

AMERICAN MEDICAL ASSOCIATION YOUNG PHYSICIANS SECTION

Resolution 1
(I-26)

Introduced by: Toni-Ann Lewis

Subject: Ensuring Augmented Intelligence Reduces Rather Than Redistributes Physician Burden

Referred to: YPS Reference Committee

Whereas, augmented intelligence (AI) technologies are increasingly incorporated into medical practice, including clinical documentation, electronic health record workflows, patient communications, clinical decision support, inbox management, and other clinical and administrative functions; and

Whereas, physician adoption of augmented intelligence has increased rapidly, with 81% of physicians reporting professional use of AI in 2026, more than double the 38% reported in 2023 [1]; and

Whereas, physicians identify reduction of administrative burden as a principal opportunity for AI in medicine, with 57% of surveyed physicians identifying automation of administrative burden as the greatest opportunity for AI to address key workforce needs, compared with 18% identifying increased physician capacity [2]; and

Whereas, our American Medical Association supports augmented intelligence systems that advance the quadruple aim, including enhancing patient experience and outcomes, improving population health, increasing value, and supporting the professional satisfaction of physicians and the health care team [3]; and

Whereas, our AMA has emphasized that augmented intelligence should enhance human intelligence and the patient-physician relationship rather than replace them and supports incorporating the perspectives of practicing physicians into the development, design, validation, and implementation of health care AI [3,4]; and

Whereas, emerging experience with AI-enabled clinical workflows demonstrates the potential for these technologies to reduce physician burden, with 78% of physicians and other health professionals using AI-driven documentation solutions at one health system reporting improved job satisfaction and 49% reporting reduced cognitive load [5]; and

Whereas, efficiency gains attributed to augmented intelligence may create incentives for health care organizations to increase patient volume, shorten appointment duration, reduce clinical or administrative support staffing, or increase physician productivity expectations; and

Whereas, anticipated, theoretical, or vendor-projected efficiency gains from augmented intelligence may not accurately reflect actual physician capacity and may fail to account for patient complexity, differences in specialty and practice environment, clinical workflow, or physician time and cognitive effort required to supervise AI-generated output; and

Whereas, existing AMA policy supports qualified physician intervention in clinical decisions influenced by AI and physician review of AI-generated clinical content [6]; and

Whereas, physicians may perform substantial clinical and cognitive work when reviewing, validating, correcting, contextualizing, approving, and acting upon AI-generated documentation, recommendations, communications, and other clinical outputs; and

Whereas, the time and cognitive effort required to supervise augmented intelligence may not be adequately reflected in traditional measures of physician productivity, despite physicians retaining responsibility for reviewing and appropriately acting upon AI-assisted clinical work; and

Whereas, automatically converting AI-attributed efficiencies into increased physician productivity requirements may redistribute rather than reduce physician burden and may undermine opportunities for augmented intelligence to improve physician well-being, meaningful patient-physician interaction, and quality of care; therefore be it

RESOLVED, that our American Medical Association oppose the use of anticipated, theoretical, or vendor-projected efficiency gains from augmented intelligence technologies as the sole basis for increasing physician patient volume, shortening appointment duration, reducing clinical support staffing, or increasing physician productivity requirements, and advocate that demonstrated effects on physician capacity, patient safety, quality of care, and physician well-being be considered before implementing such changes; and be it further

RESOLVED, that our AMA advocate that practicing physicians be meaningfully involved in determining how demonstrated efficiency gains resulting from augmented intelligence technologies are incorporated into clinical workflows, staffing models, scheduling practices, and physician workload expectations; and be it further

RESOLVED, that our AMA recognize physician time and cognitive effort spent reviewing, validating, correcting, contextualizing, approving, or otherwise supervising augmented intelligence-generated clinical output as physician work that should be appropriately considered in workload, staffing, productivity, and compensation models.

Fiscal Note: (Assigned by HOD)

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REFERENCES

1. American Medical Association. AMA: AI usage among doctors doubles as confidence in technology grows. March 12, 2026. Accessed August 24, 2026.
2. Henry TA. Physicians' greatest use for AI? Cutting administrative burdens. American Medical Association. March 20, 2025. Accessed August 24, 2026.
3. American Medical Association. Policy H-480.939, Augmented Intelligence in Health Care. AMA PolicyFinder. Accessed August 24, 2026.
4. American Medical Association. Policy H-480.940, Augmented Intelligence in Health Care. AMA PolicyFinder. Accessed August 24, 2026.
5. Feldheim B. Advancing physician efficiency while enhancing patient care. Joy in Medicine 2025. American Medical Association. Accessed August 24, 2026.
6. American Medical Association. Policy H-480.931, Assessing the Intersection Between AI and Health Care: Augmented Intelligence Development, Deployment, and Use in Health Care. AMA PolicyFinder. Accessed August 24, 2026.

RELEVANT AMA POLICY

H-480.939 Augmented Intelligence in Health Care

Our AMA supports the use and payment of augmented intelligence (AI) systems that advance the quadruple aim. AI systems should enhance the patient experience of care and outcomes, improve population health, reduce overall costs for the health care system while increasing value, and support the professional satisfaction of physicians and the health care team.

