

Consequences of Not Respecting Patient Preferences for Cancer Screening

Opportunity Lost

A 60-YEAR-OLD WOMAN PRESENTED TO HER physician for an annual physical examination. As part of the examination, she and her physician discussed colorectal cancer screening, which her physician had discussed with her at her last yearly physical. The decision at that time had been for colonoscopy, and the patient was referred to the gastroenterologist. Since the patient never followed through with the colonoscopy, the topic was broached again. As part of a quality improvement initiative designed to promote shared decision-making, the patient was given a decision support intervention (DESI) to review the options (fecal occult blood testing [FOBT], flexible sigmoidoscopy, or colonoscopy, described in a booklet and DVD) and was told to let her physician know about her decision.

The patient reviewed the DESI, decided that she wanted to pursue FOBT, and informed her physician about her choice. The physician responded that FOBT was not appropriate, and that the patient should consider only flexible sigmoidoscopy or colonoscopy. The patient was confused and upset that the very physician who had provided her the decision support material was not honoring her informed choice. To date, she has not followed through with colon cancer screening.

Routine screening for colorectal cancer is recommended in patients older than 50 years, and therefore discussion of colorectal cancer screening was an important and appropriate part of the primary care preventive care visit for this patient. Major clinical practice guidelines list several acceptable options for colorectal cancer screening, including the options discussed in the DESI.¹⁻³ Guidelines also recommend incorporation of patient preferences into care, practicing shared decision-making, and focusing on strategies that maximize the number of individuals who get screening.²

However, studies suggest that shared decision-making is not routinely occurring in primary care, especially for colorectal cancer screening.⁴ In addition, over half of adults preferred FOBT to colonoscopy when given time to consider detailed information about colorectal cancer screening tests.⁵ Despite the data indicating patient preferences for less invasive testing, colonoscopy rates are increasing, and evidence suggests that the test may be overused, particularly in the Medicare population.^{6,7} Decision support interventions, like the one given to this patient, are a way to facilitate shared decision-making and have been associated with greater knowledge, more accurate risk perceptions, and increased participation in the decision-making process.⁸

However, decision support is most effective as part of a shared decision-making process, in which physician and patient discussion leads to a mutual decision that is both evidence based and incorporates the patient's preferences.

The physician had good intentions in terms of recommending that the patient be screened for colorectal cancer and helping the patient make an informed choice by providing high-quality information and decision support. The patient also did her part to become an active and informed participant in the decision-making process. However, although the evidence base supported use of FOBT as a screening modality and the patient stated her preference for the less invasive test, the physician's preference for a more invasive and technologically advanced procedure precluded a full shared decision-making conversation, ultimately resulting in a missed opportunity to screen the patient for colorectal cancer.

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Financial Disclosure: Dr Lin received grants and travel allowances from the Foundation for Informed Medical Decision Making, and Dr Frosch served as a consultant and paid speaker for the Foundation for Informed Medical Decision Making.

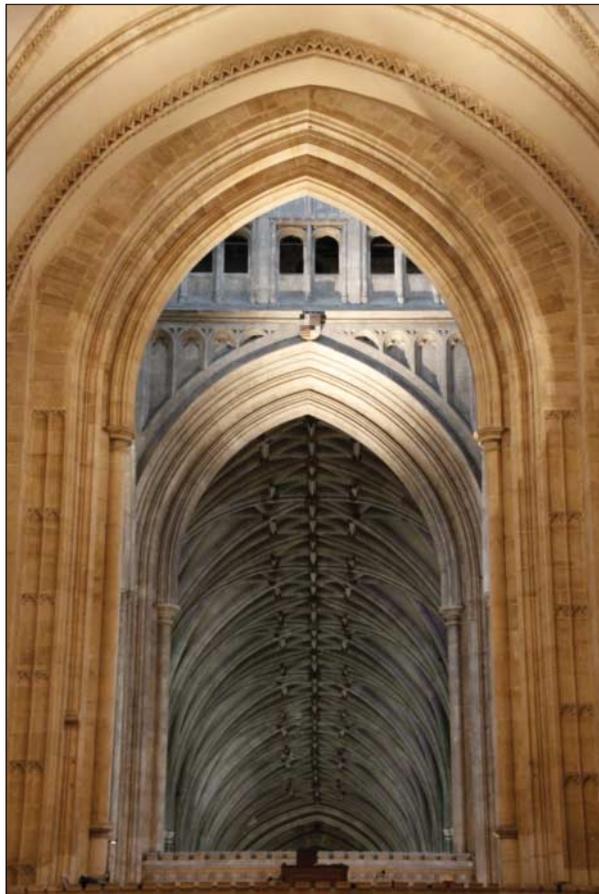
Funding/Support: This work was supported by grant from the Foundation for Informed Medical Decision Making.

Additional Contributions: We thank Suepattra May, PhD, and Caroline Tietbohl, BA, for their contributions to this manuscript.

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