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External Second Opinions: building trust between health professionals and families

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External Second Opinions: building trust between health professionals and families.

Fraser J, Goold I, Akindolie O, Linney M

Abstract

In medicine external second opinions are frequently sought to inform decisions around a patient's proposed course of treatment. However, they are also sought in more challenging circumstances such as when disagreement arises between the health care team and the family, or during complex end of life discussions in critically ill children. When done well, external second opinions can help build trust and reduce conflict. However, when done poorly they may antagonise relationships and thwart attempts to bring about consensus. While principles of good medical practice should always be followed, the actual second opinion process itself remains essentially unregulated in all its forms. In this review we set out what a standardised and transparent second opinion process should look like, and recommend key recommendations for health care Trusts, Commissioners, and professional bodies to support good practice.

Introduction

Disharmony between health professionals and parents may arise when disagreements around health care decisions occur. Many factors may contribute to this: parental distress, a sense that their child's 'voice' is not being heard, conflicting information, a lack of co-

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ordinated care and, on occasion, a difference of opinion as to the right course of action to be taken. In most cases resolution can be achieved through careful listening and sensitive explanation. Providing information to families early in the therapeutic pathway on how decisions are made helps build trust, and reassuring families that second opinions are often sought when treatment options are unclear may be one mechanism to help mitigate conflict when it arises.[1,2.]

An external second opinion occurs when a health professional (or multidisciplinary team (MDT)) requests an external medical opinion on a patient's proposed course of treatment from a second independent health professional (or MDT) within an appropriate speciality. The initial request for a second opinion may come from the patient's healthcare team or family.

In clinical practice the use of external second opinions vary widely according to circumstance. As the number of patients with complex needs increases [3], second opinions to inform MDT-decision making are often regarded as standardised good practise in many subspecialities. For example, in paediatric cardiology, an MDT in one tertiary centre will correspond with an MDT in a second tertiary centre around therapeutic options (surgery, interventional, non-treatment) in especially complex cases. Similarly, in some forms of paediatric cancer, it is routine practice for each patient's treatment to be discussed at an established national advisory panel. In both situations the value of the second opinion is to ensure that all potential treatment options have been explored and that consensus (both within the MDT and between the MDT and the family) is achieved. However, second opinions are also often sought from experts in more controversial circumstances: when conflict arises between the health care team and the family, and/or during the course of

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complex end of life discussions in critically ill children whose cases may proceed to Court for resolution.

In all situations, we suggest some common principles should apply: a focus on shared decision making in the best interests of the chid, transparency, and trusted confidence in the expertise of the individual or body giving the opinion. However, while the governance considerations that underpin second opinions should always follow good medical practice, the actual process itself currently remains essentially unregulated in all its forms. Therefore in May 2022, the Royal College of Paediatrics and Child Health, in conjunction with Together for Short Lives and the Paediatric Critical Care Society published detailed guidance for professionals and guidance for families regarding what a standardised and transparent second opinion process should look like. Use of the guidance hopes to reduce the incidence of conflict and disagreement in treatment decisions. The guidance makes specific recommendations for Health Care Trusts, Commissioners, the RCPCH, and Specialist Societies. This review summarises the key points from this consensus document.

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Relevant legal, professional, and commissioning frameworks

Shared decision-making in the best interests of the child guides practice in paediatrics. While parents have some legal and ethical authority to make decisions for their child, they do not have a specific legal right to request a second opinion.[4,5] That said, a health professional will rarely refuse a reasonable request by a parent for a second opinion if it is in the best interests of the child. However, while it may fall within their professional duty, there is no legal requirement for a health professional to obtain a second opinion if they are able to demonstrate that they have provided appropriate care for their patient. Courts will take account of professional and clinical guidance that it is good practice to request a second opinion in determining what constitutes ‘a responsible body of medical opinion’.[6,7] The law accepts that two views on appropriate treatment can co-exist as long as each has a logical basis and represents a responsible body of medical opinion. Therefore, if an MDT disagrees with an external second opinion, their refusal to carry it out will not necessarily be considered negligent. Even if the Court decides that it is in the child’s best interests to have a particular treatment, the first MDT/health professional would not be compelled to provide it.

The General Medical Council (GMC) supports a patient’s right to make free, informed health care choices in order to clarify clinical facts and define treatment options. The GMC specifically requires doctors to ‘respect a patient’s rights to a second opinion’,[8] and responding to a patient’s request for second opinion fulfils a doctor’s obligation to respect patient rights and to provide the highest standard of care.

Although the process of requesting and providing external second opinions underpin essential good practice across the NHS, there are no formal commissioning arrangements in place that recognise or facilitate its practise.

