Int. J. Radiation Oncology Biol. Phys., Vol. 62, No. 4, pp. 954–955, 2005

0360-3016/05/$–see front matter

ELSEVIER

doi:10.1016/j.ijrobp.2004.12.090

EDITORIAL

CONSULTATION CHAOS

THOMAS E. GOFFMAN, M.D., F.A.C.P.

Department of Radiation Oncology and Department of Microbiology and Molecular Cell Biology, Eastern Virginia Medical School, Norfolk, VA

A recent international billion-dollar lawsuit (1) against a well-trained medical and radiation oncologist vividly demonstrates the potential perils of rendering a second opinion. These experts were alleged to have made inaccurate, overly optimistic predictions about patient outcome, and when the patients did poorly, their families were incensed. In some cases, the basis for such allegations is the presentation of misleading data. More often, however, complaints arise because of overoptimism by well-meaning consultants, poor communication between local physicians and outside experts, and failures by (especially local) medical professionals to gain their patients' trust and adequately inform them about their true prospects. Such problems can lead to patient frustration and dismay and, if things do not go as the patient (or his or her family) expects, then allegations of wrongdoing and legal action may be the unfortunate result.

Consultants and local physicians alike should be aware of certain pitfalls that tend to arise when patients obtain second opinions (with the complexity of such problems compounded as additional experts in a variety of specialties are consulted). These pitfalls can, however, be anticipated, and specific countermeasures can quickly avert or mitigate the negative effects. Thus, this article is not directed at the risks of litigation per se, but at the common groundwork for such litigation: that the patient is not apprised by both outside expert and local oncologist of the natural history of the disease, the toxicities of treatment, and the promise of continuing interaction between the local oncologist and the expert if matters (if they often do) do not evolve in the way the patient was led to expect.

PITFALL 1: THE EXPERT AND THE LOCAL PHYSICIAN SEEM TO BE AT ODDS REGARDING TREATMENT AND PROGNOSIS

Patient confusion is common when the recommendations of a renowned expert seem to be at odds with the local oncologist's interpretation of the evolving clinical picture. Patients sometimes find themselves in the august offices of someone who is (or appears to be) ready to resect, transplant, or irradiate almost anything. Typically, the patients and their families do not know the critical questions that should be addressed when considering novel treatments and cannot judge whether the medical community has scrutinized and approved the proposed actions. Many patients persist in thinking that local doctors automatically write off novel effective therapies out of some form of conservatism or ignorance.

Patients may not understand that the local doctor disagrees with the expert because of the specifics of the case or because the local doctor's skills and experience suggest a different medically reasonable approach than that favored by the consultant. American consumers often are convinced that one "best" course of action exists and that the expert necessarily knows and suggests it (were the patients to listen to any panel of experts at any cancer conference they might change their minds!).

All physicians involved in a case should make clear to the patient and family that second opinions or treatments are frequently given by those who have not had the time to fully evaluate the case. A consultant's initial enthusiasm about a case may be understandable, and all physicians know that their own optimism can help patients through very hard, depressing times. However, one party's overoptimism, real or perceived, is likely to be confusing and counterproductive for patients, families, and physicians. This already volatile situation is compounded by the fact that patients tend to put their faith in the doctor who offers the best purported outcome—often the outside expert. The reality is that outcomes are at least as dependent on biology as on therapy, and trust in the local oncologist can be eroded dramatically when the results are not as good as projected by the specialist. For the local oncologist, a patient arriving armed with a competing second opinion may be tiring, but spending extra time with that patient is critical. The local physician has the unsavory but necessary job of helping the patient understand the full reality of his or her situation. The patient must trust that the local oncologist has carefully considered the expert's advice and must understand why it is not the best course of action in his or her case. The patient also must know that the local oncologist is talking one-on-one with the expert, and, ideally, the patient should hear the results of such discussions. A real-time telephone conference that involves the local oncologist, the consultant, and the patient is optimal but may be difficult to accomplish.

PITFALL 2: COMMUNICATION BETWEEN LOCAL PHYSICIANS AND OUTSIDE EXPERTS MAY BE INEFFECTIVE OR UNTIMELY

In this ever-shrinking world, even patients of modest means may travel to different institutions, states, or even countries for

Reprint requests to: Thomas E. Goffman, M.D., Global Oncology, 3830 Jefferson Blvd., Virginia Beach, VA 23455. Tel: (757) 446-5762; Fax: (757) 624-2255; E-mail: tomeg2@juno.com

Received Sep 23, 2004 and in revised form Nov 16, 2004. Accepted for publication Dec 20, 2004.

a second opinion or an alternative treatment. However, at some point, they usually return home. Thus, local oncologists commonly face patients who have received stereotactic irradiation of uncertain dose, who say they were told to return for whole-brain treatment for an unknown primary. Just as likely, the doctor will walk into the examining room to find a patient with a printout of orders for treatment, by no means comprehensive, clear, or definitive, from some medical Mecca he or she has visited.

