Andy Lazris: Hi, it's Sunday morning, Alan and Andy here, for Return to Healing. And Alan, just yesterday and the day before, I had a really, amazing patient of mine. He's 86, he… every now and then, when I'm out walking, I see him bicycling around the paths, and…

Andy Lazris: I see him pulling weeds in his garden, but of course, he's got a set of kids who thinks he shouldn't be living alone, he's demented because he repeats himself. Well, he had a faceplant,

Andy Lazris: at the store, and he may have passed out. So the kids brought him to the hospital, and there's a guy who doesn't take medicines or… or even really go to doctors very much, other than seeing me. But,

Andy Lazris: You know, all of a sudden, it became…

Andy Lazris: there were things. And one of the things was, they do… they drew a lab called the troponin on him.

Andy Lazris: And, and, so then they said they had to do all these heart tests and a series of troponins, and the cardiologist came in, an echocardiogram stress test,

Andy Lazris: admission overnight, just because they're worried. Mind you, CAT scan, MRI, all… everything normal, except for the troponin, which went up. So, Alan, we wrote, actually, an article both about…

Andy Lazris: people who pass out, and what we should do with them, and also about this troponin test. And the troponin test, I think, tells us a lot about the emergency room

Andy Lazris: Mentality in our country in general, and why it could be dangerous.

Alan Roth: Andy, I agree with you 100%. When you texted me about the topic, I have a great case to present as well, but, you know, when you look at this, it basically comes back to a lack of common sense in medicine as we see it all the time.

Alan Roth: And that lack of sense goes to… people don't talk to patients anymore. Like, they don't really get a history. Someone comes in, as you said, the guy fell on his face, which just triggers a line of diagnostic tests that's done without even a real history, number one. And equally important.

Alan Roth: about a physical exam, like, we don't examine people. So, ER doctors, and I hate to say it, you know, they're really busy, people are coming in, why are you here? Oh, I passed out. So the medical term for that is syncope for the folks.

Alan Roth: and it triggers a syncope workup that Andy just described without even talking or examining the patient. I've seen on these, what we call stroke protocols, that you don't even see an exam on the stroke protocol. Like, before the person is even touched.

Alan Roth: They have 47 MRI, CT angiograms, MR angiograms,

Alan Roth: Flow studies to the brain, perfusion studies to the heart, and brain…

Alan Roth: And, like, 98% of them are normal. Like, when you look at someone, you know, hey, this person's having a stroke. Like, examine people.

Andy Lazris: It is that, that whole idea of…

Andy Lazris: You know, you look at someone and you have a sense of what's going on is lost completely. It's almost irrelevant.

Alan Roth: protocol, it's like the app.

Andy Lazris: All protocol.

Alan Roth: There's an app for that.

Andy Lazris: And so, a troponin is a test that's supposed to diagnose the heart attack, early.

Andy Lazris: Now, first of all, a guy who falls on his face is not having a heart attack. It's pretty clear that that's not what's going on, so why would this test even be done? Once it's done, if you fall on your face, it could go up with any kind of damage to the body. If you run a marathon, you're gonna have a really high…

Alan Roth: And most people of that age have some slowing of the kidneys, and people with slow kidneys have higher levels of troponin.

Andy Lazris: What we found is older people all have high levels. Athletes or people who have traumatic injury have high levels. People with gallstones are gonna have high levels. It's just not a specific test, so if you do it without what's called a pre…

Andy Lazris: you know, pre-diagnostic certainty, or some… some suspicion, clinically. Like, oh yeah, he was having severe chest pain, and then he fell down.

Andy Lazris: Yeah, okay. Then that's in the equation, because we talk to the person, we examine them. But… but just to do it as part of a workup, it's gonna be positive. Yeah.

Andy Lazris: And then it's gonna lead to thousands of dollars of tests, some of which also might be positive.

Andy Lazris: In this guy's situation, thankfully, the next tests weren't, but of course, he'll have a follow-up with a cardiologist, and then we're… then we're in the… then we're in this morass for something that shouldn't have been done. So, Alan, what we found in our article is the pre-test probability.

Andy Lazris: Of a troponin meaning something, having any meaning at all, was 5%.

