8 Recommendations concerning second opinions (and tertiary referrals)

8.1 Introduction

The phenomenon of the rising demand for second opinions of the last few years goes well with patients’ increasing emancipation, but seems to be on a collision course with many other trends in health care. While virtually everywhere in health care cost containment and budgeting are of the order of the day, patients’ growing desire to seek second opinions is not only not being stemmed but is even being encouraged by the health insurers. The Dutch government for economic reasons determines the volume of medical care available, so that the question arises how far the number of second opinions can go on rising before seriously beginning to affect health care in general. As shown in the preceding chapter, if the growth of second opinions remains constant, just the university hospitals in 2010 will need four extra full-time orthopaedic surgeons for these consultations. The micro level considerations of treating consultants can (at the macro level) lead to a capacity problem in health care with negative effects on waiting lists and availability of staff.

Consequently, it would appear that both the consumers and the providers of care would benefit from correct indications for second opinions. For some years now, public health care has been in pursuit of ‘evidence based medicine’. This means that in the process of defining indications for treatment objectifiable criteria concerning efficiency and health ‘profit’ (should) play a decisive part.

Defining indications at the micro level is a part of the care/treatment process regarding an individual patient, and the aim should be care made to measure. At macro level, critical definition of indications is regarded as an instrument for cost containment, but also one to regulate the access to care and to bring about a just distribution of resources.

The criterion in testing an indication would be a generally accepted standard.

The aim of this chapter is to contribute to the development of guidelines for second opinions that should meet not only the individual’s need of care but also the government-imposed conditions of efficiency and cost control.

To this purpose we have asked ourselves the following questions:

A How do second opinions come about?
B What are the pros and cons of second opinions for patient and consultant?
C What are the current guidelines for second opinions?
D How can the result of this study improve the definition of indications for second opinions?
E Could (preventive) measures be taken to stop the rise of the number of second opinions?
F What criteria should be met by a request for a second opinion?

8.1.1 Sub A: How do second opinions come about?

Analysis of the decision making situation

It is important to know why there is a need for second opinions, who takes the initiative and how this demand might be influenced.

Our study showed that the three main motives of patients (and their GPs) to seek a second opinion were:

- impaired doctor-patient relationship or problems of communication with the first opinion consultant
- the desire of more information about diagnosis and/or treatment
- dissatisfaction with the result of the treatment.

Second opinions may be initiated by the patient, the GP or the consultant. Probably a major part of the second opinions resulted from patients’ insistence.

At the micro level, decisions to seek second opinions may be influenced by accentuating or restricting the areas of the indication; guidelines would be an appropriate means.
At the macro level, the problem might be influenced by limiting the insurance package of the health insurers.

8.1.2 **SUB B: PROS AND CONS OF SECOND OPINIONS**

To correctly weigh the indications for second opinions, their pros and cons should be listed. By what criteria can the merits of second opinions be assessed? What are the pros and cons of a second opinion, and whom do they affect?

**Pros and cons of second opinions for patients**

One of the main advantages of a second opinion should be a gain of health for the patient. Regrettably, no study data are available about the health gain resulting from second opinions. This would require a prospective randomized study design, and in this respect such design would probably not be accepted by patients.

The health gain is especially to be expected if the first opinion consultant was unfamiliar with the clinical picture, or did not possess the necessary therapeutic skills. Second opinions may then lead to new insights in diagnosis and/or treatment. Another positive outcome of second opinions might be that the patient is reassured by the confirmation of an earlier diagnosis or therapeutic proposal. Owing in part to the lay press, patients are more than ever convinced that every disorder can be cured if only the correct physician is consulted. Second opinions may help the patient to accept his or her complaints, or convict him/her of having done everything possible.

Unfortunately, second opinions have their disadvantages as well. For instance, how does a patient handle contrasting opinions? Who can tell us which consultant is right, or if both might not be wrong? To what extent do contrasting opinions create greater uncertainty, possibly prompting the seeking of even more opinions? Another important drawback of the rising demand for second opinions might be prolongation of waiting periods before the first outpatient consultation. Second opinion consultations as a rule last a bit longer than first opinion consultations (see Chapter 7) and take up more office time. Naturally, this longer office time can be planned for, but it results in restriction of the number of new patients that can be seen, and in lengthening of waiting lists of outpatients clinics.

**Pros and cons of second opinions for GPs and consultants**

A second opinion may help the consultant with disorders that are difficult to treat and with controversial therapeutic proposals. The GP may attempt via a second opinion to solve a deadlock problem (chronic unexplained pain), or his/her rejection of the therapeutic proposal of the consultant.

