Getting a second opinion

George Ampat sets out issues surrounding consent between vulnerable patients and an enthusiastic doctor

George Ampat is a consultant orthopaedic surgeon

'As the law stands, it is legal for surgery to proceed with an informed consent from the patient, and the opinion of only one doctor. A mandatory second professional opinion from another surgeon in the field would be a very positive development in the way the healthcare system is run.'

This article debates the vulnerability of patients versus the responsibility of the treating doctor. Physicians are expected to possess 'technical skill, scientific knowledge, problem-solving, and human understanding…'(M Y Rathor, et al, 2011) Therefore the patient is reliant on the doctor and often puts total faith in their knowledge, making all patients potentially vulnerable, by the very nature of this relationship with the doctor. Over the course of centuries, the relationship between patients and doctors has changed, becoming less paternalistic, though this tradition still influences patients today. Compared to a hundred years ago, people increasingly want to be kept informed about the progress of their conditions and treatments and have more power over their progress. Now, all invasive procedures recommended within the modern healthcare system legally require a patient freely giving their informed consent. If there is no informed consent, the treatment will not be allowed to proceed and if any of the factors which qualify an informed consent is absent then the consent is void.

A second opinion before surgical interventional is not a legal requirement in the current UK healthcare system, and patients do not have a legal right to one, although if it is sought by the patient they will rarely be refused.

But when the patient is arguably more vulnerable to accepting treatment because of their condition, how likely is the patient to seek a second opinion, when the possibility of relief is so close at hand? Furthermore, when the treating doctor is especially enthusiastic that they have a cure and they are encouraged (both with financial gain and by their quest or desire to do good for a patient in need) how likely are they to stop and re-evaluate?

The final question is: why is a second professional opinion not a requirement in the UK health system, before any informed consent can be accepted?

Ethics and the concept of informed consent

Informed consent is described as (Rathor):

> a voluntary and explicit agreement made by an individual who is sufficiently competent or autonomous, on the basis of adequate information in a comprehensible form and with adequate deliberation to make an intelligent choice about a proposed action.

Patients also need to understand the purpose of the operation, how long it will last, what will be involved, and all the possible benefits and risks. Informed consent is not just a one off occurrence; it must be thought of as an ongoing process of making sure the patient continues to understand new developments and results as treatment progresses.

The key ethical principle relating to all medical procedures is the belief that everyone should be treated with respect. Due consideration should be given to diversity and how this may impact their judgement about consenting to the treatment. Factors to consider are ethnicity, gender, disability, religion, culture, language and level of understanding. Once an individual has made a decision, the doctor must respect it even if they disagree, or legal action may be taken against the physician for assault.

As all patients are potentially vulnerable to coercion, all medical practitioners have an ethical responsibility to decide fairly when to intervene and when not to, after consideration of all the above factors.

What makes a person 'vulnerable'?

Vulnerabilities can be as diverse as the patient and extend from simple language barriers to serious conditions such as Alzheimers and cancer. Dr Raymond C Tait comments that the definition of 'vulnerable' has become so 'diluted' over the years that 'any research subject could be considered vulnerable according to some criterion.' However, it is only in a selection of cases were the patient legally qualifies as needing either a mandatory second professional opinion or a third party agreement on the patient's consent. For example, while dementia is considered a factor which renders the patient unable to give informed consent as they are especially vulnerable to coercion, chronic pain is not, even though research has shown that pain can alter persons judgement significantly, thereby also making them vulnerable to coercion. It is arguable that a second opinion should be mandatory for all invasive treatments to proceed as some vulnerabilities simply cannot be subject to explicit qualifiers.

It is accepted that pain is inherently bad and to be avoided, therefore any suffering patient could be more likely to consent treatments they would otherwise not consider to eradicate their pain. The level of pain or their eagerness to be back at their peak may make them more or less likely to consent for treatment. Sharon L Lewis et al explain that 'Chronic pain or loss of function may make the patient vulnerable to believing the claims of false advertising...'.

Pain specialist Michael Vagg has also discussed this:

> Having long-term pain can produce a very different lived experience to not having it, because the pain process can impact upon a number of systems which alter the way external and internal events are filtered... those who have it are walking around with 'pain goggles' on that cause them to perceive reality quite differently without being aware of it.

