Why Radiologists Lose Their Hospital Contracts: Is Your Contract Secure?
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Previously, a hospital contract meant tenure for the incumbent group of radiologists; however, those days are long gone. Exclusive contracts have morphed into exclusive contracts with carve-outs. Turf erosion has become a fact of life for radiology practices. Now radiologists are losing their hospital contracts in record numbers. Group size, though helpful for a variety of reasons, does not ensure that a practice will be secure in its hospital setting. The reasons that groups lose their hospital contracts are varied, and in this paper, the author discusses the most common ones. Suggestions to help practices avoid this unfortunate fate are presented.

Key Words: Hospital contracts, radiology professional service agreements, quality and service


INTRODUCTION

Consider the following hypothetical scenarios:

- A new CEO is hired at a major tertiary care hospital. At his previous hospital, the radiologists were all employees of the health care system, and he would like to establish that model in his new setting. The radiology group is an excellent one: well trained, hardworking, and subspecialized. The radiologists are appalled when presented with a professional service agreement (PSA) that is deemed “unacceptable” to the practice members, as it would, over time, most likely change their present independent contractor status to that of hospital employees. After almost 2 years of negotiations, the radiologists maintain their independence, but in the process, several of the younger members are emotionally affected by the process and consider leaving for more “stable” jobs.

- A dominant radiology practice in its area, after intense (and somewhat hostile) contract negotiations, is told by its hospital administrator that it will be replaced. The practice members vote to waive the “noncompete” clause in their practice employment agreements. The hospital then forms its own radiology practice and hires some of the members from the previous group as hospital employees. Other members are not included in this “new” group and are no longer able to practice at the facility.

- A large hybrid practice (a private group with a teaching program) is told by its hospital administration that in less than 2 months, it will be replaced by a company that will align its goals more closely with those of the hospital system. The company states that it will bring additional resources to the hospital system and address a variety of service concerns. The company offers group members the opportunity to work for it in a transitional (and possibly permanent) arrangement, but the practice refuses and, in an act of solidarity, opts to invoke its noncompete provisions. Although the practice is large, it is replaced by a combination of company-affiliated on-site radiologists and teleradiology backup coverage.

- A large multihospital radiology group has internal issues that result in an apparent degradation of service to referring physicians and their patients. The hospital administration of the largest facility initiates discussions with the local medical school radiology practice to take over the radiology PSA. At the last minute, these negotiations fail, but an entrepreneurial radiologist from a different locale agrees to assume the contract and proceeds to staff the hospital with a combination of locum tenens radiologists and teleradiology. He then slowly builds a permanent group to practice in the hospital. The very large incumbent radiology practice no longer exists as an entity.

- An excellent group of subspecialty radiologists is told by its hospital administration that the hospital will circulate a request for proposal (RFP) for the provision of radiology services at the hospital. Citing no specific reason, but
rather “trying to assess what’s out there,” the hospital proceeds with developing its RFP (which contains several provisions that the incumbent group has declared to be objectionable). Five radiology practices within a 75-mile radius of the hospital respond; 3 of the groups express a willingness to accept all of the terms in the RFP. The incumbent group retains its contract with the hospital, but the practice agrees to demands that it had previously considered to be unacceptable.

DISCUSSION

Situations such as these are occurring throughout the country. These are not anecdotal episodes but rather are part of an alarming “epidemic” that has gained substantial momentum in the past 5 years. The reasons for this escalation are many, and they are discussed below, but first it is important to understand how things were for radiologists and their hospitals and what has changed in our professional relationships.

Less than 15 years ago, a radiology PSA equated to a relatively hassle-free tenure. Most of the PSAs between hospitals and their radiology groups treated the practices as true independent contractors [1,2]. Although there were specifications for emergency response time and adequate coverage, these PSAs rarely contained specified hours for routine coverage; it was also rare for there to be demands for subspecialty expertise. Contracts were often “evergreen.” That meant that although both parties retained the right to renegotiate an agreement at its termination, if neither chose to do so, the PSA automatically “rolled over” for an additional term. This could happen indefinitely, and thus, these agreements were often not revisited for decades.

