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The productivity trap: will AI restore presence or accelerate throughput?

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Dear Editor,

The current discourse surrounding Artificial Intelligence (AI) in healthcare often positions it as a tool for «administrative excavation,» a means to remove the bureaucratic debris of documentation and billing that currently buries the clinical encounter. However, from the perspective of emergency medicine—a field already defined by extreme time pressure and high cognitive load—we must ask: will AI-saved time be reinvested in the patient, or will it simply be used to accelerate throughput?¹

In the Emergency Department (ED), the «Taylorization» of clinical work is most evident. For decades, physicians have been forced to function as data-entry processors. The finding that AI chatbots can outscore clinicians on empathy measures is not a failure of human compassion, but a symptom of a system that has optimized the physician for «clicks» rather than care.²⁻³ The fundamental risk for emergency care is the optimization paradox. If AI reduces the time required for an emergency encounter, systemic pressures may immediately fill that vacuum with higher patient volumes to maximize revenue. This trajectory threatens to turn the ED into a high-speed assembly line, further alienating physicians from their vocation and potentially compromising patient safety through a «faster, thinner encounter». ⁴. To prevent this, emergency medicine governance must lead a paradigm shift in how we define productivity: i) beyond volume: metrics must pivot from raw throughput to valuing the quality of clinical presence and active listening; ii) presence as an asset: physician presence should be recognized as a non-fungible clinical asset, essential for de-escalating complex cases and providing comfort in acute crises; iii) vocational focus: productive value must be reassigned to prioritize

the «life beneath the chief concern» over the relentless management of the digital inbox. AI presents a critical fork in the road for our specialty. It can either be the catalyst that restores the human essence of emergency care or the tool that finalizes its industrialization. Our goal must not be to see *more* patients, but to finally have the time to see each patient *better*. ⁵

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