The ethics of medical referral

Eustace J. De Souza

Introduction

The changing relationship between doctors and patients has undergone a sea change in the last sixty years. The old family physician is fast disappearing, no longer friend, philosopher and guide.

Advancing technologies and umbrellas of chemotherapy and antibiotics now override careful history taking and clinical examination.

Finally, the taint of lucre can tip the scales of ethical restraint.

Various arguments are raised. 'Is not the laborer worthy of his hire?'; 'Doctors too, must live!'; 'The cost of medical education is so high, and even a room to practice in costs a bomb.'; 'In all justice, is he not entitled to a fair return?' **These may be fair questions, but can never justify unethical conduct.** This is the first criterion that must pervade the medical profession if it is to rise above the ethic of the market place.

A patient, made aware by the media of these concerns weighing on the medical profession, may question the essence of the fiduciary contract between doctor and patient.

When we add to this, the ambit of the Consumer Protection Act (CPA), we are certainly at a crucial crossroad. If the CPA is empowered to equate the professional services rendered by a doctor as ***goods,*** on the same plane as a toaster supplied by a manufacturer, we lose sight of several subjective factors that separate a professional service from ***goods supplied.***

In the latter case, objective criteria of claims made or protections prescribed can clearly be spelled out and independently tested. Obviously, to protect themselves doctors prescribe, or at least recommend that certain objective tests be undertaken. While perfectly certain of his diagnosis, the doctor feels he must order the test primarily as 'insurance protection'. Naturally, this raises the cost to the patient.

The doctor-patient contract

When a patient comes to a doctor, whether he knows it or not, a contract comes into effect. This contract is essentially between two parties who agree to deliver on the one hand, and to receive on the other.

Between doctor and patient, this contract is essentially based on faith. His consent can be inferred by his voluntarily coming to the doctor for assistance; or in some cases made overt when he signs a declaration accepting some mode of therapy, especially in declarations for admission to hospitals or nursing homes. In public hospitals (and to a slightly different degree, in private hospitals), the hospital is the 'delivering' party and its doctors are, in a sense, its special agents. The honorary doctors are not paid agents and bear a greater degree of independent responsibility.

Introducing a ***third party***

I have particularly indicated 'two parties' with regard to this contract, because the question of a referral immediately involves a third party or person into this contract.

The problem of the third person must be seen in the light of individual rights and obligations, as well as professional responsibilities and inferred ethical norms, codes and guidelines.

A fundamental principle in medical ethics holds that the human being has a unique value, status and dignity. In no professional transaction must the obligation to uphold this right be violated.

While the first consent can be inferred, in a referral, this consent cannot be so easily inferred. The patient must be informed of the new entrant into the contract with the reasons for the introduction of this third party. In this circumstance the third 'person' or specialist is called because the conditions of the case warrant the need for another supportive or additionally required form of expertise. Thus it is the welfare of the patient that is the only reason for this referral.

Here lies the evil of 'cut back' or 'commission'. In trade or business, a commission can be part and parcel of the mechanism of the contract, where the prime purpose of commerce is profit. The ethic of business is primarily the prevention of fraud, or exploitation and the gimmick of false representation by skillfully worded advertising, where glamour is often a cover. The ethical 'evil' here lies when skill is often deliberately used to carefully skirt the law of misrepresentation or actual fraud.

In business, another ethical difference is that of 'putting one over' a serious competitor by skillful advertising which is forbidden in professional ethics.

The question of responsibility

In the matter of medical referral, there is also another ethical consideration with medico-legal significance.

It is the question of primary responsibility. This depends on the nature of the referral.

If for instance it is a consultation between general

Eustace J. De Souza, Director (Research), The Bandra Holy Family Medical Research Centre, Bandra, Mumbai

practitioner and specialist, the latter is mainly responsible for the continued care and concern for his patient. The general practitioner merely follows the advice of the consultant, reporting to him the progress of the patient so as to modify therapy or obtain further instructions with regard to continued care.

On the other hand, if the referral is such as to need the independent care by the consultant, the patient is transferred to the care of the consultant. The general practitioner moves aside, though courtesy and etiquette demand that the consultant keeps the refening doctor informed of the progress of the patient. Once the immediate specialized care is completed, the patient can then be returned to the general practitioner for such continued care, advice etc., as may be necessary.

