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2026 State of AI in Veterinary Medicine:

From Experimentation to Value

Foreword

Two years ago, we ran a survey to see how veterinary professionals were approaching AI. We saw cautious experimentation, a wave of early adopters, and a lot of hope for what the technology might do. The profession was still deciding. Now it has. Today, AI has become a routine tool for most practices, showing up across workflows and in every role on the team.

So this year, we wanted to understand something deeper: not if practices use AI, but how well they use it.

That difference matters now more than ever. A practice can bring in a dozen AI tools and be no better off if none of them talk to each other, no one owns the strategy, and each one just adds another login and another tab to juggle. Meanwhile, a practice down the road, using half as many, but deliberately, sees real business value.

It's the difference between dropping a Formula 1 engine into an old sedan and hoping it wins the race, and actually building a car designed to race. The engine alone doesn't get you there. What you build around it does.

That gap is what we set out to assess this year. Our goal was to see how deeply AI is woven into daily work, how these tools are deployed, integrated, and governed, and whether the team can sustain and grow it over time.

We care about this because we've seen what mindful adoption makes possible. Done well, AI takes over the repetitive, manual work that fills a team's day. They see more patients without adding hours. They reach out to pet owners proactively, catching problems earlier and delivering better care, without piling more onto already-stretched teams. Staff spend their time on medicine, not admin tasks. People get home on time.

Our hope is that this research gives veterinary teams the direction to adopt AI successfully, maximize its value, and capture everything it can do for their clinic.

None of it would exist without the thousands of veterinary professionals who took the time to share their experience with us. Thank you. This picture of the profession is yours.

Sebastian Gabor
Co-founder & CEO, Digitail

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Introduction 1

It's been almost four years since the release of the Generative Pre-trained Transformer (ChatGPT), giving a push to the massive penetration of generative artificial intelligence (AI) across industries.[1] The generative AI market is expected to grow to $1.3 trillion over the next ten years, up from a market size of just $40 billion in 2022.[2] As of this writing, 126 AI generative models were published in the last 12 months alone — a notable model release occurring roughly every three days.[3]

In animal health specifically, the global AI market was valued at $1.8 billion in 2025 and is projected to grow to $2.1 billion in 2026 and $7.0 billion by 2033, a CAGR of 18.9% from 2026 to 2033.[4] This growth is driven by rapidly rising AI adoption across veterinary medicine, its deeper integration into existing systems, sustained investment in developing and deploying new solutions, and growing awareness among veterinary professionals.

AI-powered solutions are becoming common in veterinary practices of every size and setting — from Practice Information Management Systems (PIMS) with built-in AI capabilities to voice-to-text transcription, diagnostics, predictive analytics, imaging interpretation, client communication tools, and smart wearables.

The veterinary community is generally enthusiastic about AI.[5] Younger professionals, in particular, exhibit a higher level of familiarity with these tools, expressing a belief that AI may improve pet care.[6] Practice owners largely characterize the pace of digital transformation in their own settings as "about right."[7]

Yet, investment, optimism, and adoption do not automatically translate into measurable results. Data from other industries shows that while more than 80% of organizations have explored or attempted AI implementation, 95% have not seen any financial return from these initiatives.[8] Potential reasons include difficulty training AI, poor output quality, lack of integration into existing workflows, and team resistance to new tools. Earlier research suggests that building foundational capabilities such as AI infrastructure, talent, and strategy can raise the likelihood of significant benefits by 19%.[9]

As with any new technology entering established workflows, AI in veterinary medicine requires deliberate management and human oversight to translate access into value. Quality of implementation is becoming increasingly important.

Maturity models offer one way to build a roadmap for such sustainable adoption.[10] A maturity model is a structured framework for assessing how developed an organization's processes and capabilities are in a given area. Originating in software development and now widely used across many sectors, including human healthcare, maturity models describe the stages an organization moves through as it adopts a technology, helping prioritize improvements and track progress over time.

This study set out to bring that kind of clarity to veterinary medicine. Beyond simply measuring exposure to and sentiment about AI, we aimed to map the industry's AI maturity across several structural dimensions, drawing on

practitioners' own accounts of the breadth of tools in use, how deeply they integrate into existing systems, satisfaction with their performance, and what outcomes — for the business and for patient care — are beginning to emerge.

Taken together, these measures are intended to serve as an industry benchmark: a way for veterinary practices to locate themselves within the broader adoption curve, understand what separates early experimentation from durable capability, and identify concrete next steps toward realizing the full value of AI.

Methods

2

This descriptive cross-sectional study was initiated by Digitail and administered by the American Animal Hospital Association (AAHA). It used an online survey approach in which participants received a hyperlink to a questionnaire generated by and hosted on Qualtrics XM software. The survey was distributed to AAHA's members and the Digitail community of veterinary professionals in the United States and Canada, including veterinarians, veterinary technicians, veterinary assistants, practice managers, customer service representatives (CSRs), veterinary students, business executives, and other industry representatives. To ensure relevance and clarity, the instrument was designed and reviewed in consultation with AAHA's research division and veterinary professionals on the Digitail team.

The survey opened with an introduction letter providing brief background on AI in veterinary medicine and describing the purpose of the study. The questionnaire comprised 28 closed-ended questions and 2 open-ended questions, along with several optional free-text fields for respondents to elaborate on their answers. Routing logic directed respondents only to questions relevant to them; aside from this conditional branching, questions were presented in a fixed, non-randomized sequence, though the order of response options was randomized where appropriate to mitigate order bias.

Building on Digitail and AAHA's 2024 study of AI adoption in veterinary medicine, the 2026 questionnaire retained core measures of AI usage and perception to enable year-over-year comparison, and added a new structured measurement of maturity — the degree to which practices have adopted AI deliberately, governed it proactively, integrated it into daily work, and built the organizational capability to sustain and extend it.

To measure AI adoption maturity, we adapted a published, peer-reviewed framework: the Healthcare AI Governance Readiness Assessment (HAIRA), introduced by Hussein et al. in npj Digital Medicine (2026)[11]. Based on a systematic review of 35 healthcare AI governance frameworks, it was designed for smaller, resource-constrained organizations — a profile that fits the veterinary sector well.

Since most practices are small businesses that adopt vendor AI rather than develop it in-house, the framework required further adaptation to better meet the realities of the veterinary world. HAIRA's higher maturity levels assume an organization that develops and validates its own AI models, which veterinary practices generally do not do. Applied without change, the model would place nearly all practices at its lowest levels, obscuring the real differences we set out to assess.

We consolidated HAIRA's development- and validation-oriented domains into a single dimension capturing how rigorously practices evaluate and select vendor AI, and reframed the remaining domains in language appropriate to veterinary practice. The resulting veterinary AI maturity model comprises six dimensions: Strategy and Intent,

Governance and Oversight, Vendor Evaluation and Selection, Workflow and Technology Integration, Adoption Depth, and Capability and Readiness. Each is scored on a four-level scale from ad hoc (Level 1) to advanced (Level 4). The index was calculated only for respondents whose practice uses AI.

Two dimensions, Strategy and Intent and Governance and Oversight, describe decisions made at practice level. These were asked only of respondents who reported making or influencing those decisions, or being aware of them, so that respondents describing only their own day-to-day work were not asked to characterize practice-wide strategy. The remaining four dimensions were asked of all AI-using respondents. The overall index is the equal-weighted average of the dimensions a respondent was scored on, and was calculated only where at least four of the six could be scored. Dimension scores and the overall index are reported with separate denominators, since the number of respondents eligible for each differs. Because the unit of analysis is the individual respondent, results are reported as perceived maturity rather than a verified, practice-level measure.

Data collection took place over 17 days, starting on July 27, 2026, and ending on August 12, 2026. As an incentive, respondents who provided their email addresses upon completing the questionnaire were entered into a raffle for twenty $25 digital gift cards.

The survey yielded 535 responses through direct email invitation, along with an additional 1,195 participants recruited through a social media campaign, producing a combined sample of 1,730 respondents. Of these, 1,566 (90.5%) completed the full questionnaire. The 2024 wave of this study drew 4,031 respondents.

The actual number of respondents to each question varied according to the ability of respondents to answer each question. Statistical analyses were performed using only the actual response set for each question. Chi-square tests were used for categorical comparisons, Kruskal–Wallis and Mann–Whitney tests for comparisons of ordinal scores, and Spearman's rank correlation for associations between ordinal measures. Significance is reported at the 95% level throughout. Blanks and “not applicable” answers are excluded from every denominator, and figures beyond those published on the study dashboards were derived from the respondent-level data on the same basis.

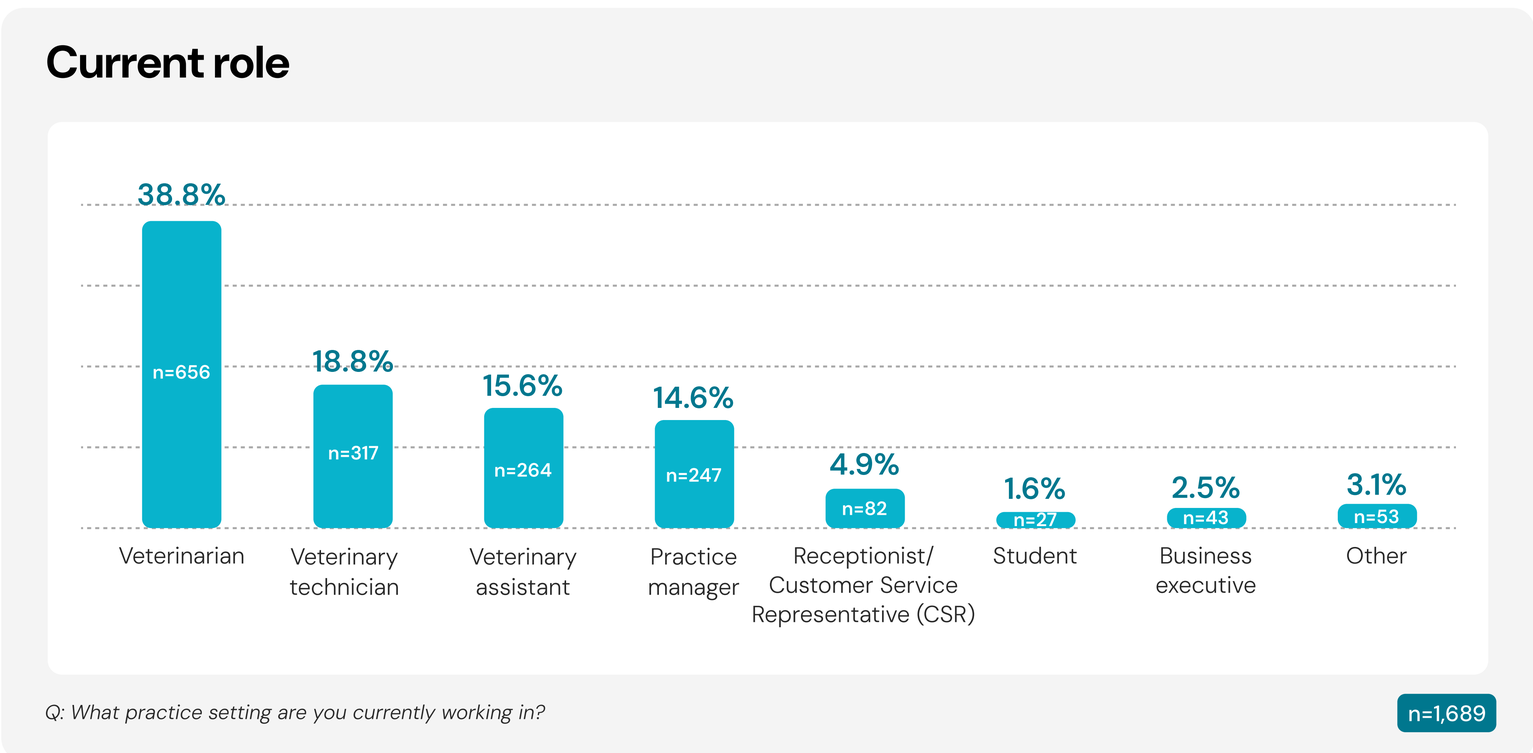
Dimension	L1 Ad Hoc	L2 Emerging	L3 Established	L4 Advanced
Strategy & Intent	No practice-level discussion; tools used incidentally.	Experimenting, but no plan or owner.	Some priority areas are chosen; someone owns it.	AI sits in documented operational or growth plans, with goals that are tracked.
Governance & Oversight	No guidelines and no oversight. AI use is unmanaged.	Informal rules, nothing documented, and nobody clearly responsible.	Written guidelines and a named person responsible, with tools reviewed before adoption.	Written guidelines, staff trained on AI use, a named AI lead, and formal review of tools.
Vendor Evaluation & Selection	Takes whatever is free, bundled, or recommended, with little comparison.	Compares a couple of options or asks peers before deciding.	Uses a consistent way of weighing accuracy, integration, support, and cost.	Formally evaluates tools, including data handling and security, and reviews performance after adoption.
Workflow & Tech Integration	Tools are not connected, and AI was added without changing how the practice works.	Partly connected with little workflow change, or workflows changed while tools stay disconnected.	Fully connected but workflows largely unchanged, or workflows redesigned with only partial connection.	Fully connected, with no manual data transfer, and workflows redesigned around the tools.
Adoption Depth	AI sits with a handful of individuals. Most of the practice works without it.	A small minority use AI. It has not reached most roles.	AI has spread through a substantial part of the practice, but a meaningful share of staff still work without it.	AI is the norm rather than the exception. Almost everyone uses it as part of their working day.
Capability & Readiness	The practice isn't equipped for AI. Systems, skills, backing, and budget are largely absent, and adoption depends on individual effort.	Some foundations exist, and others don't. AI works in places, but the practice can't rely on it holding up.	The practice is equipped for AI. Systems support it, leadership backs it, and staff are willing to use it.	The practice is fully equipped, including ongoing training and money set aside to invest, and can extend AI without strain.

