

When a physician agrees to attend to a patient, there is an unwritten contract between the two. The patient entrusts himself to the physician and the physician agrees to do his best, at all times; for the patient. This contract disallows the patient from seeing another medical expert for opinion or advice without a referral note from his physician. It also enjoins the physician to respect the autonomy of the patient so that if the patient so desires, he will refer the patient to another physician for a second opinion.

Traditionally, the concept of a second opinion is based on certain assumptions. First, that the physician has studied

the patient's medical history and clinical findings; if he is the patient's family doctor, he has also over time acquired a fund of medical and socio-economic information on the patient and his family. Second, that the physician is knowledgeable about the various specialists in the town or city and their respective strengths and capabilities, and is thus qualified to advise on whom to consult for a second opinion, and provide that consultant relevant and often-crucial medical information on the patient. Were the patient to consult another physician on his own, these benefits would be lost.

However, second opinions are often not sought on these principles. Some patients move from doctor to doctor without the primary physician's knowledge. They obtain a variety of opinions, often conflicting. Without any one doctor in overall charge of their therapy, they may follow whatever advice they choose to accept. If a complication

ensues, no particular doctor can be held responsible.

Patients who do ask their primary physicians for a note of referral to another doctor are no better off. Such requests are often taken as a personal insult and evidence of lack of faith or trust in the doctor. Some doctors react by withholding key information, such as detailed notes on surgical operations. The result is often a general breakdown in the harmonious relationship necessary for good patient care.

ship today is some sort of unwritten contract, there were many qualifying notes. Ruth Macklin raises a fundamental question: what kind of contract is it, anyway, if it is both unwritten and unstated? "A contract in which the provisions are not clearly spelled out is not really a contract at all. In a legal sense, it would be considered invalid. From an ethical point of view, how can all parties - physicians or patients - be fully aware of their obligations or, for that matter, their rights? Contracts in the strict sense of the term are (usually)

TAKING A SECOND LOOK

Some opinions on the second opinion

Twenty-eight physicians, ethicists and sociologists responded to a questionnaire on the role of the second opinion in medicine today. Their comments provide the basis for further discussion on this practice, the issues involved, and the ethical complexities in a changing health-care scenario

Sunil K Pandya

The problem is compounded by the absence of clear-cut guidelines on the use of the second opinion. In India, our medical councils have failed to contribute to the discussion, or to regulate the use of the second opinion in any way.

It is in this context that colleagues were asked their opinions on the need for, and use of, the second opinion, by recording the views of respected academicians and medical professionals, one hopes to lay the ground for further discussion on the question. The following essay is an attempt to extract, from the responses received, considered thoughts on some aspects of this issue. Excerpts from the responses have been included to illustrate various perspectives.

Is the doctor-patient relationship a contract or fiduciary relation?

While several medical colleagues agree that the doctor-patient relation-

written documents that spell out the provisions clearly, say what all parties are obligated to do, and also specify penalties or remedies for breach of contract. That sounds very different from the physician-patient relationship, which is perhaps better described as a fiduciary relationship."

Clearly, this question needs further discussion for any systematic understanding of the issue.

And in fact Thomas George holds that it makes little sense to talk of contracts and obligations in our health care system. He would support enforcing the doctor-patient contract, and expecting referral notes from every patient, if we had a structured health care system, "as, for example, in the National Health Service (NHS) in the UK. Borrowing only one part of the system leads to a lot of problems for the patient. At present there is no system at all in India and the patients are completely at sea as to whom they should consult."

The American Medical Association

According to the American Medical Association's code of medical ethics, physicians should recommend a second opinion whenever they believe it would be helpful in the patient's care. When doing so, they should explain the reasons for their recommendation and inform their patients that they are free to choose a physician on their own or with their assistance. Patients are also free to seek second opinions on their own with or without their physician's knowledge.

With the patient's consent, the referring physician should provide any information that the second-opinion physician may need. The second-opinion physician should maintain the confidentiality of the evaluation and report to the first physician, if the patient has given consent. Second-opinion physicians should provide their patients with a clear understanding of the opinion, whether or not it agrees with the recommendations of the first physician.

Where a patient initiates a second opinion, it is inappropriate for the primary physician to terminate the patient-physician relationship solely because of the patient's decision to obtain a second opinion.

