

# AI in Private Practice: 2025 Adoption Trends & Statistics

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healthcare ai

ai in private practice

medical practice technology

physician burnout

clinical documentation

ambient scribe

generative ai in healthcare

ehr integration

medical ai statistics



# Executive Summary

By late 2025, **AI technologies** are becoming commonplace tools in private medical practices, especially for offloading routine administrative tasks. For example, surveys indicate that roughly **one-half of ambulatory practices** report using at least one AI tool in daily operations (<sup>[1]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)) (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)). These tools primarily target paperwork: AI medical scribes, automated fax/document processing, and scheduling/chatbots deliver the largest time savings. In one recent survey, 72% of AI-using practices relied on an ambient scribe (e.g. [Sunoh.ai](http://Sunoh.ai)) for clinical documentation, with two-thirds of those users saving **1–4 hours or more per day** on paperwork (<sup>[3]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)). Similarly, **64% of AI adopters** reported saving at least one hour daily by automating fax and form management tasks (<sup>[4]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)).

Administrative automation, in fact, is seen as the leading AI application: 57% of U.S. physicians in 2024 identified “addressing administrative burden through automation” as the top opportunity for AI (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)). These efficiency gains are sorely needed: in 2025, clinicians estimate spending 2–3 hours on admin for every hour of patient care (<sup>[5]</sup> [www.empathia.ai](http://www.empathia.ai)).

Despite growing enthusiasm, adoption remains uneven. Physicians in large or system-affiliated organizations have far more access to advanced AI than those in small independent practices. In one AMA report, nearly **40% of hospital-based physicians** had access to **AI-assisted diagnostics** or workflow tools, versus only **~10%** of doctors in solo or small-group practice (<sup>[6]</sup> [www.hna-net.com](http://www.hna-net.com)). Likewise, **72%** of employed physicians reported using AI tools, compared to **64%** of those in private practice (<sup>[7]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Smaller practices often cite cost, lack of technical support, and implementation hurdles as barriers (<sup>[8]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[9]</sup> [www.hna-net.com](http://www.hna-net.com)). Concerns over data privacy, algorithm transparency, and liability also temper adoption in private settings (<sup>[10]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[11]</sup> [www.hna-net.com](http://www.hna-net.com)). Overall, however, doctors’ attitudes are shifting positively: two-thirds of surveyed physicians report using AI in some form (up from 38% in 2023), and 68–79% see clear advantages to these tools (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[12]</sup> [www.icthealth.org](http://www.icthealth.org)).

Looking ahead, AI is expected to deepen its role in private practices. Major EHR vendors are embedding AI functions into their platforms (for example, Athenahealth’s “AI-native” EHR, rolled out in 2025, provides seamless **AI-driven documentation**, revenue-cycle, and patient-engagement features across **160,000+** provider endpoints (<sup>[13]</sup> [www.fiercehealthcare.com](http://www.fiercehealthcare.com))). **Generative AI models** (e.g. large language models) are beginning to assist with tasks like summarizing patient data, drafting clinical notes, and answering patient queries, and most healthcare leaders (75–92%) believe generative AI will transform efficiency and decision-making (<sup>[14]</sup> [www.deloitte.com](http://www.deloitte.com)). If current trends continue, private practices that effectively integrate AI stand to achieve substantial cost and time savings, better patient experience, and relief of clinician burnout. However, closing the “digital divide” – ensuring small and rural practices have the support, affordable technology, and training to adopt AI – will be critical. Without careful policy and vendor support, disparities may grow: experts warn that unchecked, AI could become a benefit enjoyed mainly by large, well-funded systems (<sup>[15]</sup> [www.hna-net.com](http://www.hna-net.com)) (<sup>[16]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)).

**Table 1. Key AI Adoption Metrics in Healthcare (2023–2025 surveys)**

Year	Source (Population)	Key Finding
2024	MGMA Stat Poll ( <sup>[17]</sup> <a href="http://www.mgma.com">www.mgma.com</a> ) (422 medical groups)	<b>43%</b> of medical group respondents reported adding or expanding AI tools in 2024 (vs. 21% in 2023).
2024	AMA Survey ( <sup>[2]</sup> <a href="http://www.ama-assn.org">www.ama-assn.org</a> ) (physicians)	<b>66%</b> of U.S. physicians reported using AI in their practice (up from 38% in 2023); <b>68%</b> saw some advantage to AI.
2025	AMA Analysis ( <sup>[7]</sup> <a href="http://www.ama-assn.org">www.ama-assn.org</a> ) (physicians)	AI use reported by <b>72%</b> of employed doctors vs. <b>64%</b> of private-practice doctors.

Year	Source (Population)	Key Finding
2025	eClinicalWorks/Medical Economics ( <sup>[1]</sup> <a href="http://www.medicaleconomics.com">www.medicaleconomics.com</a> ) (887 practices at conference)	<b>50%</b> of ambulatory care practices reported using at least one AI tool.
2025	Moneypenny Survey ( <sup>[18]</sup> <a href="http://www.medicaleconomics.com">www.medicaleconomics.com</a> ) (U.S. healthcare orgs)	<b>66%</b> of healthcare organizations are using or actively considering AI in operations.
2025	Philips FHI Global Report ( <sup>[19]</sup> <a href="http://www.icthealth.org">www.icthealth.org</a> ) ( <sup>[20]</sup> <a href="http://www.icthealth.org">www.icthealth.org</a> )	<b>84%</b> of clinicians believe AI can automate repetitive tasks; <b>79%</b> of doctors vs. <b>59% of patients</b> expect AI to improve outcomes.
2025	UK GP Survey (Digit Health) ( <sup>[21]</sup> <a href="http://pmc.ncbi.nlm.nih.gov">pmc.ncbi.nlm.nih.gov</a> )	<b>25%</b> of surveyed UK general practitioners reported using generative AI tools in clinical practice.
2024/25	Deloitte LSHC Survey ( <sup>[14]</sup> <a href="http://www.deloitte.com">www.deloitte.com</a> ) (healthcare leaders)	<b>75%</b> of leading healthcare companies experiment with or plan to scale generative AI; <b>92%</b> expect efficiency gains with AI.

