

# The Practice of Medical Referral: Ethical Concerns

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**Abstract** Medical referral is the act of sending a patient by one professional care giver to another, who may be a specialist and therefore be more knowledgeable in the diagnosing and further management of the patient. Most cases of referral of patients is therefore for proper diagnosis, adequate investigations and their proper treatment by the receiving specialists. It is mostly assumed and believed that patients depend on the medical information available to their health care providers. Therefore, the need for a referral, its appropriateness, timing and to whom the referral is made to mostly depends on the attending physician. This should be done after due consultation with the patients family and appropriate consent obtained. It is believed that a health practitioner should make a referral when he thinks that it will be of benefit to the patient and not when he wants to avoid the challenges of unraveling the patients' complex problems. Also, referral should not be made to avoid possible death of the patient in a hospital so as not to worsen its statistics. Unfortunately, the seemingly good intention of referring of patients may cause a conflict of interests when physicians because of inherent financial gains refer patients to facilities that they own or have investment interest in. Such referral challenges as self-referral, and fee-splitting whereby a fee is paid to one physician by another for a referral is unethical, and are known to occur. Several "Anti-referral Laws" have subsequently been set up to prevent such actions and protect patients against abuse by health workers.

**Keywords:** patients, physicians, treatment, ethics, diagnosis

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## 1. Medical Referral

In the act of medical practice, referral is the transfer of a patient's care from one physician or clinician to another. It involves one physician recognizing that a patient under his care needs some expertise or skills that can be found in another physician. This other physician maybe working in the same institution with the referring physician or in a different institution entirely.

Tertiary care is usually done by a referral from either a primary or secondary care centre to a specialist who serves in such tertiary centres [1].

Appropriate referral is an integral part of a complete quality health care management, and should be based on the unique needs of a patient. It is assumed that the referring physician has the required skills and knowledge in diagnosis and treatment to determine when a referral is needed.

## 2. Ethical Observation

Consider a situation where a family physician in a busy clinic had seen a patient, and had taken a proper history, examined him and then made a working diagnosis that required the patient to be admitted onto the ward for

investigations and further management. The physician at this point explained his findings and thought to his patient and relations around and further explained the need for the patient to be admitted onto the ward so as to closely monitor his expected recovery and improvement.

The patient himself, and all his attendants and relations present understood the detailed explanation and all agreed for the admission to be made so that appropriate treatment can be administered. Then, the problem of no vacant bed space arose. There just was no free bed available in the hospital. All efforts made to get a place for him, even on the orthopedic and surgical wards were not successful. At this point, the need for a referral was suggested to them.

A senior member of the extended family was informed by one of the attendants present by telephone, and he came over to the hospital, very furious and quite surprised that such a problem could possibly endanger the life of the patient.

He announced very loudly that it was "criminal" for us to even contemplate a referral of the patient out of our facility. He maintained that since we have made a diagnosis that the onus was now on us to ensure that we get a bed space for the patient and treat him. It did not matter what we had to do, even if we had to put a mattress on the floor. Nothing else was to be accepted by him.

Furthermore, he stated that he was sure that the other place where we may send the man to "will not be able to see what we have seen" and therefore cannot administer

the kind of treatment plan that we have made. This assertion further strengthened his insistence that we must admit and treat. Anything otherwise was criminal and negligence of our responsibility to the patient. He subtly made some threats of a possible judicial recourse if we failed to admit the man and treat.

All explanation of our limitation fell on deaf ears. We explained to him that a proper referral letter detailing our findings will be given to the patient. All of these will be a good guide to the receiving doctor. But he sturdily ignored us, and by this time, the other relations/attendants were becoming restive and unmanageable by the hospital's workers. But then, what can we do? Our limitation was not our making. We were willing to admit and treat, but there was shortage of beds.

The concern here is; whether a genuine medical referral by one medical personnel to another constitutes a criminal, unethical action or not? When is it unethical to refer a patient to another physician, and what makes a referral ethical or unethical?

It is expected that a practicing physician should know his limitations and therefore knows when to seek for assistance and help in the management of his patients. This is so much so when he knows that such patients depend on him to make the correct decisions concerning their health challenges.

From a small survey that was conducted among practicing physicians at the Delta State University Teaching Hospital, Oghara, Nigeria to test their perception and attitude toward medical referral, the following remarks were analyzed.

The hospital is a tertiary institution being the major referral centre for the government owned secondary and primary health centres. Also, the numerous private hospital situated all over the state refer their critical cases either to the secondary health facilities or directly to the teaching hospital.