In general, second-opinion physicians are free to assume responsibility for the care of the patient. . . . By accepting second-opinion patients for treatment, physicians affirm the right of patients to free choice in the selection of their physicians.

There are situations in which physicians may choose not to treat patients for whom they provide second opinions. Physicians may decide not to treat the patient in order to avoid any perceived conflict of interest or loss of objectivity in rendering the requested second opinion. Physicians must decide independently of their colleagues whether to treat second-opinion patients. Physicians may not establish an agreement or understanding among themselves that they will refuse to treat each other's patients when asked to provide a second opinion. Such agreements compromise the ability of patients to receive care from the physicians of their choice and are therefore not only unethical but also unlawful.

**Council on Ethical and Judicial Affairs: Code of medical ethics.
Chicago: American Medical Association 1997. 191 pages.**

Homi Dastur argues that patients would not accept the enforcement of such regulations. "Very few patients would be willing to observe, accept or even understand (the concept of an unwritten contract), as is evident from the frequency with which those who can afford (to pay the different consultants) will seek multiple opinions. Many patients will reveal that they are under the care of another doctor only after the consultation is over. Sometimes one becomes aware (of the earlier consultant) only after reviewing reports which mention the name of the referring doctor."

Likewise, Bela Blasszauer suggests

that such a contract would work only in theory, for doctor-patient relationships rarely develop in the prescribed manner. "Physician-patient encounters may take many forms. I may bump into the physician. I may have no other choice. I may be shopping for a suitable one. And so on."

Many doctors oppose enforcing contracts because they perceive the doctor-patient relationship as unequal, and liable to be misused by unethical doctors. "I would like to spare the patient the trauma (of having to face a doctor unwilling to refer his patient for a second opinion)," writes George. Blasszauer suggests that such contracts

can generally not be made binding on the patient, since the conditions under which he sought advice or treatment were heavily weighted against him.

Others perceive the relationship differently. Eugene Robin and Robert McCauley suggest that the physician-patient relationship is a partnership and not a contract. "Either (patient or doctor) is free to 'terminate the relationship without cause', with the doctor having the additional burden of informing the patient when this occurs, and remaining available for such time as is reasonable for the patient to find another doctor who will assume responsibility for delivering medical care." This is generally true in the urban US, they state.

Sociologist Rohit Barot suggests that the Indian situation resembles private sector health services in Britain. He has been a patient in the UK National Health Service, as also with private practitioners there, and comments that the doctor-patient contract and the rules of referral seem to apply only in the NHS.

A one-way obligation?

Does the patient have responsibilities as well as rights in this relationship? "The doctor's duties, ethics, standards are well-known in theory and lapses from accepted norms are recognised in practice," writes Farokh Udawadia. "It is equally important (to emphasise) the patient's duties, responsibilities and obligations...It is time for this aspect to be discussed and the discussion circulated, for it must never be forgotten that the doctor-patient relationship is not a one-way street."

Again, this view is a matter of debate. Jagdish Chinappa and Lawrence White argue that the two groups are very different. "The patient is the consumer who has needs based on certain beliefs and attitudes. The doctor is a service provider. Patients, under the stress of their illnesses, should be expected to behave irrationally and inconsistently." Therefore, Chinappa goes so far as to say, "honest and ethical action is there-

fore dependent only on the doctor and has to be decided upon the merits of every case. Certainly, the emphasis on autonomy guarantees a patient the right to ignore a doctor's advice, and to seek whatever opinions are wished: (I believe that this, even though considered a nuisance and counter-productive regarding patient care, is nonetheless a good thing.)"

Likewise, White notes, "Just as it is not an equal relationship in terms of power distribution, vulnerability, etc, so it is unequal with respect to promises on either side... it is generally accepted that patients have the right to do whatever they wish, including shopping for alternative opinions, etc." This does not mean that many physicians like or accept (the practice). "However, to demand otherwise will reinforce the physician's position of power and elitist attitude, which I believe would be a regressive step."

Why doctors should want a second opinion

There are a number of reasons why a second opinion may be sought. Traditionally, general physicians and patients seek specialist opinion and advice with benefit, especially when the disease is uncommon or the patient's condition serious. The patient with a hole in the heart, a brain tumour or failing kidneys will do better in the hands of specialists.