**Introduction and Background Artificial intelligence (AI) – broadly defined as algorithms that learn from data to support tasks – is rapidly reshaping healthcare delivery. Initially pioneered in research settings, AI is now finding practical applications in medical practice. In hospitals and experts’ Quaternions, AI has demonstrated benefits in imaging interpretation, predictive analytics, and workflow optimization (<sup>[22]</sup> [intuitionlabs.ai](http://intuitionlabs.ai)) (<sup>[23]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)). Over the past decade, private practices and ambulatory clinics (outpatient primary care and specialty offices) have gradually adopted digital tools (e.g. EHRs), setting the stage for practical AI integration. The COVID-19 pandemic further accelerated digital health and telemedicine adoption, making providers and patients more comfortable with remote and technology-driven care.**

Private practices face acute pressures that make AI appealing. The U.S. has a well-documented physician shortage (est. 15,000–48,000 short by 2034 (<sup>[24]</sup> [www.empathia.ai](http://www.empathia.ai))), growing patient loads, and rising administrative burdens. Physicians often report spending 2–3 hours on paperwork for each hour of direct patient care (<sup>[5]</sup> [www.empathia.ai](http://www.empathia.ai)). Burdens include note-writing, coding, billing, insurance authorizations, and managing patient communications. These inefficiencies contribute to burnout and reduced capacity for patient care. AI promises to alleviate many of these tasks: by automating routine chores, clinicians can potentially devote more time to patients (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[19]</sup> [www.icthealth.org](http://www.icthealth.org)). As one expert observes, “AI-expose

tasks” such as administrative workflows are ripe for automation, enabling doctors to focus on complex clinical decisions (<sup>[25]</sup> [www.ama-assn.org](http://www.ama-assn.org)).

With this context, the past few years have seen a proliferation of AI solutions for clinics: cloud-based voice scribes (e.g. Abridge, Suki, Ambient Clinical Intelligence), chatbot schedulers, automated prior-authorization platforms, predictive triage tools, and more. EHR vendors (Epic, Athenahealth, Cerner/Oracle) are embedding AI modules for coding, documentation, and alerts. Technology advances (larger datasets, better models) and consumer-facing AI (e.g. ChatGPT) have raised expectations for what these tools can do. At the same time, public awareness of data privacy (HIPAA) and calls for ethical AI have grown. The net result is a highly dynamic landscape where innovations emerge rapidly. This report surveys the current state of AI adoption in private medical practices (as of December 2025), examining how deeply AI has penetrated non-hospital care, what factors influence uptake, and what impacts—both realized and potential—are emerging.

We draw on multiple perspectives: recent surveys of physicians and practices, case examples, expert analyses, and published data. The report covers (1) historical developments of clinical AI, (2) current adoption rates and use cases in private practices, (3) key benefits and challenges observed, (4) stakeholder viewpoints (clinicians, patients, administrators, regulators), (5) specific case studies, and (6) future implications and recommendations. All claims below are supported by data from reputable sources and peer-reviewed studies.

## Historical Context of AI in Medicine

AI in medicine traces back decades (e.g. expert systems in the 1970s), but adoption was slow outside laboratories. In recent history, two major waves enabled current developments. First, the widespread digitization of healthcare (EHR adoption accelerated by Meaningful Use incentives in the 2010s) created large electronic datasets and digital workflows ripe for AI enhancement. Second, the rise of machine learning and deep learning (circa 2010s) dramatically improved AI's capabilities (e.g. image recognition). These trends converged so that by the early 2020s, hospitals and academic centers were piloting or deploying AI for radiology **imaging analysis**, pathology slide review, and sepsis alerts (<sup>[23]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)) (<sup>[26]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)).

For example, convolutional neural nets trained on vast imaging archives now assist in diagnosing diabetic retinopathy and lung nodules. Clinical decision support systems use predictive models to flag high-risk patients. Meanwhile, administrative AI tools—like rules engines for coding or natural-language voice recognition—began to improve efficiency. However, private practices (especially small ones) lagged initially: they often lacked the IT infrastructure and capital for advanced pilots. Historically, only large hospitals or integrated groups deployed clinical AI at scale. Independent practices largely focused on converting to EHRs and addressing basic digital needs.

By 2020–2022, these barriers began to erode. Cloud-based AI services and lighter-weight SaaS tools emerged that did not require extensive local infrastructure. Telehealth platforms (adopted widely during the COVID-19 pandemic) introduced doctors and patients to new AI-driven interfaces (for example, chatbots for triage and patient portals). Concurrently, *voice assistants* became powerful: Ambient Clinical Intelligence (AI scribing) services launched, in which an AI listens to doctor-patient conversations and generates visit notes. Such innovations promised to cut documentation time dramatically. Preliminary studies showed promising efficiency gains: health systems saw documentation AI “pay off work hours” (<sup>[3]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)) (<sup>[27]</sup> [academic.oup.com](http://academic.oup.com)).

In legislative and policy arenas, awareness of healthcare AI also rose. Regulators (e.g. FDA) began clearing AI-enabled medical devices (over 1000 by 2025 (<sup>[16]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com))). The AMA and other professional bodies issued white papers and principles on AI ethics and safety. Patients and clinicians started debating when AI should be the “standard of care.” By mid-2020s, the scene was set: AI was no longer fringe, and private clinic leaders were increasingly aware of it as a tool.

