REPORT OF THE INTEGRATED PHYSICIAN PRACTICE SECTION
GOVERNING COUNCIL

<div align="right">IPPS GC Report B
(A-24)</div>

Subject: Responding to AMA Board of Trustees Report—Principles for Augmented
              Intelligence Development, Deployment, and Use

Presented by: Adnan Munkarah, MD, Chair

Referred to: IPPS General Assembly

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1   INTRODUCTION
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3   On November 14, The AMA Board of Trustees approved and published online a white paper,
4   "Principles for Augmented Intelligence Development, Deployment, and Use." The Board cited a
5   lagging effort toward the adoption of national governance policies and oversight of the use of
6   augmented intelligence (AI), thus necessitating that the physician community "engage in
7   development of policies to help inform physician and patient education, and guide engagement
8   with these new technologies."
9
10 The white paper sought to outline new principles for AI based on the AMA's foundational AI
11 policy, Augmented Intelligence in Medicine from 2018 and its subsequent 2019 policy for payment
12 and coverage of AI. The paper acknowledged the rapidly changing development of AI tools and
13 uses requires more foundational principles for AI use in the clinical practice setting. The paper
14 outlined proposed guidance under eight dimensions:
15   • Oversight of Health Care Augmented Intelligence
16   • When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and
17   Technologies
18   • What to Disclose: Required Disclosures by Health Care Augmented Intelligence-Enabled
19   Systems and Technologies
20   • Generative Augmented Intelligence
21   • Physician Liability for Use of Augmented Intelligence-Enabled Technologies
22   • Data Privacy and Augmented Intelligence
23   • Augmented Intelligence Cybersecurity
24   • Payor Use of Augmented Intelligence and Automated Decision-Making Systems
25
26 The Integrated Physician Practice Section (IPPS) convened an ad hoc workgroup[1] for the purpose
27 of developing perspectives on AI that the IPPS can use to guide its future policymaking and
28 education. The workgroup considered the Board of Trustees white paper, which is scheduled to be
29 presented to the House of Delegates as Board of Trustees Report 15 at the 2024 Annual Meeting.

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[1] The ad hoc workgroup consisted of 17 physician executives from IPPS member organizations with
expertise in AI and some with direct oversight of their organization's use of AI.

1   This report makes recommendations for further action on that report based on the workgroup's
2   findings, pending the approval of the IPPS General Assembly.
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4   DISCUSSION
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6   In reviewing the white paper, the IPPS ad hoc workgroup struggled to parse some
7   recommendations because the paper did not clearly articulate a framework for "augmented
8   intelligence." One member of the workgroup noted the AMA's Digital Medicine Payment
9   Advisory Group's recognition of three different types of AI—Assistive AI, that is tools that aid in
10 tasks like patient scheduling (e.g., chatbots); Augmentative AI. That is tools that enhance decision-
11 making (e.g., diagnostic aids); and Autonomous AI, systems capable of independent clinical
12 operations. Outlining a framework for how the AMA understands AI to be an additive player rather
13 than a substitution could help to provide needed context for later principles, particularly when
14 considering the conditions under which disclosure about the use of AI should be done.
15
16 The workgroup suggested a future iteration of the paper consider addressing distinctions between
17 so-called "narrow" and "broad" forms of AI, particularly given that the principles outlined
18 acknowledge that healthcare AI "requires a risk-based approach where the level of scrutiny,
19 validation, and oversight should be proportionate to the potential overall of disparate harm and
20 consequences the AI system might introduce." The workgroup felt the guidance could be improved
21 by acknowledging the administrative and technical burden imposed by such oversight and that
22 those burdens should be weighed against the risks to be controlled and the goals to be achieved.
23 One ad hoc workgroup member noted, "oversight should also be proportional to the variability of
24 its use. If a simple 'if-then' type of EMR alert could meet the strict definition of AI as a machine
25 doing something a human needed to before, it should be noted that the use is more standardized
26 and little organizational effort should be expended to monitor it."
27
28 In a similar vein, workgroup members also believed that the white paper's sections on disclosure
29 seemed quite wide and wondered if a more specific approach to disclosure should be adopted. The
30 group operated under the assumption that AI is likely to become more pervasive and more
31 universal, necessitating the need for careful consideration about conditions for disclosure. Members
32 pointed out that physicians are not in the practice of documenting every tool, be it a physical one or
33 a piece of technology, used for every procedure every time. If an AI algorithm is understood to be
34 the same as any other treatment tool while at the same time it becomes more and more common, it
35 could make disclosure of each incidence of use potentially overwhelming. The group considered
36 that including guidance focused on risk-based or impact-based disclosures could improve the
37 existing guidance, even if such an approach could potentially be more burdensome for health
38 systems than current practice.
39
40 The workgroup came to believe that a potentially fruitful framework for both when and what to
41 disclose could be to adopt a different procedure and level of disclosure for AI use in clinical
42 encounters compared to AI use for procedural or operational efficiencies. Promoting a higher
43 standard of oversight, review, and disclosure for AI services in clinical procedures or decision-
44 making could help to not only inform patients of information they require, but also limit the
45 operational burden on physicians and health systems.
46
47 The group considered a system whereby more detailed disclosures, including detailing exact
48 conditions under which AI tools are used during a clinical encounter, are supplied as needed could
49 contrast with a more blanket disclosure about AI use in operational tasks, such as scheduling or
50 record retrieval. Procedural disclosures could, under such a system, more closely resemble current
51 disclosures around privacy and informed consent. Such a delineation could also allow the AMA to