In certain situations a second opinion is almost a 'must'. "Take for example a 'shadow' in the lung of undetermined aetiology," writes Farokh Udwardia. "Is it tubercle, pneumonia, cancer or a rare disease, for example, Wegener's granulomatosis? What is the patient to do about it? In fact, it would be *advisable* to take more than one opinion..."

Christopher de Souza adds that young consultants would welcome second opinions from respected seniors — provided they were sure the patient would return to them for definitive therapy — in order to validate the line of treatment they propose. The senior consultant's concurrence would protect

the younger colleague against unjust accusations and boost the patient's confidence in him.

B N Colabawalla feels that a second opinion may benefit the primary physician in yet another way. "Patients are now increasingly conscious of their rights and it would be improper for any physician to deny the patient his autonomy and right to seek a second opinion. It would be in the interest of the primary physician to make the necessary reference for a second opinion."

Unfortunately, requests for a second

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opinion from other consultants are uncommon. "The practice of referral from primary to secondary to tertiary, or from general physician to specialist remains an ideal not realised," according to M S Valiathan, who has rarely had a primary consultant seeking a second opinion from a senior consultant, or referring a patient to him. In cardio-thoracic surgery, at any rate... a senior consultant usually enters the picture only when the primary consultant fears medico-legal trouble in a given situation."

That is not to say that patients aren't asking for them. One reason why second opinions are relatively uncommon is the absence of any publicly available medical audit. "Patients approach several consultants simply because, at present, they have no way to get authentic information on the quality of services provided by a given consultant or institution," says Valiathan.

Outpatients come to Anil Desai because they are dissatisfied with the information their primary physician gave them, or with the treatment's progress. "I

always request a referral from the family physician, but (find that) many families do not have a family physician."

However, the hospitalised patient is unable to obtain a second opinion without permission from the admitting physician — and even discussing such permission can be a source of stress for the patient and his relatives.

Is the second opinion a right?

All doctors surveyed felt so, though they did not agree on whether there were any limiting conditions. Some, like Blasszauer held that patient autonomy required that it be unlimited: "The patient has a freedom of choice, and even the responsibility... to go to as many doctors as he wishes. It is his life or that of his loved one that is at stake!" This right becomes particularly important with the deteriorating physician-patient relations. "Since trust in the medical profession has been greatly eroded, it is small wonder that patients (and I, myself, too) try to find the person who is up to date in his profession and displays humane features as well. In an open market system, this is no real problem. Even where there is a national health care system it may be cheaper for the system as well, if I can find the solution."

Others would limit that right, mostly to when the physician ignores the patient's wishes. Udwardia feels that "the patient's right to consult another doctor (*independently*) is absolute

The General Medical Council, UK

The General Medical Council (GMC) recommends that patients should continue to see specialists only on referral from a general practitioner. The GMC has strongly defended the referral system as a proven feature of medicine in the UK. Specialists should not usually accept a patient without referral from a general practitioner. The referral system is seen as the best way of ensuring that patients see the right specialist.

*General Medical Council News, Spring
1997, pages 1-2.*

when the treating physician refuses to allow another opinion in spite of the patient's request; is clearly disinclined or procrastinates unduly in granting permission to seek a second or third opinion, more so when the patient's condition is not improving or is, in fact, deteriorating; when he reacts with anger or displeasure to a request for another opinion, and the patient feels that he now no longer receives the care he expects and needs.

"Also, when the problem ... is of serious, unsolved diagnostic import (the patient) has an absolute right to seek as many opinions as he wishes. However, the physician, should caution the patient that ... too many opinions would only confuse and harm the patient."

But there are limits to this right, according to Udwadia. "It would be unjustified, in bad taste and bad manners if he seeks fresh medical advice of his own accord when already under treatment for an ailment for a considerable length of time by his primary physician. He should not seek a consultation with a new practitioner without permission and a referring letter from the primary physician. If the patient is dissatisfied, for whatever reason, with the primary physician, he should have the gumption to tell him so and inform him that henceforth he proposes to get treated elsewhere. This ... absolves the primary physician from further care of the patient. It is not uncommon for many patients to surreptitiously see many doctors (as if to test the primary physician's management), and then quietly go back to the primary physician without the latter even being aware of this duplicity."