The treating consultant also may benefit from a colleague’s expertise, for instance if the former cannot arrive at a diagnosis or a particular condition has arrived at an impasse. Moreover, a second opinion might be a way out of an unsatisfactory communication or a conflict. Often this will result in the second opinion consultant’s taking over the treatment. Some consultants may regard the request for a second opinion as a proof of a lack of trust on the patient’s part.

**Pros and cons of second opinions for hospitals, insurers and authorities**

Where university hospitals are concerned, the disadvantages lie mostly in the teaching sphere. Also university hospitals are on budgets, and one of the parameters is the number of new outpatients that may be seen annually. The second opinion patient (who is counted as a new patient) will often be seen by a consultant. This means that fewer new patients are seen by the resident-trainees (while this is an important training function), and fewer patients can be included for clinical-scientific trials (because as a rule these enroll untreated patients). For the insurance companies, the second opinion phenomenon probably has mostly advantages, and they even promote it in the media. On the whole, health insurers do not know how many second opinions in fact are being sought; it would be too expensive to divide the consultations into first and
second opinions in their administration. For the insurers, the possible expenses of second opinions are outweighed by their advantages. Patients like the possibility of the second opinion to be included in the basic package. Insurers who do not include it in the basic package might lose policy holders.

8.1.3 **SUB C: WHAT ARE THE CURRENT GUIDELINES FOR SECOND OPINIONS?**

*Analysis of the current recommendations for seeking second opinions*

Little has been published so far about the definition of indications for second opinions and the conditions imposed by the insurance companies.

Data from the ANALYSE care information system show nearly all insurance companies offer complete reimbursement for second opinions, at any rate the somewhat more extensive packages or policies. Some insurance companies impose conditions such as: reimbursement in case of a proposed major medical treatment or surgical intervention must be for a once-only or at least for one consultation annually, the second opinion consultant has to be a consultant, the patient has to be referred by a GP, or is reimbursed only after permission from the insurer.

The rules of conduct of the KNMG (Royal Dutch Medical Association) of 1994 state that the physician should always comply with the wish for a second opinion unless the physician has major objections. These should then be explained to the patient (section II.19). A second opinion, in the view of the KNMG should not be followed, apart from very exceptional cases by a third, fourth or fifth opinion.

A physician referring a patient to some other physician should, according to the KNMG, forward all relevant information and clearly state the purpose of the referral. If the patient consults another physician at his own initiative, the latter physician should inform the patient's GP, unless the patient expressly refuses consent for this (section III.4). In the view of the KNMG it is not the purpose of a second opinion that the second opinion consultant takes over the treatment. The LHV (Dutch National Association of General Practitioners) has detailed the KNMG point of view for the second opinion in general practice (at the patient’s request or as a collegial consultation). The LHV also holds the view that the patient’s own GP should continue the treatment. A patient can only be enrolled in the second GP’s practice at least six months after the second opinion.

The health insurers in The Hague according to their medical advisor have decided to pay for second opinions in the following situations:

- a proposed major operation
- second opinions requested by the GP or medical consultant
- second opinions requested by the medical advisor of the insurer if polypragmacy is suspected or financial aspects are concerned.

If medical shopping is suspected second opinions should not be paid for. However, the term ‘medical shopping’ is not further defined. To resume, the insurers mentioned will pay for a second opinion in almost every case. Our studies show that 97% of the second opinions were requested by the GP or consultant. Still, a major part of these probably resulted from the patient’s insistence.

The final report ‘Second Opinion’ from a working party in the province of Groningen, including guidelines for second opinions, appeared in 1997. The working party consisted of GPs, consultants and patients. The main conclusion of the working party was that the patient should be entitled to a second opinion (from a consultant at the same level of expertise) one single time, and that subsequent opinions in principle should not be paid or reimbursed by the health insurer. The working party also thought that the patient should be obliged to inform the second opinion consultant of the fact that the consultation concerned a second opinion. All relevant patient information should be made available to the second opinion consultant, and in principle the second opinion consultant always should refer the patient back to the first physician.

Reimbursing only the first ‘second opinion’ appears justifiable. One valuable opinion will probably be more supportive than the various - sometimes divergent - ideas of a number of experts. The diagnosis and/or therapeutic plan should not be made with a majority vote, not even of experts.

