Seeking second opinions

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ABSTRACT

Second opinions are being increasingly sought both by the surgeon and the patient in today’s practice. This article discusses the genesis and clinical implications of second opinions and its role in quality assurance.

Key words: Second opinion, surgeon, patient

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INTRODUCTION

The word opinion implies pluralism. Surgical decision making is often subjective and therefore prone to varied opinions. Not long ago, doctors made the decisions; patients did what they were told. Not any more.[1] In this age of patient autonomy, increasing consumer health information and strained patient-doctor relationship, second opinions have become an integral part of surgical practice. This may be patient or clinician-initiated and both have implications, albeit in different proportions in the delivery of surgical care in a trustworthy manner.

Patient-initiated second opinion

The increasing empowerment of the health consumer, market competition and societal pressure have resulted in surgeons seeing more and more patients who want a second opinion or have gone elsewhere seeking another opinion. While the first is rarely objected to, the second scenario may cause resentment. Arguably, this reflects the idiosyncratic and egoistic nature of the surgeon, as the reason for such patient-conduct is not always a lack of confidence in the initial surgeon. Whether or not, the patient is skeptical of a decision or wants reassurance in the way of concordant opinion is immaterial as long as the consultation involves honest and sympathetic communication. Current medical orthodoxy demands that the surgeon lay out all treatment options and the risks involved. The patient chooses from this with the surgeon’s evidence-backed guidance, if required. While this may reduce malpractice suits, it does not deter the patient from asking questions, looking up information on the Internet or seeking a second specialist opinion. In fact, the practice of seeking second opinion originated in the USA, not because of litigious environment but due to attempts by insurance companies and hospitals to reduce costs by preventing unnecessary operations. These clinical governance exercises revealed that the need for elective surgery could not be confirmed following a mandatory second surgical opinion in up to 19% of cases.[2,3] Statistics such as this will do very little to dissuade patients from seeking a second opinion. When one is encountered with a patient seeking a second opinion and where the initial opinion is at variance with his own, tact and caution should be exercised. Sometimes the difference between one opinion and another is not significant. Even when they are, overt criticism of other’s errors of judgement or treatment with the patient is against professional ethics. Obviously, issues such as the type of operation (when there are many operations to choose from as in rectal prolapse) are easier to explain than those with diametrically opposite opinions such as conservative treatment versus operative treatment. These principles also apply to e-mail consultations, which can be cited as a second opinion and raises new concerns – yet to be addressed by regulatory commissions or courts.[4]
Surgeon-initiated second opinion

There is hardly a surgeon who has not sought a second surgical opinion on a difficult operation or ways and means of getting out of a serious complication. It is not uncommon for a surgeon to seek a second (and further) opinion/s from a colleague or a mentor when reasonable attempts to arrive at a diagnosis or treatment plan have failed. This is mostly informal but for the sake of finality recourse of an ‘expert panel’ may be taken. An example is the multidisciplinary tumour board whose main objective, is the co-ordination of multimodal treatments besides finalization of the treatment. From a diagnostic viewpoint, a common scenario is the need for a second opinion from a cyto/histopathologist to clarify an equivocal diagnosis. A patient presenting to the surgeon with a pathologic diagnosis from elsewhere also poses a dilemma. The question is whether the pathologist at the institution where the patient will undergo surgery needs to review and confirm the outside diagnosis or whether one should trust the accuracy of the outside report. Clinical findings may not help to arrive at decision. Majority of the hospitals do not have a protocol but there is a strong evidence for a mandatory second opinion policy before definitive treatment. In one report, in-house mandatory cytology review uncovered a high rate of discrepant diagnoses (41 major changes in diagnoses which would significantly change treatment in 862 cases), with thyroid the most likely organ to have differing diagnoses.[5] In another report of a mandatory surgical pathology review on 6171 referred patients, 1.4% differed from the submitted diagnosis. While the absolute numbers are low, 93% of this group required alteration of treatment due to the change in diagnosis.[6] Such mandatory second opinion pathology programmes confer more objectivity than surgical second opinions. A significant proportion of patients for whom the initial recommendation for surgery is not confirmed eventually have the operation; in contrast very few would be expected to undergo radical surgery straightaway if pathological review fails to confirm the diagnosis of cancer.[3] Similar mandatory second opinion programs through telemedicine and teleradiology is in place for selected trauma patients in many western hospitals linked to a tertiary referral centre - the so-called “hub and spoke” arrangement. This has drastically reduced unnecessary and expensive transfers of trauma patients who do not have indications for immediate or deferred treatment.[7] Ethical considerations have led to mandatory second opinion policy in the practice of organ harvesting from brain-dead patients for transplantation.

SUMMARY

Whilst patient-initiated second opinions may be for reasons other than medical, the surgeon-initiated ones are a clinical necessity. Seeking second opinion is a learning exercise provided it does not degenerate in to ‘defensive medicine’. Cost and conflict of interests notwithstanding, specific mandatory programs in areas like surgical pathology, critical care and trauma can serve as effective quality assurance measure.[8] There is a science in surgical decision making but also uncertainty, intuition and fallibility. Second opinions are a product of this inexact science and the culture of scrutiny. They will form an inseparable part of surgical practice in the years to come.

REFERENCES