**Table 1.**

Average Age of Interviewed doctors	= 31years – 59years
Years of Practice	= 6years–25years
Rank of Doctors Interviewed	
Six Consultants:	
Family Physicians	= Two
Mental Health Physicians	= Two
Community Health Physicians	=Two
Six Senior Resident Doctors in training by department	
Obstetrics and Gynaecology Department	= Two
Mental Health Department	= One
Community Medicine Department	=One
Family Medicine Department	=One
Internal Medicine Department	=One

**Table 2.**

**What do you understand as Medical Referral?**

- Process of sending patients to a higher medical centre for a more specialized medical care.
- Sending a patient for expert management
- Sending a patient for a further specialist care
- Recommending a patient to another physician for a continued or secondary care.
- Sending a patient to another doctor to access a service that is not available in my hospital where I work.
- Transfer of care to another doctor with more experience for assessment and treatment.
- Collaboration in a patient management involving other specialists.

**Table 3.**

**Why do you refer patients?**

- For expert evaluation, investigations and treatment
- For the treatment of co-morbid health challenges that requires a general practitioner to review.
- To access health services that are not widely available
- To give management that I do not know how to give
- For proper care if there is disruption of service in my centre due to industrial disharmony resulting in a strike action by workers

**Table 4.**

**Do you have a private hospital?**

	Number		Percentage
No	10	=	83.33
Yes	02	=	<u>16.67</u>
<b>Total</b>	<b>12</b>	=	<b>100%</b>

**Table 5**

**Do you refer patients to your private hospitals or to hospitals where you do part-time practices?**

	Number		Percentage
No	11	=	91.67
Yes	<u>01</u>	=	<u>8.33</u>
<b>Total</b>	<b>12</b>	=	<b>100%</b>

**Table 6.**

**Do you receive gratuity for your referrals?**

	Number		Percentage
No	11	=	91.67
Yes	<u>01</u>	=	<u>8.33</u>
<b>Total</b>	<b>12</b>	=	<b>100%</b>

**Table 7.**

**Do you receive gratuity for your referrals?**

	Number		Percentage
Yes	05	=	91.67
Sometimes	03	=	<u>8.33</u>
Partially	01	=	41.67
Most times	01	=	25.00
Not always	01	=	8.33
No	<u>01</u>	=	<u>8.33</u>
<b>Total</b>	<b>12</b>	=	<b>100%</b>

**Table 8.**

**Do you expect feedback on your referrals?**

	Number		Percentage
Yes, but do not have often	03	=	25.00
Yes	07	=	58.33
Sometimes	<u>02</u>	=	<u>16.67</u>
<b>Total</b>	<b>12</b>	=	<b>100%</b>

**Table 9.**

**How often do you refer patients?**

	Number		Percentage
As needed	06	=	54.55
Often	02	=	18.18
Once per month	02	=	18.18
Frequently	<u>01</u>	=	<u>9.09</u>
<b>Total</b>	<b>11</b>	=	<b>100%</b>

Most of the physicians that were interviewed agreed that they do refer out patients to other physicians or to other health care facilities in order to seek for further expert assessment that they cannot offer to those patients.

Other given reasons include the need for more specialized investigations to be done on such patients and or to interpret laboratory investigation results more adequately by relevant specialists.

Some of the physicians elicited the need to refer patients to other specialists when there are other co-morbid illnesses that they cannot handle and that other physicians with better knowledge will treat better.

In this case, the referring physician calls in the required physician who maybe in the same facility with him. Thus the patient is not sent out to another hospital entirely. In some other cases, the patient may need to be referred out to another hospital completely.

This need for collaborative care for a patient exists mostly in tertiary institutions where these other specialists are available. The desired specialist simply comes in to review such a patient either on the admission ward or the patient sees him in his outpatient clinic for a review.

The physician reviews and gives suggestions on treatment and the patient goes back to his primary physician who continues the management based on the advice given. Regular check-up are subsequently made by the secondary physician.

Table 4, Table 5 and Table 6 reveals the core matter under our study. The table reveals that two physician (16.67%) out of the interviewed doctors agrees that they have their own private hospitals that they operate. They go there at their private free times after work at the primary place of work at the government hospitals. These private hospitals usually have a full compliment of dedicated staff and the physician-owner mostly do a supervisory role since he is not there always. Of utmost interest here is that one of the physician that agreed that he owns a private hospital says that he often refers patients to his hospital. We do not know the sources of these patients whether they are from his primary place of work or from the general population.

This is the crux of the matter. Is it ethical to do this or not? Referring patients to a place where you stand to gain financially is part of the present study. The act may encourage you to coerce patients to go to your facility only because you stand to make monetary income.

Also, most of the interviewed doctors do not expect to be paid for the referrals that they make (Table 6). One said that he gets paid for any referral that he makes. Will this make him to refer patients away quickly without making any significant attempt at helping them solves their problems?

Lastly, Table 8 reveals that most doctors expect some kind of feedbacks from the receiving physicians. This may help improve their diagnostic capabilities. The often poor feedback from the receiving physicians to the refereeing physicians may be due to poor or low tracking of the referred patient by the referring doctors (Table 7). The table suggests that maybe referring physicians need to check more on the patients that they refer to ensure that they even go there in the first place.

