

Democracy, Effective Referral, and the Instrumentalization of Patients

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Article abstract

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RÉPONSE À - ARTICLES / RESPONSE TO - ARTICLES

Effective Referral and the “Consumer Model of Medicine”Elyse Platt¹**Résumé**

Des philosophes tels que Roger Trigg ont contesté la politique de référence efficace du Collège des médecins et chirurgiens de l'Ontario, soutenant qu'il s'agit d'un exemple de culture de consommation en médecine. Dans cet article, je conteste cette position et soutiens plutôt que les médecins qui ne parviennent pas à référer efficacement abusent plutôt de leur pouvoir en tant que gardiens des soins de santé.

Mots clés

référence efficace, modèle de consommation médicale, contrôle d'accès, aide médicale à mourir

Abstract

Philosophers such as Roger Trigg have taken issue with the College of Physicians and Surgeons of Ontario policy on effective referral arguing that it is an example of a culture of consumerism in medicine. In this paper, I take issue with this position and instead argue that physicians who fail to effectively refer are instead misusing their power as gatekeepers to healthcare.

Keywords

effective referral, consumer model of medicine, gatekeeping, medical assistance in dying

In his recent paper *Conscientious Objection and 'Effective Referral'* [1], Roger Trigg argues that physicians ought to be respected in their decision to conscientiously object to the policy of the College of Physicians and Surgeons of Ontario (CPSO) on effective referral [2]. An argument put forward by Trigg to support this claim is that the CPSO policy succumbs to a “consumer model of medicine” that undermines the physician’s expertise. In this response, I will argue that Trigg is mistaken in his characterization of the policy as an example of the consumer model of medicine, and that this mistake rests on a confusion about the kind of expertise that is relevant to disagreements over effective referral.

In 2015, the CPSO issued a new policy on effective referral in health care. The policy states: “Where physicians are unwilling to provide certain elements of care for reasons of conscience or religion, an effective referral to another health-care provider must be provided to the patient. An effective referral means a referral made in good faith, to a non-objecting, available, and accessible physician, other health-care professional, or agency.” [2] Trigg takes issue with this policy because of concerns that it disregards the physician’s moral point of view. He argues that the policy does not sufficiently recognize the physician’s reasons for objecting to particular procedures, such as abortion or Medical Assistance In Dying (MAiD), and thereby subscribes to what he calls a “consumer model of medicine” privileging the desires of patients over their physician’s ethics. He writes: “...if a mere consumer-oriented view arises that the patient’s autonomy and right to choose overrides everything else, the ethical judgement of physicians, in this case all of them, is being put aside” [1]. He worries that this approach wrongly assumes that “the patient’s judgements and preferences are all that matters” in health care [1], and argues that a policy of deferral to the patient’s wishes represents a model of medicine in which the physician’s expertise is disregarded for the sake of the patient’s desires.

However, I’m not convinced that the CPSO policy rests on or promotes a consumer model of medicine, since its effective referral clause is not directed at physicians’ *medical* expertise. Rather, it applies to situations where a patient’s request for a medical service is incompatible with a physician’s moral beliefs, and that for reasons of conscience, the physician is unable to provide. To illustrate my point, it is helpful to think about a case which more straightforwardly embodies a consumer model of medicine. Imagine that a patient walks into her doctor’s office with a viral infection such as a seasonal flu. She demands of her doctor that she be prescribed antibiotics. Her doctor explains to her that antibiotics will not help with the viral infection because antibiotics can only treat bacterial infections. Unsatisfied, the patient threatens to file a complaint with the CPSO for neglect and medical misconduct if she does not get the “treatment she deserves.” In this case, the patient is clearly reasoning on the basis of a consumer model of medicine; she is disregarding the knowledge of her physician related to existing scientific evidence about the effective use of antibiotics, and treating the physician as a mere vendor of a chosen pharmaceutical product. Here, the physician’s medical expertise is being disregarded for the sake of the patient’s misplaced desire for antibiotics.

In cases of effective referrals covered by the CPSO policy, however, there is no distinctively medical expertise being overridden or ignored. It is important not to conflate medical and ethical epistemologies, and to remember that there is nothing in being a physician that implies conferring them with a superior moral epistemic value than patients’ for judging the ethical acceptability of medical procedures such as abortion or MAiD. In their paper *Gatekeeping and Personal Values Misuses of Professional Role* [3], Hester and colleagues address an analogous situation in which emergency contraception (EC) is being denied to women by pharmacists because of moral disagreement. They argue that “pharmacists and physicians who deny emergency contraception to women misuse their role as gatekeepers because EC is safer than many [over the counter] meds, and therefore does not require particular skill or application of special knowledge” [3]. Indeed, gatekeeping is inappropriate when there is no special knowledge or skill to legitimize the role of gatekeepers granted to a group of individuals. In cases covered by the CPSO policy on effective referral, the physician does not hold any special knowledge or

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skill that the patient lacks, and which would justify a refusal to provide a referral. The reason why the physician's resistance in this case is inappropriate is that the reasons the physician has for refusing to provide the service are moral, and not medical. The physician is inappropriately gatekeeping access to health services because of personal moral beliefs. The CPSO policy has nothing to do with a consumer-model of medicine, because it is not the physician's medical expertise that is being over-ridden but her personal view of the good life, and for instance in cases of abortion and MAiD, about lives worth living.

In their article *Conscientious Objection to Sexual and Reproductive Health Services* [4], Zampas and Ximena argue that the inappropriate use of conscientious objection clauses to protect clinicians' beliefs is widespread "...often in European countries conscientious objection clauses are being applied too broadly and sometimes even abused. The lack of adequate legal and policy framework to regulate the practice and prevent abuse results in serious violations of women's right to access quality sexual and reproductive health services with potentially detrimental impact on their health and lives." [4] They stress the need to have adequate policy to regulate the practice, and to develop safeguards against inappropriate mobilization of medical authority that may undermine some of patients' access to medical services.

Trigg is worried about the physician's perspective not being sufficiently valued. I am worried that physicians misuse their position of power as gatekeepers to services, building on justifications from a different domain, ethics, into which their expertise does not extend.

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Conflicts of Interest

None to declare

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