

Considering a new diagnosis? Preferences miscommunication

I was made aware by a graduate nursing student recently of a term that was new to me: preference misdiagnosis. My attention was caught because of my interest in patient-centred care and its foundation of understanding patient values and preferences. I thought I would search a little farther regarding the term and found some intriguing information. I think there is some benefit in thinking about this term for application in oncology nursing.

The term was originally coined by Albert Mulley, MD, (2012) in reference to physicians moving ahead with treatment that was not entirely aligned with what patients preferred. He referred to the term as a silent diagnosis because so often practitioners have made a preference diagnosis and are not aware they have even done so. They think they know what the patient wants. Yet, many times, their preference diagnosis is incorrect.

There are wide gaps between what patients want and what doctors think patients want. For example, Lee et al. (2010) reported doctors believe that 71% of breast cancer patients would rate keeping their breast as a top priority while the actual figure reported by women with breast cancer was only 7%. Similarly, doctors indicated 96% of breast cancer patients considering chemotherapy would rate living as long as possible as top priority; 59% of patients actually rated it as so (Lee et al., 2010). And, finally, not one doctor reported that avoiding a prosthesis was important to women considering breast reconstruction surgery while 35% of patients disagreed.

In general, patients are able to express outcome preferences with greater ease. Outcomes, what individuals want to see as a result of a treatment, are closely aligned with a person's life goals and values—want to be cancer free, want to be able to eat without pain, want to walk again, want to return to work, want to be able to garden. Treatment preferences, however, are more difficult to express in that patients may not be fully informed about the procedures and known outcomes of the treatment. In an international Cochrane Review, evidence consistently showed patients frequently change their decisions about treatment after becoming better informed (Stacey et al, 2011).

The risk of preference misdiagnosis is linked to two factors: the clinician knowledge of what patients want and the patient knowledge of options, outcomes and evidence. But I would argue that it is also linked to the nature of the communication process and whether it truly is an effective two-way exchange process during assessment and during patient education.

And this is where I think this topic has particular relevance for us, as oncology nurses. Our relationships with patients and their caregivers places us in an ideal position to uncover and

understand an individual patient's preferences, not only about treatment, but also about other aspects of care. We are also in an excellent position to help that individual learn what is necessary to make truly informed decisions. We can explore what they know about a situation, what they would like to know and what they expect will happen. In our leadership or advocacy role, we have the ability to inform other team members about patient preferences and ensure the action being taken is not based on a preference misdiagnosis.

However, fulfilling these roles implies we need to hone our skills in facilitating patients' expression of their preferences. Questions that could be useful to open such a conversation could include: "When you think about your illness and going forward from here, what is important to you?" or "When you think about the future, what would you like to see happen with regards to your illness?" These are not easy conversations to hold and do require focused planning and effort.

And we need to be certain we hone our skills in sharing information and patient teaching so that patients and caregivers are truly informed. Use of plain language and incorporating 'feedback loops' are two steps that can add to the effectiveness of our interactions. The Global Language Monitor reported there are 1,013,913 words in the English language as of January 1, 2012, and a new word is added every 98 seconds. The words we know and the meaning attached to those words is also very much a product of our cultural and life experiences. It is no wonder there are challenges in communicating with so many words from which to choose.

We also need to think about how our practice environments are organized so there is time and privacy to attend to this important area of practice. There is a great deal of evidence to show that the nature of the communication between patients and members of the healthcare team has a significant impact on patient satisfaction with their care and their adherence to treatment and follow-up actions (Wanzer, Booth-Butterfield, & Gruber, 2004). However, there remain systemic barriers in our healthcare environments to be overcome if we are to achieve person-centred care that is based on understanding of patient preferences.

There are many interactions with patients and their family members in the course of a day, and many opportunities to truly engage in understanding what is important to them. But it will take concerted effort and skill to avoid preference miscommunication.



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