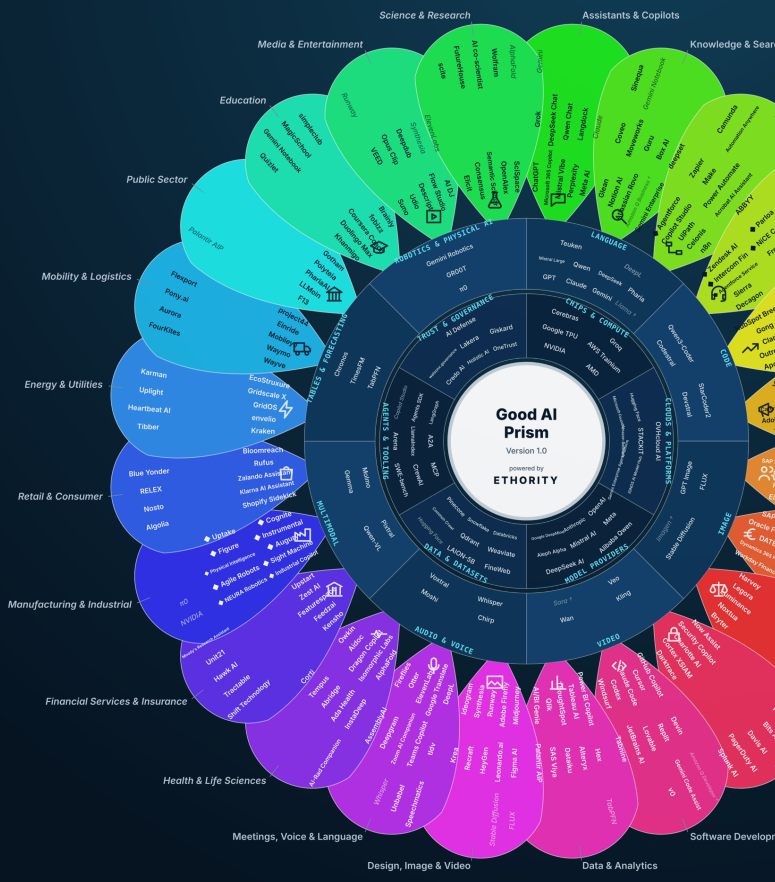
ETHORITY
AI BUSINESS OPERATING SYSTEM




GOOD AI PRISM · SECTOR BRIEF 2026/27 · HEALTH & LIFE SCIENCES · GLOBAL EDITION

# Put AI to work for patients and clinicians

Where AI already helps in care and research, what the market offers, and the rules by jurisdiction.

**25**
AI offerings mapped in Health & Life Sciences

**1,614**
AI-enabled devices on the FDA list, September 2026

**2 Aug 2028**
EU high-risk duties for AI in medical devices apply

Created by Sten Franke with a people and governance lens by Severin L. Wilson · October 2026

AT A GLANCE

# Health is where AI meets the most trusted decisions

Clinicians now use AI to write notes, summarise records and read images. Most of that use supports people; a growing share touches diagnosis and treatment, where medical-device law and the EU AI Act apply.

This brief applies the Good AI Prism Market Study 2026/27 to one industry: health and life sciences. It combines the study's market map of 25 AI offerings with current research on adoption, workforce and rules across major jurisdictions. Europe is ETHORITY's hub market and Germany its home and test market, so both get the closest look. The brief ends with the questions to settle before a pilot.

**81%**
of US physicians use AI professionally, up from 38% in 2023 (AMA, Mar 2026)

**71%**
of US acute-care hospitals used predictive AI in their EHR in 2024 (ONC/AHA)

**29%**
of UK doctors used at least one AI system in the past year (GMC, Feb 2025)

**64%**
of responding WHO Europe states use AI-assisted diagnostics (32 of 50, Nov 2025)

**18%**
of hospital physicians in Germany use AI, up from 9% in 2022 (Bitkom, May 2025)

**11.1m**
health workers projected short worldwide by 2030 (WHO)

**About this brief**

Market figures come from the Good AI Prism 2026/27 study dataset: every entry is recorded with a dated source from the provider's own pages. Job groups are ETHORITY's classification. External figures name their source, population and date; populations differ between countries and are not combined. This brief is not legal or medical advice.