In research which seems to prove this theory, Pais-Vierira et al modelled a study based on the existence of pain as a 'multidimensional phenomenon' which can result in depression, anxiety and cognitive impairment. Pain processing in the brain involves a large scale neural network, consistent with the multidimensional concept of pain. (Indeed, even without pain as a cause, it is accepted that all of these factors do alter a person's judgement and therefore warrant a second opinion. With this in mind, surely the cause of these issues, the pain itself should also make a second opinion necessary?)

Pais-Vierira and colleagues' study documents the decision making of rats suffering chronic pain. As chronic pain alters output of the orbitofrontal cortex (OFC), all rats had electrodes attached which recorded their OFC activity, monitoring their calculations of reward size. During the study, the rats were given the option of small frequent meals or large meals that were few and far between. The rats in pain were much more inclined to go for larger meals, even though another one would not come again for a long time whereas the healthy rats seemingly understood they could eventually get more food run by choosing the little and often option. In humans, impaired output of the OFC 'tends to result in impulsive, emotionally driven decision making, without much reasoning or prioritisation.' From this, the researchers deduced that a long-term sufferer of chronic pain was likely to have impaired judgement when faced with decisions involving risk. With this in mind, we can theorise that patients suffering chronic pain may be vulnerable to high-risk, high-reward suggestions such as a treatment which may work and produce great results, but which also may not work and might leave them no better, or worse than before.

Examples of impaired decision making in humans have been observed in chronic pain patients subject to the Iowa Gambling Task to assess decision making performance. In a card game style test designed to assess decision making performance, the individuals freely choose cards among four decks, the aim being to earn money. In the four decks of cards, two are advantageous in the long run because they provide immediate moderate winnings and minimum losses. The other two present immediate high gain but are associated with vastly higher future losses. Healthy patients typically make more selections of cards from the advantageous decks, whereas chronic pain sufferers perform poorly. This can be considered evidence that patients in pain can be just as vulnerable to over-treatment as patients whose judgement is impaired by a mind-ailing condition.

Vagg comments that pain may compel patients to undertake 'desperate, extreme and usually futile efforts to cure their pain' and allows that it is an understandable outcome. Lewis et al have mentioned that outside a hospital environment patients may also attempt 'unproven or even dangerous remedies [to ease their pain]'. This brings to light the pressure on doctors to do something, and quickly, to minimise cases were patients turn elsewhere for unmonitored treatment. With this in mind, the balance between over-treatment and under-treatment can be perilous for both doctor and patient.

Pressures on the doctor

In an article published by the BMJ in May of this year, A Malhotra et al explain that:

> A culture of 'more is better', where the onus is on doctors to 'do something' at each consultation has bred 'unbalanced decision making.' It is illustrated in the article that this has resulted in patients being offered treatments that 'have only minor benefit and minimal evidence [for success] despite the potential for substantial harm and expense'. This rising culture is threatening the sustainability of quality healthcare worldwide. It stems from 'defensive' medicine, biased medical journal reports, patients pressured to recover quickly, commercial conflicts of interest, and possibly most seriously 'a lack of understanding of health statistics and risk'. Malhotra et al explain that NHS right now operates on a system of payment by results, which in reality translates as 'payment by activity' which could possibly alter judgement.

There is a worrying level evidence of unnecessary and wrongful surgical interventions occurring worldwide.

Dr Epstein, a neurosurgeon from Winthrop University suggests that 60.7% of patients who attended her hospital and who were previously recommended to undergo spinal surgery by other surgeons actually did not require a surgical intervention. Dr Epstein remarks that 'for these patients, operating on pain alone was not going to help them. These unnecessary operations were going to be of no benefit.' Spinal surgeon Dr Atiq Durrani was one of numerous doctors in the news of surgeons prosecuted for unnecessary surgeries. Previously respected, Dr Durrani had numerous lawsuits filed against him for unnecessary surgeries that worsened patients' problems. The lawsuits also claimed that the hospital's Durrani worked within were purposefully ignorant of his practices because Durrani was one of the biggest money makers. By the time Durrani had fled the country, there had been more than 160 lawsuits filed against him.

