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A place for a second opinion in the field of surgery

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The modern field of surgery is undergoing a deep transformation due to technological innovations and changes in the doctor-patient relationship. Furthermore, the "cultural identity" of the general surgery specialty is subdivided and phragmented into many subspecialities, with the impending risk of serendipitous and uncoordinated approach to the problems. While the concept is a general "must" in medicine and surgery, there are specific cases in which its understanding, endorsement and compliance are mandatory. In the field of surgery, there is an increasing need to inform doctors about the fundamental role played by the second opinion leading them to its full understanding and acceptance. This institution should be planned and managed by every National Health Service, in order to offer a clear-cut problem-solving opinion about the complex unresolved health problems which may occurr especially in the old age. Furthermore, a second opinion service can also be offered by private medical facilities and online services given that the physicians and allied health professionals possess an outstanding ethical and cultural pedigree and are surrounded by adequate consulting structures and network.

Key words: Patients - Referral and Consultation - General surgery.

Day by day we all are bystanders of the increasing progresses and chances in Medicine and Surgery strongly imprinted by technological innovations. Educational information reaches the physicians through the proper multimedia channels, but also through proposed, sometimes imposed, definite "guidelines". They can safely apply to routine surgery, but they are not always suitable to a complex and unclear situation. Before any surgical intervention, the patient is often asked to sign an informed consent, a sort of agreement with his surgeon that guarantees adequate benefits only after operation recovery. The surgeon is usually chosen on the basis of his good reputation, qualifications or after a general practitioner's advice. The widespread use of self-downloading information directly from the web, if not adequately moderated by a medical counsellor, makes the patient feel confused, leading to the development of the "Web Babel Syndrome".[1, 2] The subsequent harmful psychological consequences, such as anxiety, frustration, depression, or "compensation syndrome", due to the interim low level quality of life and a few possibilities of a quick recovery, can cause unsuccessful surgical outcome.[3] Many authors suggest to apply for diagnostic, but especially therapeutic preliminary second opinion to verify the best healing chances and options. In fact, the surgical diagnosis usually follows many endoscopic, imaging, bioptic steps to achieve adequate illness staging and surgical strategy.[4-24] Actually, the role of the clinical pathologist is quite emerging and relevant due to his ability to relate clinical data to the histological evidence of each individual disease. In fact, an integrated consultation among all the different specialists and departments involved, will give the best chances of successful diagnosis and treatment, as it happens in several "Breast Units" of the main hospitals. This should not be interpreted as a lack of the doctor's decision-making capacity; conversely, it should be considered as a previous strategy to increase and ensure each single doctor's decision, and reduce unnecessary investigations simply by sharing single experiences. As a matter of fact, nowadays, the "cultural identity" of the general surgery specialty appears phragmented into many sub-specialities, with the impending risk of serendipitous and uncoordinated approach to the problems. The new specialist, or the new "sub-specialist", working in a specific field, often drops out definitely from the "common trunk" of general surgery. His professional training and choices can be affected and influenced by extrinsic factors that force him into a "one-way tunnel", with only few chances for discussion and brainstorming with other experts. His acquired technical skill can be negatively balanced by a passive acceptance of the statements of guidelines, without realizing the relevance of criticism and a multiperspective case revision. The diagnosis and especially the therapy are clearly the results of different crucial factors, derived from many sources of in-

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formation (meetings, journals, interpersonal relations with other specialists, professional experience, etc). All these factors deeply influence the physician's "modus operandi". Therefore, the physician should keep himself in his firmly-held beliefs in his field of action, but with a progressive differentiation and evolution.

Clinical cases that should require a second opinion

The mitral valve failure requires, at the proper stage, a surgical treatment. The old technique of commisurotomy, with its limited indications, has left place to the procedure of mechanical replacement according to a largely confirmed experience. Most recently, many techniques of plastic surgery have been proposed insistently. Bioprosthetic valves are mostly adopted and the surgeon must consider at least three therapeutic possibilities. As it is almost impossible for the surgeon to be expert in each therapeutic technique, he could correct his opinions through a self-critical procedure and consult other surgeons, who could have done a real controlled experience in a very careful way so that, in case of ineffective surgical outcome, the cardiac surgeon could have a second chance. In the case of a therapeutic choice for a duodenal ulcer, the surgical indication is usually forwarded by the gastroenterologist, perhaps endoscopist himself. At first, the gastroenterologist, the endoscopist and the family physician will face the problem that in the end will be left in the hands of the surgeon, who is not always able to object to the decision already taken. He must deal with many technical decisions and make a choice between the classical gastro-duodenal resection or the latest vagotomy. Up to now, only few surgeons have been able to experience these different surgical techniques and control the results of both procedures. In case of unsuccessful surgery, due to an improper and negative outcome following partial gastrectomy for a simple duodenal ulcer, the gastrointestinal surgeon can only share his therapeutic failure with his colleague gastroenterologist. For a hospital treatment of the mid rectal cancer, where oncologist, surgeon and radiotherapist are protagonists, a pre- or post-operative radiotherapy can be suggested, even joined to chemiotherapy, a very appealing option especially for the oncologist and radiotherapist. The surgeon will be entrusted later. Different surgical techniques can be applied: total or sub-total protectomy, with or without colonic reservoir, temporary protective colonic or ileal diversion, iliac lymphadenectomy, etc. Each of these therapeutic solutions runs a risk, which will be verified in the post-operative period or later. Who is appointed to control them and why? How could they influence the final result achieved after a complete recovery from a neoplastic disease? What does the patient's decision power consist in, if he is unaware of the disease risks and advantages of each treatment?

