AMA | Center for Digital Health & AI

AMA Multi-Country Study on Consumer Wearable Data in Clinical Practice

Letter from the CEO

July 2026

Millions of people around the world now use smartwatches, fitness trackers, and other wearable devices to monitor their health. As these technologies become more widely adopted, understanding how physicians use – and value – this health data is increasingly important to realizing the full potential of digital health.

To answer this question, the AMA Center for Digital Health and AI partnered with Medscape on a first-of-its-kind international survey of physicians across six countries.

The findings reveal a clear message.

- Physicians recognize the potential value of wearable health data, and most are already reviewing information from these devices in some capacity.
- The barriers to broader adoption are structural - not motivational.
- Questions about data credibility, clinical validation, workflow integration, reimbursement, liability, and physician confidence in interpreting these data continue to limit use.

John Whyte, MD, MPH
Chief Executive Officer
American Medical Association

This research also demonstrates something else: Physicians around the world show remarkably similar levels of exposure to and enthusiasm for wearable technologies. What separates countries moving toward greater integration from those that are lagging is not physician willingness, but the presence of the clinical workflows, payment mechanisms, evidence standards, and support systems needed to turn a growing stream of data into meaningful clinical insight.

Interest in wearable technology is growing quickly. Now it is time for coordinated action. Health systems, policymakers, technology developers, specialty societies, and physicians must work together to strengthen the evidence base, establish clear standards for data quality and clinical validation, develop workflows that fit naturally into practice, clarify liability, and create payment pathways that support the responsible use of patient-generated data. Innovation alone is not enough.

Realizing the full potential of wearable technologies will require the infrastructure, trust, and collaboration needed to translate a growing stream of information into meaningful clinical insight and better patient care.

We hope this report informs the next phase of discussion, collaboration, and action. The decisions we make today can help unlock the potential of wearable technologies to improve health across the globe.

Sincerely,

About the AMA Center for Digital Health and AI

The AMA created the Center for Digital Health and AI in 2025 to ensure that physicians help shape the future of medicine at a time of extraordinary technological change. The Center brings together physicians, technology developers, regulators, policymakers, health systems, and innovators to advance the safe, effective, and responsible use of artificial intelligence and digital health technologies. It works to develop the research to inform health policy decisions, as well as the evidence, standards, and policy frameworks needed to ensure these tools improve patient care, strengthen the patient-physician relationship, and earn public trust.

About Medscape

Medscape is the leading source of clinical news, health information, and point-of-care tools for healthcare professionals. Medscape offers specialists, primary care physicians, and other healthcare professionals the most robust and integrated medical information and educational tools. Medscape Education (medscape.org) is the leading destination for continuous professional development, consisting of more than 30 specialty-focused destinations offering thousands of free continuing medical education and continuing education courses and other educational programs for physicians, nurses, and other healthcare professionals. Medscape is a subsidiary of WebMD Health Corp., an Internet Brands company.

About This Survey

The 2026 International Physician Survey on Consumer Wearables was designed to assess how physicians across six countries interact with consumer-grade wearable devices in clinical practice. The survey examined current physician attitudes and behaviors, barriers to integrating data from wearables into clinical practice, trust in device data, reimbursement dynamics, and structural factors that distinguish countries where integration is advancing from those where it remains stalled.

The survey included lifestyle wearables (eg, Apple Watch, Oura Ring, WHOOP, Garmin, Fitbit) and over-the-counter biosensors (eg, Dexcom Stelo, Abbott Lingo).

Prescription medical devices, such as continuous glucose monitors and clinical diagnostic tools (eg, mobile cardiac telemetry, home sleep apnea tests), were excluded.

This report presents findings from a total of **2,222 physicians** surveyed from January through early March 2026, spanning the United States, Canada, France, Germany, Spain, and the United Kingdom. It builds on a US-only baseline wave (n = 720) and extends analysis to 1,502 respondents in five other countries.

What are consumer digital wearables?

The definition of consumer digital wearables used was: nonprescription, commercially marketed technologies used by individuals to monitor personal health, fitness, and performance. Key distinction: These are products that patients own and whose use is patient-initiated, rather than devices prescribed by a provider for a specific medical diagnosis or monitored as part of a formal clinical study.

Executive Summary

The barriers to integration of data from wearables into clinical practice are **mostly structural, not motivational**. The distance between intention and action is rooted in two things: gaps in physician trust of data from wearables and missing clinical workflows. Closing that gap will require coordinated investment in structural conditions for physicians, not efforts to build awareness or capitalize on interest that already exists.

Across the six countries surveyed, physicians show similar patterns of exposure to, and interest in, wearable data.

Most physicians are already reviewing wearable data in some capacity, and only 3% reported never reviewing any wearable data. The most commonly reviewed data categories are broadly similar across countries: heart physiology, activity and function, biometric/physical events and alerts, and sleep. Physician interest follows the same broad pattern: Most use wearables personally, and large majorities both within and outside the United States reported that wearable data offers at least some clinical advantage for patient care. Taken together, these patterns show that the six-country comparison began from a similar base of exposure to, interest in, and early clinical engagement with wearables, although countries differ in how easily that interest turns into routine clinical use of data from these devices.

Patients are not yet regularly requesting review of data from their wearables, but when they ask, physicians typically act.

Patient-initiated engagement with wearable data is visible but not yet routine. Fewer than one in four physicians reported weekly patient requests across any of the four measured demand indicators. That frequency suggests that wearable data are entering clinical conversations selectively rather than systematically. However, the consistency of physician responsiveness is notable: Across all six countries, when patients ask, physicians typically act. That relationship holds regardless of country, specialty, or structural environment, and it points to patient demand as one of the most reliable levers for closing the gap between exposure to and integration of data from wearables. The implication is that activating demand through patient education, literacy tools on wearables, and clinician-facing communication resources may be one of the most direct strategies for accelerating clinical use.

The integration of data from wearables into clinical practice/workflows is in early transition and countries differ in how far along that transition is.

The survey data make it clear that neither physician motivation nor patient demand is the primary factor separating countries where wearable data integration is advancing from those where it remains stalled. The share of physicians integrating wearable data into clinical workflows does not exceed 6% in any country, but the variation in who is moving toward integration and how quickly is closely tied to structural conditions. Germany and Spain have the largest reported near-term pipelines of physicians ready to integrate these data, whereas fewer than one in five physicians in Canada or the United Kingdom indicated a high likelihood of integration in the next 12 months. Reimbursement pathways, feasibility, and concerns all differ meaningfully by country, and those differences explain more of the variation in integration rates than physician interest does. Structural factors, including payment mechanisms, regulatory frameworks, and workflow infrastructure, shape what is possible even when intention is present.

Country-level differences reveal that beyond payment structures, physician enthusiasm, concerns about legal liability, and other factors influence integration into clinical practice.

Across the six countries surveyed, the presence or absence of a formal payment mechanism explains some of the variation in wearable data integration. For example, although France has defined reimbursement pathways, it also has the lowest integration rate in the study, driven in part by the highest medical-legal liability concern of all countries surveyed. Canada has physician enthusiasm and some provincial billing infrastructure yet remains structurally fragmented. The United Kingdom has high personal wearable use and frequent patient-initiated interactions but the lowest feasibility scores globally and no National Health Service (NHS) payment pathway. What these country profiles collectively demonstrate is that integration readiness is a product of multiple interacting conditions, including payment support, liability clarity, evidence confidence, and workflow feasibility, among others, and that addressing any one factor in isolation is unlikely to move the needle broadly.

Moving physicians toward integration of patient-generated wearable data requires coordinated investment in resolving concerns about implementation and data credibility and augmenting clinical skills.

Integrated physicians and nonintegrated physicians have similar levels of awareness of such data, interest in integrating them, and trust in regulatory bodies. The factors dividing integrated and nonintegrated physicians center around clinical skills, data credibility, and unresolved concerns about implementation. Integrated physicians rated the clinical advantage of wearable data higher than their nonintegrated peers and reported meaningfully stronger patient demand, but the two groups were nearly identical on regulatory trust and reimbursement influence. What differentiates them is interpretive confidence; trust in data accuracy; and less concern about false-positive findings, liability, and workflow burden. Physicians furthest from integration need evidence first—randomized controlled trials (RCTs), outcomes data, and inclusion in specialty society guidelines—before skill-building or workflow investment becomes meaningful. Physicians closest to integration need peer demonstration and workflow support showing that integration is feasible during a routine visit.

Defining 'Integrated' Physicians in our Survey

Integrated physicians are defined as those who responded they are currently incorporating wearable data into clinical workflows. Nonintegrated physicians are those that had a response other than currently incorporating (not at all likely, somewhat likely, moderately likely, very likely, extremely likely) into clinical workflows over the next twelve months.

Specialty remains an important second lens. Specialty shapes both how often physicians engage with wearable data and how much clinical value they see in it. Cardiologists and endocrinologists review wearable data more often and in more clinically relevant categories compared with other types of physicians. Those specialties were also more likely to report that data from wearables has clinical value and were more likely to say that this information is feasible to use during a routine visit. Primary care physicians, neurologists, and pulmonologists also engage with wearable data, but they reported more limits in relevance, confidence, and practicality.

Introduction

Consumer wearable devices, such as smartwatches, fitness trackers, and biosensors, now generate continuous streams of physiological data for hundreds of millions of users worldwide. These data will increasingly surface in clinical settings regardless of whether physicians are prepared. Yet, clinical integration of patient-generated wearable data remains underexamined at an international scale.

This report addresses that gap. Because wearable technology is a global consumer phenomenon, the barriers to its clinical integration are not purely technical or individual; on the contrary, they are shaped by the reimbursement structures, regulatory frameworks, and workflow infrastructures that vary meaningfully across health systems. Understanding which conditions accelerate integration and which impede it requires comparison across those systems, not just within one.

Drawing on survey responses from 2,222 physicians across six countries—the United States, Canada, France, Germany, Spain, and the United Kingdom—this report examines what distinguishes health systems where wearable data integration is advancing from those where it remains stalled and what that means for the path forward.

Top Wearables, by Country

Brand market share and device capabilities shape which clinical signals physicians most frequently encounter. The dominant device in each country partially determines what patient-generated data are clinically actionable.

Apple's dominance is most pronounced in English-speaking markets. In the United States, Apple commands an estimated 45% to 50% national share; in the United Kingdom, 42% to 45%; in Canada, 40% to 45%.

The European picture is more fragmented. In Germany, Samsung holds the top position, with Apple coming in second. Spain is the most distinctive market: Xiaomi has a leading market share, driven by budget positioning in a price-sensitive market.

France presents a notable exception in Europe. Withings, a France-headquartered company, holds approximately 5% market share, and its ScanWatch holds EU Class IIa medical device classification—the closest consumer-adjacent device to a regulated medical product in the French market.

Additional context for the market environment for consumer wearable devices can be found in Appendix A.

Country	Market Share	Brand 1	Brand 2
UNITED STATES	**53%**	**Apple** (~45%–50%) Source: Counterpoint Research; Statista U.S. smartwatch brand chart (2024)	**Samsung** (~15%-18%) Source: Counterpoint Research global smartwatch market recap (2024)
UNITED KINGDOM	**50%**	**Apple** (~42%–45%) Source: Mintel UK smartwatch report; YouGov UK electronics survey (2024)	**Fitbit/Google** (~25%-30%)[b] Source: YouGov 2024: 30% buyer consideration; Samsung narrows gap (Mintel UK)
CANADA	**40%**	**Apple** (~40%-45%) [a] Source: Est. from N. America composite; Ken Research North America overview	**Samsung** (~15%-18%) [a] Source: N. America market composite; no Canada-specific primary source in open data
GERMANY	**36%**	**Samsung** (~30%-35%) Source: Mintel Germany health & fitness technology report (2024)	**Apple** (~25%-28%) Source: Mintel Germany (2024): Samsung confirmed as leading Apple in smartwatches
FRANCE	**18%**	**Apple** (~38%-42%) [a] Source: Est. from European composite; Mordor Intelligence Europe wearables leaders	**Samsung** (~18%-22%) [a] Source: European market summary; no audited France-specific primary source in open data
SPAIN	**29%**	**Xiaomi** (~25%-30%) [a] Source: European composite; Xiaomi leads budget segment in Southern Europe	**Apple** (~22%-26%) [a] Source: Mordor Intelligence Europe leaders; no Spain-specific primary source in open data

Table 1. Consumer Adoption and Brand Landscape, by Country: Top 2 Brands
Sources: Counterpoint Research (2024); Mintel UK and Germany smartwatch reports (2024); YouGov UK electronics survey (2024); Mordor Intelligence European wearable device market; Ken Research North America.
Adoption rates: Statista, Pew Research Center, OECD digital technology adoption statistics.