Local follow-up treatment and monitoring are critical, yet communication between the local doctor and the outside expert is often absent or, at best, minimal. The reasons for communication failures are manifold.

One reason is that renowned experts tend to be in high demand; they frequently travel to conferences and provide care, treatment, and second opinions to many other clients. Thus, they may be unavailable for immediate consultation on the present case. The local physician, the patients, and the patients' families may all be frustrated to learn that the specialist, who has the bulk of the patient's confidence, is in another hemisphere or is working on another project and is, therefore, not readily available to take questions.

This frustration may be compounded if further complications develop as a case progresses. The patient may be too sick to travel, but the family will want the specialist's opinion. Thus, the expert will be pressured to render a judgment without knowing all the details of the new problem, or the local doctor will be pressured to adhere to expert's original plan. Either way, the local oncologist can be left holding the bag for the less-than-perfect results of another doctor's prescription.

A related issue is particularly likely when patients self-refer to an outside expert without telling the local oncologist or telling him or her only after the fact. Communications may begin later than would be optimal for case management. Also, often the local physician must initiate contact with the outside consultant and ask for details of the consultation and/or treatment and to obtain guidance as the patient's case progresses. As noted, connecting with a far-flung specialist can be extremely time consuming. Yet it must be done because the patient's trust in the local physician is in part related to the fact that he or she is conferring personally with the expert. If the patient does not trust the local oncologist, the practice of medicine falls short.

PITFALL 3: IF ONE OPINION IS CHOSEN OVER OTHERS AND PROVES UNSUCCESSFUL, THE PATIENTS AND THEIR FAMILIES RARELY REALIZE THAT NONE OF THE PROPOSED SOLUTIONS WAS LIKELY TO BE SUCCESSFUL

The local oncologist, who usually has the greater share of responsibility for case management but the lesser share of patient trust and confidence, is unlikely to be persuasive or popular in clarifying this fact unless such clarification is done at the beginning and maintained throughout the course of treatment in collaboration with the expert. Unfortunately, most patients leave a consultant's office with a very positive outlook, when, in truth, oncology is most often a mixture of good and bad news. For example, the patient needs to know that an elegant resection or the most precise tumor irradiation may not necessarily translate into long-term survival.

Transspecialty suggestions can be particularly subject to problems. A renowned gastrointestinal surgeon, for example, may not be particularly well versed in the finer points of chemotherapy or radiotherapy. Ideally, each member of the patient's local treatment team would be able to confer with his or her counterpart at the consultant's institution and, thus, ensure a consistent approach and optimal information sharing. However, hospitals survive on volume, and they do not often encourage physicians to take the time to genuinely connect with outside treatment teams. Thus, patients and their families may be left to cling to early, optimistic projections that are never revised in the face of new information. (Clearly, this is also a failure of effective, continued communication, as discussed in Pitfall 2.)

Perhaps the greatest challenge to all parties involved in patient care, not least the patients themselves, is coming to understand that medicine is as much an art as a science. As often as not, a well-known physician in New York will have an entirely different opinion than a physician in New Zealand, or even New Jersey. The family is left with the problem of deciding who among the experts is the "most expert," unaware that the differences in opinion may be based not on clinical judgment, but on diagnostic technique, clinician expertise, changes in the clinical picture, or even regional bias. Every patient should know (and physicians themselves would do well to remember) that such differences can and do affect treatment decisions and should take steps to ensure that competing opinions are weighed appropriately.

The common and unfortunate result in all the pitfalls outlined here is patient confusion, frustration, and uncertainty. If these feelings lead to silent anger in the patient, the risk of litigation may well increase. However, if the physician takes responsibility for the patient's likely confusion and frustration and addresses them quickly and consistently, the patient feels more at ease, and legal problems are less likely to arise for the physician.

We medical professionals critically need a more proactive, interactive, and respectful system of communication for our patients and their families—not only to avoid the risks of litigation but also to address the larger issues of the confusion and frustration that frequently arise when patients hear conflicting stories from multiple doctors about their condition, its treatment, and, ultimately, its prognosis.

REFERENCE

1. Smith KC. Cancer victims' $1B suit: He lied to us. *New York Post*, August 28, 2004.