Andy Lazris: In other words, of all troponins that are positive, 5% will have any meaning. And those were all done in people who had chest pain, or some other clinical manifestation of a heart attack. The other 95% led to unnecessary testing, which could have been dangerous, and often is.

Alan Roth: And it's the same with the CT of the head with syncope. Same kind of numbers, especially when it's not directed. We know there are certain signs in syncope that might say, hey, this could be a problem in someone's brain, and they should have it.

Alan Roth: But, you know, if someone's out in the hot sun, exercising, and it's in the middle of the summer, and they didn't drink enough, and they pass out, like, duh, like, we know what they passed out from, they're a little dehydrated and overheated, why are we doing any tests on them?

Andy Lazris: Yeah, I mean, it's the old, you know, cover your butt situation, some people have told me, but that's bad medicine. To me, it's also, you know, makes big money for the hospital, and for some of these specialist doctors who come in to see people there.

Andy Lazris: Like, these cardiologists just did all these tests, based on a stupid lab test. And the head CAT scan's the same thing. Well, what if the head CAT scan then finds a little something? You know, that has nothing… all older people, by the way, have abnormal CAT scans.

Alan Roth: Right, and now they're, quote, referred for observation. You can't send them home.

Andy Lazris: They're referred for observation, and that's money for the hospital. It's just… it's a perverse incentive. And, you know, I… and in my case, I had a… one of the sons is one of the smarter medical people I've ever seen, but then he had two siblings that overruled him.

Andy Lazris: And he wanted Dad to come home. Dad wanted to come home. Dad became not part of the whole equation. It became testing.

Andy Lazris: Dad might as well have not have been there. You could have gagged dad, and just, you know, put him in a corner as they did all the tests, because dad didn't matter. And that's what's happened to our medical system. The human being in the equation

Andy Lazris: has been lost, and it's just all testing. And the emergency room, which can save your life if you go for the right, the right reason, could also be quite a dangerous place.

Alan Roth: No, so I call the cardiac testing the trifecta of tests in our hospital. Everybody gets them, almost no matter what you come in for. And that's the troponin, and then there's something called a BNP that we use for heart failure, and then there's something called D-dimer, which is used for blood clots.

Alan Roth: And invariably, one of those is gonna be wrong, abnormal, and it's gonna lead down a path of the unnecessary next test. And each one of these tests that then leads to imaging adds, like, 8 hours to the person's hospital stay. So someone coming in for something totally stupid.

Alan Roth: Not stupid, I mean, on the patient's part, but that's easy for the doctor to figure out and get the person out of the ER ends up with, you know, 36 hours worth of an ER stay in testing.

Andy Lazris: And, and, yeah, and it can lead… look, so my, my dad,

Andy Lazris: Who is not one to drink a lot of water, 84 years old, had a bad heart, but never had been in pulmonary edema, which means he has

Andy Lazris: poorly functioning heart, but no… not once has that led to fluid in the lungs. But he went to the hospital because he was tired. He didn't… he actually went to his doctor, because he was tired, and the doctor needed blood work and couldn't get it, so sent him to an urgent clinic, which led to…

Andy Lazris: them thinking he should be in a hospital for what he had been experiencing for the last 5 years, every day. Just a little shortness of breath and tiredness. Anyway, that… one of those tests, that BMP, was hot.

Andy Lazris: And it's always high in him, but he was super dehydrated, and he had a high BMB. You know what they did, Alan? They…

Andy Lazris: sucked fluid off him like you wouldn't believe, and put him into an acidotic spiral from which he never recovered, because he died a couple weeks later. This is what happens with a test

Andy Lazris: And a guy who's clearly dehydrated, not fluid overloaded, but the test says otherwise, so they treat the test.

Andy Lazris: and cause massive harm. And that's the problem with just, like you say, phishing. You know, you're throwing all these tests out, one of them's gonna come out positive.

Alan Roth: And we don't think anymore, and unfortunately, this is how we're training our youth, you know, I do most of my time training residents.

Alan Roth: We're training our youth just to be robots. You know, someone comes in, the word syncope comes up, now they get the next 14 tests to rule out cardiac causes versus neurologic causes, and they have to get all these things.

