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Published in:
JAMA oncology

DOI:
10.1001/jamaoncol.2018.3495

Published: 01/01/2018

Citation for pulished version (APA):
Hillen, M. A., Woei-A-Jin, F. J. S. H., Smets, E. M. A., van Maarschalkerweerd, P. E. A., van Laarhoven, H. W. M., & Sommeijer, D. W. (2018). Assessment of Challenges Encountered by Dutch Oncologists When Patients Ask for Second Opinions. *JAMA oncology*, *4*(10), 1425-1426. https://doi.org/10.1001/jamaoncol.2018.3495

Letters

RESEARCH LETTER

Assessment of Challenges Encountered by Dutch Oncologists When Patients Ask for Second Opinions

Many patients with cancer seek second opinions to reconfirm their diagnosis, acquire more information, or receive better treatment.[1] The desirability of a high rate of second opinions has been much debated. Proponents stress potential health gains, improved acceptance of initial diagnosis, and reduced anxiety for patients.[2] Critics emphasize the limited clinical value,[3] potential treatment delays, and financial and logistical burdens for the health care system.[4] The triadic nature of second-opinion consultations, involving 2 physicians and 1 patient, can further complicate communication and induce emotional sensitivities. This study investigates the challenges cancer specialists encounter when confronted with second-opinion requests.

Methods | A data-driven constant comparative method was used to prevent bias by existing literature or theory. In the Netherlands, second opinions are fully covered by insurance with a referral by any physician. Medical files are only transferred on patients' explicit request. Twenty-six Dutch medical oncologists and hematologists were interviewed from November 4, 2016, to April 5, 2017. Purposive sampling was used to create variation in hospital setting and working experience.[5] In-depth, semistructured, in-person qualitative interviews (30-60 minutes) were conducted by 1 of us (M.H.). The interview protocol explored clinicians' recent experiences with second opinions, focusing on self-reported behaviors and emotions regarding providing a second opinion (easy/challenging aspects, consultation approach, communication with/about colleagues, and outcome and back-referral), and referring for a second opinion (easy/challenging aspects, response to patients' request, and communication with the second-opinion consultant). During data acquisition, the interview protocol was refined based on initial analysis. Recruitment was terminated when data saturation, defined as 3 consecutive interviews yielding no new information, was reached.[6] The study was approved by the institutional medical ethics review board of the Academic Medical Center, Amsterdam, the Netherlands, and oral informed consent was obtained from all participants.

Interviews were fully transcribed anonymously and entered in MAXQDA, version 12 (Verbi Software). Analysis was conducted by 2 of us (P.vM. and M.H.) to incorporate researcher triangulation,[5] concurrently with data acquisition. First, transcriptions were independently coded (open coding). Codes were compared and discussed until consensus was achieved. Finally, codes were grouped by theme and hierarchically organized (axial coding). Data triangulation was ensured by seeking disconfirming evidence in the data. As is customary in qualitative research, all findings were substantiated by the most representative quotes, not by numerical data (**Table**).

Table. Quotations Substantiating Cancer Specialists' Responses

Quotation No.	Quotation
Responses to Second-Opinion Requests	
Q1	"For the sake of the relationship with your patient you'll never stand in their way. So I'll just refer them." (F, 49 y)
Q2	"Sometimes I offer it as an option.... Because I think the act of offering it will get me a little extra trust." (M, 38 y)
Q3	"I always tell them that 'yes, I am totally prepared to arrange it.' But I sometimes add that it honestly has zero-point-zero value." (M, 46 y)
Q4	"I can remember people where I was thinking, 'What the heck is this?! I'm doing the impossible.... I've been keeping you on track for years....'" (F, 55 y)
Q5	"So I said, '...[Y]ou sought, without asking or informing me, a second opinion from someone who passed judgment without even having your medical file.... Now you got confused, and you have yourself to blame for that.'" (M, 57 y)
Conducting Second Opinions	
Q6	"Being the doctor providing the second opinion, I feel more powerless [when I have to confirm that nothing else can be done] than when dealing with my own patients. You can't offer nearly the same emotional support." (F, 55 y)
Q7	"If what [the referring oncologist] did was correct, which is almost always the case, then it's my priority to help patients regain trust.... I spend extra time on that." (M, 40 y)
Q8	"For me, emphasizing the referring doctor's competency also facilitates [back-referral and] not having to take over treatment of the patient." (M, 65 y)
Q9	"If there are several ways to Rome, I just try to take [the referring physician's] way. Because otherwise it's just confusing for the patient." (F, 52 y)
Q10	"I think you should be very careful not to immediately say, 'What on earth did that doctor do...?' In these cases, I think you should be very nuanced." (F, 43 y)
Q11	"The difficult ones are where I feel that the other doctor is doing something totally wrong and I believe I should intervene.... Because it means I will make that person look like a fool." (M, 65 y)
Q12	"I called [the second-opinion consultant]. I said, 'How in heaven's name can you provide a second opinion [without a complete medical file]...?!'" (M, 57 y)
After the Second Opinion	
Q13	"Any distrust toward me from the patient's side will be gone afterwards. Like, 'Okay, I got it now. The second-opinion consultant told me [Dr X] knows his stuff and completely agreed with him.'" (M, 45 y)

