Radiologists have experienced unprecedented prosperity for the past 3 decades. Technology has continually evolved, providing exciting opportunities for earlier diagnoses and improved patient care. The financial rewards enjoyed by radiologists have been impressive, and the quality of life has been difficult to beat. Circumstances change, and in the past few years, radiologists have been confronted with a variety of new challenges. These trends include declining reimbursement, an “image problem” at both the local and the national levels, more demanding hospital administrations, nontraditional competition from national entrepreneurial radiology entities for radiology hospital contracts, and alternative payment systems. The author outlines the genesis of these trends, describes strategies for meeting these challenges, and discusses the roles of both radiology practices and the ACR in preparing radiologists for the threats and the opportunities that lie ahead. Although it will be important for radiologists to “get to the table” to participate fully in the new health care environment, it will be imperative for radiologists to know what to do once they are at the table. This is not “business as usual,” and for radiologists, there will be winners and losers in the coming years. It will take work to succeed, and the apathy, denial, and sense of entitlement that have characterized our practitioners must be replaced by service, visibility, health policy data, and “value-added” information for referring physicians and their patients. The future for radiology is bright; the future for radiologists is far less certain. Strategic planning, scenario planning, practice building, and the efficient provision of high-quality patient care are the keys for radiologists to succeed. Radiologists must integrate themselves into the medical, social, and political fabrics of their hospitals and their communities, and they will need to get the in-depth leadership training and the important health policy data that the ACR is structured to provide.

**Key Words:** Culture shift, nontraditional competition, service specialty


### INTRODUCTION

Culture is the way that a likeminded group of individuals think and act. To survive over time, a culture must be resilient and responsive to both internal and external pressures. As radiologists, we share a culture that differentiates us as a group and defines radiology as a specialty. The culture of radiology has both good and less desirable aspects. The positive aspects of our culture include a generalized democratic philosophy that provides all practice shareholders with an equal voice, vote, and income stream after a relatively short period of time. The equity buy-in to private practices is generally kept at an artificially low value to provide an opportunity for young people to become “owners” of their radiology groups without undue financial hardship [1]. In general, radiology groups have a desire to attract bright, well-trained residents and fellows, and the culture of radiology makes it easy to do so.

Unfortunately, there is also a less desirable aspect to the culture of the specialty. A pervasive sense of apathy has caused radiologists to take a backseat to the many other interests that vie for their limited available time [2]. This widespread apathy, when mixed with an unrealistic sense of entitlement, makes it difficult to get radiologists to understand that current socioeconomic and competitive forces mandate proactive thinking and action if radiologists are to enjoy the quality of life and financial benefits to which they have become accustomed. Unfortunately, it is difficult to change what has become an indifferent approach to organizing and managing a radiology group. The majority of radiology practices are governed haphazardly and act unpredictably, and if they are successful, it is usually despite what they do, not because of it [3]. Although this indifference was possible in the past decade, such a business model is a formula for disaster in an era of diminishing reimbursement, nontraditional competition, and demanding hospital administrators.

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DISCUSSION

There is a tendency for radiologists to blame others (non-radiologist specialists seeking our turf, uninformed politicians and regulators, or national entrepreneurial radiology companies) for the current state of uncertainty that we face; however, when the situation is examined carefully, one can only conclude that we radiologists are often responsible for the difficulties we are just beginning to confront and will face in the near future.

For the past 2 years (2011 and 2012) during the AMCLC, an audience response system was used to poll councilors at the popular “economics session.” Astoundingly, in 2012, 95% of these radiology leaders stated that they believed that radiologists would not change until the pain of the status quo far exceeded the potential pain of changing. This sobering assessment is critical to understanding the potential issues that will confront radiologists in the next 5 years. The major problem, of course, is that some “pain,” such as the loss of a major hospital contract, can occur before an apathetic practice can respond in an effective manner.

Of the dozen or so major trends facing the specialty, in this paper I focus on the following 5 key challenges confronting radiologists:

- declining reimbursement affecting both the technical and professional components;
- a congressional “love affair” with the concept of family or general practice at the expense of specialists;
- greater demands from hospital administrators for increased coverage, better service, and more subspecialization;
- nontraditional competition for hospital radiology contracts and outpatient business; and
- alternative payment systems.

