Charting safely: Overcoming practical hurdles in AI scribe adoption

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By Bradley E. Byrne Jr., JD

According to data compiled by the CDC, office-based physicians spend approximately 1.8 hours per day documenting outside of normal business hours. Numerous factors have driven this behavior, starting with the checkbox-laden, compliance-focused design of many EHR systems. Maintaining patient engagement during visits is another contributor, as practitioners often defer charting to remain fully focused on patients.

With the hope of addressing this issue, clinicians are increasingly using ambient-listening artificial intelligence (AI). Commonly known as "AI scribes," these tools passively capture and analyze clinical conversations to draft suggested encounter notes for the clinician to review and enter into the medical record. According to a study published in *Nature* in September 2025, it's estimated that 30 percent of physician practices are utilizing AI scribes, and strong adoption is anticipated over the coming years. As AI scribe use grows, it's essential to examine the practical implementation hurdles for seamless clinical integration.

Clinician and patient adaptation

Unlike human scribes who can visually interpret an exam, ambient AI systems depend on auditory input. Practitioners may need to adjust their examination style and workflow to ensure they are "thinking out loud." All clinically relevant observations, findings and impressions need to be clearly articulated to be captured by an ambient listening system.



Patients will also need to acclimate to these systems, as many patients are apprehensive about their use. In a recent survey in *JMIR Medical Informatics*, a plurality of respondents expressed concerns about the accuracy of documentation generated by AI scribes. Fostering patient trust through clear communication and transparency will be necessary. Prominent signage announcing the use of AI scribes, along with readily available FAQs, can help set expectations, dispel common misconceptions and help patients better understand these new tools.

Patient consent

Securing patient consent might initially appear straightforward: Simply have patients execute a consent form during the intake process. Although a written consent form is an important part of the process, it's unlikely on its own to satisfy the legal and ethical considerations associated with passive recording systems.

Under federal law, a recording is generally legal if at least one person participating in the conversation is aware of the recording and consents to it. This is known as "one-party consent." In addition to being the federal rule, most states also follow the one-party consent standard. However, there are a handful of states – California, Florida, Pennsylvania and others – that require two-party or all-party consent. Failure to obtain the necessary consents before initiating an AI scribe session can open the door to statutory liability. This scenario is at the heart of a proposed class-action lawsuit filed in 2025, in which the plaintiff alleges the defendant health system recorded patient-clinician conversations without consent, in violation of California law.

A blanket consent executed during the patient onboarding process, or during the annual patient information update process, may help demonstrate "prior consent, but it's far from a legal certainty." Patients might later allege that they didn't understand what they were signing or didn't realize they were consenting to the recording of specific interactions with their practitioner.

Moreover, this approach likely falls short of the AMA's guiding ethical principles regarding the use of AI-enabled technologies: "The use of AI-enabled technologies by hospitals, health systems, physician practices, or other entities, where patients engage directly with AI, should be clearly disclosed to patients at the beginning of the encounter or interaction with the AI-enabled technology."

Another essential component of the consent discussion is how practitioners should respond when a patient declines to provide consent or later withdraws it. In short, patients should be able to opt out at any time. This should be frictionless, and practitioners should be prepared to use traditional documentation methods.

Other risks

Depending on the AI platform and its configuration, raw audio or complete transcripts may be retained after clinical encounters. Although it's ultimately dependent upon how it's maintained and used, this information typically falls outside the designated record set and is generally inaccessible via a standard patient medical-record request. Even so, this information may still be discoverable in litigation if the retained information is relevant to the underlying lawsuit.

Furthermore, once litigation is reasonably anticipated, this data likely becomes subject to a "duty to preserve," and failure to retain this information can lead to spoliation of evidence allegations. Crucially, a finding of spoliation may result in adverse inferences, permitting a judge or jury to assume that the missing audio would have been unfavorable to the practitioner. Given that adverse inferences are typically devastating to the defense of a case, implementing a streamlined data preservation process is essential.

Automation bias

The novelty of AI scribes will eventually diminish, and these systems will become a routine part of healthcare. However, as clinicians grow more confident in the accuracy and completeness of AI-generated documentation, they must remain vigilant against overreliance on its automated outputs – a well-recognized phenomenon known as automation bias. Practitioners should always thoroughly review recommended AI notes before entering them into the medical record. Failure to do so could be problematic.

In a worst-case scenario, an unverified AI-generated note in the medical record is inconsistent with its corresponding audio recording, which is likely to be discoverable. This could not only cast doubt on the accuracy of the entire medical record but could also call into question the practitioner's thoroughness and professionalism.

Combating automation bias could be the most crucial step practitioners can take. Doing so requires intentional and regular training on the subject. Conducting periodic "agreement audits" to see how often practitioners accept an AI-recommended note without changes can uncover over-reliance and provide an opportunity to reinforce this controlling maxim: Practitioners retain ultimate responsibility for the accuracy and completeness of the medical record.

Looking forward

The complexities of modern medicine can be overwhelming, and AI scribes offer a solution to several real problems. However, they also introduce a set of new challenges to manage. As clinicians integrate AI scribes into practice, a checklist can help support consistent decision-making around consent, documentation review and data preservation. Successful implementation requires transparency, patient choice and continued clinician ownership of the medical record. PSN

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