Results

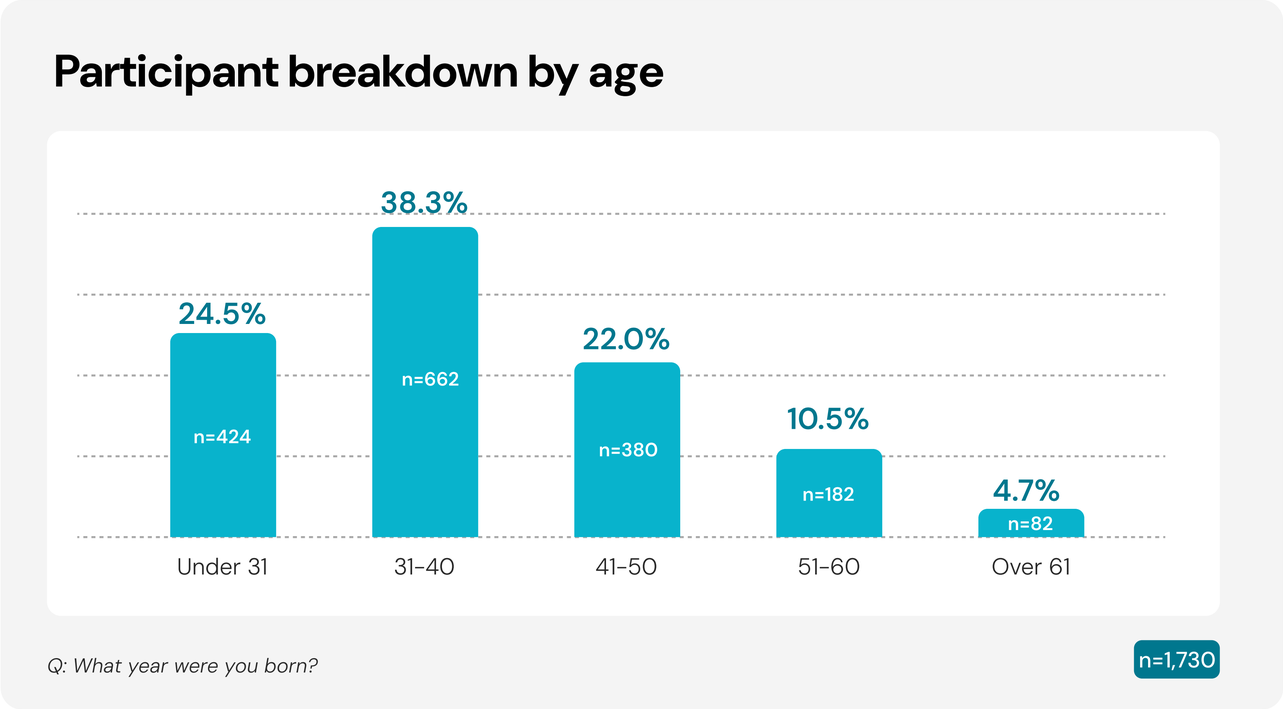
3

Respondent Demographics and Practice Profiles

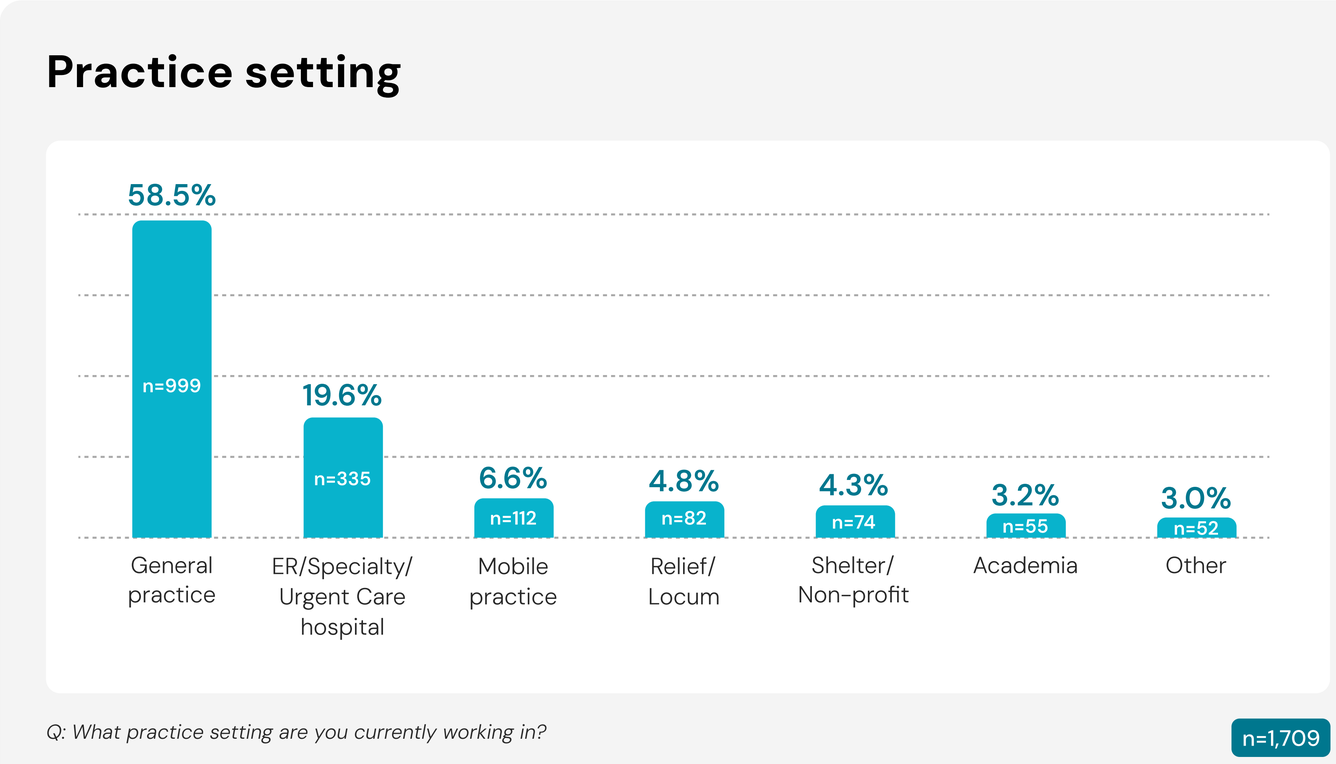
Veterinarians made up the largest share of respondents, at 38.8%. Veterinary technicians accounted for 18.8%, and veterinary assistants for 15.6%. The remaining 26.7% were practice managers, receptionists/customer service representatives (CSRs), students, business executives, and other roles. "Others" included leadership and operational titles such as medical directors and inventory managers, specialist clinical or support functions (dentistry, nephrology, behavior consulting, pharmacy, patient care coordination), and corporate or academic posts.



By age, 24.5% of respondents were under 31 years old at the moment of completing the survey. Survey participants aged 31 to 40 made up the majority group, at 38.3%. Respondents aged 41 to 50 accounted for 22%, and those aged 51 to 60 for 10.5%. Practitioners over 61 made up the remaining 4.7%. The median respondent age was 36 years.

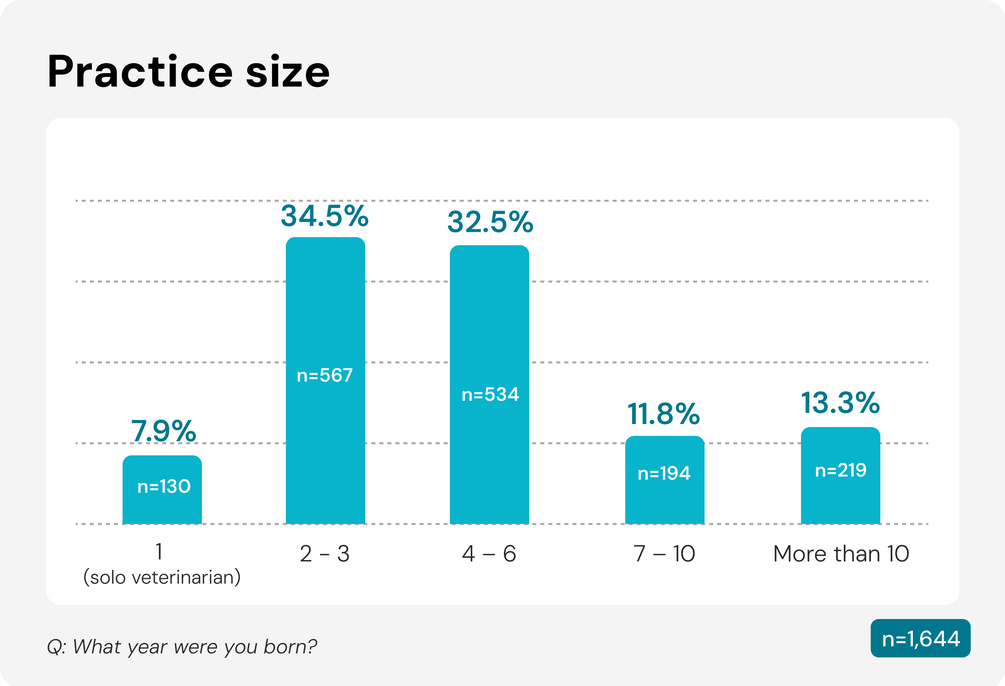


In terms of practice settings, over half of respondents were employed in general veterinary practice (58.5%). 19.6% practiced in ER, specialty, and urgent care hospitals, 6.6% worked in mobile practice, and 4.3% in shelters and non-profit organizations. 4.8% of respondents represented the relief (locum) veterinary workforce, and 3.2% were affiliated with academia. The remaining 3% who selected "Other" were mostly in hybrid, species- or discipline-specific practices (feline only, exotics, dentistry, rehabilitation, behavior), alternative delivery models (telehealth, mobile end-of-life, vaccine clinics), and a few non-clinical roles.



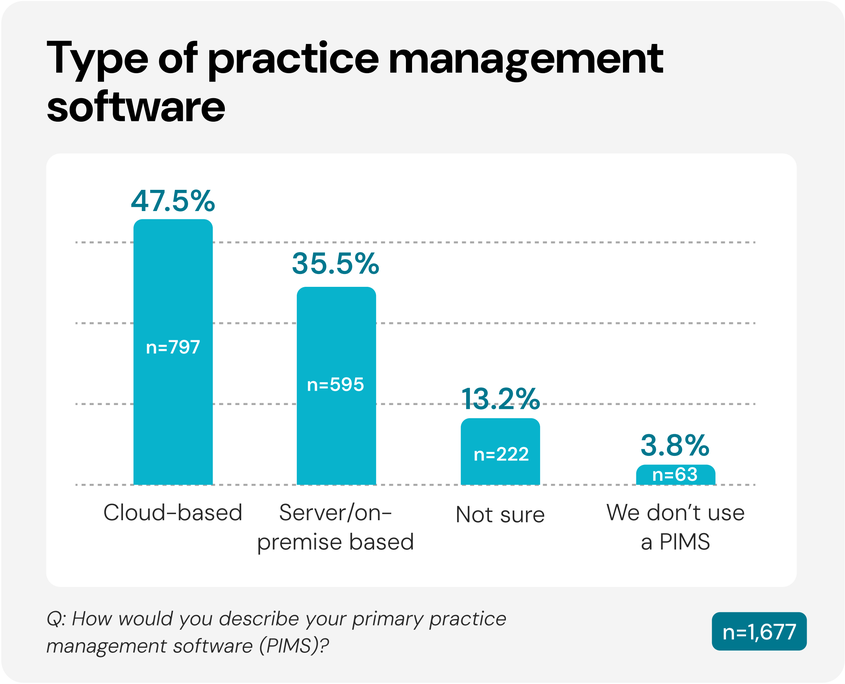
Among respondents working in general practice, ER/specialty, or mobile practice, 54.9% were affiliated with private practices and 41.5% with corporate practices. The remaining 3.6% reported other or mixed ownership arrangements, or were unsure how their practice was owned.

When asked about the size of their practices, 34.5% of respondents were in small teams of 2 to 3 doctors of veterinary medicine (DVMs), and 32.5% in medium-sized practices of 4 to 6. Larger practices accounted for 11.8% with 7 to 10 veterinarians and 13.3% with more than 10. The smallest share, 7.9%, were in single-veterinarian practices.



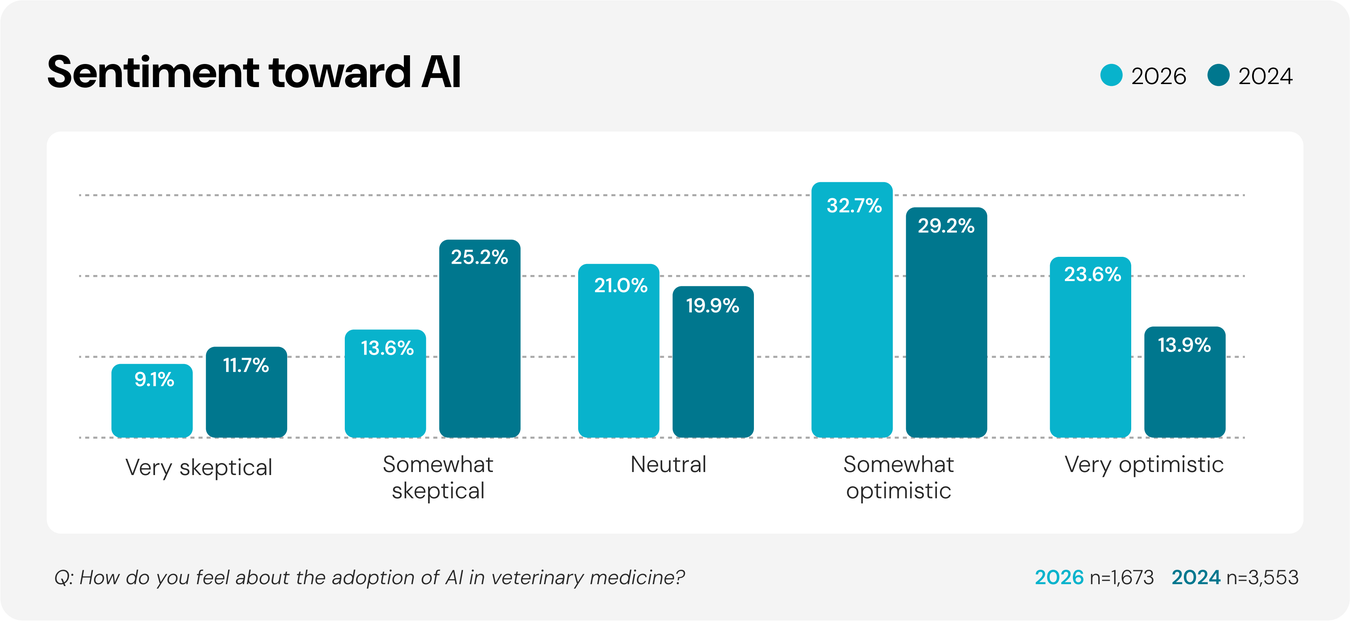
Participants were also asked about their level of influence on technology decisions at their practice, which served as a screener for the practice-level maturity dimensions. 44.4% of respondents said they make or directly influence these decisions, and 40.8% said they're aware of them but don't make them. The remaining 14.7% said their exposure to these tools is mainly through their own day-to-day use.

The survey also gathered information on respondents' primary practice management software. Cloud-based systems were the most common PIMS type, reported by 47.5% of respondents, followed by server/on-premise systems at 35.5%. 13.2% weren't sure how their PIMS was hosted, and 3.8% used no PIMS at all.



Sentiment Toward AI Across Demographics

Attitudes toward AI among the veterinary community moved toward more positive sentiment. 56.3% of respondents were optimistic about AI in veterinary medicine in 2026, versus 43.1% in 2024 — a change of +13.2 points. Skepticism fell from 37% to 22.7%, a drop of -14.2 points.

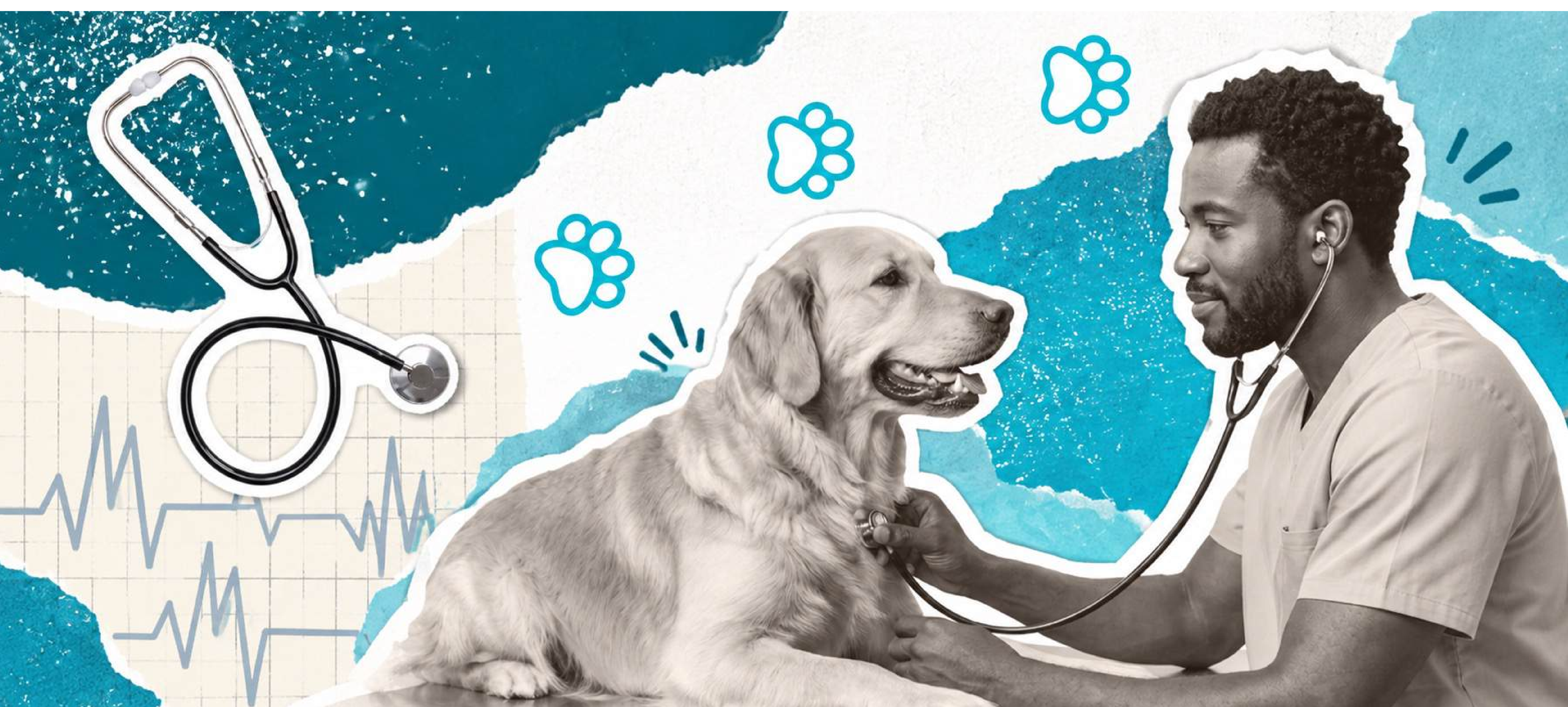


> *"AI has kept me on the edge of my career as a veterinary practitioner ever since I came into contact with it,"*
>
> — shares one of the respondents who is working as a veterinary technician*