[a] Composite Estimate: Country-level brand shares for Canada, France, and Spain are directional estimates extrapolated from North American and European regional market composites. No audited country-specific primary source was available in public data for these three markets. Figures should be treated as directional only. Ranges reflect methodological uncertainty across composite sources.
[b] YouGov UK: purchase consideration (buyer intent), not installed-base ownership share.

Our Findings

Four interconnected findings illuminate the path forward for wearable data integration in patient care across six countries: the United States, Canada, France, Germany, Spain, and the United Kingdom. Global results are presented, with key country- and specialty-specific differences highlighted.

Finding 1: Across the six countries surveyed, physicians show similar patterns of exposure to and interest in wearable data.

Physicians in North America and Europe are already encountering wearable device data in clinical care. Most physicians reported that they already review wearable data, and only 3% said they have never reviewed at least one of the wearable data types included in the survey.

Physicians Are Already Reviewing Similar Categories of Wearable Data

Heart physiology, activity and function, events and alerts, and sleep are the data categories that physicians most often encounter, although the exact mix varies somewhat by country. Spain is the outlier, having more physicians who reported reviewing oxygen and breathing, sleep, and glucose/metabolic data.

Heart physiology, activity and function, events and alerts, and sleep are the most frequently reviewed categories in most markets.

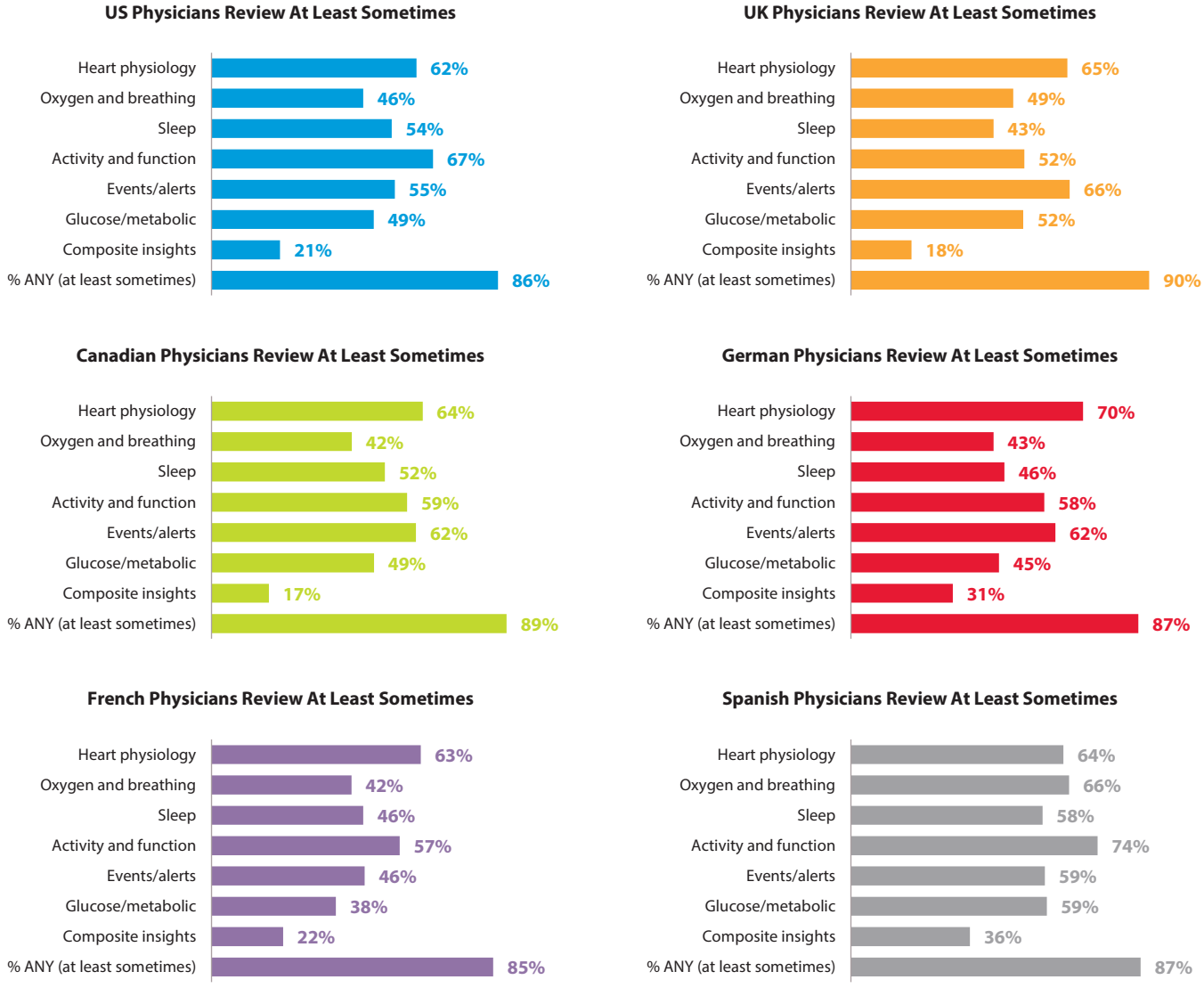


Figure 1. Category of Wearable Data Reviewed, by Country (N = 2,222)
Q5. How often do you evaluate or review the following patient wearable data types? "Sometimes/Often/Always" reported.

Physicians Have Broadly Adopted Wearable Technology for Personal Use

Eighty-two percent of physicians reported using wearables personally, including 72% who used smartwatches, 44% who used fitness trackers, and 10% who used smart rings. Only 18% reported that they do not use wearables at all.

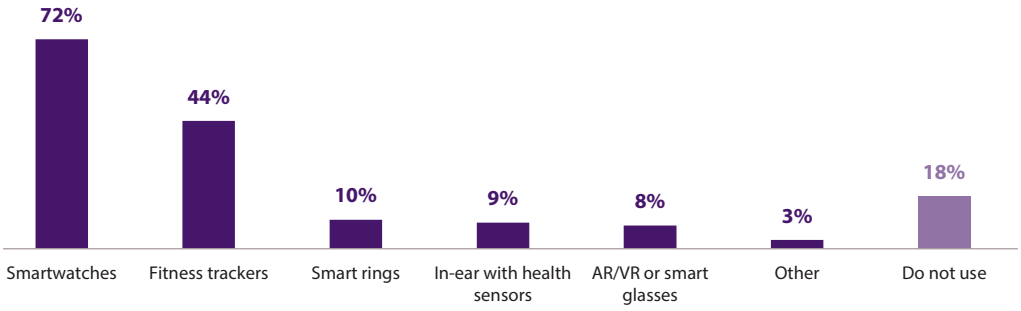


Figure 2. Physicians' Personal Use of Wearable Devices[a] (N = 2,222)
Q1. Do you personally use any of the following consumer wearable devices in your personal life?
AR, augmented reality; VR, virtual reality.
[a] Smartwatches may be used for non–health-related monitoring, so results may overestimate use for health

Most physicians see at least some clinical advantage in wearable data, with 77% of US physicians and 74% of physicians outside the US reporting at least some clinical advantage for patient care.

Physicians See the Clinical Advantage of Wearable Data for Providing Patient Care

The largest gaps between personal use of wearables and perceiving an advantage for patient care were found in Canada and the United Kingdom.

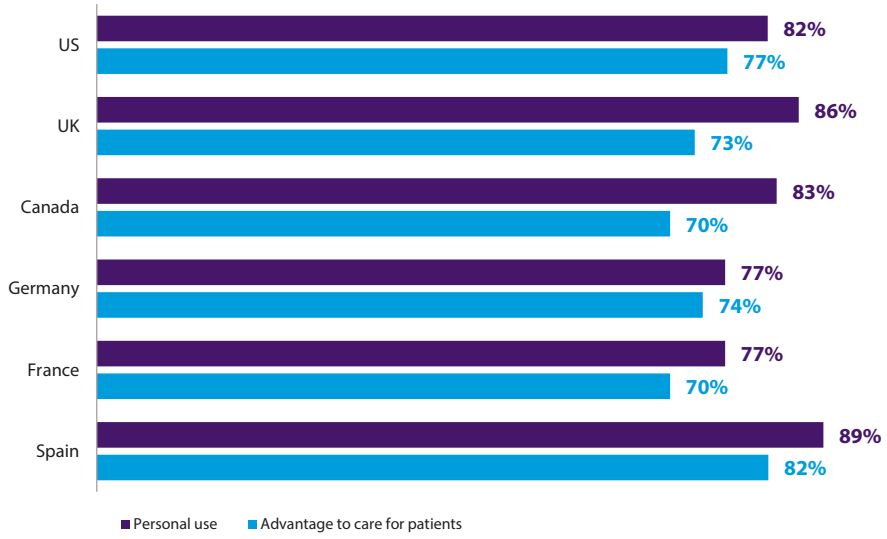


Figure 3. Physicians' Personal Wearable Use and Perceived Advantage for Patient Care, by Country (N = 2,222)
Q1. Do you personally use any of the following consumer wearable devices in your personal life?
Q8. Considering the overall impact, how much of an advantage do consumer wearables give to your ability to care for your patients?
"Some/Definite Advantage" reported.

Finding 2: Patients are not yet regularly requesting review of data from their wearables, but when they ask, physicians typically act.

Patient Demand Is Present but Not Yet Routine

Reviewing the prior 3 months, 16% of physicians reported that patients scheduled a visit because of wearable data at least weekly, 21% reported that patients asked them to review wearable data at least weekly, 23% reported that patients sought guidance on wearable data at least weekly, and 15% reported that patients explicitly asked to incorporate wearable data into care at least weekly. That pattern suggests that wearable data are entering clinical conversations, but not yet at a frequency that would make them a standard part of most visits.

Across all four measures, fewer than one in four physicians reported at least weekly patient requests related to wearable data.

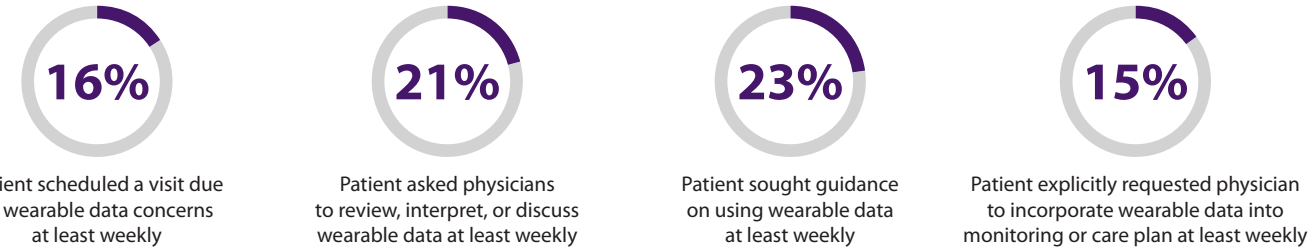


Figure 4. Patient Demand for Clinical Integration of Wearable Data (N = 2,222)
Q2. In the past 3 months, how frequently have patients done the following?