Radiologists believed that they could take a firm stance in hospital negotiations. It was the norm for radiology groups to maintain their status as independent contractors. Practices could (and did) strike provisions that would prevent them from competing with their hospitals; most often, such provisions never even appeared in proposed PSAs. Radiology groups established outpatient offices and served competing hospital systems in an almost unfettered manner. Until the past 15 to 20 years, most practices would not waive their due-process medical staff rights, unless they were legally obligated to do so. Thus, a hospital that wished to replace a radiology practice would find it difficult to deprive a group of its medical privileges. These incumbent radiologists might no longer have a contract, but they still retained their medical staff privileges and their right to practice radiology at the hospital. If a replacement group could be found, the working environment could be very unpleasant for the “newcomers.” They might have to share a department with the previous radiologists (who now could “cherry-pick” referrals from loyal physicians and not be responsible for self-pay patients).

Even under more ideal circumstances for hospitals, whereby “clean-sweep” provisions (clauses stating that a group’s medical staff privileges automatically lapse if the contracts terminate for any reason) were present in the PSAs, it was often difficult to find replacement practices. These were more collegial times, and generally, radiologists thought that it was inappropriate (perhaps even unethical) to replace a colleague in a hospital setting. For large groups, it was almost impossible for hospitals to find replacement radiologists.

Those idyllic days for radiologists are long gone. As noted in the introduction, throughout the country, practices are coming under intense pressure from hospital administrators. For the past 3 years, data from the Economics of Diagnostic Imaging: National Symposia suggest that about three-quarters of all radiology groups practicing in hospital settings have both noncompete and clean-sweep provisions in their PSAs. Turf erosion has become a fact of life, with about 90% of practices reporting that they have lost some turf despite “exclusive” contracts (see note 1). Thus, exclusive contracts with carve-outs (exceptions to the exclusivity) are the rule, and it is no stretch to opine that these turf pressures will intensify over the next several years.

Now radiology PSAs typically contain provisions mandating the minimum hours of routine coverage, and often these contracts specify the number of radiologists on-site and the types of subspecialists required to fulfill the required obligations of the PSAs. Smaller and smaller hospitals are demanding and receiving on-site evening shifts, and “termination without cause” clauses are the norm [3-5]. Clearly, there are exceptions to these changes. Hospitals in remote (or otherwise geographically challenged) areas are forced to be more accommodating to their radiologists, but in general, the trend has been for more restrictive, more controlling, and more demanding PSAs.

Why Do Radiologists Lose Their Hospital Contracts?

Why is this happening? The simple answer is, “Because it can.” Radiologists delude themselves into believing that because there is a shortage of radiologists, it will be difficult, if not impossible, to be replaced. In fact, at this time (early 2010), there are multiple ways to replace a radiology practice, and hospitals have little difficulty making a change. In my experience, the replacement groups are usually not as qualified as those whose places they take, but that doesn’t seem to matter. Picture Archiving and Com-

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1 The Economics of Diagnostic Imaging: National Symposia are meetings held each year in the Washington, DC area, usually during the last week in October. Data are gathered from registrants using audience-response technology. See http://www.edusymp.com.
munication Systems (PACS), our preoccupation with productivity over service, and our own apathy have caused us to be more remote from, and less responsive to, the needs of our referring physicians and their patients. Outsourcing has in many ways commoditized our services [6]. It has led many to believe that any study can be read by any radiologist anywhere in the world. If radiologists are perceived as a commodity, we must understand that commodities are relatively indistinguishable and therefore are traded solely on the basis of price. If radiology groups are similarly regarded as commodities, they can be retained or exchanged at the whim of the hospital system.

Radiologists tend to hide behind the mantra that they are excellent at what they do and that fact alone should be sufficient for those who interact with them. Regrettably, it is necessary to be good (and even better to be excellent), but it is not sufficient. Everyone takes for granted that radiologists are good. Has anyone yet heard a hospital administrator or a referring physician say, “Let’s bring in a bad radiology group”? Radiologists are expected to be good, but they are also expected to provide service. Radiology is a service specialty [7-9], and if a radiologist is unwilling to accommodate the legitimate service needs of patients, referring physicians, and hospitals, that individual is in the wrong specialty. If radiologists are not providing service and not providing a quality experience, why should they be surprised that they are suddenly being treated like an interchangeable commodity? With that in mind, what are the factors that are driving hospitals to replace their radiology groups? In my experience, the most common reasons that hospitals seek new radiology practices are as follows:

- They are tired of hearing complaints from referring physicians and hospital employees (service issues).
- They don’t like radiologists competing with them.
- They want more control (hours, numbers on-site, subspecialists, etc).
- They want radiologists’ turf to attract referring physicians.
- They want to own radiologists’ practices (integrated service model) and make them employees.
- They don’t like their radiologists (personality clashes).