Even so, these guidelines merit some brief comment. What to do about the despairing patient who has received two conflicting opinions? Also, the working party does not state a time limit within which a third or later opinion should not be reimbursed. If a patient, years after a second opinion, still has...
the same complaints, should a subsequent opinion not be paid for? And, are consultants of different disciplines of the same level of expertise? In other words, should a consultation from another specialism for the same complaints be counted as a second opinion never, sometimes or always? The recommendation that the second opinion physician should in principle always refer back to the first physician is a view that, although widely supported, is nevertheless disputable.

The results of our study prompt the question if it is really always so advisable that the second opinion consultant refers the patient back to the first one. If opinions differ, the first opinion consultant will not always be prepared to follow the second opinion consultant’s advice. Moreover, many patients appear to prefer to have their further treatment conducted by the second opinion consultant. Certainly if a second opinion was sought because of communication problems or a disturbed doctor-patient relationship, the patient will often want to be treated further by the second opinion consultant. An agreement that the second opinion consultant should always refer the patient back would violate the patients’ fundamental right to a free choice of doctors. Finally, an agreement among physicians always in principle to refer the patient back to the first physician would in some countries be regarded as a competition-limiting measure, in contradiction to the antitrust regulation.

The working party ‘dichotomy in health care’ of the Dutch Orthopaedic Association (NOV) recently proposed to remove patient-initiated second opinions from the standard insurance package. It proposed that only the consultant-initiated second opinion should be paid for. In other words, the patient-initiated second opinion would have to be paid for by the patient himself, who should, however, be enabled to take out a supplementary policy for these expenses. This would, in fact, entitle the patient to seek one well-founded opinion within our collective insurance system, with the possibility to request a second opinion id additionally insured.

Here we encounter the problem that it is often very difficult to establish who has been the initiator of the second opinion. On this subject, consultants and patients frequently disagree. Also, such an insurance condition would probably cause the patient to exert more pressure on the consultant to seek a second opinion.

The working party proposed to keep the second opinions outside the regular health care budget and to provide extra time for it. As a result, second opinions would take up less of the capacity of regular health care, but a further growth of the number of second opinions might be stimulated.

8.1.4 **SUB D: HOW CAN THE DEFINITION OF INDICATIONS FOR SECOND OPINIONS BE IMPROVED ON THE BASIS OF THE RESULTS OF THIS STUDY?**

**General recommendations on second opinions**

In general, the physician defines the indication for a second opinion. In view of the current budgeted health care with its limited accessibility, the demand for second opinions needs to be regulated.

In this light, requests for second opinions should preferably always involve the general practitioner. If not, the patient might go from one consultant to another (doctor shopping) without the consultants involved being informed. Mostly, the general practitioner knows the patient’s medical problems best. Only by letting the general practitioner hold the reins is it possible to prevent silent opinions (second opinions with the second opinion consultant being unaware that a second opinion is concerned) and polypragmacy.

Medical professional groups should develop guidelines, protocols and standards for second opinions, if possible, each specialism should define its own. A sketch of the development of the above-named guidelines is presented below. The essential questions regarding the definition of the indications for second opinions are:

1) when?
2) why?
3) from whom?
4) how often may second opinions be sought?
sub 1) The time when a second opinion should be sought is when the first opinion consultant, after reasonable efforts (and perhaps internal consultation) fails to present a satisfactory solution for the diagnostic and/or therapeutic problem.

sub 2) Other possible reasons to seek a second opinion may be:
   - the patients' need of extra support in making decisions about major therapies
   - a disturbed doctor-patient relationship or communication problems between doctor and patient (this situation will often lead to the treatment being taken over).

sub 3) Those asked for a second opinion should be able to judge independently. The second opinion consultant should be a person from whom a reliable and useful judgement may be expected. It should, therefore, in any case be a registered consultant and not a resident (whether or not trainee). Ideally, patients should be referred to a second opinion consultant with a special interest or experience of the problem in question. Ideally, a list should be available (e.g. via the internet) listing the differentiations of consultants so that general practitioner, patient or insurer can select a second opinion consultant (sub)specialized in the complaints concerned.

sub 4) Within one specialism, one request for a patient or GP initiated second opinion should be permitted in a period of two years.

8.1.5 SUB E: WHAT (PARTIALLY PREVENTIVE) MEASURES MAY BE TAKEN TO STOP THE RISE OF THE NUMBER OF SECOND OPINIONS?

Various parties influence the number of second opinions in various ways. In the structure and process of health care a number of factors may be distinguished, viz. the patient’s selection process, the physician’s way of practising his profession, and the method of organization of second opinions in health care.

The number of second opinions may in future be controlled by influencing the doctor-patient relationship, the physician’s definition of the indication and the issuing of rules by the government and health insurers.

