

Generative AI, Patient Trust, and the AI-Era Family Doctor

Deep research review of patient reliance on generative AI for medical interpretation, advice, and decision support

Central finding: Consumer generative AI is already becoming a meaningful health-information channel. The strongest current evidence supports a shift in the physician's role rather than the disappearance of physician relevance: information retrieval and explanation are becoming less scarce, while contextual judgment, physical examination, continuity, shared decisions, safety-netting, accountability, and therapeutic relationship become more important.

Evidence window: primarily 2023-2026. Prepared 25 August 2026.

This is a research synthesis, not medical advice. Survey estimates depend on question wording, population, tool definition, and time window; experimental comparisons of written answers should not be interpreted as evidence that chatbots can replace clinical encounters.

Executive summary

- The phenomenon is real and measurable. KFF's nationally representative U.S. poll (Feb-Mar 2026) found 32% of adults had used AI for physical or mental health information/advice in the prior year; 29% used it for physical health. In Australia, a nationally representative June 2024 survey estimated 9.9% of adults had used ChatGPT for health questions in the preceding six months.
- Use is not limited to generic education. In the KFF survey, 19% of all U.S. adults reported using AI to explain tests, laboratory results, or diagnoses; 19% to understand/compare treatments; and 16% to help decide whether to see a doctor. Among AI health users, 41% had uploaded personal medical information such as test results or doctor's notes.
- There is evidence of substitution at the margin. Only 58% of U.S. physical-health AI users said they subsequently followed up with a health professional. Among all 18-29-year-olds, 21% reported using AI for physical-health advice and not following up with a doctor.
- AI can compete strongly on the communication layer. A 2024 JMIR patient study found ChatGPT responses scored 4.18/5 for empathy versus 2.70 for physician-panel answers, and 4.04 versus 2.98 for usefulness. A 2023 JAMA Internal Medicine study found licensed evaluators preferred chatbot answers in 78.6% of comparisons.
- But this is not equivalent to replacement of clinical medicine. Written-answer experiments omit examination, longitudinal records, nonverbal cues, responsibility for follow-up, and real-world diagnostic uncertainty. JMIR also found patients did not reliably recognize AI responses that physicians considered potentially harmful.
- Professional authority is becoming more complex. A 2025 JAMA Network Open experiment involving 1,276 U.S. adults found family physicians described as using AI were rated modestly but significantly lower in competence, trustworthiness, empathy, and willingness-to-book than physicians not described as using AI. This suggests that poorly framed AI use can itself reduce perceived physician expertise.
- Best interpretation: physician relevance is changing more than declining. The scarce resource is shifting from access to medical information toward trusted interpretation of information in the context of a particular person, over time, with accountability.

1. Strongest quantitative evidence that patient behavior is changing

Evidence	Finding	Interpretation
KFF, U.S., 2026	32% used AI for health; 29% physical health; 16% mental health.	AI is now a mainstream health-information channel.
KFF, U.S., 2026	27% used AI for symptoms/conditions; 19% for tests/labs/diagnoses; 19% treatments; 16% deciding whether to seek care.	Use extends into interpretation and care-seeking decisions.
KFF, U.S., 2026	58% of physical-health AI users followed up with a clinician; therefore 42% did not report doing so.	Direct evidence of at least partial non-follow-up after AI use.
KFF, U.S., 2026	41% of AI health users uploaded personal medical information; 13% of all adults.	Patients increasingly treat general AI as a personal medical interpreter.
MJA, Australia, 2025	9.9% used ChatGPT for health in prior 6 months; 38.8% of aware nonusers were considering doing so.	Independent national evidence outside the U.S.
KFF, U.S., Jun 2026	29% reported monthly AI use for health information, up from roughly 17% two years earlier.	Suggests rapid growth, though trend questions/tool definitions must be read carefully.

Important nuance: AI use does not necessarily mean rejection of doctors. KFF still found 80% sought physical or mental health information/advice from a health professional in the prior year, versus 32% from AI. The emerging pattern is therefore multi-source medicine: patients increasingly arrive informed - or misinformed - by AI, while professional care remains dominant.

2. Why patients turn to AI

- Speed and availability: 65% of KFF AI-health users cited quick/immediate information or support as a major reason.
- Pre-visit preparation: 41% cited wanting information before deciding whether to see a provider.
- Privacy: 36% cited greater comfort asking health questions privately.
- Results arrive before interpretation: 28% cited receiving medical test results before being able to discuss them with a provider.
- Access and cost: 18% cited no regular provider or inability to get an appointment; 19% cited inability to afford a provider. Among users aged 18-29, these rose to 38% and 29%, respectively.