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The problem with current arrangements

When done well, external second opinions reaffirm the principle of shared decision-making and give assurance to the family that everything possible has been considered. However, when done poorly the process may antagonise relationships and thwart attempts to bring about consensus. In recent years, the process by which second opinions have been sought and provided in some high profile court cases has come under scrutiny.[9] Concerns that those giving second opinions may not have the requisite skills or expertise to do so, may be particularly problematic in complaint processes, coroners courts, and ombudsman inquiries. Families may perceive that the chosen professional might not be truly independent of their child's medical team. Also, the lack of a national commissioning framework frustrates formal governance arrangements around second opinions, which results in variable, unmonitored, unsupported, and, often, unremunerated practice.

What do families want?

The decision-making process in medicine is complex and, at times, uncertain. Families told us that having a transparent decision-making process, clear and honest communication, and their child being seen as an individual and their parents as the experts on their children, were key ingredients to effective shared decision-making. On entry to a treatment pathway, families should be informed how treatment decisions will be made. A transparent and collaborative approach that brings together the health professionals' expertise and the family's goals and values is most likely to create a harmonious relationship that builds trust and empowers parents to be involved in the decision making process.

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"Things should be transparent and accessible for parents – full information at all times so no misunderstanding from either side Family x, 2021" (RCPCH; the second opinion process)

Families told us that, in itself, just being told of the possibility of having a second opinion early on would increase their confidence in the team treating their child.

Families do not want to be left with any regrets. Honest communication, especially around the possibility that treatment might not be effective, helps parents prepare and plan for all eventualities.

"*For us as parents the most important thing is that when our child does pass away, we know we have done absolutely everything to give them the best quality of life for as long as possible. Family x, 2021" (RCPCH; the second opinion process)*

Families also felt, in order to avoid any perception of bias, it was important that the clinician giving the second opinion is independent of the team treating their child. Importantly, when asked for suggestions for how to seek out such a person, families stated that their health care team might approach a professional body (such as a membership organisation representing a specialist society), since such organisations were considered by them as being impartial and able to identify the most appropriate 'expert'.

Requesting and providing a second opinion

The decision that a second opinion is needed should come from the team around the child - those professionals (including the child's named consultant and the MDT) that contribute to the wider health and wellbeing of the child.

"It is very important that getting a second opinion is a way of establishing what is best for a child, rather than shoring up one or other of two conflicting viewpoints. Healthcare professional, 2021 (RCPCH; the second opinion process)"

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In complex speciality patients, where a team- or MDT- based approach may underpin decision-making, the decision to seek a second opinion should be based upon consensus. However, there will be other circumstances (e.g. when the Courts are involved) where the child's named consultant alone may make a decision to refer for a second opinion'. Ultimately, the child's named Consultant, as the person in charge of co-ordinating and leading care, is responsible, in consultation with the family, for requesting the second opinion.

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At the outset, families should be made aware that such processes are regarded as good practice. Early support from a family advocate may assist enhanced understanding of the views of the child and family and thereby contribute to building trust.

However, it is important that the clinical team explain the limitations of the second opinion process, in that some recommendations may not be possible, reasonable, or be agreed with (by the child's clinical team and/or family). If disagreement does arise, the treating team should reassure the family that they will work with them to get back to a process of shared decision-making. In such circumstances, it may be helpful to engage a third party (for example, a family advocate, palliative care team, a clinical ethics advisory committee, or a paediatric mental health team), or an independent body such as an external mediation service, to facilitate discussion. On rare occasions resolution through the courts may be necessary.

In exceptional situations it is also important to explain to families it may not be possible to request an external second opinion: either where no expert can be identified, or if the expert identified does not fulfil essential GMC or other equivalent regulatory guidance that permits his/her practice. The latter can be problematic when second opinions are sought from overseas.   It may also be the case that there is not a medical team who would be able

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to carry out the intervention that is recommended. The situation in relation to novel and/or experimental treatments is more contentious. The General Medical Council (GMC) is clear that doctors prescribing medications or other interventions must do so based upon sound theoretical knowledge, clinical reasoning, and available evidence. [10] In circumstances where the medication/intervention is 'off label' or unlicensed, the GMC states that there is an even greater responsibility on the prescriber to set out clear and careful reasoning and be satisfied that there is sufficient evidence or experience of using the medicine, and to demonstrate its safety and efficacy. [11] A clinician who wishes to provide an informed ESO about an intervention that is experimental must show that he or she has the necessary specific knowledge and training, as well as provide evidence (research or, less persuasively, from personal experience) to support a recommendation. Treatments offered on compassionate grounds for unproven therapies should be seen in the same light as novel or experimental treatments. The best benchmark for any interventions is that 'a respectable and responsible body of professional opinion and experience' would endorse its use for that indication'. This approach draws on sound ethical reasoning. However, in some circumstances, a judgement as to what is reasonable (i.e., the balance of benefit versus harm) can only be addressed in the Courts. Ultimately, any recommendation arising from a second opinion should be both reasonable and in the best interests of the child.

