My Opposition to HB0934

My name is Geoffrey Gordon. I am a Radiologic Technologist, registered with the ARRT, and licensed as a Radiographer in the state of Maryland. My education in the field took place at GBMC's School of Radiology. I had the distinction of being Class President of their final graduating class in 2016.

My first official job as a licensed technologist was with ExpressCare, which, I believe, operates under the umbrella of LifeBridge Health. I worked for this company for perhaps a little less than a year, and spent most of my time at a facility located off of North Point Boulevard. I did, on many occasions, find myself being scheduled to work at other facilities, such as a nearby location on Merritt Boulevard, as well as locations in Bel Air and Owings Mills.

The next job I had the opportunity to take was also under the LifeBridge umbrella, as I began work at Sinai Hospital, performing X-Ray examinations in the Emergency Department as part of the Evening Shift. I remained at this position for several years, until making a career move to Interventional Radiology at Northwest Hospital in 2021. Again, this facility operates under the LifeBridge umbrella.

In 2022, I had the opportunity to make a lateral career move, and took a position as an Interventional Technologist at Good Samaritan Hospital, which is a Medstar Health facility. This position includes regular rotations through Union Memorial Hospital, another Medstar Health facility.

After listening to the testimony offered recently regarding SB0830, and after reading through the legislative proposal in its current form, I would like to make it clear that I am opposed to HB0934, at least as it is currently written.

The dominant theme at the heart of testimony offered by proponents of SB0830 seemed to center on the concept that this legislation, if enacted, would have a significant positive impact on Emergency Department wait times in the state of Marlyand. I have spent approximately 8 years working as a Radiologic Technologist, and more than half of that time, collectively, has been spent in Urgent Care facilities, and the Emergency Department of a Level 2 Trauma center. Based on that experience, I would like to offer my opinion that this bill, if enacted into law as written, cannot be reliably expected to produce the results promised by its proponents.

Testimony has been offered that, in the absence of available X-Ray imaging at Urgent Care facilities, an overbearing number of patients are being unnecessarily defaulted towards an Emergency Department setting. To me, as an individual who has worked in both of those environments, this line of logic seems deeply flawed. Granted, I am not a physician, and so I cannot say with certainty that there is no medical suspicion that cannot be correlated clinically without the benefit of medical imaging. I would, however, hazard a guess that these scenarios are few and far-between in Urgent Care settings. I would urge the members of the General Assembly to ask for such testimony to be expounded upon, as it is my suspicion that this scenario is exaggerated. What patient condition would leave a MD, a PA, or a CRNP to wonder whether or not a patient needed to go to the emergency room, wherein the only tool at their disposal for making such a distinction is the presence or absence of a simple X-Ray?

For anyone who is unfamiliar with the general day-to-day workings of an Urgent Care facility, I can tell you that patients are generally discharged in one of a few ways. One is with a course of medications, and recommendation to follow up with a PCP. Common examples of this would be patients who test positive within the facility for ailments such as urinary tract infections, or strep throat, and are prescribed a course of antibiotics. Depending on the specific nature of their case, these patients may also be offered a referral to a specialist as part of their discharge.

Another scenario for discharge involves the facility calling 9-1-1, as it has been determined that the patient in question requires a level of care simply not available at an Urgent Care facility. Examples of this would be individuals who present with classic signs of a heart attack or stroke, both of which require high-level emergency care. It is true that both of these conditions involve a standard of care that includes medical imaging, such as Chest X-Rays for cardiac events, and contrast-enhanced CT scans of the brain for strokes. I would point out, however, that CT scanners are generally not pieces of equipment on site at Urgent Care centers, and so could not possibly be put to use by an Urgent Care provider who suspects a patient is having a stroke. Rather, they must rely solely on their clinical abilities to identify a facial droop, unilateral weakness, and slurred speech. By that same token, once a provider has identified cyanotic appearance of the lips, diaphoresis, and has heard complaints of “an elephant sitting on my chest,” the availability of a simple chest X-Ray on-site is in no way going to be a primary determining factor in whether or not that patient is referred immediately to Emergency Services.

Third, and most germain to the topic at hand, is the commonplace situation in which a patient with some sort of injury to an extremity has been imaged by a Radiographer, fractures have been identified, or ruled unlikely, and the patient is outfitted with some sort of immobilization device, prescribed low-level pain-management medication, and is given a referral to an orthopedic office for follow-up. These referrals tend to be included in the discharge paperwork, even if no evidence of fracture or dislocation is found with on-site imaging.