Why don't patients tell doctors that they're 'double checking'?

Why do patients behave 'dupliciously'? P. K. Sethi and Colabawalla see the reason in the behaviour of most doctors. "In practice this (request by a patient for a second opinion) seldom happens because the public has an apprehension that I may be annoyed. It is we, as a profession, who should work towards dispelling

this impression. We have not done so," writes Sethi. He holds that patients are justified in breaking their contracts if physicians are rude at the mention of a second opinion. And it is "morally, ethically and possibly even legally unjustifiable" for medical professionals to withhold information and case history details, either from the patient or the second opinion physician.

How should it be done?

Under the UK's National Health Service, only the primary physician can refer a patient for a second opinion, writes Blasszauer. The physician must make the request in writing and provide all relevant medical details. In return, he obtains in writing the diagno-

"Hospitalised patients wanting second opinions from outside doctors must first get themselves discharged," writes Prakash Tandon

Sis 'made by the consultant and his advice on treatment.

But this is rarely done in India, writes Thomas George, pointing out that patients rarely go up the primary, secondary and tertiary levels of care. Samiran Nundy notes that most patients in India do not have a doctor they can call their primary physician.

V. R. Joshi points out that even the most punctilious of consultants would find it hard to enforce such a protocol. "Patients often travel long distances from other cities or states to reach you. It is only when they reach your office that they are made aware that a referral note is required."

"Having come after seeking an appointment, I cannot refuse to see them just because they have no referral note," writes P. K. Sethi. "If, however, I discover that the patient is admitted to a local hospital and has come to me with-

out informing the treating doctor, I ask him to go back and bring a referral note. I *feel this is in the interest of the patient and also conforms to the code of medical ethics... The advice is often not implemented."

But it is not always possible to get a letter from the first doctor, feels Arunachalam, giving the patient's side of the story. He may be unavailable, or the patient hesitates to inform him, afraid the request would spoil relations. In fact the second opinion is often most needed when the patient is in the hospital — and least able to take an opinion without the admitting doctor's cooperation. Desai has always helped patients under his care obtain a second opinion without his physical presence, giving them full access to his case notes and the help of his house physician. On the other hand, if they seek a joint consultation — something Desai may also sometimes find necessary — he reserves the option on which consultant should be called in. There are also times when he recommends a joint consultation with the patient and relatives.

This is not always the practice. "We do not permit second opinions from outsiders under any condition," writes Prakash N. Tandon, arguing that the second opinion can only be used ethically within a structured format. Patients wanting such opinions must first get themselves discharged from the hospital. "Every patient discharged from our ward, either by us or at his request, is given a discharge summary with full information on the various investigations carried out, a copy of the operation note, our final diagnosis and condition on discharge. The patient is at liberty to use this information for whatever purpose he wishes." Tandon's hospital does not provide the patient copies of X-ray films and other imaging tests, but sends them directly to the consultant if asked.

Tandon argues that the patient's interests are met through multiple internal opinions. "Every patient admitted to our wards has the benefit of the collective opinion of the whole team which includes several senior consultants. By

tradition, every patient is jointly discussed on more than one occasion.

"Permitting a second opinion from outside would create administrative problems on the one hand and a difficult clinical situation." For example, he asks, what if the second opinion was at variance from the first opinion? Who would implement it?

"As a corollary, we refuse to provide a second opinion on patients admitted to other hospitals unless it is formally sought by the person treating the patient and with the permission of his administration. For purely administrative reasons, this is limited to public hospitals. The opinion is given to the treating surgeon and not to the patient or the family. At times, a joint meeting held with the family is addressed by the treating surgeon and ourselves."

White disagrees with such a practice. "If a doctor does this, it strikes me that there is a component of spite and petulance arising out of the doctor's own needs. Patients, particularly if seriously ill, often feel the need to validate their doctors' opinion; after all, it is their life in the balance. Further, there are often enormous pressures from friends and relatives to get 'another opinion'." In other words, the second opinion can be taken for many 'ethical' reasons.

Robin and McCauley add, "If the primary physician learns that the patient is following advice not consistent with his principles of treatment, the doctor should advise the patient of the difficulty/danger as best the doctor sees it...It is the patient's choice how to proceed. The doctor can be held responsible only for his own errors, not those of others."