Declining Reimbursement

Radiologists have absorbed a disproportionate amount of the reimbursement cuts mandated by the Deficit Reduction Act; however, we should not delude ourselves into thinking that we have therefore experienced the end of our reimbursement pressures. In my opinion, we will continue to see reimbursement cuts for the foreseeable future. The most likely ways for this to occur are the following:

- a further increase in the utilization rate calculation and/or an expansion of the “multiple procedures discount”;
- a continued consolidation of codes, particularly in the areas of CT, MRI, and interventional radiology;
- an adoption of the Medicare or HOPPS rate by other insurers;
- a homogenization of the regional reimbursement variations that at times seem arbitrary; and
- a failure, at some point, to “fix” the decrease mandated by the sustainable growth rate formula.

The National Love Affair With Family Practice

Both legislators and regulators seem to have what would be best described as a “Marcus Welby fixation”: the misperception that every family practitioner is a kindly, avuncular physician who spends hours with each patient and toils unselfishly in the “vineyards of medicine.” The reason radiologists should be concerned about this perception is that CMS, our major payer, plays a “zero-sum game”: if some specialty is paid more, it means that another gets less. The general perception is that family practitioners are underpaid and overworked; the perception of radiologists is just the opposite. Fair or not, perceptions are reality until proved otherwise. What is clear is that radiologists have an image problem [4].

These concerns were best exemplified by the television show House. On that program, radiology played a central role. Every week, patients received lifesaving CT and MRI scans, angiographic studies, or image-guided interventional procedures. Although radiology was prominent, radiologists were nowhere to be seen. All of the studies were performed and interpreted by Dr House’s internal medicine fellows. The show is, perhaps, a metaphor for our specialty and its practitioners: The future for radiology is bright; the future for radiologists is far less certain.

This situation was reinforced by focus groups conducted about 4 years ago by the ACR. These sessions took place in Miami, Florida; Burlington, Vermont; and Washington, DC. The results of these gatherings were startling. Most participants had no idea who or what a radiologist was. Many who ventured a guess thought that the radiologist was the individual who “took the pictures.” Some did not even know that a radiologist was a doctor.

These sessions raised several key questions. If a significant number of individuals do not think that radiologists are physicians, how long can radiology justify being one of the most highly paid specialties in all of medicine? Furthermore, how can radiologists be surprised that radiology took the brunt of the physician reimbursement cuts? Finally, how can we not expect more cuts in the future?

More Demanding Hospital Administrators

The pressures that radiologists are facing from hospital administrators have been well documented [5,6]. It is clear that there are major demands from hospitals for longer hours of on-site coverage, more radiologists on site, and greater subspecialization. These demands have a significant impact (and consequences) because hospitals are replacing radiology groups in numbers that have not previously been seen.

The major reasons that hospitals are replacing their radiology groups are as follows:

- behavior or service issues,
• competition or groups not aligning their goals with those of the hospitals,
• more control (greater numbers of on-site radiologists, longer hours of coverage, and more subspecialization),
• a desire to convert independent contractors to employed radiologists,
• a perceived lack of leadership skills, and
• an inability to provide subspecialty expertise.

It should be noted that “quality” is not mentioned in this list of “major reasons.” In fact, hospital administrators most often say that quality is the central reason a radiology group is terminated, but in my personal consulting experience, the word quality is usually a code word for a lack of service or behavioral issues the hospital administration or medical staff finds objectionable.

No matter the cause, radiologists must understand that the loss of a hospital contract is a phenomenon that can happen to any practice. There is no such thing as being “too big to fail.” It is imperative that radiologists take steps to maximize their chances of maintaining their hospital contracts; the most effective way to achieve this is to insinuate each radiologist (and his or her practice) into the medical, social, and political fabrics of the hospital and the community that he or she serves.

