College of Audiologists and
Speech-Language Pathologists of Ontario

Ordre des Audiologistes et
des Orthophonistes de l'Ontario

GUIDE FOR THE PROVISION OF SECOND OPINIONS

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GUIDE FOR THE PROVISION OF SECOND OPINIONS

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PURPOSE

The purpose of this Guide is to support members when applying practice standards, regulations and legislation to the provision of second opinions.

DEFINITION OF SECOND OPINION

A member's independent clinical finding relating to the validity and appropriateness of some, or all, of a patient's intervention, provided by another professional.

PRINCIPLES

1. The member has the knowledge, skill, and judgement in the specific area of practice (Code of Ethics 4.2.2)
2. When conducting a second opinion, members must be honourable, objective and impartial (Code of Ethics 4.1.3 and 4.1.7).
3. Members must ensure that the second opinion is reasonable, fair, balanced, and substantiated by objective data and clinical judgment (Code of Ethics 4.2.7).
4. Members must identify and mitigate bias or conflict of interest that could reasonably affect their second opinion. This may include declining their involvement.

THIS GUIDE APPLIES WHEN:

- A second opinion is requested by the patient, substitute decision maker (SDM) or a third party.
- The second opinion is a patient record review or a record review and a patient assessment with recommendations.
- The original clinical information is available.

CONSENT REQUIREMENTS

- Where members are asked to review the personal health information of a specific patient, they must ensure that knowledgeable consent from the patient has been obtained and documented. Only then can the member collect, use and disclose personal health information in their report and/or testimony.
- If members are asked to conduct a patient assessment, informed consent for the assessment must be obtained from the patient and documented.
- Consent may have been obtained by another health care professional or a third party. The member should ensure that the patient being assessed understands the purpose of the assessment, how the assessment will proceed, and where the report will be sent.

- Patients can withdraw consent at any time; however, this may prevent the member from completing the assessment and submitting a second opinion.
- Patients are entitled to place limits on the information that members can disclose in a report. The member should communicate to the patient that such limitations may affect the member's disclosure of their second opinion.

COMPETENCIES

In order to develop an objective and reasonable second opinion, members must possess the knowledge, skill and judgement to:

- Communicate appropriate information to the patient including, but not limited to:
    - the purpose of the second opinion and how it may affect the assessment procedure,
    - who is requesting the second opinion,
    - the relationship between the member and the third party
- Determine the relevance of any information received to the record review or assessment.
- Identify gaps in information and make reasonable efforts to seek out further information that may impact the second opinion.
- Provide a clear rationale for how and why you arrived at the second opinion

When assessing a patient the following additional competencies are required:

- Consider any restrictions to timelines for re-administering standardized assessment protocols.
- Identify significant clinical differences between the original intervention and the second opinion. This would include technological and clinical advances and approaches and whether assessment tools or equipment were available.
- Select an appropriate assessment protocol, especially if you cannot repeat the original assessment protocol, in order to generate a clinical finding.
- Review what is required in the provision of a second opinion, and not provide intervention outside that requirement.
- Protect the patient's well-being by mitigating potential stress or confusion stemming from the fact that the member does not develop an ongoing professional relationship and may appear more impersonal

DOCUMENTATION

Documentation requirements will differ according to the task.

- The record review and report is not patient intervention, therefore a patient record need not be developed.

- If the member is assessing a patient, a patient record must be developed and retained. Please refer to the Records Regulation (2015)

GLOSSARY

ASSESSMENT is the use of both standardized and non-standardized measures to observe and record a person's functioning in a variety of areas. This is done in order to gain an understanding of a patient's strengths and weaknesses so as to allow the member to make an evaluation statement and plan a treatment program.

KNOWLEDGEABLE CONSENT is where the patient understands why their personal health information is being collected and used and the purpose for disclosing their information to another health information custodian, agent or third party. The patient can give, withhold or withdraw consent.

INTERVENTION includes screening, assessment, treatment, management, consultation, education and counselling.

RECORD REVIEW when a member provides a professional opinion based solely on a patient record with no direct patient intervention.

REFERENCES

The College of Physicians and Surgeons of Ontario (2012) *Medical Expert: Reports and Testimony*

The College of Physicians and Surgeons of Ontario (2012) *Third Party Reports*

The Canadian Medical Association (2004) *Code of Ethics*

The College of Chiropractors of Ontario (2013) *Third-Party Independent Chiropractic Evaluations*