Artificial intelligence scribes—Are we ready?

Artificial intelligence (AI) has made the leap from blue-sky theory to bedside tool, yet many of us remain unsure how to use it safely. One application gaining traction is AI scribe technology—tools designed to generate medical notes from physician–patient conversations. The Doctors Technology Office recently published an article on choosing between the various machine learning models that can be tailored for clinical use.[1] Over the coming months, it will be interesting to see how our colleagues choose, or refuse, to integrate AI scribes and what lessons we might learn.

AI has been present in medicine for over 50 years. Early examples included programs like MYCIN, developed in the 1970s to diagnose and treat serious infections.[2,3] In more recent decades, AI applications in digital pathology[4] and radiology[5] have been proposed as physician partners, although implementation, ethics, and performance concerns remain.[6,7]

In April 2025, Doctors of BC released a policy statement on the use of AI in medical settings.[8] Among its commitments is a call for input from physicians, Indigenous Peoples, patients, medical learners, and other health care professionals to ensure all interest holders' views are reflected. The statement also notes that although Health Canada uses a risk-based approach, "this framework has not been responsive to the evolving AI landscape. Common AI tools, like scribes . . . are largely unregulated." It recognizes the need for a comprehensive set of standards—a laudable goal, but perhaps idealistic, given the pace of development in AI and the tremendous push for market adoption.

The College of Physicians and Surgeons of BC (CPSBC) published an interim guidance statement in October 2024.[9] It outlines six principles for using AI in practice:

1. Privacy, confidentiality, and consent, including familiarity with the Personal Information Protection Act as it relates to AI.
2. Accuracy and reliability—using critical thinking and clinical expertise when applying AI tools.

It's up to physicians to define how these tools fit into our practices.

3. Transparency—being open with patients about the extent to which AI is used in their care.
4. Interpretability—understanding and interpreting AI-generated outputs appropriately.
5. Bias—recognizing issues around equity, diversity, and inclusion and algorithmic bias.
6. Monitoring and oversight—ensuring tools are used safely and appropriately over time.

The CPSBC makes it clear that these principles also apply to AI scribes, including the need for a physician to review documentation before entering it into the medical record. If the software stores audio recordings, physicians should reference the photographic, video, and audio recording of patients practice standard.[10] The CPSBC also refers readers to additional guidance from the Law Society of British Columbia[11] and the Canadian Medical Protective Association.[12] After all, the responsibility for a medical record remains with the physician, even if AI drafts it.

While writing this editorial, I thought it appropriate to ask a large language model about integrating AI scribes into clinical practice. ChatGPT, perhaps surprisingly, began by suggesting that physicians start with a clear goal. Are you trying to improve patient flow? Reduce documentation burden and burnout? Setting an intention helps determine whether the intervention is actually useful. It also noted that AI cannot detect emotional tone or nonverbal cues—something we may take for granted, but worth emphasizing as we grow more reliant on AI-generated notes. Last, it recommended piloting the tool before a full rollout to gather feedback and make adjustments.

If you're already using an AI scribe, the *BCMJ* would love to hear about it. How do you approach consent? Does AI enhance your workflow or communications? Has its presence changed how you supervise or teach learners? Have you encountered bias? How do your patients feel about being recorded?

In the title of this editorial, I didn't ask "should we" use AI scribes, because their presence in medicine now seems inevitable. The real questions are: When will this happen? Who will shape how they're used? Ultimately, it's up to us—physicians—to define how these tools fit into our practices. And it may also fall to us to monitor, challenge, and guide AI developers to ensure these technologies evolve in ways that genuinely serve our patients. ■

—Caitlin Dunne, MD

References

1. Doctors Technology Office. Using AI scribe technologies. Accessed 27 May 2025. www.doctorsofbc.ca/advice-support/doctors-technology-office/using-ai-scribe-technologies.
2. Sotos JG. MYCIN and NEOMYCIN: Two approaches to generating explanations in rule-based expert systems. Aviat Space Environ Med 1990;61:950-954.

References continued on page 198

Vaccine-hesitancy conversations

Measles outbreaks in several countries, including Canada, have exposed the ongoing struggle physicians face with vaccine hesitancy. Measles was declared eliminated in Canada in 1998.[1] As of 23 June 2025, there were 3381 cases of measles reported in Canada, and numbers continue to rise in several provinces[2]—a stark contrast to the three reported cases in Canada in 2022.[2] Despite our immunization levels remaining high as a country, there are pockets of undervaccinated populations, whether due to barriers in access, vaccine hesitancy, or misinformation, allowing outbreaks to be possible.

Vaccine hesitancy is something I encounter every day as a family physician. From routine childhood immunizations to prevention of shingles, pneumonia, and respiratory syncytial virus in older populations, vaccines impact every patient we encounter. Along with administering and discussing vaccines, there is also the uphill battle of debunking the misinformation patients hear from other sources, whether the Internet, acquaintances, or, more significantly, governing officials. In the US, the antivaccine rhetoric from the Secretary of Health and Human Services, Robert F. Kennedy Jr., has grown increasingly concerning. False claims that vaccines cause autism and questions about the safety and efficacy of the measles-mumps-rubella vaccine have gained traction in the media. The recent measles outbreak in Texas, with reported fatalities, highlights the very real outcomes of vaccine hesitancy and misinformation.

During influenza season, I hear "I don't believe in the flu vaccine" several times a day. I try to encourage discussion and explore patients' beliefs about why they think the flu vaccine does not work. Unfortunately, with the reality of a busy practice, I pick and choose my battles. Sometimes I spend 15 minutes discussing a vaccine and answering a patient's questions and concerns, only to be met with continued skepticism. It can be exhausting.

During influenza season, I hear "I don't believe in the flu vaccine" several times a day.

