Attributing a decision is not organizing its oversight

What a human-oversight guarantee must specify, and what the signatory's name leaves undetermined

Three review regimes

A regulatory mitigation agreement concluded between the Utah Department of Commerce and the company Doctronic, made public on 6 January 2026, authorizes prescription renewals by an artificial intelligence system. The scope is narrow: 30-, 60- or 90-day renewals of already prescribed medications, chronic conditions and mental health, excluding controlled substances, within an approved formulary, with no new prescription and no change to the treatment plan.

The program's public page states the guarantee as follows: renewals are signed and approved by a licensed physician, "either directly or *vicariously through the AI system's protocol*".

The agreement is more instructive than the formula. It organizes three successive review regimes. First, a review of every decision *prior to the renewal being submitted to the pharmacy*. Then a review of every decision, but *retrospective*. Finally a periodic review covering a monthly sample of 5 to 10 % of processed renewals, supplemented by a quarterly analysis of escalated cases and an annual review of the indicators.

Two points of status. The initial document set progression thresholds in numbers of patients; those criteria have since been amended, the official page now describing eligibility by medication group. This analysis bears on the review architecture, not on the thresholds applicable today. And nothing publicly establishes, in the sources consulted as of 15 September 2026, that a change of regime has taken place: these are planned regimes, not observed practices.

What changes, what does not

Between the first and the second regime, the review does not disappear. It still covers the totality of decisions. What changes is its *timing*: it moves from before transmission to the pharmacy to after. Between the second and the third, two things change together. *Coverage* falls from the totality to a sample. And the scheduled cadence becomes

monthly, which must lead, absent the effect of the other channels, to later detection than in a review conducted shortly after issuance.

The 5 to 10 % figure characterizes one modality of scheduled review, not the whole of human intervention. Three escalation channels persist across all three regimes: the pharmacist retains authority to refer a case to a physician, the patient may request a review at any time, and the system automatically refers cases whose clinical complexity exceeds predefined thresholds. Any reading of the figure therefore requires its denominator, and aggregating the channels requires not counting the same decisions twice.

Throughout these variations, one term does not move: the physician's name remains attached to the prescription in all three regimes. Whether the obligations and the liability attached to that name are identical from one regime to the next is a separate question, and the agreement does not settle it.

From this follows the central proposition. *Two systems can display the same attribution, and even the same review coverage, while offering different preventive capacities*. The signatory's name indexes neither the timing, nor the coverage, nor the effectiveness of the oversight.

What a guarantee must state

Common usage says that a system does or does not include human oversight. That is a binary vocabulary for an object that is not binary. Describing how oversight is organized requires at least three dimensions, to which two characteristics they do not capture must be added.

Timing: the position of the intervention relative to the person's exposure, and the associated delays. *Coverage*: the decisions reviewed, the sampling method, the complementary channels. *Capacity to act*: the authority to impose a correction, the technical means to apply it, the execution and verification of that correction.

To these is added the *quality of the review*: the professional's competence, the information available to them, their effective ability to detect the error, the independence of their judgment. It is not separable from the first three, since a constrained review time degrades its depth and a high coverage increases the load, but it does not follow from them either. Two systems can share the same timing, the same coverage and the same means of action while detecting very different proportions of errors.

Added finally are the *purposes pursued*, and the way their achievement is measured. The next section returns to them, because they govern how the third regime should be read.

Together, these elements form a minimal description of how oversight is organized, not a complete characterization of its guarantee. It is a specification floor, and it is already more than a name provides.

Domain of validity. The thesis bears on what an attribution allows one to establish, not on the safety of the Utah pilot. It does not disqualify supervision by sampling: exception-based monitoring endowed with a capacity to stop can be substantial, and substantial oversight does not require universal review.

Precedence

Distinguishing oversight exercised before the effect from oversight exercised after is nothing new. French public accounting separates ex ante from ex post financial control. Internal audit contrasts preventive controls with detective controls. Financial markets have long distinguished *pre-trade* from *post-trade* compliance, precisely because the same coverage rate does not protect in the same way on either side of execution.

On this pilot, the distinction has already been named. Michelle M. Mello, in JAMA Health Forum of 19 March 2026, describes a medical review occurring before action for the first patients, then retrospectively for the following cohort, and notes the absence of any independent evaluation planned after deployment.

Medicine was moreover familiar with arrangements in which a professional answers for acts they do not review one by one, the standing order or the cooperation protocol, the delegate remaining a professional who can refuse and whose appraisal is itself a review. What automation widens is not the idea of placing human intervention at one point of the circuit or another, which was already an organizational choice. It is the possibility of moving that point, or of removing certain individual interventions, without the circuit standing in the way.

