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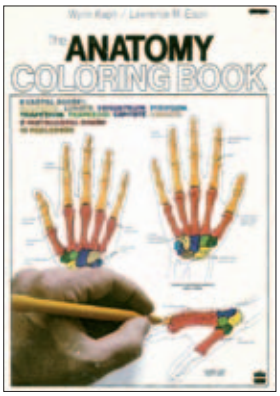

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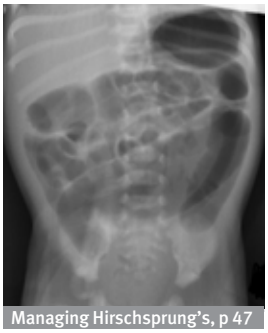
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### ENDGAMES



### MINERVA

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## PICTURE OF THE WEEK

**End of life care pathway 15th century style? Dutch artist Marinus van Reymerswaele's *The Death Room/ Last Rites*, which dates from 1480 and is a leaf from an illuminated manuscript, is one of 300 works on show as part of the Wellcome Collection's Death exhibition, which opened this week.**

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## RESPONSE OF THE WEEK

"I believe the *BMJ* should allow us to opt out of receiving the paper edition and only have the downloadable edition. The paper edition could then be donated to colleagues or libraries in needy parts of the world.

Speaking personally I often read the *BMJ* on my iPad on Friday night or early Saturday, well before the paper edition drops through the letterbox. I then might not open the paper edition until it is time to separate it from its wrapping to join the rubbish for recycling."

D E A Luxton, retired geriatrician, King's Lynn, UK, in response to "Drop the *BMJ* paper edition entirely" (*BMJ* 2012;345:e7232)

## BMJ.COM POLL

Last week's poll asked: "Should all cosmetic surgery advertising be banned?"

**64%** voted yes (total 919 votes cast)

- Head to Head

Yes (*BMJ* 2012;345:e7489) No (*BMJ* 2012;345:e7508)

This week's poll asks: "Is the Liverpool care pathway fit for purpose?"

- News (*BMJ* 2012;345:e7511)
- Editorial (*BMJ* 2012;345:e7718)
- **Vote now on bmj.com**

## MOST COMMENTED ON

Psychotic depression

Clinical trial data for all drugs in current use

Breast screening is beneficial, panel concludes, but women need to know about harms

A licence to bill

How the Liverpool care pathway has transformed end of life care

## MOST READ

Plantar fasciitis

Minerva

Clinical trial data for all drugs in current use

Psychotic depression

Association between fish consumption, long chain omega 3 fatty acids, and risk of cerebrovascular disease

EDITOR'S CHOICE

# Diagnosing the patient's preference

**Engaged patients consume less healthcare, so there are likely to be financial benefits**

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 (p 23)? 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."

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