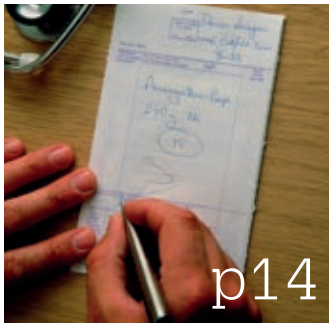
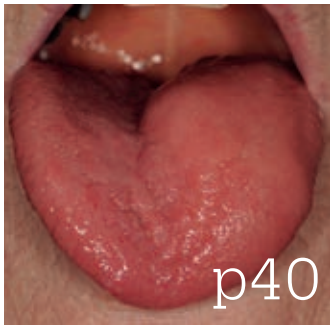
THIS WEEK

Articles appearing in this print journal have already been published on thebmj.com, and the print version may have been shortened





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MICHAEL HALBERT/INKART.COM

How Monitor is reducing services in England under the guise of continuity
ANALYSIS, p 15

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Patients Included

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thebmj.com

The BMJ website is fully responsive, which means that its pages automatically fit the different screen sizes of desktop and laptop computers, tablet devices, and smartphones.

The new design is also less cluttered, which should mean that browsing is easier and pages load faster, with more prominent links to *The BMJ*'s campaigns, investigations, and advice for authors.

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CORRECTION

The three week long "People's March," which featured as picture of the week in the 13 September print issue, covered a distance of 300 miles, not 300 km as we incorrectly stated in the picture caption.

PICTURE OF THE WEEK

British artist Damien Hirst with a piece from his latest exhibition "Schizophrenogenesis." Based around the design of the medicinal pill, the exhibition includes prints, sculptures, and drug packaging. It continues Hirst's investigation into people's relationship with science and pharmaceuticals and runs at the Paul Stolper Gallery, London, until 15 November.

Photographed by Prudence Cuming Associates, courtesy Paul Stolper Gallery © Damien Hirst and Other Criteria, All rights reserved, DACS 2014 www.paulstolper.com

RESPONSE OF THE WEEK

The reach of the GMC extends ever further. The graduate now faces a career of 45 years plus with the prospect of a licensing examination in addition to a degree that he or she has attained after studying hard for 4 or 5 years, including content that is overseen by the GMC. Also the graduate has the continual requirement to produce pages of self reflection for appraisal which is the main informant for 5 yearly revalidation. I am thoroughly fed up with paying for the privilege of being policed by this increasingly bureaucratic behemoth.

Yours, etc.

Owen Powell, GP, Swansea, UK, in response to, "GMC will develop single exam for all medical graduates wishing to practise in UK" (*BMJ* 2014;349:g5896)

MOST READ

- Vitamin B12 deficiency
- Benzodiazepine use and risk of Alzheimer's disease: case-control study
- Mild hypertension in people at low risk
- Management and prevention of exacerbations of COPD
- Should patients be able to email their general practitioner?

THEBMJ.COM POLL

Last week's poll asked:
Is seven day access to GPs in England a good use of NHS resources?

74% voted no (total 282 votes cast)

News ▶ *BMJ* 2014;349:g5960

This week's poll asks:
Is the private sector a good thing for the NHS?

Head to Head ▶ *BMJ* 2014;349:g5865

▶ **Vote now on thebmj.com**

EDITOR'S CHOICE

Optimism and consent to treatment

Having lots of time for questions doesn't help if the patient doesn't know which questions to ask

We know that patients and doctors tend to overestimate the benefits of treatment and underestimate the harms. We also know that people's natural optimism is often boosted by the systematic optimism bias of the medical literature (*Br J Psych* 2010;197:441-7, *PLoS One* 2014;9(5):e98246). But in the case of percutaneous coronary intervention there is no such excuse. Experts and guidelines are clear: it improves symptoms but not survival. Nor does it reduce the risk of myocardial infarction. It should be offered to patients with stable coronary artery disease only if medical treatment is failing to manage their angina.

Despite this clarity, Faraz Kureshi and colleagues confirm that patients still believe that it will do more than just control their symptoms (p 11). Of about 1000 patients surveyed, the vast majority thought that the procedure would extend or save their lives and would prevent myocardial infarction. Only 1% correctly reported that relief of symptoms was the only expected benefit.

Efforts to improve informed participation of patients in decision making are clearly failing. In what I believe is our first editorial coauthored by patients, Jeff Whittle and colleagues ask why this might be (p 9). The three coauthor patients all have personal or family experience of coronary revascularisation. Their views may prompt new thinking. One recalled that, although there was no statement that the procedure would prolong life, he sensed that the surgeon thought it would. Another was made aware of the seriousness of his condition and congratulated on its early discovery, which perhaps suggested that intervention would change the course of the disease. A third noted that having lots of time for questions doesn't help if the patient doesn't know which questions to ask.

Our editorialists consider what they acknowledge might be considered a heretical question: does it matter if patients don't have an entirely accurate understanding of the benefits of treatment? They conclude that it may not—and they even say that insisting that patients understand that treatment won't prolong life may be demoralising.

Some of us may find this hard to swallow. What of the risks of overtreatment based on unrealistic expectations? In their study Kureshi and colleagues found that patients' level of understanding varied between the 10 different sites and that the informed consent procedures differed. It may take only a few words to give a patient a false impression of what they can expect from a procedure.

I'm reminded of one of Daniel Sokol's recent columns (*BMJ* 2014;348:g2192). Consent should not be something we do to patients, he said. It should be seen more as a unique gold coin. "The clinician should not snatch it away, abruptly, deceptively, or without careful explanation. He or she should explain why the patient may wish to hand over the coin. What will the patient get in return? What if the patient wishes to keep it? Explaining all this can take time and skill. It is a two way process, but ultimately the decision remains with the patient."

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