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Beyond Traditional Healthcare IT Consulting: Most Valuable AI Advice Is Knowing When Not to Use It

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Abstract:
As artificial intelligence (AI) moves from pilots into routine clinical and operational work, healthcare's most important question is no longer *where can AI be used?* but *where should it not be used?* This Viewpoint argues that the decisive capability is not technical adoption but advisory judgment: knowing when AI can improve care, when workflows must be redesigned, and when the risks outweigh the benefits. Evidence from AI adoption, clinical documentation, model validation, and governance shows that AI creates value only when use cases are clearly defined, workflows are redesigned, performance is locally validated, and accountability for errors is explicit. Even promising applications, such as ambient documentation, remain imperfect and require ongoing clinician oversight.

Implications for medicine: AI should be treated as a clinical and organizational intervention, not merely an IT deployment. Physicians and healthcare leaders must retain responsibility for validation, workflow integration, patient safety, and professional judgment. Before adoption, organizations should require advisors to make the case against an AI project; those that survive this scrutiny are more likely to deliver safe, measurable, and trustworthy improvements in care.

Across industries, nearly nine in ten organizations now use AI in at least one business function. Yet only 37% report that AI has contributed to their earnings, a share that has not moved in a year, and only about 6% attribute a meaningful slice of earnings to it.[1] Healthcare leaders will recognize the pattern. AI is already part of how organizations document care, analyze data, streamline operations, and support decisions, and HIMSS has been urging the sector to move beyond pilots toward responsible scale.[2][3]

The usual diagnosis is that healthcare needs better technology or more data scientists. I believe the more accurate diagnosis is that it needs better advice: people who can say where AI belongs, where it does not, and what must change around it before it earns trust. That changes what leaders should expect from consultants, internal advisors, and vendors. Those who will matter are not necessarily the ones who know. They are the ones who can help an organization make AI useful, safe, measurable, and sustainable, which takes technical fluency, domain understanding, regulatory awareness, and the ability to brief an executive team.[3][4][5]

The job has moved from implementation to judgment

Healthcare IT consulting used to be anchored in applications, interfaces, and delivery plans. Those fundamentals still matter, but the role is shifting toward strategic guidance, AI-enabled workflow design,

governance advisory, and value delivery.[3][6][7][8] Clients now want advisors who can identify where AI should be used, where it should not, and how it will be governed once it enters a clinical or operational setting.[3][4][6]

Leadership structures are changing to match. In IBM's 2026 survey of 2,000 CEOs, 76% of organizations had a chief AI officer, up from 26% a year earlier, and 79% of executives said they were decentralizing decision-making as AI takes on a larger role. Eighty-three percent of CEOs said AI success depends more on people's adoption than on the technology itself.[7] For the C-suite, the advisor is no longer just a project contributor. The advisor is a strategic interpreter between technology opportunity and enterprise risk: someone who can explain AI in operational language, connect it to outcomes, and help leaders make decisions that withstand clinical, financial, and regulatory scrutiny.[4][7][8]

Why "more AI" is the wrong instinct

The strongest signal in the data is not about models. McKinsey's 2026 survey found that nearly three-quarters of AI high performers had fundamentally redesigned workflows because of AI, compared with about one-quarter of other organizations. High performers were also twice as likely to have defined processes for measuring the impact of their AI initiatives.[1] The lesson for healthcare is that AI should not be bolted onto an old process. The process has to be redesigned around the capability.[6][9]

Clinical documentation shows why. A systematic review of 129 studies cites estimates that physicians spend 34% to 55% of their workday creating and reviewing records, an opportunity cost of $90 billion to $140 billion a year in the United States. The same review found that, through mid-2024, no highly accurate end-to-end AI documentation assistant had been reported in the peer-reviewed literature, even as narrower techniques such as structuring data delivered targeted gains.[6] A 2025 randomized trial of 238 physicians across 14 specialties then tested two commercial ambient scribes. One reduced time spent on notes by roughly 10% compared with usual care; the other showed no significant difference. Both showed possible improvements in burnout, which the authors say need confirmation in larger trials, and both occasionally produced inaccuracies that required ongoing physician vigilance.[10]

Even in one of the best-evidenced healthcare use cases, then, the technology is only part of the result. Consider a discharge summary. Asking a model to draft one is the easy step. The advisory work is deciding when the summary is generated, who validates it, how it fits into the record, and what happens if the model is wrong.[6][11]

The cost of getting that design wrong is higher in healthcare than in most industries. An external validation of the Epic Sepsis Model, which had been implemented at hundreds of US hospitals, found that it generated alerts for 18% of hospitalized patients while missing 67% of those who developed sepsis.[12] Vendor performance claims are a starting point for local validation, not a substitute for it, and that is exactly the kind of judgment an advisor is hired to exercise.[4][5][13]

Prompting is not strategy

Prompt engineering is useful. IBM's guidance reflects that effective prompts are structured, specific, and intentional, and knowing how to ask better questions improves output quality and speeds daily work.[11] But it is a tactical skill, not the core of the profession. A field experiment by Harvard Business School and Boston Consulting Group gave GPT-4 to 758 consultants. On tasks within AI's capabilities, those using it were more productive and produced higher-rated work. On a task deliberately set just outside those capabilities, they were 19 percentage points less likely to reach the correct answer than consultants

working without AI. A group that also received an overview of prompting techniques was, if anything, less accurate on that task.[14] The researchers call this uneven boundary the jagged technological frontier. The practical implication is that a fluent prompter who cannot tell which side of the frontier a task sits on is a liability, not an asset.