Nontraditional Competition
National entrepreneurial radiology companies have evolved since they first appeared in the mid-1990s. For a variety of reasons (some beyond their control), the first wave of national companies failed or changed their missions [7]. The second incarnation of these entities came in the early 2000s, with the establishment of NightHawk Radiology Services. It became apparent at that time that many radiologists were willing to trade cash for an improvement in their quality of life. Thus, the practice of night-call coverage outsourcing became an established “way of life” for about half the radiology practices in the country [7] (per data from the Economics of Diagnostic Imaging: National Symposia 2010-2012).

The barrier to entry into this market was low, so many companies vied for the small remaining portion of this outsourcing business. As the major entities in this space became desperate to gain the capital necessary to grow, they evolved from focusing solely on night-call coverage (or subspecialty interpretations) to the pursuit of entire radiology hospital contracts. The tactics used to gain these contracts were unfamiliar to radiologists. These companies dealt directly with hospitals, often “cold calling” administrative personnel in an attempt to cut radiologists entirely out of the negotiations. In several cases, this “disintermediation” of radiologists has proved to be successful, and radiologists have been displaced from their hospitals, sometimes with little advance warning [7].

Radiologists must understand that this is not “business as usual.” These companies are experienced, well capitalized, and skilled at appealing to the perceived needs of hospital administrators. Basically, there are 5 “benefits” these entities typically provide [7]:

• fewer or no problematic radiologists: if a problem occurs, that radiologist is removed from the hospital;
• quality metrics provided to the hospital on a monthly basis;
• 24/7/365 subspecialty expertise;
• savings because there is no longer a need for transcriptionists and editors (these companies use self-editing voice recognition systems); and
• the possibility of future savings through purchasing arrangements.

Although it is apparent that the promise of these benefits is often different from the reality, radiologists wishing to maximize their chances to retain their hospital contracts should take steps to provide the same (or better) services than those promised by these national entrepreneurial radiology entities.

Alternative Payment Models
Fee-for-service reimbursement has worked very well for radiologists; however, it is clear that practices and hospitals will have to cope with a variety of alternative payment methodologies. Bundled payments, capitation “offshoots,” and accountable care organization (ACO) options are some of the possible payment mechanisms that will compete with traditional payments for radiologic services. Hospitals can most easily deal with any nontraditional payment model by employing the physicians who work in those hospitals. Salaries are paid, and if there is money left over at the end of the year, it can be kept as profit or paid as bonuses to the physicians. Alternatively, if there is a shortfall, salaries can be lowered the following year (additionally, most hospitals will institute a “partial salary withhold” to insure against any cash shortage).

Although employment is an option for radiology practices, most radiology groups are currently functioning as independent contractors. According to data presented at the 2010 and 2011 Economics of Diagnostic Imaging: National Symposia, fewer than 10% of private practice radiologists are employed by their hospitals. Because independence (independent contractor status) seems to be the preferred mode of working with hospitals, radiologists must convince their hospitals that they do not have to be in the “radiology human resources business.” To do so, radiologists must be able to assume leadership roles in the ACO projects or similar programs in which their hospitals wish to participate. “Getting to the table” is just the first step; once radiologists get to the table, they must have the knowledge and the data to act appropriately. The ACR must be the entity to provide that data and expertise.
THE NECESSARY ROLE OF THE ACR
What must the College do for its members? Most everything the ACR does is important; however, there is a major difference between important and essential. Essential functions are those an organization provides for its members that they require but cannot do themselves. Typically, issues of this magnitude involve government affairs and economics. For these reasons, the ACR has established the Harvey L. Neiman Health Policy Institute. This institute is structured to provide the data and the associated information radiologists will require to participate effectively in the turbulent times ahead. It will enable radiologists to interact with knowledge and with fairness with medical staff members, hospital administrators, business leaders, and health policy experts.

The College has made major commitments to the well-being of its members, to quality patient care, and to the missions of the hospitals we serve; however, this is a two-way street. For the College to do what is required for the membership, it needs time and money from its radiologist members. This necessitates a massive culture shift because presently, most radiologists give neither. Every practice, academic and private, should mandate that all of its radiologists be members of their state chapters and the ACR. Furthermore, these practices should mandate that all members contribute to their state political action committees and to the Radiology Advocacy Alliance Political Action Committee.