Essential principles around the External Second Opinion process (Table 1)

It is good practice to formulate the request for the second opinion in conjunction with the family. The request should clearly articulate the clinical question that is being asked and, where appropriate, frame the family's priorities and concerns. In a world where the use of

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social media is ubiquitous health care professionals should recognise that families may, on occasion, come across and seek the opinion of 'experts' from other countries. [12] In such situations we suggest there this presents no fundamental ethical dilemmas as long as the essential principles outlined in Table 1 are adhered to.

In appendix A we set out two vignettes that illustrate good external second opinion processes in practice: an ESO from an expert clinician on the management of a long stay patient on a paediatric critical care unit, and an ESO from an MDT in another hospital to advise on the management of a complex cardiac patient.

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Table 1: Essential Principles around the External Second Opinion process

Essential Principles around the External Second Opinion process	
Best interests	The duties and expectations of a health professional (or MDT/national panel) who provides a second opinion are the same as the primary caregiver, i.e., to the welfare of the child.[13]
Independence	Given the limited pool of available healthcare professionals able to support this work, it is prudent to remain pragmatic with assuring independence. In such circumstances an external second opinion provided via an inter-hospital MDT or national advisory panel may in part address challenges of bias since a review of a case by a group of peers may likely provide a more dispassionate and objective view of the facts than a review by an individual acting alone.
The request for the second opinion	Should be clear in terms of: a) The question that is being asked and the time frame in which the report is required. b) Who is requesting it (usually the child's named consultant) c) The understanding and expectations of the family
Competencies of the opinion giver	a) Possess relevant knowledge and training to advise on the case in question. **(How to assess: current GMC or equivalent registration; evidence of 5-yearly revalidation).** b) Possess experience as demonstrated by active engagement in relevant clinical practice. **(How to assess: up to date curriculum vitae; membership of professional body; evidence of subspeciality experience)** c) Possess relevant other skills**. (How to assess: previous second opinion/ expert witness work; attendance relevant courses)** d) Transparent declaration of conflict of interests The responsibility in ensuring that the second opinion giver is competent in giving an opinion is held both by the organisation requesting the opinion as well as that employing the opinion provider.
Duties of the opinion giver when the advice	a) Read and review all relevant clinical documents. b) Determine the views of those close to the child i.e., the clinical team, the family, and the child. This might necessitate a face to face meeting

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sought from an individual consultant	if appropriate to the clinical situation (e.g., advising on limitations of treatment) c) Examine the child if appropriate to the clinical situation (e.g., advising on limitations of treatment)
The Second Opinion report	a) Should answer the clinical question that is posed and, where relevant, any concerns raised by the family. b) Should be written in plain English. c) Should be objective, unbiased, and state and reference the assumption upon which any advice is based. d) Should contain sufficient detail to explain and justify the conclusions drawn. e) Should be reasonable (i.e. take into account restraints on resources and/or local /national policy) f) Should comply with UK Data Protection legislation. This report will form part of the patient record. Therefore, authors should be mindful that it may appear as material evidence in subsequent judicial settings.

How to support good practice around second opinions (Table 2)

We suggest that good practice in this area encompasses support for families and their children, the workforce, education and training, and service planning. Most second opinion work is carried out in an informal manner in a variety of formats across all paediatric subspecialties. Health Care trusts need to recognise that, when conducted well, second opinions support patient choice and may reduce complaints and litigation. Commissioners should acknowledge the activity of interhospital MDTs and national advisory panels through service specifications. Hospital senior management and legal teams might be automatically notified when second opinions are sought to mitigate professional-parental conflict and/or when escalation through the Courts is anticipated, to ensure that all possible avenues of resolution are explored first.

Table 2 Recommendations to support good practice.

Domain	Recommendation

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Families and their children	• Trusts should provide information and resources to families describing what 'shared decision making' means in relation to the specialist care that is provided. • When an external second opinion is sought from an individual clinician at another hospital, the family should be involved in the process and their questions and concerns should inform the request.
Workforce	• The RCPCH and specialist Societies such as the Paediatric Critical Care Society should consider establishing subgroups for colleagues interested in ESO work. These would provide a pool of credible professionals to whom ESO requests might be directed, as well as support the decision making process in complex cases, while also forming a focal point for mentorship, training, audit, and peer review of cases. • Specialist Societies might alternatively consider establishing National Advisory Panels to support professional expert consensus in selected groups of diseases.
Education & training	• The RCPCH should consider the implications arising from these issues (children with complexity, parallel planning, second opinion processes) in its post graduate paediatric training curriculum. • The RCPCH should review and update its revalidation framework so that second opinion work is considered as Continual Professional Development.
Service planning	• Service planners should acknowledge second opinion work within service specifications. • Paediatric clinical directors should notify Trust executives when second opinions are being sought beyond usual practice. • Hospital Trusts should recognise and remunerate (in a timely fashion) second opinion work within team based annualised job plans and provide administrative assistance as applicable. • Hospital Trusts should ensure families and clinicians have access to a paediatric-focused Clinical Ethics Advisory Committee

