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Концепция «второго мнения» в психиатрии

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АННОТАЦИЯ

В статье анализируется стратегия «второго мнения» («second opinion»), подразумевающая предоставление пациентам возможности получения второго (другого) мнения квалифицированного специалиста в тех случаях, когда пациенты не уверены в правильности своего диагноза или хотят рассмотреть другие варианты лечения. Сравнивается использование «второго мнения» в общей медицине и психиатрии. Указывается, что в психиатрии редко можно получить «второе мнение», и научных исследований по этому вопросу крайне мало как в общей, так и в судебной психиатрии. Делается вывод о том, что невостребованность концепции «второго мнения» со стороны психиатров связана с множеством факторов, в частности с распространённостью диагностического и терапевтического релятивизма. Утверждается, что психиатры должны пересмотреть своё отношение к концепции «второго мнения», обрести навыки коммуникации с пациентами на темы обоснования правильности собственного диагностического заключения и создать критерии объективной оценки квалификации врачей.

Ключевые слова: *второе мнение, психиатрия, психиатрическая диагностика, диагностический и терапевтический релятивизм, судебная психиатрия, состязательность сторон*.

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The concept of a second opinion in psychiatry

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ABSTRACT

The article analyses the "second opinion" strategy, which involves providing patients with the opportunity to obtain a second (different) opinion from a qualified specialist in cases where patients are not sure of the correctness of their diagnosis or want to consider other treatment options. The use of "second opinion" in general medicine and in psychiatry is compared. It is pointed out that it is rare to get a "second opinion" in psychiatry, and there is very little scientific research on this issue in both general and forensic psychiatry. It is concluded that the lack of demand for the concept of "second opinion" on the part of psychiatrists is associated with many factors, in particular with the prevalence of diagnostic and therapeutic relativism. It is argued that psychiatrists should reconsider their attitude to the concept of "second opinion", gain communication skills with patients on the topics of substantiating the correctness of their own diagnostic conclusion and create criteria for an objective assessment of the qualifications of doctors.

Keywords: *second opinion, psychiatry, psychiatric diagnostics, diagnostic and therapeutic relativism*.

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Recently, the second-opinion concept has become one of the trendy, in-demand, and legally formalized medical technologies, which implies providing patients with the opportunity to obtain a second (different) opinion from a qualified specialist when they are unsure of the correctness of their diagnosis or want to consider other treatment options [1–16].

The medical market offers several proposals to utilize this approach face to face, online, and possibly with the help of Internet assistants and artificial intelligence [7]. Patients are urged not to postpone seeking a second opinion, and ratings of the most qualified doctors of various specialties, to whom to seek a second opinion, are compiled and made public [17]. In addition, it lists pathological conditions that require seeking a second opinion, such as suspected cancer, attention-deficit and hyperactivity disorder, Parkinson's disease, depression, and bipolar disorders and cardiac surgery [18]. Legal regulations are being adopted to allow insurance coverage for this procedure, i.e., to finance a second examination and additional medical consultation [19].

However, patients were not restricted in their rights previously, can check and double-check their diagnoses, question initial diagnostic conclusions, and seek clarification from other specialists. The basis of such activity was the desire to avoid medical errors and tragic outcomes [12].

Studies confirmed a significant reduction in the number of errors when a second opinion was sought. For example, in a simulated situation in which about half of the diagnoses were incorrect, getting the diagnostician one extra second to make a diagnostic decision reduced the error rate to 25.8%, and getting two second opinions reduced the error rate to 16.0% [12]. The model showed that second opinions matter even with perfect diagnostic accuracy.

Currently, a new trend among patients has emerged, i.e., the use of online self-diagnosis with a further desire to challenge diagnoses in dialog with a physician or demand that the latter scientifically justify his/her diagnostic or therapeutic position [20, 21]. Physicians react differently to patients seeking a second opinion, which frequently results in irritation and frustration from distrust of the treating physician [22].

The main problem in using the second-diagnosis concept is what to do in the case of inconsistent medical opinions and who should make further diagnostic and therapeutic decisions in such situations. According to the informed consent principle, the responsibility for choosing between the correctness of the primary and secondary medical opinion rests with the patient, who has the right to rely on various objective or subjective parameters. Specifically, the patient may rely on the authority of the physician, his/her popularity among patients, academic or practical career, academic degrees and titles, personal qualities, or psychological support skills.

The mismatch between the initial and subsequent diagnoses was found to be the rule rather than the exception. Several authors [23] confirmed that the independent second opinion disagreed with the first one in a significant proportion of patients. Other studies did not confirm significant discrepancies but drew attention to the described problem of the principles of choosing between the first and second medical opinions [13].

