EDITOR'S CHOICE

Diagnosing the patient's preference

Fiona Godlee *editor, BMJ*

All doctors fear getting a diagnosis wrong, because patients may suffer avoidable harm as a result. So what do you make of the two hypothetical patients described by Al Mulley and colleagues this week (doi:10.1136/bmj.e6572)? Both are women who have been diagnosed with breast cancer. Both undergo surgery. One is then told that there was no cancer. The other is told that there was cancer but finds out from a friend that, given her age, she could have opted for hormone treatment instead. She is beset by regret. Which of them was misdiagnosed? Mulley et al say both of them were.

The responses, however, could not have been more different, say the authors. "In [the first woman's] case, the corrective actions by the medical establishment were numerous, immediate, and loud. For [the second woman], there were no corrective actions. The problem was not even recognised."

This is an example of preference misdiagnosis. The doctor recommends treatment based on what is known of the patient's disease, age, and general health, and using evidence on which treatments work best, but fails to discover what matters most to the patient.

How often does it happen? It's hard to know, say the authors, because preference misdiagnosis usually goes unnoticed. But there are several reasons for thinking that it's common: studies have shown gaps between what patients want and what doctors think they want; patients choose different treatments after they become better informed; and geographical variation in practice suggests treatment is heavily influenced by the expertise and interests of local providers.

So what's to be done? Most of you will already be making efforts to understand what your patients want, or will think that you are doing this. And many patients won't know what they want to do even when the options are fully explained to them. So what do you say when a patient asks you to recommend a course of action? What you shouldn't do, say the authors, is ask yourself what you would choose, or what you would advise someone you love. And you should beware of the tendency to think that the right treatment for this patient happens to the one that you specialise in or your institution performs a lot.

Instead, try adopting a mindset of scientific detachment, using data to reach a provisional preference diagnosis, and having a conversation with the patient. The authors suggest breaking this conversation into three elements: team talk (in which the patient is encouraged to understand that he or she is "on the team"), option talk, and decision talk.

This may all sound rather formulaic, and it will certainly take more time than the paternalistic approach. But knowing what we know now, there can be no excuse for failing to identify and document the patient's preference. And, as the authors say, engaged patients consume less healthcare, so there are likely to be financial benefits. "It is tantalising to consider that budget challenged health systems around the world could simultaneously give patients what they want and cut costs."

Cite this as: *BMJ* 2012;345:e7745

© BMJ Publishing Group Ltd 2012