Specify, measure, evaluate

A serious objection awaits here: what counts is not how many files a physician looks at, but the net balance. Errors avoided or introduced, quality of referral, treatment interruptions spared, burden shifted onto pharmacists and patients. The number of files reviewed is a process measure, and a process measure is not a measure of clinical benefit.

The objection is sound and it narrows the scope of what precedes. It does not make the net balance sovereign for all that: a favorable average net benefit can conceal harm concentrated in a subgroup or a degradation of access to redress.

Three operations are conflated in this debate, and distinguishing them clarifies it without settling the trade-offs. *Specifying* the planned oversight, *measuring* its actual execution,

evaluating its consequences. The dimensions described above serve the first two. They do not make the clinical guarantee evaluable before any data, and a contractual declaration of delays does not establish actual delays. One can, moreover, measure practices, delays and errors without prior specification; what is missing then is a declared reference against which to judge the conformity of practices to the promise.

Who is protected

Correcting the file under review and preventing errors on subsequent files are not the same operation.

A late review loses interception capacity on the case reviewed. It retains, and sometimes increases, another value: limiting consequences that are still unfolding, detecting a systematic rather than an isolated error, triggering suspension of the system, preventing errors to come. Monthly sampling does not constitute a prior barrier for the totality of decisions; it can be a good instrument for monitoring the system.

Two populations therefore benefit from protection, the patient whose file is reviewed and the subsequent patients, while the system itself is the object monitored. One oversight arrangement can serve several of these purposes at once. A useful specification does not choose between them: it states which ones it pursues and how their achievement is measured.

What the regulation prescribes, what it leaves to be translated

Article 14 of Regulation (EU) 2024/1689 requires that high-risk systems be capable of being overseen by natural persons during the period in which they are in use. Its paragraph 3 requires that the oversight measures be "commensurate with the risks, level of autonomy and context of use". Its paragraph 4 enumerates capacities: to understand, to interpret, to decide not to use the system, to disregard, override or reverse its output.

This is a general and proportionate requirement, not a purely declarative one. The absence of a universal rate does not mean the absence of operational specification: it means that the specification is referred to the provider and the deployer, as a function of risk and context.

Paragraph 5 offers, within that article, the most explicit prescription of prior verification. For remote biometric identification systems referred to in point 1(a) of Annex III, no action or decision may be taken by the deployer on the basis of an identification unless that identification has been separately verified and confirmed by at least two natural persons. The text there fixes the moment, the coverage and the redundancy, and attaches to the

rule an exception where Union or national law deems that double verification disproportionate in certain law enforcement, migration, border control or asylum uses.

Everywhere else, translating the general obligation into verifiable modalities falls to the provider and the deployer. The dimensions described above supply a partial translation of it, centered on how the intervention is organized. They do not exhaust the requirements of the regulation.

The contractual consequence

A contract clause, an attestation or a tender response promising human oversight becomes usable if it sets out the elements above instead of settling for a designated responsible person. Failing that, the promise does not allow a preventive capacity to be appraised. An audit can always find the specification insufficient, look for actual practices, examine other dimensions; it will work without a declared point of comparison.

A conditional relation guides the trade-off: the more irreversible the consequences of an error, the more decisive prevention before exposure becomes, and the less a retrospective monitoring arrangement can stand in its place. That is the only general rule this file supports.

Limits

The file documents what a contract provides and what an operator declares. It documents neither actual execution, nor what supervisors verify, nor what courts sanction.

Capacity to act is posited as a dimension and not measured. Establishing it would require the actual delays of transmission, dispensing and first dose, but also the reviewer's effective authority, their means and the verification of the corrections decided. None of this appears in the sources consulted.

The initial agreement states its progression triggers in numbers and lists its performance indicators, concordance between physician and system, approval rate, patient and pharmacist escalation rates, without stating any numerical threshold on those indicators. That is an observation about that document in its initial version, and not a conclusion about the protocol or about the criteria in force.

Closing

Eleven of the fourteen members of the Utah Medical Licensing Board called for the pilot to be suspended, insisting on clinical reassessment, the risk of interactions and the absence of prior consultation of the Board. The State's response, for its part, spells out the review regimes and the rate of the first of them. The exchange therefore makes timing

and coverage visible, which shows well enough that these terms are available when the guarantee is under discussion.

It is the signatory's name that does not carry them. The timestamp on a signature does not establish, on its own, when or how the file was reviewed.

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