An apparent significant omission from this list of common reasons for replacing radiology groups is the issue of “quality.” In fact, in my experience, quality is cited most often by hospital administrators as the prime reason for a hospital’s seeking to replace its radiologists. However, when this situation is examined in greater detail, it usually turns out that quality is a code word for “service.” It is unusual for a group as a whole to have quality issues, although on occasion, there might be a quality issue with a particular member. That said, it is always wise for a radiology practice to have a comprehensive quality assurance or quality improvement program in place to deal proactively with real or perceived quality issues. In addition to the obvious benefits to patient care that such a program brings, it probably will also be beneficial for future reimbursement opportunities, such as pay for performance [10,11].

To understand better how radiologists should protect their practices, it is instructive to look individually at the common reasons why radiology groups get replaced. Although understanding these reasons does not ensure tenure, it can help a practice proactively take measures to avoid some of the more prevalent concerns.

They Are Tired of Hearing Complaints From Referring Physicians and Hospital Employees (Service Issues). Service issues are the most common reason why radiology groups are replaced. Hospital administrators have a universe of issues that affect them daily. Radiology is one small part of a very complex operation. If a hospital administration is continually bombarded with complaints by referring physicians and technical staff members about the responsiveness or behavior of the radiologists, the administration is diverted from what it perceives to be more important issues. If radiologists are considered to be a commodity, it is far better to have a group that “causes no problems.”

It may seem heretical, but it is my firm, experience-based belief that most referring physicians don’t know how to evaluate the skill sets of radiologists. If physicians (for the most part) use subjective means to assess us, how can we expect hospital administrators to be more discriminating? Radiologists need to be integrated into the medical, political, and social structures of their hospitals and their communities [8]. Failure to do so courts danger for the tenure of a practice. Some obvious steps that can be helpful to radiologists are holding medical staff offices, serving on hospital boards, and being politically involved at the local or state level.

They Don’t Like Radiologists Competing With Them. Noncompete clauses in radiology PSAs are, in my opinion, counterintuitive. If there is an economic opportunity to place an office in proximity to a hospital, and if the incumbent radiology practice is not permitted to open that office, almost assuredly, their competition will. When that happens, referral patterns change, and when more invasive procedures are required, patients get referred to the hospital system of the competing group. It seems obvious that a hospital would welcome the opportunity to have “its radiology group” protecting it from entrepreneurs and competitive radiology practices; however, what might seem obvious to a radiologist is far from obvious to a hospital administrator, and the perception of “competing with the hospital” can be a very visceral issue for the administration. Contracts have been lost over this issue, and at this time, noncompete clauses are the norm rather than the exception in radiology PSAs.

Although radiologists might not agree with the posi-
They Want More Control (Hours, Numbers On-Site, Subspecialists, etc). Walking the fine line between independent contractor and employee can be difficult. In private practice, neither radiologists nor most hospitals usually want an employer-employee relationship, although there are exceptions to this general rule (see “They Want to Own Radiologists’ Practices” below). Typically, an independent contractor determines how a “job is to be best performed.” An employer can specify how, where, and when an employee works, but that employer has an obligation to provide benefits to the employee and pay state and federal taxes on the employee’s behalf. There are additional legal obligations to the employer-employee relationship that are not required when dealing with an independent contractor relationship. That said, there is an increasingly insistent demand by hospital administrators for radiology groups to provide expanded hours of coverage, ensure that appropriate (by the hospital’s definition) numbers of radiologists are on-site, and make available a variety of subspecialty expertise. From the perspective of the administration, these demands are merely manifestations of the hospital’s desire to optimize patient care and facilitate diagnostic and therapeutic evaluations. Although there are associated financial reasons for these demands (hospitals have incentive to shorten stays), the “patient care” arguments are difficult to refute. Radiologists who have resisted these requests or demands often find that they have little sympathy from referring physicians, hospital administrators, and community opinion leaders.