There *are* a few things I find helpful to generate discussion, or at least plant a seed that we can revisit later.

I deliver a strong, confident recommendation and listen to concerns without judgment. I have had instances where a patient comes back to request a vaccine several months after I had a seemingly futile discussion with them. Having educational materials like pamphlets and posters in our office has encouraged patients to ask questions about vaccines and do more research if they wish.

I try to increase convenience for the patient. When a patient comes in for a routine visit like a medication refill, I always ask, "We also have the flu vaccine in office; would you like one?" I have also worked in offices with drop-in vaccine clinics to increase convenience. The availability of vaccines in pharmacies with administration by pharmacists has also been extremely valuable. As many patients reach out to social media for information, trusted sources like our public health agencies and organizations can continue to promote vaccine information and encourage vaccination.

Even when it feels like a struggle to address vaccine hesitancy in a busy practice, I hope we can continue to encourage thoughtful discussion with our patients and believe that we are making a difference. As we brace for another respiratory illness season in the fall, what are some beneficial ways you have found to promote vaccine uptake in your practice? ■

—Yvonne Sin, MD

References

1. Osman S, Crowcroft N, McLachlan E, et al. Population immunity to measles in Canada using Canadian Health Measures survey data – A Canadian Immunization Research Network (CIRN) study. Vaccine 2022;40:3228-3235. https://doi.org/10.1016/j.vaccine.2022.04.011.
2. Government of Canada. Measles and rubella weekly monitoring report. Modified 23 June 2025. Accessed 25 June 2025. https://health-infobase.canada.ca/measles-rubella/.

References continued from page 196

3. Smith JW Jr, Svirbely J, Fannin E. A gentle introduction to knowledge-based systems in medicine. Top Health Rec Manage 1988;9:36-54.
4. McGenity C, Clarke EL, Jennings C, et al. Artificial intelligence in digital pathology: A systematic review and meta-analysis of diagnostic test accuracy. NPJ Digit Med 2024;7:114. https://doi.org/10.1038/s41746-024-01106-8.
5. Friedlander Serrano J. AI hasn't killed radiology, but it is changing it. Washington Post. 5 April 2025. Accessed 27 May 2025. www.washingtonpost.com/health/2025/04/05/ai-machine-learning-radiology-software.
6. Mello-Thoms C, Mello CAB. Clinical applications of artificial intelligence in radiology. Br J Radiol 2023;96:20221031. https://doi.org/10.1259/bjr.20221031.
7. Parker W, Jaremko JL, Cicero M, et al. Canadian Association of Radiologists white paper on de-identification of medical imaging: Part 1, general principles. Can Assoc Radiol J 2021;72:13-24. https://doi.org/10.1177/0846537120967349.
8. Doctors of BC. Artificial intelligence in health care. Policy statement. Updated April 2025. Accessed 27 May 2025. www.doctorsofbc.ca/sites/default/files/documents/2025-04-11-chep-ai-in-hc-policy-statement.pdf.
9. College of Physicians and Surgeons of British Columbia. Ethical principles for artificial intelligence in medicine. Revised 3 October 2024. Accessed 27 May 2025. www.cpsbc.ca/files/pdf/IG-Artificial-Intelligence-in-Medicine.pdf.
10. College of Physicians and Surgeons of British Columbia. Photographic, video, and audio recording of patients. Practice standard. Revised 7 October 2024. Accessed 27 May 2025. www.cpsbc.ca/files/pdf/PSG-Photographic-Video-Audio-Recording.pdf.
11. Law Society of British Columbia. Guidance on professional responsibility and generative AI. Practice resource. Accessed 27 May 2025. www.lawsociety.bc.ca/Website/media/Shared/docs/practice/resources/Professional-responsibility-and-AI.pdf.
12. Canadian Medical Protective Association. The emergence of AI in healthcare. Revised May 2023. Accessed 27 May 2025. www.cmpa-acpm.ca/en/advice-publications/browse-articles/2019/the-emergence-of-ai-in-healthcare.

Letters to the editor

We welcome original letters of less than 500 words; we may edit them for clarity and length. Email letters to journal@doctorsofbc.ca and include your city or town of residence, telephone number, and email address. Please disclose any competing interests.

Re: Infertility among physicians

I am writing in response to the editorial "Infertility among physicians," published in the April 2025 issue of the *BCMJ*. It is staggering that 24% to 33% of physicians experience infertility, double or more the proportion of the general population.

The majority of fertility challenges are related to advanced maternal age. In 1992, 54% of medical school applicants in Canada were under the age of 22. In 2021, that number had fallen to 40%. In the same time period, specialty training programs evolved to obligate medical graduates to commit to a specialty program varying in length from 2 to 6 or more years. Most medical schools require applicants to have graduated from at least an undergraduate program prior to entry into the 4-year medical school. Many students complete additional years of research or master's programs to better their chances of medical school acceptance. This journey can take 9 to 15 years.

Is all this really necessary? Do older medical school graduates who have accrued more than a decade of student debt, with long-term partners and aging parents, really serve the medical needs of the Canadian population? Or would we have a more robust workforce by returning to undergraduate programs, graduating younger students with less debt and fewer familial obligations who are willing and able to work in rural and remote areas, complete specialty training, and still have time in their precious fertility windows to have children themselves?

Physicians make countless sacrifices in their personal lives for their profession. Having the choice to have children, ideally without reproductive technology, is a basic human right. Women shoulder the burden of childbearing and child-rearing in the early years of a child's life. Over 60% of medical school students are women. The current paradigm of seeking perfection in medical school applicants, to the detriment of good enough, is harming our profession in ways that cannot be measured. We should not be asking this of our graduates, and we should be ensuring they enter medical training fully informed of the risk of being childless without choice.

—Deena Case, MD
Fernie