Along the healthcare evolution, debates emerged about whether it is a right or a concession for a patient to seek a second opinion and whether physicians must refer patients for a second opinion in cases of potential malpractice. Finally, the arguments for and against treating patients who are referred for a second opinion were examined, i.e., whose treatment prescriptions the patient should be guided to? [16].

The practical activity analysis showed that physicians do not always inform patients, primarily the older ones and those with little education, about the possibility of seeking a second opinion. In this regard, Benbassat [23] concluded that changes in the medical care system are necessary. Particularly, physicians' self-awareness regarding the possible tendency to discriminate against certain groups of patients should be raised, and programs that would help patients to get a second opinion, offer specialists for treatment, and "provide tools for reconciling conflicting opinions" should be created.

Among medical specialties, allowing the patient to seek a second opinion became a routine medical technique that did not require discussion. In this respect, psychiatric diagnosis was not really involved in the discussion. The number of scientific publications in PubMed devoted to the study of the organization of second opinion in all medical specialties tends to increase significantly (Fig. 1). The only exception is

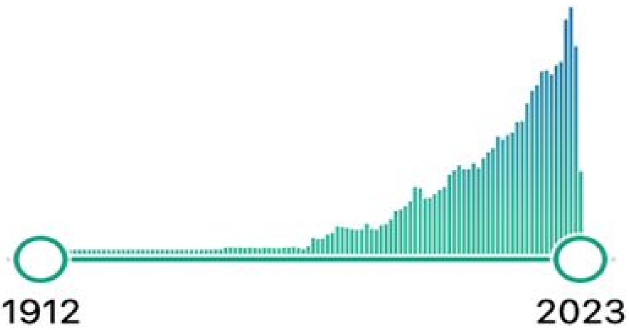

Fig. 1. Dynamics of the number of scientific publications on the second opinion according to PubMed [9]

psychiatry, where such studies are practically absent, and this topic does not become the subject of a wide professional discussion.

Patients with psychiatric disorders require confirmation of their diagnosis and choose adequate and safe therapy because of the psychologically traumatic nature of psychiatric diagnosis, difficulties of the differential diagnosis of psychiatric disorders, and lack of laboratory methods to verify the diagnosis and its stigmatizing effect on the patients [24]. In this context, patients with hypochondriacal and dissociative disorders are a special group.

The authors of a scientific review "Second opinions in psychiatry" [25] confirm that second opinions are uncommon in psychiatry and only a few scientific studies have explored the subject. The stigmatization of mental disorders and patients and the unique nature of the patient–physician relationship in psychiatry may pose significant barriers to the use of second opinions. In addition, more stakeholders such as social workers, government agencies and regulators, health and disability insurers, and social welfare agencies are involved in the mental health sector than in the somatic health sector, which may complicate the achievement of a coordinated approach to mental healthcare. However, the authors of the review did not find a convincing reason as to why second opinions were not and are not discussed by psychiatrists. "Psychiatry could benefit from ongoing discussions of second-opinion findings in other medical disciplines" [26–28].

Despite the obvious demand for a second opinion by patients and their relatives, we wondered why the second-opinion concept is not at the center of psychiatrists' attention. We were interested in what reasons underlie psychiatrists' neglect of the topic of the second diagnosis—objective or subjective?

Second opinions in general psychiatry

In psychiatric practice, psychiatrists are increasingly treating psychiatric diagnoses as a formality and do not consider the accurate diagnosis according to the International Classification of Diseases (ICD) or the Diagnostic and Statistical Manual of Mental Disorders (DSM) as fundamental to the choice of therapy. Russian psychiatrists frequently make diagnoses that are so-called "preliminary" (e.g., mixed anxiety and depressive disorder and adjustment disorder), which do not always lead to the prescription of therapy adequate to the patient's condition [29]. Psychiatrists are convinced that accurate diagnosis of, for example, generalized anxiety disorder, panic disorder, or sociophobia, will not change treatment approaches. This approach was evident in the transition to spectral psychiatric diagnosis [30]. Spectra actually "blurred" the idea of a precisely formulated diagnosis.

Attention should be paid to the paradigmatic changes taking place in the diagnostics of mental and behavioral disorders. The nosological diagnosis concept disappeared from classifiers, and mental illnesses were renamed "mental disorders." According to the apt remark of Taylor [31], "the classification of mental illnesses gives a false sense of order and a 'crude' system of adequate prescribing. Often the indications for use have little or nothing to do with the spectrum of psychotropic action of the drug, and, as a consequence, accurate diagnosis is not required for optimal prescribing." This phenomenon was called "diagnostic and therapeutic relativism" [30].

