AI is just a Tool: Lessons from a Conversation with Dr. Brita Hansen

Artificial intelligence is being touted as the solution to almost every problem. Some view it as a savior and others are very worried about its impact to medicine and the environment. For internists—who manage longitudinal relationships, diagnostic uncertainty, and a relentless volume of data—the question is whether it can meaningfully help to decrease burden and put the attention back on the patient.

To explore this question, I spoke with **Dr. Brita Hansen**, Vice President of Medical Informatics and AI at Allina Health who sees patients at their Uptown Clinic, a practicing internist, and a longtime leader at the intersection of clinical care, informatics, and health system strategy. Our conversation offered a grounded, experience-based perspective on what AI is doing well today, where it routinely falls short, and what clinicians should realistically expect over the next several years.

A Career Shaped by Documentation and Workflow

Dr. Hansen's entry into informatics predates medical school when she worked on documentation workflows for a high-volume pediatric practice as an undergraduate, helping design systems that could manage large volumes of clinical information and communicate effectively with primary care clinicians. Importantly, this work was done before advanced digital tools were widely available—using paper-based workflow mapping and early electronic systems. She reflected that many of the core challenges we face today—documentation burden, fragmented workflows, and misaligned incentives—are not new. The electronic health record has not created these problems; it has simply exposed them more clearly.

During residency and early faculty years, Dr. Hansen trained in environments that were early adopters of electronic health records. She became involved in EHR build and optimization during training, gaining firsthand experience with how clinical systems are designed, implemented, and adapted over time. This background positioned her to move naturally into formal informatics leadership.

From CMIO Work to AI Governance

Dr. Hansen currently serves in a role that blends traditional CMIO responsibilities with oversight of AI strategy, governance, and implementation. The role itself was created in response to the rapid emergence of generative AI tools—reflecting a recognition that health systems need dedicated clinical leadership to evaluate, govern, and responsibly deploy these technologies.

A significant portion of her work focuses on **governance**: assessing vendors, defining acceptable use, addressing data privacy concerns, and helping clinical and operational leaders distinguish between genuine value and "shiny object" syndrome. She described how enthusiasm for AI—particularly among operational leaders—can lead organizations to accumulate numerous point solutions without a coherent data or integration strategy.

This, she noted, creates friction rather than relief. "The massive amount of customization in our environment, combined with the number of point-solution vendors, makes it very hard to be strategic—especially with AI." Over time, her team has shifted focus toward strengthening underlying **data architecture** and defining an **orchestration layer** that allows AI tools to plug into a coherent platform, rather than requiring brittle, one-off integrations.

Where AI Actually Helps Today

When asked where AI shows up most meaningfully in her daily work, Dr. Hansen emphasized **administrative and cognitive support**, rather than diagnostic decision-making. Like many

physician leaders, she spends much of her time in meetings. AI tools such as Copilot are now routine for drafting documents, summarizing discussions, managing email, and developing committee charters. These use cases are not headline-grabbing, but they directly address a major source of physician frustration: the time spent on non-clinical work.

In clinical practice, Dr. Hansen has used ambient documentation tools for several years. What was once novel has become normalized—for both clinicians and patients. She noted that patients increasingly recognize these tools and often require less explanation than they did even a year ago. However, she was careful to emphasize that these systems are **assistive, not autonomous**. They can help draft a progress note or a prior authorization denial appeal, but aren't going to make a diagnosis anytime soon.

Understanding Errors: Not Hallucinations, but Drift

Much of the public conversation about AI focuses on hallucinations—fabricated or wildly incorrect outputs. In practice, Dr. Hansen has seen fewer dramatic errors and far more subtle ones. Common issues include:

- Confusion about whether the clinician or the patient made a particular statement
- Mishearing short or similar-sounding words
- Failing to remove an abandoned plan when a clinician changes direction mid-visit

These errors are especially likely when clinicians think out loud, revise plans during encounters, or share similar vocal characteristics with patients. Importantly, these are not failures of intent, but limitations of current systems. One potential remedy for many of these issues also has added benefits for patient care. She has noted that the AI scribe does better when she clearly summarized and articulates the plan out loud with the patient in the visit. This practice not only helps AI get the note right, but provides clarity and open dialogue with patients. She has noted that her own practice has changed for the better because of this.

The implication for clinicians is clear: **AI-generated documentation must be reviewed carefully**, and responsibility for accuracy remains with the physician.

Evidence, Context, and the Limits of AI Knowledge

AI systems often rely on published literature without understanding whether recommendations are outdated, unavailable, or no longer standard of care. This highlights a critical principle: AI excels at **summarizing what has been written**, but struggles with **what is known implicitly** by experienced clinicians. For general internists, this distinction matters. AI may be very helpful for synthesizing new guidelines or summarizing recent trials, but less reliable for nuanced, under-researched, or rapidly evolving clinical scenarios.

The Near-Term Opportunity: Care Operations

Looking ahead, Dr. Hansen was clear that the most realistic and impactful applications of AI lie outside of diagnosis. Over the next one to two years, she expects the greatest gains in **care operations**, including:

- Scheduling and access management
- Prior authorization workflows
- Form and document processing
- Phone triage and intake
- Pre-procedural screening and care coordination

These tasks consume enormous amounts of clinician and staff time while adding little intrinsic clinical value. Improving them would directly address burnout and inefficiency—pain points that are especially acute in general internal medicine.

By contrast, she cautioned against overpromising in diagnostic AI. While imaging and pattern recognition continue to mature, the idea that AI will soon generate comprehensive diagnoses or treatment plans independently remains unrealistic and overhyped.

A Tool to Reclaim Cognitive Space

One of the most resonant insights from the conversation was this: clinicians digitized healthcare data largely through their own labor. AI now offers an opportunity to reclaim some of that time and cognitive space.

Dr. Hansen framed AI not as a threat to professional identity, but as a means of restoring it. The goal is not to think less, but to think **more clearly**, with fewer distractions and less clerical overhead.

For general internists, the challenge is not whether AI will change medicine overnight—it will not—but whether we can shape its use to reduce friction, preserve judgment, and support sustainable practice.

Used thoughtfully, AI may not transform what we do for patients. But it may determine whether we can keep doing it well.

What to Do Now with AI

One of Dr. Hansen's strongest themes was education for physicians about the benefits (and limitations) of AI. She described wide variation in clinician attitudes toward AI, ranging from uncritical enthusiasm to principled refusal. Both, she suggested, stem from misunderstanding.

Her advice to clinicians was practical:

- **Start using AI in low-risk, high-friction areas**, especially administrative tasks like prior authorization appeal letters or call schedules.
- **Avoid treating AI as either magical or inherently dangerous,** it is simply a fancy math program that predicts what word should go next.
- **Continue applying clinical judgment, verification, and skepticism,** it is the responsibility of the physician to make sure anything written in your name is accurate.

For clinicians who feel behind, her message was reassuring. AI is not magic. It is particularly good at handling large volumes of data—something clinicians have been forced to do manually since the introduction of EHRs. In many ways, AI offers a chance to undo a historical mistake: turning physicians into full-time data-entry clerks. There is still plenty of opportunity to learn and start using AI.

Interview by Dr. Sonja Short, MN-ACP AI Committee Member