Unfortunately, in both public and private hospital health care systems, the patient decides for himself on which consultant specialist or department, he should go to. The result is a waste of time, undue expense and the unnecessary shuffling of a patient from one consultant to another. For instance, a young woman decides that her pain is due to appendicitisand goes to a surgeon. He decides that there is no disease in the appendix but suspects need for gynaecological intervention. The patient is referred to the gynaecologist. The general practitioner would have identified the need for a gynaecologist and made the appropriate referral, at diminished expense and certainly a saving of valuable time on the part of consultants as well as the patient. The two tier system, which poses definite advantages, needs to be resuscitated. Here all patients can be first seen by individuals or teams of general practitioners, adequately qualified to treat and deal with the ordinary run of ill health while at the same time equally qualified to know to which consultant to go and order appropriate tests prior to the visit to the consultant.

Referral of patients admitted to hospitals

In-patient referrals, both in public and private hospitals, are either for particular supportive consultation or to effect a transfer to another appropriate speciality. Generally, these consultations are facilitated between the various consultants on the staff of the hospital. If a patient seeks another doctor not on the staff, he has a perfect right to seek discharge from the hospital to be treated by the doctor of his choice elsewhere.

Respecting patient autonomy, in some private hospitals, there is a provision whereby the hospital will permit the second consultant (not on the staff of the hospital) being called at the request of the patient provided the current treating doctor also agrees. If it is a mere consultation, the original treating doctor bears full responsibility for continued treatment. In cases of surgery where an outside consultant is actually involved in the surgery jointly, it is only ethical that both doctors continue to bear joint responsibility. Legally, this problem of joint responsibility is quite a vexed question. However, the doctor in whose unit or under whose care the patient is registered, cannot abdicate responsibility, unless it is a question where the patient has been transferred to the care of another specialist, who must accept this independent responsibili ty. Here too, the patient's informed consent is an ethical necessity.

Second opinion

In the matter of referral, it sometimes happens that the patient will ask (rather hesitantly - for fear of offence) that the treating doctor agree to a second opinion. No one should see this as a lack of faith but rather respect a patient's right to total autonomy and gladly give his consent, unless he honestly feels it would not be in the best interest of his patient. In this latter case, he should explain his reasons for non agreement, but clearly leave his patient free to seek treatment from the other doctor. However, as the doctor too, has rights and professional autonomy he should make it clear that the discharge from his care also involves discharge from future responsibility. Incidentally, this discharge does not absolve the first treating doctor from proven incompetent or negligent treatment while under his care. Thus, if the second surgeon were to operate again and find that a swab had been left behind, the first operating surgeon is ethically, morally and legally responsible.

It frequently happens that a patient 'shops around' from doctor to doctor, often in the hope of getting an opinion that he/she would find either convenient or to preformed expectations. Or the patient seeks treatment from one for a period of time, then leaves that doctor to go to another without telling the second, either details or facts of previous treatment.

Doctors should understand that patients are human beings, especially vulnerable under the burden of sickness. While the doctor is certainly entitled to a true and full past history, failure on the part of the patient to disclose an earlier consultation should not always be construed as an inability to keep the faith so vital to the contract. Prudent questioning is certainly the right of any doctor who is concerned to give of his best to his patient, and part of good history taking.

Can a doctor refuse to treat a patient?

Being a professional in his own right, the doctor certainly has an ethical right to refuse to treat a patient, who will, in his view, not follow treatment directions to their logical ends.

This right not to treat or accept for treatment also extends to those situations where a patient approaches a doctor insisting on a predetermined mode or line of treatment.

My only plea in this context is that the doctor is a man of morality first. By morality, I mean that every man, be he theist, or atheist, agnostic, or 'secular humanist', has the ability, right and obligation to choose between what he sees as right and wrong. Every doctor is a professional, who by his chosen vocation agrees to abide by a code of ethics guided by morality. Finally, as social beings, both doctor and patient are guided and restricted by the laws of the land in which they live. They may not agree with those laws. For this they must seek legal redress to gets these laws changed. [illegible] a [illegible]st. 'A law that is not