> *"Vet med has been behind the times for years regarding technology. I think investing in technology is a way to advance our hospitals and medicine. Our teams are more efficient and motivated to continue working."*
>
> — Practice manager

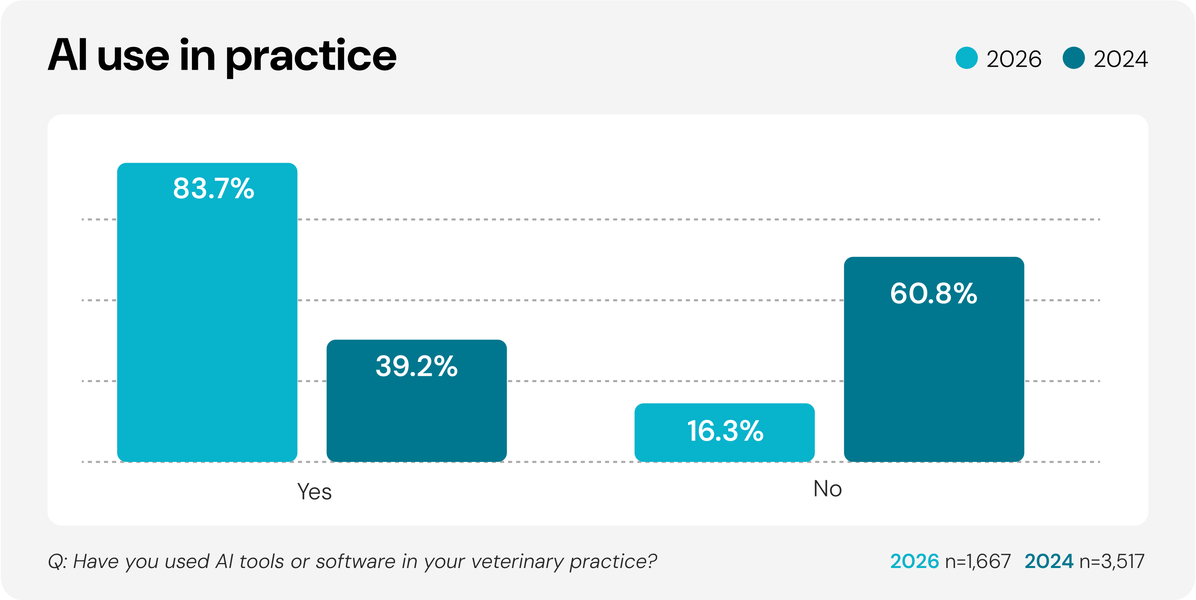
*The respondents' quotes have been slightly edited for clarity and brevity.

Respondent age was associated with sentiment toward AI in 2024, but not in 2026. In 2024, respondents under 30 were the most skeptical group in the sample, with 44.5% reporting skepticism and only 9.8% very optimistic, while every older age group recorded a positive mean sentiment score ($P < .001$). By 2026, skepticism among under-30s had fallen to 22.2%, and the share who were "very optimistic" had risen to 19.5%. Mean reporting sentiment across all five age groups sits in a narrow 0.3-to-0.5 range, and the association between age and sentiment was no longer statistically significant ($P = .27$).

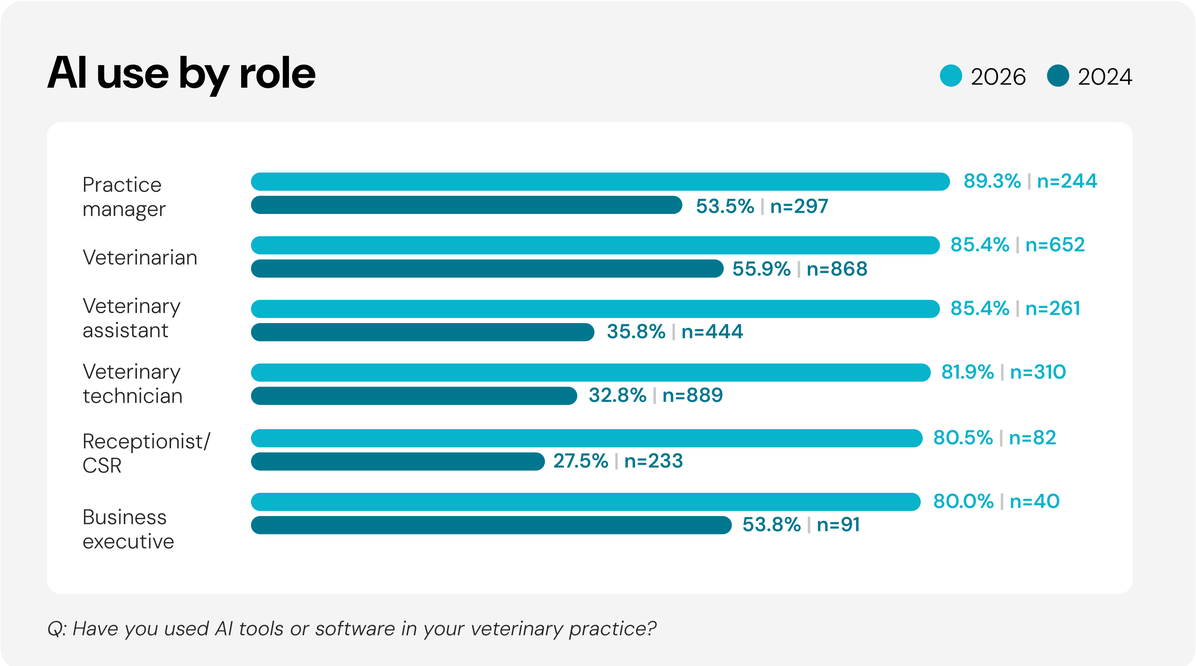


Adoption Trends and Frequency of Use

The overall share of veterinary professionals using AI in practice has more than doubled — from 39.2% in 2024 to 83.7% in 2026, an increase of +44.6 points.



Every role saw adoption climb across the profession. Practice managers reported the highest AI use at 89.3%, followed by veterinarians and veterinary assistants (85.4% each), and veterinary technicians (81.9%). The sharpest growth in AI usage was recorded in support roles: among receptionists and CSRs, it nearly tripled, from 27.5% in 2024 to 80.5% in 2026.



> *"In daily work, AI serves as an efficient auxiliary tool. I use it to optimize the medical record archiving template, create health education materials for pet owners, and quickly translate veterinary materials. For common diseases, I can quickly compile a differential diagnosis list as a learning reference, effectively reducing the burden of non-diagnostic work and allowing me to focus on animal care and clinical diagnosis."*
>
> — Practice manager

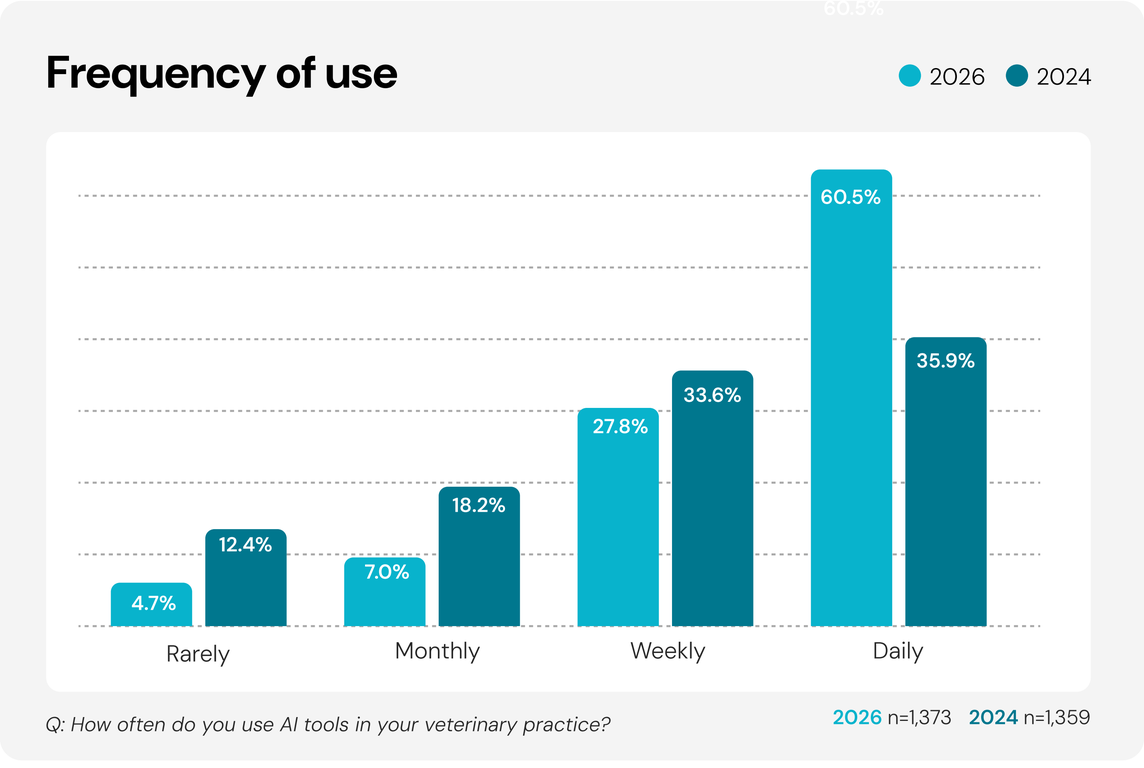
> *"One of my best experiences with AI in my practice was implementing a diagnostic tool that uses machine learning to analyze radiographs. It improved our diagnostic accuracy, and I found it particularly helpful in identifying subtle issues the human eye might miss. Clients were impressed by the speed and accuracy, which helped in building trust."*
>
> — Veterinarian

In 2024, respondents under 30 reported the lowest rate of AI use, at 29.5%, while those aged 31 to 40 reported the highest, at 51.6% ($P < .001$). By 2026, this association was no longer significant ($P = .07$): respondents under 30 recorded the largest increase between waves, rising by 52.4 percentage points to 81.9%.

No significant association between practice setting and level of AI adoption was found in the 2026 survey ($P = .12$, excluding the small "Other" setting), and sentiment likewise did not differ by setting.

The survey found an association between AI usage and the type of PIMS: respondents at practices using a cloud-based practice management system were more likely to report using AI than those at practices using a server or on-premise system (89.3% vs 81.2%, $P < .001$).

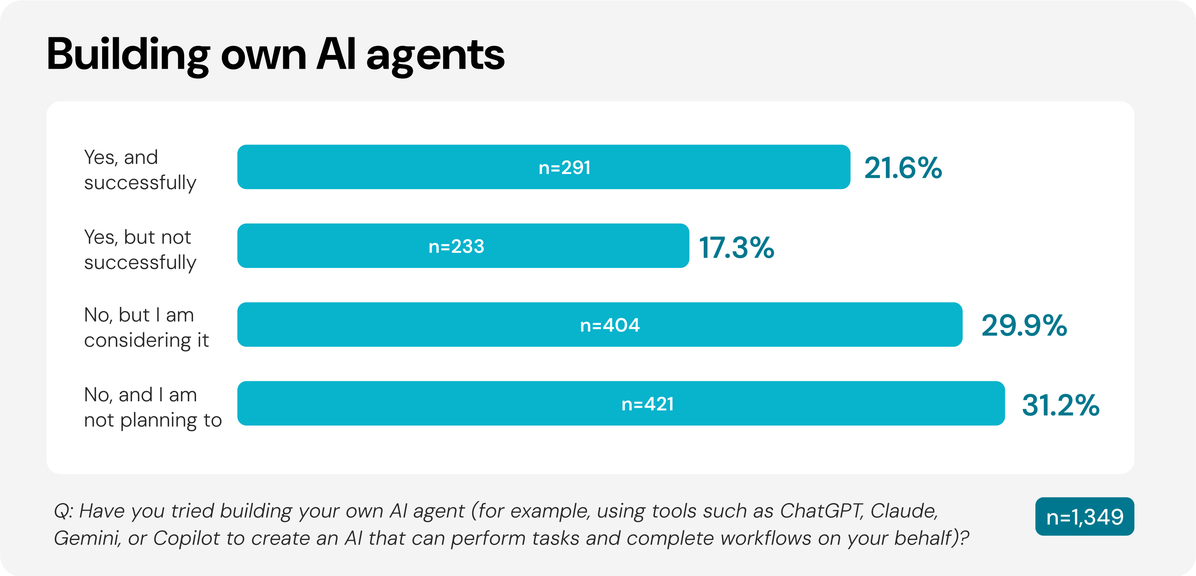
Among practitioners utilizing AI, use became far more habitual. Daily use rose from 35.9% to 60.5%, and daily-or-weekly use combined climbed from 69.5% to 88.3%. Occasional use shrank down to 7% for monthly use and 4.7% for rare use.



> *"Using AI has taken a tremendous weight off my shoulders. At the end of a busy day, I don't have to worry about little details being forgotten when I get around to finishing records. I'm not spending nearly as much time after hours catching up, and my work-life balance has improved greatly."*
>
> — Veterinarian

> *"DVMs can complete charting more efficiently, thereby reducing their workload and stress. I use it personally to help with PM tasks such as organizing my thoughts and getting feedback on ideas. I'm alone in this role, so it has been a great tool for me to make better decisions for the team, communicate more effectively, and save time and brainpower."*
>
> — Practice manager

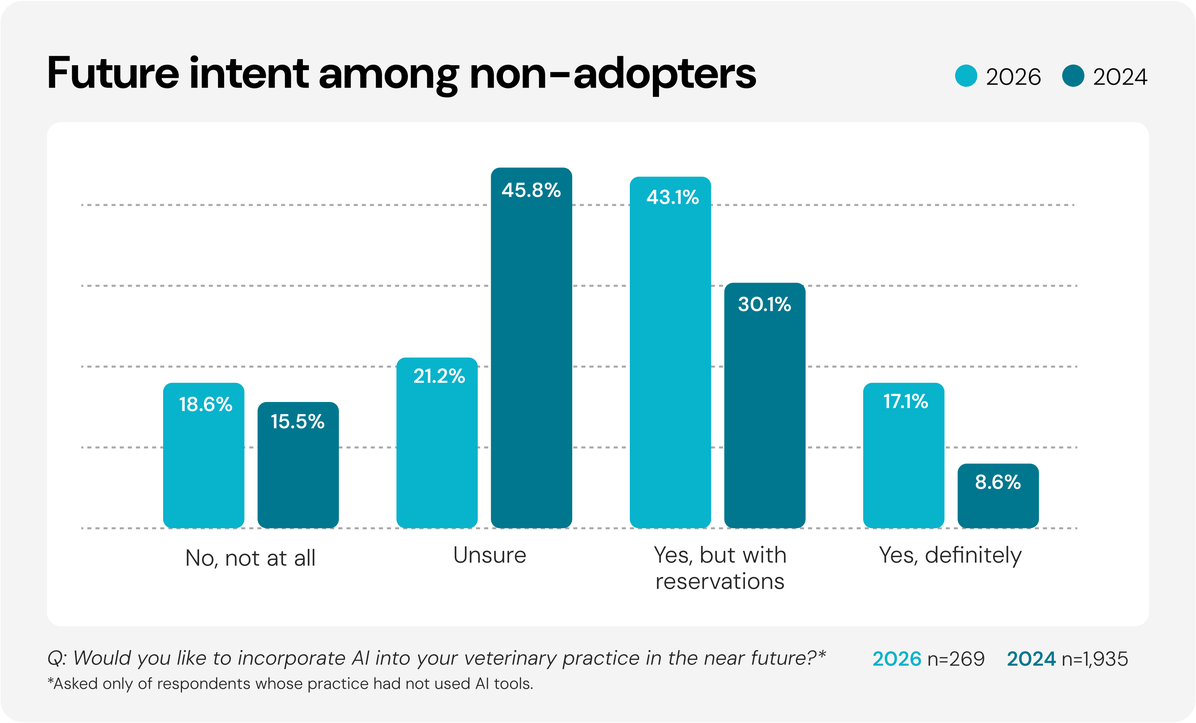
38.9% of AI-using practitioners tried building their own AI agent, and another 29.9% were considering creating one in the future.



