AMA | Center for Digital Health & AI

fsmb FEDERATION OF STATE MEDICAL BOARDS

AI and the Practice of Medicine:

Examining accountability and responsibility in the AI era



Executive Summary

Artificial intelligence (AI) is rapidly changing how medicine is practiced, how care is delivered, and how patients engage with the health care system. As capabilities advance and adoption expands, AI challenges traditional frameworks for professional responsibility, accountability, oversight, and more.

On September 14, 2026, the American Medical Association (AMA) and the Federation of State Medical Boards (FSMB) convened experts and stakeholders in Washington, D.C. to explore these implications, with a focus on autonomous and semiautonomous AI tools. Discussions grappled with evolving clinical responsibilities, the role of state medical boards, regulatory approaches, and the patient-physicians relationship.

Five key learnings emerged:

1. AI is already changing how medicine is practiced, but views differ on how quickly and to what extent it will transform clinical practice.
2. As evidence emerges demonstrating that autonomous AI can effectively perform select clinical functions, the line between supporting and practicing medicine becomes critical for regulation and oversight.
3. AI will redefine the physician's role and transform how health care teams are organized and trained.
4. Existing regulatory, licensure, and liability frameworks were not designed for AI and need to be modernized.
5. Patients are adopting AI faster than the health system is adapting.

The convening also identified future work related to AI and the practice of medicine:

- **Establish best practices for appropriate use of AI in clinical care:** Establish the conditions under which AI can perform autonomously, what evidence should be required for adoption in clinical settings, and how organizations should safely deploy and monitor performance.
- **Clarify the boundary between clinical technology and the practice of medicine:** Define when AI functions as a clinical tool and when it constitutes the practice of medicine.
- **Modernize oversight, accountability, and liability frameworks:**[1] Establish how responsibility for AI-related patient harm should be assigned and clarify the roles of state medical boards, federal regulators, AI developers, physicians, and other health care stakeholders.
- **Prepare the physician and care team workforce:** Adapt formal education, clinical training, continuing professional development, and team-based care models to support responsible AI use.
- **Preserve patient-centered care and trust:** Develop best practices for integrating AI into care delivery in ways that are safe, transparent, and equitable, while strengthening the patient-physician relationship and upholding medical ethics.

The AMA and FSMB are committed to taking a leading role in shaping this uncertain future. Through its Center for Digital Health and AI, the AMA is advancing AI governance, economic sustainability, and care transformation to ensure physicians shape how AI is developed and used in medicine. The FSMB's Workgroup on the Regulation of Artificial Intelligence in the Practice of Medicine is supporting state medical boards in developing a consistent, patient-centered approach to AI oversight. The learnings from this convening will help guide future efforts and areas of focus.

1 The AMA released an Issue Brief on Liability for Clinical AI following the September 14, 2026 AMA and FSMB convening.

About the AMA and FSMB Convening

On September 14, 2026, the AMA and the FSMB convened experts in Washington, D.C. to discuss accountability and responsibility for the practice of medicine in the AI era. Participants included representatives of state medical boards, physicians, specialty societies, patients and patient advocates, health systems, technology developers, regulators, policymakers, legal experts, and academics. Together, they examined a central question: **When AI increasingly performs functions historically reserved to a licensed physician, how should physician responsibility and state medical board oversight evolve?**

Opening speakers described different visions for the future of medicine, from one in which physicians remain central to patient care to one in which autonomous AI increasingly takes on clinical tasks performed by physicians today. AMA's CEO and Executive Vice President, Dr. John Whyte, framed this tension as the difference between automating medical tasks and automating the practice of medicine itself, asserting that human judgment, empathy, trust, and the patient-physician relationship must remain central to patient care. Alternatively, the University of Pennsylvania's Vice Provost for Global Initiatives, Dr. Ezekiel Emanuel, stated that autonomous AI is rapidly approaching and may soon exceed human performance on many cognitive tasks, potentially even on perceived empathy and earning patients' confidence. FSMB's President and CEO, Dr. Humayun Chaudhry, and Chair of the Board, Dr. Christy Valentine Theard, emphasized that as the physician role evolves, there are implications for accountability, oversight, patient safety, and trust to grapple with in order to maintain medical boards' critical role in protecting patients.

