VIEWS & REVIEWS

NO HOLDS BARRED

Margaret McCartney: The conflict of choice

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Shared decision making is the pivot on which modern medical ethics rest. Doctor appraises patient of the choices available. Doctor supplies evidence and lays out the pros and cons. Patient has the intervention of choice. We are all happy.

Except we're not. Doctors deny patients treatments all the time. A patient may want 40 mg temazepam nightly as the only effective long term treatment for insomnia. Evidence may show ineffectiveness, dependence, and associated risks of falls and dementia; the patient may want it anyway, understanding the evidence and fully accepting the risks. I might prescribe if my patient had metastatic cancer and was at the end of life. I wouldn't, however, if my patient was otherwise fit and well, with a history of drug misuse. Similarly, I would not prescribe antibiotics for a simple sore throat, even if I heard that it would spoil the holiday booked for tomorrow and that I was responsible.

Earlier this year Victoria Coren Mitchell, the professional poker player, wrote that her GP would no longer prescribe the combined oral contraceptive for her at age 35 "because I smoked and thus sat badly on the contraindications graph for heart attacks. I pleaded that, as an ageing gambler with a professional understanding of mathematical risk, I should be allowed to make that decision for myself—but no dice. So I gave up and got prescriptions privately at enormous expense."¹

Should she have been allowed to make that choice? Who was taking the risk: the patient or the doctor?

We do not have a drugs free-for-all. Doctors have duties at the interface of prescription and patient. We are not expected to agree with our patients' choices, and we are definitely not to pressure them into accepting our personal preferences.²

But we are in conflict. We are meant to act in the "best interests" of patients, but a patient may have radically different views from us on what those interests are. Our regulator says that we must "follow the advice" of the *British National Formulary*,³ which advises us to "avoid" the combined contraceptive pill for 35 year old smokers. The risk for doctors is to their registration, reputation, and conscience if the stats play out badly. The patient, of course, risks side effects—including death, although rarely.

Where does medical responsibility meet patient autonomy? Shared decision making is much more than us all simply

agreeing to disagree: it's dirtier and messier. Coren Mitchell's doctor seems to have refused to sign off on her drug of choice; she went elsewhere and got what she wanted. Another doctor was presumably willing to let the risks play out. But what of diazepam or codeine or long term use? Should the patient be allowed to accept all responsibilities for hazards and side effects?

Choices are often skewed: antidepressants are available today, but cognitive behavioural therapy is 12 long weeks and several hoops away. Choosing to stop smoking would help your asthma, but your "choice" to stop smoking may be rather harder if you're looking after children while surviving on a zero hours contract.

Doctors often do not know the "right" answer, but they at least should acknowledge the irresolvable tension in choice. Mostly, it should be possible to negotiate a reasonable path of mutually acceptable risk—but sometimes it won't be. This becomes even more acute when parents or proxies decide against recommended treatments or threaten complaints for refusal to prescribe. Disagreements are inevitable; they're not necessarily a sign of bad medicine or bad doctors.

Competing interests: I have read and understood BMJ policy on declaration of interests and declare the following interests: I'm an NHS GP partner, with income partly dependent on Quality and Outcomes Framework points. I've written two books and earn from broadcast and written freelance journalism. I'm an unpaid patron of Healthwatch. I make a monthly donation to Keep Our NHS Public. I'm a member of Medact. I'm occasionally paid for time, travel, and accommodation to give talks or have locum fees paid to allow me to give talks but never for any drug or public relations company. I was elected to the national council of the Royal College of General Practitioners in 2013 and am chair of its standing group on overdiagnosis. I have invested a small amount of money in a social enterprise, Who Made Your Pants?

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- 1 Coren Mitchell V. The doctor won't see you now. *Guardian* 2015 Mar 29. www.theguardian.com/commentisfree/2015/mar/29/doctors-gps-appointments-hard-to-get.
- 2 General Medical Council. Consent: making decisions together. 2 Jun 2008. www.gmc-uk.org/Consent_English_0415.pdf_48903482.pdf.
- 3 General Medical Council. Prescribing guidance: keeping up to date and prescribing safely. 2013. www.gmc-uk.org/guidance/ethical_guidance/14317.asp.

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