When Patients Ask, Physicians Act—and That Pattern Is Consistent Across Countries

Even though demand remains limited, the relationship between patient request and physician action is strong. The survey found that when patients ask physicians to review or discuss wearable data, physicians typically respond, and that relationship is consistent internationally.

In each country, patient request and physician action are strongly correlated. Germany is a standout for number of requests, probably due to their Digitale Gesundheitsanwendungen, or Digital Health Applications (DiGA), prescription pathway.

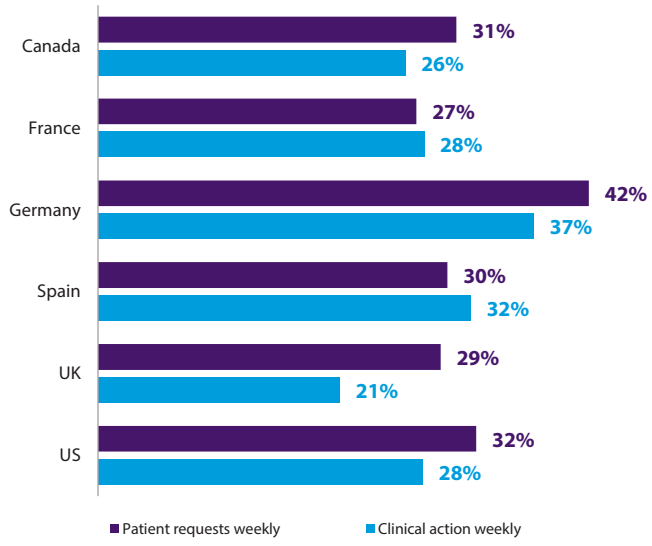


Figure 5. Patient Requests and Physician Actions With Wearable Data at Least Weekly, by Country (N = 2,222)
Q2. In the past 3 months, how frequently have patients done the following?
Q4. In the past 3 months, how frequently has reviewing consumer wearable data led you to take the following specific clinical actions?

These findings show a consistent pattern across countries: Physicians personally use, see clinical value in, and have already encountered wearable data in practice. The more important question now is why some countries have moved beyond this early stage toward structured clinical use while others have not.

Finding 3: The integration of data from wearables into clinical practice/workflows is in early transition and countries differ in how far along that transition is.

Countries Show Different Patterns of Support and Constraint

The six-country comparison reveals that physicians are operating in meaningfully different environments when it comes to wearable data use and readiness for integration. While active integration into clinical workflows remains a minority experience everywhere—no country exceeds 6% of physicians currently doing so—the variation in who is moving toward integration is wide and is closely tied to structural conditions in each country.

Germany and Spain stand out at one end of the spectrum; physicians in these countries actively engage with wearable data and are largely open to expanding that use. Physicians in both countries reported high levels of use in weekly clinical actions and likelihood of integrating data use in the next 12 months. Spain, however, reported nearly half of the workflow integration of Germany.

Canada and the United Kingdom are at the other end of the spectrum. Fewer than one in five physicians in either country expressed high likelihood of integrating wearable data in the next 12 months. France indicated similar expectations to integrate, although current integration rates are much lower. The United States resembles Canada in its overall wearable data use profile, with moderate current integration and a modest near-term pipeline of physicians who anticipate integration in the next 12 months.

Data Are Used for Clinical Actions Despite Lack of Full Workflow Integration

Physicians in Germany and the United States have the most workflow integration, but their profiles of use in clinical actions and likelihood to integrate are very different.

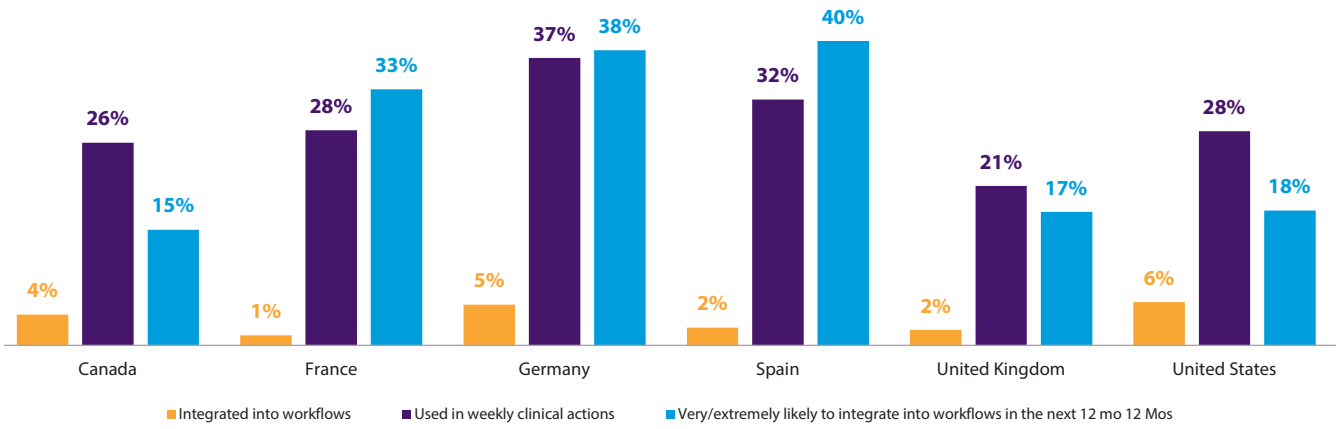


Figure 6. Wearable Data Use and Expectations for Use, by Country (N = 2,222)
Q16. How likely are you to incorporate wearable data into clinical workflows over the next 12 months?
Q4. In the past 3 months, how frequently has reviewing consumer wearable data led you to take the following specific clinical actions?
At least weekly reported.

Taken together, these patterns suggest that the gap between countries is not primarily one of physician interest or awareness; rather, it is one of structural and clinical readiness. The sections below examine where those structural and clinical differences are the sharpest.

Countries Differ in Wearable Data Reimbursement Pathways and Usage

Countries differ substantially in how the review of patient-generated data is supported and paid for in clinical care. Existing pathways are not designed to reimburse use of data from consumer wearable devices in clinical care and generally do not apply to them.

In the United States, CPT codes for remote patient monitoring require FDA-cleared devices used under a clinician-directed plan of care and do not extend to consumer-grade wearables regardless of FDA-cleared features (eg, ECG). As a result, there is no current dedicated reimbursement pathway for review of consumer wearable data.

CANADA	**Provincial Billing Codes**	Province-specific codes (e.g., OHIP in Ontario, RAMQ in Quebec, MSP in British Columbia) for claiming payment on remote monitoring of review of patient-generated data.
FRANCE	**PECAN: Prise En Charge Anticipée Numérique**	Early-access reimbursement for digital medical devices pending full evaluation
	LATM: Liste des Activités de Télésurveillance Médicale	Established telemonitoring reimbursed under national insurance.
GERMANY	**DiGA: Digitale Gesundheitsanwendungen**	Statutory health insurance reimbursement for approved digital health applications, including those incorporating wearable data.
UNITED STATES	**CPT® codes: Current Procedural Terminology**	Codes used to bill Medicare and commercial payers for setup, data transmission, and clinician review of remote monitoring.

Table 2. Reimbursement Pathways, by Country

Table 2 above shows the mechanisms used in the four countries that have existing digital health pathways.

Where formal reimbursement pathways exist for appropriate medical devices, physicians who use them tend to review wearable data more frequently. At the same time, wearable data review is already happening across countries, including outside of formalized payment systems. This suggests that payment support shapes how review becomes more structured and routine, even if it does not fully determine whether physicians review wearable data at all.

Country	Reinmbursment Pathway	Physician Utilizing % (n)
GERMANY	DiGA	**35% (104)**
CANADA	Provincial billing codes for remote monitoring or patient-generated data review	**15% (45)**
UNITED STATES	CPT® codes for remote monitoring	**10% (71)**
FRANCE	PECAN or LATM	**5% (14)**

Table 3. Physicians Utilizing Reimbursement Pathways, by Country[a]
Q12US. Do you currently bill CPT codes (eg, 99453, 99454, 99457) for remote monitoring using consumer wearables?
Q12DE. Have you ever prescribed a DiGA that utilizes wearable data?
Q12FR. Do you utilize the PECAN or LATM pathways for reimbursement of digital monitoring?
Q12CA. Do you use provincial billing codes to claim payment for remote monitoring or reviewing patient-generated data?
Abbreviations : DiGA, Digitale Gesundheitsanwendungen; CPT, Current Procedural Terminology; LATM, Liste des Activités de Télésurveillance Médicale; PECAN, Prise en Charge Anticipée Numérique.
[a] Spain and the United Kingdom do not have reimbursement pathways; as such, they are not included in this table.

Across the four countries with defined payment mechanisms—Canada, France, Germany, and the United States—physicians in countries where a reimbursement pathway is available review wearable data more often than those who do not participate in such pathways. Germany showed the strongest effect, consistent with the availability of DiGA as an option. France's biller group was small (n = 14) and the findings should therefore be interpreted with caution, but the direction was consistent. Spain and the United Kingdom, which have no dedicated reimbursement pathway, are not included in this comparison.

Physicians in Countries With Payment Pathways Review Wearable Data More Often

Across countries with defined payment mechanisms, participation in a reimbursement pathway was associated with more frequent review of consumer wearable data.

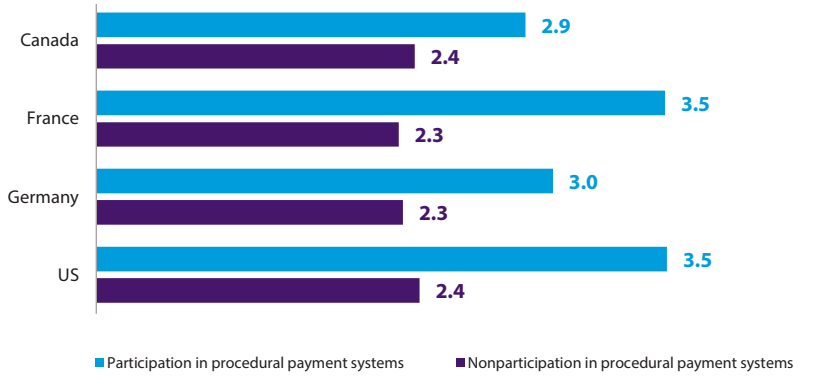


Figure 7. Mean Patient Wearables Review Score for Physicians Participating in Procedural Payment Systems vs Those Who Did Not, by Country[a] (n = 1,621)
Q12US. Do you currently bill CPT codes (eg, 99453, 99454, 99457) for remote monitoring using consumer wearables?
Q12DE. Have you ever prescribed a DiGA that utilizes wearable data?
Q12FR. Do you utilize the PECAN or LATM pathways for reimbursement of digital monitoring?
Q12CA. Do you use provincial billing codes to claim payment for remote monitoring or reviewing patient-generated data?
Q5. How often do you evaluate or review the following category of patient wearable data? (composite of 7 items: heart physiology, oxygen and breathing, sleep, activity and function, events/alerts, glucose/metabolic)
Scale 1 = Never, 3 = Sometimes, 5 = Always. France participation.
[a]Spain and the United Kingdom do not have procedural payment systems; as such, they are not included in this figure.

Finding 4: Country-level differences reveal that beyond payment structures, physician enthusiasm, concerns about legal liability, and other factors influence integration into clinical practice.

The payment comparison is most useful when it is read as one part of the country's story. Some countries had clearer and more formalized reimbursement mechanisms, while others relied on fragmented, emerging, or indirect approaches. Those differences matter because they affect how easy it is for wearable data review to become compensated and repeatable in practice.

Concerns Outweigh Optimism About Feasibility in All Countries but Germany

Physicians in five out of six countries find wearable data integration more clinically concerning than feasible to act on, but the size of those gaps differs meaningfully by country.