Regarding team-wide AI adoption, 37.8% of respondents said more than half of their team uses AI tools for work. Over half (52.1%) put their team's AI usage between 10% and 50%, and only 10.1% reported fewer than 1 in 10 team members using AI.

Attitudes of Non-Adopters

Non-adopters are less undecided than they were two years ago. The share choosing "unsure" fell by 24.6 points, while both "yes" answers gained ground. Combined intent to adopt (either "yes" answer) rose from 38.8% to 60.2%, a change of +21.5 points. Outright refusal also ticked up slightly (+3.1 points), leaving the remaining non-adopter group more polarized.



> *"Never used AI and don't plan to. The one time a sales rep pitched me a "smart" ear tag reader, it couldn't even tell a cow from a horse in the demo. I laughed."*
>
> — Veterinarian

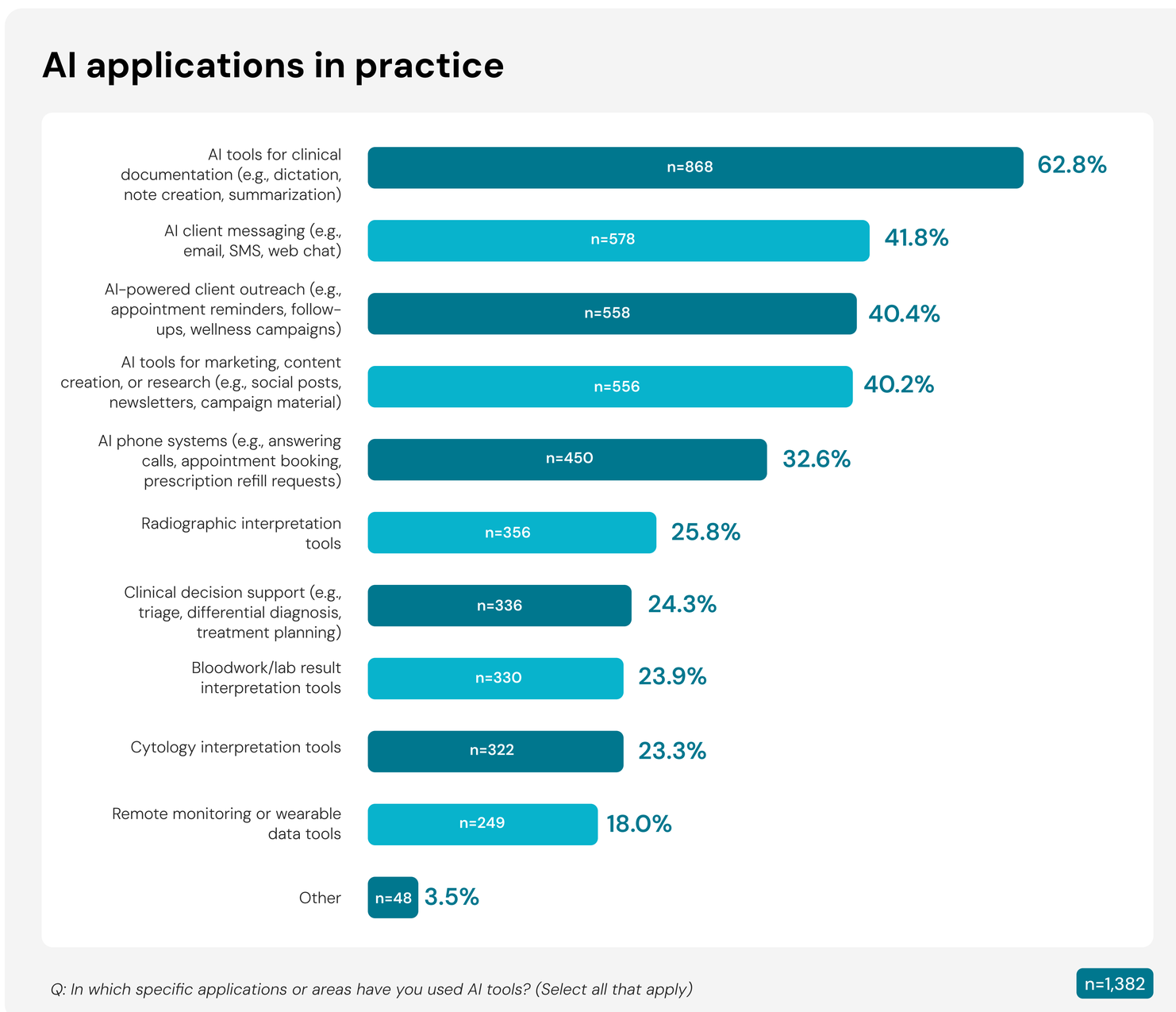
Among non-adopters, 41% agreed that adopting AI could give their clinic a competitive advantage; 24.1% disagreed with this statement (n = 261).

> *"I think AI will be part of every aspect of human and animal life; it is the next step. I think we just need to be prepared to make sure it is used as a responsible tool and not abused."*
>
> — Practice manager

AI Applications in Practice

Respondents who use AI in their work apply it across a wide range of tasks. On average they reported using AI in 3.4 of the eleven application areas offered, including a write-in option (n = 1,382). Although individual application categories were not directly comparable across waves, the number of areas in which respondents reported using AI increased. Respondents used a mean of 2.45 of the six comparable application groups in 2024 and 2.67 in 2026 ($P < .001$), and the proportion using AI in three or more of them rose from 45.2% to 51.5% ($P = .001$).

Tools for clinical documentation led by a clear margin, used by 62.8% of AI-using respondents, followed by client messaging tools (41.8%), client outreach (40.4%), applications for marketing and content creation (40.2%), and AI phone systems (32.6%). Free-text responses clustered around internal operations, most often staff training materials, SOP and protocol writing, financial and performance reporting, spreadsheet data analysis, and custom in-house tools built for specific workflow problems.



> *"Charting and writing medical notes is faster and more efficient, therefore allowing us to not have to stay as late after we close, finishing our notes."*
>
> — Veterinary assistant

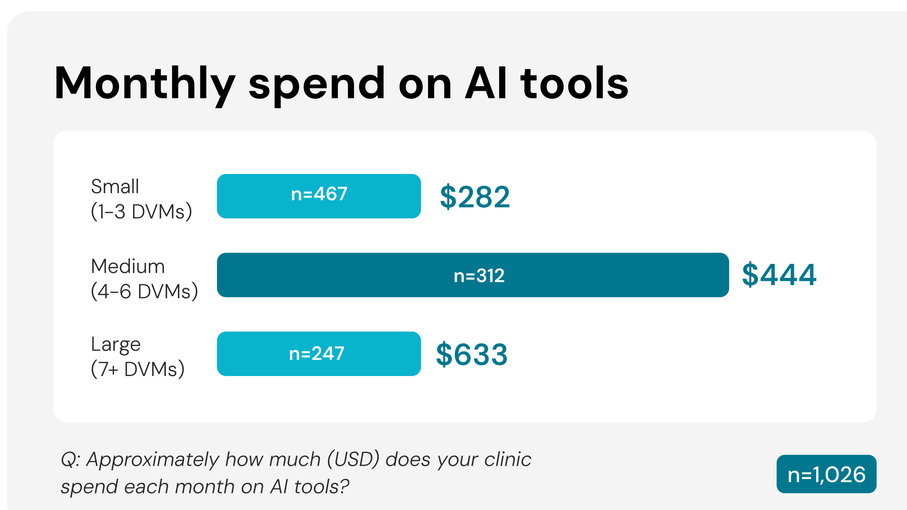
> *"One of the best experiences we've had was using our AI-assisted documentation tool during a particularly busy day. It summarized the veterinarian's exam notes and generated a draft medical record within seconds. I reviewed it, corrected a couple of details about the patient's medications, and finalized it much faster than typing everything from scratch would have. It saved time, reduced paperwork, and allowed us to focus more on patient care and communication with pet owners."*
>
> — Veterinary assistant

Usage patterns also varied by practice setting. Clinical documentation tools were most common in general practice, used by 71.2% of respondents there, compared with 49% in ER/specialty/urgent care hospitals and 38% among relief respondents ($P < .001$). Remote monitoring and wearable data tools were most common in shelter and non-profit settings (37.7%) and more than twice the rate seen in general practice (14.4%, $P < .001$). Bases for shelter and non-profit ($n = 53$), as well as relief ($n = 71$) respondents were small, so these figures should be read as indicative rather than definitive.

Spending on AI

The survey also measured approximate monthly spend on AI, as estimated by respondents for their own practice. Most clinics spent between $101 and $500 per month (USD), while 1 in 10 spent over $1,000 per month. The average is $417 per month ($n = 1,039$). 9% of respondents reported no AI-related expenses at all.

In terms of the correlation between approximate AI spending and team size, the USD band midpoint is highest for large teams of 7+ DVMs ($633) and lowest for small teams of 1–3 DVMs ($282) — a significant relationship ($P < .001$, $n = 1,026$).



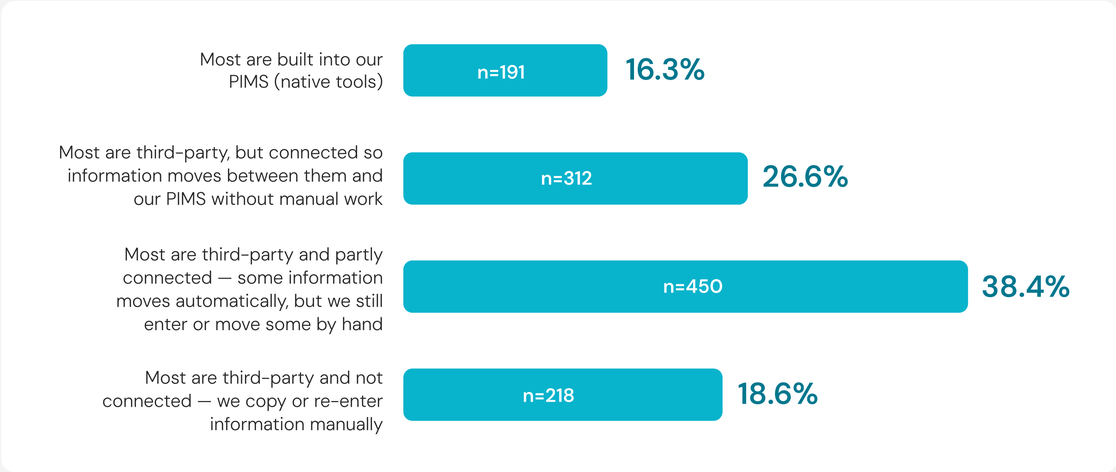
> *"I hope veterinary-specific AI tools can become more affordable and reliable for small clinics."*
>
> — Veterinarian

> *"Hope developers create cost-effective AI solutions for small practices. AI should be limited to office support work, and training materials for veterinary staff are needed to build trust."*
>
> — Veterinarian

PIMS Integration

Respondents were asked how most of their AI tools connect to the practice management system, framed in terms of how much information has to be moved by hand rather than in technical integration terms. The question was shown only to respondents whose practices use a PIMS, and those unsure how their tools connect were excluded. 16.3% reported that most tools are built natively into the PIMS, and a further 26.6% use third-party tools connected such that information moves without manual work, functionally a two-way integration. 38.4% described partial connection, and 18.6% reported no connection at all. Taken together, 57% still moved at least some information between systems by hand.

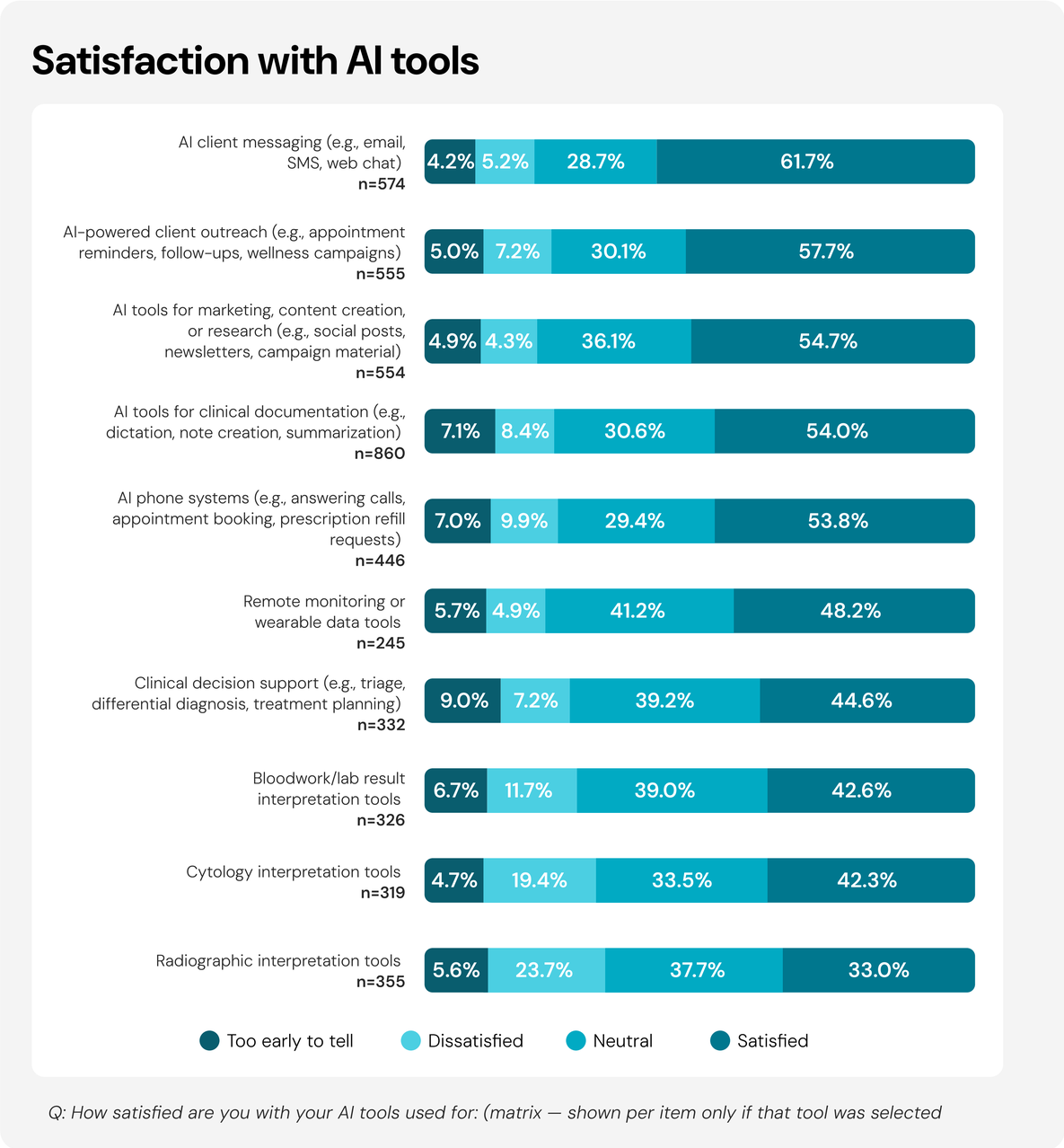
AI tool integration with the PIMS



Q: Overall, how are most of your AI tools connected to your PIMS? n=1,171

Satisfaction with AI

When asked about satisfaction with the AI tools they use, respondents rated client messaging highest at 61.7%, followed by client outreach (57.7%) and applications for marketing and content creation (54.7%). Diagnostic interpretation tools sat lower on the scale, though satisfied users still outnumbered dissatisfied ones in every category.