"If the patient is already admitted to hospital under another consultant, I would under no condition see the patient unless specifically asked to do so by the treating consultant," writes Udwardia. "This would apply even if the patient concerned has been previously under my care for several years."

"In the initial stages, before starting on a course of treatment, a patient may

seek multiple advice," says Mr Harsh Sethi. "But once treatment has started, then a new doctor should not accept a patient without a note of referral from the first doctor (provided he knows that the patient has been under treatment). At the last, he should speak to the first doctor and seek concurrence."

The unreferral approach

What does one do when a patient seeks a second opinion without obtaining a note of referral from his primary physician? Macklin does not see this as a dilemma. "If a patient approaches you, seeking a medical opinion (whether it is a first or a second opinion), the patient is in need of diagnostic or therapeutic attention. You can decline to form a relationship . . . or accept the patient in your care and thereby establish a new doctor-patient relationship."

Most respondents feel that it is the duty of the second physician to see the patient even without a note of referral from the primary physician, though such a note is desirable.

S. H. Advani adopts a firm stand. "I am absolutely clear in my mind regarding the patient and doctor relationship. In this relationship, the patient has the major say. It is the patient who is going to receive the treatment and he has to make sure that he receives the best treatment. I give my frank opinion to the patient (whether or not he comes with a letter from the primary physician) because I strongly believe that the patient has the right to take a second opinion. I don't want the letter from the primary physician to participate in the second opinion."

Ashok
Bhanage

emphasises that the doctor must work at all times with the patient's interests at heart. "If I realise that I am the second consultant, I write my notes in more detail and elaborate the reasons for my decision. The patient is at liberty to show this note to the first or a third consultant."

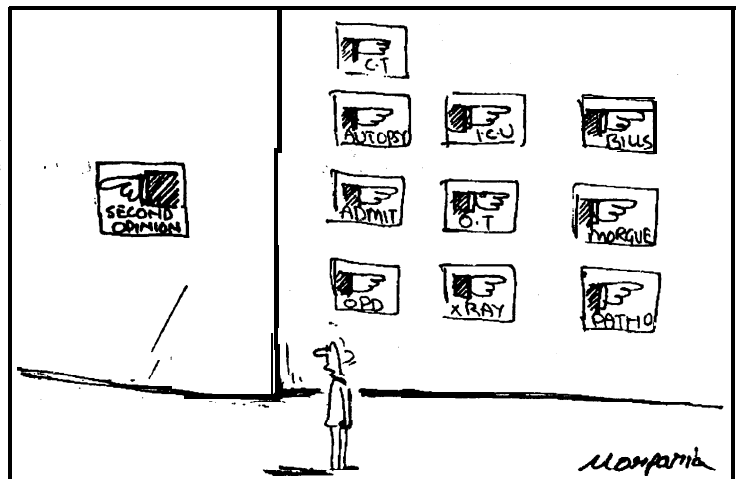
Aniruddha Malpani emphasises that the autonomy of the patient demands that a second opinion, should be provided. A letter from his primary physician is not necessary. "My relationship is with the patient and I am answerable to him, not to his primary doctor."

Taking over the patient

Would you take over treatment of a patient already under the care of another consultant? This is one fear physicians have when referring their patients to their colleagues.

Some might argue that this is the patient's prerogative. Arunachalam notes, "If I have changed doctors, I will certainly expect the second doctor to take full responsibility in treating me. If I consult more than one doctor (for getting opinions), I will retain the right to decide by whom I should ultimately be treated."

Others are unequivocal: "If I find out that the patient is under the care of another consultant, I advise him to go back to that consultant," writes Gajendra Sinh. "I do not take over treatment of these patients."



On the principle that a patient has a right to autonomy over his decisions, most respondents see no difficulty in taking over the patient's management at his express request — provided such a step is in his interests.

However, Homi Dastur adds, "The suggestion to take over medical care would, at no time, come from me. It would have to be broached by the patient's general practitioner, if present, and the patient himself. Acceptance would follow only **when** persuasion to return to the primary physician fails."