The overlap between health professionals giving second opinions and those acting as expert witnesses and/or doing medico-legal work.

Second opinion and expert witness / medico-legal work are on a continuum in that they may relate to the same patient, involve the same group of 'experts', and demand very similar expectations in terms of integrity, professional competence, and governance. Health professionals may act as expert witnesses in the following settings: coroners court, family court (where the RCPCH and the Family Justice Council have produced specific guidance)[14], civil court where claims of clinical negligence are brought by patients, by police forces and

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the National Crime Agency in criminal matters, and tribunals/ fitness to practice settings held by professional regulatory bodies or public enquiries. The Academy of Medical Royal Colleges has set out clear guidance for health professionals undertaking this work. [15] Nationally, there is a limited pool of paediatricians prepared to undertake second opinion and expert witness/medico-legal work which is problematic since this frustrates both the judicial process and good medical care. The reasons for this include unwarranted social media and press attention, the inflexible timetable of court processes, and perceived criticism by the legal profession. Both types of work are also hugely time-consuming, relatively poorly remunerated, and generally not supported by either hospital Trusts or recognised by Commissioners. The President of the Family Division Working Group on Medical Experts in the Family Courts has made recommendations to address the shortfall of experts prepared to undertake expert witness work, and ask for *'engagement at senior level with the Department of Health and Ministry of Justice as well as the NHS*".[16] It is suggested that many of the proposed solutions will also address the shortfall of professionals prepared to undertake second opinion work to the mutual benefit of both processes; in particular, awareness of training provided by the Academy of Experts and Expert Witness Institute, and changes to contracting arrangements and job plans to promote a more supportive environment for professionals who wish to undertake this crucial work.

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Summary

Children and families are not only beneficiaries of healthcare but also key stakeholders with valuable insights and experiences. Transparency around how decisions are made, especially in the context of critically illness, can help build trust and confidence. As the number of

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children with complex care needs continue to increase, external second opinions are one mechanism that reaffirm the principles of shared decision making for the best interests of the child. When done well they are an essential element in good patient care, support patient choice, and may mitigate complaints and litigation. When done poorly they may exacerbate tensions and/or complicate legal processes.

Second opinions may be sought to gain further professional consensus around treatment options, in the context of challenging end of life discussions, and as one mechanism to resolve conflict between the health care team and the family. Prevention is always better than intervention. Therefore, acknowledging the contribution of, and giving appropriate weight to, all professionals' opinions from the bedside nurse to the consultant, as well as a deliberately holistic assessment of the family's goals may improve team based decision making.[17-18] Similarly, addressing the causes of disagreement - communication breakdown (*conflicting messages, insensitive use of language*), disagreements about treatment (*misunderstanding, challenges to standards around best interests versus harm*), a sense that the family may have unrealistic expectations, and differences in values and/or faith, is likely to pay greater dividend at a system level than solely focusing on the fact of conflict itself.[19-20]

There is currently no formal commissioning arrangement in place that recognise or facilitate ESO work which results in variable practice across the UK. Healthcare professionals who undertake this work report it to be extremely onerous, frequently done 'out of hours' and, in the main, unremunerated. Whilst informal arrangements may be made between medical directors at hospital Trust/Health Board level, the lack of a national commissioning framework frustrates formal governance arrangements, job planning and the proper resource to support an optimal process. New statutory responsibilities upon integrated care

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systems for some specialised services may create an opportunity for local systems to work with hospital Trusts and service planners to both raise standards and realise models of funding that fairly recognise the work involved.

We advocate that families are supported to understand a) how they should be involved in the decision making process from the outset, b) that seeking second opinions (in all their forms) may be regarded as standardised good practice, and c) that the family's priorities and values are central to any referral process.

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Vignette 1: an ESO from an expert clinician to advise on the management of a long stay patient on a paediatric critical care unit.

Background

Imani is a 15 year old girl with a rare neurodegenerative condition, severe epilepsy and learning difficulties. In the last two years Imani's breathing has significantly deteriorated so that she now requires non-invasive home ventilation at night. She is looked after by her elderly parents who love her very much though they find it increasingly difficult to lift her and manage her daily needs. She also has two older siblings.