The chances of a therapeutic strategy failure are impending and the final result will be a recurrent disease. The surgeon will be held responsible for his action and there will be no way of improving the unpleasant and difficult situation. A warning against hyper technology comes from surgical laparoscopy, nicknamed "keyhole surgery" in the medical slang expression. It has been strongly promoted by the industries which are involved in producing surgical equipment and have the financial monopoly. The young surgeons are therefore primarily addressed towards the laparoscopic surgery, without any adequate previous training in general open surgery to face complications. Moreover, the hospital governors enclose the single day or even an hour of the patient's stay in the surgery cost analysis. In this way the main aims and objectives are postponed to financial priorities, mismatching, especially in the oncological field, the palliative with the radical therapy. Unfortunately, it also happens in a surgical treatment where a second repairable procedure is impossible. Therefore, we highlight the necessity of a continuous medical education that always promotes a useful integrated exchange of general clinical knowledge and technological skills among different specialties. Moreover, the surgeon must take decisions, often irrevocable, basing on his personal experience and using his own initiative. His professional behaviour is a summary of his university studies, experiences, advice and training courses, whose efficacy must be proved. Finally, we must consider the psychological, scientific and financial pressure exerted by health care industries which bring the clinical research into profit. The patient, alone or supported by his family or by his doctor often chooses the nearest hospital, but the happy outcome of his decision will be postponed until the end of the surgical pathway. Today, the progressive division of each specialty into smaller "subspecialties" makes this choice more and more difficult, also considering the strong influence of the mass media. The probability of a mistake is directly connected to the number of choices of each algorithm and the number of doctors involved in the operation. In fact, the diagnostic and therapeutic algorithm defining every surgical disease encloses a variable number of specialists and a definite surgical branch. They have to be chosen carefully on the basis of each one's professional skill, but it is also very often modified by suggestions, advice, advertising, web news and not often definitely acquired new technologies and strategies that force the surgical candidate into a puzzle that can become a labyrinth.

Discussion

We should keep in mind that clinical medicine is the science of each particular case and that the lack of success can engrave the doctor's mind more than many positive results. Therefore, it follows that the situation is rather grim since there is always the chance that something goes wrong. The Italian medical tradition has been addressed to be individually tailored in a dialectic perspective of each diagnosis and treatment. This intellectual criticism should be supported by a large comprehensive basic, rather than specialty based, holistic approach, inspired by the European philosophy from Socrates to Hegel. The modern technologies of phisiopathological monitoring and imaging might be very helpful to support the integrated decision making algorithm which cannot be exclusively computer- and web- dependent. It must also take into account the doctor-patient direct relationship, with a formal empathic interview that answers the many queries and copes with the patient's anxiety, his physical examination and psychological profile.

Summary

The updated Medical science is at risk as it is conditioned by protocols and guidelines which can reduce the physician's intellectual horizons, and lower his progressive autonomous professional judgement and behaviour. On the other hand, the excessive independence of each surgeon from the acquired strategies for self-advertising and promotion, approved by the scientific community, should be warned and avoided. Moreover, the technical innovations ought to be cautiously accepted when in agreement with the standard criteria for effectiveness and safety. Moreover, the common citizen feels the necessity of a "selected second opinion" asked to independent specialists, experienced and qualified experts who, with great consciousness and responsibility, address the patients to the best suitable surgical and medical options. This policy has just been experienced as an institutional service in the Anglo-Saxon countries, supported by the insurance companies that have promptly realized the financial burden of unsuccessful medical and surgical treatments. Actually, due to the impending worldwide financial crisis, this opportunity should also be endorsed by every National Health Services, to offer a clear-cut problem-solving opinion to the complex unresolved, especially in the old age, health problems either in medicine or in surgery, enclosing pathology counselling, and image interpretation. Obviously, the second opinion can also have a private practice basis and be available on the web, assuming that doctors, who care of the second option counselling, have an outstanding ethical and cultural pedigree and are surrounded by adequate consulting structures and network.

Riassunto

Uno spazio per un secondo parere medico nel settore della chirurgia

Il moderno settore della chirurgia sta subendo un profondo cambiamento dovuto a innovazioni tecnologiche e a cambiamenti nella relazione medico-paziente. Inoltre, "l'identità culturale" della specialità della chirurgia generale è suddivisa e frammentata in numerose sotto-specializzazioni, con il rischio incombente di un approccio casuale e non adeguato ai problemi. Sebbene il concetto sia in generale un "*must*" in medicina e chirurgia, vi sono casi specifici nei quali la sua comprensione, approvazione e aderenza sono obbligatori. Nel settore della chirurgia, vi è stata una crescente necessità di informare i medici sulla comprensione e accettazione di un secondo parere medico. Tale istituzione deve essere pianificata e gestita da ciascun servizio sanitario nazionale, al fine di offrire un'opinione chiara, precisa e risolutiva sui problemi di salute complessi e irrisolti, soprattutto in età avanzata, sia in medicina che in chirurgia, includendo la consulenza patologica e l'interpretazione delle immagini. Inoltre, un servizio di secondo parere medico dovrebbe anche essere offerto da strutture mediche private e servizi online, visto che i medici e gli operatori sanitari possiedono una notevole formazione etica e culturale e sono circondati da adeguate strutture e reti di consulenza.

PAROLE CHIAVE: Pazienti - Consulti - Chirurgia.

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