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Article abstract

The case illustrates how fragmented communication and blurred accountability between primary and specialty care can compromise the principles of beneficence and nonmaleficence, resulting in preventable harm for patients. To prevent such outcomes, healthcare providers should collaboratively determine who holds primary responsibility for the patient's care at each stage of the referral process.

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ÉTUDE DE CAS / CASE STUDY

Shared Responsibility After Referral: Ethical Challenges in Preventing Harm

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Résumé
Ce cas montre comment une communication fragmentée et une répartition floue des responsabilités entre les soins primaires et les soins spécialisés peuvent compromettre les principes de bienfaisance et de non-malfaisance, entraînant ainsi des préjudices évitables pour les patients. Pour éviter de telles conséquences, les professionnels de santé devraient déterminer ensemble qui assume la responsabilité principale des soins du patient à chaque étape du processus d'orientation.

Mots-clés
responsabilité, redevabilité, orientation vers un spécialiste, médecin, soins, préjudice

Abstract
The case illustrates how fragmented communication and blurred accountability between primary and specialty care can compromise the principles of beneficence and nonmaleficence, resulting in preventable harm for patients. To prevent such outcomes, healthcare providers should collaboratively determine who holds primary responsibility for the patient's care at each stage of the referral process.

Keywords
responsibility, accountability, referral, physician, care, harm

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CASE PRESENTATION

A 60-year-old man presented with uncontrolled type 2 diabetes after discontinuing his medications in the context of depressive symptoms. He refused antidepressant therapy and objected to any form of psychological support. Eventually, he agreed to restart his diabetes medications with gradual improvement during weekly primary care follow-ups. Several weeks later, he developed a foot wound sustained at work. The wound was treated with antibiotics, and he was referred to a specialized foot clinic. At this point, his care unexpectedly shifted toward endocrine testing for rare disorders.

From our perspective (the three authors), his unbalanced diabetes clearly stemmed from depressive-related nonadherence to diabetes therapy. We feared overdiagnosis. Nevertheless, the patient underwent the recommended workup. The specialists identified hormonal abnormalities and an abnormal growth in the pituitary gland on imaging, which together were interpreted as consistent with acromegaly (a hormonal disorder characterized by the excessive production of growth hormone). The patient subsequently underwent transsphenoidal neurosurgery. Postoperatively, laboratory values remained atypical for acromegaly, and pathology revealed a pituitary adenoma subtype (a typically benign tumor originating from hormone-producing cells of the pituitary gland) that did not support growth-hormone excess, raising doubt about the initial acromegaly diagnosis. In retrospect, the patient likely underwent surgery as a result of a false-positive test combined with the incidental discovery of a pituitary mass, culminating in an erroneous diagnosis of acromegaly.

Throughout this process, we remained concerned about a possible misalignment between the patient's clinical picture, primarily his depressive symptoms and discontinuation of medication, and the laboratory and pituitary findings. However, once the specialty evaluation began, the primary care team did not take a proactive approach or attempt to speak directly with his endocrinologist to reconcile divergent views. The referral pathway functionally shifted patient responsibility to the specialty service, while accountability for outcome remained shared under the principles of beneficence and nonmaleficence — each team retaining a duty to act in the patient's best interest and prevent harm despite operational separation.

In our setting, a "shifted outpatient model" exists in which subspecialists conduct regular on-site consultations with primary care teams, fostering direct, collegial dialogue and shared decision-making (1). In this case, the patient was referred outside that familiar pathway to another endocrinologist not personally known to the primary team. We believe the absence of a pre-existing collaborative relationship reduced opportunities for timely bidirectional communication and contributed to passivity on the part of the primary team as the diagnostic cascade progressed. The central ethical issue is the breakdown of shared responsibility after referral, which allowed a diagnostic cascade to cause harm to the patient contrary to the principles of beneficence and nonmaleficence.

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ETHICAL ANALYSIS

Referrals to consultants can often be perceived as a loss, or redistribution, of authority and accountability for our patients' care. Yet, under the principles of beneficence and nonmaleficence, ethical responsibility for outcomes remains shared. In this case, the specialty workup moved forward in a direction that diverged from the primary care assessment. A laboratory test obtained against the primary care plan initiated an expanding diagnostic snowball that culminated in surgery. Although authority effectively shifted to the specialty service, accountability for the patient's safety and the proportionality of further testing remained a joint obligation.

A tendency toward passivity from primary care physicians (PCPs) after referral can be a common challenge in primary care and raises ethical concerns about nonmaleficence (avoiding harm) and professional duty. Uncertainty about the limits of responsibility is also frequent; PCPs may struggle to delineate their role relative to that of consultants, particularly when recommendations conflict or when rare-disease testing is proposed. As PCPs, we aim to avoid harm and act for the patient's good; when the risk of overdiagnosis or overtreatment increases, as it did here, the decision to proceed with consultation and testing requires explicit, shared justification.

Structural and relational factors can exacerbate these dilemmas. Historical tensions between hospital specialists and community PCPs, clinician isolation and burnout, and gaps in role definition and communication all hinder collaboration. While electronic information exchange is necessary, it is insufficient on its own (2). Effective collaboration depends on trust, clear expectations, and direct collegial dialogue (3,4). In this case, no prior personal or collegial relationship existed with the consulting endocrinologist, which likely reduced opportunities for timely discussion and course-correction.

This case reveals how the fragmentation of healthcare professionals' accountability following referral can breach the principles of beneficence and nonmaleficence: when no clinician assumes active responsibility for ensuring diagnostic proportionality, the risk of preventable harm increases. To prevent such situations, we argue that healthcare providers should meet to explicitly determine and agree on who holds primary responsibility for the patient's care at each stage of the referral process.

CONCLUSION

Collaborative safety is enhanced when healthcare practitioners' capacity to identify and bridge gaps in care is both recognized and actively supported (5,6). Yet, primary care clinicians and consultants often struggle to close communication gaps and rarely have protected time to reflect meaningfully on these challenges. Such gaps create potential harm to patients and can foster passivity rather than active problem-solving. Both primary care and specialty teams should share accountability for clear communication and coordinated decision-making for the benefit of patients. Improved models of collaboration that are grounded in trust, direct dialogue, and shared responsibility are essential to balancing the risks of overdiagnosis and underdiagnosis in patient care. Strengthening these structures advances core professional commitments to avoid harm and to promote the good of patients (5).

DISCUSSION QUESTIONS

1. What ethical obligations does a primary care physician retain after referring a patient to a specialist, especially when clinical judgment diverges?
2. How should accountability and authority be distributed between PCPs and consultants to reduce the risks of overdiagnosis and unnecessary interventions?
3. What structures or models best support collaboration and ethical responsibility in complex cases?
4. How should physicians navigate incidental findings in ways that respect patient safety while avoiding harm from overdiagnosis?
5. Can the lack of communication between teams be considered a form of moral injustice toward the patient?

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