# Current State of AI Adoption in Private Practices

## Overall Adoption Rates and Trends

Recent surveys indicate that **AI adoption in ambulatory practices is accelerating**. A late-2025 study of nearly 900 participants across U.S. clinics found that **half of practices** were already using at least one AI tool (<sup>[1]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)). In CMS terms, “practices” include small doctors’ offices up to mid-sized groups; this suggests AI is moving from large institutions into community medicine. An AMA physician survey (Nov 2024) similarly found **66% of doctors** reported using some form of AI in practice (up from 38% in 2023) (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Another AMA query (May 2025) highlighted a gap by practice type: about **72% of hospital-employed physicians** reported AI use, versus **64% of private-practice physicians** (<sup>[7]</sup> [www.ama-assn.org](http://www.ama-assn.org)). These figures contrast sharply with earlier years; for example, a 2024 MGMA poll showed only 21% of medical groups had expanded AI usage in 2023, rising to 43% by 2024 (<sup>[17]</sup> [www.mgma.com](http://www.mgma.com)). In short, AI adoption has roughly **doubled each year** in many polls of U.S. healthcare (Table 1).

This growth is largely driven by workflows that demand efficiency. Survey respondents consistently cite **administrative efficiency** as the primary reason to adopt AI. In 2024, 57% of physicians identified “addressing administrative burden” as the top AI opportunity (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)). By contrast, pure clinical diagnostic assist tools remain a minority of AI use in private clinics. Nonetheless, some practices (especially larger multispecialty groups) have begun implementing AI in clinical roles (e.g. radiology triage, dermatology image analysis). According to a 2024 survey of U.S. health systems (hospitals/large practices), *all* respondent organizations had adopted at least ambient clinical documentation AI, whereas only “many” had imaging/risk tools (<sup>[28]</sup> [academic.oup.com](http://academic.oup.com)). This suggests that while small-practice adoption of true diagnostic AI is still emerging, no-practice area has been untouched by AI (Table 2).

The trend is global. A UK survey (Jan 2025) found **25% of general practitioners** using generative AI for tasks like documentation and differential diagnosis (<sup>[21]</sup> [pmc.ncbi.nlm.nih.gov](http://pmc.ncbi.nlm.nih.gov)). In Italy’s Lombardy region, a 2024–2025 study of public and private providers reported that 43% had deployed some AI applications (mostly CE-marked imaging tools), while 57% had not adopted any AI (<sup>[29]</sup> [pmc.ncbi.nlm.nih.gov](http://pmc.ncbi.nlm.nih.gov)). Similarly, an international survey by Philips reported that **84%** of healthcare workers believe AI can automate repetitive tasks, and that **79% of doctors** expect AI to improve patient outcomes (<sup>[19]</sup> [www.icthealth.org](http://www.icthealth.org)) (<sup>[12]</sup> [www.icthealth.org](http://www.icthealth.org)) (though only 59% of patients shared that optimism). In Asia-Pacific and other markets, industry reports project robust growth (often >30% annual growth) in healthcare AI spending through 2030, indicating global momentum.

In Table 1 above, we summarize multiple recent studies. The consistency is notable: around two-thirds of doctors or organizations report some engagement with AI, and this is rising rapidly year-to-year. Crucially, however, *engagement* ranges from pilot/consideration to production deployment. Many practices may be “exploring” a tech but not yet fully integrated with workflows. But the baseline – a majority having at least one AI project – is unprecedented for will-be era.

## Key AI Applications in Private Practices

Private practices today apply AI primarily to **workflow and administrative tasks**, with secondary use in clinical support and patient engagement. Table 2 highlights major application areas. Some illustrative examples:

- **Clinical Documentation (Ambient Scribing).** AI-powered scribes listen to the doctor-patient conversation and generate structured visit notes. Sunoh.ai, Abridge, Suki, and Epic's ambient notes (Powered by Nuance) are examples. In the survey of AI-using practices, **72%** reported relying on Sunoh.ai for note-taking (<sup>[3]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)). Two-thirds of those users saved 1–4+ hours per day. An AMA survey similarly found ~22% of private physicians using AI for documentation or coding (physicians in employed settings reported 21%) (<sup>[30]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Most adopters say the time saved is the greatest immediate benefit. Ambient AI allows clinicians to avoid tedious transcription after each visit, potentially improving thoroughness and reducing burnout.
- **Fax and Document Management.** Many U.S. clinics still receive orders, lab results, and referrals by fax or paper. AI systems can now automatically extract data from scanned faxes/forms and route it. In the eClinicalWorks survey, users reported **64%** saving at least an hour per day through automated fax sorting (<sup>[4]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)). (This may contribute to smaller clinics achieving "paperless fax".) Automated inbox tools also simple triage e-prescriptions and referral requests. MGMA notes "triage of inbound communications (phone/text/fax)" as a top AI use case (<sup>[31]</sup> [www.mgma.com](http://www.mgma.com)). Some vendors (such as Relaymed Intellect and PokitDok/Titles) target insurance verification and referrals via AI.
- **Patient Communication and Scheduling.** Chatbots and voice agents can answer routine patient inquiries (e.g. "When's my earliest appointment?") and book visits 24/7. While broad adoption data is limited for small practices, industry surveys suggest **two-thirds of healthcare organizations** are now using or considering AI for customer-facing automation (<sup>[18]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)). AMA data show only ~8–12% of doctors in 2025 report using AI chatbots for patient messaging or scheduling (<sup>[32]</sup> [www.ama-assn.org](http://www.ama-assn.org)), but this is a rapidly growing area. Notably, one testimonial claimed an AI assistant handled 67% of appointment booking requests in an ophthalmology practice (<sup>[33]</sup> [www.simbo.ai](http://www.simbo.ai)). Even if such anecdotes are preliminary, many practices report fewer no-shows and higher patient satisfaction when reminders and rescheduling are automated. (For example, an OsF Healthcare case study reported multi-million savings from chatbots, though detailed figures vary by source.)
- **Patient Portal and In-Basket Automation.** AI can draft responses to patient portal messages, summarize lab results for patients, or provide simple health education answers. In an AMA survey, **9–10%** of physicians reported using AI to draft portal replies (<sup>[34]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Many practices are beginning to test or pilot these tools (for instance, Epic and Microsoft have been developing AI email responders). Although uptake remains low, interest is high because physicians often spend many hours on inbox management.
- **Revenue Cycle Management (RCM) and Coding.** AI-driven platforms can check coding accuracy, auto-generate billing codes from notes, and expedite insurance approvals. Large EHR and billing companies (e.g. Change Healthcare/Optum, R1) are incorporating AI for claim scrubbing and prior authorization. A MGMA report lists "revenue cycle management using AI" (for prior auth, claim status, chart scrubbing) among leading uses (<sup>[35]</sup> [www.mgma.com](http://www.mgma.com)). In practice, private groups that deploy AI in RCM have seen faster billing cycles and fewer denials, though adoption figures in small offices are not widely published. It is expected that adoption in billing will continue as regulatory requirements (like ePA mandates) and coding complexity grow.
- **Clinical Decision Support.** While still less common in small private clinics, AI is gradually entering the clinical realm. Examples include AI-assisted diagnostics (e.g. skin lesion analysis on a smartphone, or automated ECG interpretation). A notable case is Cleveland Clinic's use of an AI sepsis alert: this hospital-record platform reduced false alarms by 10x and increased early sepsis identification by 46% (<sup>[26]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)). (While this example is from an 18-hospital system, it illustrates potential clinical benefits.) Some multispecialty groups also use AI risk scores to identify diabetic complications or hospital readmission risk. As generative AI models improve, primary care doctors are exploring LLMs to summarize patient histories or suggest differential diagnoses, but robust clinical validation is ongoing.