Influencing the doctor-patient relationship

This study shows that the doctor-patient communication is one of the main reasons to seek a second opinion. Improving this communication might have a preventive effect so that the second opinion could often be avoided.

Owing to the increased autonomy and independence of the patients, much more is demanded of the physician’s communication skills than used to be the case. The patient-doctor communication is one of the main tools in medicine. The communication between doctor and patient has three main objectives: to create a relationship of trust, to exchange information and to make treatment-related decisions. The doctor-patient communication affects the patient’s satisfaction, the compliance and the probability of the patient’s seeking other physicians’ opinions 7. The interest in communication training in the study of medicine has increased since the seventies. Medical students have gradually encountered more and more stringent demands concerning communicative skills and confidentiality.

For the last decade, all medical schools have some form of communication training, albeit that on the whole less than 5% of curriculum time is available for this subject. The ‘Outline Plan’ for the study of medicine in the Netherlands lists the capacities to empathize, to give information and to attempt to establish a respectful, equal relationship as endpoints of the training 8. The Concilium Orthopaedicum has also for some time recognized the importance of communication education during training of orthopaedic surgeons. It is to be hoped that the learning of communication techniques during the training will continue to develop fast.

Hulsman et al. (1999) carried out a meta analysis of the effects of training physicians in communication skills. It was found that physicians after a communication training had more positive ideas about their own knowledge, attitude and skills 9. Patients first of all proved to be more satisfied with the communication. A doctor’s affective behaviour, in particular, led to greater patient satisfaction 10. The training in the first place improved the physician’s skill in affective behaviour. The conclusion read that physicians as a rule function more competently in the area of giving information than in the areas of interpersonal contact and affective behaviour.
Even so, information-giving might be improved further. Most patients feel a strong need for information. Information gives the patient a grip on his/her disease. The studies by Van der Pas et al. (1995) and Ley (1988) show that 35% of their patients expressed themselves critically about the supply of information during outpatient care. There is also criticism of the existing supplementary written information sometimes offered by physicians for the patients’ support. It is allegedly sometimes obscure, with use of difficult language. There is a striking discrepancy between the patient’s expectations and the degree to which physicians believe they meet them. According to Waitzkin (1984) physicians in 65% of their consultations underestimate the need for information. Also, doctors overestimate the amount of information they give. There is a discrepancy between doctors’ statements about the information they supply and what actually happens during the consultation. Observational studies by means of analysis of video tapes proved that the information given by physicians may be regarded as providing real insight in less than 20%.

Van der Pas et al. (1985) published the results of a nationwide project on ‘cooperation on patient-friendliness of general hospitals’. It was found that a considerable proportion of the patients were of the opinion that the information-giving could be improved. Before, during and after an examination patients want better information about possible after-effects and/or side effects and the results to be expected. They would like to discuss more alternatives to the proposed treatment. In addition, doctors and patients differ in their opinion about what is relevant information.

Doctors’ providing information is time-consuming. Studies have shown that a consultation of at least 19 minutes is necessary to satisfy the patient’s need for information and participation. It is not known if this length of time is the same for every specialism. In these studies, no attention was given to possible differences between the various disciplines. In general, a consultation in a peripheral orthopaedic practice takes much less than 19 minutes. Increasing the duration of the consultation is not very feasible in the given circumstances, because it would severely affect the accessibility of the office hours. Time and money are scarce in health care. Although lengthening of the consultation is desirable, it is not to be expected that in the future the time available for the doctor-patient contact will increase that much.

Furthermore, the patient is not always in a situation in which information can be adequately understood and remembered. The preexisting medical background knowledge, attention and the emotional weight of the information determine what the patient will remember of the consultation. Fear may interfere with effective remembering of information.

The problem of inefficient information transfer can be partially overcome by using other means of providing information. One possibility is to produce clearer and more informative booklets. The visual information might be extended, and the provision of information via the internet might be further increased, streamlined and adjusted to the needs of the Dutch patient. Another important point is education of the patient. The patient should be stimulated to ask questions, because the more information is asked, the more information will be given by the physician.

Influences at government, insurers or hospital level

Reimbursement of the costs

To visit a consultant, patients with compulsory health care insurance need to be referred by the GP or the consultant. The insurer then reimburses the costs. Persons with compulsory insurance are not automatically entitled to a second opinion from a different GP. Private insurance policies have variable conditions to reimburse second opinions. Referrals from one consultant to another are not subject to restrictions. The health insurers might limit the reimbursement for second opinions, but currently they do not regard this as opportune. On the contrary, insurance policies are sold on the possibility of including second opinions in the basic package.

