Should you tell patients about beneficial treatments that they cannot have? No

John Firth

BMJ 2007;334:827
doi:10.1136/bmj.39171.511794.AD

Updated information and services can be found at:
http://bmj.com/cgi/content/full/334/7598/827

References

These include:

2 online articles that cite this article can be accessed at:
http://bmj.com/cgi/content/full/334/7598/827#otherarticles

Rapid responses

15 rapid responses have been posted to this article, which you can access for free at:
http://bmj.com/cgi/content/full/334/7598/827#responses

You can respond to this article at:
http://bmj.com/cgi/eletter-submit/334/7598/827

Email alerting service

Receive free email alerts when new articles cite this article - sign up in the box at the top left of the article

Topic collections

Articles on similar topics can be found in the following collections

- Urology (1194 articles)
- Patients (1459 articles)
- General practice / family medicine (6949 articles)
- Chronic renal failure (59 articles)
- Urological surgery (2239 articles)
- Medical error/ patient safety (374 articles)
- Drugs: endocrine system (525 articles)

Notes

To order reprints follow the "Request Permissions" link in the navigation box

To subscribe to BMJ go to:
http://resources.bmj.com/bmj/subscribers
No healthcare system can afford to pay for all available treatments. Robert Marcus believes doctors have a duty to tell patients about unfunded drugs, but John Firth argues that it will cause them harm.

**NO**

I am a nephrologist. Mr Brown, a frail 79 year old man who lives in social housing, comes to my clinic. He has advanced chronic renal failure, cause unknown, but not so far advanced that dialysis would be likely to benefit him, and in previous discussion with me and the dialysis nurses he has said that he doesn’t want it in the future anyway. He tells me that he is tired, has no energy, and getting around is more of an effort than it used to be, but he is eating satisfactorily and his diagnosis is that he thinks he’s getting old. His haemoglobin is 101 g/l.

I suspect that he would feel better if his haemoglobin was higher. Erythropoietin would be the most appropriate treatment on clinical grounds and likely to be successful. Such treatment agrees with the current guidance from National Institute for Health and Clinical Excellence (NICE) on managing anaemia in people with chronic kidney disease.¹

But in these financially more aware times, where will the money come from? The renal service has no budget for erythropoietin for people who are not on dialysis. The primary care trust, many millions of pounds in debt, has declined to provide funding to allow clinical practice to follow the NICE guidance. My trust, which is continually having to deal with both rapidly changing, mutually incompatible imperatives from the centre and unpaid bills for work done, would be put in a difficult position if I were to ignore all of the above and write a prescription with a likely cost of £2500 a year. And not just for Mr Brown; literally for at least 100 others.

So what do I say to Mr Brown? If he asks me about erythropoietin, then I have no hesitation in talking to him about the matter in an open and honest way. But he does not ask: he is unfamiliar with the internet and has not heard of NICE. Even if he was aware of the drug, I strongly suspect that he “wouldn’t want to cause any trouble.” So I say nothing about erythropoietin to him. This is undoubtedly a pragmatic approach: discussion would take time and I have an overbooked clinic to finish. There will be complaints if it over-runs by more than it usually does; patients understandably do not want to be kept waiting; loyal nursing and phlebotomy staff want to get home.

But am I right not to tell Mr Brown about the treatment that he cannot have? The very fact that not telling him assists my need to get through the clinic means that my silence deserves particularly careful scrutiny.

**Duty of care**

Forget everything else—my responsibilities to the other patients and colleagues, etc—my main duty of care is to Mr Brown, and I must behave properly towards him. Would he be better off if I told him that there were some injections that would probably give him a bit more energy, but the wherewithal cannot be found to get them for him?

Two ethical principles seem to be clearly relevant and in conflict. By not telling him about the drug I could be said to be failing to respect his autonomy, but in any real sense autonomy must mean that he could make a choice, and he has none. By telling him I will be doing him harm: he could not benefit physically from a treatment he would not receive, and if he ruminated on the matter then I cannot imagine that such ruminations would do anything other than cause unhappiness. So I keep silent.

**The very fact that not telling him assists my need to get through the clinic means that my silence deserves particularly careful scrutiny**

**Matching up to GMC guidelines**

But again I am worried that I might have got things wrong. How does my behaviour match up to the stipulations of the General Medical Council’s guidelines on good medical practice?² Paragraph 9 states: “You must give priority to the investigation and treatment of patients on the basis of clinical need, when such decisions are within your power. If inadequate resources, policies, or systems prevent you from doing this, and patient safety is or may be seriously compromised, you must follow the guidance in paragraph 6.”

So, if I decide that Mr Brown is being seriously compromised I must (paragraph 6), “Draw the matter to the attention of [my] employing or contracting body.” This is what I have done and will continue to do, in more discussions than I can remember with primary care trusts, commissioners, and within the trust, and in the drafting of one of many (not yet accepted) business plans.

Should the day come that the financial shackles are loosened I will tell Mr Brown that there is something that may help, and if things get really bad for him before then I will prescribe and take the flap. But in the meantime it would simply cause harm and be bad medicine to tell him about a treatment that he cannot have.

**Competing interests:** None declared.

References are in the full version on bmj.com.

---

¹ Arguments are in the full version on bmj.com.