The convening[2] featured a series of panel discussions and interactive workshops that explored:

- **The future of the practice of medicine,** including what AI can do today, where the technology is headed, and how physician roles may evolve.
- **Policy, regulation, and accountability in an AI-enabled health care system**, including physician responsibility, oversight, licensure, liability, and the role of state medical boards.
- **Patient trust, safety, and the evolving physician-patient relationship**, with a focus on keeping future AI governance frameworks patient-centered.
- **The boundaries of the practice of medicine**, through an interactive exercise that challenged attendees to consider whether various AI use cases function as tools that support physicians or as the practice of medicine, and how this distinction should inform oversight.
- **Accountability for AI-related patient harm**, through a case-based workshop that explored how responsibility should be distributed and state medical boards should evolve.

Throughout these discussions, participants returned to the central questions of physician responsibility, accountability, and oversight, as they considered various scenarios for the future of medicine. This document synthesizes the perspectives shared during the convening and identifies priorities for the AMA and FSMB as they consider how the physician role will evolve with autonomous AI.

> **Together, the AMA and FSMB represent two essential parts of the framework that patients depend upon: the practice of medicine and the public accountability that must accompany it.**
>
> **Humayun Chaudhry, DO, MS, MACP,** President and CEO, FSMB

2 The convening was conducted under Chatham House Rule to encourage candid discussion. Any attributed quotes included in this document are from speakers or panelists who provided explicit permission for attribution.

Key Learnings

1 AI is already changing how medicine is practiced, but views differ on how quickly and to what extent it will transform clinical practice.

Physician adoption of AI has accelerated rapidly, with AMA survey data showing professional AI use increasing from 38% in 2023 to 81% in 2026.

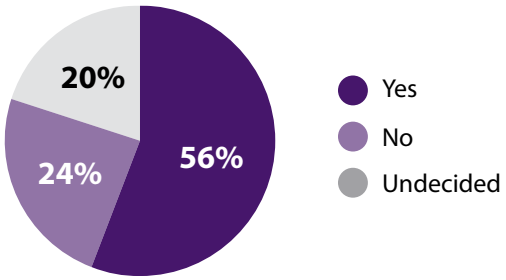
Most current uses of AI augment, rather than replace, physician work. Physicians most commonly use AI to summarize medical research and standards of care, generate clinical documentation and chart summaries, and draft patient communications. More autonomous applications are beginning to emerge, such as discrete diagnostic screenings and prescription renewals. As these technologies advance, they raise questions about how care delivery, physician responsibilities, the patient-physician relationship, and the practice of medicine may evolve. AI also raises questions about how to preserve patient trust and uphold the code of medical ethics.

Participants broadly agreed that AI will change health care, but they differed on the pace and extent of that transformation, with debate centering around five questions:

- **What physician work is AI ready to take on?** Some participants suggested that AI already matches or exceeds physicians on certain cognitive tasks and may ultimately outperform physicians working in certain hybrid AI-human models. From this perspective, the health care system should begin preparing for a near-term future in which AI assumes responsibility for an expanding set of functions traditionally conducted by physicians.
- **Does the evidence base today support broad AI adoption and for which tasks?** While some speakers highlighted promising early evidence, others pointed to material gaps in today's real-world evidence. Most studies today measure older models' performance in controlled or simulated settings, with limited data on implementation, effectiveness, and safety in the complexity of real-world clinical care. Many argued that more evidence from real-world studies is needed to evaluate whether, and how, AI can reliably take on more clinical tasks without a physician or other clinician 'in the loop'.
- **Are health care organizations ready?** Accurately performing a discrete clinical task, such as making a diagnosis, does not by itself lead to better patient outcomes. Health care organizations need to be ready to act on the information. One panelist illustrated this point by describing a family member with sepsis who, despite a clear diagnosis, waited hours in an emergency department for a bed before IV fluids could be administered. An accurate diagnosis was not sufficient to translate into real patient impact.
- **Should AI be preferentially used if it outperforms physicians?** When polled on whether AI should be preferentially used when evidence shows it outperforms physicians, more than twice as many respondents said 'yes' than 'no' (Figure 1). The results highlight an openness to AI use in clinical care when it has demonstrated strong performance.
- **How can the ethical foundations of medicine be preserved?** Even where AI outperforms physicians on select tasks, many noted that medicine rests on a social contract grounded in competence, trust, accountability, and medical ethics. These obligations remain with physicians regardless of the tools used and upholding them is essential to preserving trust in the patient-physician relationship.

