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Preference Misdiagnosis

Story from the front lines:
I first met Mr. X, a pleasant 90 year old man, in clinic during my Intern year. Despite an extensive medical history Mr. X was doing remarkably well from a clinical standpoint and had no specific complaints during our initial encounter.

Upon reviewing his chart, I learned that he had previously expressed a desire to avoid any aggressive, end of life interventions like CPR or intubation. After clarifying these wishes, Mr. X signed the appropriate forms and I documented our conversation in the electronic medical record. Formalities aside, our discussion evolved into something more philosophical, as he elaborated on his overall goals—his desire to prioritize comfort over survival, and quality over quantity of his remaining years. Even though this was our first time meeting, I felt that I had truly gained an understanding of his values and outlook on life.

I continued to see Mr. X every few months or so to check in. Almost 2 years later he came to my office with complaints of fatigue and neck soreness. His exam was unremarkable, so I offered some words of encouragement, and recommended ice packs and Acetaminophen for his neck discomfort. When he returned a month later without any improvement, we discussed further work up. In the back of my mind, I knew that at 90 years old his vague symptoms could represent malignancy, but without localizing symptoms, I worried about exposing him to a battery of tests, some invasive, that may not change management in a man who valued “letting nature take its course”. While I did bring the possibility of cancer to his attention, I quickly shifted the plan to getting some basic blood work to look for easily reversible causes of his fatigue. When his labs revealed some mild anemia and hypothyroidism, I gladly wrote for some iron supplements and Levothyroxine, satisfied for identifying what I believed to be the cause of his unease, all the while avoiding a more aggressive work-up.

A few more months went by, when one day I walked into clinic to find a stack of hospital records on my desk. While I had interpreted his long hiatus from clinic as a sign of good health, it turns out his symptoms had progressed. Annoyed by what he perceived as indifference on my part, he went to a private hospital for a 2nd opinion. Although his complaints continued to be fatigue and neck discomfort, they obtained a chest x-ray which revealed a sizeable right upper lobe lung mass, suspicious for malignancy. He was admitted briefly overnight for observation, and his in-patient doctors discussed the possibility of bronchoscopy versus biopsy to further characterize this mass. True to character, Mr. X declined further work-up, stating that he would not want to undergo treatment anyway and just wanted to be “as comfortable as possible”. Shortly thereafter, he was discharged home.

Teachable Moment:
In their recent BMJ article, *Stop the Silent Misdiagnosis: Patients’ Preferences Matter*, Mulley, et al., outline steps doctors can follow in order to achieve what they call a “preference diagnosis,” or “an inference of what a patient would choose if he or she was a fully informed decision maker.” Instead of taking the time to eliminate my own biases and fully engage Mr. X in the process, I erroneously jumped to conclusions about his desires. Although I was correct to assume that he would not want a biopsy or any form of cancer treatment, I was wrong to assume that I was acting in accordance with his wishes. Subsequently, I made the wrong preference diagnosis, and perhaps caused my patient harm as a result.

In an age of over-testing and over-diagnosing, it is tempting to choose a more conservative approach in the hopes of not having to subject our patients to invasive, and potentially harmful, tests and procedures. With regards to Mr. X, however, I have to wonder if we achieved more harm than good by avoiding certain tests and effectively delaying his diagnosis. By focusing all of my energy on avoiding imaging studies (which in my mind would certainly lead to a biopsy), I essentially lost sight of my patient, failing to recognize his need for a diagnosis and validation of his symptoms. Ultimately, something as simple as a chest x-ray was all it may have taken to provide this sense of closure for him.