Outsourcing to Teleradiology Companies: Bad for Radiology, Bad for Radiologists

David C. Levin, MD, Vijay M. Rao, MD

Outsourcing night and weekend call to teleradiology companies has become a common practice among private radiology groups. While this may lead to an easier lifestyle, the authors discuss the serious negative consequences for radiologists and the specialty as a whole. These include the likelihood of commoditization of the field, lowering of fees, displacement from hospital contracts and outpatient reading contracts, greater encroachment by other specialties, and lowering of quality.

Key Words: Medical economics, diagnostic imaging, radiology and radiologists, socioeconomic issues, teleradiology


I fear we radiologists will regret it [outsourcing to nighthawks]. In the short run, people may get a good night’s sleep. But in the long run, they may find they have lost their practice or contributed to reducing the importance of their group in the hospital, such that they are not special anymore. . . . When you outsource, you start down the road of outsourcing the importance of radiology altogether.

—Barry Pressman, MD, past president of the ACR [1]

What is the message that radiologists send to their referring (and possibly competing) physicians when they sign off at 5 PM, 10 PM, midnight, or whatever, to nighthawks? Is their personal convenience more important than service to their local patients? If a radiologist does not believe that he or she personally is critical to patient care in the local hospital, how can he or she expect anyone else to believe this?

—Paul Larson, MD, and Murray Janower, MD [2]

Unfortunately I believe [the nighthawk concept] is a “Trojan horse” to the radiology community. . . . many practicing physicians within their medical communities, especially emergency department physicians, have begun to wonder what value radiologists at their hospitals bring to this arrangement other than being middlemen. . . . Other specialists will argue to governing boards or medical executive committees that radiologists should not have exclusive rights to complex imaging when they outsource these studies at night or up to 12 hours each day.

—James Dreisbach, MD [3]

The comments above are just a few of many expressing concern about outsourcing that have appeared in the past several years. These 3 all come from experienced radiologists whose roots are in private practice. More than half of radiology practices in the United States are now outsourcing their night or weekend coverage, or both, to teleradiology companies [4-6]. This policy is considerably more common in private than in academic groups, as well as in smaller groups as opposed to larger ones [4]. We believe this kind of outsourcing and the companies in the business represent one of the most fundamental and dangerous threats to radiologists in recent years. Our purpose in this paper is to discuss what led us to this conclusion and what can be done about the problem.

The teleradiology industry dates back about 10 years [7,8], but it has grown rapidly. An October 2008 supplement to the magazine Diagnostic Imaging listed no fewer than 33 companies that offer this service. The first of its kind was Nighthawk Radiology, and the generic term “nighthawks” has been around ever since. When this concept was first developed, it seemed like a clever and potentially useful new business model that offered a number of advantages to radiology practices [6-10]. The most obvious advantage was the respite it provided to radiologists from night and weekend call. But it had daytime advantages as well. It gave small groups access to subspecialty interpretations. It helped groups even out the peaks and valleys of demand without having to hire new radiologists. It could provide coverage to hospitals in underserved areas. Turnaround times were often faster than local radiologists could accomplish. Despite the actual or potential advantages to patient care, a survey of radiologists using nighthawks showed that their principal motivation for doing so was not to provide better care but rather their own convenience [5].

*Center for Research on Utilization of Imaging Services, (CRUISE) Department of Radiology, Thomas Jefferson University Hospital and Jefferson Medical College, Philadelphia, Pennsylvania.

bHealthHelp, Inc, Houston, Texas.

Corresponding author and reprints: David C. Levin, MD, Thomas Jefferson University Hospital, Department of Radiology, Main 1090, Philadelphia, PA 19107; e-mail: david.levin@jeffersonhospital.org.
Unfortunately, things have changed for the worse in recent years. Those friendly companies that were helping radiology groups with night call and subspecialty reads gradually morphed into predators bent on ousting those groups from their hospital contracts. Consider the statements made recently by executives of some of the companies [11]. Mike Lampron, CEO of Imaging On Call, said in an interview,

Teleradiology...provides a substantial cost savings by saving the hospital the need to hire new staff...For example, a full-time radiologist might cost $250,000 to $500,000 a year and they can read about 15,000 scans. In contrast, a teleradiology provider can handle 20–30,000 scans for the same amount...Currently those winds are taking us into the daytime and on-site radiology marketplace.

