Second Opinion

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Decisions taken by pediatric cardiologists and cardiovascular surgeons are rarely done in isolation. Patients with congenital heart disease requiring catheter and/or surgical intervention are presented in patient management meetings traditionally labelled “cath. conference”. This concept is common practice in medical centers throughout the United States and most advanced medical centers around the world. The cath. conference allows pediatric cardiologists in all their disciplines to meet with cardiovascular surgeons, anesthesiologists, critical care specialists and other health care providers to review patient data for those patients who are in need of catheter based intervention, surgery or merely to confirm the wisdom of current management. This unique platform offers counsel to the treating (primary) pediatric cardiologist who then shares with patients and families the consensus or divergence of opinions provided through these meetings, an advantage otherwise not available to patients.

I have learned in my clinical practice to share with patients and families this process. I inform them of what I believe the next treatment option should be, but explain that a final decision should not be made until the collective wisdom and experience of my colleagues is attained through the cath. conference, thus coming to an ultimate decision supported by many specialists in the field. I have found that parents are comforted by this process and look forward to my phone call after the meeting to discuss the next step in their child’s medical management.

The elaborate process of presenting cases in cath. conferences and the sometimes fierce debate it precipitates is,

in my opinion most valuable in patient care; therefore, I find it difficult to understand why this practice is not uniformly applied in medical systems throughout the world. In those regions where this step in management care is missing, patient’s management discussions are restricted to fellow cardiologists, with an eventual referral to a surgeon or an interventional cardiologist for further management. Each key player works in a silo, without the benefit of engaging in a meeting-based discussion with those involved in the future care of the patient. I believe that a system void of the cath. conference concept deprives patients of alternative options that may be superior to what a lone specialist may decide. Patient management conferences provide patients and their families with the consensus of multiple opinions based upon intimate knowledge of patient’s medical history. It goes beyond the “second opinion” where a 2nd, 3rd, 4th and many more opinions are provided, hashed, rehashed and finally molded into a meaningful treatment strategy.

Over the course of my career, cath. conferences have provided me with a solid platform to feel confident in the recommendations I provide my patients. Occasionally this was not enough for some patients who felt the need to seek a “second opinion” which I always welcomed since much of the care we provide our patients and their families includes the comfort and confidence that the best plan for treatment was indeed adopted. I too, at times suggested seeking opinion from specialists outside my medical center when it dealt with procedures not available at our center, such as cardiac transplantation or fetal intervention.

Although seeking a second opinion, as suggested by parents or myself, was an unusual occurrence in my experience, it has provided my patients much needed comfort. Lately though I have come to see a dark side to this practice: a means to solicit business by pediatric

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cardiologists to increase revenues. This is a disturbing development on what is intended to be a means for the patient to ensure that the care recommended by the primary cardiologist and his or her colleagues through the cath. conference is indeed the right path to pursue.

In the most elaborate rendering of this business driven model, a pediatric cardiology practice at an academic center established a “second opinion clinic”. Seekers of a second opinion do not merely receive the opinion of a seasoned pediatric cardiologist, but are then subjected to a presentation of charts and brochures elaborating the performance of that medical center followed by a tour of the facility where medical care could be provided if the patient chooses to transfer their child’s future medical management. The process unfortunately seems to emphasize salesmanship over proffering medical opinion.

Upon hearing of this new and aggressive approach in increasing market share I wondered how the offering of “second opinion” is viewed and practiced elsewhere in the United States and worldwide. Therefore, I developed a short questionnaire which I shared with fellow editors of this journal attempting to choose practitioners from various parts of the world. I did not intend this to be a scientific process, but instead a guide and means to understand the process of seeking “second opinions” in these other areas. I am very grateful for my colleagues who were most generous in their time and wisdom.

The concept of second opinion appears to be practiced more widely than I have personally experienced. Unlike what is practiced in the United States, the second opinion is mostly initiated in Western Europe by the primary pediatric

cardiologist to provide comfort to patients and their families particularly when the course is expected to be fraught with complications. In the United States, although either party may initiate the process, it is mostly driven by patients and families. To my surprise insurance companies usually pay for second opinion visits, this is astonishing to learn since insurance companies in the United States tend to balk at paying anything which could be deemed unnecessary. As for using a second opinion to expand one’s own patient volume, this seems to be an American practice amongst developed countries. To a certain extent this is to be expected since American health care is financially driven in its nature. Nevertheless, to me, this remains tasteless and robs the seeker of second opinion from getting an unbiased opinion from a medical practitioner.

For second opinions to be void of ulterior motives regional “second opinion boards” should be established. These boards can be staffed by seasoned practitioners in the various sub-fields of pediatric cardiology and cardiovascular surgery attempting to encompass all specialists who meet set criteria in that particular region to eliminate competition or unfair advantage. Patients and families can seek second opinions from these regional boards without having to worry that profit is a hidden agenda from the second opinion rendered.

Collaboration amongst competing medical centers, such as in the United States, where this service is needed most will be hard to forge and in my opinion is near impossible to bring to fruition, but one remains hopeful that common sense may occasionally prevail.