1. Oversight and regulation of health care AI systems must be based on risk of harm and benefit accounting for a host of factors, including but not limited to: intended and reasonably expected use(s); evidence of safety, efficacy, and equity including addressing bias; AI system methods; level of automation; transparency; and, conditions of deployment.
2. Payment and coverage for all health care AI systems must be conditioned on complying with all appropriate federal and state laws and regulations, including, but not limited to those governing patient safety, efficacy, equity, truthful claims, privacy, and security as well as state medical practice and licensure laws.
3. Payment and coverage for health care AI systems intended for clinical care must be conditioned on
 - a. clinical validation.
 - b. alignment with clinical decision-making that is familiar to physicians.
 - c. high-quality clinical evidence.
4. Payment and coverage for health care AI systems must

- a. be informed by real world workflow and human-centered design principles.
 - b. enable physicians to prepare for and transition to new care delivery models.
 - c. support effective communication and engagement between patients, physicians, and the health care team.
 - d. seamlessly integrate clinical, administrative, and population health management functions into workflow.
 - e. seek end-user feedback to support iterative product improvement.
5. Payment and coverage policies must advance affordability and access to AI systems that are designed for small physician practices and patients and not limited to large practices and institutions. Government-conferred exclusivities and intellectual property laws are meant to foster innovation, but constitute interventions into the free market, and therefore, should be appropriately balanced with the need for competition, access, and affordability.
6. Physicians should not be penalized if they do not use AI systems while regulatory oversight, standards, clinical validation, clinical usefulness, and standards of care are in flux. Furthermore, our AMA opposes:
 - a. Policies by payers, hospitals, health systems, or governmental entities that mandate use of health care AI systems as a condition of licensure, participation, payment, or coverage.
 - b. The imposition of costs associated with acquisition, implementation, and maintenance of healthcare AI systems on physicians without sufficient payment.
7. Liability and incentives should be aligned so that the individual(s) or entity(ies) best positioned to know the AI system risks and best positioned to avert or mitigate harm do so through design, development, validation, and implementation. Our AMA will further advocate:
 - a. Where a mandated use of AI systems prevents mitigation of risk and harm, the individual or entity issuing the mandate must be assigned all applicable liability.
 - b. Developers of autonomous AI systems with clinical applications (screening, diagnosis, treatment) are in the best position to manage issues of liability arising directly from system failure or misdiagnosis and must accept this liability with measures such as maintaining appropriate medical liability insurance and in their agreements with users.
 - c. Health care AI systems that are subject to non-disclosure agreements concerning flaws, malfunctions, or patient harm (referred to as gag clauses) must not be covered or paid and the party initiating or enforcing the gag clause assumes liability for any harm.
8. Our AMA, national medical specialty societies, and state medical associations:
 - a. Identify areas of medical practice where AI systems would advance the quadruple aim.
 - b. Leverage existing expertise to ensure clinical validation and clinical assessment of clinical applications of AI systems by medical experts.
 - c. Outline new professional roles and capacities required to aid and guide health care AI systems.
 - d. Develop practice guidelines for clinical applications of AI systems.
9. There should be federal and state interagency collaboration with participation of the physician community and other stakeholders in order to advance the broader infrastructural capabilities and requirements necessary for AI solutions in health care to be sufficiently inclusive to benefit all patients, physicians, and other health care stakeholders. (New HOD Policy)
10. AI is designed to enhance human intelligence and the patient-physician relationship rather than replace it.

[BOT Rep. 21, A-19; Reaffirmation: A-22; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 226, A-25]

H-480.940 Augmented Intelligence in Health Care

As a leader in American medicine, our American Medical Association has a unique opportunity to ensure that the evolution of augmented intelligence (AI) in medicine benefits patients, physicians, and the health care community.

To that end our AMA will seek to:

1. Leverage its ongoing engagement in digital health and other priority areas for improving patient outcomes and physicians' professional satisfaction to help set priorities for health care AI.
2. Identify opportunities to integrate the perspective of practicing physicians into the development, design, validation, and implementation of health care AI.
3. Promote development of thoughtfully designed, high-quality, clinically validated health care AI that:

- a. is designed and evaluated in keeping with best practices in user-centered design, particularly for physicians and other members of the health care team;
 - b. is transparent;
 - c. conforms to leading standards for reproducibility;
 - d. identifies and takes steps to address bias and avoids introducing or exacerbating health care disparities including when testing or deploying new AI tools on vulnerable populations; and
 - e. safeguards patients' and other individuals' privacy interests and preserves the security and integrity of personal information.
4. Encourage education for patients, physicians, medical students, other health care professionals, and health administrators to promote greater understanding of the promise and limitations of health care AI.
5. Explore the legal implications of health care AI, such as issues of liability or intellectual property, and advocate for appropriate professional and governmental oversight for safe, effective, and equitable use of and access to health care AI. [BOT Rep. 41, A-18; Reaffirmed: CMS Rep. 07, A-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed: Res. 505, A-26]

H-480.931 Assessing the Intersection Between AI and Health Care

Augmented Intelligence Development, Deployment, and Use in Health Care.. [BOT Rep. 01, I-24; Reaffirmed: CSAPH Rep. 08, A-25; Reaffirmed in lieu of the first resolve: Res. 226, A-25; Reaffirmed: Res. 505, A-26]