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Radiologists have become experts in evidence-based medicine. Both they and their clinical colleagues who refer patients for diagnostic tests wish to do their best for patients: to provide them with the diagnostic test or tests perceived or proven to have a high sensitivity and specificity for a particular diagnosis, and to proceed with a treatment plan based on as certain a diagnosis as possible.

Information on diagnostic accuracy is available from the published literature, or from synopses and syntheses of the evidence by organisations such as the Cochrane Library. Similarly, for interventional procedures, no longer is it enough for an individual doctor to decide on a patient's behalf what the most appropriate procedure is. This should now be evidence-based, often decided by a group, such as a multidisciplinary team, with treatment results locally audited and outcomes compared with those from elsewhere.

But is this enough? With the spectre of uncontrolled healthcare inflation, can decisions still just be made on the basis of the maximum certainty of a particular diagnosis, however many tests are done to confirm the original impression? Is a test with a much higher cost but marginally higher accuracy justified? As radiologists, our aim is to do the best for patients. But if the health budget is fixed, or even declining, more resources spent on the patient in front of you means fewer resources for others you cannot see, so called 'opportunity costs'. In other words, the opportunity to use those resources elsewhere is lost.

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