

How to use AI scribes and assistants effectively

Clinical documentation is a time-consuming burden for many physicians. Physicians often spend more time completing administrative tasks than interacting with patients. This contributes to burnout, reduced job satisfaction, and decreased face-to-face engagement.

Ideal future

In response, a large metropolitan teaching hospital implements AI-powered scribe technology across its outpatient clinics. The AI tool integrates with the electronic medical record (EMR) platform and is designed to transcribe natural conversations between physicians and patients during consultations, generating consultation summaries and action lists.

The aim is to automate note-taking, capturing clinical narratives, patient history, medications, diagnoses, and care plans with minimal human input. Pilot departments include internal medicine and endocrinology, where clinicians have expressed frustration over growing administrative loads and noted duplication.

Clinical scenario

With a full schedule of patients presenting to his clinic today, Dr Webster, an endocrinologist, opens the AI scribe that the hospital has implemented. His first consultation for the day is a review appointment with an existing patient. **Despite having used the AI scribe for previous visits with this patient, Dr Webster asks whether the patient is comfortable with having the AI scribe listen in and transcribe the consultation.** When verbal consent is received, Dr Webster inputs the patient’s details into the scribe application, noting that this is a review consultation and that verbal consent has been received. Dr Webster then starts the consultation, with the AI scribe listening and transcribing.

Risk managed:
Dr Webster ensures that patient consent for the use of the AI scribe is obtained prior to each consultation—written consent for the initial visit and verbal consent for follow-ups. During initial consultations, Dr Webster provides information about data collection and storage.

Risks		Benefits	
	Privacy and data security: Patients may not be comfortable having sensitive consultations recorded. Concerns around privacy regulation have also been raised.		Time efficiency: Physicians can save up to 2 hours per day previously spent on documentation. ¹
	Accuracy and misinterpretation: AI may misinterpret accents, medical terminology, or context, leading to errors in consultation summaries or other outputs.		Improved patient interaction: Clinicians can focus on the patient rather than the computer. ²
	Over-reliance: Clinicians may overlook review steps, assuming AI-generated notes are fully accurate.		Consistency and completeness: AI scribes can ensure standardised note-taking, reducing variability in records.

¹ Scrivas. 2024. Reduction in Documentation Time: How AI Scribes Can Significantly Decrease the Time Physicians Spend on Documentation, Allowing More Time for Patient Care. Scrivas. [Reduction in Documentation Time: How AI Scribes Can Significantly Decrease the Time Physicians Spend on Documentation, Allowing More Time for Patient Care](#) | Scrivas

² Scrivas. 2024. Reduction in Documentation Time: How AI Scribes Can Significantly Decrease the Time Physicians Spend on Documentation, Allowing More Time for Patient Care. Scrivas. [Reduction in Documentation Time: How AI Scribes Can Significantly Decrease the Time Physicians Spend on Documentation, Allowing More Time for Patient Care](#) | Scrivas

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Clinical scenario – after consultation

Following the consultation, both the patient and Dr Webster feel that the consultation was a productive one. Once the patient has left, **Dr Webster reviews the output from the AI scribe related to the consultation, adjusting phrasing based on his own interpretation and comparing notes to the previously recorded consultations.** Given the patient's complex needs, Dr Webster decides, in collaboration with the patient, that a referral to another specialist for a related condition was necessary. Dr Webster is able to use a Dictate tool as part of the AI scribe to quickly draft up the referral letter. **After he has reviewed the consultation summary and referral letter, these files are stored on the AI-scribe's platform and sent to the patient for their information.**

Risk managed:

Dr Webster reviews all transcriptions and AI generated outputs to ensure there are no errors. He adapts phrasing within the consultation recording and referral letter to reflect his own interpretation and suit his style.

Clinical scenario – end of day

Prior to finishing for the day, Dr Webster reviews his notes for each consultation, particularly the AI scribe summary, to ensure that there are no inconsistencies between what he remembers and what the AI scribe has recorded. By the end of the day Dr Webster has used the AI scribe for roughly 60% of his consultations. He has been able to see his full patient load and has finished all the related administrative tasks on time.

Key considerations for physicians using AI scribes



Patient consent: Ensure patients are informed about, and provide consent for, the use of an AI tool for consultation documentation during visits.



Vendor selection: There are an ever-growing number of vendors that have developed AI scribes. When choosing an AI scribe for your clinical practice, consider:



Review responsibility: Always verify AI output before signing off.



Customisation and training: Perform regular updates and feedback to improve accuracy based on specialty and workflow.



Compliance and governance: Adhere to institutional policies on data use and retention.

- **Data governance:** How is the data the product uses and receives stored?
- **Interoperability with your existing software platform:** Can the AI tool be integrated into the software platform your clinic uses?
- **Your physician style:** Which AI tool best complements your approach and style as a clinician?
- **Your patient population:** Which AI tool best complements the patient cohort that you see?

To learn more about AI, see the *Evolve AI in Healthcare* webinar series on the [Evolve homepage](#).