Figure 1: Audience views on the use of AI[3]

Should AI be used preferentially if it is shown to outperform physicians?



Looking Ahead: Future work should establish the conditions under which AI may operate independently, the evidence required before broader adoption, and how health care organizations can assess readiness to implement and monitor AI safely and effectively.

3 Based on an audience vote by 70 participants.

2 As evidence emerges demonstrating that autonomous AI can effectively perform select clinical functions, the line between supporting and practicing medicine becomes critical for regulation and oversight.

As AI advances from informing clinical decisions to diagnosing conditions, prescribing treatments, and managing disease, the line between a clinical technology that supports the practice of medicine and one that is itself practicing medicine becomes increasingly difficult to define. This distinction is consequential because it implicates different regulatory oversight, licensure, liability, and reimbursement constructs (Figure 2).

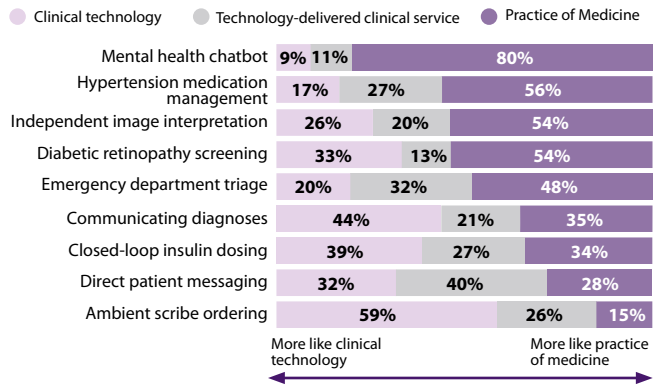
Existing governance frameworks were designed around a distinction between products, which are regulated as medical devices at the federal level, and professionals, who are regulated through licensure and standards of care at the state level. AI challenges this distinction.

Figure 2: How AI is characterized informs gaps in today's regulatory frameworks



To explore how AI could fit within today's governance frameworks, participants classified a range of AI use cases, each already deployed or in development, as a "clinical technology," "technology-delivered clinical service," or the "practice of medicine." (Figure 3).

Figure 3: Audience vote: Is this AI use case clinical technology or the practice of medicine?[4]



> **There's a difference between automating medical tasks and automating medicine itself.**
>
> **John Whyte, MD, MPH,**
> CEO and Executive Vice President,
> American Medical Association

The discussion centered around three questions:

- **Where is the line between a clinical technology and the practice of medicine?** There was broad agreement that AI does not fit neatly into either category. Instead, AI exists on a spectrum, with classification depending on the activity performed and the degree of human judgment. Where attendees drew the line varied by use case: 80% classified a mental health chatbot as the practice of medicine, compared with 15% for an ambient scribe that generates a clinical note and orchestrates follow-up imaging orders. This highlights the complexity of applying existing governance models to technology that performs some, but not all, aspects of clinical care.
- **Which elements of the practice of medicine should remain human-led?** The discussion extended beyond how AI should be classified to which clinical functions should remain human-led. Communicating a diagnosis was one of the most debated examples. While 44% classified an AI solution that delivers diagnostic results as a clinical technology, others argued that interpreting results and helping patients understand their prognosis, treatment options, and next steps is a core component of the practice of medicine because it requires clinical judgment. Some emphasized that AI cannot do "the dance of medicine," which, as one panelist described, is knowing "when to pause, when to look into someone's eyes, when a patient is about to cry, and when to hold a hand." By contrast, some viewed the activity as primarily communicating information, pointing to a literature review suggesting that AI may exceed humans at communicating with empathy in certain circumstances.

