Scientifically Speaking

Second opinion on surgery

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Washington, DC—Never before has spending on health in the United States been so great. At an estimated \$162 000m plus in 1977, health expenditure is rising to nearly 9% of the gross national product (the market value of all goods and services produced in the country). As a proportion of Federal Government budget outlays, health spending is nearing 10%. Never before have there been so many surgeons at work in the US—about 100 000. That total contributes to the biggest ratio of surgeons to population that the nation has ever experienced—about 46 per 100 000. These surgeons are performing about 20 million operations a year—also a superlative statistic.

Nationwide drive

In a country whose officials express increasing concern about health care costs, it was only a matter of time before official discouragement was brought to bear on surgical procedures. Last September, the Department of Health, Education, and Welfare formally opened a national campaign to persuade patients that one surgeon's advice was not enough, that they should get a "second opinion" before having any operation that was not an emergency. HEW Secretary Joseph A Califano, jun, said that such a consultation should help reduce a "tremendous amount" of unnecessary surgery. Primarily, HEW was aiming the effort at the Medicaid and Medicare programmes, for the elderly and the poor respectively, that it funds. Nevertheless, the publicity campaign mounted for the effort—including radio and television announcements, distribution of five million brochures, and establishment of a toll-free "hotline" telephone to provide names of referral doctors—was plainly meant to sway everybody headed for the operating room.

Oddly, the HEW nationwide drive was begun before any firm results had been received from two pilot studies that HEW funded to determine the feasibility of programmes that provide second opinions on elective surgery. Both pilot programmes got under way last year and are intended to run for three years at a total cost of \$1m. Both programmes—one in New York City and the other in Detroit—are for Medicare patients who are over 65. Incentives for them to seek a second opinion, and even a third if they wish, include Government payment of the entire consultant fee instead of only a portion—as would be the case under customary Medicare schedules for paying doctors. An intensive education programme is directed at Medicare patients

in the areas of the pilot projects, and special referral centres are being established.

The pilot projects will collect information on the use and costs of medical and surgical services by patients who do and do not get a second opinion. Some incomplete figures from the New York City project after the first three months indicate that 564 patients had requested second opinions; 268 got them; and six of those had asked for a third opinion. An HEW official said that the second opinions did not agree with the first in 79 cases, which constitutes about 29% non-confirmation. There was no information on how many—or which—of those patients went to surgery.

The national campaign for second opinions was described by HEW Secretary Califano as a programme that would "improve the quality of health care and cut costs." But even within HEW there is uncertainty about the eventual lowering of health care expenditure. Each second opinion is expected to cost about \$50, of which Medicare will pay about 80%. HEW will also be paying something towards the paperwork expenses of 162 referral centres around the country that will maintain rotating lists of doctors willing to participate as consultants.

It isn't the fees and the paperwork, however, that call into question the ability of second opinions to cut health care costs: it is that if second opinions are to save a substantial amount of money they should accomplish a substantial reduction in "unnecessary surgery." But HEW officials have acknowledged that they don't know how much unnecessary surgery is going on. Those acknowledgments, however, have not deterred one Government body or another from coming up with various estimates of "loss," "waste," or simply "cost" of surgery that has, by some method ostensibly short of divination, been determined unnecessary.

One such estimate—much favoured by HEW spokesmen—came out of hearings conducted by a subcommittee of the House of Representatives in 1975. The subcommittee chairman, John E Moss of California, announced during the proceedings that he had an estimate that about 17% of surgical operations performed in the US in 1974 had been unnecessary. That percentage, he said, amounted to 2.38 million operations and a cost of \$3920m. The American College of Surgeons, understandably interested in that kind of arithmetic, has attempted to track such estimates to their origins. An article¹ in last December's *Bulletin* of the college describes the results of an investigation into that 17%.

Two second surgical opinion programmes for members of New York City labour unions have been under study for several years. The first report² of the study indicated that, in a programme where second opinions were mandatory, more than 17% of first opinions were not confirmed. As it turned out, there were several reasons for non-confirmation; more than a third of the differences were caused by the consultant's belief that medical treatment was preferable to surgery or, at any rate, should be tried first. In some quarters, however, the percentage of instances in which a consultant physician does not agree with a recommendation for surgery apparently can be viewed as a percentage of unnecessary surgery that is performed. Once that leap is made, the statistics start rolling.

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Another imaginative use of figures is described by the staff members of the College of Surgeons. They wondered where HEW came up with an estimate of \$655m as its own losses in 1977 caused by unnecessary surgery. The answer eventually was wrung from the responsible HEW office. Its analysts began with the 17% figure for unnecessary operations. But they also were aware of another estimate⁴ that unwarranted surgery constituted only 1% of all procedures. The analysts assigned those percentages as the outer limits of the problem and promptly settled on a point mid-way between—8.5%. From there it was easy to ascribe one-third of the Medicare and Medicaid costs in 1977 to surgery, multiply that figure by 8.5, and come up with \$655m spent for unnecessary surgery.

A question of participation

Unless more patients participate second-opinion programmes, whatever their problems in rooting out unnecessary surgery and cutting costs, may be unable to contribute to improving the quality of health care. The Blue Cross/Blue Shield health insurance plans have more experience than the Government in conducting second-opinion programmes, currently offering them to some nine million subscribers. Of the subscribers getting recommendations for elective surgery, only 2 to 3% have availed themselves of a second opinion. Either they have confidence in the first doctor's pronouncement, or were too embarrassed to question it, or perhaps had undergone a long course of medical treatment for a condition before deciding to settle the matter through surgery.