WHERE HEALTH STANDS

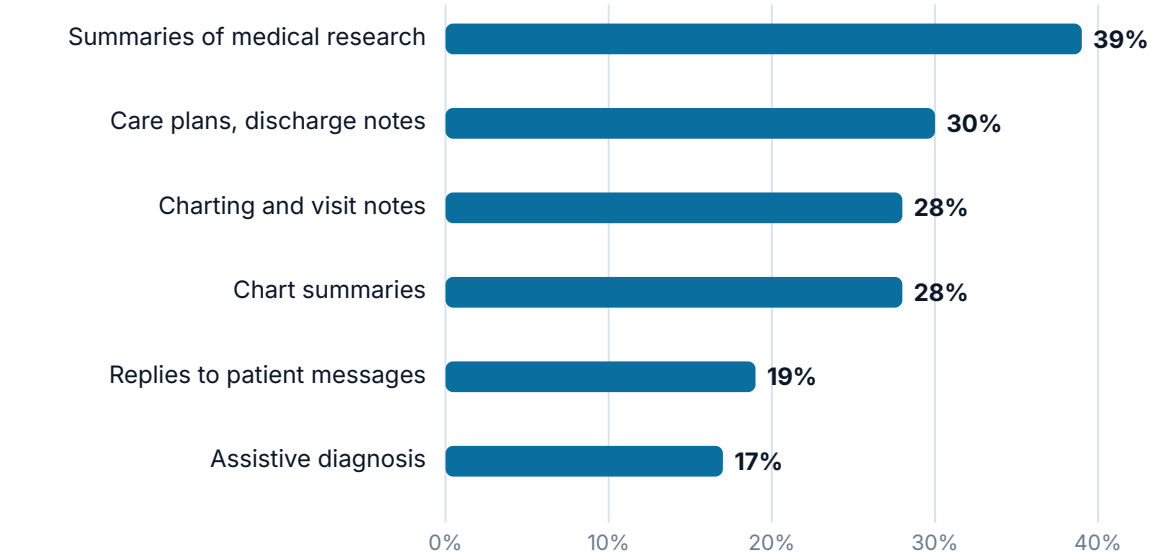
# From documentation to diagnosis

AI has become part of clinical work. 81% of US physicians used AI professionally in 2026, against 38% in 2023, and the average physician now uses it for more than two tasks (AMA, Mar 2026). 71% of US acute-care hospitals run predictive AI inside their electronic health record (ONC/AHA). In the UK 29% of doctors used an AI system in the past year (GMC), and 32 of 50 responding European states report AI-assisted diagnostics (WHO Europe).

The most common uses lift the paperwork: research summaries, care plans, notes and chart summaries. Diagnosis support follows at 17% of US physicians. In Germany, ETHORITY's test market, adoption is lower but rising: 18% of hospital physicians and 15% of practice physicians use AI (Bitkom, 2025).

**Exhibit 1 · What US physicians use AI for**

Share of physicians using AI for each task, 2026




AMA Physician Survey on Augmented Intelligence, 12 Mar 2026 · about 1,700 physicians

THE WORKFORCE SIDE

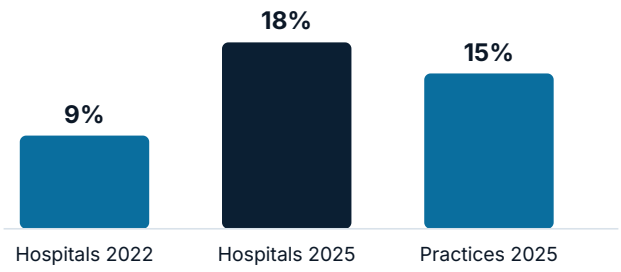
# AI arrives in a stretched workforce

The pressure is structural. WHO projects a shortfall of 11.1 million health workers by 2030. US physicians spend 5.8 hours in the electronic record for every 8 hours of scheduled patient time (JGIM, 2024), and employed physicians in Germany spend about three hours a day on administration and documentation (Marburger Bund, 2024).

Documentation tools show the first measurable relief: in one large US programme, ambient scribes saved physicians about an hour a day at the keyboard (NEJM Catalyst via AMA). Germany shows the gap between scale and use: about 73 million electronic patient records exist, while 3.6% are actively used by patients.