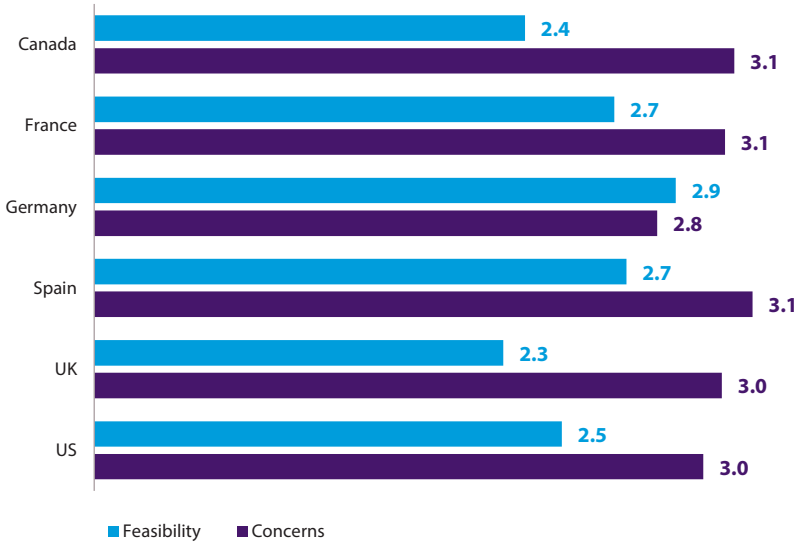


Figure 8. Feasibility of Clinical Action and Clinical Concerns, by Country (N = 2,222)
Q9. How feasible is it for you to perform the following actions with consumer wearable data during a routine visit? (composite of 3 items: reviewing raw data, interpreting for decisions, discussing with patients)
Scale: 1 = Not feasible at all, 3 = Moderately feasible, 5 = Completely feasible.
Q10. How concerned are you about the following clinical issues when using consumer device data? (composite of 6 items: false positives, false negatives, patient anxiety, device accuracy, relevance, outcomes evidence) Scale: 1 = Not concerned, 3 = Moderately concerned, 5 = Extremely concerned.
Q11. How concerned are you about the following practice and workflow issues when using consumer device data? (composite of 4 items: data overload/time, medical-legal liability, equity/access, data upload to EHR [electronic health record])
Scale: 1 = Not concerned, 3 = Moderately concerned, 5 = Extremely concerned.

Germany has both the highest feasibility—meaning physicians are more confident they can use wearable data during a routine visit—and the lowest clinical concerns of any country surveyed (scores of 2.9 and 2.8, respectively). Germany is also the country where a payment pathway is both available and most actively used. The United Kingdom and Canada have the lowest feasibility scores and among the highest concern levels, and neither has a billing pathway. France sits in an intermediate position on feasibility and concerns but is a distinctive outlier: Fifty-three percent of French physicians rated medical-legal liability as very or extremely concerning—the highest of any country. This may help explain why its reimbursement pathway, although available, remains largely unused.

Canada: Enthusiasm Meets Provincial Variation and Results in Low Likelihood of Integrating

Physicians in Canada are interested in wearable data integration but lack consistent system-level support. They reported relatively high personal wearable use and belief in the clinical value of wearable data, but provincial variation in billing structures and electronic health record (EHR) systems means that two physicians in the same specialty may face entirely different conditions depending on where they practice. The result is an environment where individual motivation to integrate data from wearables is present, but system-level support is uneven. In Canada, the limiting factor appears to be less about physician willingness to integrate the data and more about whether the structures around them are strong enough to make routine integration a realistic expectation.

> *"There is a significant burden associated with interpreting the data and also medical liability so allowing me to have more time with patients would be helpful as well as billing codes."*
>
> **— Canada, Primary Care Physician**

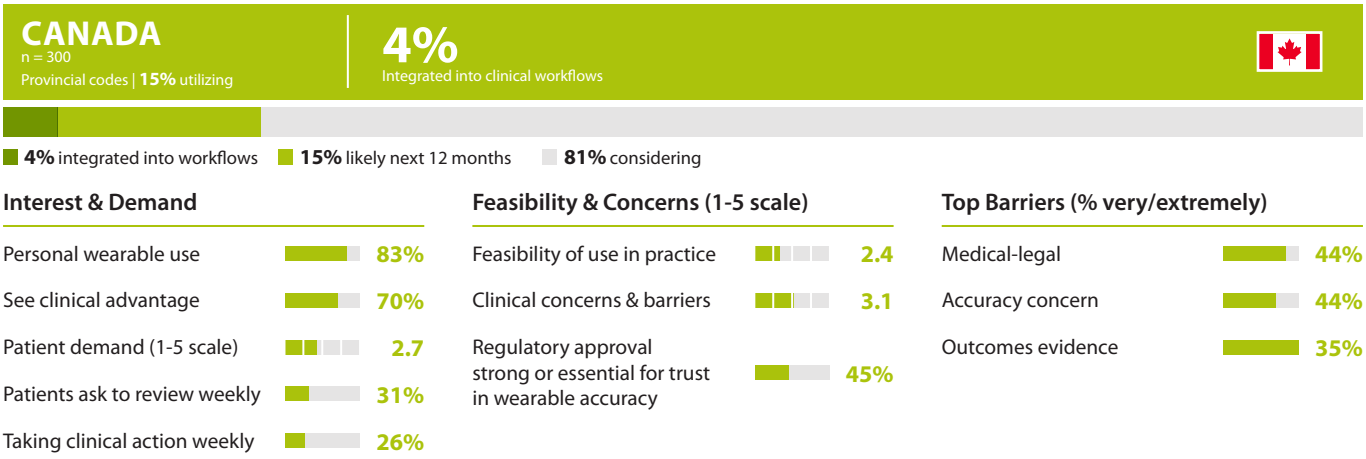


Figure 9. Country Profile: Canada
Note: 1-5 scales, higher = greater concern/barrier.

France: Formal Mechanisms Alone Are Not Enough

France has defined mechanisms for digital monitoring, but those mechanisms have not translated into broad routine use. Physicians reported high legal concern and continued demand for stronger evidence, and overall integration remains low. The limiting factor appears to be less about whether formal structures exist and more about whether physicians feel sufficiently protected and convinced to use them.

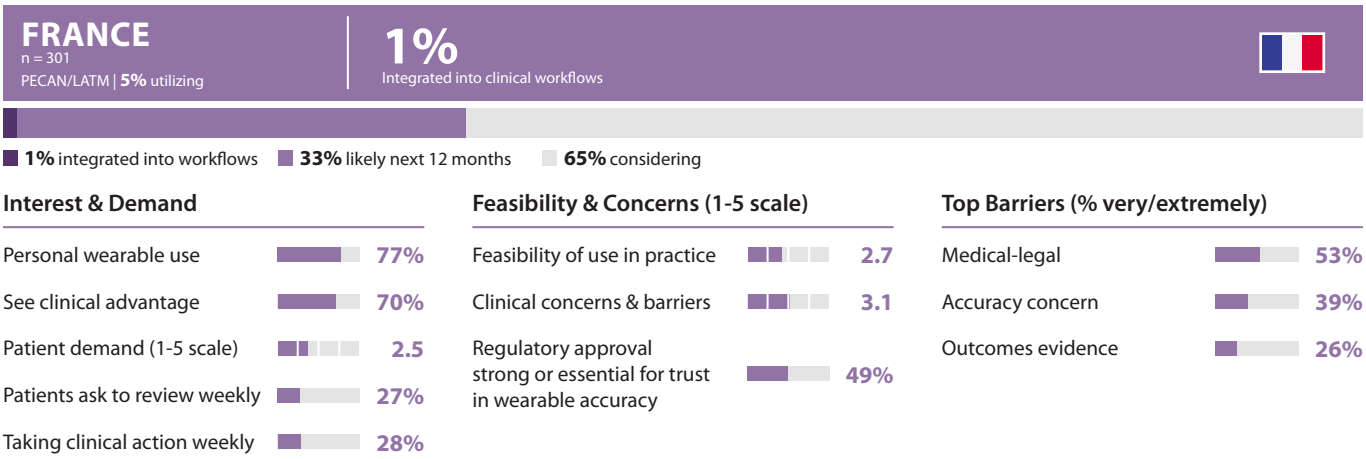


Figure 10. Country Profile: France
Note: 1-5 scales, higher = greater concern/barrier.

Germany: What Stronger Formal Support Can Look Like

Germany has the clearest formal pathway for integrating wearable-related digital health tools into care. German physicians also reported one of the strongest readiness patterns in the study, along with relatively low levels of concern and fewer workflow barriers than physicians in many other markets. Taken together, those patterns suggest that Germany stands out not because physicians are uniquely interested in wearable data but because the supporting conditions around use appear to be stronger and more established.

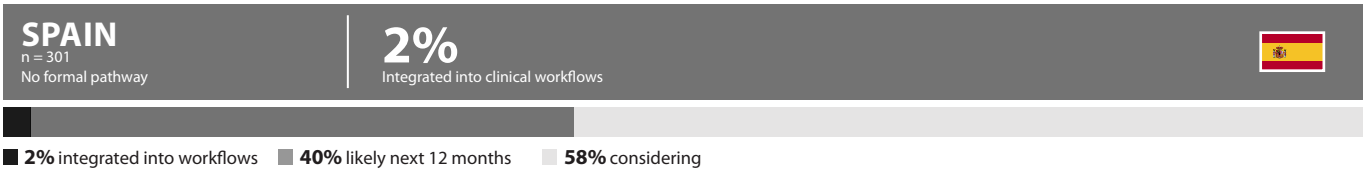
Interest & Demand		Feasibility & Concerns (1-5 scale)		Top Barriers (% very/extremely)	
Personal wearable use	77%	Feasibility of use in practice	2.9	Medical-legal	32%
See clinical advantage	74%	Clinical concerns & barriers	2.8	Accuracy concern	31%
Patient demand (1-5 scale)	2.7	Regulatory approval strong or essential for trust in wearable accuracy	52%	Outcomes evidence	25%
Patients ask to review weekly	42%				
Taking clinical action weekly	37%				

Figure 11. Country Profile: Germany
Note: 1-5 scales, higher = greater concern/barrier.

Spain: High Enthusiasm With Weaker Infrastructure

Spain combines very high personal use of wearables with strong belief in their value for patient care. At the same time, physicians reported barriers tied to access, EHR upload, and absence of a more formal dedicated pathway. The main constraint does not appear to be physician interest. Instead, the infrastructure needed to make that interest easier to act on in routine care is lacking.

> *"Right now it is practically impossible due to IT service limitations."*
>
> **— Spain, Pulmonology**



Interest & Demand		Feasibility & Concerns (1-5 scale)		Top Barriers (% very/extremely)	
Personal wearable use	89%	Feasibility of use in practice	2.7	Medical-legal	36%
See clinical advantage	82%	Clinical concerns & barriers	3.1	Accuracy concern	35%
Patient demand (1-5 scale)	2.5	Regulatory approval strong or essential for trust in wearable accuracy	57%	Outcomes evidence	40%
Patients ask to review weekly	30%				
Taking clinical action weekly	32%				

Figure 12. Country Profile: Spain
Note: 1-5 scales, higher = greater concern/barrier.

United Kingdom: High Exposure to Wearable Data, but Skepticism Persists

The United Kingdom has high exposure to wearable data but no infrastructure to support integration. Physicians reported high rates of personal wearable use and regular patient-initiated interactions involving these data, but the systems around them have not kept pace. Specifically, there is no formal NHS payment pathway. Feasibility scores were the lowest of any country in the survey, and medical-legal concern remained high. The limiting factor appears to be less about whether physicians encounter wearable data and more about whether the clinical environment gives them sufficient confidence, protection, and practical support to act on those data routinely.