The remedy for low participation in second-opinion programmes is, of course, to make them mandatory. If the patient is recommended for an operation and doesn't get a second opinion, the insurance plan doesn't pay for the operation. Thus far, the second-opinion programme being pushed by HEW and the many offered by Blue Cross/Blue Shield are voluntary; the patient gets his operation paid for whether he seeks a second opinion or not. A harbinger of possible change in that course arrived last year from the large Prudential Insurance Company.

The company urged its regional offices to market a health insurance policy with an "option" that would pay less for operations conducted with no second opinions, or conducted notwithstanding a non-confirmatory second opinion.

Some mandatory second-opinion programmes have been tried. Massachusetts has one for indigent Medicaid patients, who are required to get a consultation if the first doctor recommends tonsillectomy and adenoidectomy (T&A), cholecystectomy, haemorrhoidectomy, hysterectomy, disc and spinal fusion, nasal septum repair, or excision of varicose veins. New York State had a version of mandatory second opinion for Medicaid, but dropped it after a law suit by a Medicaid patient. HEW has made some noises expressing appreciation of the potential value of mandatory second-opinion programmes, and even the expansion of second opinions to health-care procedures other than surgery.

There is a possibility, however, that a push for mandatory second-opinion programmes may be sapped by growing public awareness that some common surgical operations are not generally efficacious and, in fact, are overdone. Statistics on American surgery and surgeons compiled in 1978 by the College of Surgeons indicated some influences at work to reduce operations: the rate of growth of surgical procedures has slowed since 1973; from 1973 to 1976 the incidence of T&A declined 29%, appendectomies were down 10%, hernia repair was down by over 3%, and hysterectomies dropped almost 2%.

For some reason, the top-ten list of operative procedures in 1976 contained two that were not there in 1973: ligation of fallopian tubes, and caesarean section.

No reprints will be available from the authors.

References

- ¹ Lance, R, and Haug, J N, *Bulletin of the American College of Surgeons*, 1978, **63**, No 12.
- ² McCarthy, E G, and Widmer, G W, *New England Journal of Medicine*, 1974, **291**, 1331.
- ³ Emerson, R, *New York State Journal of Medicine*, 1976, **76**, 454.

STRANGE ENCOUNTERS

The bureaucracy of references

Recently, having received a particularly blatant example of the worst form of request for a reference, posted by second-class mail in an unsealed envelope and not marked "confidential," I wrote to the personnel officer in whose name it appeared to have been sent. My letter, which was posted for recorded delivery, was primarily a protest about the lack of confidentiality, and I made the point in it that my opinion of the candidate would follow shortly. The request, which had a printed facsimile of the personnel officer's signature, initialled *pp* by someone else, carried an unsigned typewritten addendum that read, "What is candidate's status alcohol-wise?" The candidate, whom I know well, is one of the few of my colleagues who is, as he always has been, a total abstainer from alcohol.

My protest brought no immediate answer. A week later, still having no reply to it, and the deadline for receipt of referees' letters being close, I telephoned. The personnel officer refused to accept the call. I got through then to the chief medical officer of the region, who was obviously distressed by my complaints. He arranged for the personnel officer to ring me back.

When he rang, the personnel officer wasted no time on civilities: "You are McCurdy?" he said, a statement more than a question. "Macredie," I replied, but he ignored the interruption. "So you tried to go over my head," he went on, "you academics are all the same, troublemakers. What is it you want?" I explained. He said that no letter such as I claimed to have written had arrived. I had already heard from the post office that the letter had been delivered seven days earlier and signed for. The post office's recorded delivery service is the bane of those whose standard excuse for not replying to letters is that the letters were never delivered; unfortunately, there remain possibilities of claiming that letters must have been lost in the

institution's internal delivery service, intercepted for a security check, or washed away during a routine trial of the fire precautions system—bureaucracy, back to the wall, is ingenious and experienced in exculpation.

A further approach to the chief medical officer disclosed that the letter had in fact been received by the personnel officer, but pressure of work had put it from his mind. The personnel officer then wrote me a letter: or, to be precise, I then received a letter purporting to be from the personnel officer but indecipherably signed by somebody else on his behalf.

The letter read, "If you are not prepared to take the trouble to meet your obligations as a referee when you have agreed to do so it is in my opinion quite improper of you to imply his unsuitability for the appointment by the extraordinary device of presuming to take me to task for the way in which I conduct this office. Your refusal to meet your responsibilities in this matter will be notified to the chairperson of the committee which interviews the candidates and to the candidate himself. In the absence of your contrary statement I have no option but to report to the committee that you have implicitly confirmed the candidate's alcoholism. Please accept my best personal thanks for your helpful attention. I have no doubt that within the limits that you have placed on your co-operation your attitude will not go unremarked by the chairperson and his committee, who are not without influence. Be informed that this correspondence is now closed."

The closing information proved to be incorrect. For instance, it transpired, before the committee met, that the question about alcohol was intended to have been added to the letters about one of the other candidates.

I heard later from the candidate who had named me as one of his referees that he was closely questioned at his interview on his attitude to alcohol and alcoholism. He was offered the job.—WILL MACREDIE.