Clay Larson, senior vice president of Franklin & Seidelmann (now called Radisphere) stated, “We admit that we replace some radiologists in on-site relationships, but to the advantage of our clients.” The Web sites of many teleradiology companies now openly proclaim their intent to try to take over hospital contracts formerly held by private radiology groups. And they are succeeding. Well-publicized company takeovers occurred in Lima [11] and Toledo [12], Ohio, as well as Sacramento, California [13] (J. Breslau, personal communication). The latter is especially surprising because the breakup involved a large hospital chain, Sutter Health, and Radiological Associates of Sacramento, a large and very well established radiology group that had held the contract for decades. This tells us that no one is safe. Isn’t it ironic that in what it proclaimed as its “unwavering commitment to the radiology community,” Nighthawk Radiology recently announced in a press release [14] that it would consider bidding on a hospital contract only if the hospital initiated an open competition for the contract and neither the incumbent radiology group nor any competing group was a Nighthawk customer. In other words, if you currently are a Nighthawk customer, you’re safe. But if you’re not, watch out!

THE DARK SIDE: DRAWBACKS OF OUTSOURCING VIA TELERADIOLOGY

Outsourcing to teleradiology companies can create a host of real and potential problems.

The Com commoditization of Radiology

As Borgstede [10] noted, if radiology is to continue to be recognized as a specialty, 4 components of our services are required. First is a preexamination evaluation of the request for appropriateness and necessity. Second is supervising and monitoring of the examination to ensure its quality. Third is the interpretation. Fourth is a postexamination consultation with the referring physician (and perhaps the patient as well) [10]. By outsourcing to a teleradiology company, radiologists abdicate 3 of those 4 responsibilities. What kind of a message does that send to our physician and hospital administration colleagues? The message would seem to be that radiology is just a commodity and that radiologists are more concerned with their own convenience than with taking care of patients. Moreover, if the radiology group isn’t indispensable at night, why should they feel they are indispensable during the day? Brant-Zawadzki [15] put it even more strongly:

The 3 basic messages it gives—that radiologists are lazy, that radiologists are overpaid (they can afford to pay cheaper surrogates at night), and that anyone can do what selectively hired radiologists can do—constitute a potential death blow to the specialty.

Outsourcing Will Likely Lead to Lower Fees for Radiologists

Hillman [9] and Brant-Zawadzki [15] raised this concern, and we believe they are correct. It is well known within the radiology community that we are facing the threat of falling reimbursements, both from government programs and commercial payers. Quite possibly, some of the impetus for this comes from the price wars the teleradiology companies have openly engaged in and the lower fees they are willing to accept. We even have the spectacle of a teleradiology company that auctions image reading contracts to the lowest bidder [9], thus further reinforcing the impression throughout the health care industry that radiology is nothing more than a commodity.

Outsourcing Will Pave the Way for Radiology Groups to Be Displaced from Their Hospital Contracts

As noted above, teleradiology companies are now actively involved in competing with incumbent radiology groups, and no one can afford to feel complacent. There are plenty of reasons why a hospital administration may wish to replace its radiology group [8,16,17]. They may resent that the radiologists have a nearby private imaging center that competes with the hospital department. They may feel the radiology group doesn’t provide the necessary subspecialty expertise. They may feel the radiologists aren’t responsive to service needs or complaints from referring physicians. They may want to be able to give away some radiology “turf” to attract physicians in other specialties. They may want to employ the radiologists on a salaried basis so the hospital can bill globally and derive additional profit on the professional component. Or they may simply not like their radiologists.
Radiologists Could Lose Reading Contracts with Independent Diagnostic Testing Facilities or Nonradiologist Physicians Who Own Advanced Imaging Equipment

Many radiology groups currently read for independent diagnostic testing facilities or for nonradiologist physicians who have installed MRI, CT, or PET scanners or other imaging equipment in their offices. The radiologists generally bill for their professional component separately or receive a percentage of global collections. The owners of the equipment could potentially realize greater profits by contracting with a teleradiology company that would accept lower compensation.

