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Bernard Rollin

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# Commentary Commentaire

## The ethics of referral

Bernard Rollin

**T**he rapid growth of veterinary specialty practices has created a number of vexatious ethical issues relevant to veterinary medicine. The preeminent question pertains to “the duty to refer.” Do primary care practitioners have such a moral duty? If so, when does this duty arise? Does it pertain in all cases where specialized knowledge is relevant to a disease?

This raises the fundamental question of “Veterinary Ethics” — namely, does the veterinarian ideally have primary obligation to the client/owner or the animal? (1) There are 2 possible ideal types that a veterinarian can aim for — the Garage Mechanic Model or the Pediatrician Model (1). On the Garage Mechanic Model, the practitioner has primary obligation to the animal owner, just as a car’s mechanic has primary obligation to the car’s owner. On the Pediatrician Model, the veterinarian is like the pediatrician, whose primary moral obligation is to the patient; at best, the owner or parent pays the bills.

Most veterinarians accept the Pediatrician Model, even though society does not as yet stand behind it, as it does with children. This is not surprising; Plato made a similar point over 2000 years ago. A shepherd he says, in his or her role as shepherd, has a primary duty to care for and better the sheep. Although they are paid for this, it is in their capacity as wage earner, which does not trump their primary obligation to the animal (2).

### Issues facing referring veterinarians

Adherence to the Pediatrician Model provides a *prima facie* answer to the preeminent question regarding referral: If the animal will benefit from the ministrations of a specialist, say an oncologist, and the primary care veterinarian is not well versed in oncology, the veterinarian has a moral duty to refer and defer to greater expertise.

This, however, is not the end of the story. The general practitioner enjoys certain marked advantages over the specialist. First, the general practitioner most likely knows the animal and should be more adept at picking up subtle signs of pain and distress, or other behavioral signs specific to that animal. He or she and probably knows the animal’s peculiarities, for example, if it has an idiosyncratic reaction to certain drugs, is fearful of men but not women, is a fear biter, etc. Second, the general practitioner knows the family unit, the animal’s home circumstances, the lifestyle, the personality of the owner, the owner’s degree of medical sophistication, and any tensions in the household that may be relevant to the animal’s condition; all enormously important to assuring compliance with treatment regimens. For example, the referring practitioner knows not to expect the owner to give a

treatment every 4 hours, because the owner works 14-h days; knows that the household contains 6 raucous small children, so that there is no hope of the animal resting undisturbed; knows that the neurotic owner will never cut back the animal’s rations; knows that the owner will never rake through the stool looking for blood; and, most importantly, knows not only how to translate biomedical technicalities for the client in question, but also how to assure that what the specialist says is understood and not reinterpreted through wishful thinking. What one perceives does not depend one’s level of medical knowledge alone. We hear not only with our ears, but also with our beliefs, expectations, theories, hopes, biases, etc. As philosophers might say, “Perception is theory-laden.” For example, when a medical professional says, “cancer,” patients almost immediately expect a death sentence, preceded by exquisite suffering. While there is no guarantee that the referring practitioner can effect communication, knowing the client certainly provides an advantage the specialist lacks.

Specialists are prone to perceive with the theoretical biases and predilections of their specialty. For example, the specialty of oncology, both in human and in veterinary medicine, has taken as its goal, extending length of life. The oncologist “wins” if the quantity of life is prolonged; although, the quality of life has historically been ignored in both human and veterinary medicine, leading many suffering human patients to demand euthanasia. Insofar as quality of life looms large in a client’s mind, and is everything to an animal, and since all indications are that animals are incapable of understanding that current suffering, if treated, can mean extended life later, the referring practitioner, knowing the consequences of the treatment modalities for the animal’s well-being, can and should serve as an animal advocate by mediating between specialist and client and tempering the natural specialist zeal to try everything and some clients’ desire to keep the animal alive at all costs.

Thus, in my view, the referring practitioner can and must play a major role in referral situations. This is not to suggest that the mediation be done without compensation; the process described can be significantly consumptive of the referring veterinarian’s time and energy, so it is perfectly reasonable for referring veterinarians to charge for the time they spend mediating between client and specialist.