Q: How satisfied are you with your AI tools used for: (matrix — shown per item only if that tool was selected

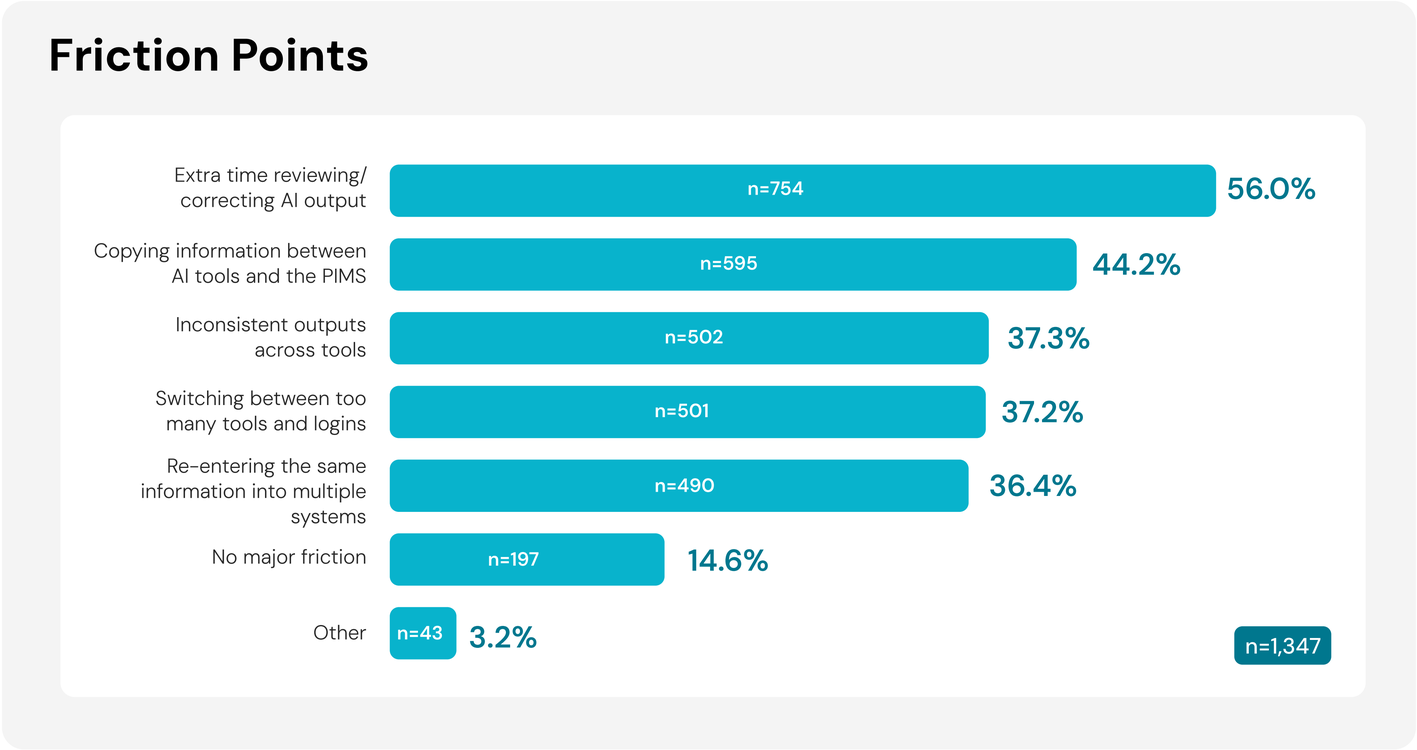
> *"I believe there is likely benefit to medical record documentation; beyond that, I feel we should not rely on AI tools for diagnostic interpretation, as clinical and critical thinking about cases is a must for accurate interpretation."*
>
> — Veterinarian

> *"Most AI tools are currently trained on human medicine. We need more AI models trained specifically on veterinary species, breeds, and conditions to ensure accurate and relevant diagnostics."*
>
> — Veterinarian

Satisfaction with AI tools was higher among respondents using a wider range of applications. Mean satisfaction rose from 2.15 among respondents using a single application area to 2.49 among those using four, with smaller gains beyond that point ($\rho = 0.19$, $P < .001$, $n = 1{,}329$). Because the study measured both at a single point, the direction of the relationship cannot be established.

Friction Points with AI Tools

Respondents could also share which friction points they run into using AI. The most common was extra time spent reviewing, editing, or correcting AI output (56%), followed by transferring information between AI tools and the PIMS (44.2%), inconsistent outputs across tools (37.3%), and switching between too many separate tools or logins (37.2%). Additionally, respondents noted issues such as technical glitches and downtime, an inability to maintain context over longer interactions, transcription that misreads regional accents, and difficulty correcting errors once recorded.

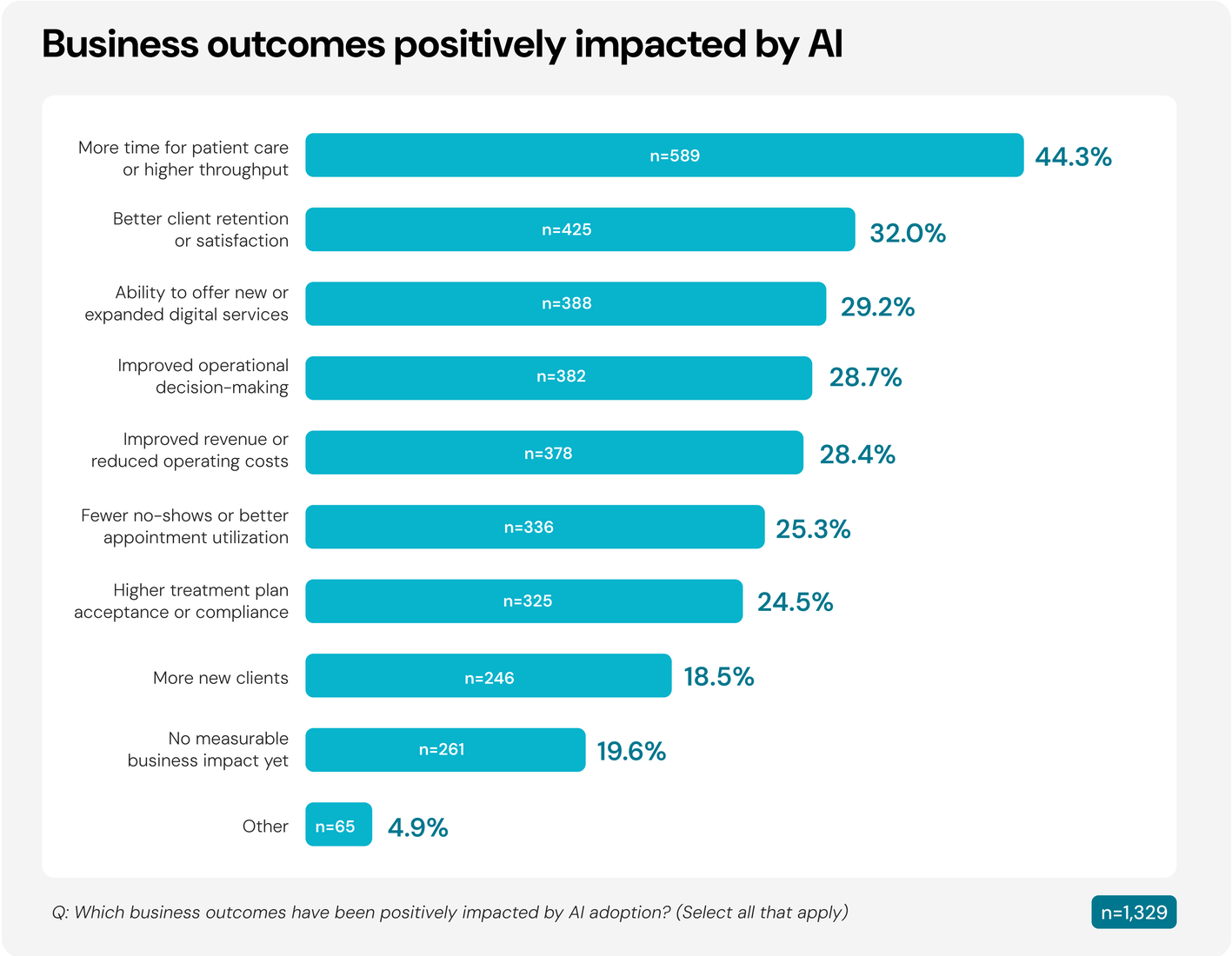


> *"I want people to be very cautious about how they implement AI in the medical side of veterinary medicine, including record-keeping, but especially when it comes to lab interpretation. There's a huge disclaimer to double-check AI outputs for very good reason, and many errors can arise from relying on AI when it can't actually comprehend the full medical picture."*
>
> — Veterinarian

> *"The most disappointing experience is that AI often outputs plausible yet inaccurate information. It requires careful manual fact-checking to avoid wrong conclusions."*
>
> — Respondent of other veterinary-field-related professions

Business Outcomes from AI Use

Among respondents whose practice uses AI, more time for patient care led the list of business outcomes positively impacted by AI, cited by 44.3%. 32% pointed to better client retention or client satisfaction, and 29.2% had introduced new digital services or expanded existing ones. 19.6% reported no measurable impact yet.



> *"Simply amazing! We have several AI modalities within our practice, and it clearly brings us measurable increases in efficiency, productivity, and revenue."*
>
> — Practice manager.

Write-in responses centered on documentation, describing faster and more complete records, notes finished during appointments rather than after hours, and easier transfer of records to other practices and insurers. Many framed the gain in terms of staff wellbeing rather than output, citing veterinarians leaving on time, reduced burnout and stress from paperwork, better work-life balance, and higher morale. Respondents also mentioned stronger internal communication between clinicians, and gains in training and SOP development.

Mobile practices reported the highest mean count of business outcomes attributed to AI (3.11), compared with 2.12 in general practice ($P < .001$), though the mobile base was small ($n = 91$).

Respondents at privately owned practices reported a greater number of positive business outcomes from AI than those at corporate practices (mean 2.48 vs. 2.20, out of nine possible outcomes, $P = .004$). Two outcomes account for most of the difference: better client retention or satisfaction (34.8% private vs. 26.8% corporate, $P = .006$) and improved operational decision-making (33.5% vs. 24.5%, $P = .002$). The remaining outcomes didn't differ significantly by ownership. The proportion reporting no measurable impact was similar in both groups (20.5% and 19.1%).

Differences were also recorded by practice size: respondents at large practices were more likely to attribute higher treatment plan acceptance or compliance to AI adoption than those at medium or small practices (32.2% vs. 20.7% and 22.7%, $P < .001$).

Concerns and Barriers to Adoption

The 2026 findings reveal that the primary concerns and barriers to adopting AI in veterinary practice shifted from "will AI replace me" to "can we operate it well." The most prevalent concern today, cited by 67.4% of veterinary professionals, is the reliability and accuracy of AI systems. Close behind are data security and privacy concerns (59%) and lack of training and knowledge (47.1%).

> *"It is necessary to establish unified veterinary data standards and protect animal medical privacy."*
>
> — Veterinarian

> *"More investment should be made in developing AI tools adapted to different animal species. It is necessary to improve data security and protect animal medical information. Furthermore, systematic training for veterinarians is essential to ensure the rational and safe application of AI in clinical practice."*
>
> — Veterinary technician

Reliability and accuracy remain the single largest concern in both 2024 and 2026, and lack of training and knowledge is the only concern to rise materially, up 4.2 points since 2024. It also varies widely by role: concern over reliability and accuracy ranges from 44% among students to 74.3% among receptionists and CSRs ($P < .001$).

> *"I think AI is contributing to laziness in the field and to a lack of accuracy in medical record writing. And decreases our DVMs' practice in interpreting diagnostics, which can also decrease their competency in clinical judgment."*
>
> — Veterinary technician

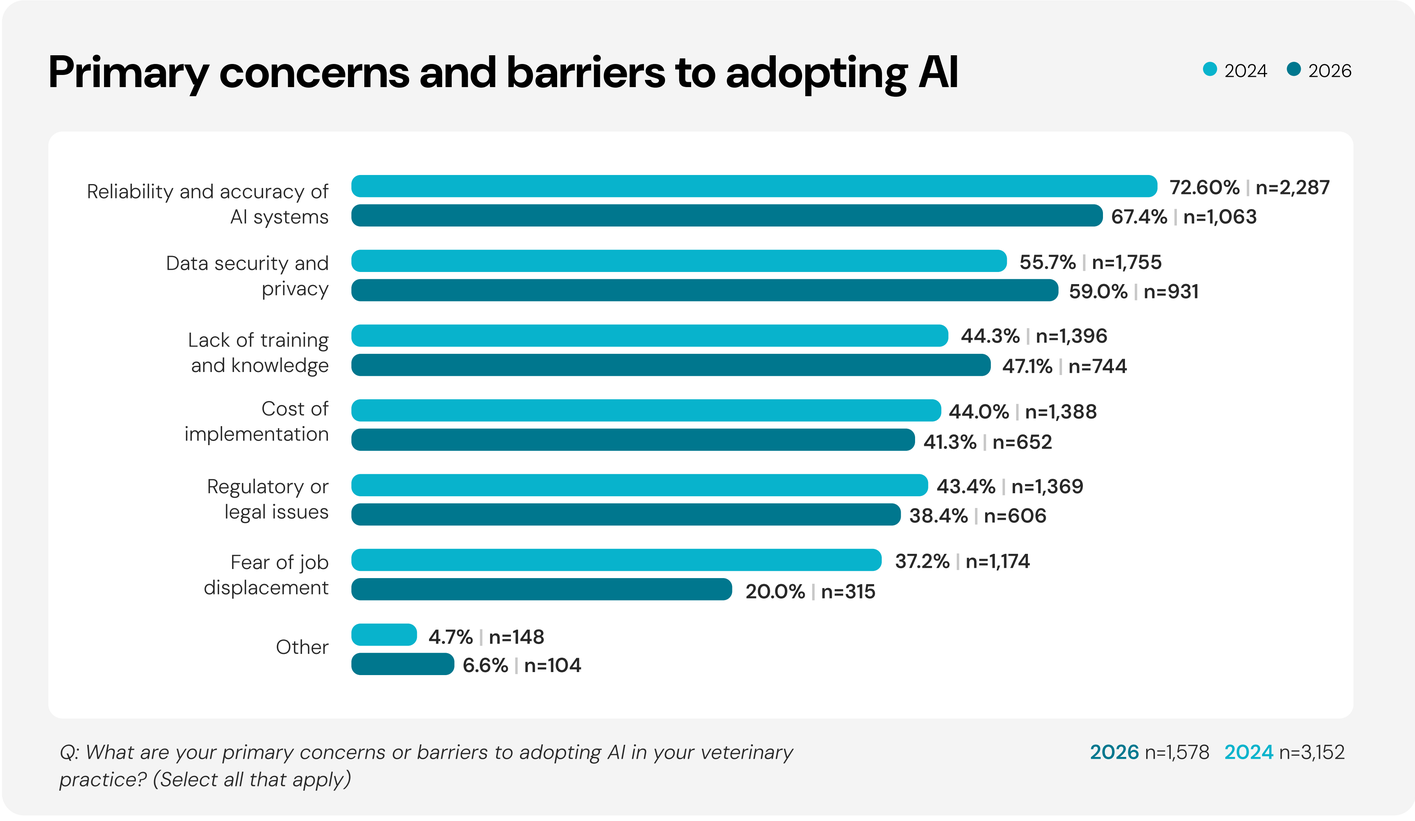
> *"I think it is a good tool, but I do fear that there will become a bit of an overreliance or an effort to transition teams to use AI for things that don't need it. There is for sure a place for AI in vet med, but it has to be approached with realistic considerations and understanding of how to use it."*
>
> — Practice manager

Fear of job displacement, by contrast, has fallen sharply — from 37.2% in 2024 to 20.0% in 2026, a drop of 17.3 points. The decline tracks closely with age: 26.7% of respondents under 30 cited this concern, compared with 22.3% of those 31–40, 16.0% of those 41–50, and 9.8% of those 51–60 ($P < .001$). It also varies by role, from 37.8% among receptionists and CSRs to 13.3% among practice managers ($P < .001$).

Because the 2024 questionnaire offered a "none of these" option and the 2026 questionnaire did not, cross-wave comparisons use the 2024 base restricted to respondents reporting at least one concern ($n = 3{,}152$).