Abbreviations: F, female cancer specialist; M, male cancer specialist; Q, quotation.

Results | After 26 interviews, data saturation was established. Of the 26 cancer specialists interviewed, 14 (54%) were female; the mean age (range) was 47 (35-65) years.

All specialists interviewed reported that they cooperated with patients' requests for second opinions, although they frequently doubted the added value. They recounted various response strategies, including referring patients to prevent damaging the physician-patient relationship (quotation 1 [Q1], Table); proactively offering the option of second opinions, hoping this would enhance trust and obviate patients' need for the

actual opinion (Q2); and trying to convince patients to reconsider the request (Q3). Feelings of insecurity or offense were reported only when respondents had already committed themselves deeply to patients' treatment (Q4) or when patients had arranged a second opinion without informing them (Q5).

Specialists who provided second opinions struggled with feelings of helplessness toward patients if their opinion was in accordance with the first opinion and they thus took away the patient's hope (Q6). Moreover, respondents struggled with patients' unwillingness to be referred back to the first specialist after the second opinion. To reduce patients' reluctance, they actively tried to restore trust in the first specialist (Q7, Q8). Respondents were hesitant to communicate minor discrepancies with the first opinion to patients, fearing this would harm the patients' trust in the referring specialist, their own relationship with their colleague, or both (Q9, Q10). When differences in opinion were conveyed bluntly between the 2 specialists involved, this resulted in tension or anger (Q11, Q12).

After back-referral, most referring specialists perceived that the physician-patient relationship had strengthened. Especially when both opinions aligned, patients gained acceptance, certainty, and trust (Q13).

Discussion | The second-opinion process is complex and places great demands on the communication skills of medical specialists because of the emotions involved, especially when the attitudes they wish to convey conflict with their true beliefs and emotions. The physicians must balance objectivity with diplomacy to avoid harming their relationship with their patient or colleague. Interpersonal sensitivities between physicians and patients or colleagues may be managed by explicitly ascertaining patients' motivations and expectations, both when conducting and referring patients for second opinions.

Although respondents in this study may not have been fully open about their personal experiences (a potential limitation of this study), the range of emotions identified suggests that acceptable candor was achieved. Addressing the identified challenges in medical training may improve the second-opinion process and enhance collaboration among medical specialists. Our research indicates that although some physicians believe they are often unnecessary, second opinions can strengthen the physician-patient relationship after back-referral. Future research incorporating subjective and objective outcomes of second opinions should further establish their value.

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Accepted for Publication: June 5, 2018.

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Published Online: August 23, 2018. doi:10.1001/jamaoncol.2018.3495

Author Contributions: Dr Hillen had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.
Concept and design: Hillen, Smets, van Laarhoven, Sommeijer.
Acquisition, analysis, or interpretation of data: Hillen, Woei-A-Jin, van Maarschalkerweerd, van Laarhoven, Sommeijer.
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Critical revision of the manuscript for important intellectual content: All authors.
Statistical analysis: Hillen.
Obtained funding: Hillen.
Administrative, technical, or material support: Hillen, Sommeijer.
Supervision: Woei-A-Jin, Smets, van Laarhoven.
Coding data: van Maarschalkerweerd.

Conflict of Interest Disclosures: Dr van Laarhoven reported serving in a consulting or advisory role for Eli Lilly and Company and Nordic Pharma and receiving research funding from Bayer, Bristol-Myers Squibb, Celgene, Janssen, Eli Lilly and Company, Nordic Pharma, Philips, and Hoffmann-La Roche. No other disclosures were reported.

Funding/Support: Financial support for this study was provided by grant UVA 2014-6671 from the Dutch Cancer Society (KWF Kankerbestrijding) (Dr Hillen).

Role of the Funder/Sponsor: The Dutch Cancer Society had no role in the design and conduct of the study; collection, management, analysis, and interpretation of the data; preparation, review, or approval of the manuscript; and decision to submit the manuscript for publication.

Additional Contributions: We thank all of the respondents for their willingness to openly share their experiences.

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