Antihypertensives and the Risk of Temporary Impotence: A Case Study in Informed Consent

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Dr. Sylvia Kramer pondered what she would tell Robert Williams on his next visit to her primary care clinic. Mr. Williams was an affable 40-year-old African-American, and one of Dr. Kramer's favorite patients. He had recently remarried, and enjoyed telling his doctor about his two young stepdaughters. The problem that brought him to this inner-city clinic was high blood pressure, which was first diagnosed by Dr. Kramer a year ago, during her first year as a resident in family medicine. Mr. Williams's blood pressure had then measured 180/103: not frightening numbers, to be sure, but still very much on the high side of "mild hypertension." If his blood pressure were not lowered, Mr. Williams could anticipate some serious related health problems, such as an increased risk of stroke.

Dr. Kramer's initial recommendation to Mr. Williams was that he attempt to control his weight and blood pressure through a regimen of regular exercise and a sensible diet low in salt and fat. She had recalled one of her mentor's lectures on hypertension: "No need to burden your patients with expensive drugs with side effects when they can solve the problem on their own through good behavior." Although Mr. Williams had achieved some lowering of his blood pressure during the ensuing months, down to 160/95, this improvement still left him in the marginal zone and was, in any case, short-lived. His blood-pressure readings were now consistently elevated. On his last visit, he had expressed some frustration to Dr. Kramer that, try as he might, no amount of exercise or diet seemed to be working.

Given Mr. Williams's lack of progress, Dr. Kramer was considering prescribing a common diuretic, hydrochlorothiazide, as the second line of defense against his hypertension. This particular drug, she knew, has a long history as a cheap and highly effective remedy. The price tag, 5 cents per pill, was particularly attractive to Dr. Kramer, who realized that her clinic patients often had a hard time paying for some of the more "high-tech" and high-priced hypertension medications that had been flooding the market in recent years.

Notwithstanding its relative safety, efficacy, and affordability, this particular drug still posed problems. First, it had a tendency to leech potassium from the body. She could address that problem by prescribing bananas. The second problem, a more serious matter, was a risk of causing impotence in males. The risk was small, however: only about 3 to 5 percent of men who took the pill were likely to be affected, and the impotence was easily reversible. One simply had to stop taking the drug for this side effect to disappear.

Dr. Kramer pondered the question of what "informed consent" should mean in this situation. In particular, she wondered whether she had an obligation to inform Mr. Williams of the risk of temporary impotence when recommending that he start with this diuretic. While this risk was certainly a lot less worrisome than the remote possibility of death attendant upon many medical and surgical procedures, it was still significant. If Mr. Williams, a newlywed, were to experience an unexpected and unexplained episode of sexual dysfunction, he would no doubt be extremely upset and anxious about it. Dr. Kramer, the product of a family-medicine training program committed to the value of patient self-determination, initially felt that she should share all the risks that Mr. Williams would likely consider relevant to his decision. Cost was certainly a factor, but so was his sex life. He should have the right, she reasoned, to make his own trade-offs among competing values. If sexual dysfunction is high on his list of things to avoid, especially at this time in his marriage, he might be willing to pay extra for another drug.

Still somewhat uncomfortable with her conclusion, Dr. Kramer asked the advice of Dr. Robert Black, a senior physician in her program. Dr. Black registered total disbelief upon hearing the resident's plan of action. "Look," he said, "I'm a staunch supporter of patients' rights, autonomy, and all that, but this is just ridiculous. The risk is quite low, entirely reversible, and consider this: if you share this possible side effect with your patient, this

This case study has benefited from helpful discussions with my brother, Ernest Arras, M.D., and from the careful scrutiny of several physician-colleagues at Montefiore Medical Center, including Michael Alderman, Ellen Cohen, Tom McGinn, and Doug Shenson.

little bit of truth is likely to make him extremely anxious about what could happen. You've heard of the Hawthorne effect, haven't you? Telling him about the risk of impotence could actually make Mr. Williams so worried that he would become impotent at your suggestion. I've been practicing medicine for fifteen years, and I've never told a patient about this sort of thing beforehand. If Mr. Williams comes back to you in a couple of weeks complaining about his sex life, you can deal with it then. But in the meantime, don't make a counterproductive fetish of informed consent. Lighten up!"

At this point, Dr. Kramer was truly puzzled. If she were to be entirely honest with her patient, she might end up doing him harm, and all for a very remote and reversible risk. On the other hand, it still bothered her to hide a fact from her patient that she suspected he would consider significant. He was, moreover, a rather shy man, especially about sexual matters. Dr. Kramer was not entirely confident that, should a problem develop, Mr. Williams would feel comfortable talking with a young female physician about his sexual "failure." He might just conclude that it was his or his new wife's fault, not the result of the drug, and live with impaired sexual function for some time.

How should Dr. Kramer resolve her ethical conflict? Should she (a) have a serious discussion with Mr. Williams about the small risk of temporary impotence, (b) casually mention the risk, perhaps using medical jargon, but only in passing along with many other minor risks, (c) withhold information about this particular risk until the patient complained of sexual dysfunction, or (d) withhold the information at first, but inquire specifically at a later date about the patient's sex life?