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A new AI radiology tool gets announced, and someone in healthcare media writes the same article. You know the one. It goes by some variant of “Will AI Replace Radiologists?” The answer, depending on the author’s mood and their publication’s editorial calendar, is either “absolutely, and soon” or “relax, the human touch is irreplaceable.”

Both miss the point. Entirely.

Because while that argument runs in circles, your actual problem is sitting right there in your contract.

The Math Is Already Against You

Imaging demand isn’t simply rising, it’s compounding. More patients, more scans per patient, more complex studies with more to read in each one. Meanwhile, the supply side isn’t keeping up. Training pipelines are fixed. Burnout is real. Recruiting is getting harder. It’s been estimated that more than 25% of practicing radiologists will be 55 or older by 2028. Retirements aren’t a future event, they’re a rolling present one, and many radiologists slow down well before they stop entirely.

The result is a system that looks fine on paper and feels increasingly strained in practice. More work. Same people. Then fewer people.

Where This Gets Very Real: The FTE Problem in Your Contract

In my work with independent radiology groups, this dynamic shows up most directly in hospital contract negotiations. Hospitals negotiate for coverage and groups negotiate for financial compensation, both centering around the concept of FTEs. But the number of FTEs required isn’t just a function of coverage, it’s a function of workload. And workload is not static.

As imaging volumes rise and studies become more complex, each funded FTE is asked to do more. Over time, a gap opens between what the contract assumed when it was signed and what the actual workload now requires. That gap shows up in slower turnaround times, increased outsourcing, and rising operating costs. It also shows up in burnout and turnover, which, of course, makes the gap worse.

No one priced this correctly when the contract was written. And now AI is entering the picture.

Think of AI as Invisible Staffing

Here's the frame that most people are missing. AI doesn't add headcount. What it does is increase what each radiologist can handle in a given shift: faster prioritization, reduced time on repetitive reads, earlier flagging of critical findings. Even a 10–20% efficiency gain can meaningfully increase effective capacity. At scale, AI begins to function like invisible staffing: more throughput without onboarding another radiologist.

That's not a small thing. In a field where recruiting is competitive and training pipelines are slow, throughput per radiologist may be the most important operational variable you have.

The question your group needs to be asking isn't "should we adopt AI?" It's "how does AI change the FTE math in our next contract negotiation?" Those are very different questions, and only one of them matters to your group's future.

Now Bring That Back to the Table

If AI materially increases throughput, how should that change what's negotiated in your exclusive contract? Hospitals will argue that AI means fewer FTEs are needed to cover the same workload. Your group may see AI as the tool that finally lets you absorb rising demand without burning out your people or outsourcing the overflow at a margin-killing rate.

Both positions have logic. But only one of them reflects a strategy.

A hospital that treats AI purely as a cost-cutting opportunity will push for FTE reductions. If you accept that framing, you've traded your capacity buffer for the hospital's savings. And the next time demand spikes, and it will, you're in trouble again. You've handed your group a workload problem disguised as an efficiency gain.

The better argument: AI is a capacity multiplier that allows your group to absorb volume growth, reduce outsourcing costs, and stabilize performance metrics, without adding to the hospital's FTE bill. That's a value argument, not a headcount argument. It's a much stronger place to negotiate from. Use it.

Some Timely Takeaways For You

1. **The replacement debate is a distraction.** The real question isn't whether AI can read a scan as well as a radiologist. It's how AI changes the economics of the FTE model your contract is built on. Those are very different questions, and only one of them matters to your group's future.
2. **Understand the throughput math before you walk in.** If your group is deploying AI tools, or considering them, you need a clear picture of what efficiency gains you're actually realizing or projecting. "We're using AI" is not a negotiating position. Documented throughput improvement is.
3. **Don't let the hospital define the frame.** If you walk into a renewal and the hospital is already talking about FTE reductions based on AI, they've set the agenda. Your counter-frame should be about service performance: turnaround times, reduction in outsourcing, coverage reliability. AI is the mechanism. Those outcomes are the argument.
4. **Recruiting and retention depend on what you negotiate now.** Workload sustainability isn't just a quality-of-life issue, it's a competitive positioning issue. A group that uses AI to manage volume growth intelligently is a group that can recruit, retain, and hold a contract. A group that trades FTEs for short-term savings will find out the hard way why that was a mistake.

The "Will AI Replace Radiologists?" articles will keep coming, and the same people will keep writing them. Meanwhile, the groups that matter will be figuring out what AI actually does to the FTE math in their next contract negotiation.

That's where the game is being played. Make sure you're in it.

If you'd like to discuss how AI-related efficiency gains should be addressed in your group's exclusive contract, reach out to start the discussion.



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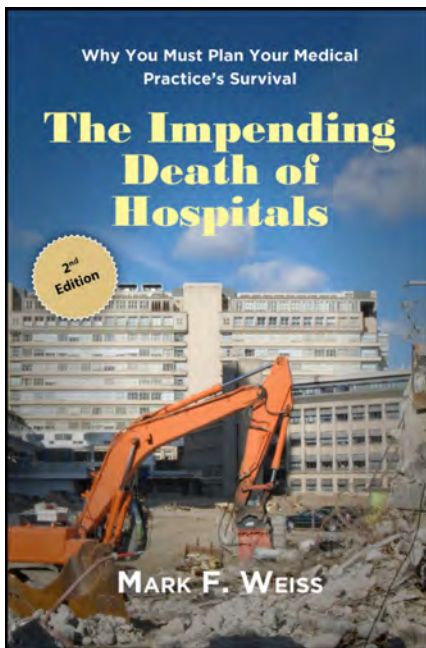


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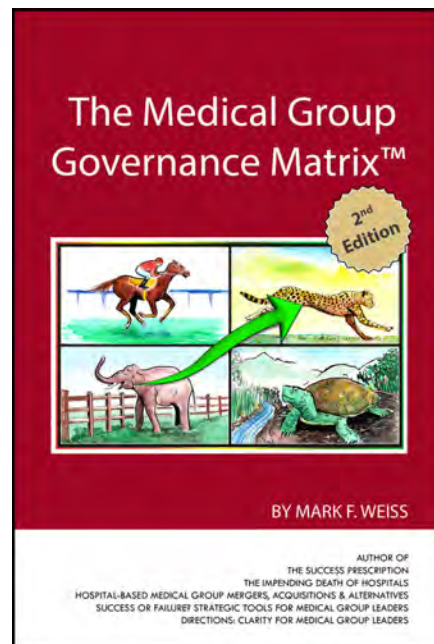
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