

its vital role as the hidden science that saves lives and is not relegated to a 'cost centre'!

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1. Burns DG. Responsible use of scarce health care benefits. *S Afr Med J* 2007; 97: 38-39.
2. Pretorius C. Utilisation of pathology procedures in the South African private pathology sector between 2003 and 2005. *S Afr Med J* 2007; 97: 51-57.
3. Royal College of Pathologists. Guidelines: Good medical practice in pathology. http://www.rcpath.org/resources/pdf/good_medical_practice_for_web.pdf#search=%22Good%20medical%20practice%20pathology%20%22 (accessed 22 August 2006).
4. Khoury M, Burnett, Mackay MA. Error rates in Australian chemical pathology laboratories. *Med J Aust* 1996; 165: 128-130.
5. <http://www.ampath.co.za/AntiBiotGuide/antibioguideline.pdf> (accessed 30 January 2007)
6. Australian Association of Pathology Practices Submission No 38. Parliament of Australia Inquiry to Health Funding. <http://www.aph.gov.au/house/committee/haa/healthfunding/subs/sub038.pdf> (accessed 22 August 2006).

Dr Pretorius replies: Attacking the messenger to obfuscate the message is Dr Harrison's prerogative. He dismisses my article outright without providing a measured argument or alternative explanations on any of the findings. In the Council for Medical Schemes (CMS) annual report for 2005/6,¹ the total benefit paid by medical schemes for pathology tests in 2005 increased by 26.6% over 2004 (p. 88). The beneficiaries of all medical schemes increased by 2.6% (p. 47), and the NHRPL tariff increase was 5.2% for 2005. The difference of 18.8% can only represent an increase in utilisation. My article under discussion reported a 14.5% increase in the cost per beneficiary who underwent pathology testing. If anything, the CMS report would suggest that the magnitude of the problem may be even greater than reported in the article.

To satisfy Harrison's quest for recent literature I wish to refer him to an article in *Clinical Chemistry*² that expresses similar concerns regarding test utilisation and in which the authors describe an innovative mechanism to manage utilisation at the test initiation stage.

Harrison states that pathology is a 'referral discipline', with testing driven by the referral doctor. He then contradicts himself by pontificating on the reasons why pathologists should be allowed to initiate additional testing without deference to the referring doctor or patient. What was discussed in the article was the phenomenon of reflex testing (a test triggered by the result of another test without pathologist intervention) and not additional tests as a result of clinical interaction. Although not relevant to the article, my personal opinion is that pathologists should play an active role in providing health care; this role extends to not doing tests that are ordered inappropriately, and initiating tests that are appropriate but not requested. What I cannot accept is the notion that as a 'referral discipline' pathologists should do inappropriate tests just because they are instructed to do so by referring doctors, and then in the same breath add tests on the basis that they have a responsibility for patient care.

It is unfortunate that Dr Harrison chose not to contribute to a discussion on the reason/s for the greater-than-anticipated increases in pathology expenditure.

I wish to thank Dr Erasmus for his comments. I am pleased that he agrees with me that both under- and over-investigation of patients should be frowned upon. Taking the cost per active beneficiary of the lowest cost provider and multiplying this amount with the total number of active beneficiaries from all providers in the sample was used to arrive at the quoted figure of a potential 15% saving in expenditure. This theoretical cost was then compared with the actual cost to estimate the quantum of the potential saving. The statement that Erasmus has correctly quoted verbatim, qualified this potential saving.

The purpose of the comments on non-health care expenditure as well as the comments on the costing exercise of the NPG is not relevant to the discussion, and it escapes me why this was raised.

Dr Erasmus misrepresents my efforts to address issues surrounding the design of pathology request notes. The requisitioning of laboratory tests (handwritten or electronic) has been shown in a number of articles to be a crucial interface in promoting appropriate utilisation of resources. I unashamedly advocate unambiguous requesting of individual tests by a competent clinician and fail to see how this can be interpreted as rationing.

In defence of maintaining the current version of the tick box request form, Erasmus quotes an error rate of 17%³ from an Australian article. This 'evidence' is then used to prove the unworkability of a proposed solution that was modelled on the Australian rules on laboratory request forms. Dr Erasmus is selectively quoting the worst performance achieved in the study. The median error rates, of various categories of errors examined, were in fact between 1.0 and 2.5%. This figure differs markedly from the 17% we are led to believe would be the result of implementing the recommendations in the article. Nowhere in the article by Khoury or in an accompanying editorial⁴ were handwritten request forms blamed for errors, nor was it suggested by any of the authors that the rules pertaining to the requisitioning of pathology tests in Australia be changed. Dr Erasmus's concerns about the consequences of increased errors can therefore be dismissed.

Lastly, Dr Erasmus is invited to submit for public scrutiny the academic evidence underlying the composition of the NPG-sanctioned profiles.

1. Council for Medical Schemes Annual Report 2005/6. http://www.medicalschemes.com/publications/ZipPublications/Annual%20Reports/CMS_annual_report_2005-6.pdf (accessed February 2007).
2. Poley MJ, Edelenbos KI, Mosseveld M, et al. Cost consequences of implementing an electronic decision support system for ordering laboratory test in primary care: Evidence from a controlled prospective study in the Netherlands. *Clin Chem* 2007; 53: 213-219.
3. Khoury M, Burnett, Mackay MA. Error rates in Australian chemical pathology laboratories. *Med J Aust* 1996; 165: 128-130.
4. Bryant SJ. Ensuring quality in all phases of the pathology cycle. *Med J Aust* 1996; 165: 125-126.