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phrenological ideas of localised brain organs and emerging concepts of cerebral localisation.

Crichton-Browne's title, *The Story of the Brain*, nailed his narrative colours to the mast: the complexities of brain structure were the evidence of its lengthy evolutionary history and development. He paid tribute to George Combe, comparing him to Robert Chambers and Charles Darwin. He introduced his father W.A.F. Browne as 'a phrenologist of the old school' and gave a wide-ranging account of neurological psychiatry with emphasis on the discovery of functional asymmetry in the second half of the 19th century.

Conclusion

Sir James Crichton-Browne was not prominently linked with the Colleges of Physicians, did not occupy a senior academic position, endowed no lectures or institutions, left no textbook of psychiatry and was 'owned' neither by England nor Scotland.

Yet in his very long life and career, there is conspicuous lineage between early asylum medicine and contemporary ideas of the cerebral basis of psychotic disorder. Renewed study of his life and many contributions, perhaps starting with his links to Charles Darwin and Hughlings Jackson would throw new light on the origins of evolutionary psychiatry.

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Service innovations: second opinions in child and adolescent psychiatry

AIMS AND METHODS

To devise a protocol, reflecting best practice, for obtaining second opinions in child and adolescent psychiatry through discussion with consultants in child and adolescent psychiatry within the Yorkshire region at their quarterly meetings.

RESULTS

The major pressure for second opinions falls upon the Academic Unit of Child and Adolescent Mental Health and on the in-patient units. Other consultants who are considered to have specialist expertise in certain areas may also receive referrals for second opinions. Both consultants requesting and offering second opinions considered a protocol for obtaining them would be helpful to their practice.

CLINICAL IMPLICATIONS

An agreed protocol between consultants in child and adolescent psychiatry within a region ensures that young people with complex problems have access to second opinions on their diagnosis and management by consultants who can be recommended to referrers by other consultants. The network of consultants ensures such opinions are not requested excessively and that 'rogue' opinions without therapeutic follow-up are avoided.

Second opinions are every person's right, although there are not the resources within the NHS to provide them on a large scale. As with all health care delivery within the NHS, methods have to be found to restrict availability to those who might really benefit. The General Medical Council (2001) only refers obliquely to second opinions by pointing out that, in providing good clinical care, doctors must 'be willing to consult colleagues'. Similarly, the Royal College of Psychiatrists' *Good Psychiatric Practice 2000* (2000) makes no reference to second opinions, only offering guidance on 'referring patients'. *The Consultant Handbook* (Central Consultants and Specialists Committee, 2000) does not refer to second opinions. The absence of guidance means that those who request and provide second opinions must devise a *modus operandi*. The child and adolescent psychiatrists within the Yorkshire region used their quarterly meetings to develop a protocol for accepting requests for second opinions, the principles of which are described here.

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Methodology and results

Consultants in child and adolescent psychiatry within the Yorkshire region were asked to send details of their practice in relation to second opinions to the secretary of the regional group. Common issues raised were then incorporated into a protocol. Up to this point, colleagues acknowledged that they had not discussed their practice in this area and, to a greater or lesser extent, had 'made it up as they went along'. It became clear that the majority of second opinions were sought from two sources. The Academic Unit of the Child and Adolescent Mental Health Service (CAMHS) in Leeds was asked for specialist opinions because its academic expertise was perceived to equate with clinical excellence (a hypothesis not always shared by the Unit's staff!). The consultants in in-patient units were also frequently asked to provide second opinions, as part of a request for consideration of in-patient care. Indeed, some requests for admission to a Tier 4 resource may have a sub-agenda that a second opinion would be helpful, especially if that opinion is in accordance with the referrer, who does not consider admission is appropriate but would like some support in the management of the case.

A list of the special interests or areas of expertise of consultants within a region would be very helpful to their colleagues when seeking a second opinion and it is recommended that such lists should be prepared and circulated.

The consultant psychiatrists agreed it would be useful to set guidelines for requesting second opinions, these being based on the following operational principles.

Referral from a colleague within the multi-disciplinary CAMHS

If the request is from a member of the CAMHS within which the consultant psychiatrist works, this should be given priority as part of normal inter-disciplinary service operations. A CAMHS with just one consultant psychiatrist will only be able to obtain an opinion from another discipline within the same service. If the second opinion requested is that of a child and adolescent psychiatrist, then they will have to refer outside their locality. A CAMHS with more than one consultant psychiatrist may be willing to offer second opinions within the local group, if this is acceptable to the child and the family. This will have the advantage of ensuring that views of locality agencies can be incorporated in the development of that second opinion and the agencies can be involved in subsequent management. Such an arrangement has much to commend it, but demands considerable respect and tolerance for colleagues' views within the same service.

