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EDITOR'S PAGE

Second Opinion Rights

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When patients want to question their doctor's decision, where do they turn? I was recently contacted by a man who was questioning a recommendation that his 85-year-old grandfather should enter a trial of transcutaneous aortic valve implantation (TAVI) for his aortic stenosis. The grandson had seen a lot of public information about TAVI and began to wonder if it was being overpromoted. This family advocate decided he would investigate the relative merits of open surgery versus TAVI. He read medical articles extensively and consulted guidelines. He went to national societies and state databases to learn hospital and specific surgeon outcomes. He found surgical mortality to be around 1% for 1 surgeon and over 2% for another and concluded that they were different. Without risk adjustment and with limited numbers, these percentages are, of course, meaningless. However, with extensive investigation on his own (he describes this in detail in *Consumer Reports* [1]), he provided information to his grandfather who ultimately selected open aortic valve replacement surgery and had a good result. If the result had been otherwise, would the conclusion have been that the investigation had led to the wrong recommendation? No one can fault a grandson who wants the best for his grandfather, but is this now to become the required way to arrive at informed decision making? We have come a long way from "the doctor knows best."

In an effort to define quality in decision making about myocardial revascularization, the American College of Cardiology launched the appropriate use criteria (AUC) process. Clearly stated, it is a quality improvement initiative that was not designed to automate the decision making process for individual cases. Nonetheless, the use of the term "inappropriate" was just too much to resist, and now some payers are using this designation to deny payment. No one should question the right and responsibility to assure that public funds are used correctly and that when fraud is found it is prosecuted, but this is simply not the purpose or the capability of the AUC. If it was, then all patients could be assigned a box on the AUC chart, and the patient and family could see the appropriate treatment. Is the problem of decision making solved? Not so, as medical judgment, although endangered, remains alive. These quality improvement tools are a helpful guide to our overall performance but are of little comfort for the concerned patient or the family. An editorial by Skip Anderson and colleagues in this issue of *JACC: Cardiovascular Interventions* expands on the appropriate and inappropriate use of the AUC (2).

Patients and families want to know that the decision is best for them. Is there consensus around the recommendation? The heart-team approach to decision making is not a new concept, but has been endorsed for difficult decisions by the American College of Cardiology/American Heart Association guideline and the European Society of Cardiology guideline process. For aortic valve disease, the process was formalized during trials, as was the decision making about extensive coronary artery revascularization during the SYNTAX (SYNergy Between PCI With TAXUS and Cardiac Surgery) trial. The concept is that decisions that could lead to surgery, interventional procedures, or medical therapy should have input from practitioners of these disciplines, and that primary care with the patient should play a pivotal role. In concept it is perfect. In application, there are problems. Some disciplines formalize this activity, such as oncology with their tumor conferences, but it is rare in cardiology. Assembling a surgeon, an interventional cardiologist, a clinical cardiologist, and a primary care provider to discuss a case with a patient is daunting. With busy schedules and the emphasis to maximize clinical throughput, and with no reimbursement for this activity, it is an uphill struggle.

So how does a patient or a family come to a comfortable decision when the doctor's recommendation is not enough? Gail and I were recently visiting Michaela Gruentzig, first wife of Andreas, in Zurich. A close friend of Andreas and his wife came to dinner. It was a delightful evening, and the discussion turned to this question of how decisions are made. The retired surgeon with vast experience said that he was often asked to give his opinion regarding medical recommendations. It occurred to me that I was also becoming a second opinionist or a second opinionator (we need a name). Most of these requests are from family about friends, friends of friends, or the cousin of someone we met at a cocktail party. It occurred to us that there is no mechanism for patients to get these fresh looks unless they have connections or request and pay for another evaluation. If second opinions are to be made available to those who need them, will it remain pro bono work, and if so, how much fee-for-service time can physicians spare from their relative value unit work? Consultations, which were common during most of my career, are generally not reimbursed now. Should they be? Would it lead to abuse? Perhaps, but a reasonable copay should reduce that risk. How often is a second opinion needed or desired? "Doctor knows best" works for most patients and situations, but when patients want more input they should have it. Most of the time, when I have been asked about a decision, I have agreed with the recommendation and supported it. Sometimes the information is incomplete, and I am unable to make any recommendation. On occasion I provide the patient with other options that have not been explained, and I advise the patient or family to make further inquiry of the doctor with specific questions.

There may be many ways of helping patients and families become comfortable with decisions and gain confidence in the profession. A referral for a second opinion seems a much more palatable way to proceed rather than any adversarial shopping around. The internet will not go away, and informed patients are better patients, but it should not be the only way; the judgment of an informed and disinterested second opinion should not be undervalued. Patients are increasingly standing up for their "second opinion rights."

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