Alan Roth: Including in my office with a cardiac complaint, so what do you… I'll say, you know, a patient comes in with chest pains, like, what do you want to do? And, like, literally, troponin comes up in the office, like.

Alan Roth: I was like, you were doing a troponin in the office? Like, if you're thinking my patient had an MI, we better be sending them to the hospital, because finding out tomorrow is not a good thing. It's like, the clinical judgment has just totally gone out the window.

Andy Lazris: And what's your ER story? Because you said you had one.

Alan Roth: Oh, so I literally…

Alan Roth: I have an elderly, you'll appreciate this one. He's about 78, and he's got really bad Parkinson's. I mean, the guy could barely walk. He walks with a walker and an aide by his side

holding him, you know, coming, shuffling along into the office. I'm sure he's got another month or two before I'll be seeing him in the office in a wheelchair.

Alan Roth: And he calls me up, you know, constipated. So, for, like, 3 days in a row, I'm talking to him on the phone, telling him what to do.

Alan Roth: For his constipation.

Alan Roth: And now he calls me up and says, I can't pee.

Alan Roth: And I'm like, -oh. I was like, when was the last time you peed?

Alan Roth: He goes, I don't remember.

Alan Roth: I said, you need to get to the emergency room.

Alan Roth: So, I literally called my people in the emergency room, because I knew what would happen to this guy, because he could barely speak for himself. He'd get thrown in a corner until somebody evaluated him, like, 6 hours later.

Alan Roth: When he was there, because he hadn't pooped in a week, and he hadn't peed in 2 days, probably, and he had probably had a urinary obstruction from the poop.

Alan Roth: So I, I sent him… with the diagnosis.

Alan Roth: Well… Bless you. So… He did get seen right away.

Alan Roth: And unfortunately, instead of a reasonable exam and putting a Foley catheter in him, they ordered a CT of his abdomen and pelvis.

Alan Roth: I sent him with the diagnosis. CT, abdomen, and pelvis.

Alan Roth: And what got me even more is, I always laugh that every patient of mine that goes into the ER now, because

Alan Roth: everything is ultrasound in the ER, point-of-care ultrasound. That's an ultrasound that people go for, that some of the surgeons, literally, and some of the medical doctors, they carry portable ones in their jacket. It's like their stethoscope now is portable ultrasound, and someone

comes in with something like that, you put the ultrasound over their bladder and see that it's full. But instead, no, we did a CAT scan.

Alan Roth: Well… 8 hours later, the CAT scan showed constipation.

Alan Roth: and a distended bladder up to the umbilicus. That's up to your belly button, folks, so your bladder's up to there. They put a folio in and drain out 2,000 liters of fluid.

Alan Roth: The guy immediately feels better.

Alan Roth: goes to the bathroom with his aid, and has a huge bowel movement, which I would have expected, you know, after you emptied out 2 liters of fluid from his bladder that was pressing on his rectum so he couldn't pee.

Alan Roth: And, all well, right?

Andy Lazris: Secured.

Alan Roth: The ER doctor calls and says, I'm referring for your patient for admission.

Alan Roth: And I said, for what?

Alan Roth: Well, you know he's gonna have post-obstructive diuresis, and he's gonna need several days of IV fluids.

Alan Roth: like… He's… he's been drinking.

Alan Roth: Like, why do you say that's gonna happen? I said, give them a liter of fluid, if that's what you think, and we'll repeat it in a couple of hours.

Alan Roth: She refused. Wow. So our protocol in the hospital is, if ER doctor recommends admission.

Alan Roth: Which will be denied, because I sent him home the next day, because he was fine and wanted to go home. And the patient wanted to go home, by the way.

Alan Roth: And they determined the category, like, admit versus refer for observation. And she just insisted, it was 10 o'clock at night, and either I come in and send the patient home, which I could do, or I just go along with it, because I want to sleep for 3 hours.

Andy Lazris: I…

Andy Lazris: That's just, you know, that's… on so many levels, because A the diagnosis was given, and they just needed to listen to the doctor who knows the patient, and go with that, and they…

Alan Roth: family doctor, I don't know shit.

Andy Lazris: You don't know anything. You know the patient. We don't… we don't know anything, but if they listened to you, they would have…

Andy Lazris: put in the Foley, and poop, pee.