During the course of contract negotiations, radiologists sometimes argue that they cannot meet these administrative mandates because it would affect them financially. This is an argument that has little traction. Radiologists are perceived by many hospital administrators and most referring physicians as “making too much money for the work that they do.” Although one can argue the fairness or the veracity of this stereotypic assertion, the fact is that “financial hardship” is an argument that most often falls on deaf ears. As a result, radiologists throughout the country are providing more extended hours of on-site coverage and greater subspecialty expertise. Although hospitals are not terminating radiology contracts in any appreciable numbers over coverage issues, they are making more specific demands of their incumbent radiology groups. Furthermore, virtually all radiology RFPs that are issued now have provisions specifying the minimum hours of coverage; the desired number of radiologists on-site during the day, evening, and weekend; and the type of subspecialty expertise needed.

They Want Radiologists’ Turf to Attract Referring Physicians. There is little question that turf incursion is expanding. As nonradiologists find their incomes squeezed by third-party payers, they often look to imaging as a means of augmenting their declining compensation. Throughout the country, in both academia and private practice, cardiologists and vascular surgeons have made substantial inroads into procedures that traditionally had been performed by radiologists. It is not logical to believe that this turf incursion will stop with those two specialties.

One way to slow this erosion is for incumbent radiology groups to provide “value added” to referring physicians and their patients. This is why subspecialty radiology has begun to flourish in the private sector [12]. Not only do subspecialists provide a greater depth of expertise and an expansion of services offered, but they serve to protect practices from “whimsical” turf attacks from marginally trained, nonradiologist, “would-be” imagers. Radiologists become far more valuable when they “speak the language of the referring specialist,” and turf is often (but not always) more difficult to pry from radiology subspecialists.

The most effective way to protect turf (and a practice’s contract) is for a group and its members to be integrated into all aspects of a hospital. Although there may be an exception somewhere, I have never seen a group lose its contract when a member sits on the hospital board or is an officer of the medical staff.

They Want to Own Radiologists’ Practices (Integrated Service Model) and Make Them Employees. The integrated service model is still rare. Data from the Economics of Diagnostic Imaging 2008: National Symposium suggest that far fewer than 10% of radiologists are employed by their hospitals (see note 1). Although still uncommon, this model seems to be gaining some traction with hospital administrators. The reason for interest in this model stems from the issue of control (see “They Want More Control” above). In addition to being better able to dictate the hours of routine on-site coverage, the number of radiologists on-site, and the available subspecialty coverage, a hospital can also prevent any competitive initiatives and address service issues more directly. Additionally, with an employment model, there is the potential for the hospital to profit from the productivity of the radiologists (Paul Larson, MD, personal communication, August 2009). In my experience, the issue of control presently seems to be the driver for this model; however, in the future, that could easily change. Although I do not favor an integrated...
service model at this time, it does make it far easier for hospitals to align their incentives with those of the physicians they employ.

I believe that this model will gain further “popularity” if, in the near future, the Obama administration is able to institute a bundling method of reimbursing physicians. Under this type of compensation model, all physicians who care for a patient are, in aggregate, given a single payment that must be divided in an equitable manner among all those who provided the care. It takes little imagination to visualize the chaos and potential conflict that such a payment methodology could engender, although feeding time at the shark tank at SeaWorld might easily serve as an appropriate analogy. When physicians deal with financial issues, the thin veneer of civility that governs their interactions often erodes quickly. Under a bundled payment system, the easiest way to handle compensation is with an employment model. Fortunately for all of us in radiology, the ACR is studying this issue, and hopefully there will be alternative methodologies in place that could meet the needs of both radiologists and their hospitals.