The people who access these health centres are mostly the middle-class civil service personnel and the rural subsistent farmers with low income. The upper-class members of the populace access the usually better equipped but expensive private hospitals. Therefore, referring these people to self-owned private medical centres may become a burden on their already low finances and many may not honour the referrals and then go to purchase self-prescribed medicines from chemist shops. This medicine that the people buy from across the counter from chemist shops are often adulterated or even

expired and these will impact negatively on the health status of the people.

Subsequently, a negative cycle sets in whereby the patient who from the onset is financially handicap will not get properly treated of his ailment because of poor finances, will loose office working time. The subsistent rural farmers may not be able to tend to his farm and may loose his farm produces. All these will lead to lose of earning powers, poor wages and this will impact on his health and psychology and self esteem.

This is a viscous cycle that may have been triggered off by self referring rather than offering the patient service at the cheaper government owned hospitals.

### 3. Why Medical Referral?

The physician's primary responsibility is to be an active advocate for his patients' care and well-being. He is to always place the interest of his patients first. The physician has a duty to accept ultimate responsibility for his medical decisions.

The physician should treat each patient with compassion, dignity and respect, and he is not to exclude or discriminate against any patient for whatsoever reasons. He is also expected to be truthful and honest with everybody.

Physicians should be aware of the limitations of their expertise and seek consultation or assistance in clinical situations in which they are not experts. Physicians, as steward of medical knowledge, have an obligation to share information with colleagues [2].

This responsibility in seeking consultation rest solely on the attending physician, who having realized that he needs the expertise that he does not have, then refers such a patient to such a physician that by training has the expertise and skills that is needed.

One of the Codes of Medical Ethics of the American Medical Association says "A Physician shall continue to study, apply, and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talent of other health professionals when indicated" [2].

This in talking of referral of patients to other health workers that can help such patients. Ultimately, the patient's wellbeing is of greatest concern, and not our self esteem of being seen as the "all knowing Doctor".

### 4. Why Write a Referral?

Physician's primary responsibility is to promote the best interests of his patient. Patients are dependent on physician's expert, clinical knowledge, skills and compassion. They must be confident that their physicians will make treatment recommendations in their best interest, based on objective clinical judgment and relevant guideline [3].

When a physician agrees to provide treatment to a patient, he assumes an ethical obligation to treat that patient to the best of his ability. Physicians have an obligation to disclose to their patient appropriate treatment alternatives, and therefore all necessary information should be given to the patient so as to make an informed decision [4].

One good factor to consider is whether the need for a possible referral is appropriate or not, that is, whether there is a good reason for one health care provider to refer a patient to another.

This ability to know what is appropriate depends on the good practitioner's education that must be regularly updated to reflect scientific breakthroughs and their clinical implications, both in medical schools and throughout the practitioners practicing career [5]. This is so as to remain competent and up to date in all areas of their practice.

Therefore, a general practitioner makes a referral when he realizes that it will be beneficial for the patient to receive a second opinion or see someone else who has more insight in a given area.

This seemingly simple act of accepting one's limitation may create ethical issues when problems of conflict of interests arise, when the referring physician refers such patients to health facilities where he has investment interests or are part/full owners of such facilities [4].

This practice which is known as self-referral creates secondary interest that can compete with the physicians' responsibility to their patients [4].

## 5. Ethical Challenges that can Arise from Referring Patients

1. The act of a physician referring patients to health providing facilities that they own or have investment interest in, and that they are in position to refer patients to is known as self-referral. This arrangement creates a conflict of interests that may obscure the physician's sworn responsibility to promote the best interest of his patient [4].

The major ethical issue of self-referral erodes the expected fidelity of physicians to their patients, whereby doctors are expected to put the interest of their patients ahead of their own [4].

Self-referral may lead to unnecessary referring because of the expected financial gains by the facility where the physician has some investments [4].

Our study revealed from the Table 5 an 8.33 percentage of self-referral with only one physician out of the twelve physicians interviewed agreed that he refers patients to his own health care facility. But, this percentage (8.33%) that agreed to self-referral is quite significant if it is extrapolated to the totality of practicing physicians in the country. This may then be quite significant and may necessitate a bigger study to look into the problem.

The patients who are poor may then be forced into borrowing money and going into debt so as to be able to afford the usually exorbitant bills of private hospitals.

Self-referral can lead to loss of trust by the patients even by fellow physicians when and if they discover that the primary reasons for many referrals done by the involved physician is for his own financial gains. Such loss of trust can be damaging to the well-being of patients who may refuse to adhere to treatment plans, or not disclose information to the physician or worse still, may refuse to seek medical help and care altogether [4].