These applications are summarized in **Table 2** along with reported adoption/impact. In sum, the **major early wins** of AI in private practice are strongly weighted toward *reducing routine work*. Preliminary data indicate that when implemented thoughtfully (and with clinician oversight), administrative AI can *recoup multiple staff-hours per clinician per day*. This translates directly into cost savings or capacity to see more patients. CMS's estimate that 77% of healthcare workers waste 45 minutes/day on inefficient workflows (four weeks lost annually) underscores the available opportunity (<sup>[36]</sup> [www.icthealth.org](http://www.icthealth.org)). Practitioners view automation of such tasks as a sanity-saving solution: 92% of healthcare leaders say AI will boost operational efficiency, and 84% of doctors believe it will automate tedious tasks (<sup>[14]</sup> [www.deloitte.com](http://www.deloitte.com)) (<sup>[19]</sup> [www.icthealth.org](http://www.icthealth.org)).

**Table 2. Common AI Applications in Private Practices**  
(Examples of use cases, tools, and impact from recent studies and industry reports)

AI Application	Description / Example Tools	Adoption / Impact
<b>Clinical Documentation Assistants</b>	AI scribes that transcribe and structure physician-patient encounters (e.g. Sunoh.ai, Abridge, Suki, Nuance Dragon Ambient)	~72% of AI-using practices rely on ambient scribes (Sunoh.ai) for documentation, with ~66% of those users saving <b>1-4+ hours/day</b> <sup>[3]</sup> <a href="http://www.medicaleconomics.com">www.medicaleconomics.com</a> ). An AMA survey found <b>22%</b> of private physicians use AI to draft notes/coding <sup>[30]</sup> <a href="http://www.ama-assn.org">www.ama-assn.org</a> ). Big time-savings reported.
<b>Fax/Form &amp; Document Management</b>	Automation of incoming information (faxes, lab reports, referral forms)	~64% of practices using AI report saving ≥1 hour/day on fax sorting and processing <sup>[4]</sup> <a href="http://www.medicaleconomics.com">www.medicaleconomics.com</a> ). (Behind scenes, this reduces lost paperwork and staff work.) Vendors now OCR and route forms automatically.
<b>Patient Communication &amp; Scheduling</b>	Chatbots and voice agents for appointment booking and FAQs (e.g. conversational AI schedulers, reminder bots)	In industry surveys ~66% of healthcare orgs use or plan AI (various uses) <sup>[18]</sup> <a href="http://www.medicaleconomics.com">www.medicaleconomics.com</a> ). AMA finds <b>8-12%</b> of doctors using chatbots for patient-facing tasks <sup>[32]</sup> <a href="http://www.ama-assn.org">www.ama-assn.org</a> ). Early adopters report fewer no-shows and more patient engagement, though wide use is nascent.
<b>Revenue Cycle Automation (Billing)</b>	AI for coding, claims, prior authorization (e.g. auto code suggestions, AI payer scrubbing)	MGMA reports RCM and prior-auth as leading use cases <sup>[35]</sup> <a href="http://www.mgma.com">www.mgma.com</a> ). Practices report faster claims processing and fewer denials. (Formal ROI data limited, but one industry source noted ~60% of AI adopters expect near-term positive ROI on GenAI projects <sup>[37]</sup> <a href="http://www.makebot.ai">www.makebot.ai</a> .)
<b>Patient Portal Management</b>	Automated drafting of portal message responses or summarizing labs for patients (LLMs, smart templates)	AMA data: ~9% of physicians use AI to generate portal message replies <sup>[34]</sup> <a href="http://www.ama-assn.org">www.ama-assn.org</a> ). Usage is low but growing. Some vendors now offer AI email assistants; others integrate LLM summaries of records to reduce reading time.
<b>Decision Support &amp; Predictive Models</b>	AI tools for diagnosis or risk prediction (e.g. sepsis alerts, diabetes risk scores, imaging analysis)	Limited in small practices; more common in large systems. Notable example: an AI sepsis alert at Cleveland Clinic reduced false positives 10x and identified 46% more cases <sup>[26]</sup> <a href="http://newsroom.clevelandclinic.org">newsroom.clevelandclinic.org</a> ). <b>Future:</b> broader adoption of validated AI diagnostics is expected.

## Practice Size and Specialization

Adoption also varies by practice size and specialty. Large group practices (multi-specialty clinics, urgent-care chains) tend to have more resources to trial AI and benefit from standardization. Solo and very small practices often struggle with integration: they lack IT staff to vet tools or negotiate integrations with their EHR, and the relative cost per provider is higher. An AMA analysis notes that **cost** is a consistent issue: employed physicians often benefit from their organization covering implementation expenses, whereas private doctors must undertake vetting and contracting on their own <sup>[8]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Specialists using common platforms (like Epic) may get embedded AI features, while small practices using lightweight EHRs may wait for vendors to update. Urban/rural differences are significant: federal data show ~77% of urban hospitals using predictive AI versus only ~46% of rural critical-access hospitals <sup>[38]</sup> [www.healthit.gov](http://www.healthit.gov)). By analogy, independent rural clinics similarly lag behind system-affiliated clinics. In short, larger, system-supported practices lead in adoption; typical small group practices are more cautious and slower-moving.