They Don’t Like Their Radiologists (Personality Clashes). It has been my experience that radiologists do not do well in the arena of hospital contract negotiations. Generally, radiologists don’t know how to negotiate, they don’t know what to negotiate, and they don’t know when to negotiate. The first mistake they make is that they do not prepare appropriately. Thus, they react to the situation rather than having a proactive plan for the negotiation process. Radiology practices must decide what is important for them to achieve in their PSAs, what they must do to accomplish their goals, and what concessions might be reasonable to make. This information should be discussed with the partners and partner-track radiologists, so that everyone knows what is at stake. A practice must develop a set of goals, understand its options and alternatives, and analyze the sources of power that it may have to bring to the negotiations. The group must be united in its stance, and members must not negotiate independently from those empowered to act on behalf of the entire practice.

The second mistake radiologists make is that they take the negotiations personally. Radiologists must understand that this is a process to achieve an end, not an attack on their professional capabilities. Negotiations should always be kept professional; the parties should focus on the issues, not on the personalities. Far too often, negotiating a hospital PSA brings out the worst in radiologists. The interactions can quickly deteriorate and reach a point at which resolution becomes difficult, if not impossible. Radiologists who participate in PSA interactions must become familiar with the negotiation process and try to structure the discussions so that they are a win for both sides. To do this, radiologists must understand the needs, the alternatives, and the power of the administration. If radiologists are to be successful, they must know what is important to the hospital administration, as well as what is desirable for the radiology practice. Finally, radiologists must always remember that adversarial situations, unreasonable demands, and matters of questionable ethics or legality are best left to advisors or lawyers for resolution.

How Can Hospitals Replace Their Radiologists?

There are a variety of means hospitals have available to them to replace incumbent radiology practices. As noted above, these options have expanded with the prevalence of outsourcing. Radiologists have “taught” their referring physicians and their hospital administrators that images can be read off-site by trained radiologists who have no allegiance to the hospital or to the community. The advent of PACS and the lifestyle demands of practice members often make radiologists less accessible and less an integral part of their hospitals and their communities. Even when referring physicians are satisfied with us, they are not willing to “go to the mats” to protect radiologists’ contracts. Many years ago, the radiology reading room was a place for physicians to interact and consult; now radiologists are often “hidden” in remote areas of the hospital, and interactions tend to be far less frequent.

If a hospital wishes to replace its incumbent radiology group, the most common steps it can take are as follows:

- Send an RFP for radiology services to competing private practice groups.
- Contract with a local medical school to take over the PSA.
- Convert the radiology practice from an independent consultant relationship to an integrated service model (employment model) or hire new radiologists as employees.
- Contract with an established outsourcing company to provide both on-site and outsourced coverage.
- Contract with a company organized to take total responsibility for the PSA.

At present, the most common means of replacing a practice is for the hospital administration to send out an RFP. This is usually sent to practices in the general vicinity of the hospital (within 25 miles), although some administrators solicit coverage from groups geographically remote from their hospital’s campus. When this happens, radiologists are usually required to establish a satellite group, with members living in the community where the hospital is located. Despite the relative shortage of radiologists, most hospitals requesting proposals find that there will be multiple responses.

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2 Bundling as a compensation model is presently being studied by a committee called the ACR Future Trends Committee.
In addition to the replacement of one private practice group with another, there are other options hospital administrators might find more appealing. As noted above, the employment model is beginning to develop traction, although at this time it is too early to assess its impact. There is no doubt that under a bundled payment system, such a model will have greater appeal.

Medical school radiology departments are becoming more competently aggressive as money from grants and other more traditional sources becomes more difficult to obtain. For the medical school, a community hospital becomes another potential site for resident training, a source of much needed cash, and a potential “feeder” to the main university facility. For the community hospital, its image (and its bottom line) can be enhanced by marketing the prestige of the medical school. In addition, expanded capabilities made possible by the subspecialty orientation of academia can bring “value added” to patients who might not otherwise have had the benefit of these services. Entrepreneurial initiatives by medical schools are expanding, and the assumption of community hospital radiology department coverage is just one manifestation of this phenomenon.