Another example, although the case does not deal with pain, is Dr Mahmood Patel, a cardiologist practising in Louisiana in the USA, who fitted a 22-year old with a pace maker after a fainting spell brought him to hospital. Months after Stelly's surgery, local news reported that Patel was being investigated for performing unnecessary surgeries. Stelly had other doctor's review his case and they all agreed that he needed blood pressure medication, but he never needed the pacemaker. Stelly, now 34, told *USA Today* 'I did what the doctor said. I trusted him.' This is an unfortunate example of a patient's vulnerability versus an over-enthusiastic doctor. Medical practitioners worldwide have moral responsibility to justly decide when to perform an intervention, when to step back, to respect this doctor-patient paternalism and not abuse the patient's trust.

Conclusion

As the law stands, it is legal for surgery to proceed with an informed consent from the patient, and the opinion of only one doctor. A mandatory second professional opinion from another surgeon in the field would be a very positive development in the way the healthcare system is run. Within private healthcare a second opinion is more common than within the NHS, presumably because the bill is the responsibility of the patient and not the state. If mandatory second opinions were to become the norm, concerns may be expressed about the extra expense on a healthcare system with a finite budget. However, when the extra expense of obtaining a second opinion is measured against the saving that would be made by rationalising thousands of unnecessary surgeries, the concept surely becomes more attractive. The more information and informed opinions a patient has access to, the less likely they will be to undergo a treatment they may not actually need, combating the rise in over-diagnosis and over-treatment, which will cause great harm and waste if left unchecked. This would also reduce the prosecution of medical practitioners for unnecessary surgery. ■

Reference list

M Y Rathor, et al, 2011, Informed Consent: A Socio Legal Study, International Islamic University Malaysia, *Med J Malaysia*. 2011 Dec 66(5):423-8: www.ncbi.nlm.nih.gov/pubmed/22390094

Beisecker, A E and Beisecker, D T, 2009, 'Using Metaphors to Characterize Doctor--Patient Relationships: Paternalism Versus Consumerism', *Health Communication* (1): 41- 58, Routledge: www.tandfonline.com/doi/abs/10.1207/s15327027hc0501_3#.VcvDNflVhBc

Royal college of Nursing, 'Informed consent in health and social care research', *RCN guidance for nurses, 2nd edition*: www.rcn.org.uk/__data/assets/pdf_file/0010/78607/002267.pdf

NHS Choices, 2014, *How do I get a second opinion?*: www.nhs.uk/chq/Pages/910.aspx

Tait, R C, 2009, 'Vulnerability in Clinical Research with Patients in Pain', *J Law Med Ethics*. 2009 Spring; 37(1): 59–72: www.ncbi.nlm.nih.gov/pmc/articles/PMC3148022/

Pais- Vieira, et al, 2012, 'Decision making in the chronic pain patient (and rodent): Contribution of the Orbitofrontal Cortex', *PAIN*, Volume 153, Issue 8, 1553-1554: http://journals.lww.com/pain/Citation/2012/08000/Decision_making_in_the_chronic_pain_patient__and.6.aspx

Lewis, SL, et al, 2014, *Medical-Surgical Nursing: Assessment and Management of Clinical Problems*, Single Volume 9e, Elsevier Mosby.

Vagg, M, 06/8/2012, 'Chronic Pain Changes Your Perception of the World... 4 studies from growing literature', *The Conversation*, UK: http://theconversation.com/chronic-pain-changes-your-perception-of-the-world-4-studies-from-a-growing-literature-8664

Malhotra, A, et al., 2015, *Choosing Wisely in the UK: Academy of Royal Medical Colleges' Initiative to reduce the harms of too much medicine*, Academy of Royal Medical Colleges, The BMJ.

Epstein NE, 'Are recommended spine operations either unnecessary or too complex? Evidence from second opinions' *Surg Neurol* Int 2013 Oct 29:4(Suppl 5):S353-8.

Eisler, P, Hansen, B, 20/06/2013, 'Doctors perform thousands of unnecessary surgeries', *USA TODAY*: www.usatoday.com/story/news/nation/2013/06/18/unnecessary-surgery-usa-today-investigation/2435009/

Leggate, J, 17/06/2015, WCPO-TV, 'Lawsuits: Local Hospitals Hosted "unnecessary" surgery by Dr Atiq Durrani': www.wcpo.com/news/local-news/hamilton-county/cincinnati/lawsuits-local-hospitals-hosted-unnecessary-surgery-by-dr-atiq-durrani