**Exhibit 2 · Test market Germany: physicians using AI**

Share of physicians using AI at work, by setting




Bitkom and Hartmannbund, 27 May 2025 · 616 physicians, not representative

**3 h**

a day on administration and documentation for employed physicians in Germany (Marburger Bund, 2024)

**3.6%**

of about 73 million electronic patient records in Germany are actively used by patients (Jan 2026)

THE RULES

# Europe sets the reference dates

ETHORITY reads the rules by jurisdiction. Europe is the hub market: the EU AI Act together with the medical-device regulations sets the most detailed rulebook for AI in care. Germany, the home and test market, adds digital health apps, the electronic patient record and research access to health data. The next pages map the other major jurisdictions.

**European Union: the hub market**

| | | |
|---|---|---|
| **2 Feb 2025** | IN FORCE | Prohibited AI practices apply; providers and deployers take measures to support AI literacy (Art. 4, as amended). |
| **2 Aug 2026** | IN FORCE | Transparency: patients must be told when they interact with an AI system, and generated content must be marked (Art. 50). |
| **2 Dec 2027** | ANNEX III | High-risk uses include emergency triage of patients (5d), risk pricing in life and health insurance (5c) and eligibility for public health services (5a). |
| **2 Aug 2028** | DEVICES | AI in medical devices and in-vitro diagnostics that need a notified body becomes high-risk under Annex I. MDR and IVDR continue to apply; delegated acts may limit duplicated requirements. |

Dates as amended by the Digital Omnibus on AI, Regulation (EU) 2026/1744, in force since 27 July 2026. The European Health Data Space, Regulation (EU) 2025/327, applies from 26 March 2027; secondary use of health data largely from 26 March 2029.

**Germany, the home and test market, adds its own building blocks**

- Digital health apps (DiGA): 58 apps listed at the end of 2025; about 1.9 million prescriptions or approvals since 2020 (GKV-Spitzenverband).
- Electronic patient record for all (opt-out): about 73 million records; data flows to research by default unless the patient objects (Health Data Use Act, GDNG).
- Research data centre for health at BfArM: purpose-based access to health data in the public interest (GDNG, 2024).
- German Medical Assembly 2025: AI supports decisions; final responsibility stays with the physician.

RULES BY JURISDICTION · EUROPE AND THE AMERICAS

# Where you treat decides which rules apply

Rules for AI in health differ in kind: device law everywhere, the AI Act on top in the EU, disclosure laws in US states, professional rules in Brazil and Germany. Status October 2026; sources on the next page.

| JURISDICTION | INSTRUMENT | APPLIES | WHAT IT MEANS FOR HEALTH |
|---|---|---|---|
| **European Union** | AI Act, amended by the Digital Omnibus on AI; MDR, IVDR; EHDS | Art. 50 since 2 Aug 2026; Annex III from 2 Dec 2027; devices from 2 Aug 2028 | AI medical devices are high-risk alongside MDR/IVDR; emergency triage and health-insurance pricing under Annex III. EHDS opens secondary use of health data from 2029. |
| **Germany** | DiGA (SGB V), GDNG, ePA für alle | In force | 58 digital health apps listed; about 73 million electronic records with research use by default (opt-out); physicians keep final responsibility. |
| **United Kingdom** | MHRA AI Airlock; NHS England guidance on ambient voice technology | Airlock phase 3 to 2029; registry since Jan 2026 | A regulatory sandbox for AI devices; a national registry of ambient scribe suppliers, with procurement by local trusts. |
| **United States** | FDA device law and guidance; ONC HTI rules; CMS | In force; HTI-5 proposed Dec 2025 | 1,614 AI-enabled devices authorised (76% radiology); predetermined change plans for model updates; relaxed rules for decision support and wellness (Jan 2026). |
| **US states** | California AB 3030 and AB 489; Texas SB 1188 and TRAIGA; Illinois HB 1806 | Since 2025–2026 | Disclosure of generative AI in patient communication; practitioners review AI output; AI therapy banned in Illinois. 22 states enacted health AI laws in H1 2026. |
| **Canada** | Health Canada guidance for machine-learning devices | Final Feb 2025 | Change plans for models allowed under licence terms. |
| **Brazil** | Federal Council of Medicine, Res. 2.454/2026 | Since 10 Aug 2026 | Institutions set up AI committees, classify systems by risk and inform patients; physicians stay responsible. |

RULES BY JURISDICTION · ASIA-PACIFIC

# Asia-Pacific: device regulators lead

In Asia-Pacific the medical-device regulators set the pace, with dedicated tracks for software and AI. China adds the rule that AI may not replace the physician.

