Medical tests—pause, think and prescribe

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Of the zillion ills of the corporatisation of medicine, the numero uno bane is the issue of unnecessary testing. This has been brought out, yet again, in a recent structured review in *JAMA Internal Medicine* [1], which examined the cascading effects of ordering unnecessary tests, the case in point, ordering electrocardiography (ECG) and X-rays for routine clearance for such basic surgeries as cataract and hernias. Every minor change in the ECG is followed up by stress imaging, and in a large number of cases, coronary angiography, which infact can even be harmful. The ‘routine’ troponins in the physicians’ outpatient clinics and in the emergency ward, and the recent fashion of sending B type Natriuretic Peptide (BNPs) in any and every case of dyspnoea, are more than an anecdotal digression. Indiscriminate coronary computed tomography (CT) scans is yet another recent addition to this malady of so-called unnecessary testing. Let alone the cost, the radiation exposure and the risk of malignancy itself must make all of us sit back and answer a very basic question, before we order a test—what is the yield expected?

Partly, tests are ordered indiscriminately under the garb of an oft-repeated euphemism, ‘Routine Testing’, sans any degree of cerebration. At other times, the medical professionals take the plea of potential medico-legal litigation. Unfortunately, in reality, it is more either to cover our own ignorance of the disease process and what is going on or for the ulterior motives of financial gains involved that we order blanket all-encompassing investigations. All this is contrary to the first tenet of the practice of medicine, as charged on us by the Hippocratic oath, ‘Primum Non Nocere’—first, do no harm.

Tests should always be carried out, when there is intermediate probability of an event. Dr. Kevin Campbell, in a

commentary on MedPage Today, succinctly puts it: ‘If you have a low pre-test probability, you do not need the test. If you have a high pre-test probability, you should treat, not test’.

We should order only those tests, which materially affect the decision-making. If there is only one path available, and that path is pre-ordained, then testing should only be limited to research protocols. Further clinical decision-making should be encouraged, and mistakes and faults thereof condoned, rather than punished. There should be an implicit policy in this regard, and only in a rare anecdotal case, reeling of gross negligence, should any fault of clinical decision-making be taken cognisance of, other than for learning purposes.

Once again, I borrow from Campbell, ‘... as physician leaders, we must THINK before we TEST. Lets harken back to Shakespeare and Hamlet’s ‘nunnery scene’ – to test or not to test, that is the question...’ and my two pence on this, ‘Not to test’. At the gross population level, the incidentalomas and accidentalomas have done more harm to the patients, than good.

It thus behoves us to not spare our self a wink before prescribing a test.

Reference

1. Morgan DJ, Dhruva SS, Coon ER, Wright SM, Korenstein D. 2018 update on medical overuse. *JAMA Intern Med.* 2019;179: 240–6.

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