Kipperman (3) has raised the intriguing question of whether the general veterinarian ought to be “a guardian of the client’s pocketbook,” pointing out that assuming such a role sometimes serves to block the animal’s receiving state-of-the-art care, and derides such a role. Kipperman thus condemns the idea that veterinarians should blatantly worry about the client’s pocketbook, but I think that is something of an oversimplification. In some cases, the referring veterinarian is somewhat the guardian of the

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Department of Philosophy, Colorado State University, Eddy Hall 240, Fort Collins, Colorado 80523-1781, USA.

clients' pocketbook. Suppose the primary care veterinarian knows that the client is a single mother who is strapped for cash, and suppose the animal is a 20-year-old cat with kidney failure, where doing everything for the animal may become psychologically confused with doing everything for the client. The client has heard about the possibility of a kidney transplant and feels compelled to pursue that treatment modality, which she cannot even begin to afford. The prognosis for the animal is dismal, and even if the surgery is successful, the quality of life will be poor. In such cases, the referring veterinarian should use his or her Aesculapian authority to persuade the client not to choose a delusive goal (4) and similarly discourage the client from pursuing dialysis (which creates suffering) or expensive new experimental chemotherapy remedies that may also cause suffering and may bleed the client financially or emotionally, or both.

In general, then, although the primary veterinarian has a prima facie obligation to put the animal first and to refer, there are occasions where the situation is hopeless and will cause the animal major suffering and where it would be the primary veterinarian's role to temper the clients' zeal for trying anything, even at the expense of animal's quality of life. A specialist is not likely to temper such excess; after all, these cutting edge treatments are what they do. Sometimes primary concern for the animal, therefore, dictates discouraging referral to a specialist!

It is for this reason I am quite skeptical about "pawspice." These "for-profit" hospices that treat terminally ill animals, provide hope for the owners for keeping the animal alive as long as possible and, in some cases, try as many unproven treatments as the client wishes. Certainly, palliative care is of great importance, but does not outweigh long-term suffering.

Thus the primary care veterinarian must find the middle ground between failing to refer at the expense of state-of-the-art treatment that could benefit the animal and referring to all sorts of extreme treatments or those that may cause suffering the client wishes to try. This, in turn, raises the "hot-button" issue of complementary and alternative medicine. Should veterinarians refer to practitioners of such unproven, nonevidence-based medicine? In a word, my answer is "no!" (5) While the client may freely seek any and all such modalities, it is not the job of the veterinarian to validate such choices. Recall that society charters veterinarians to be science-based; the American Veterinary Medical Association (AVMA) explicitly affirms that for accreditation veterinary schools must be rooted in science (6). That is the societal expectation, and scientific knowledge is a major defense against malpractice.

### Issues facing specialists

What of the specialist to whom cases are referred? Foremost, the specialist has a moral obligation to stay in good communication with the referring clinician, keeping him or her apprised of case development and using his or her knowledge of the client's situation to assure compliance with treatments and regimens, and to seek counsel. Veterinary medicine, paradoxically, is more of a "people" profession than human medicine, where the legal system backs the doctor even if he or she must work through the parent or guardian. The veterinarian, conversely, must keep the client happy to be allowed to continue to treat. The special-

ist, therefore, needs the primary veterinarian's knowledge of the client and the client's psychology.

Occasionally, the specialist's distance from the client provides a different set of moral obligations. Knowing the client well and being close to the client can get in the way of the primary care veterinarian's advocacy for the animal's quality of life. For example, a situation where the referring veterinarian knows that the dog is an elderly client's life and life-line may mitigate his or her advocacy for the animal by rationalizing the animal's prolonged suffering and deferring to the client's emotional needs. In such cases, the specialist may need to speak for the animal. Not being closely enmeshed in the client's life, the specialist can more easily say, "The animal is suffering, and it is time to let it go. Additional treatment is torture for the sake of living, at most, a few more months of poor quality of life."

I strongly disagree with some veterinary circles that affirm that a veterinarian should never say "it is time for euthanasia," and should never answer the client's plea, "what would you do, doc?" With your better knowledge of the animal's suffering, disinterested objectivity, and concern for the animal's welfare, it is your responsibility to alert the client to suffering that he or she chooses to ignore, and to recommend the blessing of euthanasia to bring the suffering to an end. Although, ultimately, euthanasia is the client's decision, your Aesculapian authority can heavily influence that decision, not only for the benefit of the animal, but also in granting the client absolution from the guilt that deciding on euthanasia can bring. Or, correlatively, you can use that authority to work against premature euthanasia decisions.

Just as a primary care veterinarian has an obligation to refer when it is in the best interest of the animal, in some situations, a specialist has the obligation to return some clients to the primary care veterinarian. Suppose you are an orthopedic surgeon who has successfully treated a dog referred to you for a complicated crush injury, and 5 years later, the same client brings a dog to you with a simple fracture that you know the primary care veterinarian is quite capable of treating, you have an obligation to refer the client back to the primary care veterinarian. This sort of backwards referral would go a long way to alleviating general practitioners' concerns that specialists erode their practice.

The emergence of ever increasingly sophisticated specialties in veterinary medicine should not denigrate general practice and the role of general practitioners. Without generalists, there could be no specialists — who would do the relevant referring? It was in response to this issue that human medicine was forced to make general practice itself a specialty!

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