| JURISDICTION | INSTRUMENT | APPLIES | WHAT IT MEANS FOR HEALTH |
|---|---|---|---|
| **China** | NHC rules on internet diagnosis; NMPA device approvals; AI + healthcare opinions (Oct 2025) | In force; NMPA draft Jun 2026 | AI may not replace physicians; class III imaging AI needs clinical validation; 154 AI devices approved by mid-2025. |
| **Japan** | PMDA/MHLW SaMD framework (DASH for SaMD 2, IDATEN) | Ongoing | 51 AI devices approved by Sep 2025; two-step approval and pre-agreed change plans. |
| **South Korea** | Digital Medical Products Act | Since 24 Jan 2025 | A dedicated authorisation track for digital and AI medical products. |
| **Singapore** | MOH/HSA AI in Healthcare Guidelines 2.0 | Since 10 Mar 2026 | Guidance for developers and deployers, including generative and direct-to-consumer AI; HSA software device rules apply. |
| **India** | CDSCO draft guidance on medical device software | Draft Oct 2025 | Risk classes A–D and an algorithm change protocol for AI. |
| **Australia** | TGA review of AI and medical device software | Report Jul 2025; consultations 2026 | Framework largely fit for purpose; urgent review of digital scribes. |

Sources: statutes and regulators (FDA, ONC, MHRA, NHS England, NHC, NMPA, MHLW/PMDA, MFDS, MOH/HSA, CDSCO, TGA, Health Canada, CFM, GKV-Spitzenverband, gematik); White & Case, Taylor Wessing, Kennedys, Hogan Lovells, Manatt, Akerman, Baker McKenzie, MinterEllison, BLG, Mayer Brown. Status October 2026. Not legal advice.

### Where the 25 providers are headquartered

**12**
Europe, of which 2 in Germany

**9**
North America

**4**
Asia-Pacific and Middle East

Headquarters per provider pages and public registers, October 2026. By parent company: Europe 10, North America 11. Alphabet owns Google DeepMind and Isomorphic Labs; RadNet acquired Gleamer (2026); Tempus acquired Paige (2025); Dassault Systèmes owns Medidata; BioNTech owns InstaDeep.

THE MARKET MAP

# 25 AI offerings for health, from the consultation room to the lab

The Good AI Prism 2026/27 places 25 offerings in Health & Life Sciences. Seven capture the conversation between clinician and patient and draft the documentation. Six read images and pathology slides. Six support drug discovery and biology, three run clinical trials and precision data, two assess symptoms and one plans hospital capacity.

**Exhibit 3 · The Health & Life Sciences map by job**

Number of offerings per job group; names alphabetical, not a ranking

**7 Clinical documentation & ambient scribes**

Abridge · Corti · Dragon Copilot (Microsoft) · Heidi · Nabla · Suki Compose · Tandem Health

Art. 50 disclosure for patient-facing use; device rules if it supports diagnosis or treatment

**6 Imaging & diagnostic AI**

Aidoc · AI-Rad Companion (Siemens Healthineers) · BoneView (Gleamer) · e-Stroke (Brainomix) · Lunit INSIGHT · Paige Prostate Detect

High-risk via Annex I (MDR/IVDR) from 2 Aug 2028 when placed on the market as a medical device

**6 Drug discovery & biology**

AlphaFold (Google DeepMind) · InstaDeep (BioNTech) · Isomorphic Labs · Owkin · Pharma.AI (Insilico Medicine) · Recursion OS

Research-only use falls under the scientific R&D exclusion (Art. 2(6))