Referral by another child and adolescent psychiatrist

Such a request may arise either because the child and family wish for another opinion or the consultant wishes another consultant psychiatrist to review the child to help them in the child's management. The child and family are entitled to a second opinion if they consider there is more to the child's difficulties than has been agreed or that other therapeutic options should be considered. It is helpful for the consultant psychiatrist who has provided the first opinion to discuss this with the family and offer to arrange the referral. Sometimes, this offer reassures the family that the consultant does not object to outside review and they decide not to pursue the second opinion after all. To ensure continuity of care, there should be communication between the providers of both opinions. This communication channel should be opened by the person providing the second opinion, with the permission of the family if necessary. This will clarify the reason for referral and determine the purpose of the second opinion, and an appointment can be offered.

Referral from a GP, paediatrician or other colleague

Referrals by a paediatrician or general practitioner (GP) should lead to a discussion about the reasons for the second opinion and what it is about it that is required to manage the child. It should be pointed out that, for referrals outside the child's catchment area, no supporting CAMHS work will be available and there will not be ready access to other agencies. This emphasises that the most comprehensive support can be provided locally. These matters should be discussed with the referrer, and the reason for the referral clarified. The conversation should include the following.

- Why this specific opinion is being sought and whether it is in the child's interests to pursue it.
- Whether the referrer sees the second opinion as having a specialist interest that is relevant to the young person, and whether this perception is accurate.
- If the referral should be redirected to another child and adolescent psychiatrist in the region, or further afield, who has the specialist expertise required.
- Clarification that local services, by virtue of working relationships with local schools and agencies, can usually provide better and more comprehensive services in the long run.
- A discussion as to whether the first opinion has been consulted, and if not, why not.

Personal decisions about whether to accept a second opinion

1. In view of the pressure of work on consultant psychiatrists, second opinions add to the workload. However, if a psychiatrist has developed expertise in a particular area, it may be reasonable for their colleagues to expect to consult them about children who fall into this category. Such consultants must assess the additional workload and include it within their priorities. Similarly, academic departments and Tier 4 services might expect to be asked for second opinions on a reasonably regular basis and should gear their timetables and clinics accordingly. Those

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who are not prepared to provide second opinions should make this clear, but they may be in difficulty if at some stage they themselves request a second opinion from a peer.

2. When asked for a second opinion, if a special interest/expertise in the particular problems is not available, an alternative should be discussed with the referrer.
3. If the referrer and the provider of the second opinion have mutual respect for each other then all should be well, but if they are competitive or distrust each other it may be as well to seek a second opinion elsewhere. This ensures that any such problems will not interfere with the subsequent care of the child.
4. The providers of second opinions must make sure that the referrer and the family understand what they can offer. Will it be an assessment only, which may disrupt further care if the opinion is at variance with the local CAMHS? Or is the provider of the second opinion prepared to take on future care and monitoring? The latter will clearly have an effect on workload that must be considered carefully.

What priority should second opinions be given?

Referrals for a second opinion, once accepted, should not jump to the top of any waiting list but should wait their turn so as not to disadvantage local referrals. A service that receives regular requests for second opinions will have to find a way of incorporating the provision of such opinions into its regular practice via a specialised clinic or by reviewing its prioritisation and allocation procedures. A second opinion requested from a Tier 4 service may need to be provided quickly to clarify the need for day or residential treatment, but this is part of the routine practice of such a service. Third opinions should not be offered unless specifically requested by a consultant colleague for a specific reason.

Contentious issues

1. Is it acceptable to agree to a referral for a second opinion without the consent of the first opinion? The consultants agreed that the right to a second opinion overrides the wish of the first opinion not to seek a second opinion. If at all possible, a discussion with the first opinion should be an important part of the decision whether to take the referral. However, a refusal to accept requests for a second opinion without the agreement of the first may look like a medical 'closed shop' and may disadvantage families unfortunate enough to experience unacceptable practice. However, if a second opinion is offered without the knowledge of the first opinion, it is the responsibility of the person giving the second opinion to provide ongoing care. This appears to be the case more often when the second opinion is provided privately. However, treatment initiated privately cannot then become an NHS responsibility, especially if the initial NHS opinion is not in agreement with the second opinion.
2. If the second opinion agrees with the first, the family should be directed back to the local service to ensure that they receive an integrated inter-agency service. However, if the second opinion disagrees with the first, the new opinion must be discussed with the first opinion and the management plan reviewed. Before seeing the child, those providing a second opinion must make it clear if they are only prepared to offer an assessment or whether they are prepared to offer ongoing management if their opinion is at variance with that of the first opinion. If the first opinion is unwilling to agree a new management plan, based on the new opinion, there may be a moral obligation for the second opinion to take on treatment.

Conclusion

Second opinions may improve or blight the care of children and their families. An agreed protocol between consultants in a region ensures second opinions are only carried out when their purpose has been clarified and those responsible for the care of the young person have agreed their terms of reference.

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Declaration of interest

None.

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