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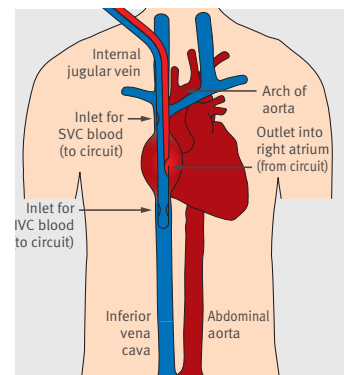
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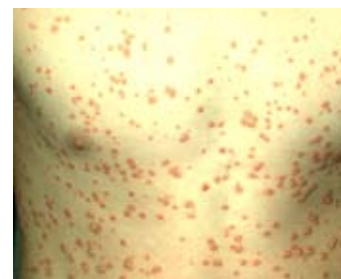
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PICTURE OF THE WEEK

One of the survivors of the Haiti earthquake carries water back to a provisional camp in Port-au-Prince. Deaths from cholera, which has not been seen in the country for over a century, are slowing as people become more aware of the disease and treatment is provided.

► **bmj.com** News: Haiti's cholera outbreak could spread to neighbours (*BMJ* 2010;341:c6057)

THE WEEK IN NUMBERS

13% Proportion of cases of colorectal cancer that may be attributable to lack of adherence to just one additional lifestyle recommendation (**Research**, p 978)

1972 Year extracorporeal life support was first used successfully for an adult. The first successful use for a child was 1974
(**Clinical Review**, p 982)

1/5 Proportion of patients with psoriasis who also have psoriatic arthritis (**Practice**, p 987)

100 000 Number of people in the United Kingdom affected by Parkinson's disease (**Practice**, p 990)

QUOTE OF THE WEEK

“Selection to a medical course should not depend on the applicants' financial status”

Lucy Stephenson and Terence Stephenson on the hidden, upfront costs of applying to medical school
(**Personal View**, p 996)

QUESTION OF THE WEEK

Last week's poll asked, “Are the cuts fair?”

62% said no (total 236 votes cast)

This week's poll asks, “Does choice matter more to politicians and patient advocates than it does to patients?”

► **bmj.com** Cast your vote

EDITOR'S CHOICE

Decisions, decisions . . .

If choice can be disabling as well as enabling, it's important that "choice" in the serious matter of healthcare is well managed and supported

At a trivial level I've always found too much choice disabling: too many types of pasta sauce on the supermarket shelves and I've walked away empty handed. So if choice can be disabling as well as enabling, it's important that "choice" in the serious matter of healthcare is well managed and supported. This week's *BMJ* offers lots of evidence on choice and how to support it.

Angela Coulter reviews what we know about giving patients more choice over their healthcare, against the background that the government in England wants to increase their choices (p 973). In general, she says, patients like the idea of choice and respond to offers of options of where to be treated (even though their providers don't always make those options clear). Patients don't make much use of performance data in choosing between clinical providers, but they do want more involvement in choosing their actual treatment. Coulter says that use of evidence based decision aids improves patients' knowledge, understanding of options, and perception of risks and can reduce demand for surgical procedures, but that UK patients rarely get effective support to make their treatment decisions. One barrier is clinicians' unwillingness to offer such support.

This reluctance is also dealt with by Glyn Elwyn and colleagues (p 971). They too look at the evidence on shared decision making and describe a pilot project in the east of England where patients are given access to online decision support on osteoarthritis of the knee, benign prostatic hypertrophy, and prostate cancer at the point when they need to decide on their treatment. This pilot aside, the authors say that much more research has gone into creating the decision aids themselves than into creating a culture where professionals espouse shared decision making as a skill and routinely use the tools. "Professionals often claim that there is no

need for this approach because shared decision making already occurs, but the available evidence contradicts this . . . 48% of inpatients and 30% of primary care patients would have liked more involvement in decisions about their care."

An Australian study by Sian Smith and colleagues shows a decision aid in action (p 977). They randomised people with a low level of education and literacy to receive either standard information about screening for bowel cancer (by faecal occult blood testing) or one of two variants of a decision support aid. The people using the decision aid showed greater knowledge, made a more informed choice, and had less decisional conflict than the people who didn't—and fewer of them decided to take the test.

This last finding dismays our editorialist, Hilary Bekker (p 948). She quotes the authors' speculation that this result was due to the way risks were represented in the decision aid. She then suggests that in the context of bowel cancer screening the facts might be better structured to facilitate adherence with testing—"a policy of informed uptake rather than informed decision making."

I wonder if the many authors of one of our letters would agree. Michael Baum and colleagues write on behalf of a large group who in February last year wrote to the Times calling for the UK's breast cancer screening leaflet to be rewritten because "none of the invitations for screening told the truth about its harms and benefits" (p 955). Despite a promise from the national cancer director that a review of the guidance would result in a new leaflet in the autumn, the new leaflet has not appeared.

Jane Smith, deputy editor, bjsmith@bmj.com

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Career Focus, jobs, and courses appear after p 1000

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