> *"Would have to be NHS-provided — CE marked, approved for NHS use."*
>
> **— United Kingdom, Pulmonologist**

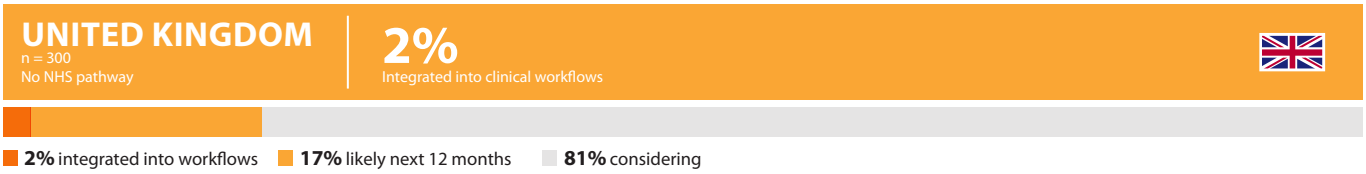


Figure 13. Country Profile: United Kingdom
Note: 1-5 scales, higher = greater concern/barrier.

The United States: Activity Without Broad Consistency

The United States has the highest share of physicians already using wearable data in clinical workflows, but it also has a large proportion of physicians who are interested yet do not use these data routinely. Liability concerns, feasibility gaps, and lack of automation appear to be major constraints. The result is a market with visible activity but not broad consistency.

> *"We need to have this data available prior to the clinic appointment or it takes up valuable time to obtain and interpret the data during an already busy appointment time."*
>
> **— United States, Neurologist**

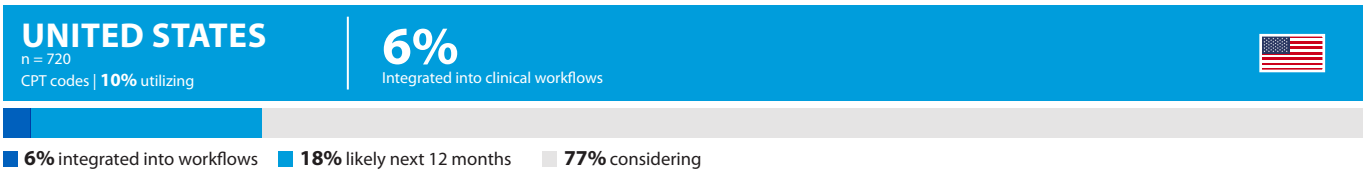


Figure 14. Country Profile: United States
Note: 1-5 scales, higher = greater concern/barrier.

Finding 5: Moving physicians toward integration of patient-generated wearable data requires coordinated investment in resolving concerns about implementation and data credibility and augmenting clinical skills.

Regulatory Trust Is Influential but Not the Primary Motivational Factor for Reviewing Data

Regulatory clearance is a threshold that most physicians have already cleared, and it does not explain differences between countries in integration of wearable data. Across the United States, the United Kingdom, Canada, and the European Union, consumer wearables with wellness-only positioning are subject to lighter oversight, while features intended for diagnosis, monitoring, or treatment bring devices under full medical-device rules—creating a mixed regulatory environment for clinical use.[1-5] The US Food and Drug Administration (FDA) recently expanded enforcement discretion for lower-risk wearable functions while maintaining traditional requirements for products with clinical claims.[6] The UK Medicines and Healthcare products Regulatory Agency (MHRA) requires Conformité Européenne, also known as European Conformity (CE), or UK Conformity Assessed (UKCA) marking for wearables that qualify as medical devices, and Health Canada applies a risk-based framework through its Digital Health Review Division.[7,8] EU member states apply Medical Device Regulation (MDR), under which medical-purpose wearables must obtain CE marking and meet stricter conformity assessment obligations, while wellness-only devices remain outside its scope.[1,9]

Approximately half of physicians across all six countries reported that regulatory clearance or approval is essential to or strongly influences their trust; however, this requirement does not explain the country-level differences observed in the integration of wearable data. For example, Spain showed the highest trust in wearable data if regulatory clearance is available, and the United Kingdom showed the lowest, yet both countries share the same integration rate. Similarly, while the United States and the United Kingdom reported nearly identical levels of trust regarding regulatory clearance, their integration rates differ meaningfully.

Figure 15. Trust in Wearable Data if Regulatory Clearance Is Provided, by Country (N = 2,222)
Q14. How much does regulatory clearance or approval from the following bodies influence your trust in a consumer wearable device's clinical accuracy? "Strong Influence/Essential" reported.

What Distinguishes Wearable-Integrated Physicians: Perceived Advantages, Not Regulatory Trust or Reimbursement

Physicians who integrate health data from wearables in their practices (ie, "integrated physicians") rated the clinical advantage of this information nearly a full point higher than did their peers who do not integrate these data (ie, "nonintegrated physicians"), and they reported meaningfully stronger patient demand. Regulatory trust and reimbursement feasibility are nearly identical in both groups, confirming that structural factors alone do not explain which physicians are integrating wearable data and which ones are not.

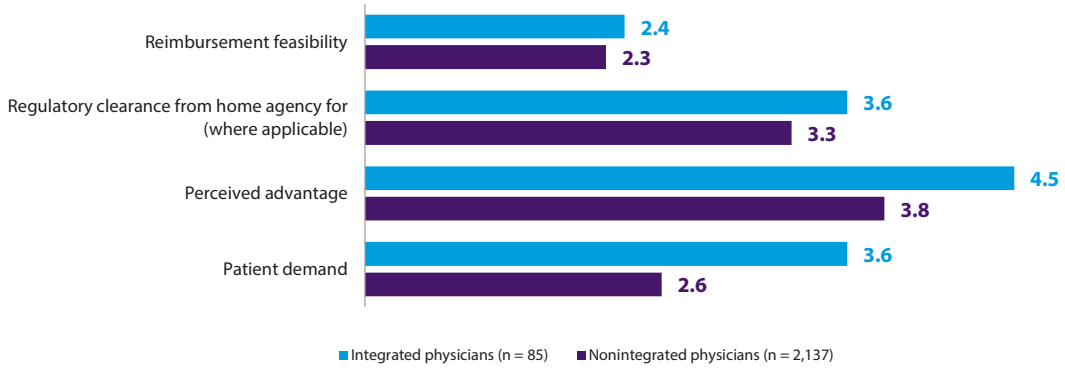


Figure 16. Patient and Perception Factors, by Integration Status (N = 2,222)
Q2. In the past 3 months, how frequently have PATIENTS done the following? (composite of 4 items: scheduled a visit specifically because they were concerned about data from a consumer wearable device; asked you to review, interpret, or discuss their consumer wearable data during a clinical visit; sought guidance on using data from consumer wearables to manage their health; explicitly requested you incorporate data from their consumer wearables into their ongoing monitoring or care plan)
Scale: 1 = never; 2 = less than once per month; 3 = one to three times per month; 4 = once or twice per week; 5= several times per week.
Q8. Considering the overall impact, how much of an advantage do consumer wearables give to your ability to care for your patients?
Scale: 1 = definite disadvantage, 3 = no advantage or disadvantage, 5 = definite advantage.
Q13. How much influence does reimbursement have on your decision to review consumer wearable data?
Scale: 1 = no influence, 3 = moderate influence, 5 = essential for my review.
Q14. How much does regulatory clearance or approval from the following bodies influence your trust in a consumer wearable device's clinical accuracy? (composite of 4 items: US FDA Clearance/Approval, EU CE Mark (under MDR), Domestic/Local Regulatory Approval, Independent Third-Party Validation Studies)
Scale: 1 = no influence, 3 = moderate influence, 5 = essential for my review.

Trust, Skills, and Implementation Concerns Are Differentiating Factors for Integrated vs Nonintegrated Physicians

The factors that separate physicians who are integrating wearable data into their workflows from those who are not center around trust in the data, clinical skills in applying these data, and implementation concerns, with skills rising to the top. The chart on the left shows that physicians without integrated workflows have higher levels of concern, whereas the right shows where physicians with integrated workflows perceived greater feasibility.

> *"Ultimately it's always about liability when a physician makes a diagnosis using such a device, initiates therapy, and side effects arise."*
>
> **— Germany, Cardiologist**

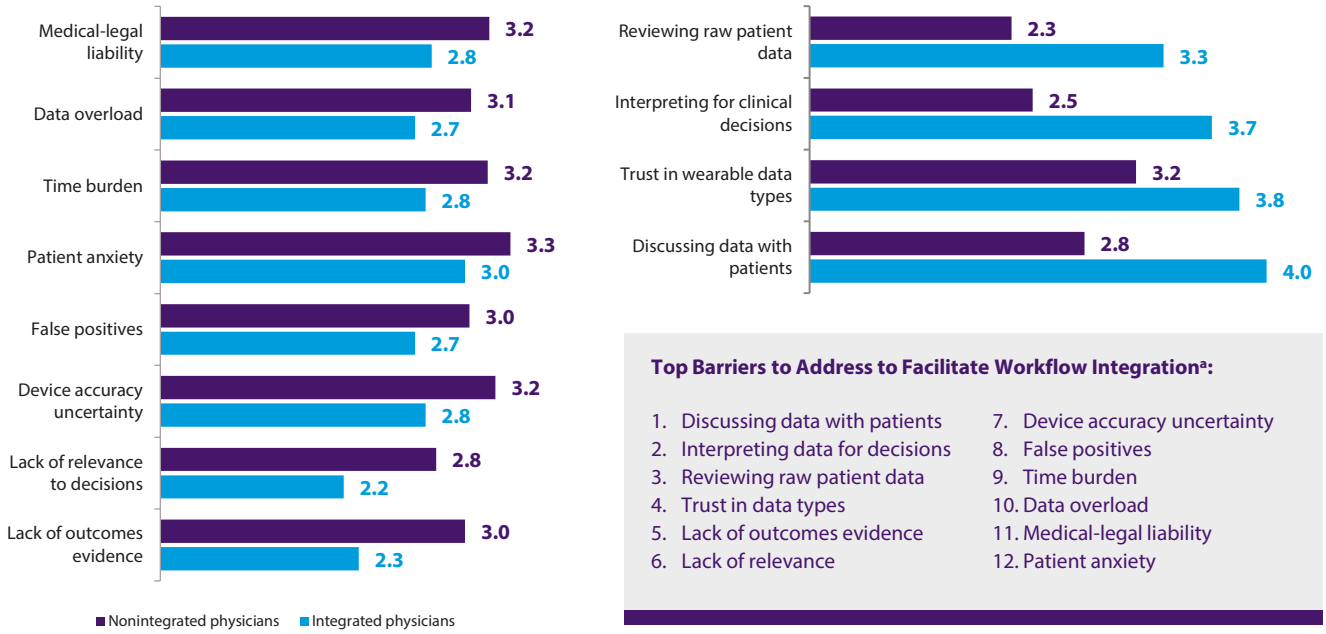


Figure 17. Barriers and Feasibility, by Workflow Integration Status (N = 2,222)
Q10. How concerned are you about the following clinical issues when using consumer device data? (six items: false positives, false negatives, patient anxiety, device accuracy, relevance, outcomes evidence)
Scale: 1 = not concerned, 3 = moderately concerned, 5 = extremely concerned.
Q11. How concerned are you about the following practice and workflow issues when using consumer device data? (4 items: data overload/time, medical-legal liability, equity/access, data upload to EHR)
Scale: 1 = not concerned, 3 = moderately concerned, 5 = extremely concerned.
Q9. How feasible is it for you to perform the following actions with consumer wearable data during a routine visit? (3 items: reviewing raw data, interpreting for decisions, discussing with patients)
Scale: 1 = not feasible at all, 3 = moderately feasible, 5 = completely feasible.
Q6. Compared with medical-grade testing, how accurate is consumer wearable data for each of the following? (presented with specialty-specific wearable data types)
Scale: 1 = not accurate, 3 = moderately accurate, 5 = nearly equivalent.
[a] Ranked by standardized difference between means for integrated vs nonintegrated physicians

RCTs and peer-reviewed clinical outcomes data are the most trusted sources of evidence: 60% of integrated physicians and 57% of nonintegrated physicians ranked them first. This convergence signals that the foundational evidence standard in medicine is universally valued. Investment in RCTs and development of society guidelines create the broadest possible impact, because these sources reach physicians at all points in the process of adopting wearables data into practice.