**3 Clinical trials & precision data**

Medidata Plus · Saama AI Platform · Tempus

Depends on the modules and intended use

**2 Symptom assessment & triage**

Ada Health · Infermedica

Annex III 5(d) for emergency triage; Annex I when certified as a medical device

**1 Hospital operations**

Qventus

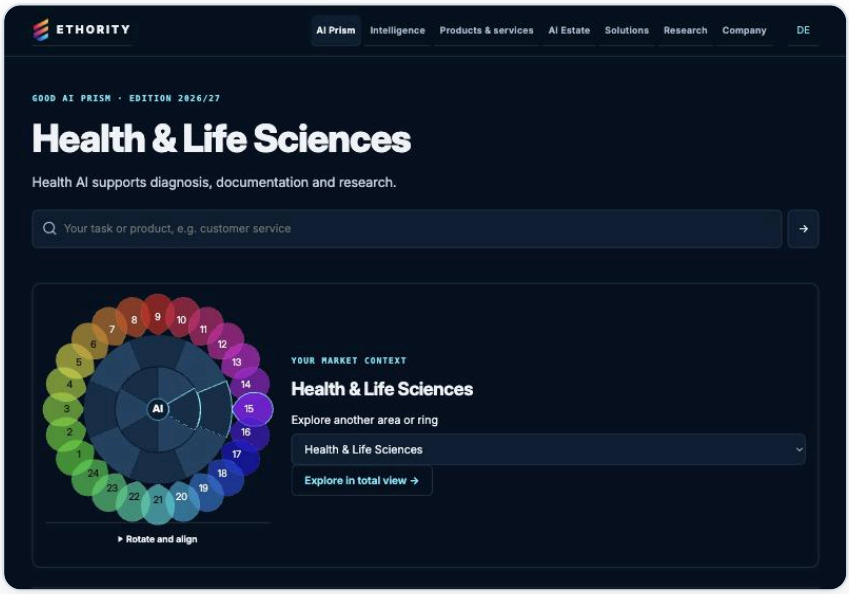
Depends on the modules and intended use

Good AI Prism 2026/27 study dataset · job groups: ETHORITY classification · The AI Act classifies uses, not products. Whether an offering is high-risk depends on its intended purpose and certification.

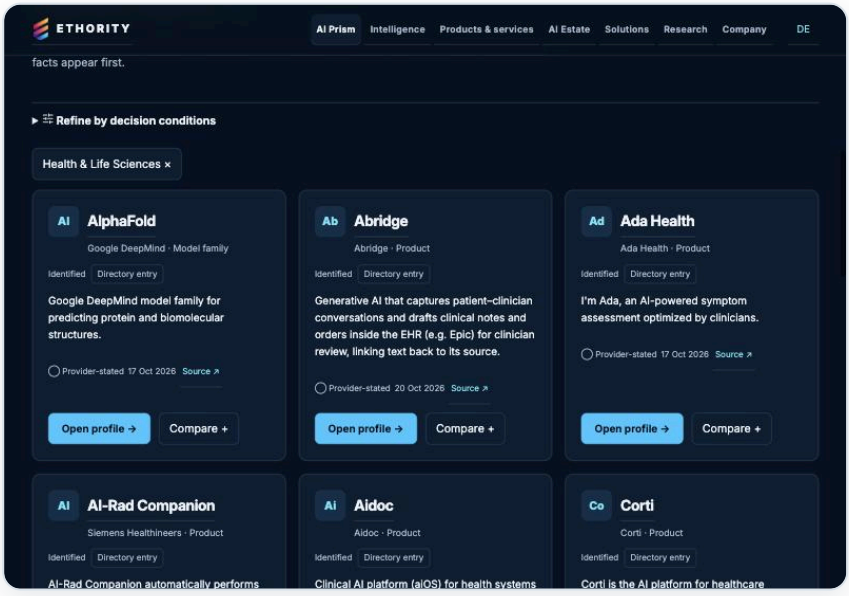
ONLINE VIEW

# The Health & Life Sciences area in the Good AI Prism

The online Good AI Prism places each offering in its business area and shows the source and date behind every entry. The preview below shows the Health & Life Sciences area as it appears in October 2026. Select an area to see the offerings placed there, then open a profile to check the provider's own statement, its date and the decision facts recorded for it, such as pricing basis, data hosting and training on customer data where documented.




Good AI Prism online preview: Health & Life Sciences selected (area 15), October 2026.




Entries with their source and date. The preview shows 11 profiled entries; this brief counts all 25 recorded for the edition.

NEEDS AND DECISIONS

# What health leaders need, and what to ask before a pilot

### What the evidence shows

**Time**
US physicians spend 5.8 hours in the record per 8 hours of patient time (JGIM, 2024); German hospital physicians about 3 hours a day on administration (Marburger Bund).

**People**
WHO projects a shortfall of 11.1 million health workers by 2030.

**Skills**
One in four UK GPs uses generative AI clinically; most report no training (GPAI-UK, 2025).

**Rules and trust**
8% of WHO Europe states have a national health-AI strategy; 86% name legal uncertainty as a barrier (WHO Europe, Nov 2025).