4 Based on an audience vote by 80 participants; see appendix for use case definitions.

> **What is scarce today is real-world evidence of real-world implementations for real-world use cases.**
>
> **Mark Sendak, MD, MPP,**
> CEO and Co-Founder, Vega Health

- **What should be delegated to AI, and under what conditions?** Views differed on what activities could be delegated to AI and whether current oversight frameworks are sufficient. Delegation within the practice of medicine is not new, as nurses and other non-physician licensed professionals already perform clinical functions under supervisory frameworks. Yet some questioned whether these precedents translate to AI. One emergency room physician noted that nurses triage based on objective criteria, while AI may take a "black box" approach. Discussion also highlighted a tension between existing regulatory classifications and physician perceptions of responsibility. For example, half the participants classified an FDA-cleared diabetic retinopathy screening as the practice of medicine, though it is already regulated as a medical device. The result suggests that some may view AI-enabled clinical functions differently than existing regulatory frameworks do, raising broader questions about how AI should be classified and supervised.

Looking Ahead: Future work should clarify when AI functions as a clinical technology and when it constitutes the practice of medicine, identify which clinical functions should remain human-led, and define the appropriate level of human involvement when functions are delegated to AI.

3 AI will redefine the physician's role and transform how health care teams are organized and trained.

As AI becomes capable of taking on more clinical functions with little or no physician oversight, the roles of physicians and other members of the care team will evolve. Several responsibilities may become more central to physician practice, such as:

- **Authorizing and supervising AI-enabled care:** Physicians may determine when AI-enabled systems are appropriate, define the scope of their activities, and oversee their actions. One panelist compared this role to a "head chef" who authorizes and supervises a "cook in the kitchen" by prescribing a clinically bounded AI agent to perform defined activities. For example, a primary care physician could prescribe an autonomous agent to conduct ongoing hypertension management for a patient.
- **Applying judgment in context and taking responsibility for the full spectrum of patients' care:** Physicians may focus more heavily on interpreting information considering a patient's unique circumstances, preferences, values, and goals. Many suggested that judgment, influence, understanding, and responsibility for patients' entire care pathway may become more central to clinical practice.
- **Managing exceptions and escalation:** Physicians may spend less time on routine monitoring and protocol-driven care and more time addressing complex situations and cases that require human judgment or intervention.

> **Medical malpractice traditionally asks whether the clinician used the tool appropriately, while product liability asks whether the tool itself worked as it should have. But those lines start to blur when we talk about AI practicing medicine.**
>
> **Shannon Curtis, JD,** Senior Director, Digital Health and AI Policy, AMA

- **Interpreting and validating AI outputs:** Physicians will need to understand the strengths, limitations, and appropriate use of AI systems and determine how AI-generated information should inform patient care.
- **Overseeing population-scale care:** Rather than acting only during episodic patient encounters, physicians may supervise AI systems that continuously monitor patient populations, identify care gaps, predict disease progression, and trigger interventions. The physician's role may shift from personally delivering each service to overseeing AI-enabled, population level care while closely managing only a small population of patients with specific needs.
- **Guiding patients in an AI-enabled environment:** Physicians may need to help patients navigate information generated by AI tools, including direct-to-consumer applications that patients use outside traditional health care settings that may not be built for health care. They will help patients interpret information, make informed decisions, and navigate AI-enabled care.

Given evolving responsibilities and capabilities, organizations may redesign care delivery models and team structures. While acknowledging that many logistical, operational, and physical constraints would remain, panelists emphasized that AI creates an opportunity to redesign care around more continuous, proactive, and population-based management rather than simply automate existing clinical tasks.

Participants also emphasized that AI's impact extends beyond physicians. As AI is embedded across workflows, organizations will need to determine how responsibilities are distributed across a team, including who reviews AI outputs, who acts on recommendations, when issues should be escalated to a human, and who is accountable. For example, one panelist noted that several early AI use cases in their organization supported nurses and pharmacy technicians.