This matters for family medicine because many of the functions consumers are giving to AI - symptom interpretation, first-line explanation, triage, test interpretation, and treatment education - overlap directly with traditional primary-care information work.

3. Does AI reduce perceived physician expertise?

Evidence supports a pressure on informational authority, but not yet a broad collapse of trust in doctors.

The strongest direct experimental evidence comes from Reis, Reis & Kunde (JAMA Network Open, 2025). In a randomized online study, 1,276 U.S. adults saw fictitious advertisements for family doctors. Merely mentioning that the doctor used AI - administrative, diagnostic, or therapeutic - lowered ratings relative to a no-AI control. Competence fell from 3.85/5 in the control to 3.66 for diagnostic AI and 3.58 for therapeutic AI; trustworthiness fell from 3.88 to 3.62 and 3.61, respectively. Willingness to book also declined. The authors stress that effects were relatively small and the scenario was hypothetical.

This finding creates an important paradox: patients are increasingly willing to use AI themselves, while some may penalize a physician who appears to outsource judgment to AI. The practical implication is not that physicians should hide AI, but that they must communicate how it is used: as a second reader, summarizer, safety aid, or administrative assistant under physician responsibility - not as a substitute for professional judgment.

4. AI versus physician answers: trust, empathy, usefulness, and accuracy

Two influential studies show why patients may perceive generative AI as surprisingly competent:

- JMIR 2024: 64 patients evaluated 2,000 ChatGPT and 2,000 expert-panel answers to 100 questions across five specialties. ChatGPT scored higher for empathy (4.18 vs 2.70) and usefulness (4.04 vs 2.98), both $P < .001$. Specialist evaluators also rated ChatGPT highly. Critically, however, patients did not lower their ratings for ChatGPT answers that physicians flagged as potentially harmful.
- JAMA Internal Medicine 2023: licensed health-professional evaluators preferred chatbot responses over physician responses in 78.6% of 585 evaluations of 195 online patient questions. Chatbot responses were rated good/very good quality in 78.5% versus 22.1% for physician responses and empathetic/very empathetic in 45.1% versus 4.6%. Chatbot answers were also much longer (median 211 vs 52 words), an important confounder.

What these studies prove: LLMs can be exceptionally competitive at producing polished, comprehensive, empathetic written explanations. What they do not prove: that a chatbot is safer or more effective than a physician conducting a real consultation. They compare text responses under constrained conditions, not full clinical practice.

5. Risks when AI becomes a substitute rather than an adjunct

Risk	Mechanism	Why a physician matters
False reassurance / delayed care	Plausible language can make an incomplete or incorrect assessment feel authoritative.	Examines, triages, safety-nets, and owns follow-up.
Overdiagnosis / anxiety	Broad differentials can surface rare diseases without calibrated probability.	Applies prevalence, history, examination, and longitudinal context.
Missing context	Consumer AI may not know complete history, medications, pregnancy status, social factors, or prior trajectory.	Integrates the whole patient record and lived context.
Automation bias	Users may accept a confident output without recognizing uncertainty or harm.	Challenges AI output and communicates uncertainty.
Privacy	Users may upload labs, notes, and other sensitive data.	Can direct patients to governed, clinically appropriate tools.
Accountability gap	A chatbot can suggest; it does not provide continuity, arrange follow-up, or bear clinical responsibility.	A clinician remains responsible for decisions and care coordination.

WHO's 2024 guidance on large multi-modal models specifically highlights risks including false or incomplete statements, biased training data, automation bias, cybersecurity, and unequal access, and calls for governance, evidence, transparency, and human oversight in health applications.

6. Why family medicine is especially exposed - and especially valuable

Primary care sits at the exact boundary where AI is strongest and weakest. AI is strong at explanation, summarization, pattern-based suggestions, question generation, and 24/7 conversational access. Family medicine, however, derives much of its highest value from tasks that require integration across time and domains rather than a single answer.

- Longitudinal knowledge: recognizing that today's symptom is different because the doctor knows the patient's baseline, prior investigations, adherence, family situation, and trajectory.
- Physical examination and observation: touch, gait, breathing effort, affect, skin findings, vital signs, and other information that may never enter the prompt.
- Probability and uncertainty management: deciding what is likely, what is dangerous, what can wait, and what needs a test now.
- Shared decision-making: translating evidence into a choice compatible with the patient's goals, risk tolerance, resources, and values.
- Continuity and accountability: ensuring that a result is acted on, symptoms are rechecked, referrals happen, and responsibility is not lost between systems.
- Relationship: trust is not merely warmth in text. It includes knowing the patient, delivering difficult news, negotiating adherence, and being present when decisions carry consequences.