> *"I like AI tools and want to adopt more of them. However, job displacement is always on my mind."*
>
> — Practice manager

> *"I am 100% concerned that medical professionals will lose their jobs because of AI."*
>
> — Veterinarian



Environmental impact emerged as a new issue — no respondent raised it in the 2024 free-text responses. In 2026, it appeared repeatedly, with survey participants citing data centers' water consumption and energy demand, their effects on the communities where they're built, and their climate consequences. Several respondents named environmental impact as the reason they will not adopt AI at all. Other write-in worries included the ethics of AI companies and training data, erosion of clinical judgment and critical thinking, and loss of human contact in client interactions.

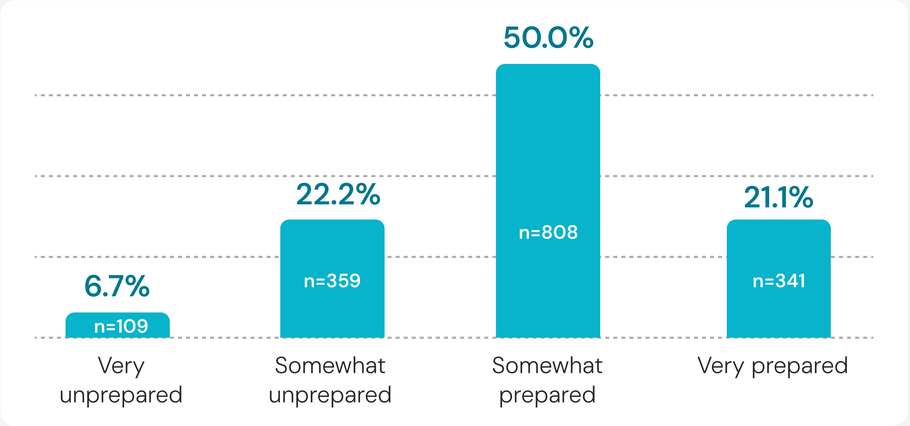
> *"We are not for AI until the environmental issues are solved."*
>
> — Practice manager

> *"Environmental impact is my primary concern. I do not personally believe we should be using it at all. We keep adding new ways to accelerate extinction and ecosystem destruction. No one seems to care."*
>
> — Veterinarian

The Level of Organizational Readiness

Regardless of their previous answers, all survey participants were asked how prepared they believed their organization was to adopt and implement AI technologies. 71.1% believed their practice is at least somewhat prepared, against 28.9% who feel it's unprepared. Self-reported organizational preparedness rose with practice size: it's highest among large practices with 7+ DVMs (3.01 on a 4-point scale) and lowest among small teams of 1–3 DVMs (2.78) ($P < .001$).

Organizational preparedness for AI

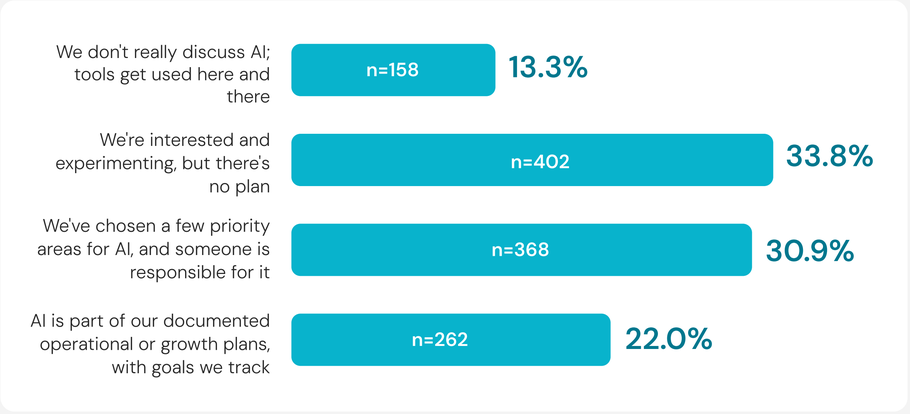


Q: How prepared do you believe your organization is to adopt and implement AI technologies? n=1,617

The questions that follow were asked of respondents whose practice uses AI, and those on strategy and governance only of respondents with visibility of how practice decisions are made.

22% of respondents said their practice has a documented operational or growth plan for AI, with goals and steps mapped out. Another 30.9% chose priority areas for AI use and named someone responsible for it. The remaining 47.1% had no plan for AI usage — and 13.3% of all respondents weren't yet having any AI-related conversations at their practice at all.

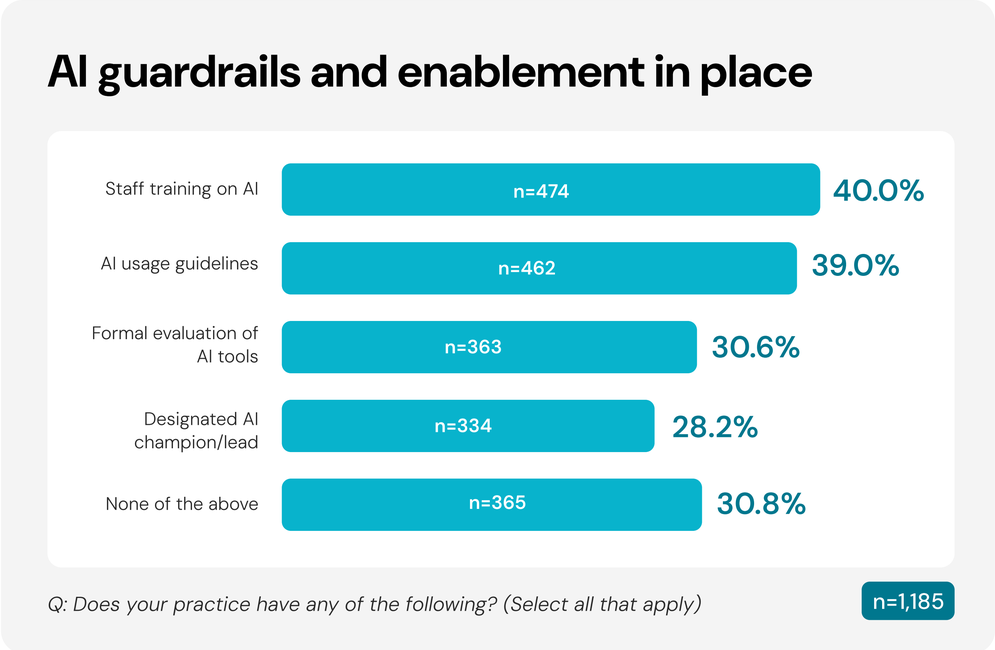
Practice approach to AI adoption



Q: Which best describes how your practice approaches AI? n=1,190

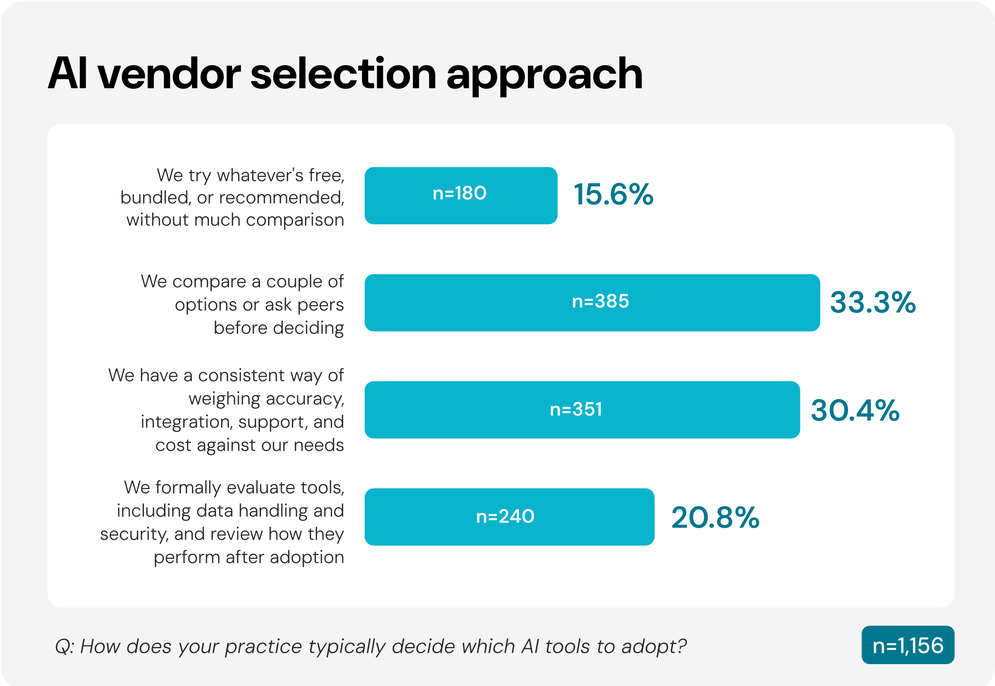
> *"Honestly, I was very skeptical at first and had to be dragged into the conversation about AI tools. After researching tools we could add to our software and comparing them to cloud-based systems already integrated or with native AI, it became clear we needed to change or be left behind. I had a 5-year plan to move off of server-based PIMS to cloud-based. That timeline went to 6 months when we found the perfect option for our business that provided all the cloud-based services, along with native AI integration throughout the software. It has been a great partnership, and we have no looking back. We are still adapting to AI and making workflow changes so we can continue to excel in our patient and client care."*
>
> — Practice manager

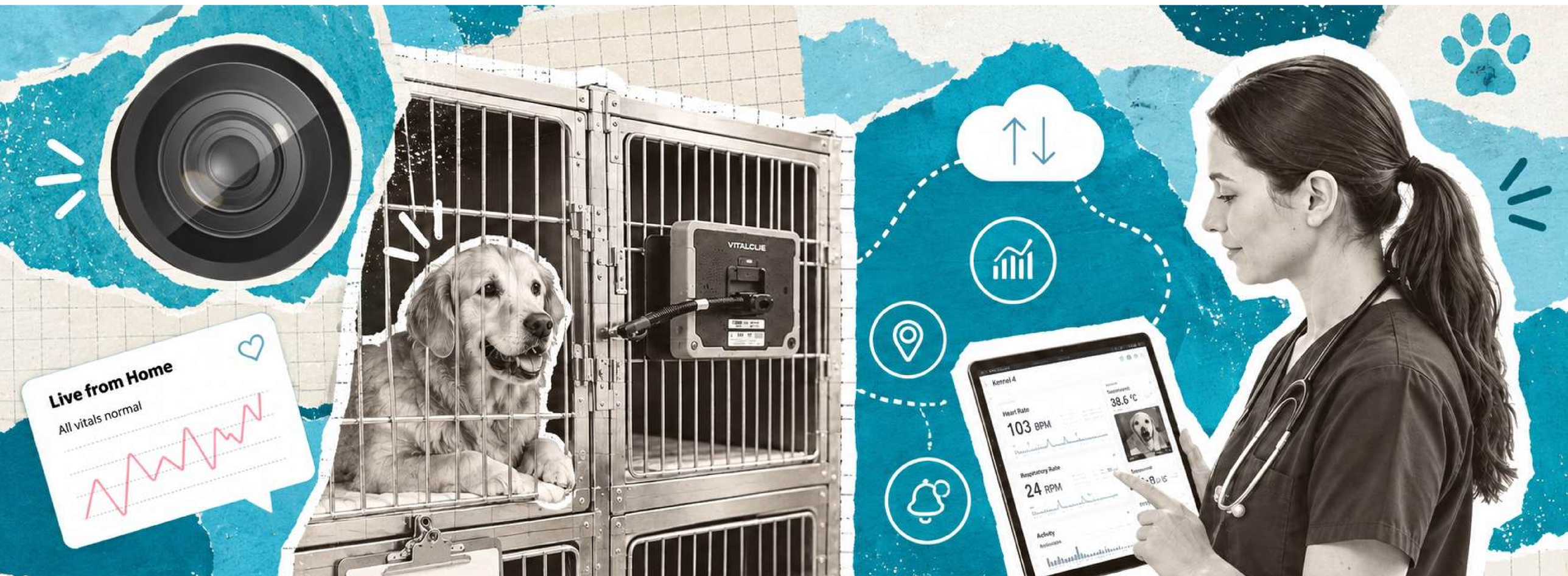
On specific governance supports, 40% of practices had staff training on AI use, 39% had AI usage guidelines, and 28.2% had a designated person responsible for AI adoption. 30.6% had formally evaluated their AI tools, while 30.8% had none of these.



Vendor Selection Process

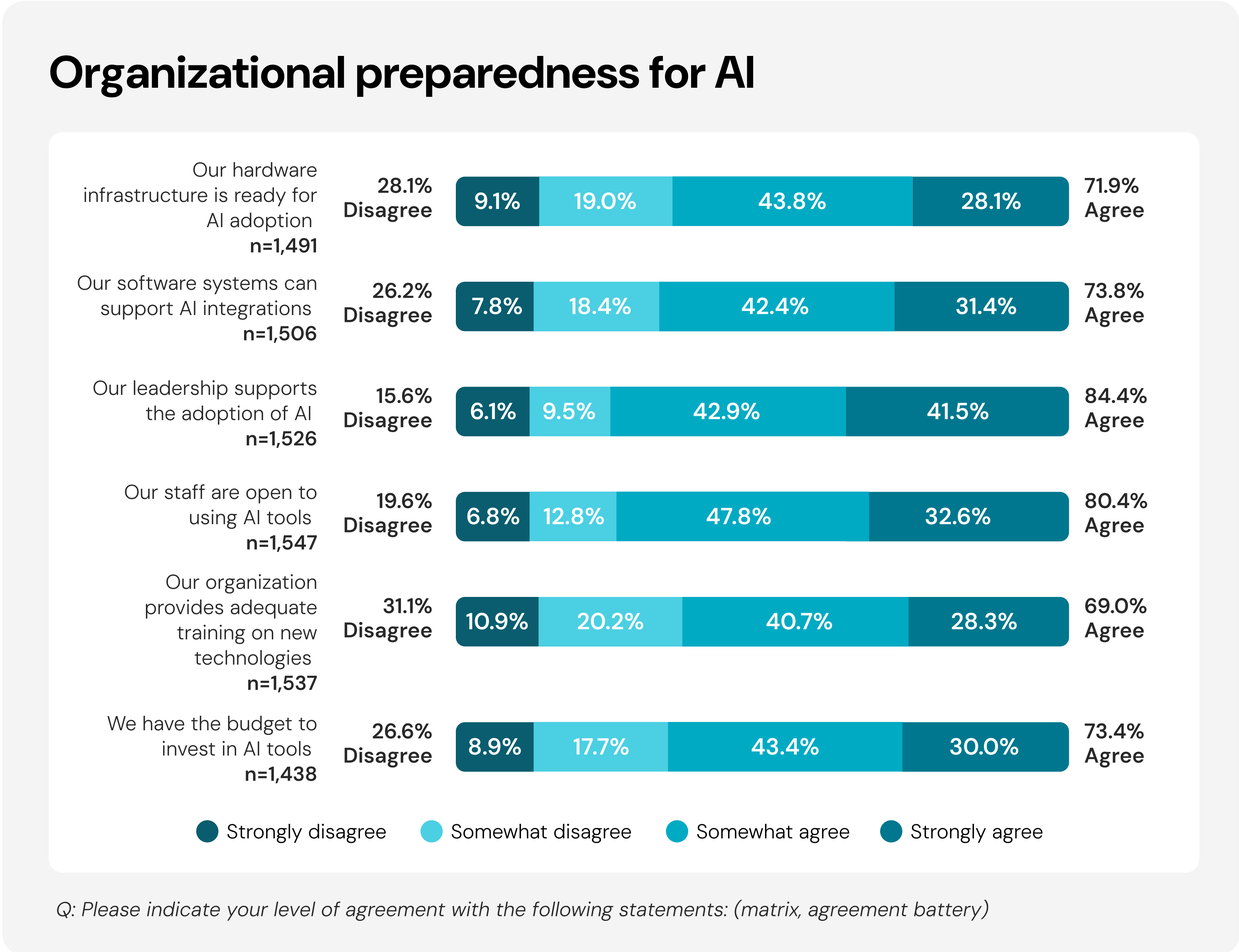
The respondents were also asked about their vendor selection approach. The most common was comparing a couple of options or consulting peers before deciding (33.3%), followed by weighing accuracy, integration, support, and cost against practice needs (30.4%) and formally evaluating tools, including data handling and security (20.8%). 15.6% implemented AI tools with little comparison, based on price or what's bundled.





