.6 [87.9–91.0]
Mudge et al. <sup>49</sup>	Hospital inpatients	12	No	513	17.9	90.2 [82.4–94.8]	55.8 [51.0–60.5]
Ouchi et al. <sup>50</sup>	Emergency department	12	No	207	21.3	77.3 [63.0–87.2]	58.3 [50.6–65.6]
Schmidt et al. <sup>51</sup> (derivation cohort)	Kidney disease	12	No	749	13.5	60.4 [50.6–69.4]	82.7 [79.6–85.4]
Schmidt et al. <sup>51</sup> (validation cohort)	Kidney disease	12	No	437	10.1	61.4 [46.6–74.3]	76.8 [72.4–80.7]
Tanasyichuk et al. <sup>52</sup>	Kidney disease	6	No	475	52.8	41.8 [35.9–48.0]	35.3 [29.3–41.7]
Aaronson et al. <sup>53</sup>	Cardiac disease & emergency department	12	No	193	29.0	78.6 [66.2–87.3]	56.9 [48.6–64.9]
Gastelurrutia et al. <sup>54</sup>	Cardiac disease	12	Yes	922	9.7	78.7 [69.0–85.9]	69.4 [66.2–72.4]
Haydar et al. <sup>55</sup>	Emergency department	1	No	6089	2.6	31.8 [25.1–39.5]	85.4 [84.4–86.2]
Lakin et al. <sup>56</sup>	Primary care	24	No	1163	15.5	79.4 [73.0–84.7]	68.6 [65.6–71.4]
Ouchi et al. <sup>57</sup>	Emergency department	1	No	16,223	9.7	43.3 [40.9–45.8]	82.0 [81.3–82.6]
Raubenheimer et al. <sup>58</sup>	Acute medical services	12	No	822	20.0	70.7 [63.4–77.2]	65.0 [61.3–68.6]
Straw et al. <sup>59</sup>	Cardiac disease	12	No	114	34.2	84.6 [70.3–92.8]	58.7 [47.4–69.1]
Tripodoro et al. <sup>60</sup>	Cancer	12	No	313	46.6	93.8 [88.7–96.7]	72.5 [65.2–78.7]
Veldhoven et al. <sup>61</sup>	Primary care	12	No	292	8.9	92.3 [75.9–97.9]	48.5 [42.6–54.5]
Verhoef et al. <sup>62</sup>	Cancer and ED	12	No	245	78.8	89.1 [83.9–92.8]	40.4 [28.2–53.9]
Edge et al. <sup>63</sup> – 6 month timeframe	Cancer	6	Yes	1276	25.4	71.0 [65.8–75.7]	53.6 [50.4–56.7]
Edge et al. <sup>63</sup> – 12 month timeframe	Cancer	12	Yes	655	42.4	68.7 [63.0–73.9]	63.7 [58.7–68.4]
Ernecoff et al. <sup>64</sup>	Kidney disease	12	Yes	95	9.5	66.7 [35.4–87.9]	75.6 [65.5–83.4]
Flierman et al. <sup>65</sup>	Hospital inpatients	12	No	252	30.6	81.8 [71.8–88.8]	48.6 [41.3–55.9]
Ikari et al. <sup>66</sup>	Cancer	0.1	No	1411	47.8	94.4 [92.4–95.9]	26.3 [23.3–29.6]
Estifan Kasabji et al. <sup>67</sup>	Kidney disease	12	Yes	178	15.7	71.4 [52.9–84.7]	64.7 [56.7–71.9]
Lai et al. <sup>68</sup>	Kidney disease	12	No	401	8.5	52.9 [36.7–68.5]	95.6 [93.0–97.3]
Maes et al. <sup>69</sup> – subgroup 1	Hospital inpatients	12	No	185	24.9	67.4 [53.0–79.1]	78.4 [70.9–84.4]
Maes et al. <sup>69</sup> – subgroup 2	Cardiac disease	12	No	183	20.2	67.6 [51.5–80.4]	76.0 [68.5–82.2]
Rauh et al. <sup>70</sup>	Cancer	12	No	309	23.6	75.3 [64.4–83.8]	68.6 [62.5–74.2]
Taberner Huguet et al. <sup>71</sup>	Pulmonary disease	12	Yes	361	23.5	65.9 [55.3–75.1]	86.6 [82.1–90.1]
Tak et al. <sup>72</sup>	Pulmonary disease	12	Yes	123	18.7	73.9 [53.5–87.5]	84.0 [75.6–89.9]
Valerio and Farinha <sup>74</sup>	Kidney disease	12	Yes	194	11.3	68.2 [47.3–83.6]	77.3 [70.5–82.9]
van Wijmen et al. <sup>75</sup>	Primary care	12	No	3640	1.0	50.0 [34.5–65.5]	98.6 [98.2–99.0]
Yen et al. <sup>76</sup>	Hospital inpatients	12	No	21,098	8.3	45.6 [43.2–47.9]	90.6 [90.2–91.0]
Ermers et al. <sup>77</sup>	Cancer	12	No	379	31.1	87.3 [80.1–92.1]	67.4 [61.5–72.8]
Tripp et al. <sup>73</sup> – 1 month timeframe	Pulmonary disease	1	No	381	4.2	12.5 [3.5–36.0]	95.3 [92.7–97.1]
Tripp et al. <sup>73</sup> – 12 month timeframe	Pulmonary disease	12	No	365	22.2	46.9 [36.4–57.7]	75.4 [70.0–80.0]

\*Confidence intervals (CI) were calculated using Wilson's method and can differ slightly from the CI's presented by the original studies.



Appendix 5. Forest plot of the sensitivity of individual studies.



Appendix 6. Forest plot of the specificity of individual studies.