She has recently stopped attending her special school, though she frequently has respite care at her local hospice. Her consultant neurologist and community paediatrician have led parallel planning discussions with Imani's parents since she was eight years old and there are clear instructions around their wishes and plans for what to do should she become unwell.

This admission

Over the past year Imani has had six admissions to the regional paediatric intensive care unit (PICU) with chest infections needing intubation and ventilation. Each time the PICU team finds it harder to get her off the ITU ventilator and back on to her home breathing (CPAP) machine. This is mainly because she has worsening upper airway obstruction and her cough is getting weaker.

On this occasion she has been admitted a seventh time and despite the team's best efforts she has now been ventilated for a month. The family would like their daughter to have a tracheostomy but the PICU and respiratory team worry that, while this will help Imani's carers manage her secretions better, it may result in time with her being dependent on the ventilator via her tracheostomy not just at night but 24 hours a day.

A 'best interests' meeting is held with Imani's family, her community team, a palliative care consultant from the hospice and the hospital team to fully understand the family's perspective and to discuss with them a potential road map for decision-making.

It is first agreed to seek an opinion from the hospital clinical ethics advisory committee (CEAC). The CEAC supports the health care team's position. Imani's parents are very disappointed and wish for everything to be done for their daughter. They still have a good relationship with their PICU consultant who they respect and have got to know well during the last six weeks. It is agreed therefore to now get an external second opinion.

External second opinion

Imani's PICU consultant sits down with her parents and suggests that they might get an opinion from a respiratory consultant who works in a centre that specialises in long term ventilation (LTV). Both parties agree this is a good idea. Imani's PICU consultant makes some background enquiries and identifies an appropriate senior consultant before drafting a letter of referral which she shares with the family. Both parties agree the question they would like advice on: "Acknowledging Imani has a progressively deteriorating condition, would the potential requirement for 24-hour ventilation in the future outweigh any benefits that a tracheostomy would bring in the short term?"

The medical expert receives the letter of referral and contacts the PICU consultant to better understand Imani's medical history and the family's concerns. She arranges to visit the PICU at a time that is convenient to Imani's family. She examines Imani and speaks at length with her parents. She writes a detailed report to Imani's clinical team and her parents in language that all parties understand. She is very sympathetic to how challenging the situation is. However, she expresses her concern that if a tracheostomy were done, although Imani would be kept alive, in time as her neurological condition deteriorated, she might increasingly not be able to show her distress to invasive procedures, particularly deep suctioning.

Imani's parents are very appreciative of the attention the medical expert has paid to their situation. They sit down again with the PICU consultant and both parties agree that it might be best to re-orientate care. Imani is transferred to her local hospice where her breathing tube is removed with her family and palliative care team nearby.

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Vignette 2: an ESO from an MDT in another hospital to advise on the management of a cardiac patient.

Background

Mohan, a 3-year-old boy with hypoplastic left heart syndrome. He has already had major cardiac surgery as a baby and a second operation when he was six months old. He has done very well after his heart surgery so far although has some developmental delay for which he requires additional support at home. The family is well known to the cardiac team at the tertiary hospital and Mohan is regularly followed up by his named cardiologist in outpatient clinic. They have also had a cardiac liaison nurse assigned to them who they are able to call if they have any questions or concerns.

This admission

Mohan is now due to have a third cardiac operation called a Fontan procedure without which his life expectancy will be limited. In preparation for this he is admitted to hospital for a diagnostic cardiac catheter procedure (cardiac catheter test) to assess the pressures in his lung. Unfortunately, the results of the investigation make Mohan's surgeon and cardiologist worry that he might not be a suitable candidate for the operation. They share their concerns with his parents and schedule his case for discussion at the weekly joint cardiac conference (JCC). This meeting provides a forum for all members of the MDT (cardiologists, surgeons, intensivists, anaesthetists) to discuss the cases planned for heart surgery in the forthcoming weeks. At this meeting Mohan's data is reviewed, and it is decided that it would be sensible to get a second opinion from colleagues at another paediatric cardiac centre.

External second opinion

Mohan's named cardiologist sits down with his parents and their cardiac liaison nurse and explains the outcome of the JCC. The family are aware that second opinions between cardiac centres often occur and are already familiar with the process. A referral letter, along with the data from the cardiac catheter and the echocardiogram, is sent to the chairperson of the JCC at the second paediatric cardiac centre. The parents receive a copy of the referral letter.

The following week the JCC at the second centre review Mohan's case notes and information. This MDT discuss Mohan's case and decide that a cardiac MRI scan might be helpful to inform the decision about surgery. This is relayed back to Mohan's named cardiologist.