In my time working for ExpressCare, I can attest that my imaging was responsible for the identification of many different fractures. Some of these were very subtle, and required highly specified techniques to adequately demonstrate. Others, due to obvious limb deformity, would have been impossible to overlook, whether or not anyone in my position had been available for the requisite imaging. In these more dramatic instances, even though I was able to generate on-site imaging, those patients still found themselves en-route to the Emergency Department. Primarily, this is because fractures that are complicated, or severely displaced, are going to need to be manipulated back into place prior to long-term immobilization, or surgery. None of which, I would stress, is available at an Urgent Care facility.

At no point can I ever recall being in a situation wherein my ability to produce a quality X-Ray examination prevented a patient from being sent to the Emergency Department. Of course, I cannot say for certain that such a scenario doesn’t exist. I can, however, attest that, over the course of a year, while rotating through multiple Urgent Care facilities, it’s a scenario I was never able to witness.

I can appreciate that Hospital systems are struggling to deal with overloaded Emergency Rooms. I can also appreciate that Urgent Care centers provide much needed services for

sub-acute ailments, freeing up precious hospital resources. And, of course, I can appreciate that staffing those sub-acute facilities is ultimately in the best interest of the general populace. The prevalence of these facilities has grown rapidly over the years, in an attempt to keep up with the healthcare needs of the surrounding citizenry, which is certainly a noble endeavor.

At the same time, I would take this opportunity to levy a criticism of those who have sought to expand so aggressively, even if it was with the best of intent. These companies, I can only hope, are well aware of their own internal metrics. There's no reason, that I can see, that they would not know how efficiently they have been able to historically fill positions for Radiologic Technologists at their facilities. They should certainly be aware of their own recruitment and retention metrics. Not just now, when those metrics are so clearly problematic. Rather, they should have been considered as new facilities were being planned, and developed.

These organizations knew, without a doubt, when they installed the machinery necessary to produce X-Ray imaging, that they would also be responsible for employing staff licensed in its use. In spite of what seem to be inadequate graduation rates, closures of educational facilities like GBMC, the increased engagement of RT(R)s with Radiologic Travel Agencies, and the increased cost of doing business with said Agencies, entities like Concentra, LifeBridge, Medstar, and UMMC have all insisted on installing more equipment, and opening more doors to the public.

Now, it seems, they have found their situation to be untenable. They are either unable, or unwilling, to address their recruitment and retention issues with more competitive compensation packages. Rather, they are seeking a legislative solution for a problem they have created for themselves, and, whether they are meaning to or not, are doing so at the expense of my profession.

The testimony offered thus far regarding the potential positive impact this bill might have on the career paths of current or prospective Radiographers is not reflected in the language of the bill, as it is currently written. Nowhere in the bill is there a framework for a proposed "educational path." Nowhere is there any detail regarding how this limited licensure could be implemented as part of a "bridge program." My fear is that, should this bill be passed into law as-is, we will find ourselves in a scenario wherein a single RT(R) will be responsible for the imaging done by Medical Assistants, not just at a single facility, but within a larger region, spanning multiple sites.

If this were to be the case, entry-level positions for new graduates from X-Ray programs would likely become less accessible. By definition, a diminished demand for professionals within the field will likely lead to decline in compensation packages that are offered. For someone such as myself, who started on a path towards an advanced skill set by gaining experience first in a low-acuity setting, this would have long-term effects on my projected earning potential. Taken in aggregate, over time across the entire state, a trend like this could easily serve to make the profession overall less desirable. This would be a disastrous outcome, as there are already too few educational institutions generating graduates throughout the state, and the demand for quality imaging within the medical field is only growing.

I would urge the members of the General Assembly to consider just how damaging a piece of legislation like this could be, absent a much more detailed, and clearly-constructed

framework. Certainly, a shortage of any medical personnel, regardless of their specific professional qualifications, can only be viewed as a net negative. And certainly, such challenges must be addressed, and overcome. It is my hope that the solutions developed will be carefully considered, and will offer deference to the rank and file immediately impacted.

I would love to see my profession grow. I would love to see the skill set that I have worked so hard to obtain gain visibility, as what technologists do is often overlooked, misunderstood, or viewed as obscure. This bill, as written, appears as though it will most likely serve to instead undercut what credibility we, as imaging professionals, currently have. I would ask the members of the General Assembly to protect what individuals like myself have worked so hard for, and allow us to be active participants in solving the problems plaguing the industry we have chosen to be a part of.

Respectfully,
Geoffrey Gordon, RT(R)
Interventional Technologist
951 Morgan Run Road
Middle River MD 21220
410.596.5573