Outsourcing Will Encourage Encroachment by Other Specialties

Perhaps the best arguments for why radiologists should be given exclusive rights to do most types of imaging in a hospital are that they are the ones with the most training and experience, and that they have assumed the responsibility of providing the most complete and best possible imaging services of all types to patients in the hospital. The latter argument loses all credibility when radiologists abrogate this responsibility every night and weekend. If radiologists feel they are a crucial part of the patient care team only during normal business hours, why should other physicians or the hospital administration be willing to grant them exclusivity? As Larson and Janower [2] pointed out,

If these emergent examinations during the night are too burdensome, maybe radiologists should also shed some of their less critical elective daytime work. . . . Some of our nonradiology colleagues, who may already be doing some of their own imaging, would undoubtedly be willing to help unburden us.

Outsourcing would seem to create a surefire precedent under which radiologists will lose turf battles in the future.

Poor-Quality Imaging Could Result

Although the teleradiology companies profess to hire only the top radiologists and to provide only the highest quality work, the reality may be somewhat different. There are a number of reasons why the work done by company radiologists may be inferior to that done by hospital-affiliated on-site radiologists [9,18,19].

First, as noted above, at the teleradiology companies, speed is of the essence, and radiologists are expected to read as quickly as possible. After all, that is the only way the companies can make money. The less time available to spend on each case, the more likely it is that mistakes will be made.

Second, teleradiologists at remote sites have little or no contact with referring physicians (and are in fact incentivized not to do so). This means they do not get input from clinical colleagues on the nature and nuances of the case. And the referring physicians have no one they can come and consult with on a face-to-face basis.

Third, teleradiologists have no contact with patients. In an era when radiologists are being urged to personalize care by speaking with more of their patients, teleradiology goes in the wrong direction.

Fourth, teleradiologists have little or no access to other important clinical information about the patient. Although some companies can provide them with access to prior studies in the same modality, it is unlikely that they will be able or willing to provide other information, such as the patient’s chart, laboratory results, pathology or surgery reports, previous discharge summaries, imaging studies in other modalities, and so on. While interpreting complex imaging studies in this kind of vacuum may be in the best interests of the company’s bottom line, it is clearly not in the best interest of the patient.

Fifth, teleradiologists generally cannot consult with colleagues about a difficult study. Think of how many times, when confronted with a tough case, you have tapped a colleague at the next reading station on the shoulder to ask for a quick consult. We all learn from each other, but with teleradiology there is no “other.”

Sixth, we also learn by getting clinical follow-up on studies we have interpreted. This kind of feedback will be almost impossible to obtain when the reader is at a distant site.

Seventh, teleradiologists are not there in the hospital department to protocol examinations, supervise the technologists, or answer questions.

Finally, there is little or no oversight of an individual teleradiologist’s performance by hospital quality assurance or risk management committees, or by a chairperson or senior member of the group.

WHAT DO ON-SITE RADIOLOGY GROUPS PROVIDE THAT TELERADIOLOGY COMPANIES CAN’T?

Hospitals that outsource to teleradiology companies will quickly learn that they have lost vital aspects of the support that on-site radiologists provide every day. On-site radiologists are available to consult with referring physicians and patients. They protocol the imaging studies and supervise the technologists who perform them. They provide education and guidance for the technologists. They provide education to their fellow physicians in other fields, through such vehicles as multidisciplinary conferences, tumor boards, and grand rounds. They consult with hospital administration on purchases of new equipment and often negotiate on behalf of the hospital to obtain better pricing from the vendors. They make themselves available to participate in marketing, strategic
planning, and various hospital committees. They are available to help handle the many operational issues that come up virtually every day, such as triaging patients, billing, scheduling, communicating critical results, or resolving problems relating to the PACS or the radiology information system. They are right there on the spot to oversee quality and safety programs. It is difficult indeed to envision an efficient and service-oriented radiology department in which most of the radiologists are scattered around the country in remote locations.

ONE GROUP’S TRAVAILS

A detailed and honest appraisal of one private radiology group’s bad experience with outsourcing was provided by Sherry [20]. She described what happened after her 24-person group in Dallas decided to outsource its night ED and inpatient imaging to a teleradiology company. At first, it seemed to be advantageous for them; they were able to sleep nights, and it helped them in recruiting. However, the move alienated some of their physician colleagues and hospital administrators. One ED physician at one of their hospitals became especially angered and made an issue of it. The result was that the group lost its contract at that hospital. This damaged their reputation and impeded their efforts to secure new contracts at other institutions. They had to let some radiologists go. They lost some credibility with the administration at their main hospital. A local newspaper printed an unflattering story. It turned out to be a bad financial arrangement as well because the money they paid out to the company was often not recouped from uninsured ED patients. As Sherry put it,

In some ways, punching the clock at 10 PM reinforced the impression that we were not a necessary part of the medical team. We became more ancillary, nameless, and faceless shift workers, viewed as abandoning our colleagues and our patients. . . . It dawned on us that the model of outsourcing our night work actually threatens not only our livelihood but the very existence of our specialty as a profession; nobody ever questions the value of imaging in the modern practice of medicine today, but many question the value of radiologists.