Mohan has the scan locally the following week and the results are reviewed at the local JCC. Fortunately, the scan is encouraging, and all agree that Mohan should proceed to have the Fontan operation. His parents are reassured everything has been very carefully considered and give their informed consent for surgery to proceed. Mohan has his surgery, spends several days in paediatric intensive care, but makes a good recovery and returns home a few days later.

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Reviewer 1

Query	**Response**
Scope of practice: a clearer statement describing how this guidance applies across different paediatric specialities	Thankyou. We have amended the Introduction and introduced a new passage of text to address this concern*:* *'In clinical practice the use of external second opinions vary widely according to circumstance. As the number of patients with complex needs increases* [3]*, second opinions to inform MDT-decision making are often regarded as standardised good practise in many subspecialities. For example, in paediatric cardiology, an MDT in one tertiary centre will correspond with an MDT in a second tertiary centre around therapeutic options (surgery, interventional, non-treatment) in especially complex cases. Similarly, in some forms of paediatric cancer, it is routine practice for each patient's treatment to be discussed at an established national advisory panel. In both situations the value of the second opinion is to ensure that all potential treatment options have been explored and that consensus (both within the MDT and between the MDT and the family) is achieved. Second opinions are also often sought from experts in more controversial circumstances: when conflict arises between the health care team and the family, and/or during the course of complex end of life discussions in critically ill children whose cases may proceed to Court for resolution.* *In all situations, we suggest some common principles should apply: a focus on shared decision making in the best interests of the child, transparency, and trusted confidence in the expertise of the individual or body giving the opinion.*
Scope of practice: further clarification of the use of the word 'usual'	We have removed the word 'usual' from the document.
Inset box of text on Page 5 appears truncated	Thankyou. This seems to have occurred during the manuscript conversion to pdf. The inset should read *'.., rather than shoring up one or other of two conflicting viewpoints'*
Comment whether there should be consensus among treating team that an ESO opinion required.	Thankyou. We agree that a consensus approach in the MDT should be adopted as to whether a second opinion is merited. However, considering the scope of situations where a second opinion might give value (see above), and the obligation upon individual consultants by the GMC to respect a parents request for a second opinion, we do not think it wise to restrict second opinions to a consensus basis alone. Therefore, in the section 'Requesting and providing a Second Opinion' we have added this sentence: *'In complex speciality patients, where a team- or MDT- based approach may underpin decision-making, the decision to seek a second opinion should be based upon consensus. However, there will be other circumstances (e.g. when the Courts are involved)*

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	where ~~a single lead~~the child's named consultant may make a decision to refer for a second opinion'.
Request for suggestions when a Trust's senior leadership team (SLT) should approve the need for a second opinion. Further discussion would improve the paper.	Thankyou. We suggest that hospital SLTs and other bodies should formally recognise the occurrence of national panels and inter-hospital MDTs, but that on a patient by patient basis, the SLT might pragmatically only be notified in cases where there is conflict and/or court resolution might be required. We have added this sentence to the section "How to support good practice: *'Most second opinion work is carried out in an informal manner in a variety of formats across all paediatric subspecialties. Health Care trusts need to recognise that, when conducted well, second opinions support patient choice and may reduce complaints and litigation. Commissioners should acknowledge the activity of interhospital MDTs and national advisory panels through service specifications. Hospital senior management and legal teams might be automatically notified when second opinions are sought to mitigate professional-parental conflict and/or when escalation through the Courts is anticipated, to ensure that all possible avenues of resolution are explored first'*
The role of overseas SOs and the problems associated with these could be discussed in more detail.	Thankyou. We do allude to this in Table 1. However, we have added an extra sentence in a revised final paragraph of the section "Requesting and providing a second opinion': *"..or if the health care professional identified does not meet essential GMC or other equivalent regulatory guidance. The latter can be problematic when second opinions are sought from overseas.* We have also added this further text (with a supporting reference) to the Section "Essential principles around the external second opinion process": *'In a world where the use of social media is ubiquitous health care professionals should recognise that families may, on occasion, come across and seek the opinion of 'experts' from other countries.* [10] *In such situations we suggest there this presents no fundamental ethical dilemmas as long as the essential principles outlined in Table 1 are adhered to.'*
"I was hoping for a more conclusive discussion of how SOs should best be funded. Consultants could be given time in their job plans to provide second opinions, but if these opinions result in experts being	Thankyou. We accept that at present the process is ad hoc and we advocate that the solution, at a national level, lies with specialist commissioners and recognition of ESO work within service specifications (see above) and, at a local level, with integrate care boards. We do refer to issues around remuneration in Table 1 and in the section on 'Overlap between health professionals giving second opinions and those acting as expert witnesses'. However, we have added this further section in the Summary to give emphasis to the issue: *'There is currently no formal commissioning arrangement in place that recognise or facilitate ESO work, which results in variable*