Another commitment made by the College is the development and the operation of its comprehensive accreditation program. Accreditation is the least expensive “insurance” radiologists can have to set the “quality bar” high and to protect against turf incursion. It is difficult for the casual practitioner of imaging to meet the rigorous standards mandated by accreditation. All practices should support and participate in ACR accreditation programs. Accreditation is a win for radiologists, but most important, it is a win for the patients we serve. When the quality bar is set high, patients are the major beneficiaries.

WHAT SHOULD RADIOLOGISTS DO TO MEET THE CHALLENGES AHEAD?
There are multiple actions a progressive practice should take to cope with the challenges confronting the specialty. Time and space considerations mandate that I focus on 6 basic, but critical, actions for a practice.

Get Your Practice Documents in Order
Documents to consider at a minimum include the following:
- employment agreements between the practice and its radiologist members,
- practice by-laws,
- practice policies,
- shareholder agreements,
- hospital contracts, and
- mission statements and business plans.

It is important to understand that contracts between radiology groups and their members are not “agreements between two equal entities.” The protections are in place for the benefit of the group, not the individual. Six important clauses that should be included in contracts between radiology practices and their members include the following:
- termination without cause,
- noncompete (including teleradiology),
- automatic resignation from all the group’s hospitals at the end of employment,
- full-time medical employment with the group,
- protection against the sale or repossession of stock to or by an “outside entity,” and
- repayment of any expense that radiologist causes the practice without prior approval.

The reasons for these clauses have been discussed in the literature [8,9], but the need for them has never been more acute.

Optimize Your Governance Structure to Facilitate Decision Making
The governance model that works best for radiology practices is the corporate model, similar to that used to govern most businesses. Essentially, there is a president who works at the direction of the executive committee and the shareholders; an executive committee, which is reflective of the demographics of the practice but small relative to the size of the practice; and shareholders, who are expected to participate in the affairs of the practice by serving on practice committees, developing and agreeing to the mission statement and business plan, and writing and implementing practice policies [3].

Leaders should be chosen wisely. Although it is important to get everyone involved in the operations of a practice, the leaders who should be chosen with tenure in mind are the practice president and the chairs of the radiology departments at the hospitals served by the group. Although most radiologists are indifferent to the nuances of leadership, those individuals (hospital administrators, business leaders, and community stakeholders) with whom we interact are finely attuned to titles and tenure. A leader who is in place for a significant amount of time is accorded far more respect than a leader perceived to be a “short-timer.”

Great practices make decisions on the basis of a group-developed and group-approved mission statement and business plan. An essential task of a practice is to develop these documents. The mission statement and business plan provide focus. They define who the group is and what it needs to accomplish. Most important, they provide leaders with a blueprint (including timelines) for action.

Three committees that are essential to the efficient organization of a practice are the finance committee, the
operations committee, and the new business and marketing committee. Each committee should be chaired by a member of the executive committee, and each shareholder should be a member of at least one practice committee.

Do Both Strategic Planning and Scenario Planning
Outstanding practices hold strategic planning retreats at which they adopt goals to pursue for the coming year. These retreats provide an opportunity to discuss issues and resolve differences in a structured environment. Time can be spent on matters affecting the practice, and decisions can be reached in a manner that permits input from all shareholders.

Turbulent times mandate that practices confront certain issues prospectively. To best accomplish this, excellent groups have implemented scenario planning. In this exercise, group members deal with potential problems in a manner that permits an examination of the issues and their possible solutions and a prioritization of options. Two scenarios that practices should consider are the following:

- What steps should you take when your hospital’s CEO tells you that in the next month, he will be sending out a request for proposal for radiology services to regional groups and national entrepreneurial radiology companies?
- What steps should you take when your hospital’s CEO tells you that in 60 days, the health care system will begin participation in an ACO demonstration project?

Scenario planning gives radiology practices the time to examine issues and options, and it informs shareholders of possible solutions. In confronting issues such as the renegotiation of a hospital contract, a group can prioritize potential concessions and explore likely outcomes.

