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

As a radiologist with extensive experience in both academic and private practice as well as a cofounder of Third Eye Teleradiology, I found the commentary and conclusions of Levin and Rao [1] perplexing.

Radiologists over the world need to accept and embrace 2 concepts or risk facing diminished revenues or unacceptable working conditions: (1) radiology is changing quickly, and (2) adaptation is the key to survival.

Rapidly evolving technology combined with the meteoric ascent of the Internet has obviated the need for radiologists to be sitting in a room near their imaging equipment or their referring physicians. This work model is not always in the best interests of hospitals, practices, or, most important, patients. That is not to say that having a radiologist on-site has no utility; it absolutely does. However, the authors' perspective that this is the only model of value is not accurate. Consider the following 2 scenarios.

Scenario 1: Patient X goes to Dr P, who refers him to the local imaging center for an abdominal CT with the on-site general radiologist, Dr Y. Dr Y meets the standard of care in his community. Patient X has a small islet cell tumor in his pancreas, which is dismissed as an incidental finding by Dr Y, and patient X returns to Dr P with reportedly normal CT results. Months later, patient X, with increasing symptoms, is referred to University Hospital for another CT scan. The tumor, now larger, is diagnosed.

Outcome?

1. Patient X suffers unnecessarily, is angry, may sue, and receives unnecessary radiation.
2. Dr P is upset and stops referring to his local imaging center.
3. University Hospital is denied payment.

No one wins.

Scenario 2: Radiology Practice D, a group of subspecialists, provides service to Community Hospital B. One of the neuroradiologists is in an accident and needs to miss 10 weeks of work. Practice D can (1) absorb the extra work among the remaining two neuroradiologists, (2) hire a locums tenens radiologist, or (3) contract with a teleradiology practice to provide a neuroradiologist, with a certificate of added qualification, for those 10 weeks.

Outcome?

1. Practice D's 2 remaining neuroradiologists work 12- to 14-hour days for the next 10 weeks, which breeds resentment, as the other radiologists work no harder yet share the same income pool.
2. Practice D's referring physicians are dissatisfied with the quality of work provided by the locums tenens radiologist.
3. Subspecialists maintain quality patient care and referring physician satisfaction. The cost for coverage is shared by all members of the practice.

Concerns about outsourcing are equally perplexing. When a radiology group hires quality radiologists to read remotely, they are not outsourcing. They are adding well-trained, board-certified physicians who happen to work from a different location.

Levin and Rao [1] stated that exclusive hospital contracts are based on an arrangement under which radiology practices assume the responsibility of "complete" patient care. "The latter argument loses all credibility when radiologists abrogate this responsibility every night and weekend." Using quality teleradiologists is not abrogation. It is uninterrupted excellent patient care. Plenty of practices around the country take call from home, with the ability to look at cases without having to be at the hospital. This is still teleradiology, but somehow this scenario is not only preferable, it deserves "kudos"! We must embrace the concept of quality radiologists reading remotely and frown upon cases read by less qualified physicians, even if on site.

Levin and Rao bring up some excellent points. Radiologists cannot expect to maintain their turf if they do not maintain quality patient care and keep referrers content. There are unquestionably some unscrupulous, predatory teleradiology companies, but condemning all teleradiology is myopic.

As in any field (medical or not), there are reputable members who think outside the box to advance their craft, and there are sharks. Not all teleradiology groups are "high-volume" machines attempting to displace radiology practices. I, for one, never want to replace on-site radiologists with drones. However, I firmly believe that supplementing a practice with subspecialized teleradiologists—to add expertise, cover volume demands, support short-term or long-term staff shortages, and so on—has a great benefit to radiologists and patients.

This model is growing in acceptance. We can either embrace it as part of our radiology milieu, or we can fear and condemn it. Either way, it will continue to grow. Why not think outside the box (or at least make the box bigger) and adapt to change? The goal is to provide the best patient care possible and ensure the future of radiology.

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1. Levin DC, Rao VM. Outsourcing to teleradiology companies: bad for radiology, bad for radiologists. J Am Coll Radiol 2011;8:104-8.

DOI 10.1016/j.jacr.2011.03.013 • S1546-1440(11)00141-4

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0091-2182/11/$36.00 • DOI 10.1016/j.jacr.2011.03.013