Advani differs. "The patient has the absolute right to be treated by the physician of his choice. If the patient decides to be treated by me, I would not normally hesitate to accept. I may inform the primary physician, though I don't consider this obligatory."

Blasszauer argues that the doctor must

Bypassed physicians may tell a seriously-ill patient that they do not wish to have anything further to do with their medical care

was incompetent, mistaken, negligent, or in some other way not acting in the best interest of the patient. Patients need physicians who seek to act in their best interest. Physicians owe more to the patient before them than they owe to other members of their profession. Even if 'physician etiquette' dictates that one doctor should not treat another doctor's patient, medical ethics demands that patients receive the best medical care. Notes of referral and reluctance to treat patients under the care of another doctor are elements of physician etiquette, not medical ethics as understood today."

Barot feels that the second consultant is duty-bound to approach the primary physician for all relevant medical information on the patient.

Colabawalla outlines his approach: "If I am aware that the patient has been under the care of another colleague, I will offer my opinion and leave the choice to the patient. I would not 'take

over' the case by ascribing to myself the arrogance that I know better! I **would then** try and persuade the patient to allow me to discuss the case with the primary physician.

"The difficulty arises when the patient unequivocally informs you that he does not wish to be treated by the primary physician, and requests you to take over the management. I would try to resolve that dilemma -- not that any dilemma can ever be resolved -- by accepting that the patient's autonomy and right to choose must be respected."

"If the patient is being looked after correctly I would persuade the patient to return to his consultant," writes Udawadia. "If the patient's problem has been wrongly diagnosed and if it is critical or life-threatening (e.g. a dissecting aneurysm of the aorta or an impending myocardial infarction), I would admit him to hospital under my care, inform the primary consultant and request him to see the patient in hospital as and when he wishes, so that we can jointly look after him."

The dangers of mixed therapy

Some patients will see several physicians to obtain a clutch of prescriptions, selectively following that advice which suits them. How can we help such patients avoid the complications that may follow?

Udawadia has seen patients who have gone through half a dozen or more physicians. "This is not uncommonly revealed to me at the end of the consultation! I ask that the treatment advised be carried out under the supervision of any one doctor of the patient's choice, as I would be unable to follow-up on his problem as often as I would like to. I then write a letter to that doctor, outlining what I feel about the patient's problem and how, in my opinion, it should best be tackled. (Finally,) I tell the patient that if he wishes to see me again he will now have to get a letter from this doctor."

White agrees that selectively following advice offered by several physicians

is courting trouble. "These are difficult situations, and in my opinion there is no one right answer. If I have a patient who is 'mixing and matching', I gently tell him he is receiving fragmented care, and that this is dangerous. Usually I tell the patient that I wouldn't continue management without a clear mandate. I feel strongly that patients have the right to several opinions, but that one doctor must quarterback the actual care. If he should suffer a complication, which of his medical attendants would be held responsible?"

And the state of the bypassed...

Many feel that the primary physician is justified in terminating his relationship with the patient. Valiathan sums up this sentiment: "The primary physician is not obliged to treat a patient who consults another physician or follows another line of treatment without his knowledge. When a doctor undertakes to take care of a patient he accepts a sacred contract with obligations on both sides. I do not agree that the doctor must take care of a patient 'under any circumstance'. Even Charaka, who imposed many strict conditions on the physician, **recognised** situations when a physician can terminate his sacred contract."

At times, the bypassed physician feels rejected and acts accordingly. Sometimes a seriously ill patient is told, "You have decided to consult X without informing me. I do not wish to have anything further to do with your medical care. Please go back to X."

All our experts frowned upon such behaviour. White writes: "Under these circumstances, the doctor's behaviour would be considered patient-abandonment. I would consider it a breach of ethical standards on grounds of beneficence, non-maleficence, fidelity to patient, and respect for patient's autonomy. What would be the physician's reasons for wanting to do this? The relationship starts out unequally, with the doctor having more power. This is counterbalanced, in my opinion, by the greater responsibility of the doctor, who

needs to put **his needs** and wants aside and honour what is both a contract and a covenant. This is a critical issue - the physician's failure to put the patient's needs ahead of his own."

Colabawalla writes that the physician should "gracefully end the 'contract... in his own interest" if he feels that he has lost the patient's confidence "for whatever reason".