Foster a Practice Culture of Participation and Mutual Expectation
It is essential that groups demand that everyone in the practice contribute to the practice-building activities that, by necessity, occur after routine working hours. Great groups have long understood that a “9-to-5 mentality” is for shift workers but not for the owners of a radiology practice. That said, it seems to be a truism that 90% of the practice-building activities vital to the success and tenure of a radiology practice are performed by 10% of the group’s members. These individuals feel underappreciated, are often resented, and at times suffer burnout. In these days of aggressive nontraditional competition for hospital contracts, the unengaged behavior of the majority of radiologists cannot and should not be tolerated [10].

Develop and Maintain Key Relationships in Your Hospitals
Tenure can never be guaranteed; however, to optimize the chances for tenure in your hospitals, you must integrate your group and all of its member radiologists into the medical, political, and social fabrics of your hospitals and your communities. Obvious steps include participation on key hospital committees, service as medical staff officers, and the provision of value-added consultations to referring physicians.

Communication is the key to the development and maintenance of relationships. A radiology group should schedule regular meetings between

- the practice president and the president of the hospital,
- the department chair and the vice president in charge of radiologic services,
- the subspecialists in the department and their clinical counterparts,
- the department chair and the technical director of the department, and
- modality champions and their technical counterparts.

Modality champions are subspecialty-trained radiologists who take responsibility for working with their technical counterparts to set protocols, establish quality metrics, and solve problems in given sections of the department. The interactions between physicians and technologist modality champions tend to elevate quality, increase efficiency, and improve department morale.

Develop a “Service First” Mentality
There is usually a tendency, particularly in a time of downward reimbursement pressures, to try to maximize a practice’s financial position. Great groups realize that if they are to be successful, money cannot be the prime motivator of practice members. You cannot pay the wrong people to do the right thing. Radiology is a service specialty, and if radiologists are unwilling to accommodate the reasonable service needs of patients and referring physicians, they are in the wrong specialty. Radiologists must be visible and available. Those practices that provide service will find that the money will be there; groups that focus unreasonably on clinical productivity and fail to provide appropriate service will find that their hospital contracts will be given to entities willing to make the needed service accommodations. A radiology group’s commitment to service provides a “value added” to referring physicians. Failure to focus on the importance of service is often the root cause of a hospital contract loss.

CONCLUSIONS
In the old days, all we wanted was to get our “slice of the pie.” Now we must understand that the pie will be smaller, so to maintain our share, we will have to get a bit of someone else’s piece. If we want to grow, we may have to develop a different type of pie. In the past, virtually all
radiologists were winners (although to different degrees); in the future, there will be winners and losers. In the past, it took work to fail; in the future, it will take work to succeed. What we have now is not guaranteed. It will take effort and planning to have a successful radiology practice.

The ACR must take charge of radiology; that is its mandate. It must also do for its members what they cannot do for themselves. Young radiologists must choose their jobs wisely, and then they must take an ownership interest in their practices and in their specialty. This is important because if we continue with “business as usual,” there are others who will gladly take what we have, and in many cases, they will succeed. We have few friends at the national level; therefore, we must “play by the rules.” Political action committee involvement is essential in both the state and national arenas.

A culture shift for radiologists is not a luxury; it is an imperative for professional survival. Are you and your colleagues prepared to do what is necessary to survive and thrive in the turbulent times ahead?

TAKE-HOME POINTS

- Several trends are affecting radiology and radiologists. These include declining reimbursement, the lack of “friends” at the national level, more demanding hospital administrators, nontraditional competition, and alternative payment systems.
- Radiologists must substantially alter the culture of the specialty, which presently includes apathy, dysfunctional governance, denial, and a sense of entitlement.
- Strategic planning helps a group identify opportunities, while scenario planning permits a group to rehearse responses to threats before those threats confront the practice.
- Most everything the ACR does is important; however, there is a difference between important and essential. Essential data and services are those that individual members cannot provide themselves. The College must provide the essential information radiologists will need to thrive in the new health care environment.
- The future for radiology is bright; the future for radiologists is far less certain. We must become proactive in dealing with both problems and opportunities, we must act more like owners of our practices rather than shift workers, and we must develop the skills necessary to be major participants in ACOs and other alternative payment systems.

REFERENCES