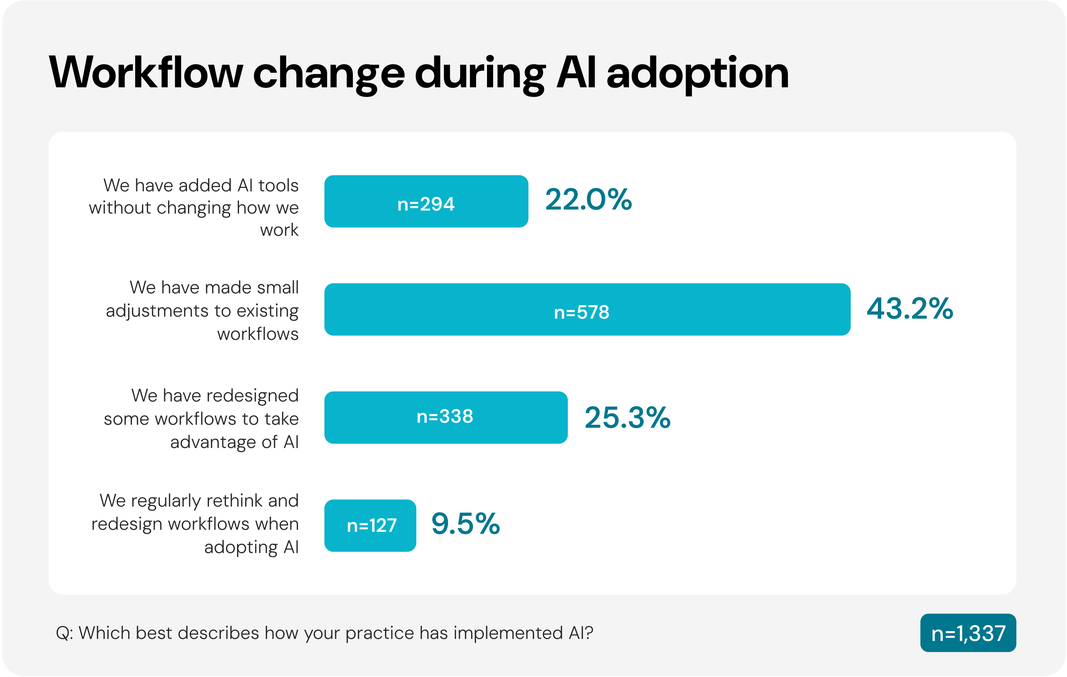
Organizational Readiness

On the readiness battery, agreement is highest on "our leadership supports the adoption of AI" (84.4%) and "our staff are open to using AI tools" (80.4%). Agreement was more modest on "our organization provides adequate training on new technologies" (69%) and "our hardware infrastructure is ready" (71.9%).



Respondents at privately owned practices rated their organization's capability and readiness higher than those at corporate practices (3.29 vs. 3.10, $P < .001$). The gap was consistent across all six statements in the battery, reaching significance on five: hardware and software infrastructure, leadership support, staff openness, and training. The budget showed the same direction but a smaller difference that did not reach significance.

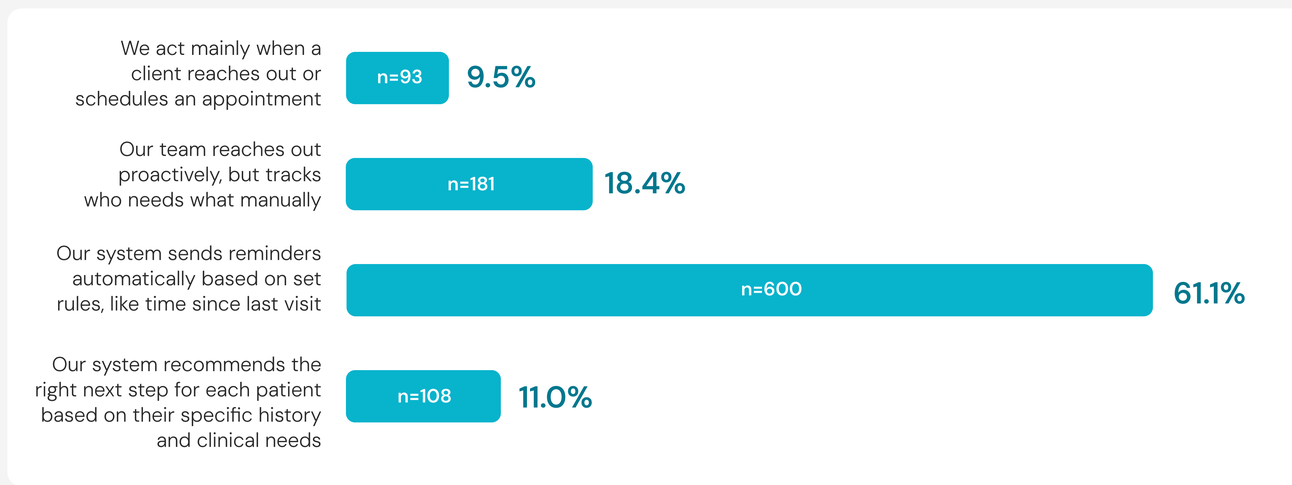
Respondents whose practice uses AI were also asked how far their practice had adapted its workflows to accommodate this technology. 65.2% had either not changed how they work at all (22%) or made only small adjustments to existing workflows (43.2%). A further 25.3% had redesigned some workflows to take advantage of AI, and just 9.5% regularly rethinked and redesigned workflows as they adopted AI.



Approach to Client Outreach

Respondents in general and mobile practice were also asked how their team handles client outreach, a capability that can be delivered with or without AI. 61.1% rely on automatic, rule-based reminders (e.g., time since last visit), 9.5% acted mainly reactively, and only 11% had a system that recommends personalized outreach based on each patient's own history and clinical needs (n = 982).

How patient care and client outreach are handled



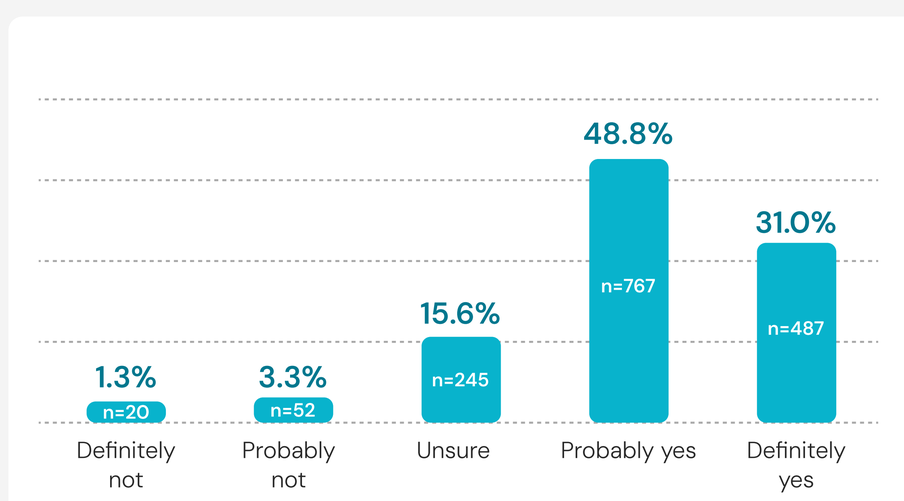
Q: Which best describes how your practice handles patient care/client outreach? n=982

> *"Our best experience with AI is automated appointment and follow-up reminders. The AI system sends regular recheck notifications based on fixed cycles, which greatly cuts down no-show rates and saves our front desk plenty of manual notification work. However, we also have disappointing limitations. Our AI tools cannot fully sync data with our clinic management system, so we have to manually copy and input pet medical records repeatedly."*
>
> — Veterinarian

Future Outlook and Expectations

The survey closed by asking respondents about their outlook on AI in veterinary workflows. 79.8% expect AI to be integrated into most clinic workflows within five years, against just 4.6% who don't.

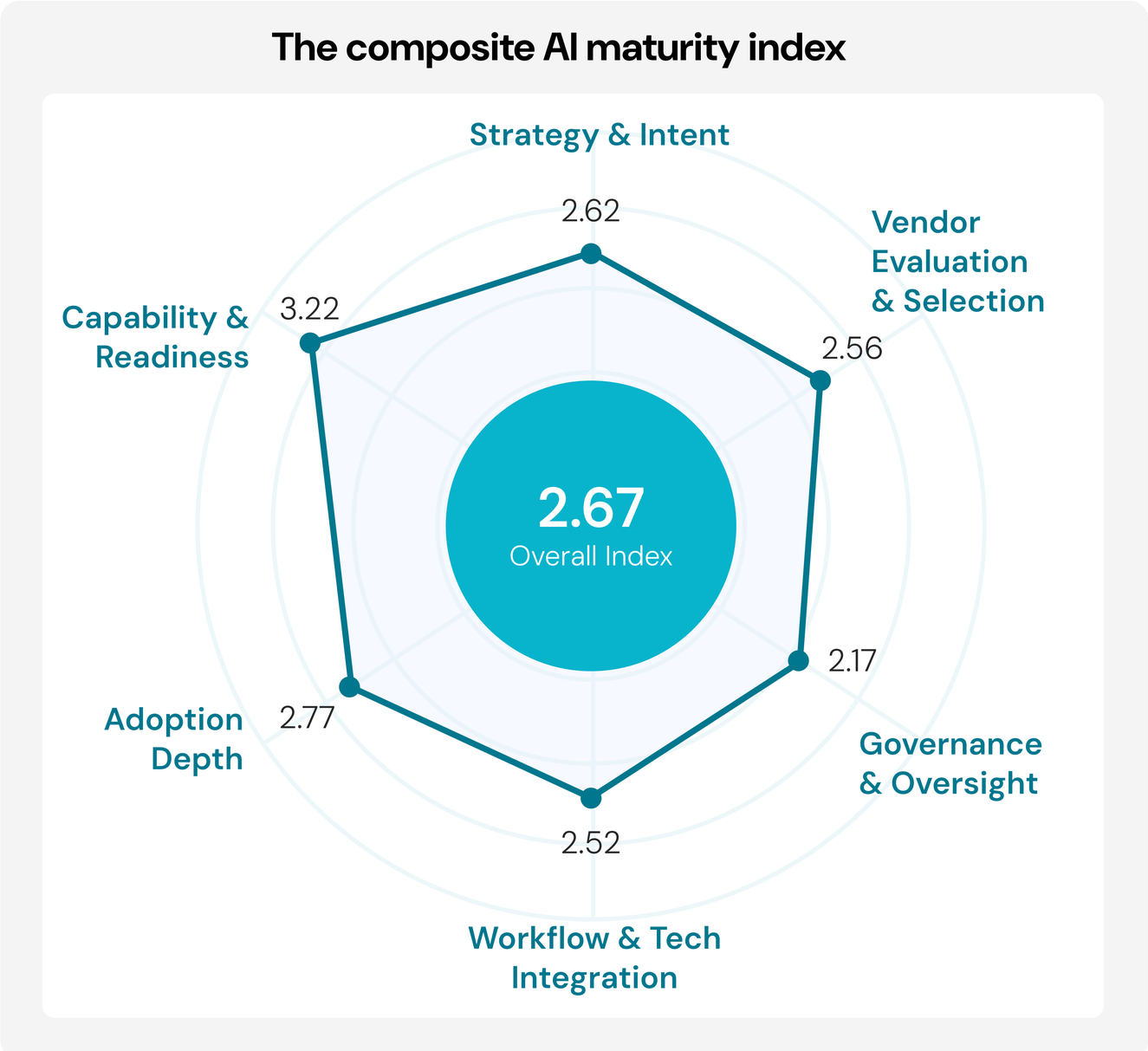
Expectations for AI in five years



Q: Do you believe AI will become integrated into most veterinary clinic workflows within 5 years? n=1,571

Veterinary AI Maturity Index

Beyond adoption, practices that used AI were scored on a six-dimension index of AI maturity, designed to assess whether the strategy, systems, processes and team capability are in place to support sustained use of the technology. Respondents whose practices did not use AI (16.3%) sit outside the index.



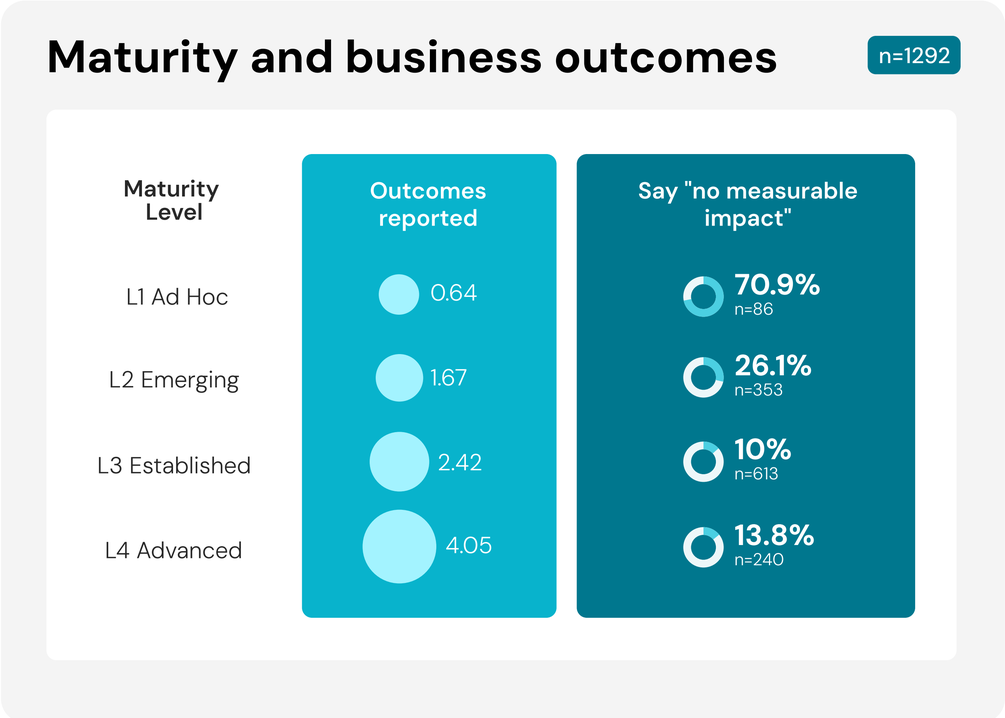
The overall index of perceived maturity scored 2.67 out of 4 (SD 0.60, n = 1,305). The six dimensions varied considerably. Capability and Readiness, which measures whether the infrastructure, leadership backing, skills, and budget are in place, was highest at 3.22 (n = 1,322), followed by Adoption Depth, the share of the team using AI, at 2.77 (n = 1,370). Three dimensions fell close together: Strategy and Intent (2.62, n = 1,190), Vendor Evaluation and Selection (2.56, n = 1,156), and Workflow and Technology Integration (2.52, n = 1,337). Governance and Oversight, covering usage guidelines, staff training, a designated lead, and formal review of tools, was lowest at 2.17 (n = 1,185), a third of a point below the next dimension and more than a full point below the highest.

Practice size was associated with maturity. The overall index rose from 2.58 at small practices (1–3 DVMs) to 2.7 at medium practices (4–6) and 2.77 at large practices (7+) ($P < .001$). The pattern varied by dimension: Strategy and Intent and Capability and Readiness rose steadily with size, while Vendor Evaluation and Selection rose from small to medium practices before leveling off (2.45, 2.65, 2.66). Governance and Oversight stayed flat between small and medium practices (2.10 and 2.11) and only climbed at large ones (2.36). Adoption Depth and Workflow and Technology Integration didn't differ meaningfully by size.

Ownership was not associated with overall maturity. Privately owned practices scored 2.68 and corporate practices 2.62, a difference that did not reach significance ($P = .07$). Four of the six dimensions did differ at the 95% level: private practices scored higher on Capability and Readiness (3.29 vs 3.10, $P < .001$), Strategy and Intent (2.66 vs 2.51, $P = .01$) and Adoption Depth (2.80 vs 2.71, $P = .03$), while corporate practices scored higher on Vendor Evaluation and Selection (2.62 vs 2.46, $P = .02$). Governance and Oversight was nearly identical in both (2.16 and 2.12).

AI Maturity and Business Outcomes

Maturity was associated with the number of positive business outcomes survey participants attributed to AI (ρ = 0.50, $P < .001$, n = 1,292) — among the strongest relationships measured. The most mature practices reported roughly six times as many positive business outcomes from the use of AI as the least mature practices (4.05 versus 0.64). Among Level 1 practices, 70.9% see "no measurable business impact" from AI at all; that falls to 26.1% at Level 2 and to around one in eight at Levels 3 and 4 (10.0% and 13.8%). The relationship held even after accounting for how many AI applications a respondent used (partial r = 0.34), meaning higher maturity isn't just a proxy for broader adoption.