Self-referral can limit the patient's right of autonomy, a core ethical principle; because the involved physician will want all referrals even when necessary to go to his own

place when there maybe better qualified places than his choice/own. The blind desire to make more money could affect his better judgment [4].

This concern that health care provision was being influenced by financial incentives that may becloud the doctors better judgment led to the enactment of the Ethics in Patients Referral Act of 1989 in the Congress of the United States, popularly known as the Stark I, after congressman Pete Stark who proposed it [4,6].

The act prevents physicians from making referrals to any facility in which he or his family members have financial relationships such as ownership or investment interests. This law was further broadened by the Health Care Financial Administration in 1995 to Stark II, in which the ban was expanded to include an extensive list of health services such as physical therapy, radiological services and even outpatient treatments. Also, the kind of patients that may not be referred was broadened and well defined.

The Protective Anti-Kickback Law was passed by the U.S Congress in 1972. This statute forbids physicians from receiving or paying anything of value so as to encourage referrals of patients to their centre [4].

Again, our study from Table 6 showed that one physician of the twelve interviewed physicians received some gratuity from the receiving physician.

This act whereby a physician is paid or pays another physician for patient's referral is fee splitting and it is unethical. The American Medical Association as well as the American College of Physicians Ethics manual also states categorically that fee splitting is unethical.

The American Medical Association Code of Medical Ethics went further to state that "a physician may not accept payment of any kind, in any form, from any source for referring a patient to a said source". And offering or accepting payment for referring patients to a research study (finders fee) is also unethical [7, 8].

The anti-referral laws help to regulate referral arrangement, but may subject physicians to monetary fines, imprisonment, license revocation and other disciplinary actions. Several out-of-court settlement and agreements had been reached by the office of Inspector General of the Department of Health and Human Services based at Washington, U.S.A, against several health care providers who had fallen foul of the anti-self-referral laws and had paid hundreds of thousands of dollars as fine (9, 10).

## 6. How do You Write a Medical Referral Letter?

A medical referral letter is sent from one doctor to another when referring a patient for care. Most often, the letter is sent from the patient's general practitioner to a specialist, with a request for diagnosis or to take over treatment of the patient altogether.

Writing a medical referral letter is up to each doctor to determine. Some hospitals have prepared template that requires the doctor to fill-in the patient's information and medical history [11].

Most others do not have such templates and the referring physician must then write a formal letter which may include - the date, the referring doctors name and address, the address of the receiving doctor and name, and then the body of the letter.

The body of the letter must include the patient's personal information referring doctors contact information, the reasons for the referral, patients medical history, clinical findings, results of laboratory investigations and previous treatments. The department that you are referring the patient to must be indicated and the referring doctor must sign the letter.

The elements of dental patient referral may include an authorization for the release of the past records of the patient among all other appropriate information [12].

Referral templates as against a properly written letters have been found to provide grossly inadequate information to the accepting/receiving specialists. *Chetcuti et al [11]* found that minor information such as the data of the referring doctors are usually incomplete and they strongly suggest the introduction of structured letters rather than prepared fill-in template [11].

They discovered that the use of standard referral templates made it difficult to adequately provide relevant informations because of limitations of space. They strongly suggested the need for receiving physicians to write feedback letters to the referring physicians. Such feedback letters helps give the referring doctor information about the appropriateness of the referral itself, of the timing of the referral and also gives recommendation for follow-up care.

Evidence shows that such referral replies serves as a great source of continuing education and learning and may improve referral practices [5,11].

## 7. Conclusion

It is ethical to refer patients for specialist care if the need arises. A referral from a physician should be for the best interest of the patient's well-being and not the basis for some monetary gains for the attending physician.

Also, referring should not be seen as an escape mechanism or route by a physician who refers difficult cases away so as not to make any effort to alleviate the patient's problems. It should not be done so as to keep a clean slate of no/or low deaths rate records in your centre since you probably will refer out any severely ill patient to other centres.

Practitioners have an obligation to be certain that economic gain or desire to satisfy referral sources does not unduly influence the types and amount of therapy provided.

Physicians should not selectively refer patients with "good insurance" or those regarded as being well-to-do to the physicians own practice, while they refer patients who are likely to generate less money to other centres of care. This is because self-referral is usually influenced by financial incentives [13].

This desire, which is not wrong at all, led to a great increase in the number of physician-owned specialist hospitals, but the Stark I and II anti-referral laws have helped eliminate certain forms of self referral [14].

It was probably not unethical for the family physician to want to refer out a patient because there was no available bed to admit the patient on. It would have been unethical to put him on the bare floor, when there were other hospitals nearby that can properly admit him onto a bed and administer proper treatments.

In all, accepting payments for a referral is illegal but a patient advocate says that "**No Doctor will intentionally make a bad referral**" [15].

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