## Physician and Staff Attitudes

Clinician enthusiasm for AI is generally high and rising. In 2024, **68%** of U.S. physicians saw definite or some advantage in AI tools (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)), up from 65% the year prior. Only ~9% of doctors were mostly against AI (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Many physicians report that AI lowers workloads and burnout: 79% of healthcare workers believe AI will improve outcomes (<sup>[20]</sup> [www.icthealth.org](http://www.icthealth.org)), and 84% agree it can automate repetitive tasks (<sup>[19]</sup> [www.icthealth.org](http://www.icthealth.org)). AMA surveys specifically show that doctors expect tasks like note-taking, inbox management, and drug ordering to benefit most from AI. For example, 57% ranked automation of paperwork as the top AI opportunity (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Doctors also value tools that “empower them” rather than replace them; a majority (57–88%) indicate that features like dedicated feedback channels, privacy assurance, and integration are critical for adoption (<sup>[39]</sup> [www.ama-assn.org](http://www.ama-assn.org)).

Nonetheless, transparent trust is a concern. Patients have lower trust in medical AI, especially for direct care: only 59% of patients surveyed trust AI to improve their care, vs. 79% of doctors (<sup>[20]</sup> [www.icthealth.org](http://www.icthealth.org)). Even among clinicians, 25% remain more skeptical than enthusiastic about AI (<sup>[40]</sup> [www.ama-assn.org](http://www.ama-assn.org)). The AMA notes that fears about data privacy, algorithmic “black boxes,” liability for AI errors, and poor integration with EHRs are hindering some doctors (<sup>[10]</sup> [www.ama-assn.org](http://www.ama-assn.org)). In one analysis, physicians in small practices were particularly wary of opaque tools, preferring “clinically validated” and transparent solutions (<sup>[41]</sup> [www.hna-net.com](http://www.hna-net.com)). Overall, however, expert panels and AMA guidance urge cautious, phased adoption: for instance, starting with usage in documentation or triage where impact is easier to gauge (<sup>[42]</sup> [www.hna-net.com](http://www.hna-net.com)), rather than leapfrogging to high-stakes diagnostics.

## Drivers of AI Adoption

Several key factors are driving AI uptake in private practice settings:

- **Efficiency and Cost Pressure.** Practices are under constant pressure to see more patients with limited resources. AI's promise of automating tasks translates to potential revenue gains (via more visits) or cost savings. Organizations are motivated by both labor shortages and financial sustainability: one industry analyst noted that healthcare leaders adopt AI not only for care improvement but to “strengthen sustainability” (<sup>[43]</sup> [cloudgate.healthcareitnews.com](http://cloudgate.healthcareitnews.com)). Philips' survey quantified the irony: clinicians spend about **4 weeks per year** dealing with avoidable data fragmentation, and 35% report rising paperwork time (<sup>[36]</sup> [www.icthealth.org](http://www.icthealth.org)). In that context, AI is viewed as a pragmatic fix.
- **Technology Maturation.** The maturity and accessibility of AI tools have improved. Ambient scribing, once error-prone, now uses advanced NLP models trained on medical language. Cloud APIs allow practices to “bolt on” AI without huge local investment. EHR companies are baking AI into upgrades (see box below on Athenahealth). Competition among vendors has also driven prices down: for instance, open-access LLMs and commoditized GPU infrastructure mean that even small firms can develop chatbots or image analyzers. As technology barriers fall, more practices see AI solutions within reach.
- **Physician Interest.** Many doctors are curious about AI and want time savings. The AMA survey showed that a plurality in both private and employed settings agree that “it is (or will become) the standard of care” to use AI tools (<sup>[44]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Some specialties have become early adopters (e.g. radiology, pathology, dermatology) and they help normalize AI. Younger clinicians also tend to have more familiarity with digital tools and push for AI features.
- **Vendor Push and Marketing.** EHR vendors and startups are passionately pitching AI to practices. Athenahealth's August 2025 release of an “AI-native” EHR platform is a case in point: it promises that *every one* of its 160,000 providers will instantly get new AI features (document services, clinical summaries, intelligent workflows) via cloud updates (<sup>[45]</sup> [www.fiercehealthcare.com](http://www.fiercehealthcare.com)). Epic, Cerner, Allscripts and others similarly advertise AI modules (e.g. Epic's NoteAssist, Cerner's Patient Canvas). Moreover, third-party startups (drchrono, Augmedix, Notable Health, etc.) aggressively market to practices. This vendor-driven momentum means that practices often encounter AI offerings when seeking routine software updates, pushing adoption.

- **Regulatory and Reimbursement Incentives.** Although there are no direct federal subsidies for AI in offices, parallels to the EHR Meaningful Use era exist. Payors and regulators are beginning to encourage data-driven care. For example, CMS and commercial insurers are experimenting with AI-based pre-authorizations and remote monitoring codes. In some value-based contracts, efficiency benchmarks may indirectly reward AI usage. Internationally, national health systems (UK's NHS, Data.gov initiatives in Canada, etc.) are funding AI pilots that trickle into private specialties. Regulatory acceptance (FDA-cleared AI devices now number over a thousand (<sup>[16]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com))) also reassures practices that AI can be safely integrated.

Hence, a confluence of need, opportunity, and supply is boosting adoption. Practices today often view AI as “another tool in the toolkit” for streamlining operations. See **Table 2** for how these tools fit into typical practice tasks, and **Table 1** for measures of adoption.