These changes will require investments in education and workforce development. One participant, citing a recent AI readiness analysis of physicians and a similar one of nurses, said today's workforce cannot yet use or critically evaluate AI, a gap that runs across undergraduate, graduate, and continuing medical education and is wider for nurses. Physicians and other team members will need new skills to evaluate AI outputs, understand AI limitations, oversee AI-enabled workflows, and support patients in AI-enabled decisions. Clinicians will also need to increasingly hone and adapt soft skills for the AI era.

> **We need to decide whether we are going to be reactive or proactive about what the physician role looks like in 2030. The role of the physician is not going to be about knowledge. It's going to be about judgment. It's not going to be about making decisions. It's going to be about influence. And it's not going to be about liability, but responsibility.**
>
> **Ezekiel Emanuel, MD, PhD,** Vice Provost for Global Initiatives and Professor, University of Pennsylvania

Looking Ahead: Medical education, continuing professional development, scopes of practice, team structures, and care team models should evolve to reflect how responsibilities will change in AI-enabled care. Physicians and other members of the care team will need the skills to use AI responsibly while preserving the human judgment, communication, and accountability that patients expect from medicine.

> **If we believe the art of medicine is what doctors are going to contribute in the future, then we need to fix medical education. The problem starts at admissions: we don't focus on compassion, trust or empathy; we focus on organic chemistry, physics, and calculus.**
>
> **Shannon Curtis, JD,** Senior Director, Digital Health and AI Policy, AMA

4 Existing regulatory, licensure, and liability frameworks were not designed for AI and need to be modernized.

AI differs from other clinical technologies because it performs functions historically performed by physicians, in some cases with limited or no human involvement. This raises questions about the relevance of today's legal and regulatory frameworks for oversight, accountability, and liability allocation.

How should legal and regulatory oversight frameworks evolve as AI takes on clinical functions that challenge existing frameworks?

- **Regulatory Authority and Oversight:** Views were mixed on which regulators should regulate and oversee AI use in health care and what type of oversight is appropriate. The discussion focused on the roles of state and federal regulators, including whether state medical boards should play a significant role in overseeing autonomous or semiautonomous AI systems. Some panelists questioned whether state boards have the technical expertise, resources, and authority necessary to oversee AI deployment. Others suggested that boards could play an important role if supported by new authorities, partnerships, and oversight models. The role of federal regulators was also debated, including whether the FDA is the appropriate agency to oversee autonomous AI.
- **AI Classification:** Participants noted that oversight questions are complicated by the lack of consensus regarding how AI should be classified. Discussion explored whether AI should be regulated as a product or device, as a professional service, or under a distinct new category.
- **AI Licensure Options:** At the state level, ideas included AI-specific state licensure models that would operate in parallel to physician licensure (e.g., Cicero Institute model legislation). Dr. Emanuel raised the possibility of a federal AI licensure model that would license AI systems through a framework analogous to physician licensure while preempting state law. Some viewed this approach as a way to modernize oversight and reduce friction associated with deployment across state lines. Others cautioned that licensing AI at the federal level while continuing to license physicians at the state level could create conflicting oversight systems. They noted that state medical boards already hold authority that reaches AI-enabled care, including the power to define the practice of medicine and enforce prohibitions on unlicensed practice, and that new oversight models could extend these existing mechanisms rather than displace them.
- **Scope of Regulatory Responsibility:** In addition to establishing requirements and safeguards for AI, participants emphasized the importance of regulators in requiring developers to engage in ongoing evaluation and oversight and holding stakeholders accountable through mechanisms such as performance reporting and audits. Regulatory sandboxes and similar programs were also discussed as potential mechanisms for gathering evidence and informing future oversight approaches. However, participants noted that these mechanisms do not resolve the broader question of which regulators should be responsible for overseeing AI throughout its lifecycle.

> **We should not try to fit digital devices into pre-digital categories. We should recognize that the delivery model and the technologies that underlie it are fundamentally different, and develop new regulatory approaches rather than continue layering old frameworks on top of new technologies.**
>
> **Barak Richman, PhD, JD,**
> Professor of Law, George Washington University

Who is responsible for overseeing the development, deployment and use of clinical AI, and ensuring compliance with appropriate standards of safety and conduct?