Other possibilities may be authorization procedures for second opinions or restriction of the number of second opinions that may be requested for one complaint. Officially this is the case even now, because in general only one referral slip a year is issued for a particular specialism. Nevertheless, insurers apparently cannot estimate precisely how often this opportunity is used.
In special cases a second referral to another consultant in the same specialism is possible; this may be a tertiary referral or a second opinion. Health insurance companies sometimes find it very difficult to distinguish between a request for a tertiary referral or for a second opinion. Also, to check this would be an enormous administrative burden. Consequently, a number of second opinions may remain unnoticed, for instance because some patients requests a second opinion from a different specialism. Second opinions may also escape notice because the long chart has expired and the patient is given a new long chart for the specialism in question with another consultant. Moreover, it is not easy to keep a check on the number of times that second, third or fourth opinions are requested. Probably, only the most excessive cases are noted. Accordingly, reduction of the number of second opinions by limiting the indemnification is not feasible in the given circumstances.

Regulating the number of second opinions within the hospital

When the health insurance companies are unable (and unwilling) to regulate the number of second opinions, hospitals might take over this task. The hospitals, which purchase care from the health insurers may make agreements with them about the number of ‘second opinions’ that should be granted. Such a measure has a number of drawbacks. It makes for much administrative work in the hospital, and the number of ‘silent’ second opinions will probably increase. The main disadvantage, however, is that such a measure would once again impair the accessibility of the care.

8.1.6 Sub F: What criteria should be met by a request for a second opinion?

The first consultant should provide the second with all relevant patient information, including supplementary examinations and earlier and/or proposed treatments. These data should be available at the time of the consultation. Without complete information the second opinion consultant is not well able to form a well-based opinion. The first physician should state clearly what diagnostic or therapeutic problem is to be solved (clear definition of the problem and/or the reason of referral) and should also give his or her own opinion. Preferably, the second opinion consultant should know beforehand whether a second opinion is being sought, or a take-over of the treatment requested. This study shows that the first consultant’s wishes are regularly disregarded, without it being clear if that is the decision of the patient or of the second opinion consultant. This phenomenon might have a dampening effect on referrals to second opinion consultants for second opinions, however adequately indicated. In deciding which consultant should continue the treatment, the patient’s choice should be of overriding importance. Patients without a clear preference should in principle be referred back to the first opinion consultant.

In case of a second opinion initiated by patient or GP, the first consultant ideally should be informed, so that all necessary information becomes available to the second consultant. Not all patients will agree to this, but for a well-considered second opinion detailed medical information is often necessary. Silent second opinions should be discouraged.

In case of consultant-initiated second opinions, the GP should always be informed both by the first opinion and by the second opinion consultant. The second opinion consultant should inform the first opinion consultant of his/her findings, unless the patient refuses to consent.

8.2 Advised checklist for a standard referral letter from GPs or first opinion consultants to second opinion consultants:

Name consultant, discipline, hospital, date
The patient should be referred to a consultant with expertise and experience of the subject of the case in question. Explicitly stating the name of the consultant renders it more likely that the patient will indeed be seen by the consultant meant.

Patient’s personal particulars
Name, date of birth and address
Main complaint, patient’s request for assistance, further anamnesis, physical examination

Supplementary examination
Results of supplementary laboratory tests, roentgen and other imaging examinations stating the dates in order to avoid unnecessarily repeated examinations.

(Preliminary) diagnosis/definition of the problem

Treatment already started, if any, and its results
- operations
- conservative therapies
Name and functions of earlier physicians, mention of earlier treatments and/or diagnoses.
Relevant consultant letters should be sent along.

Supplementary data
Who requested the referral?
Is a tertiary referral or a second opinion concerned.
For what other disorders is the patient currently being treated by GP or consultant(s)?
Relevant case history
General state of health
Use of pharmaceuticals
Family anamnesis
Psycho social factors.

Definition of the problem and motive for referral
What concrete questions are there about diagnosis and/or treatment and/or management if the consultant in his/her discipline finds no explanation for the patient’s complaints?

8.3 Advised checklist for a standard referral letter of second opinion consultants to GPs and first opinion consultants

Name consultant, discipline, hospital, date

Patient’s personal particulars
Name, date of birth and address

Main complaint, patient’s request for assistance, further anamnesis, physical examination

Supplementary examination
Results of supplementary examinations carried out by the second opinion consultant, as well as the re-evaluation of earlier examinations.

(Preliminary) diagnosis and definition of the problem

Proposed treatment

Supplementary data
Which consultant will in principle take charge of the continued treatment?
8.4 Bibliography

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