Maturity was also linked to how proactively practices use AI in patient care (ρ = 0.18, a weak relationship): those whose systems recommend a next step based on a patient's own history scored 3.02 on the index, versus 2.59 among practices that only respond when a client reaches out directly ($P < .001$).

Finally, maturity was associated with sentiment toward AI (sentiment toward AI (ρ = 0.40, $P < .001$, n = 1,305). Mean maturity rose from 2.31 among very skeptical respondents to 3.03 among the very optimistic — echoing the 2024 study, where familiarity with AI was linked to optimism, perceived competitive advantage, and usage.

Discussion

4

By **Adam Wysocki,** the founder of VetSoftwareHub, an independent veterinary software directory, and creator of the PIMS Selection Navigator

After the Breakthrough Comes the Work

Making AI Matter in Veterinary Practice

"A bad system will beat a good person every time."

W. Edwards Deming, 1993

Two years ago, this survey asked whether the profession would try AI. The 2024 answer was a cautious maybe. Fewer than two in five were using it at work, sentiment leaned optimistic but not by much, and veterinary professionals under the age of 30 were the most skeptical group. The 2026 wave asked a different question and got a different kind of answer. Use is no longer the story. Management is.

That shift is the focus of this discussion. Adoption more than doubled, and most of the people using AI now use it every day. Every role, every age band, and every practice type sit in a narrow range. The gaps that structured the first paper have closed. What hasn't closed is the gap between using a tool and running a system. Nearly half of AI-using practices have no plan for it and nobody responsible for it. Governance is the weakest dimension on the maturity index. Two thirds bolted AI onto existing work rather than redesigning the work around it. And the practices that did the unglamorous work of organizing around AI reported roughly six times as many business outcomes as the ones that didn't.

The profession has finished the easy part. The rest of this discussion is about what that means and what should happen next.

From Curiosity to Habit

In 2024, familiarity predicted almost everything that mattered. Optimism, personal use, professional use, intent to adopt, belief in a competitive advantage. That finding was useful and, in hindsight, incomplete. Familiarity is what you measure when a technology is still optional. Once four in five people are using it, the more interesting question is whether the organization around them can keep up.

The 2026 data show how completely the optional phase ended. Occasional use all but disappeared. Non-adopters stopped hedging. Two years ago, nearly half of them were undecided. Now most intend to adopt, a firm minority has decided against, and even among non-users the largest group believes practices using AI will gain an advantage. Four in five respondents expect AI to be standard in clinic workflows within five years.

The demographic story reversed itself. In 2024 the under-30 group was the most skeptical cohort in the profession and among the least likely to use AI at work. In 2026 every age band sits at the same level of optimism, and adoption doesn't differ by age at all. The under-30s closed the largest gap. Practice setting doesn't matter either. General practice, emergency, mobile, shelter, and relief all sit in a narrow band. The profession didn't adopt AI from the top down or from the young outward. It adopted it everywhere at once.

That's the first implication for the industry. Arguments that treat AI as a generational preference, a corporate fashion, or a specialty hospital luxury are out of date. The remaining non-users aren't a lagging demographic so much as a mix of the still hesitant and a small group, concentrated among older respondents, who've made a real decision to sit this out. Outreach to that group should be practical rather than evangelical. Show the work, show the guardrails, and leave the decision alone.

A Whole-practice Tool, Still Pointed at the Paperwork

The second change is who uses it. In 2024 AI was a clinician and manager tool, and the spread between roles was wide. In 2026 it has nearly closed. Receptionists and CSRs moved furthest, and technicians and assistants closed similar gaps. AI left the exam room and reached the front desk, which is exactly where a technology that drafts messages and writes notes would be expected to land.

What people use it for has been slower to change. Documentation remains the dominant application by a wide margin. Client messaging, outreach, and marketing follow. Radiographic interpretation, clinical decision support, lab interpretation, and cytology sit well behind. Breadth of use grew only modestly. General practice, which is most of the profession, reports the highest use of documentation tools and the lowest use of clinical decision support and remote monitoring. The pattern isn't mysterious. Practices automated the work that was already drowning them.

Satisfaction follows the same line. Communication tools score highest. Diagnostic tools score lowest. Radiographic interpretation ranks last on every measure and carries the highest dissatisfaction of any application in the survey. That finding should be read carefully. It doesn't prove that veterinary imaging AI is a failed category. It does show that the profession's lived experience of those products, in 2026, hasn't matched the marketing. Accuracy remains the top worry in both waves. When a tool's job is to draft an appointment reminder, a clumsy sentence is an inconvenience. When its job is to read an image, a miss is a clinical event. The market hasn't yet earned the trust that the administrative tools have.

This is the cautious-adoption thesis from 2024, still intact and now supported by usage rather than speculation. The profession treated AI first as a productivity layer on top of existing medicine, not as a new way of practicing it. That was rational. It's also incomplete. The next increment of value won't come from writing the same SOAP note faster. It'll come from connecting documentation, imaging, lab data, and client communication into a single patient record that can recommend a next step. Very few practices are there. Only about one in ten general and mobile practices have a system that recommends the next step for an individual patient based on history. Most have automated the reminder and stopped. Rule-based recalls aren't AI, and practices that run them score no higher on maturity than practices that wait for the phone to ring. Automating yesterday's outreach isn't the same as practicing proactive care.

Adoption Ran Ahead of Management

The Veterinary AI Maturity Model, adapted from the University of Chicago's HAIRA framework for healthcare AI governance, is the new instrument in this wave. It scores six dimensions on a four-level scale. Strategy, governance, vendor evaluation, workflow integration, adoption depth, and capability. The shape of the scores matters more than any single number.

Practices score highest on feeling equipped and on how widely the team uses AI. They score lowest on governance, with workflow integration and vendor evaluation just above it. Strategy sits in the middle, which sounds respectable until the underlying item is unpacked. Nearly half of AI users with visibility of practice decisions have no AI plan and nobody responsible for it. Nearly a third have none of the four basic supports. No guidelines, no training, no named lead, no formal evaluation. Half of practices choose tools informally, comparing a couple of options or taking whatever is bundled or free. Only one in five formally evaluates tools for data handling and security and then reviews performance after adoption.

This isn't a story about reluctant staff. Leadership support and staff openness are both high, and budget and infrastructure aren't the binding constraint either. Training is. One in three say training on new technology is inadequate. The will is present. The operating system isn't.

Integration makes the same point in a more concrete way. More than half of AI users with a PIMS are only partly connected or not connected at all and still move information by hand. The daily cost shows up in the friction data. Reviewing and correcting output is the most common friction point, and it's the right kind. That's clinical judgment being applied to a draft. Copying information between tools, re-entering the same data, and switching logins are the wrong kind. Connecting the tools changes which friction a practice feels. It doesn't, by itself, remove friction. Practices that integrate without redesigning the work trade copy-paste for inconsistent outputs across products.

Two thirds of practices added AI without changing how they work or made only small adjustments. Fewer than one in ten regularly rethink workflows when they adopt a new tool. That number should bother anyone who has watched a practice install new software and then keep the old paper process next to it. Tools don't change the day. Changed work changes the day. The maturity model treats full connection and redesigned workflow as a single top level for a reason. One without the other is an expensive way to stand still.

Maturity Is What Predicts Results

The clearest pattern in the study is the link between the maturity index and reported business outcomes. Practices at the bottom of the scale report fewer than one outcome each, and seven in ten say AI has produced no measurable impact. Practices at the top report six times as many. By Level 3 the share seeing no impact is down to about one in ten, and it stays there. The relationship survives after accounting for how many AI applications a practice uses. Buying more tools isn't a substitute for running them on purpose.

The outcomes themselves are mostly operational. More time for patient care or higher throughput is the most common, followed by client retention, new digital services, and better operational decisions. The free-text answers add a detail the checklist didn't ask for. The respondents who wrote something in didn't describe using the recovered hours to book more appointments. They described leaving on time. Doctors finishing notes before they walked out the door, less paperwork burnout, higher morale. The 2024 discussion hypothesized that AI could improve staff well-being by taking repetitive work off the team. The 2026 write-ins are that hypothesis in a smaller group of respondents' own words. Time is the outcome practices notice. Well-being is how they spend it.

Ownership doesn't explain maturity or adoption. Corporate and private practices are statistically indistinguishable on both, and private practices use AI only slightly more often. What ownership does explain is experience. Private practice respondents rate readiness higher on most measures, express more satisfaction with the tools, and report more business outcomes, with the largest gaps on client retention and operational decision making. The survey can't say why. Plausible mechanisms include shorter decision chains, a closer link between the person choosing the tool and the person using it, and less standardization of workflow across sites. Those are hypotheses, not findings. But corporate groups should treat the experience gap as a design problem rather than a talent problem. The tools are in the building. The results aren't landing the same way.

Practice size works differently. Larger hospitals score higher on the organizational dimensions and no higher at all on adoption depth or workflow integration. Small practices spread AI across their teams as widely as large ones. What they lack is the scaffolding. Governance barely exists below seven veterinarians. That's a structural observation, not a moral one. A three-doctor practice doesn't need an AI officer. It does need one person responsible for it, a one-page rule for what may and may not go into a prompt, and a habit of asking vendors where the data lives. Those are cheap. The cost of not having them will rise as tools move from drafting emails to touching the medical record.

The Worry Changed Its Object

Reliability and accuracy remain the leading concern, as in 2024. Almost everything underneath that headline has moved. Fear of job displacement fell by almost half. Concern about data security rose, and concern about training gaps rose with it. The profession is less afraid of being replaced and more afraid of operating the software badly. That's a more useful fear.

Displacement anxiety isn't evenly distributed. It falls steadily with age, and by role it concentrates at the front desk, where it runs at more than double the rate among veterinarians. The same roles that adopted AI fastest are the ones most worried it will take the job. That's not a contradiction. It's what it looks like when a tool arrives in the part of the hospital whose work is most legible to software. The constructive response is to redefine those roles around the work AI can't do. Judgment with a distressed client, triage when the waiting room is full, the conversation that happens after the draft is generated. And to train for that work out loud.

A new note appears in the free text. Some respondents object to AI on environmental grounds and still expect it to become standard. That combination is going to get more common. Practices and vendors that can talk plainly about compute, data retention, and model choice will have an easier time with a workforce that has already moved past "should we use this" and on to "on what terms."

The Do-It-Yourself Current

Two in five AI users have tried to build their own agent in tools like ChatGPT or Claude, and about one in five says it worked. Nearly a third more are considering it. For a profession that historically buys software rather than writes it, that's a large number, and it cuts two ways.

On one side it's evidence of appetite, and of a workforce that's no longer waiting for the vendor roadmap. A technician who can stand up a discharge-instruction assistant on a Saturday isn't a problem to be managed. On the other side, unmanaged agents are how client data leaves the practice by accident. The same survey that documents this appetite documents the absence of guidelines in nearly a third of hospitals. Those two facts shouldn't be allowed to coexist for another two years. The answer isn't to ban shadow AI. It's to give people a sanctioned path, with approved tools, approved data classes, and a named reviewer, so the energy goes into useful agents instead of workarounds. It's also a signal to every PIMS vendor. Practices want software that acts on their data. The systems of record that let it in, on the practice's terms, will be the ones the agents get built around.

What This Means for the Industry

Vendors should stop selling adoption. Adoption has occurred. The buying criteria that will matter in the next cycle are integration with the PIMS, consistency of output, performance review after deployment, and training a three-doctor practice can finish. A feature being inside the PIMS doesn't settle any of those. The bundled option is a candidate, not a shortlist. Diagnostic products have a specific credibility problem that administrative products don't, and closing it takes published validation in veterinary populations, not testimonials.

Practice groups, corporate and independent, should treat maturity as an operating discipline rather than a technology project. The index isn't a trophy. It's a punch list. Put one person in charge of it. Write down what the tools are for. Decide how a new product gets evaluated, including where the data goes. Connect the tools or stop adding them. Redesign one workflow end to end, and medical records is the obvious candidate, instead of sprinkling copilots onto an unchanged day. Measure something other than whether people logged in. The practices already doing this are the ones reporting results. The ones that aren't are the ones reporting that AI did nothing.

Educators and associations have a narrower, more urgent job than they did in 2024. The last paper called for AI in the veterinary curriculum. That call still stands, but the content must change. Students who arrive fluent in chat interfaces don't need another lecture on what a large language model is. They need supervised practice in checking a draft, declining a bad suggestion, documenting the human decision, and explaining an AI-assisted recommendation to a client. The training gap in this survey isn't conceptual. It's operational. Continuing education should follow the same rule.

Professional bodies should notice that the profession is writing its own rules in the absence of theirs. Informal guidelines, peer recommendations, and bundled tools are how most hospitals currently decide. That's fine for a drafting assistant. It isn't fine for anything that touches diagnosis, prescribing, or the official medical record. Clearer guidance on data handling, disclosure to clients, and the veterinarian's retained responsibility wouldn't slow adoption. Adoption is done. It would make the next phase safer.

Recommendations

- Put one person in charge of AI this quarter. A practice doesn't need a chief AI officer. It needs one person who can say which tools are in use, what they're for, and who reviews them. Nearly half of AI-using practices currently have neither a plan nor that person.
- Write a one-page usage guideline before adding another product. Say what data may be pasted into an external model, what must stay inside the PIMS, and when a human must sign the output. This is the cheapest governance step available, and the one most hospitals haven't taken.

- Evaluate vendors for data handling and security, then review performance after 90 days. One in five practices does this today. A short, repeatable scorecard is enough. Accuracy in your caseload, integration cost, support, and whether the tool still earns its fee. Four questions, asked on a schedule, would move a large share of the market from 'bundled and hoped' to 'chosen and checked'.
- Fix the medical record workflow first. Documentation is the dominant use case, the leading source of recovered time, and the leading source of after-hours burnout. Redesign that path so the note is captured, checked, and filed without a copy-paste step. Practices that bolt a scribe onto an unchanged records process shouldn't be surprised when the evening doesn't come back.
- Train the front desk and the technical staff as carefully as the doctors. Those roles adopted fastest and worry most about displacement. Training that only addresses veterinarians will miss the people who now run the tools all day.
- Don't confuse automated reminders with proactive care. Most hospitals have the first. Almost none have the second. The next clinical dividend is individual, history-aware outreach, not another six-month vaccine text.
- Publish veterinary validation for diagnostic tools. Communication products have earned their satisfaction scores. Imaging, cytology, and lab interpretation haven't. Until independent performance data exist for the species and settings these tools are sold into, skepticism about diagnostic AI is a professional standard, not a lag.
- Measure well-being alongside throughput. The write-ins are unambiguous. Teams are spending the saved time on leaving work, not on adding appointments. Hospitals that capture the hours and then refill the schedule will have used AI to speed up burnout rather than relieve it.

Limits of This Reading

I want to include two caveats with the conclusions. First, maturity and outcomes are both self-reported at a single point in time, so the survey can't establish which way the relationship runs. Deliberate adoption may produce results. Early good results may persuade a practice to invest in structure. Or a bad early experience may cause a practice to pull back and stay at Level 1, which would mean some of the least mature practices are there because AI disappointed them, not the other way round. All three are plausible, and the data can't separate them. What it can say is that practices that adopt deliberately report better results, and that the gap is large. Second, the 2026 sample is smaller than 2024 and isn't a matched panel. Comparisons across waves describe the profession as sampled, not the same people two years later. None of that weakens the central pattern. It does mean the maturity index should be used as a diagnostic, not a ranking.

Closing

The 2024 paper ended in a posture of preparation. Train people. Publish case studies. Write ethical guidelines. Shift the mindset. Those remain good ideas. They're no longer the bottleneck. The bottleneck is operational. Someone in charge, written rules, integration, redesigned work, and training that matches the jobs people are already doing.

AI is now ordinary veterinary infrastructure, about as remarkable to most of the workforce as the practice management system it still, too often, fails to talk to. Ordinary infrastructure still must be governed. The hospitals that treat it that way are already seeing more time, better retention, and clearer decisions. The hospitals that treat it as a collection of clever tabs will keep reporting that nothing measurable happened. The difference isn't the software. It's whether anyone oversees it.

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