The one meaningful difference between the two groups is seen for algorithmic transparency. Not a single integrated physician ranked this as their first-choice evidence type compared with 4% of nonintegrated physicians. Integrated physicians have already resolved the question of whether they can trust the device—through use, specialty experience, or peer validation. Nonintegrated physicians, particularly those who are very close to integrating wearables data into their workflows, are still asking that question. Vendor-published validation data sets, testing protocols, and health system pilot data speak directly to this group and are largely within the vendor's control to produce.

RCTs and Peer-Reviewed Studies Dominate as the Top Evidence Source

Peer-reviewed evidence is the top source that increases physicians' confidence in the clinical utility of consumer wearable data.

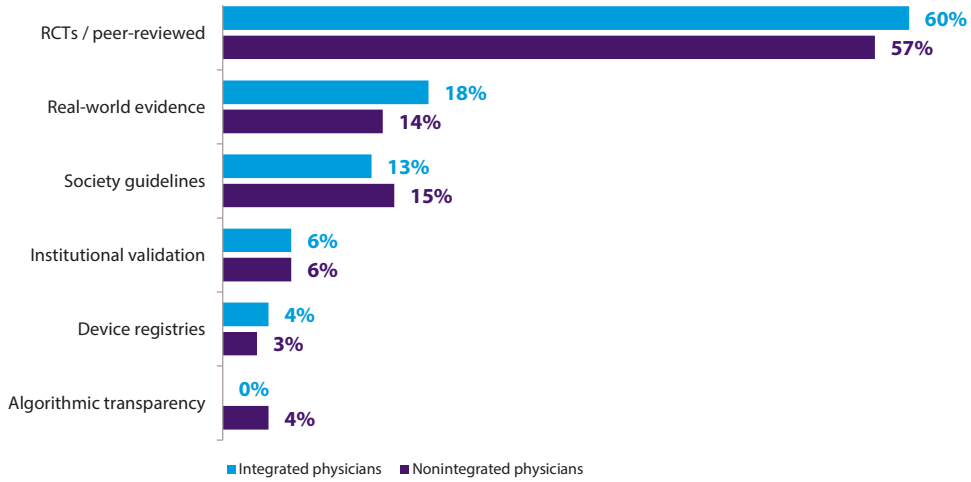


Figure 18. Top-Ranked Source of Information for Trust in Wearable Data for Clinical Use, by Physician Integration Status (N = 2,222)
Q16. How likely are you to incorporate wearable data into clinical workflows over the next 12 months?
Q15. Excluding regulatory clearance, please rank the top 3 types of evidence that would be most likely to increase your confidence in a consumer wearable's accuracy.

Reducing the barriers to integrating wearable data requires a concerted effort across multiple domains of behavior change. Nonintegrated physicians are not a uniform group, and the data make it clear that a single intervention strategy will not move all of them toward integration. Physicians with low near-term likelihood of integration are held back primarily by unresolved clinical concerns—lack of proven outcomes evidence and uncertainty about relevance and accuracy. For this group, evidence comes first: RCTs, outcomes data, and society guideline inclusion establish the credibility threshold that makes skill-building and workflow investment meaningful.

Physicians who are actively considering integration face a different obstacle. Their concern levels are lower, but their feasibility scores remain far below those of integrated physicians. They are not waiting for more evidence; they are waiting to feel confident that they could integrate wearable data during a routine visit. Workflow training, peer learning, and specialty-specific education showing how integration works in practice are the highest-leverage investments for this group.

For physicians closest to crossing over to integration, the data point to a specific lever: patient demand. Integrated physicians reported patient demand nearly a full point higher than nonintegrated peers (on a 5-point scale), and the final step into active integration is most consistently associated with patients actively asking for data review. Patient-facing communication, resources to enhance knowledge about wearables, and tools that make it easier for patients to share data with their physician are the most direct investments for closing that last gap. In addition, peer demonstration from integrated physicians in the same specialty may resolve the remaining confidence deficit faster than a formal education program can.

Across Countries, Specialty Still Matters

Some Specialties Are Further Along Than Others

Although the main message in this report is international variability in integration of data from wearables, specialty remains an important second lens. Cardiologists and endocrinologists review wearable data more often and in more clinically relevant categories than do other types of physician. Those specialties were also more likely to report that wearable data offer clinical value and were more likely to say the data were feasible to use during a routine visit. Primary care physicians (PCPs), neurologists, and pulmonologists also engage with wearable data, but they reported more limits in relevance, confidence, and practicality.

Specialty Affects Which Data Physicians Review

Cardiologists review heart-related data and events/alerts more often than other groups do. Endocrinologists are more concentrated around glucose and metabolic data, along with activity and heart physiology. By contrast, other specialties are less frequent reviewers of their top categories, suggesting that wearable data use is already stratified by clinical relevance rather than evenly distributed across the profession.

The Wearable Data Physicians Review Most Often Align With Their Clinical Focus

Most physicians are already reviewing some wearable data at least sometimes. Cardiologists, endocrinologists, and PCPs are among those with the highest data review frequencies.

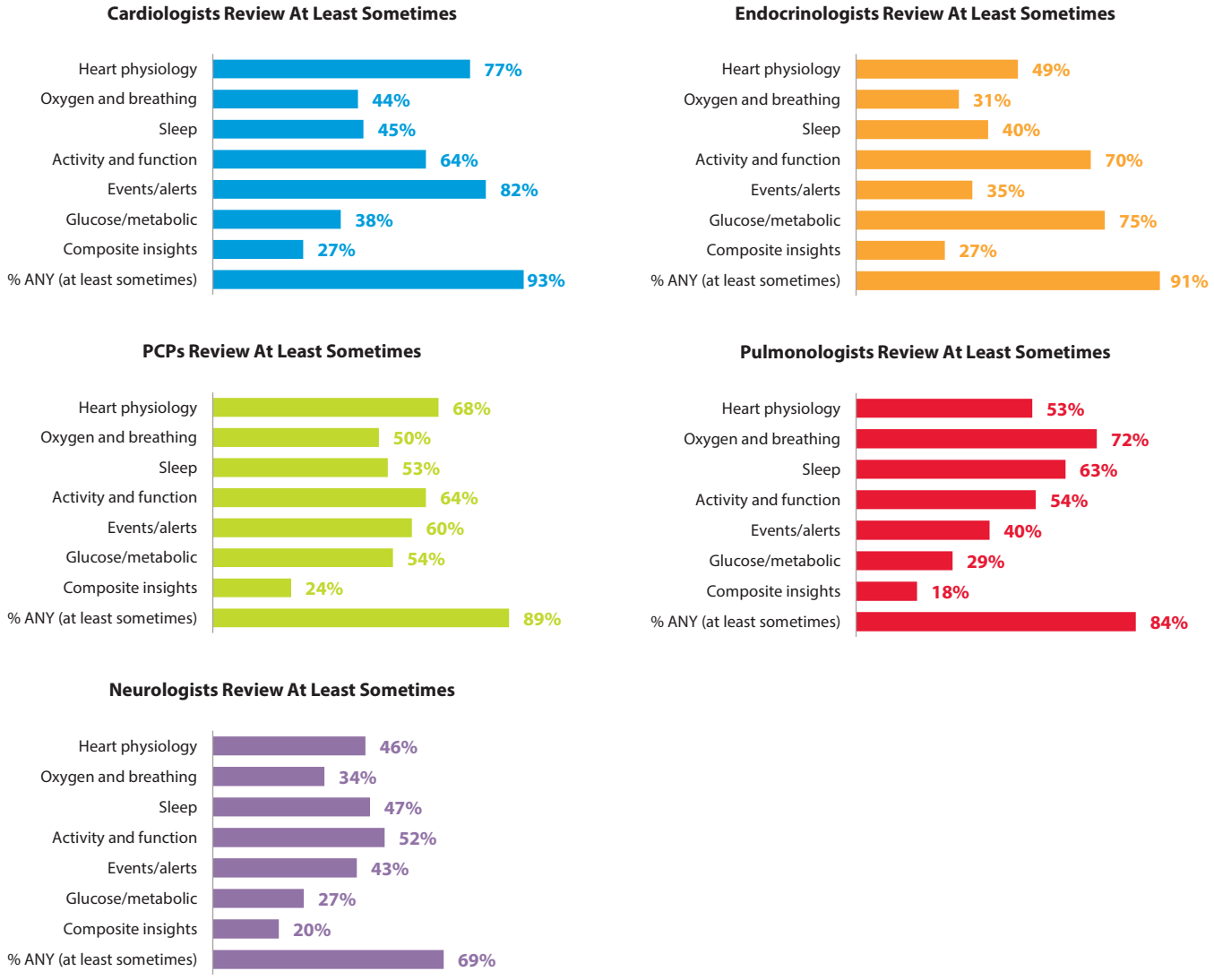


Figure 19. Wearable Data Categories Reviewed, by Specialty (N = 2,222)
Q5. How often do you evaluate or review the following patient wearable data types? "Sometimes/Often/Always" reported.

Specialty Is Associated With Integration and Use for Clinical Decisions

Cardiologists integrate wearable data into workflows and use it in weekly clinical actions more than other types of physicians. Additionally, cardiologists who are not already integrating wearable data are more likely than other groups to do so in the next 12 months. Neurologists, PCPs, and pulmonologists reported the lowest frequencies of workflow integration and data use, as well as likelihood of integration, suggesting that these groups face greater barriers to adopting wearable data into their practices.

Workflow Integration Aligns With Use of Data for Clinical Actions

Cardiologists and endocrinologists have the most workflow integration and use of data in clinical actions, as well as higher likelihood of integrating data if they are not already doing so.

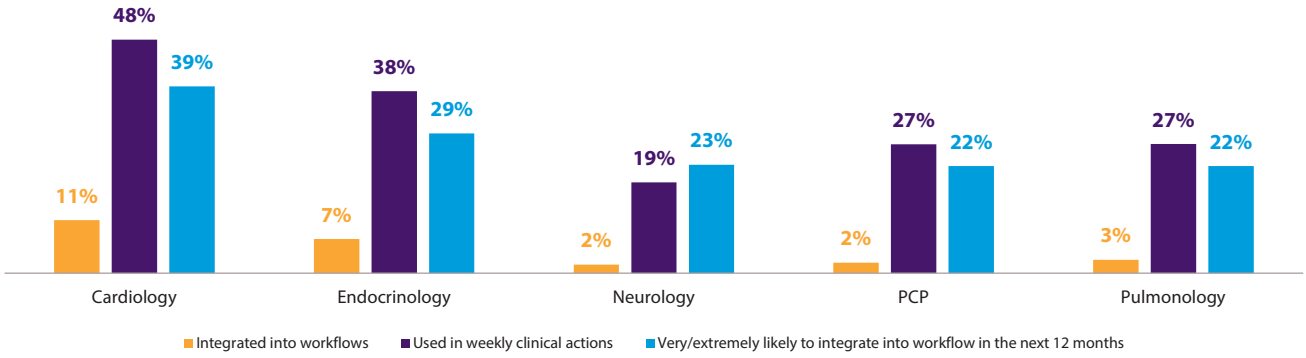


Figure 20. Wearable Data Use and Expectations of Use, by Specialty (N = 2,222)
Q16. How likely are you to incorporate wearable data into clinical workflows over the next 12 months?
Q4. In the past 3 months, how frequently has reviewing consumer wearable data led you to take the following specific clinical actions?

Specialty Also Affects Perceived Value

Specialty differences are not limited to integration and what kind and how much data physicians review. They also show up in whether physicians think wearable data are useful for patient care. Cardiologists and endocrinologists were most likely to report that wearables offer some or a definite clinical advantage. Neurologists, PCPs, and especially pulmonologists were less likely to say the same.

Physicians Across Specialties See the Clinical Advantages of Wearable Data for Providing Patient Care

The largest gaps between physicians' personal wearable use and perceived advantages for patient care are seen for neurologists and pulmonologists.