It isn’t easy to acknowledge adverse consequences of one’s decisions, and Sherry deserves credit for telling it like it is.

RECOMMENDATIONS FOR RADIOLOGISTS

What can you do as a radiologist to help save your practice from the woes recounted by Sherry [20] and save our specialty from this new threat? In our opinion (and some will no doubt disagree), there are several things. First, take back the night. Cover your practice 24/7, just like in the old days before the easy-life mentality took over. Don’t outsource night and weekend imaging to the teleradiology companies. Without the business we give them voluntarily, they will cease to exist. This will not be easy, but it must be done if we hope to remain a respected and well-compensated specialty, rather than a commodity. Second, do not go to work for these companies, even on a part-time basis. Without radiologists, again they will cease to exist. One of the most satisfying aspects of practicing radiology or any other branch of medicine is the opportunity to interact with colleagues and get the sense that you are helping patients. Sitting alone at a workstation in your basement and never interacting with others doesn’t seem like a very pleasant alternative.

There are options that small radiology groups in a geographic area should consider in an effort to achieve the potential advantages of outsourcing without actually dealing with the teleradiology companies [10,15,19]. One option is to consolidate into a single larger group. This would spread the pain of night call around and make it more tolerable. Also, the enlarged group would be more likely to have subspecialty expertise in a number of radiologic subspecialties. If this type of consolidation cannot be achieved, another option is for the groups to remain separate but to work out a cooperative arrangement under which night and weekend call would be shared among them. Teleradiology is a great technology that affords this kind of opportunity for groups to work together in one aspect of practice, even though they might compete in others. A third option is for private groups to work out creative partnerships with academic radiology departments in their state to cover night and weekend cases, and also to provide subspecialty consultations or overreads. Academic departments all have subspecialized radiologists and some now have emergency radiology sections that cover nights and weekends and could possibly take on more work. We recognize that logistically, this could be very challenging. All these options require groups to give up some degree of autonomy, but as pointed out by Borgstede [10], the threat of this small degree of practice loss pales in comparison to the threat of a takeover by a distant corporation that is beholden to stockholders, rather than to patients or radiologists.

We also recognize that as academic radiologists, we could be criticized for these recommendations. After all, we have residents providing night and weekend coverage, so one could retort that it’s easy for us to talk. But the quotations above are all from private practice radiologists, and they show that many in the private community agree with us.

Perhaps this whole issue can best be summed up by one more quotation. It was contained in an e-mail from Tim Hall, MD, on November 20, 2008, that was part of an e-mail train on the subject of outsourcing to night-hawks. Dr Hall is a practicing radiologist in Boise, Idaho, and here’s what he had to say (used with his permission):
Following this thread from rural Boise has been very interesting. Twelve years ago our group decided to initiate in-house call. We have been at it ever since. Our after-hours practice continues to grow, and now our night call guy is by far and away our most productive radiologist. We have 15 members who share in night call duty (initially it was 8, but we have expanded), and I would say our presence has become “indispensable” to the medical community. We consistently score the highest scores in medical staff satisfaction surveys. While the personal toll is great, the professional satisfaction more than offsets that toll. We are identified by the medical staff as a “can-do” group, and as we are “in the trenches” are identified along with our trauma surgeons, our neurosurgeons, our intensivists, and our ED doctors as the hardest working physicians on the medical staff. Radiologists nationwide need to wake up and realize that being identified as the highest paid of medical specialists with the most time off is an honor of dubious distinction. We can achieve both, if we continue to pursue medical and professional excellence.

Dr Hall and his group deserve kudos. With that kind of history, we doubt very much that they will ever have to worry about being displaced from their hospital contract. If every radiology group in the country adhered to that work ethic, one of the greatest threats to our discipline would be promptly and permanently squelched.

REFERENCES