1 have greater influence in how these controls are ultimately enacted. As one member observed, the
2 AMA should "advocate for an industry-wide strength of recommendation taxonomy about AI that
3 can more clearly convey the levels of evidence reviewed when responding to clinical queries"
4 effectively allowing the AMA to take the lead in crafting health AI taxonomies.
5
6 The group also noted that at times, some guidance offered in the paper seemed to work in
7 opposition to itself. Under the section "When to Disclose: Transparency in Use of Augmented
8 Intelligence-Enabled Systems and Technologies, the paper states, "transparency requirements
9 should be tailored in a way to best suites the needs of the end users," however the paper then goes
10 on to recommend that AI be meticulously documented and disclosed at every step of treatment.
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12 The workgroup considered that adopting a balanced approach to transparency of disclosure at a
13 general level ensures both clinicians and patients are aware of the use of AI tools and the risks of
14 those tools is appropriate. Removing the requirement of disclosure with every intervention or use
15 would be helpful for avoiding inadvertently hampering the adoption of beneficial applications of
16 AI. Given the ubiquity of algorithms and AI already in practice, it is difficult to envision how a
17 physician or a practice would opt out of AI. Thus, a policy of ensuring that escalation or concerns
18 about algorithm performance or bias would be addressed would go a long way to assuring that AI
19 is judiciously and effectively applied to care delivery.
20
21 The group considered that the guidance could be improved by acknowledging that a balance exists
22 between the trust that patients place in their physician's expertise and physicians' judgment about
23 what to disclose to help patients make informed, contextualized choices. For example, when
24 ordering needing lab tests for clinical action the physician knows which tests to order to obtain the
25 desired information about a patient's health. The physician is likely to disclose to the patient which
26 tests should be ordered and why having such information will be beneficial, but unlikely to explain
27 why *that* test exactly should be used because of its sensitivity or specificity relative to the
28 likelihood of obtaining the right information. Such metrics exist for the benefit of clinical decision-
29 making, not necessarily for the edification of the patient, who presumably trusts the physician to
30 make the correct decision on their behalf based on the physician's expertise. If augmented
31 intelligence tools can be seen as additive components in a similar manner to how lab tests are, then
32 having some distinctions for disclosures in the final guidance could make sense.
33
34 It is not lost on the workgroup how important getting the details right in this guidance is. One
35 workgroup member noted that legislation in California, specifically AB 3030, would require any
36 communication to patients to have warning labels that AI was used it its construction even if
37 physicians review and sign off on such communications. The member noted that the author of the
38 bill reported drawing on AMA-published principles to support the legislation. "These discussions
39 are no longer theoretical," the workgroup member noted. "[T]here is some urgency to [AMA] input
40 and action."
41
42 CONCLUSION
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44 After consideration, the IPPS ad hoc workgroup generally finds the content and guidance in the
45 white paper to be reasoned and substantive, however the workgroup does believe that more
46 specificity is warranted at this stage of principle development. In particular, the workgroup would
47 recommend the final report provide a framework for understanding the types of AI that are likely to
48 be found in medical practices and how those differing examples relate to best practices around
49 disclosure. In particular, the workgroup would like to see greater consideration given to
50 distinguishing between disclosure about AI for clinical decision-making versus disclosure for

1 procedural or operational efficiency, including guidance about the appropriateness of full or partial
2 disclosure under each setting.
3
4 RECOMMENDATION
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6 The IPPS Governing Council recommends that the following be adopted in response to Board of
7 Trustees Report 15:
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9   1. That the Integrated Physician Practice Section Delegate and Alternate Delegate seek to
10   refer Board of Trustees Report 15 during consideration at the Annual 2024 Meeting.
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12 2. Alternately, if referral of the entirety of Board of Trustees Report 15 is not an option, that
13   the Integrated Physician Practice Section Delegate and Alternate Delegate seek to refer
14   only the sections of the report titled "Oversight of Health Care Augmented Intelligence",
15   "When to Disclose: Transparency in Use of Augmented Intelligence-Enabled Systems and
16   Technologies", and "What to Disclose: Required Disclosures by Health Care Augmented
17   Intelligence-Enabled Systems and Technologies" with the remainder of the report filed.
18
19 3. That the Integrated Physician Practice Section Delegate and Alternate Delegate seek
20   amendment to Board of Trustees Report 15, in whatever means or manner they deem
21   appropriate, either at Annual 2024 or beyond, in the following ways:
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23   a. Considering a more thorough review of the different forms of AI (generative,
24   ambient, autonomous, etc.) with particular attention given to how those
25   distinctions may change the risk-based approach to oversight of the AI tools and
26   their potential effect on patients.
27   b. Amending the "When to Disclose" section so that risk-based or impact-based
28   decisions incorporating AI are the guiding light for disclosures, rather than broader
29   blanket disclosure.
30   c. Adopting the perspective that algorithms and other AI components should be
31   disclosed when use is clinically significant.
32   d. Distinguishing between requirements for disclosure of the use of AI for clinical
33   decision making and use for non-clinical procedural efficiency and potentially
34   adopting recommendations for blanket disclosures in the style of current privacy
35   disclosures in the non-clinical situations.
36   e. Advocating that there is disclosure by payors to physicians and other clinicians
37   regarding the use of AI for administrative functions such as prior authorization.
38   f. Considering that recommendations under what to disclosure could be updated to be
39   more focused on guidance for the physician as a purchaser of AI tools first and
40   foremost with additional guidance accounting for the needs of patients to be
41   meaningfully informed about their care.