Andy Lazris: Pull out the Foley, go home. And like you say, why would you ever put a needle in someone's arm with artificial fluid when someone could drink? It doesn't make sense. I mean, that's for people who can't drink. Yeah, I get it, but if you could drink, that's the best way to get fluid, always.

Andy Lazris: But everything has to be one step higher there. Like, it's not good enough to listen clinically and say, obviously, this is poop blocking the bladder, the bladder's blocking the bowel, it's like…

Andy Lazris: a double whammy. You fix one, both get better. No, instead, they have to do a bunch of testing to show what they already know. And that's a huge problem. You don't want to…

Andy Lazris: Because that test could show something else. And then, now what? You know, then they start calling in consults and specialists and blah blah blah. So he got away with the fact that you're his doctor. In our world, and in most of the country, primary care doctors aren't even allowed in the hospital.

Andy Lazris: We are not part of the whole hospitalization emergency room experience. We're not allowed… they have their own doctors, and those doctors are…

Andy Lazris: They're to refer to specialists and to do tests. So… and not to know the patient. So, we have removed us even further. So, be glad, Alan, you had… you were part of the conversation, at least. You were offered something, which I can't even be offered.

Alan Roth: So, you know, I speak, you know, I'm friends with the chair of the ER, and we have this discussion, like, every week, almost, about some ridiculousness that went on in the ER, and he goes, Alan, you know, we average 350 visits a day in the ER.

Alan Roth: Okay? And, you know, think about it. If you rush through something, if you don't order the test, and you miss something, you're wrong. We do the test, we're wrong. We do the blood, we're wrong. We do the CAT scan, we're wrong. Like, we just can't win.

Alan Roth: I said…

Andy Lazris: And I get that also.

Alan Roth: I get that.

Andy Lazris: I actually… there are doctors who are not like us, Alan, and who,

Andy Lazris: If someone goes in the hospital and they didn't get a million dollars of tests, these doctors get upset.

Andy Lazris: So, the emergency room has to deal with all these people, but it would be nice if there was some communication, and if they listened to us. You know, if we knew the patient, and we kind of knew why they were coming, and we didn't care… like, I've sent people to the emergency room…

Andy Lazris: Or they went for severe vertigo, and they end up having a hydroponin, and end up leaving with a stent. And with the vertigo completely not even addressed while they're in the hospital.

Andy Lazris: So the idea of talking to the patient and addressing the issue at hand in a logical way, not a protocol way, is all we're asking for. And that can be done, even with 350 people coming in a day. People can still be treated as individuals.

Andy Lazris: So that's… hopefully, you know, for those of you who go to the emergency room, you know, again, I say it all the time, you're in charge.

Andy Lazris: And they may make you think that's not the case, but there has to be some common sense, and you should question things. Like the idea of giving someone, taking off fluid in someone who's dehydrated.

Andy Lazris: that shouldn't make sense to most patients, even if it seems to, to the doctors. So, yeah, question things, and

Andy Lazris: And don't, you know, protocols will not accept your questions, but you could… you should ask them anyway. Any last thoughts, Alan?

Alan Roth: Yeah, I mean, so it's similar in our hospital, so, you know, the elderly fall thing is one of the biggest ones I have the argument about. Again, you get a senior that comes in.

Alan Roth: with a fall, and in our hospital, that's an automatic trauma consult. Automatic trauma consult. And an automatic trauma consult comes with what I call the total body CT. They CT head, neck, chest, abdomen, pelvis, and spine.

Alan Roth: And…

Alan Roth: I understand if the patient's out of it, they can't tell you. But if you have many of our, or most of our elderly people that are yours and my patients, Andy, tell us what's wrong with them.

Alan Roth: And they just end up being in the ER, getting so many tests.

Alan Roth: And it's not the test. It's not the blood test that might be a dollar, or the CAT scan, which probably doesn't cost that much to really do in a busy ER, because the tech is sitting there, and the machine is sitting there. So, you know, it's really a fixed expense with most of these tests, in my opinion. I know they say how much it costs.

Alan Roth: But, you know, an empty CAT scan with the tech

Alan Roth: It's still costing you to be sitting there in your ER, whether you use it or not.