Barot strongly feels that the primary physician must pass information about the patient to the consultant or whoever else the patient may have chosen to deal with on health matters. The underlying ethic is that the primary physician should provide all necessary information as it concerns the patient's health (potentially a question of life and death).

Blasszauer agrees. "The primary physician should not shed his responsibility to the patient without clarifying his patient's motives," he writes. "The physician should . . . understand: he may have failed the patient; the patient may be out looking for hope, or proof that his doctor's diagnosis is right or that the recommended therapy is the only solution. If he cannot find the answer for his patient's motives, than he should sit down with the patient and have a frank discussion. If he sees that the patient had no ground whatsoever to abandon him, he may advise the patient to look for another physician, since without trust no such relationship could be beneficial. But until that moment, I believe, he does have some responsibility. The patient should not fall between two stools. The primary physician should be available till he -- on acceptable grounds -- terminates the relationship 'officially'. An insult to my vanity is not an acceptable ground."

Gajendra Sinh concurs with the need for reform within the profession. "Unless we put our own house in order it is difficult to see how we can restore the doctor-patient relationship."

Will a second opinion clinic work in India?

In Australia, a group of consultants from different disciplines offer counsel on the clear understanding that they will not takeover the patient's medical management. Would such a clinic work in India?

"It is fairly common in the U.S., in this connection, for a patient to be referred to a second physician for a decision about, say, the desirability of hysterectomy," write Robin and McCauley." The ground rules here are that the consultant will not be involved in the surgery; is not affiliated with (preferably doesn't even know) the treating doctor; and is paid the same, whatever his opinion. As you may imagine, this system has its own flaws and a long essay could be written about the good and bad aspects of this practice."

Several respondents felt that such a clinic has little chance of success. Chinappa holds that it could not work in "an unorganised health care facility like that in India. You need a high level of education in the patient and a high level of ethical and moral integrity in the medical profession for this system to work."

Teachers and colleagues who offered their views:

Dr. S H Advani, chief, department of oncology, Tata Memorial Hospital, Mumbai

Dr. Subbiah Arunachalam, visiting professor, department of humanities and social sciences, Indian Institute of Technology, Chennai

Professor Rohit Barot PhD, department of sociology, University of Bristol, UK

Dr. Ashok Bhanage, consultant neurosurgeon Shivajinagar, Pune

Dr. Ravi Bhatia, consultant neurosurgeon Apollo Indraprastha Hospital, New Delhi

Dr. Bela Blasszauer, medical ethicist, Medical University of Pecs, Hungary

Dr. H B Chandalia, consultant endocrinologist, Jaslok Hospital, Mumbai

Dr. Jagdish Chinappa, consultant paediatrician, Manipal Hospital, Bangalore

Dr. B N Colabawalla, consultant urologist, Mumbai

Dr. Homi M Dastur, consultant neurosurgeon Jaslok Hospital, Mumbai

Dr. Anil D Desai, consultant neurologist, Jaslok Hospital, Mumbai

Dr. Christopher de Souza, consultant E.N.T. surgeon, Holy Family Hospital, Mumbai

Dr. Thomas George, consultant, Orthopaedic Hospital, Railway Hospital, Chennai

Dr. V R Joshi, consultant physician, Hinduja Hospital, Mumbai

Dr. Ruth Macklin, medical ethicist, Albert Einstein College of Medicine, New York, USA

Dr. Aniruddha Malpani, consultant in assisted fertility, Mumbai

Dr. Bashir Mamdani, professor of medicine, Cook County College of Medicine, Chicago, USA

Dr. Meenal Mamdani, professor of neurology, Chicago, USA

Drs. Eugene Robin and Robert McCauley, medical ethicists, USA

Dr. Samiran Nundy, consultant gastrointestinal surgeon Gangaram Hospital, New Delhi

Mr. Harsh Sethi, associate editor, *Seminar*, New Delhi

Dr. P K Sethi, consultant orthopaedic surgeon, Jaipur

Dr. Gajendra Sinh, consultant neurosurgeon Jaslok Hospital, Mumbai

Dr. Prakash N Tandon, professor emeritus of neurosurgery, All India Institute of Medical Sciences, New Delhi

Dr. Farokh E Udawadia, consultant physician, Breach Candy Hospital, Mumbai

Dr. Lawrence W White, medical ethicist, Berkeley, California, USA

Dr. M S Valiathan, vice-chancellor, Manipal Academy of Higher Education Manipal

Colabawalla adds that the idea is good, but "I doubt if it will ever be welcomed by most professional colleagues. There will always be the doubt that patients would be misappropriated." Also, most medical professionals in India think they are too good to be challenged thus.