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called to court, having to prepare a medico-legal report, prepare for and give evidence in court, remuneration would need to come from the Trust requesting the second opinion under current, mostly ad-hoc, arrangements."	*practice across the UK. Healthcare professionals who undertake this work report it to be extremely onerous, frequently done 'out of hours' and, in the main, unremunerated. Whilst informal arrangements may be made between medical directors at hospital Trust/Health Board level, the lack of a national commissioning framework frustrates formal governance arrangements, job planning and the proper resource to support an optimal process. New statutory responsibilities upon integrated care systems for some specialised services may create an opportunity for local systems to work with hospital Trusts and service planners to both raise standards and realise models of funding that fairly recognise the work involved'*
Suggestion (Page 8) that experts may also be instructed by police forces and the NCA in criminal matters	Amended

Reviewer 2

Query	Response
Update to Reference 3	Thankyou. Have updated.
Page 4, line 12, should read 'give assurance'	Page 4, line 12. Amended
Page 4, line 24. Should this be 'coroner's courts'?	Thankyou. We have amended this sentence to '..*problematic in complaint processes, coroners courts, and ombudsman inquiries.'*
Page 5, lines 24-28. Clarity required in relation to what is suggested.	Thankyou. This short section refers to what parents stated might be a mechanism whereby their health care team seek out an appropriate expert. We have amended as follows: *"Families also felt that, in order to avoid any perception of bias, it was important that the clinician giving the second opinion is independent of the team treating their child. Importantly, when asked for suggestions for how to seek out such a person, families stated that their health care team might approach a professional body (such as a membership organisation representing a specialist society), since such organisations were considered by them as being impartial and able to identify the most appropriate 'expert'.* We have also amended the text in Table 2: • *"The RCPCH and specialist Societies such as the Paediatric Critical Care Society should consider establishing subgroups for colleagues interested in ESO work. These would provide a pool*

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	of credible professionals to whom ESO requests might be directed, as well as support the decision making process in complex cases, while also forming a focal point for mentorship, training, audit, and peer review of cases. • *Specialist Societies might alternatively consider establishing National Advisory Panels to support professional expert consensus in selected groups of diseases.*
Page 5, boxed quote. End of quote missing.	Thankyou. This seems to have occurred during the manuscript conversion to pdf. The inset should read '*.., rather than shoring up one or other of two conflicting viewpoints*'
Page 6, line 18-20. 'Experimental treatment per se is not a reason for not seeking an ESO or even a poor evidence base. ESOs were sought in the case of CG, for example, as to whether an experimental treatment might be in his best interests and in that case, there was limited evidence. Can the authors be clearer about circumstances that might preclude SO?	Thankyou. We have added this paragraph in the section 'Requesting and providing a second opinion': *'The situation in relation to novel and/or experimental treatments is more contentious. The General Medical Council (GMC) is clear that doctors prescribing medications or other interventions must do so based upon reasoning arising from sound theoretical knowledge, clinical reasoning, and available evidence. [10] In circumstances where the medication/intervention is 'off label' or unlicensed, the GMC states that there is an even greater responsibility on the prescriber to set out clear and careful reasoning and be satisfied that there is sufficient evidence or experience of using the medicine, and to demonstrate its safety and efficacy. [11] A clinician who wishes to provide an informed ESO about an intervention that is experimental must show that he or she has the necessary specific knowledge and training, as well as provide evidence (research or, less persuasively, from personal experience) to support a recommendation. Treatments offered on compassionate grounds for unproven therapies should be seen in the same light as novel or experimental treatments. The best benchmark for any interventions is that 'a respectable and responsible body of professional opinion and experience' would endorse its use for that indication. This approach draws on sound ethical reasoning. However, in some circumstances, a judgement as to what is reasonable (i.e., the balance of benefit versus harm) can only be addressed in the Courts.* Plus 2 additional references: 1. *Off-label or unlicensed use of medicines: prescribers' responsibilities. https://www.gov.uk/drug-safety-update/off-label-or-unlicensed-use-of-medicines-prescribers-responsibilities#prescribing-in-a-patients-best-interests* 2. *The General Medical Council. Good practice in prescribing and managing medicines and devices. Prescribing unlicensed medicines. April 2021 https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices/prescribing-unlicensed-medicines*