Alan Roth: So I understand, kind of, the rationale, but it's what these tests find, so many incidentalomas, which are just…

Alan Roth: Useless things that we end up having to investigate, because they're there, which leads to the next test, and the next test. And unfortunately, many times, this thing leads to…

Alan Roth: a problem…

Alan Roth: interventional test that could hurt somebody. And we just, you know, we know it all from the work we did with the Lowen Institute and our Right Care Alliance when me and Andy volunteered for, like, 10 years and didn't get too much thanks for it, but…

Alan Roth: But, you know.

Andy Lazris: Oh, boy.

Alan Roth: You know, what did we find? We find that…

Alan Roth: over-testing leads to overdiagnosis, which leads to over-treatment, which leads to so many harms to the healthcare system, whether it's a backed-up ER,

Alan Roth: financial losses, or true harm to the patient. And it's just… common sense needs to come back to medicine. We gotta lower the cost, our country can't afford the cost, and we're just escalating it. You know, we're coming up with a test for just everything, and it's screwing up our system.

Andy Lazris: And the test, that one test that I said had the 5% positive predictive value, which is 5% of the test actually shows something, that same exact test in England.

Andy Lazris: Has a 60% positive predictive value, and the reason is they don't do it on everyone.

Andy Lazris: They do it on people who have symptoms of a heart attack. So again, spreading out, you know, just throwing a lot of tests at you versus using them judiciously are two completely different things. And Alan and I completely agree with the judicious use of testing. We're not opposed to that, but when you throw them out like this… one of my patients said to me, well, you can never get too much information.

Andy Lazris: Whoa.

Alan Roth: Yes, you can.

Andy Lazris: Yes, you can, because information, like what it did to my dad, will lead you in the wrong direction if that information is removed from the patient sitting in front of you. And the ultimate guide to your decision, as Osler said.

Andy Lazris: If you want to know what's wrong with the patient, talk to the patient. And… and that's what skipped… that part is skipped, so…

Alan Roth: That's what's gone away. We don't talk to people anymore. Or talk to the primary care or other doctor. Talk. Talk. History is still important. AI is not gonna take over a patient's history. It's not.

Andy Lazris: They can't.

Alan Roth: You know, those are questions that need to be asked, that you need to feed into AI. If you don't ask the questions, AI isn't going to be asking them.

Andy Lazris: And that's the problem, is, you know, you as an emergency room doctor or a hospital doctor don't know the patient at all. So, if there are other people who do know the patient, whether it's the patient, or the family, or the primary care.

Andy Lazris: You should have them involved, if you really cared about getting this person better, versus just going through the motions, which seems to be what's going on now, the going through the motions thing.

Andy Lazris: And it's unfortunate, because the patient's the one who loses, in this equation, even though they say, wow, that was a thorough evaluation. That's what I hear all the time, Alan. That was a thorough evaluation. No, that was a stupid evaluation, that's all it was.

Alan Roth: Yeah, I get that in the office, too. We could talk about office evaluation as well, like, do you ever finish with a patient and they say, like, that's it?

Andy Lazris: Yeah, all the time.

Alan Roth: And I'm like.

Alan Roth: Well, tell me, did I miss something? Like, what else would you like? Well, aren't you gonna do more tests and stuff? And I was like, sure, but for what?

Andy Lazris: Yeah, well, I always say, what do you think the physical is? Some people say, well, it's an EKG and a urine specimen. I'm like, and? Well, that's it. That's what we want. Everyone has their own idea of what thorough means, but thorough means being a smart doctor, and…

Alan Roth: Right.

Andy Lazris: Also means the courage to do less, and that's also thorough, even though the medical community has kind of leaped off that train.

Andy Lazris: Okay, Alan, hopefully you could have a decent day today.

Alan Roth: You too, Andy. You guys take care. Don't forget, our book, Return to Healing, talks about all this in a very simple way, made for, you know, every reader out there, and, you know, it's a good book.

Andy Lazris: They're good books. One of my patients read it, her son's in medical school, and she said, why isn't this not required reading? This is… everybody should read this. And so, we agree.

Alan Roth: Alright, have a good week.

Alan Roth: buddy. Bye-bye. Bye.