There was agreement that accountability for AI is shared across multiple parties: state medical boards are responsible for holding physicians accountable for upholding standards of medicine; health systems and provider organizations are responsible for ensuring that AI systems and tools are selected with appropriate diligence, integrated thoughtfully, and deployed safely, with ongoing monitoring; developers are responsible for designing and maintaining safe AI tools; and government regulators are responsible for establishing and enforcing rules and safeguards.

This prompted questions about how accountability, and corresponding liability, should be enforced and allocated, respectively, for each stakeholder. Many viewed state medical boards as central to articulating standards for physician accountability, and holding physicians accountable under professional standards through licensure, oversight, and disciplinary action. However, participants questioned whether physicians should be held accountable for autonomous or semiautonomous systems in the first place. Views also differed on the extent to which patients should share responsibility for outcomes in patient-facing AI-enabled care, highlighting open questions about patient agency and new approaches to informed decision-making.

Who bears legal and financial responsibility when clinical AI contributes to patient harm?

Current legal frameworks generally distinguish between malpractice liability for clinicians and product liability for manufacturers, a distinction more difficult to apply as AI takes on additional functions historically performed by physicians and acts less like a static product. As AI becomes more autonomous, discussion focused on whether liability should rest with physicians, health care organizations, AI developers, or be shared across multiple parties. Approaches raised included physician safe harbors for appropriate use and reliance on AI, enterprise liability models, and liability frameworks, such as strict liability, for developers and deployers as AI systems become more autonomous.

Concerns were also raised about how risk is allocated in practice today, given that this is mostly addressed through contract provisions. Some shared that vendor contracts often shift liability onto physicians or the health care organization, despite their limited ability to evaluate or control how AI systems are developed and maintained. AI has already demonstrated in non-health care domains that human reviewers cannot reasonably keep up with the quantity and pace of AI output, not to mention additional errors humans may inadvertently introduce when reviewing it. Others suggested that health care organizations may have leverage to negotiate liability allocation, indemnification, and other contractual protections, particularly when purchasing solutions designed specifically for health care.

Looking Ahead: Future work should define the respective roles of state medical boards, federal and state regulators, health care organizations, AI developers, and other stakeholders in overseeing AI-enabled care. It should also establish liability frameworks and define how accountability will be enforced and liability allocated when AI contributes to patient harm.

5 Patients are adopting AI faster than the health system is adapting.

Patients are already integrating AI into personal health management, often turning to consumer tools to fill gaps in access, information, affordability, and support. They are using AI to better understand symptoms and diagnoses, prepare for clinical visits, evaluate treatment options, and navigate decisions. For many, the alternative to AI is not expert and timely human guidance, but no access at all. As one panelist observed, patients will adopt AI "at the speed of desperation."

Against this backdrop, panelists explored considerations that may shape how AI is integrated into patient care, including the role of the health care community in supporting patient use, the future relationship between AI and physicians, expectations for transparency, and implications for health equity:

- **Patients are already using AI:** Nearly one-third of adults in the U.S. report using AI chatbots for health information monthly. At the same time, clinicians feel unprepared to address AI-generated analyses or questions that patients bring to them. Supporting patient AI literacy and developing approaches for discussing AI-generated information may become professional responsibilities. The use of AI outside clinical settings also raises questions about who is responsible for the information these technologies provide and how patients act on it.

> **It is already happening. The discussion for medicine is how do we [advocates and policymakers] then support patients in navigating this new landscape? How do patients and the provider build a new relationship? One way is that providers can help sift through misinformation. They can help the patients understand what's best for them, knowing that they're going to make the choice that they make.**
>
> **Natalie Davis, CEO,** United States of Care