## Barriers and Challenges

Despite these drivers, private practice adoption faces significant impediments:

- **Cost and Financial Risk.** The upfront investment (software licences, training, implementation support) can be substantial. Unlike large hospital systems, small practices usually have no IT department to negotiate contracts or absorb pilot losses. AMA physicians frequently cite **cost** as a prohibitive factor (<sup>[8]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[46]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Even for cloud-based SaaS, subscription fees and integration costs add up and may not fit tight practice budgets. Moreover, the ROI is not always immediate: if a practice doesn't capture more patients or bill more due to AI, the cost can feel unjustified.
- **Technical Integration.** Many practices use EHR/CMS systems that are outdated or have poor interoperability. Integrating new AI tools with the EHR can require technical workflows (API, HL7 data exchange, security compliance). For instance, if an AI scribe doesn't “talk” to an EHR, staff must copy-paste notes, defeating efficiency. Lack of standards can lead to vendors creating one-off connectors. Practices report friction in onboarding AI solutions that are not seamlessly embedded in their existing electronic systems (<sup>[10]</sup> [www.ama-assn.org](http://www.ama-assn.org)).
- **Data Quality and Privacy.** AI quality depends on data. Smaller practices may have poor data hygiene (incomplete records, inconsistent coding) which limits AI effectiveness. Indexing and training on a practice's own patient data requires informatics effort most small offices lack. Additionally, HIPAA and patient privacy laws impose constraints: any AI that uses patient-identifiable data (e.g. cloud-based transcription) must be fully compliant. Some doctors worry about sending patient notes to a chatbot (e.g. a cloud LLM) due to confidentiality risk. Strict privacy guarantees and business-associate agreements are mandatory, and not all AI vendors easily provide them. These concerns slow or prevent deployment of cloud AI in some practices (<sup>[10]</sup> [www.ama-assn.org](http://www.ama-assn.org)).
- **Clinical Validity and Liability.** Many physicians hesitate to rely on “black-box” AI for clinical decisions. In private settings, the margin for error is slim. Concerns include: “What if the AI misses a diagnosis or suggests a wrong treatment?” and “How does this affect my liability if audited?” Lack of clinical evidence or FDA approval for many AI claims causes skepticism. High-quality validation studies are often conducted by large academic centers, and smaller practice physicians may find it difficult to evaluate vendor claims independently. As one expert noted, doctors want AI tools that are **transparent and clinically validated** (<sup>[41]</sup> [www.hna-net.com](http://www.hna-net.com)). Until such trust is firmly established, many will limit AI use to low-risk tasks (e.g. note-taking rather than prescribing guidance).
- **Workflow Disruption and Training.** Implementing AI often requires staff training and changes in daily routines. For example, using an AI scribe means doctors may shift from dictating themselves to “conversing naturally” with an AI listener, which can feel strange at first. Staff may also resist if they fear job replacement. Adequate training time and change management are needed, which busy practices may struggle to provide. In short, the *transition cost* – in time and learning curve – can be a hidden barrier.
- **Lack of Staff Expertise.** Many small practices have limited IT or data expertise. When problems arise (e.g. AI system errors, needed customization), they can become debilitating. Larger institutions often have CIOs or informaticists to manage AI projects; small offices generally do not. Some AI vendors attempt to fill this gap (offering onboarding help), but it remains a constraint on accelerated uptake.

- **Ethical and Equity Concerns.** Although often overlooked in practice-level discussions, there are systemic issues. Unchecked, AI could widen **healthcare disparities**: wealthy urban clinics may attract the latest AI investments, while rural/underserved clinics lag. Indeed, as mentioned, rural hospitals have markedly lower AI use <sup>[38]</sup> [www.healthit.gov](http://www.healthit.gov)). On the ethical side, if AI algorithms are biased (for example by underrepresenting certain patient groups in training data), automated decisions might inadvertently reduce care quality for some populations. Practices will need to consider these factors, especially in diverse communities.

Each of these challenges is well-documented. The AMA and other bodies emphasize that for responsible AI adoption, practices must insist on safeguards: patient data privacy, transparent algorithms, oversight policies, and clarity on liability <sup>[10]</sup> [www.ama-assn.org](http://www.ama-assn.org)) <sup>[16]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)). Until and unless these issues are addressed, some private clinicians will progress cautiously.

## Case Studies and Real-World Examples

### Oak Medical (Wisconsin Multispecialty Practice)

Oak Medical Group (a Wisconsin-based private multispecialty practice with ~90 providers) provides a useful real-world illustration. According to AMA reporting, Oak did not have the capital to adopt a big hospital EHR (Epic/Cerner) that often comes with AI features. Instead, the practice itself identified and deployed AI tools to boost efficiency <sup>[47]</sup> [www.ama-assn.org](http://www.ama-assn.org)) <sup>[48]</sup> [www.ama-assn.org](http://www.ama-assn.org)). For instance, Oak uses AI for **scheduling automation**: once a patient is admitted to one of their post-acute facilities, an algorithm automatically schedules follow-up appointments <sup>[48]</sup> [www.ama-assn.org](http://www.ama-assn.org)). They also use AI to **process incoming faxes** and **handle billing/admin tasks**. Their AI tools generate visit notes by pulling relevant information from patient records and dictation <sup>[48]</sup> [www.ama-assn.org](http://www.ama-assn.org)). Dr. Keshni Ramnanan (Oak's CMO) reports that these tools have measurably improved workflow, freeing staff to focus on care rather than paperwork. Notably, Oak Medical's experience underscores two themes: (1) even small groups can tailor AI tools to their needs, especially for routine "back-office" functions <sup>[48]</sup> [www.ama-assn.org](http://www.ama-assn.org)), and (2) adoption was driven bottom-up by clinicians seeking relief, not top-down mandates. Oak's approach – solving their most time-consuming tasks first – exemplifies the pragmatic "start small and scale" strategy recommended for private practices <sup>[42]</sup> [www.hna-net.com](http://www.hna-net.com)).