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Reviewer 3

Query	Response
Challenge to further reflect (and comment) on the contributory factors that lead to families and professionals seeking ESOs.	Thankyou. In practice, as we set out in our Introduction, external second opinions may be sought for several reasons: to gain further professional consensus around treatment options, in the context of complex end of life discussions, and as one mechanism to resolve conflict between the health care team and the family. You are quite correct that, in the latter, the profession's primary focus should be to understand why such conflict has arisen. As you state this could amount to a different paper. However, we have added this paragraph to the Summary and included 3 additional references: *Second opinions may be sought to gain further professional consensus around treatment options, in the context of challenging end of life discussions, and as one mechanism to resolve conflict between the health care team and the family. Prevention is always better than intervention. …… Similarly, addressing the causes of disagreement - communication breakdown (conflicting messages, insensitive use of language), disagreements about treatment (misunderstanding, challenges to standards around best interests versus harm), a sense that the family may have unrealistic expectations, and differences in values and/or faith, is likely to pay greater dividend at a system level than solely focusing on the fact of conflict itself.*[18-19] 3. *Birchley G et al. 'Best interests' in paediatric intensive care: an empirical ethics study. ADC. 2010 Oct; 102(10): 930-935.* 4. *Forbat L et al. Conflict in a paediatric hospital: a prospective mixed methods study. ADC. 2016; 101(1): 23-27.* 5. *Forbat L et al. Conflict escalation in paediatric services: findings from a qualitative study, ADC. 2015; 100: 769-773.*
Suggestion to include 1 or 2 case illustrations	Thankyou. We have uploaded 2 vignettes that illustrate the breadth of second opinions that occur in actual practise and which, in our opinion, encapsulate both the pragmatic as well as ethical factors for which second opinions are sought. They are: 1. An ESO from an expert clinician to advise on the management of a long stay patient on a paediatric critical care unit. 2. An ESO from an MDT in another hospital to advise on the management of a cardiac patient.
What does 'partnership' really mean, and how should 'SDM' actually work in practice?	Thankyou. A succinct discussion around 'shared decision making' and how it relates to best interests is challenging and indeed, as you infer, ethical. Other authors have written at length on this subject. With respect, we feel it is not central to a paper on second opinions. Rather than summarising the authors experience we believe it more helpful to summarise parents' views, and therefore

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	we have added this sentence to the beginning of the section "What do families want?" *'Families told us that having a transparent decision-making process, clear and honest communication, and their child being seen as an individual and their parents as the experts on their children, were key ingredients to effective shared decision-making.'*
Suggestion to add 'paediatric mental health team' to list of 3rd party advocates	We have added.
'What are the anxieties, how can different perspectives within the MDT be accommodated, how can each individual's (even those with the least experience/status) be seen to have a valid point'? 'What are the family's views …and how can they be respectfully understood'? 'The evidence on which we make decisions can be enhanced if we add the perceptions and impressions of all the players, patient , family, and staff to the clinical data we already have"	Thankyou. We entirely agree and would wish to expand on this if word count allowed. We have added this sentence to an additional paragraph (see above) in the Summary section, with an appropriate reference: *"Therefore, acknowledging the contribution of, and giving appropriate weight to, all professionals' opinions from the bedside nurse to the consultant, as well as a deliberately holistic assessment of the family's goals may improve team based decision making."* [17] Birchley G et al. Factors affecting decision making in children with complex needs: a consensus approach to develop best practice in a UK children hospital. BMJ Paediatr. Open. 2022; 6(1): e001589.

Editor 3

Query	**Response**
Who should be asking for the ESO?	We state in the Introduction that the initial request for the ESO can come from the '.., *patient's health care team as well as the family*' . We qualify this in the first sentence of the section 'Requesting and providing a second opinion' that the *"The child's named consultant, as the person in charge of co-*

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	ordinating and leading care, is responsible for requesting a second opinion in consultation with the family'
Who should decide a ESO is needed?	Thankyou. We have added this qualifying sentence in the section 'Requesting and providing a second opinion': *'The decision that a second opinion is needed should come from the team around the child -those professionals (including the child's named consultant and the MDT) that contribute to the wider health and wellbeing of the child. "*
Does the college mediate/nominate?	Thankyou. We have revised this section in Table 2 to add clarity: *'The RCPCH and specialist Societies such as the Paediatric Critical Care Society should consider establishing subgroups for colleagues interested in ESO work. These would provide a pool of credible professionals to whom ESO requests might be directed, as well as support the decision making process in complex cases, while also forming a focal point for mentorship, training, audit, and peer review of cases.'.*
A couple of vignettes for flavour	Thankyou. We have uploaded 2 short vignettes that illustrate the breadth of second opinions that occur in actual practise and which, in our opinion, encapsulate both the pragmatic as well as ethical factors for which second opinions are sought.. They are: 1. An ESO from an expert clinician to advise on the management of a long stay patient on a paediatric critical care unit. 2. An ESO from an MDT in another hospital to advise on the management of a cardiac patient.

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