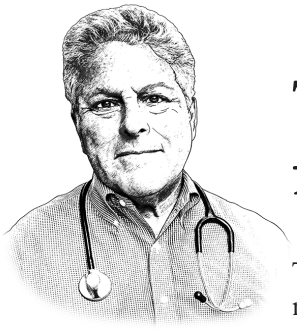

Test ordering: Balancing the good for the many with the good for the one

This issue of the *Journal* includes 3 articles on how we order clinical tests. One article relates to screening and treating patients with asymptomatic bacteriuria.[1] The authors review data that generally argue against treating asymptomatic bacteriuria, with its untoward financial ramifications, the potential to increase the prevalence of antibiotic resistance, and the risk of iatrogenic antibiotic-associated complications. The authors persuasively discuss why the frequent practice of treating asymptomatic genitourinary bacterial colonization is unlikely to provide clinical benefit to the patient in all but a few special circumstances. The concern with unnecessary treatment is magnified given the still common utilization of quinolone antibiotics for urinary tract infections.

These underlying issues resemble those encountered when considering antibiotic treatment in patients with acute upper respiratory infection. Although these patients are symptomatic, current evidence indicates that most have a viral not a bacterial infection, and thus are not likely to benefit in the long run from a course of antibiotics. However, antibacterial therapy may offer modest short-term benefit to some,[2] and I confess utilizing them occasionally in select patients (and at times for myself). And there is the rub: Will even selective usage of antibiotics for this condition accumulate to represent too-frequent utilization and thus contribute to the development of antibiotic resistance in the patient and in the community? How do we balance the possible and usually modest immediate good for 1 person against the potential long-term harm for many? Hopefully, this can be accomplished by exercising conservative and justifiable clinical judgment, not by always taking the path of least resistance, which is often prescribing an antibiotic to an expectant, cajoling (and paying) patient.

The other 2 articles in this issue present different perspectives on balancing the advantages and disadvantages of a daily standing order for basic laboratory tests for patients in the hospital.[3,4] Here, the focus is only partly on the patient. Murphy and Schram[3] argue that there is more hype and postulating than actual data demonstrating patient detriment from excess blood draws, and that ordering standing tests takes some of the stress off the attending medical teams. They also argue that the rationale for some institutional and regulatory policies and procedures has blurred the line between quality clinical care and quality fiduciary stewardship. Each added "quality" initiative likely adds to the clinicians' workload and to the time spent away from delivering clinical care as they shift their focus to designing and monitoring these initiatives. During a time when increased attention needs to be devoted to clinician well-being, Murphy and Schram wonder if focusing on the ordering of daily tests is effort well spent.

Reddy and Henricks[4] counter this with the clinical laboratory and institutional perspective on the not trivial cost-savings that can be accrued by reducing what is often wasted testing—and they raise the important point of the need to inculcate a culture of financial and clinical stewardship into clinical healthcare delivery at every reasonable opportunity.

I can understand both sides of this discussion. Analogous to the time-honored algorithmic approach in trauma medicine, when there is a lot going on for the inpatient and medical team, it may not be unreasonable to place a standing order for daily or alternate-day laboratory tests to monitor values that might be unpredictably changing due to the effects of illness or therapy in

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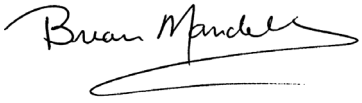
order to ensure that changes are not missed due to oversight in ordering. We have an expectation for regularly scheduled measurement of vital signs for most inpatients. On the other hand, in the patient not on anticoagulant therapy or needing significant transfusions and fluid replacement, there is little need to be checking coagulation parameters on a regular basis. Finding an abnormality does not mandate additional testing or reaction—clinical judgment must be utilized. There are important practice and fiduciary challenges, but not necessarily clinical quality-related issues. All are important and warrant our attention, but the purpose of attending to them should be clear to all.

I, like many of you, live a related underlying issue every day as I confront the electronic medical record with a patient in front of me. There seems to be a minimally accepted myth that including endless, templated, reiterated information (only some of it accurate) in each note will enhance the *quality* of patient care. But will noting yet again my 78-year-old patient's family history of coronary disease and personal history of Bell palsy help me manage his tophacious gout and post-MI heart failure, or will it instead just bolster the billable moment? This more "complete" visit note does not add quality care to his visit with me. But it does add time and frustration for both the clinician and patient, both in writing and in reading prior notes.

Stressors and expectations continue to pile up on individual clinicians and can be measured by counting our keyboard clicks at the terminals and the time and clicks spent answering additional patient questions in our inbox that we didn't have time to address in person. Compromises need to be made and, hopefully, they can be thoughtful ones that accommodate all constituents. As Ashton discussed several years ago,[5] with attentiveness much can be done to streamline our time spent in clinical documentation.

As a tumultuous 2022 comes to a close, we all realize that public health, socioeconomic, and political situations that have challenged and divided us remain. We can hope and contribute our individual efforts to try to smooth the edges of our lives as they touch others. Although there is much beyond our individual control, we are in unique professional positions to have a positive impact on the lives of our patients and their families. But we need also to focus some energy on protecting our own well-being within the health systems where we work. We can't help others fully if we don't take care of ourselves.

I want to publicly express my personal thanks to all those people who touch the production of the *Journal* in so many ways. Many individuals are listed on our masthead, and there are others who serve invaluable roles. I remind our readers that behind the apparently seamless publication of each monthly issue, there are real people comprising our editorial and production teams. To their credit, and as testimony to their superb professional skills and undaunted attitudes, the many challenges that they have faced this past year have been invisible to those outside of our (virtual) offices. Thank you!



Brian F. Mandell, MD, PhD
Editor in Chief

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