Occasional essay

Could we have a second opinion?

The request for a second opinion by the relatives of an unconscious patient in the intensive care unit (ICU) is rare, and I was somewhat surprised when recently I outlined to a mother the diagnosis, plan and prognosis for her severely head injured son only to be asked 'could we have a second opinion?'.

The patient had just been admitted to the ICU after a motor vehicle accident in which his only major lesion was a closed head injury. He arrived at the hospital accident and emergency department with a Glasgow coma score of 7 (E1, M4, V2), was intubated and mechanically ventilated, and underwent a cerebral CT scan which revealed bifrontal lobe contusions and early signs of cerebral oedema. The 'on call' neurosurgical team assessed the patient, inserted an intracranial pressure (ICP) monitor and referred him to the ICU team for further management. I had told the mother that her son had a severe head injury with signs of brain damage. There was evidence of increased pressure inside his head, which was not a particularly good sign, although it was early in the course of his illness and that the final outcome could not be predicted with any certainty. On one hand, he could make a very good recovery, yet on the other hand he could be severely disabled; we just had to wait and review his progress daily.

"Was there anything more that could be done?", "Is there any centre in the world that specialises in head injuries where we could send him ?", "Please spare no expense" were just a few of the many questions and comments that were rattled off by a genuinely concerned divorced mother who had reared her son without any help from a father who had long gone.

I explained to her that at our institution we had a lot of experience in dealing with head-injured patients and that, as a teaching hospital, we constantly reviewed world literature to keep in touch with recent developments. We knew what was available and genuinely believed that the patient would not benefit from being moved to another center. The ICU team consisted of 5 specialists, all of whom would be either directly or indirectly involved in her son's care, and all of whom would ensure that an excellence in care would be maintained.

Later that day she returned with her sister and two brothers, and asked me to go through what I had said to her - to all of them. This I did, attempting to make sure that the dialogue was honest, unhurried and almost identical with that which I had said some four hours before. At the end I looked at them and said 'are there any questions'. The mother looked at me and said 'please don't misunderstand us, as we know that Kevin is receiving the best care possible, but *could we have a second opinion?*'

"Sure" I said, not wanting to appear obstructive.

"As I said, we solicit opinions from all our ICU specialists when dealing with critically ill patients – so what had you in mind?". I wanted to reassure her we consulted widely, but did not want her to feel she was losing control of her right to another opinion. It appeared that her sister knew a neurosurgeon at another hospital and wondered whether he could provide the 'second opinion'.

"Sure" I said again "I know him well, and will give him a call. We would be happy for him to be involved". I quickly informed our neurosurgical team of these developments, and a cryptic message was relayed back: 'do what you like. The current management is non-surgical'.

The 'second opinion' arrived two days later and deep into the evening. The patient by this time was heavily sedated with morphine and midazolam. He was non-responsive to pain, had pinpoint pupils and a cerebral CT scan performed that morning revealed a generalised increase in cerebral oedema but no surgically remedial lesion. His ICP had been varying between 17 - 20 mmHg, the serum osmolality was 305 mosm/kg (increasing over the last 24 hr due to intermittent osmotherapy) and the arterial PO_2 and PCO_2 were 116 mmHg and 36 mmHg, respectively. The consultation was brief. Unfortunately, no 'on site' medical staff knew of his presence, so he remained unaccompanied throughout. Next morning the 'advice' was noticed in the case record, which included hyperventilating the patient down to a PCO_2 of 25 - 30 mmHg, intravenous dexamethasone 8 mg 4-hourly and thiopentone until the ICP was below 15 mmHg - administering noradrenaline and intravenous fluids if the cerebral perfusion pressure fell below 70 mmHg. These recommendations had also been relayed by the neurosurgeon to the mother via her sister, so that by mid-morning we were confronted with an enthusiastic family believing that a formula had been found which would somehow transform their boy rapidly into an awake and vibrant individual. I remembered telling the family 24 hours previously that everything that could be done was being done. How could this be reconciled with steroids, thiopentone and hyperventilation?

To say that I was a little irritated at the second opinion's advice and method of communication was to

put it mildly. "We were thankful for these added thoughts" I said suppressing my ire, "and were aware of these treatments. However, we had not used them because large trials involving many patients with an injury similar to your son's, have shown them to be of little use".

"But what have we got to lose" was the cry from a mother desperate to try anything.

"Well…. side effects can occur, which are not insignificant, and which may cause more harm than good" I said in an attempt to justify what was appearing to be a therapeutically nihilistic position.

"What about trying it" was all she could say.

"What we will do" I said, attempting to reach middle ground "is to introduce each of these suggested therapies carefully, but will withdraw them if there seems to be any adverse effects". She seemed relieved.

"Unless you would prefer us to transport the patient to another hospital where the other neurosurgeon could continue his management" I said hastily, wanting to allow her all options concerning her son's treatment, and allowing the 'second opinion' to deal with the problem first hand.

"Oh no. We are perfectly happy with your management. We would just like to make sure that no stone is left unturned"; a puzzling statement that I thought best left unchallenged.

As it would happen (probably fortuitously) my rostered 'week on' for the ward was almost over, and I handed over to a consultant who was less troubled than I about the external control of management of this head-injured boy. I introduced him to the family, saying that I had acquainted him with all the relevant facts and that further management would be under his 'watchful eye'.

However, I could not forget this episode. I kept wondering about the 'second opinion' and its value in medicine. When doctors consult, the advice is usually received gratefully, with the referring doctor taking up some or all of the suggested changes in the patient's management. The relatives are informed of the suggested changes with the referring doctor discussing the advantages and disadvantages of each; rarely are they directly involved in the consultation process. Consultation differs from a 'second opinion' in that the latter is usually initiated by a patient (or relative) who is unhappy with the first opinion (which not only relates to the advice given, but also to the relationship developed between patient or relative and doctor).[1,2] Concerning the advice, both the reliability and reproducibility of clinical judgement varies with time, indicating that the doctor giving the 'second opinion' varies his or her advice with time.[3] Concerning the doctor-patient relationship, this is a matter of trust which is an essential, but fragile, element of good medical care.[4]

If the patient wishes to undergo treatment recommended by the second doctor, clearly the management should be taken over by that doctor. It would seem to me that continued management by the first doctor undertaking management advised by the second doctor would be untenable. Who then is responsible for the patient's management? Who is liable for adverse effects or treatment failures?

While a second opinion is a patient's 'right', as a tool it has to be used carefully.

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