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By Editor-in-Chief Prof. Iain McCall

Dear readers,

In this issue of IMAGING Management, we cover the top three papers presented at 2008's Management in Radiology (MIR) congress. Included is a focus on the explosion in the demand for ultrasound (US) exams, and the impact it is having on managers in imaging departments. Also, the selection includes a paper on the techniques used by private imaging practices in running their facilities: their common aim is to share and explore the need for better management practices through discussing the evolving challenges and the guidelines that we can take away from those.

President-Elect of the World Federation of Ultrasound in Medicine and Biology (WFUMB) Prof. Michel Claudon, gamely speaks out as a pioneer and luminary in the field of US. His presentation notes that US's range of uses has constantly expanded over the years from the initial focus of obstetrics and gynaecology to include the abdomen, musculoskeletal and vascular system and the heart. Endoscopic US has further increased its range of uses and has proven a valuable means of real-time guidance for biopsies and injections. Radiologists are urged to take notice of this growing trend and to think of ways for the profession to capitalise on it.

Initially, US equipment was expensive and the resolution limited, but developments have resulted in a wide range of scanners, some of which are inexpensive but limited in their use while others are much more complex multipurpose, high-resolution and expensive. As a result of this growth, US is now used by a number of clinical specialties and has become in certain situations, the equivalent of the stethoscope to some clinicians, especially as there are no radiation hazards.

Healthcare managers face challenges such as the proliferation of equipment, the staffing requirements to use it, the training of users and ultimately the clinical effectiveness and diagnostic accuracy for the patient. There have also been differing views regarding the use of US across Europe where in some areas radiologists are not officially recompensed for undertaking US, whereas in other areas they are the main providers.

It is therefore wise to review the provision of US based on the type, frequency and cost of the task to be undertaken, the availability of properly trained staff and what that training should entail. It is also important to weigh up the alternative imaging options and to ensure that the operator appreciates the full extent of information revealed on an exam.

Present experience indicates that obstetric and cardiac departments are heavy US users and require dedicated and good quality equipment while anaesthesia often requires relatively simple equipment for the placement of central venous pressure lines. There is greater debate in terms of gastroenterologists and orthopaedic medicine and surgery, heavy but less consistent users whose requirements vary, resulting in difficult choices of equipment and focus.

In order to avoid the proliferation of expensive and underutilised US scanners operated by either inexperienced or infrequent personnel, it seems managerially wise to centralise the sophisticated and expensive equipment in the imaging department performed and managed by professionals who are widely trained in its use to maximise clinical- and cost-effectiveness. This allows developments to be assimilated and organised in a safe way so that standards are maintained and the resources that are committed to the new techniques, particularly contrast agents, are controlled and effectiveness maximised.

However, the importance of rapid access for diagnosis and treatment must be recognised and built into operational pathways with the emphasis on one-stop clinics and primary care. Radiologists must also be prepared to take on and explore the challenges of the modality while continuing to provide primarily a system-based service.

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