By enthusiastically embracing the outsourcing of night call, radiologists have unwittingly provided hospitals with another avenue of potential coverage, either on a permanent or on a transitional basis. Radiologists have deemphasized the importance of relationships and in some cases have actively urged hospitals to accept outsourcing companies as an acceptable proxy for them during certain hours that they have chosen as being acceptable. Thus, how can radiologists feign surprise and express outrage when hospitals turn to these companies as a means of replacing them when they (hospital administrators) deem it appropriate to do so? The market for night call coverage has become relatively saturated, and the number of companies providing this coverage has increased. The only way for these companies to achieve growth will be for them to pursue both day reads and specialty reads (final interpretations).

Finally, there is an industry evolving comprised of companies that intend to “disintermediate” radiology. This is a fancy way of saying that they intend to eliminate the interaction between radiologists and their hospitals and replace radiology groups as the primary entities providing imaging services. These companies are well funded, have radiologists serving as advisors and as employees, and are prepared to undertake the contractual obligations that had previously been delegated to individual radiology practices. In most any situation, these established companies can mobilize sufficiently to provide coverage of a hospital (or a hospital system) in a rapid fashion through a combination of radiologists currently employed by the companies and outsourcing to teleradiology entities (either ones that they own or ones that contract with them to provide this service).

How Can Radiologists Protect Their Hospital Contracts?

Radiologists must understand some important principles to maximize their opportunities for tenure at their hospitals. First and foremost, radiology is a service specialty. Radiologists must be willing to provide reasonable service to their referring physicians, their patients, and the hospital administrations. Radiologists must be visible and available in their hospitals, and they must embrace their roles as consultants [15]. If radiologists cannot or will not provide “value added,” they will not be appreciated as contributing medical staff members [16]. Although the general radiologist is far from becoming an endangered species, the practice of radiology is becoming more subspecialized, and radiology groups will have to accommodate that trend, or that need will be fulfilled by others [12].

Next, radiologists must integrate themselves into the medical, social, and political aspects of their hospitals and their communities [8,14]. They must sit on the important hospital committees and, if possible, seek medical staff office or seats on hospital boards. When events are planned by the hospital, practice members must be actively involved. Radiologists must be seen as important participants in their hospitals, aligning (when possible) their incentives with those of the hospitals they serve.

Finally, radiologists must strive for loyal (as opposed to satisfied) referring physicians and patients. When those physicians whom radiologists serve are merely satisfied, they will most likely be satisfied by the group that replaces yours; when they are loyal, they will work diligently to see that you are not replaced. Loyalty is based on experiences, and experiences are created by individuals [17]. Radiologists must be cognizant of the effect their behavior has on those with whom they interact, and they must demand good citizenship from all of their group members. All radiologists must work to protect and build their practices. The complacency that has enveloped the specialty [14] must be replaced by an expectation that all members will participate in this important obligation to practice-build.

CONCLUSION

The practice of radiology will be much more difficult than it has been for the past decade. In the past, most everyone was a winner; in the future, there will be winners and losers. In the past, a radiologist had to work hard to fail; in the future, radiologists will have to work hard to succeed. The sting of losing a hospital PSA is presently eased by the fact that most radiologists can find jobs
elsewhere with relative ease. In the near future, that may not be the case. The job market is slowly tightening, and the economic downturn and the availability of nonphysician professionals will further affect the number of available positions.

Radiology is a service specialty. Radiologists must facilitate (not prolong) the evaluations of the patients referred to them. Radiologists must be visible, they must be available to consult with referring physicians, and they must provide “value added” to the diagnostic, interventional, or therapeutic process. Finally, there must be a shift in the interactions radiologists have with referring physicians from “This is what I can offer” to “What is it that you need?”

The future of radiology is bright, but the future of radiologists is less certain. If radiologists are to thrive in the turbulent times ahead, they must understand the importance of service and relationships. Skill sets are necessary, but they are not sufficient. Radiologists must take steps to decommoditize their practices and their specialty. There are many options for hospitals that wish to replace radiologists, and these options will only proliferate in the future. Radiologists must learn to negotiate, and whenever possible, they must seek to align their incentives with those of the hospitals with whom they affiliate. This is not a call for a one-sided capitulation; rather, it is a plea for all of radiologists to educate their patients, their referring physicians, and their hospitals about the value added by and importance of radiologists within the hospital setting. Failure to accomplish this will have dire consequences for radiology practitioners and for the specialty as a whole.

REFERENCES