- **AI does not eliminate the need for trusted, compassionate, human-led care:** While patients value AI's continuous availability and convenience, they still want human clinicians involved in their care. AI may expand access to information while clinicians help patients interpret information, navigate tradeoffs, and provide relationship-based care. Physicians and other health care professionals may increasingly serve as guides and trusted advisors.
- **Transparency is important, but there are different perspectives on how it should work in practice:** Some cautioned that blanket consent forms could add paperwork without improving understanding or trust. Others favored disclosure when AI meaningfully influences a clinical decision, treatment recommendation, or patient risk. Transparency could eventually extend beyond disclosure, with patients expecting access to AI-generated outputs and insight into how those outputs influenced care decisions. Importantly, panelists emphasized that transparency should support patient agency and shared decision-making.
- **AI has the potential to improve access and advance health equity, but ensuring it works for the patients who rely on it will be critical:** Panelists cited survey findings showing that lower-income, uninsured, and racial and ethnic minority populations may be among the most frequent users of consumer AI tools. This suggests that AI could help address longstanding gaps in access to health information and support. Others questioned whether the evidence supporting AI performance applies equally to populations often underrepresented in health care data (e.g., those with multiple chronic conditions or limited English proficiency). Panelists warned that the populations relying on these tools may also be those most affected if they perform poorly.

Looking Ahead: Future work should define how clinicians and health care organizations can support patients who use consumer AI, when and how AI use should be disclosed, and how patients can meaningfully participate in AI-enabled decisions. It should also ensure that AI-enabled care is evaluated across diverse populations and strengthens the patient-physician relationship.

Conclusion and Next Steps

The discussions throughout the convening reinforce the impact that AI will have on care delivery, with broad implications on professional responsibility, accountability, oversight, and the practice of medicine. There is broad agreement that existing governance frameworks for liability, licensure, and regulation were not designed for an era in which AI systems may independently perform select clinical functions.

The convening identified several priority areas for future work:

- **Establish best practices for appropriate use of AI in clinical care:** Establish the conditions under which AI can perform autonomously, what evidence should be required for adoption in clinical settings, and how organizations should safely deploy and monitor performance.
- **Clarify the boundary between clinical technology and the practice of medicine:** Define when AI functions as a clinical tool and when it constitutes the practice of medicine.
- **Modernize oversight, accountability, and liability frameworks**[5]**:** Establish how responsibility for AI-related patient harm should be assigned and clarify the roles of state medical boards, federal regulators, AI developers, physicians, and other health care stakeholders.
- **Prepare the physician and care team workforce:** Adapt medical education, clinical training, continuing professional development, and team-based care models to support responsible AI use.
- **Preserve patient-centered care and trust:** Develop best practices for integrating AI into care delivery in ways that are safe, transparent, and equitable, while strengthening the patient-physician relationship and upholding medical ethics.

Building on the themes surfaced in the convening, the AMA Center for Digital Health and AI and FSMB Workgroup on the Regulation of Artificial Intelligence in the Practice of Medicine will continue working with stakeholders to advance priorities identified as most critical to the future of AI in health care.

manatt

AMA and FSMB would like to acknowledge Manatt Health for its support in its planning and execution of this important event.

5 The AMA released an Issue Brief on Liability for Clinical AI following the September 14, 2026 AMA and FSMB convening.

Appendix

Emerging and Hypothetical AI Use Cases	
Diabetic Retinopathy Screening	Primary care staff capture images; AI returns a diagnostic result to the patient and treating primary care provider without ophthalmologist review.
Independent Image Interpretation	AI classifies chest imaging as normal; images released to the ordering physician without radiologist review.
Ambient Scribe Ordering	AI scribe generates a clinical note and prepares medication eRx and imaging orders for one-click signature.
Direct Patient Messaging	AI sends replies to "low-risk" patient questions with "routine" messages, without physician review.
Mental Health Chatbot	Chatbot facilitates a structured therapy session directly with the patient without psychiatrist participation or concurrent review of individual messages.
Emergency Department Triage	Models assign acuity, including deprioritization of patients unlikely to require emergency care. Neither emergency department physicians nor triage nurses review all individual determinations.
Hypertension Medication Management	AI continuously monitors blood pressure and symptoms, makes "low-risk" Rx adjustments directly with patients; routes only "high-risk" Rx decisions to primary care physician and/or cardiologist for review.
Communicating Diagnoses	AI communicates diagnostic findings and supporting information directly to the patient, in lieu of a physician conversation.
Closed-loop Insulin Systems	Next-generation AI-enabled devices titrate medication(s) continuously, without clinician involvement.

AMA | Center for Digital Health & AI

© 2026 American Medical Association. All rights reserved. 26-1960050:prt:10/26