Udwadia agrees. "You require a general improvement in ethical standards for this to come about. When this does happen, specialist clinics for second opinions would be redundant."

Bhanage expresses some hesitation: "It is virtually impossible to get a genuine second opinion in private practice where even the most senior doctors are very insecure and distrustful of their colleagues. A second opinion clinic will have to be manned by a senior doctor with a reputation for integrity.

White sees a similar problem in the US. "Medicine here has rapidly become a market commodity (unfortunately, in my opinion). A physician's income often depends on 'capturing market share' from other physicians. Thus physicians and hospitals engage in extensive marketing and advertising, to 'steal' patients from others."

Can a member of the clinic reject the patient's request for treatment after he has attended the clinic?"

Hemraj Chandalia feels that if a patient insists he be followed up by the new consultant, "I will not deny the patient such an option."

Bhanage cautions: "The medico-legal role of such a clinic will have to be defined. I feel it will be predominantly used by dissatisfied patients. Once it is seen by doctors as a forum used by patients to obtain evidence against them in a court of law, its role will shrink to this purpose only."

My own comments:

My professors in medical ethics -- Drs. H. S. Mehta and H. I. Jhala -- taught me the procedure to be followed when referring a patient for a second opinion: a formal referral through a tele-

phone call making the appointment and a confirmatory note also carrying a report on the patient's medical history, findings and precise reason for referral. I believe it can only work in the patient's best interests. This practice, was routine in Bombay some decades ago. It can function with the strengthening of the role of the family physi-

By providing certificates when its experts are convinced, the clinic can help patients as well as ethical doctors and testify on their behalf

cian.

I fully agree that the consultant must send the patient to the referring physician with a full report on diagnosis and advocated treatment. Taking the patient over when the referral was for an opinion is unfair, immoral and unethical. However, where surgery is indicated, the referring physician must always choose the surgeon based on the single criterion of competence.

I recognise the need for patients to obtain a second opinion, especially when a potentially hazardous form of treatment such as surgery is advocated. Towards this end, a second opinion clinic is to be welcomed, provided the clinicians categorically state that they will not take over the patient's treatment.

Unlike Dr. Bhanage, I strongly support an additional medico-legal role for those working in this clinic. Current regulations require that the aggrieved patient seeking redressal from a court obtains two independent medical certificates on the validity of his claim, without which the case will not be admitted for hearing. Most doctors are reluctant to provide such certificates. By analysing the patient's case dispassionately and providing such certifi-

cates when its experts are convinced that a valid case has been made, the clinic can help patients who have suffered from medical negligence or malpractice. It can also support and help doctors who practice ethically and conscientiously by testifying on their behalf, thus helping frustrate frivolous or malicious litigation and restore the fair name of the victimised physician.

I remain unsure on whether I should treat a patient who is under the care of another neurosurgeon in Bombay, without a referral being made to me. Whilst I recognise the autonomy of the patient, I am also concerned about the motives and outcomes of the current fashion for doctor-shopping. I often see patients obtain contradictory advice, experience

delay in treatment, ending up confused and impoverished. I make every attempt at guiding the patient back to the original consultant.

Of late we have unreservedly accepted patients who have come to the K. E. M. Hospital because they cannot afford treatment in a private hospital. This seems to be an ethically valid ground for taking over even without a referral.

The clinician refusing to refer a patient elsewhere deserves censure. He would be well within his rights to terminate his relationship with the patient even as he writes a detailed note of referral. As has been stated effectively above, the interests of the patient must gain precedence over his own feelings.

I am sorry that the doctor-patient relationship - one that should be imbued with trust, friendship and an urge to help - has degenerated into mere commerce. I have had the good fortune of experiencing the ideal doctor-patient relationship during my childhood and youth and can only wish that we do all we can to restore it.

In the next issue we will carry responses to this discussion. Those interested can send their comments as early as possible.