

Patient Safety Bulletin

Overtesting

What happened and what were the issues/implications?

I was copied into a discharge letter about a patient I had met many years previously. It was really 'just for information'. I knew this man because of his history of pulmonary embolism years ago following major surgery. I brought up his old letters just to remind myself about him and what had happened more recently. What I saw was a surprise. He had had seven CT pulmonary angiograms (CTPAs) in the last 18 months, all of which were negative for embolism.

This was a large number of what were now clearly unnecessary scans, exposing the patient to lots of radiation and the associated risks of that.

The repeated nature of the scans made me think this man was probably anxious about something, so why hadn't the team spotted this and stopped doing scans? Was everything being protocol-driven, without any way to veer off guidance? And why had no one stepped back and taken an overview of the whole situation to manage things better for this man? By doing a scan every time, we were effectively telling him he needed a scan every time he had chest pain. There was no way this man would feel able to manage his symptoms himself.

What actions were taken?

I spoke to the consultant physician who was responsible for the last admission. She reviewed the notes and got back to me. Guidelines were being followed in the requesting of scans. Whenever he was in hospital, his Wells score was always high enough to justify a scan.

She agreed that the situation needed a review and arranged to see him in an outpatient clinic to talk things over in more detail. It turned out he was severely anxious, and suffered with chest pains and breathlessness as a feature of this. She put in place a series of appointments with him, giving him an alternative route to discuss symptoms, and also arranged for him to see a health psychologist.

What did you learn?

Even in the best hands, the positive pick-up rate on CTPA scanning is of the order of 15%–30%.

This man's history of PE made it very hard for him to ignore the symptoms and he didn't know how else to manage them other than by going to the hospital when they got really bad. I learnt the value of taking your time with explanations to make sure patients know what to look for and how to manage some things themselves. I learnt about health coaching and the benefits it can bring to those with chronic disease. I also learnt not to worry about expressing my concerns about a patient's care to the teams involved. They were all happy to hear from me and put in place a number of things which have really helped this man.

How was the learning shared?

We have a Realistic Medicine group in the trust who are always seeking stories and subjects to help inform others. Not long after this man was seen, we started displaying posters in all our departments to raise awareness. We suggest to patients and their doctors to always consider these four questions a patient should feel able to ask, based on the global Choosing Wisely initiative:

- What are my options?
- What are the possible benefits and risks?
- What would happen if I did nothing?
- How can we make a plan together that is right for me?