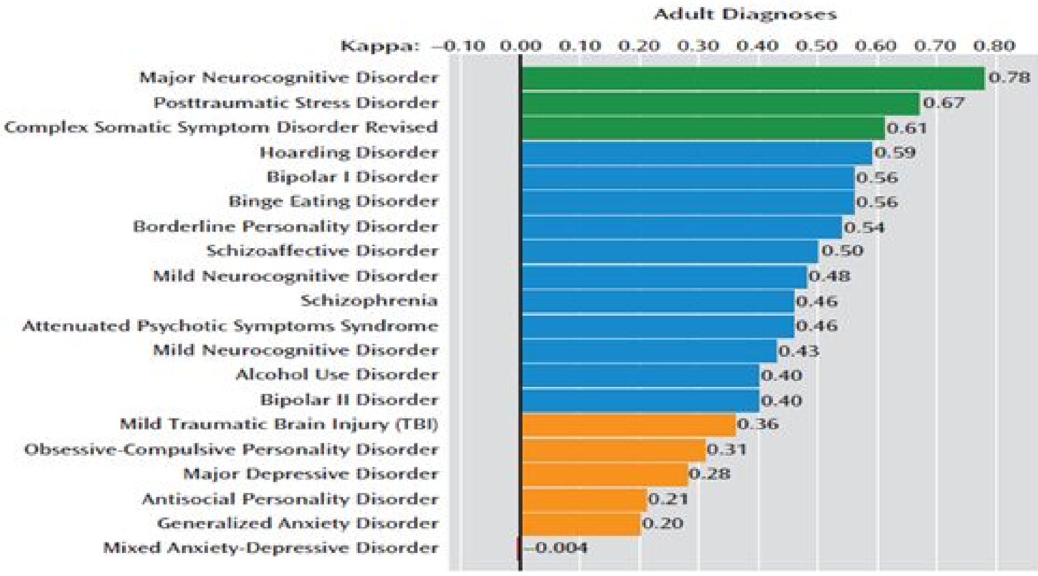

Fig. 2. Consistency of psychiatric diagnoses in adults (by Robert Freedman [33])

A striking example of diagnostic relativism in psychiatry is the data of a special survey showing that 48% of psychiatrists are convinced that "it is impossible or unlikely to create an accurate and convenient list of diagnostic criteria for schizophrenia," and another 44% of the respondents say that "it can be done, but it is necessary to improve the lists of diagnostic criteria" [32]. The results of this study reflected the skepticism of specialists about the accuracy of their diagnostic conclusions; however, this did not affect the continued practice of diagnosing schizophrenia even in uncertain cases.

Studies of the consistency of psychiatrists' diagnoses of mental disorders showed differences in psychiatrists' opinions. The most obvious discrepancies are observed for disorders such as mixed anxiety–depressive disorder, generalized anxiety disorder, major depressive disorder, and personality disorders such as obsessive–compulsive and antisocial disorders in adults and nonsuicidal self-harming behavior in children (Figs. 2 and 3) [33].

The situation analysis revealed that unlike psychiatric professionals, patients give a different meaning to the diagnosis of mental illness. In many cases, patients do not agree with the psychiatrist's diagnosis [34]. They are not ready to accept the position on spectrum diagnosis and seek information from physicians about a precise and unambiguous diagnosis.

In discussions with physicians about what criteria from the ICD or DSM they were given a particular diagnosis based on, the patients insist not so much on listing these criteria as on presenting clinical evidence for the detection of specific phenomena in a particular clinical situation. During such a diagnostic discussion, the physician is frequently unable or unwilling to engage in confrontation with the patient and avoids further discussion. Thus, patients may consider the physician's initial opinion unargumented and seek a second or even third opinion.

Briefly, the attitudes of the psychiatrists and patients toward psychiatric diagnosis are not identical. For psychiatrists, an ICD or DSM diagnosis is a formality that has no direct bearing on the development of psychopharmacotherapy and tactics ("we treat the syndrome, not the disease"). For patients, the diagnosis is specific, strictly defined, and different from other psychopathological conditions, which is essential for effective and safe treatment ("The one who diagnoses more accurately is the one who treats better") [35].