7. A practical model for the AI-era family doctor

Stage	AI role	Family physician role
Before the visit	Collect structured history; explain terminology; help patient formulate questions.	Set safe boundaries; provide approved tools; review red flags and longitudinal context.
During the visit	Summarize chart; surface guidelines; draft differential/questions; translate jargon.	Examine; test assumptions; integrate context; decide; communicate uncertainty; obtain consent.
AI-output review	Patient brings chatbot interpretation, differential, or treatment ideas.	Validate what is correct, identify missing context/errors, explain why the final plan differs when necessary.
Decision	Offer evidence summaries and option comparisons.	Own the recommendation with the patient; incorporate values, feasibility, risk, and accountability.
After the visit	Generate instructions, reminders, education, monitoring prompts.	Define safety-net thresholds, review response, close loops, and preserve continuity.
Long-term care	Track routine metrics and support self-management.	Coach prevention and chronic disease; detect trajectory changes; coordinate specialists and social care.

Proposed identity: the family physician becomes the patient's trusted medical integrator - not the person who wins by knowing more facts than the internet, but the professional who turns abundant information into a safe, individualized, longitudinal plan and remains accountable for what happens next.

8. How the consultation itself should change

- Ask about AI explicitly: “What did you already look up or ask an AI system, and what worried or convinced you?” This normalizes disclosure instead of forcing patients to hide it.
- Review rather than dismiss: treat the patient's AI output like any other external information source. Mark correct statements, uncertain statements, and errors.
- Show reasoning: when the physician disagrees with AI, explain the missing variable, probability, examination finding, contraindication, or follow-up requirement. Authority becomes transparent rather than positional.
- Prescribe information: recommend specific governed AI tools or prompting practices for low-risk education, and define situations in which the patient should contact the clinic rather than continue chatting.
- Use AI to buy back human time: documentation, summarization, routine instructions, and inbox drafting should create more attention for listening, examination, decisions, and difficult conversations - not simply increase throughput.
- Make continuity visible: use follow-up plans, proactive prevention, and longitudinal interpretation as explicit parts of the service. These are difficult for a stateless consumer chatbot to reproduce safely.

9. Demonstrated trends versus plausible extrapolations

Claim	Evidence status
A substantial minority of patients already use AI for health questions.	DEMONSTRATED - national surveys in the U.S. and Australia.

Claim	Evidence status
Patients use AI for lab/test interpretation, treatment comparison, and decisions about seeking care.	DEMONSTRATED - KFF and MJA survey items.
Some AI users do not subsequently consult a clinician.	DEMONSTRATED - KFF self-report; causality and appropriateness of non-follow-up are unknown.
AI can be perceived as more empathetic/useful than physician-written online answers.	DEMONSTRATED in constrained written-response studies.
Patients are broadly losing trust in their own doctors because of AI.	NOT YET DEMONSTRATED. Existing evidence is mixed; high trust in clinicians persists.
Family doctors will become obsolete.	NOT SUPPORTED by current evidence.
The physician's competitive advantage will move from information possession toward judgment, relationship, integration, and accountability.	STRONG SYNTHESIS / PLAUSIBLE DIRECTION, consistent with current evidence and professional guidance, but not yet proven by long-term outcome studies.

10. Conclusions

- 1. Strongest evidence the phenomenon is occurring: KFF 2026 provides the clearest current U.S. picture: 32% used AI for health information/advice, 19% used it to explain tests/labs/diagnoses, 16% used it to help decide whether to seek care, and 41% of AI-health users uploaded personal medical information. The Australian MJA national survey independently confirms substantial uptake.
- 2. Is physician relevance declining? The evidence is stronger for role transformation than for generalized decline. AI is eroding the scarcity value of explanation and first-pass interpretation. It has not replaced examination, longitudinal responsibility, contextual judgment, or the social and legal institution of the physician-patient relationship.
- 3. Practical AI-era family doctor: a physician-led, AI-augmented model in which patients are encouraged to bring AI outputs; the doctor validates and contextualizes them; AI handles low-risk explanation and administrative work; and the physician concentrates on examination, uncertainty, decisions, prevention, coaching, continuity, and accountability.

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Source-quality note. The core quantitative claims in this report rely primarily on peer-reviewed studies, nationally representative surveys, WHO guidance, and major U.S. professional organizations. Some evidence is observational or experimental rather than longitudinal. The literature is moving quickly; prevalence estimates should be treated as time-specific snapshots rather than stable constants.