### Cleveland Clinic Bayesian Sepsis Alert

Although a large academic network rather than a private practice, Cleveland Clinic's sepsis alert illustrates AI's high-end clinical potential. In 2025, Cleveland Clinic rolled out an AI algorithm (Bayesian Health platform) across 13 hospitals to identify sepsis early <sup>[23]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)). In a published press report, they reported **dramatic improvements**: a *ten-fold reduction* in false alerts (among those screened), a **46% increase** in identified sepsis cases, and a *seven-fold rise* in alerts sent *before* antibiotic administration <sup>[26]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)). This means many patients were treated much sooner, likely saving lives. Key lessons for private practices: AI can provide value by catching dangerous conditions faster, but achieving such benefits required integration into the clinical workflow and a large scale of data. Smaller practices should note the gains (more accurate triage, less alert fatigue for true cases) but also the complexity and need for integration into patient management systems.

### Athenahealth's AI-Native EHR

In August 2025, Athenahealth announced a major platform upgrade to an "AI-native" athenaOne EHR <sup>[13]</sup> [www.fiercehealthcare.com](http://www.fiercehealthcare.com)). Athenahealth's customer base is primarily independent docs and small groups. They will deploy new AI features for all (160,000+) practice endpoints simultaneously <sup>[49]</sup> [www.fiercehealthcare.com](http://www.fiercehealthcare.com)).

These include AI-enhanced document services (auto-complete notes), improved interoperability tools (smart translation of external records), and intelligent clinical summaries (e.g. AI-drafted care plans). Athenahealth's approach highlights how EHR vendors are actively pushing AI into private practice channels. For an individual practice, this means that tomorrow's EHR update may bring new AI capabilities "automagically," lowering the integration burden. It also means small practices can gain access to advanced features through their vendor relationships, rather than procuring standalone systems.

## Research Study: UK General Practices

A peer-reviewed UK study (Digit Health, Nov 2025) surveyed 1005 UK general practitioners on generative AI use ([21] [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)). It found 25% had already tried GenAI chatbots or assistants in practice. Of those users, common tasks included generating documentation after appointments (35% of GenAI users), suggesting differential diagnoses (27%), and generating treatment or referral suggestions (24% each) ([21] [pmc.ncbi.nlm.nih.gov](https://pubmed.ncbi.nlm.nih.gov/)). Notably, 71% of the GenAI users said the tools **reduced their workload**. This is one of the first large-sample surveys globally showing that even "office-based" doctors are experimenting with advanced AI. The cautionary part is that 75% of doctors **not** using GenAI had never even tried it (though 79% of all doctors in the larger AMA survey expressed some trust in AI's potential ([12] [www.icthealth.org](https://www.icthealth.org/))). For private U.S. practices, this suggests a comparable early-adopter segment (perhaps a quarter of practices) is already using generative AI in some fashion, mostly for documentation and decision support.

These case studies illustrate that **when appropriate AI tools are implemented, private practices can reap significant benefits**. They also illustrate common themes: start with the highest-payoff tasks (notes, scheduling), ensure tools fit the workflow, and involve clinicians in selecting and monitoring the AI.

## Implications, Future Directions, and Recommendations

### Implications for Care Delivery

The spreading use of AI in private practices will have broad implications:

- **Workflow Transformation.** Anticipate continued automation of mundane tasks: by 2026–27, it is plausible that almost all scheduling, reminders, and paperwork generation could be handled by AI tools in forward-looking practices. This would free up medical assistants and nurses for higher-value tasks (patient education, follow-ups) and allow doctors more face-to-face time. A recent Philips report suggests up to \$200–\$360 billion in U.S. healthcare spending *could* be saved nationally through widespread AI, mainly by streamlining processes and reducing unnecessary procedures ([50] [www.icthealth.org](https://www.icthealth.org/)).
- **Shift in Skills and Roles.** Clinicians will need new skills in "AI literacy": understanding the limits of tools, interpreting AI suggestions, and communicating with AI-assisted systems. Medical training (Residency and CME) is beginning to incorporate AI topics. Practices may see roles like 'AI coordinator' or a consult arrangement with informatics experts. Reductions in administrative workload might offset some burnout, but some worry that new tasks (monitoring AI, verifying outputs) will arise.
- **Patient Experience Changes.** With AI scheduling and chatbots, patients will enjoy 24/7 convenience (evenings/weekend bookings). Conversely, patients will interact more often with algorithms (e.g. answering routine questions via chatbot). Trust becomes key: as noted, patients accept AI for appointments but are wary of AI making clinical judgments ([12] [www.icthealth.org](https://www.icthealth.org/)). Practices must transparently communicate how they use AI, and ensure human oversight, to maintain patient trust.
- **Quality and Equity.** If properly validated, AI has the potential to improve diagnosis and outcomes. For example, automated screening tools (like Diabetic retinopathy detection) can help ensure no patient slips through. However, there is also risk: if smaller practices cannot implement AI, they may lag in quality. There is an equity concern if only affluent practices benefit. Policymakers and professional societies will need to address this "digital divide" (for instance, by subsidizing AI in underserved areas or including AI-readiness in quality metrics).

## Emerging Trends

Looking ahead through 2026–2030, several trends are on the horizon:

- **Generative AI Integration.** Large language models (LLMs) are improving rapidly. Expect to see integration of generative AI into EHRs and practice apps: e.g. one-click GP summaries of patient history, AI drafting of referral letters, or conversational Q&A tools for patient triage. Deloitte's 2024 Life Sciences survey found **92%** of leaders see efficiency promise in GenAI (<sup>[14]</sup> [www.deloitte.com](http://www.deloitte.com)), and **75%** are already scaling it. For private practices, accessible GenAI could democratize some advanced analyses (a solo doc with a GPT-based assistant may draft research proposals or complex care summaries).
- **AI-Assisted Virtual Care.** Hybrid care models (combining virtual and in-person) will use AI more. For example, initial triage through an AI can determine whether a patient needs an in-office visit, lab test, or if a doctor's teleconsult suffices. AI tools will link more medical devices (wearables, home monitors) into the practice's data stream, flagging significant changes (e.g.). With remote monitoring reimbursable by CMS, private practices might leverage AI analytics on patient-generated data (e.g. home blood pressure trends).
- **Standard-of-Care Expectations.** A key finding in the AMA's analysis was that **57%** of private physicians already consider AI to be (or soon-to-be) "the standard of care" (<sup>[44]</sup> [www.ama-assn.org](http://www.ama-assn.org)). In certain specialties (radiology, cardiology), failing to use standard AI tools may raise malpractice questions (e.g. "Why wasn't this algorithm used to catch that finding?" (<sup>[44]</sup> [www.ama-assn.org](http://www.ama-assn.org))). Over time, it is likely that guidelines will evolve to incorporate AI recommendations where evidence is strong, meaning private practices will need to adopt to meet care standards.
- **Expanded Telehealth and Consumer Platforms.** Private practices increasingly compete with telehealth startups and retail clinics that heavily use AI (e.g. symptom checkers, fully automated tele-consults). To stay relevant, private clinicians may integrate similar tools (or partner with those companies). For example, an AI-powered triage chatbot on a clinic's website could book patients directly, mimicking large telehealth services.
- **Regulatory Oversight.** Because FDA-cleared AI tools are growing rapidly (over 1000 as of 2025 (<sup>[16]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com))) and state legislatures are considering laws, we can expect new regulations on healthcare AI. Practices will need to track compliance (e.g. with HIPAA-like rules for AI, or use of nationally certified algorithms). On the positive side, guidelines from AMA and others (including governance toolkits (<sup>[51]</sup> [www.ama-assn.org](http://www.ama-assn.org))) should help doctors adopt responsibly. Practices should prepare by establishing clear "governance" over any AI use (as recommended by AMA STEPS Forward toolkit).

## Recommendations for Private Practices

1. **Start with High-Value, Low-Risk Use Cases.** Focus first on tasks with clear ROI and low clinical risk – e.g., documentation, billing, patient reminders. The AMA and others recommend pilots in these areas (<sup>[42]</sup> [www.hna-net.com](http://www.hna-net.com)).
2. **Engage Staff and Stakeholders Early.** Involve physicians, nurses, and even patients in selecting and testing AI tools. Obtain thorough demos and trial periods. Ensure a feedback loop so users can report issues.
3. **Validate and Monitor Outcomes.** Choose AI solutions with published validation, and monitor real-world performance. For example, audit a sample of AI-generated notes for accuracy, or track how many coding suggestions are accepted. Implement oversight processes as recommended by professional guidelines (<sup>[10]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[16]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)).
4. **Plan Financially.** Perform a basic ROI analysis. Even if immediate ROI is unclear, consider cost savings (staff hours, fewer X-ray repeats, etc.) and revenue gains (more visits possible). Look for grants or group purchasing cooperatives to offset costs (some state programs may help rural clinics).
5. **Ensure Data Privacy and Security.** Only work with vendors that offer HIPAA-compliant solutions and are willing to sign a Business Associate Agreement. Keep sensitive data encrypted and use on-premises or verified cloud services. Patients should be informed (consent) if AI is used in their care.
6. **Stay Informed and Flexible.** The field is evolving. Attend relevant conferences (MGMA, AMA digital health summits) and follow updates from professional associations. Consider joining collaborative networks (e.g. MGMA, AAFP AI discussion forums) to share lessons.

7. **Advocate at Policy Level.** Given the adoption gap, private practice groups should advocate for incentives (e.g. grants for rural clinics), clear regulations, and industry standards. Collaboration with state medical societies and the AMA's AI initiatives can help shape supportive policy (such as reimbursement for AI-assisted services or funding for EHR integration support).

By taking a proactive, informed approach, private practices can harness AI to improve care efficiency and patient satisfaction while avoiding pitfalls.

## Conclusion

AI integration in private medical practices has moved from speculation to reality. Exhaustive recent surveys and case studies show a clear trend: practices are adopting AI to tackle their greatest headaches – documentation, communication, and billing – and are observing tangible time savings (<sup>[3]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)) (<sup>[36]</sup> [www.icthealth.org](http://www.icthealth.org)). Although current adoption is uneven, with small practices lagging behind hospital systems (<sup>[6]</sup> [www.hna-net.com](http://www.hna-net.com)) (<sup>[7]</sup> [www.ama-assn.org](http://www.ama-assn.org)), the gap is narrowing as technology matures and costs fall. Doctor enthusiasm is high, with many viewing AI as an essential tool in modern care (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[44]</sup> [www.ama-assn.org](http://www.ama-assn.org)), and an emerging consensus that AI will be part of standard practice.

Nevertheless, challenges remain. Overcoming cost, data, and trust barriers is critical. Both vendors and regulators have a role to play in providing validated, interoperable, and affordable AI solutions suitable for small practices. Policymakers must also ensure equitable access so that AI-driven quality improvements do not become the exclusive domain of well-funded systems.

The implications for healthcare are profound: if widely and wisely deployed, AI can significantly reduce clinicians' administrative load, improve patient engagement, and even save lives by enhancing diagnostics. On the other hand, failure to adopt responsibly could widen disparities and yield misplaced trust in unproven tools. Moving forward, the healthcare community – from private doctors to national leaders – must continue to share data, experiences, and best practices. This will help ensure that the promise of AI in private practice translates into better outcomes for patients and a more sustainable practice environment for physicians.

**References:** All data and assertions above are drawn from peer-reviewed studies, industry surveys, and expert analyses (<sup>[1]</sup> [www.medicaleconomics.com](http://www.medicaleconomics.com)) (<sup>[2]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[7]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[36]</sup> [www.icthealth.org](http://www.icthealth.org)) (<sup>[6]</sup> [www.hna-net.com](http://www.hna-net.com)) (<sup>[30]</sup> [www.ama-assn.org](http://www.ama-assn.org)) (<sup>[28]</sup> [academic.oup.com](http://academic.oup.com)) (<sup>[14]</sup> [www.deloitte.com](http://www.deloitte.com)) (<sup>[13]</sup> [www.fiercehealthcare.com](http://www.fiercehealthcare.com)) (<sup>[26]</sup> [newsroom.clevelandclinic.org](http://newsroom.clevelandclinic.org)).

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