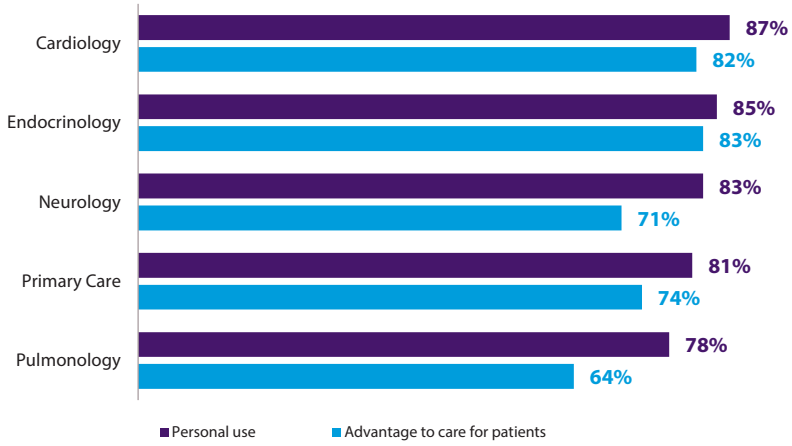


Figure 21. Physicians' Personal Wearable Use and Perceived Advantage for Patient Care, by Specialty (N = 2,222)
Q1. Do you personally use any of the following consumer wearable devices in your personal life?
Q8. Considering the overall impact, how much of an advantage do consumer wearables give to your ability to care for your patients?
"Some/Definite Advantage" reported.

Specialty Affects Whether Using Wearable Data Feels Practical

The same pattern appears when physicians were asked whether wearable data use is feasible during a routine visit. Cardiologists and endocrinologists were more likely to say it is feasible to review, interpret, and discuss raw data with patients. PCPs, neurologists, and pulmonologists were less likely to say the same. In practice, that means specialty type shapes whether use of wearable data feels manageable within clinical workflows.

Physicians Across Specialties Report Moderate Implementation Feasibility

Physicians are finding it moderately feasible to integrate data from wearables into routine visits. They reported that discussing data and their limitations with patients was more feasible than reviewing and interpreting data.

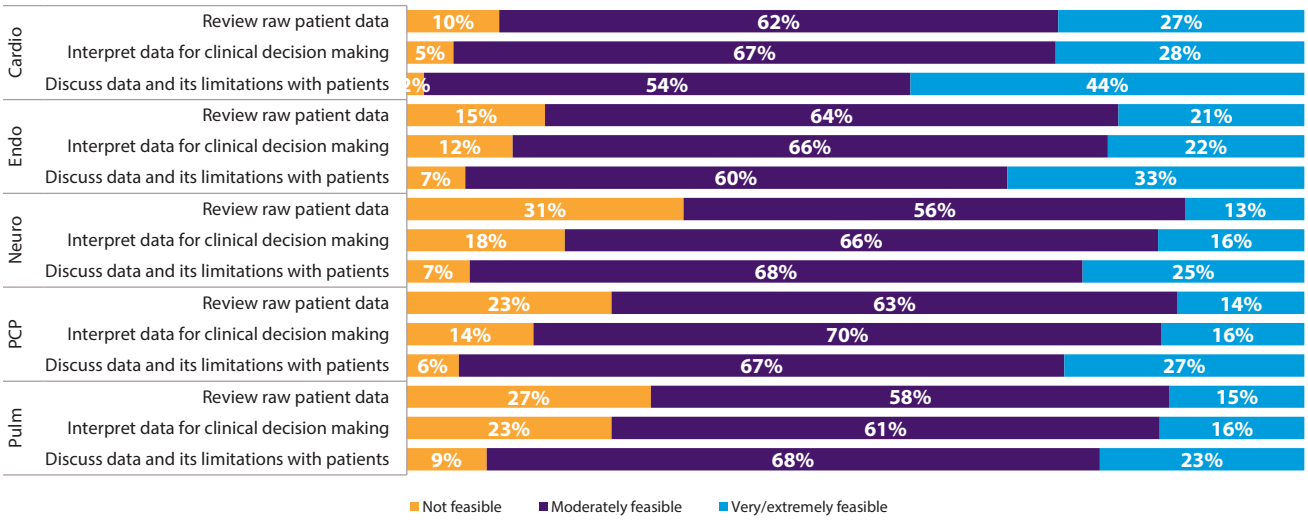


Figure 22. Feasibility of Implementation, by Action and Specialty (N = 2,222)
Q9. How feasible is it for you to perform the following actions with consumer wearable data during a routine visit?

Specialty Adds a Second Layer

The country comparison explains how systems differ, but the specialty comparison shows that physicians are not all starting from the same clinical position within those systems. Some specialties are already closer to routine use of wearable data because the data feel more relevant, usable, and feasible in day-to-day care. Other specialties are further behind not necessarily because they are uninterested in using such data but because fitting those into clinical practice and workflow is more challenging. This makes specialty an important second layer in the story: Country helps explain the external structural factors, while specialty helps explain which physicians are most ready to use wearable data within it.

When physicians find wearable data to be more relevant to their specialty, they also tend to show higher workflow integration and use in clinical practice.

Conclusion

The physicians who are most likely to integrate wearable data into clinical care are not uniformly convinced of its value. Closing the motivation-to-integration gap among physicians is the main challenge. The path forward requires a coordinated effort to build clinical credibility through evidence, develop interpretive capability through education and peer learning, reduce implementation friction through workflow and structural support, and activate patient demand.

In summary, there is a clear gap between the perceived clinical advantage of health data from wearable devices and the extent to which these data are being integrated into practice. Understanding the factors that account for this gap will help efforts to better integrate data from consumer wearables into clinical practice. What follows are recommendations for stakeholders capable of creating a path forward. Recommendations are framed globally, drawing on comparative data from six countries, with US-specific implications where appropriate.

Interpretive skill, trust in the data, better clinical evidence, patient requests, and systems that make acting on wearable data straightforward are the factors that can help close this gap.

For Physicians

- Prioritize review of wearable data from algorithms that carry published clinical validation. Consider vendor-originated and proprietary composite scores as low-confidence adjuncts until accuracy data are available.
- Advocate within your practice or health system for structured wearable data workflows that make data review feasible within routine visit time rather than absorbing it as uncompensated, unstructured effort.
- Proactively discuss false-positive and false-negative results with your patients. Set expectations about what types of alerts will prompt clinical action to mitigate patient anxiety and liability concerns.
- Prioritize clinical utilization of regulatory-cleared outputs over proprietary wellness composites when making or documenting clinical decisions.
- Establish a consistent in-practice approach to recording when and how wearable data inform clinical decisions. Medical-legal liability is the top-ranked workflow concern among US physicians in the survey, and rigorous documentation is the most immediately available risk management tool.

For Policymakers

- Develop or clarify billing code pathways for in-visit review of consumer wearable data, distinct from remote monitoring of prescribed devices, with illustrative examples drawn from common clinical scenarios.
- Consider regulatory frameworks that build trust and confidence in health data, including privacy and security protections and requirements to capture and represent data in standardized, consistent ways.
- Support clinicians with operationally useful guidance on patient-generated wearable alerts that clarifies practical risk-management considerations, such as documentation and response workflows, while making clear that such guidance should not serve as a basis for new enforcement, payment, and reporting or waste, fraud, and abuse requirements.
- Consider the German DiGA model and cardiology/endocrinology as evidence-based frameworks for condition-specific reimbursement pathways that bundle app/wearable data flow and interpretation; adapt these to structural realities, such as Spain's Sistema Nacional de Salud and other national health systems, or provincial systems in Canada.
- US specific: Issue guidance clarifying how existing Current Procedural Terminology (CPT) remote monitoring codes (eg, 99453, 99454, 99457) apply or do not apply to in-visit review of patient-owned consumer wearable data. The survey showed that US physicians participating in procedural payment systems review significantly more data types with greater frequency ($P < .001$).

For Innovators

Medical Device Innovators

- Publish specialty-stratified algorithm accuracy reports that compare each detection data type (atrial fibrillation, heart rate alerts, falls, sleep apnea, illness/strain) against named medical-grade standards; avoid relying on broad "wellness composite" branding in clinical communications, because physician trust in composite outputs is lowest.
- Prioritize two distinct evidence investments: rigorous peer-reviewed clinical outcomes data to address the skeptical majority and published validation data sets and real-world performance evidence to convert physicians already close to adoption. The latter group is the nearer-term opportunity, and the evidence they are asking for is largely within the vendor's control to produce.
- Prioritize development of postmarket surveillance programs to help ensure continued accuracy and performance.
- Provide transparent access to validation data sets and methods ("algorithmic transparency"), including clear statements of limitations, data privacy and security controls, and subpopulation performance, especially where false reassurance is a stated fear. Provide clear statements of intended use.
- Develop standardized, one-page clinician reports by domain—cardiac rhythm, sleep/obstructive sleep apnea screening, oxygenation, activity/gait—with consistent metrics and thresholds designed for EHR embedding across vendors and countries. Work with EHR developers to advance standards adoption.
- US specific: Clearly communicate cleared features prominently and distinctly from general wellness outputs to address the physician trust gap in the United States.

> *"Include clinicians in the development of such devices, and establish direct comparisons between the results these devices produce and those obtained with validated medical equipment."*
>
> **— France, Pulmonology**

Health Information Technology Innovators

- Implement and support Fast Healthcare Interoperability Resources (FHIR)-based standards for consumer wearable data to enable consistent ingestion and display across major EHR platforms.
- Replace "phone-based" review with auto-uploading verified data into the EHR in a structured format; design a trusted and reusable "wearable data check-in" component with previsit data availability, triaged alerts, note templates, and associated billing suggestions.
- Develop mitigation strategies by embedding bias checks into data standards (eg, clearly indicating where algorithms have been validated and where performance is uncertain), so that systems work for patients regardless of socioeconomic status and digital fluency.

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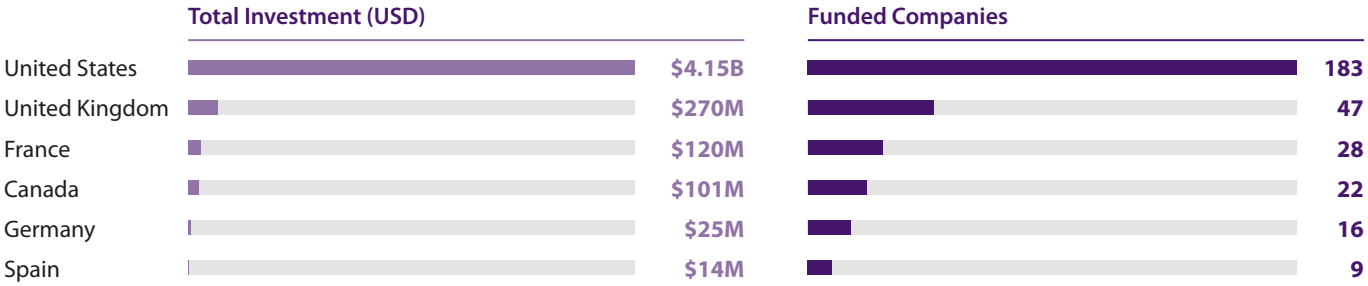
Appendix A: Market Environment for Wearables

Investment Activity by Country

Private company investment patterns show a clear specialty-driven concentration that varies by country. Cardiology and metabolic health lead consistently, but for different structural reasons. The United States leads in investment funding across nearly all specialties, particularly in cardiac monitoring and metabolic/glucose sensing, reflecting strong commercialization pathways, established remote patient monitoring reimbursement, and a startup ecosystem optimized for scaling single-condition solutions into platforms.

