

Second Opinion: Is it desirable?

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Introduction

Second opinion refers to the practice of a second physician evaluating the patient for the same medical problem to give another opinion on the diagnosis or the proposed plan of care. The patient, the physician or a third party payer such as a private insurance company or the government may seek a second opinion. The patient may be apprehensive about a suggested invasive procedure, or unhappy with the care being provided. The primary physician may disagree with a consultant. A consultant may seek another opinion in a complicated condition, or where the patient is perceived as demanding or litigious. The prevalence of 'second-opinion' is difficult to determine accurately: often the patient may not let the consulting physician know, for a variety of reasons, that a second opinion is being sought and accurate data on referral source are rarely maintained. In USA, increased patient education about their rights, high number of malpractice lawsuits and lately cost-containment issues have led to increased use of second-opinion programs particularly for invasive procedures. Thus, improved quality of care, cost containment and increased patient satisfaction are the major reasons for establishing a second opinion program.

Reasons for seeking a second opinion

We performed a Medline search with 'second opinion' as the primary search field restricted to all English language publications from 1987 to 1997 to review published literature. The search yielded 19 references. Of these, we selected 17 representative articles for further review.

Concerns with the high number of coronary artery bypass graft (CABG) surgeries in the US led Graboyes and coworkers¹ to examine outcomes in 88 patients referred for a second opinion for CABG. The patient, his/her primary physician or an insurance carrier sought the second opinion. Based on published guidelines from large multi-center studies, 74 patients (84%) were advised to defer surgery and continue medical management. Sixty of the 74 patients (81%) elected to follow this advice. The patients were followed up for 28 months. Patients who continued medical therapy as advised did not experience any adverse outcomes as compared to those who opted for surgery. A review of the subsequent *Letters to the Editor* showed that most concurred with the authors that a second opinion was invaluable where surgery was contemplated. However, a few considered the sample non-representative and therefore the results not generalizable.^{2,3,4,5} The same group carried out a second study in 1992 to evaluate recommendations for

coronary angiography in patients with angina.⁶ They reported on 171 patients who were recommended coronary angiography, and found that almost 80% did not need it. At a mean follow up of 46.5 months, only 15.4% ultimately underwent coronary bypass or angioplasty, showing that in the majority of cases, angiography was either unnecessary or could be safely postponed. As expected, this generated a storm of protest.^{7,8,9,10,11} The major contention was that the patient sample was not representative therefore the results were invalid. Some felt that patients who seek second opinion are a dissatisfied group for many reasons, and others expressed concern that the lay press would focus on the conclusion and generate inflammatory and provocative headlines. Influenced by such studies the insurance industry developed mandatory second-opinion programs that hoped to avoid 'unnecessary surgery'. Rosenberg et al¹² assessed patients' opinions about one such program in New York in 1984. Patient responses were obtained by anonymous surveys and included satisfaction with the second opinion program. The patient's report of advice given was compared to what the consultant had actually advised. 83% of patients found the program beneficial. Apart from providing reassurance, the second opinion helped them decide whether to have surgery and gave them an opportunity to ask questions. In 12%, the advice reported by consultants did not match the advice reported by their patients. These instances occurred mainly when the patients felt that the consultant's communication skill was less than optimal. Also, discrepancy between what the patient heard and what the physician said depended on the level of complexity of the advice. As expected, there was less discrepancy when there was a simple complete agreement or disagreement with previous advice. Discrepancy was greater when a complex advice incorporating need for additional tests, a 'wait and see' approach, a different type of surgery or medical management in place of surgery was recommended.

Reducing costs and unnecessary surgery

If cost containment is the main reason for looking at elective surgery, then perhaps one needs to scrutinize only those procedures that are very expensive or those that are high volume. Barr and her colleagues¹³ looked critically at the cost-benefit ratio in 5,108 patients participating in a mandatory second surgical opinion program. They found that fewer than 10% of consultations did not confirm the initial opinion. Most of the non-confirmation occurred for procedures such as prostatectomy, breast or back surgery where there is considerable disagreement among physicians about the optimal treatment for these diseases. The cost benefit ratio was high for some expensive procedures such

as hysterectomy and back surgery but was negligible for other procedures such as cataract or tonsil/adenoid surgery. The authors recommended that mandatory second opinion programs be restricted to procedures that are very expensive or **may** have serious health consequences.