### Seven questions before AI touches patient care

1. Is it a medical device? If its intended purpose covers diagnosis, treatment or triage, device law applies, and in the EU the AI Act from August 2028.
2. Who reviews every AI output before it reaches a patient or the record?
3. Do patients know when they deal with AI, as the EU (Art. 50), California and Texas require?
4. Which data trains and feeds the system, where is it hosted, and do GDPR, HIPAA or the EHDS rules on secondary use apply?
5. Does the provider show clinical evidence for our patient population, and a plan for model changes?
6. How do clinicians report errors, and how fast can a model change be rolled back?
7. How will we measure time returned, quality and patient outcomes before we scale?

WORKFORCE PLAN

# Plan the people side with the technology

When agendas change quickly, the people side breaks first: half-adopted tools, skills that lag the system, employees who were not involved, and decisions no one owns. Plan adoption, training, employee participation and accountable oversight as part of every staged commitment, not after it.

Severin L. Wilson, workforce lens in the Good AI Prism Market Study 2026/27

**Workforce annex to the pilot charter**

| | |
|---|---|
| **Affected roles** | Which clinical and administrative roles the pilot touches, and how many people |
| **Baseline workload** | Documentation time, waiting times and quality today, measured before the pilot |
| **Skills needed** | Operating, reviewing and improving the system; training plan and owner |
| **Staff and patient involvement** | Works council, clinical leads and patient representatives where applicable |
| **Oversight owner** | The named clinician accountable for outputs that affect patients |
| **Escalation and appeal** | How clinicians and patients can challenge an output, and the response time |
| **Capacity plan** | Where returned time goes: patient contact, quality, training or access; who decides |
| **Measured quality** | Error rate, incident reports and review findings, tracked with the outcome measure |

**Saved time is not realised value. Count it when returned time has demonstrably gone into patient care, quality or access.**

NEXT STEPS

# A 90-day start for health organisations

01
### Inventory
List every AI use, including scribes and chat tools clinicians bring themselves.

02
### Classify
Separate device and non-device uses and map them against the rules where you treat, with legal review.

03
### Involve
Bring in clinical leads, data protection and employee representatives early; in Germany, the works council.

04
### Enable
Document AI literacy measures and name trained clinical overseers.

05
### Pilot
Run one documentation or imaging use with the workforce annex and a baseline.

06
### Decide
Scale only on measured time returned, quality and patient outcomes.

ETHORITY recommendation, derived from the rules and evidence in this brief.

CONCLUSIONS

# What the evidence adds up to

AI already writes notes, reads images and supports research. The question for health leaders is how to scale it safely and prove it gives time back to care. Five conclusions for decisions now.

**1** **Start with documentation**

**Evidence.** Ambient scribes saved US physicians about an hour a day; German hospital physicians spend about three hours a day on administration.

**What to do.** Pilot documentation first, with a baseline of time and quality. · The workforce side

**2** **Know when it is a medical device**

**Evidence.** AI that supports diagnosis or treatment falls under device law and, in the EU, high-risk rules from Aug 2028.

**What to do.** Classify every use by intended purpose before procurement. · The rules

**3** **Keep the clinician accountable**

**Evidence.** Professional rules in Germany and Brazil and US state laws keep final responsibility with the physician.

**What to do.** Name a clinical owner for every AI output that reaches patients. · Rules by jurisdiction

**4** **Close the gap between infrastructure and use**

**Evidence.** Germany has about 73 million electronic records, but 3.6% are used actively.

**What to do.** Design AI around clinicians' and patients' daily work, not around systems. · The workforce side

**5** **Measure time returned and outcomes**

**Evidence.** Most evidence still measures accuracy, not patient outcomes or time.

**What to do.** Count time returned, quality and patient outcomes before scaling. · Needs and decisions

THE PROBLEM

# Health is not short of AI. It is short of time, evidence and safe paths to scale.

Health leaders must choose AI that clinicians trust, classify it correctly under device and AI law, and prove it improves care.

| THE PROBLEM | WHAT WE SEE IN THE EVIDENCE | WHAT IT COSTS |
|---|---|---|
| **Administrative burden** | Clinicians spend hours a day on documentation. | **Less time for patients; burnout.** |
| **Device and AI law** | Diagnosis and treatment support is regulated as a medical device and high-risk AI. | **Delays and liability risk.** |
| **Thin outcome evidence** | Many tools show accuracy, few show patient benefit. | **Purchases that do not improve care.** |
| **Data access** | Health data rules and fragmented records limit use. | **Models that do not fit the population.** |
| **Workforce shortage** | WHO projects 11.1 million missing health workers by 2030. | **Care not delivered.** |

**The question behind every project**

What should improve, which options are credible, what evidence is missing, what implementation requires, and who owns the outcome?