In contrast, European markets (especially Germany and France) show relatively more balanced or targeted investment across specialties, with capital flowing toward solutions that could integrate into formal pathways (eg, digital therapeutics tied to chronic disease management) rather than pure consumer-driven categories. Canada and the United Kingdom exhibit lower overall investment volumes but a selective emphasis on remote monitoring and primary care–adjacent specialties, aligning with publicly funded system priorities and pilot-based adoption. Notably, across all countries, multiparameter and cross-specialty platforms are garnering investor attention, indicating a shift away from siloed use cases (eg, sleep-only or activity-only) toward integrated solutions that could serve cardiology, endocrinology, and general medicine simultaneously.

Wearable Venture Capital Investment and Funded Company Count, by Country: 2020-2025



Source: CB Insights. 244 companies mapped across 6 survey countries. Values represent total disclosed funding (USD M), 2020–2025.
European investment may be understated due to lower funding disclosure rates. Company counts reflect unique funded entities with at least one disclosed round.

Appendix B: Survey Respondent Profile

Respondents represent a broad range of specialties, practice settings, and career stages. Approximately 60% practice primary care (family medicine, internal medicine, or general practice); the remaining 40% comprise mixed-specialty physicians, including cardiology, endocrinology, neurology, and pulmonology. Across all countries, 83% of respondents devote the majority of their clinical time to direct patient care.

Figure B1. Respondent Characteristics

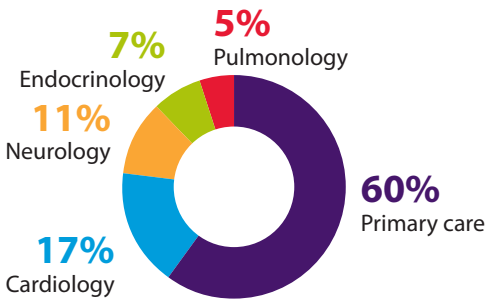
2,222
Total physician respondents

6
Countries surveyed

62%
Practiced 11+ years

83%
Majority time in direct patient care

Specialty Distribution



Country Distribution

Country	n
United States	720
Canada	300
United Kingdom	300
France	301
Germany	300
Spain	301

Appendix C: Methodology

Study Design and Objectives

The 2026 International Physician Survey on Consumer Wearables was conducted to assess physicians' adoption, awareness, perceptions, and anticipated impact of consumer wearable devices across clinical, administrative, and patient-facing domains in six countries. The study examined how physicians interacted with wearable technology in patient encounters, structural barriers to integration, trust in device data, reimbursement utilization, and readiness for systematic integration.

Sample and Fielding

A total of 2,222 physicians participated in a web-based survey from January 15 to March 5, 2026. Respondents represented a broad range of specialties, geographic regions, career stages, and practice settings in the United States (n = 720), Canada (n = 300), United Kingdom (n = 300), France (n = 301), Germany (n = 300), and Spain (n = 301). Approximately 60% practice primary care, and 40% practiced mixed specialties, including cardiology, endocrinology, neurology, and pulmonology.

Survey Instrument

The survey instrument included multiple domains: personal wearable use patterns, frequency of patient-initiated wearable data interactions, clinical feasibility assessments, algorithmic trust ratings, workflow and clinical concerns, regulatory body influence, evidence preferences, reimbursement utilization, and 12-month adoption likelihood. Country-specific billing pathway questions were included (CPT Codes for the United States, DiGA for Germany, Prise en Charge Anticipée Numérique [PECAN]/Liste des Activités de Télésurveillance Médicale [LATM] for France, and provincial codes for Canada). Localized languages were used for surveys in France, Germany, and Spain.

Statistical Analysis Strategy

Data were drawn from the 2026 International Physician Survey on Consumer Wearables (Medscape International; N = 2,222 physicians across six countries). Likert or ordinal scales (1–5) were recoded and treated as continuous for mean and correlation comparisons prior to analysis. Stage of change was assigned to each respondent using a prespecified rule applied to the survey question on 12-month adoption likelihood, in which action = currently incorporating, preparation = very/extremely likely, contemplation = moderately/somewhat, and precontemplation = not at all likely. Application of this rule yielded four mutually exclusive groups: action (n = 85), preparation (n = 557), contemplation (n = 1,257), and precontemplation (n = 323).

Pearson correlations were computed between continuous predictor variables to characterize the linear association between items on the same Likert-type or ordinal scale.

A 95% confidence level was applied to examine the effect size difference between cohorts (eg, country, specialty, etc). Instances where the effect size was significantly different are noted throughout.

Data Interpretation Notes

Survey findings were based on physician responses at the time of survey participation. Country-specific reimbursement questions were only asked to physicians in the relevant country. Percentages were calculated using respondents who answered each question; due to rounding, totals may not equal 100%.

Data Sources

Medscape International Wearables Survey (N = 2,222) fielded January 15 to March 5, 2026.

CB Insights for total funding, company counts, and investment by clinical specialty.

Regulatory comparisons sourced from FDA, European Medicines Agency/MDR, MHRA, Health Canada, and national agencies (eg, Agence Nationale de Sécurité du Médicament et des Produits de Santé, Bundesinstitut für Arzneimittel und Medizinprodukte).

Reimbursement pathways sourced from US Center for Medicare and Medicaid Services CPT codes, Germany DiGA, France Prise en Charge Anticipée Numérique (PECAN)/Liste des Activités de Télésurveillance Médicale (LATM), Canada provincial systems (Ontario Health Insurance Plan, Medical Services Plan of British Columbia, Régie de L'assurance Maladie du Québec), and UK NHS/National Institute for Health and Clinical Excellence.

Consumer adoption rates sourced from Rock Health (United States), UK Government Participation Survey, Mintel (Canada Future of Health Tech), Bitkom (Germany), Kantar/Statista (France), and Eurostat (Spain).

Brand rankings and estimated market share ranges from analysis of IDC, Counterpoint Research, Statista Global Consumer Survey, and company market reports (Apple, Samsung, Google/Fitbit, and Garmin).

Appendix D: Respondent Demographics

Table D1: Specialty by Country

	Canada	France	Germany	Spain	United Kingdom	United States
Total Respondents	**300**	**301**	**300**	**301**	**300**	**720**
Cardiology	7%	21%	27%	9%	11%	12%
Endocrinology	6%	9%	5%	10%	9%	7%
Neurology	5%	8%	19%	12%	5%	11%
Primary care	75%	50%	43%	60%	67%	63%
Pulmonology	7%	12%	6%	8%	8%	8%

Q: Which of the following best describes your primary area of clinical practice?

Table D2: Age by Country

	Canada	France	Germany	Spain	United Kingdom	United States
Total Respondents	**300**	**301**	**300**	**301**	**300**	**720**
18-34	13%	15%	3%	23%	10%	14%
35-44	36%	30%	32%	24%	45%	31%
45-54	23%	22%	29%	29%	31%	22%
55-64	20%	23%	28%	18%	12%	21%
65+	8%	10%	9%	7%	2%	13%

Q: What is your age?

Table D3: Gender by Country

	Canada	France	Germany	Spain	United Kingdom	United States
Total Respondents	**300**	**301**	**300**	**301**	**300**	**720**
Female	39%	36%	29%	40%	40%	37%
Male	59%	64%	71%	60%	58%	61%
Non-binary/third gender	0%	0%	0%	0%	0%	0%
Prefer not to say	2%	0%	0%	0%	2%	2%

Q: What is your gender identity?

Table D4: Years in Practice by Country

	Canada	France	Germany	Spain	United Kingdom	United States
Total Respondents	**300**	**301**	**300**	**301**	**300**	**720**
1-5 years	8%	4%	1%	5%	3%	14%
6-10 years	29%	22%	13%	23%	25%	22%
11-20 years	26%	35%	43%	34%	49%	26%
More than 20 years	36%	39%	43%	39%	23%	39%

Q: How many years have you been in active clinical practice including residency/fellowship programs?

Table D5: Percentage of Time in Direct Patient Care by Country

	Canada	France	Germany	Spain	United Kingdom	United States
Total Respondents	**300**	**301**	**300**	**301**	**300**	**720**
Less than 20%	0%	0%	0%	0%	0%	0%
20-50%	0%	0%	2%	1%	1%	2%
51-80%	15%	9%	18%	16%	25%	14%
Greater than 80%	85%	91%	81%	84%	74%	84%

Q: Which of the following best describes your primary practice setting?

Table D6: Practice Setting (Canada)

Total Respondents	**300**
Academic Health Science Centre / University Hospital	16%
Community Hospital	8%
Family Health Team (FHT) / Community Health Centre (CHC)	16%
Private Practice / Community-Based Office	58%
Walk-in Clinic / Urgent Care Centre	2%

Q: Which of the following best describes your primary practice setting?

Table D7: Practice Setting (France)

Total Respondents	**301**
Academic/University Hospital	17%
Private For-Profit Hospital	5%
Private Not-For-Profit Hospital	4%
Private Practice	52%
Public Non-Academic Hospital	22%
Other	0%

Q: Which of the following best describes your primary practice setting?

Table D8: Practice Setting (Germany)

Total Respondents	**300**
Medical Care Center (MVZ)	13%
Non-Academic Hospital	16%
Private Practice	50%
University Hospital	20%
Other	1%

Q: Which of the following best describes your primary practice setting?

Table D9: Practice Setting (Spain)

Total Respondents	**300**
Private For-Profit Hospital/Clinic	2%
Private Practice / Independent Office	5%
Public Primary Care Health Center	40%
Public Specialist / Hospital Care	12%
University Hospital	41%
Other	0%

Q: Which of the following best describes your primary practice setting?

Table D10: Practice Setting (UK)

Total Respondents	**300**
Mixed Practice (NHS and Private)	4%
NHS General Practice / Primary Care	61%
NHS Hospital (District General or Acute Trust)	14%
Teaching Hospital / Academic Health Science Centre	21%
Wholly Private Practice	0%
Other	0%

Q: Which of the following best describes your primary practice setting?

Table D11: Practice Setting (US)

Total Respondents	**720**
Academic / University Hospital	28%
Community Hospital / Health System	27%
Government / Public Clinic (e.g., VA, FQHC)	4%
Private Practice (Solo or Group)	39%
Urgent Care / Walk-in	1%
Other	1%

Q: Which of the following best describes your primary practice setting?

Table D12: Age by Specialty

	Cardiology	Endocrinology	Neurology	Primary Care	Pulmonology
Total Respondents	**310**	**169**	**227**	**1,336**	**180**
18-34	7%	9%	14%	15%	11%
35-44	33%	31%	34%	32%	33%
45-54	28%	28%	32%	23%	26%
55-64	24%	24%	16%	20%	21%
65+	7%	8%	4%	10%	9%

Q: What is your age?

Table D13: Gender by Specialty

	Cardiology	Endocrinology	Neurology	Primary Care	Pulmonology
Total Respondents	**310**	**169**	**227**	**1,336**	**180**
Female	20%	47%	34%	40%	33%
Male	80%	52%	64%	58%	67%
Non-binary/third gender	0%	1%	0%	0%	0%
Prefer not to say	1%	0%	2%	2%	1%

Q: What is your gender identity?

Table D14: Years in Practice by Specialty

	Cardiology	Endocrinology	Neurology	Primary Care	Pulmonology
Total Respondents	**310**	**169**	**227**	**1,336**	**180**
1-5 years	3%	5%	8%	9%	7%
6-10 years	20%	23%	24%	23%	17%
11-20 years	43%	32%	38%	30%	39%
More than 20 years	35%	40%	30%	38%	37%

Q: How many years have you been in active clinical practice including residency/fellowship programs?

Table D15: Percentage of Time in Direct Patient Care by Specialty

	Cardiology	Endocrinology	Neurology	Primary Care	Pulmonology
Total Respondents	**310**	**169**	**227**	**1,336**	**180**
Less than 20%	0%	0%	0%	0%	0%
20-50%	1%	1%	1%	1%	1%
51-80%	13%	21%	21%	15%	19%
Greater than 80%	86%	79%	78%	84%	81%

Q: What percentage of your professional time is spent in direct patient care?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