Meyers¹⁴ warned that although second-opinion programs were initiated to improve quality of care or weed out 'unnecessary' surgery, of late, the emphasis had shifted solely to cost-containment. He pointed out quite rightly that there was little research on long-term outcome for patients who defer or refuse a surgery based on the second-opinion. In a rush to contain costs, were we sacrificing patient's rights?

In a setting where invasive procedures are not an issue, second opinion is still valuable, particularly for chronic diseases. Also, contrary to prevalent opinion, patients with functional diseases shopping endlessly do not form the bulk of such practice. This was the conclusion of Sutherland and colleagues who looked at a university based gastroenterology clinic in Canada to study the group characteristics of those who seek a second opinion? Only 7% of their clinic population had come for a second opinion. Those seeking a second opinion had more chronic disease, had spent more time in a hospital in the past year, and perceived their health as poor. Sixty percent of patients felt dissatisfied with the physician, either because they felt that the physician had not spent enough time with them or that the physician had not answered all their questions. Thirty percent of patients wanted to confirm the opinion given by the first physician. The decision to seek a second opinion appeared to be uninfluenced by family or friends. There was agreement between consultant and referring physician on the diagnosis in the majority of cases. To the surprise of the researchers, patients with functional disease were not preponderant.

The authors looked at the same clinic in 1992¹⁶, 5 years after their first study and found an increased incidence of patients (16%) seeking a second opinion. Those who perceived their health as poor, those who felt that their health was under their control, and those who demanded to know all modalities of available treatment were more likely to seek a second opinion. Commenting on the cost-containment issue, the authors pointed out that when a patient does not have to pay, as in the Canadian system where all patients get free care, second-opinion is likely to be patient driven. Even though the cost of evaluating these second-opinion patients was no different than the cost for those seeing the gastroenterologist for the first time, the overall cost to the system would increase with greater use of second opinion. Therefore the authors recommended that if the Canadian system wanted to decrease the use of second-opinion then future studies of second opinion programs should include comprehensive measures of patient satisfaction to identify specific sources of dissatisfaction and devise ways to address these issues.

Ability to change medical practice

Second-opinion programs are capable of changing physician practice patterns through education and not just through external pressure. This was the finding of a study by Asaph et al¹⁷ who retrospectively reviewed carotid endarterectomy (CEA) performed over a 22-month period in a community hospital. Of these 56% were for asymptomatic patients with 37% having stenosis less than that considered needing surgery according to guidelines based on a national study. These findings and the guidelines were widely publicized in the hospital. This prompted the hospital's surgical department to develop internal criteria for CEA, including a supporting second-opinion from a disinterested vascular surgeon or neurologist. In the following 21 months, there was a 36% reduction in CEA thus demonstrating a reduction in 'unnecessary' surgery.

Relevance in India

What relevance does second-opinion have for India? The prevalence of second-opinion in India is unknown. The frequent anecdotes of unnecessary and inappropriate care at all levels in government and private practice settings suggest that such a program would be greatly beneficial. The primary beneficiaries would be the patients. The honest and competent physicians would also benefit from the legitimizing of their recommendations by disinterested, qualified, personnel. Fear of scrutiny and legal action may reduce unethical recommendations for tests and procedures. Scarce resources of a government or charitable institution would be better utilized. But who will initiate such a program? The government has shown only minimal interest in providing quality medical care to urban and rural poor. The insurance industry may in future initiate such programs if it finds that escalating cost of medical care is outstripping its ability to recoup this cost via insurance premiums. But the insurance industry is a very small player in today's medical scene. The majority of medical care in India is private practice, which is mostly unregulated through inaction by the watchdog medical councils. Only patients who pay for their medical care out of their own pockets can demand and bring about change in physician behavior.

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