HOW ETHORITY HELPS

# From AI ambition to time returned to care

ETHORITY helps hospitals, practices and life-science organisations choose, govern and prove AI: from independent market evidence to decisions that can be defended to clinicians, regulators and patients.

**01**
### Discover
Find and qualify the opportunity: options, evidence, constraints and rules.

**02**
### Create
Design and build the solution with your data, systems and people.

**03**
### Run
Operate it responsibly, with owners, controls and support.

**04**
### Improve
Measure against the objective and adjust.

**05**
### Grow
Turn what was learned into new capability and value.

## WHERE A PROJECT CAN BEGIN

**AI opportunity case**
One use, such as documentation, imaging support or patient communication, assessed against evidence, cost and rules, ending in a decision: pilot, redesign, expand or stop.

**Vendor and evidence due diligence**
Good AI Prism research profiles and comparisons of the 25 health offerings, with a structured check of clinical evidence and data terms.

**AI estate audit**
An inventory of AI across clinical and administrative work, including tools clinicians bring themselves.

**Governance and readiness**
Each use mapped to the AI Act, device law, health-data rules and professional duties, with proportionate controls.

**AI literacy for clinicians**
Role-based training for physicians, nurses and managers, with named clinical overseers.

**From pilot to operation**
A pilot charter with baseline, threshold and stop conditions, then building and running the solution on ETHORITY's AI Business Operating System.

**Who we work with**

Hospitals and hospital groups, practices and care networks, insurers, life-science companies, health authorities and associations.

**Start with one question. Talk to us: sten@ethority.ai · severin@ethority.ai · ethority.ai/ai-prism-study**

ABOUT ETHORITY

# From understanding markets to building AI capability

ETHORITY connects market intelligence, research and practical delivery to help organisations put AI to work. It is built as an AI1st organisation: humans and AI agents work on one AI Business Operating System, with the research, engineering and operations to build and run AI after the pilot. Its roots lie in the digital intelligence business Sten Franke founded in 2005, which combined monitoring, research and advisory work to help organisations understand changing markets.

The Good AI Prism is the entry point: research profiles, documented relationships and comparisons help users investigate their options. Advisory, governance and transformation work connect those options with an organisation's objectives, data, systems, people and operating conditions.

### SELECTED REFERENCES AND PARTNERS SINCE 2005

**Bosch · Bayer · BMW · Siemens · Mercedes-Benz · Coca-Cola · Deutsche Bank · T-Mobile · Telefónica o2 · DHL · EDEKA · AIDA Cruises**

Selected historical references and partners from the group's market-intelligence and advisory heritage, in projects or through former group companies.

### METHOD

Market figures: Good AI Prism 2026/27 study dataset, Health & Life Sciences area, 25 entries, each with a dated source from the provider's own pages (October 2026). Job groups and AI Act relevance: ETHORITY classification by intended use. Jurisdictions: status October 2026 from statutes, regulators and law-firm briefings. External figures as cited and not combined. Not legal or medical advice.

### MAIN SOURCES


- AMA, Physician Survey on Augmented Intelligence, 12 Mar 2026
- ASTP/ONC data brief via AHA: predictive AI in US hospitals, 4 Nov 2025
- Bitkom and Hartmannbund, KI in Praxis und Klinik (n = 616), 27 May 2025
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- Regulations (EU) 2017/745 (MDR), 2017/746 (IVDR) and 2025/327 (EHDS)
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- Good AI Prism Market Study 2026/27 and study dataset (ETHORITY, October 2026)
- GMC and Alan Turing Institute, doctors' use of AI, Feb 2025
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- JGIM 2024: EHR time of 200,081 US ambulatory physicians

ETHORITY
AI BUSINESS OPERATING SYSTEM



FROM BUSINESS AMBITION TO AI THAT WORKS

# Put AI to work, with evidence.

ETHORITY helps organisations choose, govern and prove AI: from independent market evidence to decisions that can be defended and outcomes that can be measured.

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## THE ETHORITY STUDY SUITE

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| 02 | **Put AI to Work: The Good AI Prism Market Study 2026/27** | Germany–US focus · EN and DE |
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