Psychiatrists are most commonly consulted for a second opinion after an initial diagnosis of schizophrenia. Patients are often satisfied with a second diagnosis, such as schizotypal personality disorder. Unlike physicians, patients are convinced that schizotypal personality disorder is fundamentally different

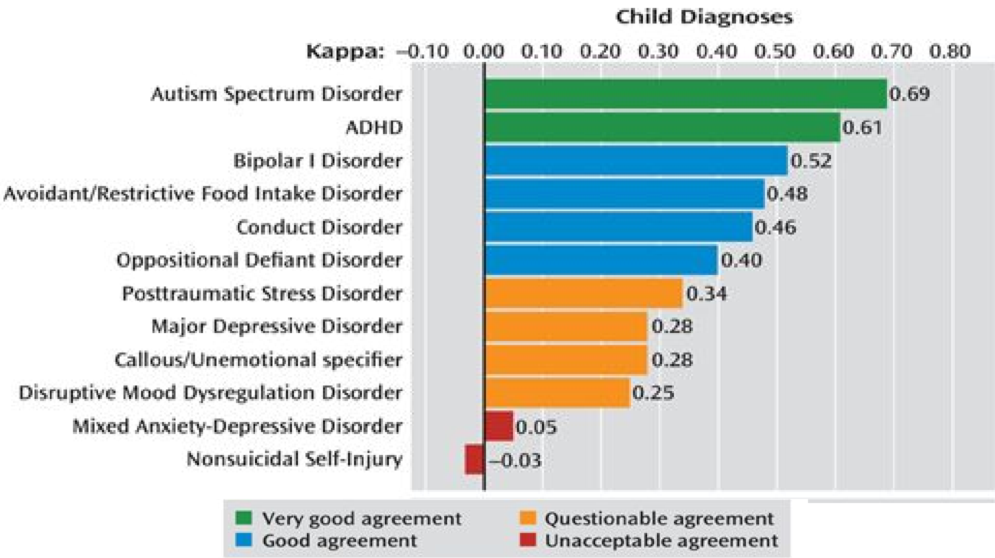

Fig. 3. Consistency of psychiatric diagnoses in children (by Robert Freedman [33])

from schizophrenia and that the initial diagnosis is wrong, whereas psychiatrists view both as part of the schizophrenic spectrum of disorders and often equate schizotypal disorder with “sluggish schizophrenia” (i.e., “latent or symptom-poor schizophrenia”).

The second opinion is important in formulating therapeutic techniques and the choice of specific drugs. However, standards developed in the course of scientific research in the paradigm of evidence-based medicine can be referred to, as opposed to diagnostics. Clinical guidelines developed by professional societies are open for review and contain specific indications for medicines with a high level of therapeutic efficacy. Thus, a second opinion (as well as a first opinion) can be verified and evaluated by the patient by comparing the prescribed therapy with the clinical guidelines for the treatment of the diagnosed mental disorder.

Second opinion in forensic psychiatry

Forensic psychiatry, a special area of psychiatric practice, needs objectification. Within the framework of the adversarial principle, the conclusions of forensic psychiatric examinations are frequently criticized and subjected to professional evaluation during repeated forensic psychiatric examinations or oppositions by psychiatric specialists in court [36].

Recently, we have witnessed a series of high-profile court cases in which different expert psychiatrists made mutually exclusive psychiatric diagnoses that became the subject of public criticism (the cases of serial killers Breivik, Colonel Budanov, artist Pavlensky, skoolshuter Galyaviev, etc.). The specificity of forensic psychiatric examinations lies in the fact that in addition to typical medical errors, legal errors involving social and reputational risks are possible.

The attempts of expert psychiatrists to avoid defending the conclusions of their research in court and their unwillingness to engage in discussions with psychiatrists invited by the defense are criticized by the public and forensic experts. This means that forensic psychiatry ignores the principles of the second-opinion concept, which does not benefit either the experts or psychiatrists, whose authority is significantly diminished in this regard. Admittedly, both society and the psychiatric professional community are interested in the maximum possible objectivization and openness of forensic psychiatric examination and thus the introduction of the second-opinion concept into practice.

Thus, the analysis of the problem of introducing the second-opinion concept into psychiatry and its lack of demand by psychiatrists necessitates an assessment of the causes of this phenomenon.

Psychiatrists should reconsider their attitudes to the second-opinion concept, acquire the skills to communicate with patients to justify the correctness of their diagnostic opinion, and create criteria for the objective evaluation of doctors' qualifications. Moreover, the introduction of the third-opinion concept using artificial intelligence [37] is on the way, and the opinions of human diagnosticians and therapists will be controlled by the technology. Unlike general medicine, psychiatry is not threatened by machine diagnosis because the most difficult thing is the definition of a psychopathological symptom not the further algorithm for recognizing the disease.

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