The strategic work happens earlier. Before any tool is deployed, an advisor must define the use case, the target outcome, the success criteria, the risks, and the human checkpoints. That is why healthcare consulting in the AI era is less about using AI and more about designing the conditions under which AI can be trusted. It requires judgment and a healthy skepticism.[4][5][13]

Four disciplines advisors now need

The first is AI fluency. That does not mean becoming a full-time data scientist. It means understanding how generative AI, machine learning, and natural language processing work well enough to evaluate use cases, question assumptions, and spot obvious risks.[11][14]

The second is data literacy. AI depends on data quality, interoperability, and context, and healthcare data is fragmented across systems, formats, and workflows. An advisor who does not understand data provenance, coding standards, quality controls, and governance will struggle to advise with confidence.[3][6]

The third is workflow design. Technology fails in healthcare when it conflicts with how clinicians and administrators actually work. In documentation, AI can structure notes, detect errors, and identify trends, but it still needs human oversight and sensible integration into the clinical workflow.[6][9]

The fourth is governance, which now has a regulatory layer and an organizational layer. On the regulatory side, Australia's Therapeutic Goods Administration regulates software, including AI, according to its intended purpose rather than the technology behind it. Its own guidance uses a digital scribe as an example of a product that can start outside the medical device definition and be drawn in through how it comes to be used.[5][15] In the United States, the Joint Commission and the Coalition for Health AI issued guidance in September 2025 setting out seven elements of responsible AI use, from governance structures and patient transparency to ongoing quality monitoring, safety-event reporting, and staff training. It is voluntary for now, but widely read as a preview of future accreditation expectations.[16] A systematic review of the governance literature found a patchwork of frameworks and checklists and proposed a readiness assessment so organizations can set pragmatic targets.[13] The upshot is that advisors must recognize when an AI capability becomes a regulated-product issue and not just an IT issue, and must build in model oversight, bias awareness, documentation, change control, privacy, and accountability.[5][15]

What executives should ask

Healthcare executives are under pressure to show that AI investments lead to real results.[8] Before approving any project, they should expect their advisors to answer five questions plainly:[4][7]

1. Where should AI be deployed, and where should it not be?
2. What value will it create?
3. What risk does it introduce?
4. Who owns accountability when it is wrong?
5. How will success be measured?

An advisor who can answer these without jargon becomes useful very quickly. One who cannot will be treated as a technical vendor rather than a strategic partner. Executives do not need a lecture on model

architecture; they need a crisp account of trade-offs, business cases, and implementation consequences. The best advisors speak to clinicians, operations leaders, compliance teams, and boards in different languages while keeping the strategy aligned.[3][4]

How to build the capability

Upskilling should be structured rather than casual. The foundation layer is AI literacy: models, limitations, use cases, and basic terminology. The next layer is practical application: prompt design, clinical workflow analysis, documentation automation, and analytics interpretation. The highest layer is advisory capability: governance, risk framing, change management, and executive facilitation.[3][6][11] HIMSS's career resources are one place to map roles and training paths.[17] A useful path includes:

- Learning the basics of generative AI, machine learning, and NLP in healthcare.
- Studying how AI is used in documentation, triage, scheduling, and operational analytics.
- Building confidence in data quality, interoperability, and information governance.
- Understanding regulatory boundaries, especially where software may be treated as a medical device.
- Strengthening executive communication so AI can be explained in business and clinical terms.[3][5][6][9][11]

Advisors should also build a habit of documenting outcomes. Even when they are not building AI systems, they should be able to show how they improved a process, reduced manual work, supported a governance framework, or moved a client from pilot to production. Given that high performers are far more likely to have defined impact-measurement processes, measurable judgment is a form of credibility.[1][3][4]

How the work itself must change

AI can accelerate drafting, summarization, research, and analysis, but it can also create a false sense of completeness. The disciplined workflow is to use AI for first-pass thinking, then validate, refine, and align the output to the client's context. Speed matters, but so does verification.[6][11]

Advisors should also get comfortable working in shorter cycles. AI projects often move faster than traditional IT programs, and organizations expect visible value early. That means defining narrow, high-value use cases, proving outcomes quickly, and scaling only after the solution has earned trust. It also means planning for monitoring from day one, because performance can drift as data, vendor updates, and workflows change.[2][3][16]

Finally, advisors must preserve professional judgment. Not every problem needs AI. Sometimes the best answer is process simplification, better data governance, or clearer operating rules. The strongest advisors know when to introduce AI and when to hold back, and that discernment is increasingly what clients are buying.[4][6][13]

The opportunity

For Healthcare IT consultants, the age of AI is not a threat. It is a chance to become more valuable, because organizations need help navigating uncertainty, regulation, workflow redesign, and executive decision-making at the same time.[3][7][8] What will separate future-ready advisors from the rest is the ability to combine technology understanding with healthcare context and governance discipline. They will not just implement systems; they will help organizations build intelligent, trustworthy, and scalable operating models.[4][5]

In my view, this is the defining professional challenge of the next decade. The advisor who adapts will become indispensable. The one who does not will be reduced to supporting tools that others control.[8][13][18] For healthcare leaders, the implication is direct: before you sign the next AI contract, ask your advisor to make the case against the project first. If they cannot, you have learned something important. If they can, and the project survives, it will have earned its place.

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