

COMMENTARY

We Need Common Sense Accountable Care

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I was recently consulted to evaluate a 94-year-old woman with a medical history of hypertension for syncope. She had just finished eating lunch at a restaurant and went to scrape the snow off her windshield when she slipped on a patch of ice and hit her head. She briefly lost consciousness, and her daughter, who was with her, called 911. She quickly returned to normal without any chest pain, shortness of breath, palpitations, nausea, vomiting, bowel or bladder incontinence, or seizure-like activity. The ambulance came and took her to the local emergency room.

In the emergency room, the patient had a stat head CT, CT of the cervical spine, chest x-ray, complete blood count, complete metabolic panel, urinalysis, troponin, EKG, and coagulation panel. The head CT showed a small subdural hematoma; the remaining labs were normal. She had a normal neurological exam, and her vitals were normal; however, she was transferred to a tertiary care facility for further evaluation of her subdural hematoma.

The patient was rushed by ambulance to the tertiary care facility emergency department one hour later. Her neurological and physical exam remained stable. Her head CT and other laboratories were repeated and stable. She was admit-

ted to neurosurgery for “further evaluation.”

On our evaluation, the patient had a blood pressure of 130/80 with a pulse of 80, respirations of 16, and oxygen saturation of 96% on room air. She was alert and oriented without distress. The patient had unremarkable head, neck, lung, heart, abdomen, extremity, pulse, skin, and neurologic exams with normal sensation proprioception and strength. She did not have orthostatic symptoms. She reiterates to us that she was fine until she slipped on the ice and hit her head. We encouraged her to maintain good hydration and have a physical and occupational therapy consult; we considered discharge.

However, outside hospital imaging showed a “shadow” on the portal film of the chest. The patient never smoked, maintained her weight, and had no shortness of breath or cough. Chest CT with contrast was recommended and was obtained by the primary service, which showed normal lung fields but a thyroid nodule that “recommend clinical correlation and ultrasound for further characterization.” The patient then had a thyroid ultrasound, which confirmed cystic nodules. TSH was obtained and was normal.

The family asked why all these tests were ordered. I asked the pri-

mary team the same thing. The response was: “We don’t want to miss anything.” I discussed this with the family, and they appreciated the workup but felt that if they had more discussion on the topic many of the tests could have been averted without increased risk of litigation. They stated that even if the patient had a lung cancer or thyroid cancer she would not want to pursue biopsy or surgical resection or chemotherapy at her age. They stated that patient lived happily and wanted to continue talking with family, living in her community, and baking pies—the things that gave her a good quality of life.

In looking back on this case and other cases like it, more time should be taken with history and physicals instead of dropping the “syncope bomb,” which can lead to serial troponins, EKG, head CT, EEG, carotid duplex, echocardiograms, and event monitors. This clinical approach is not good for patients or the health care system; it increases costs and creates delays for patients who really need the tests. Also, completely shared medical records need to be more widely used so the same tests are not repeated unnecessarily. We hope with the Affordable Care Act that both physicians and patients will receive more thoughtful medical care.