

# Alberta Doctors' Digest

## Beware of silent mistakes of ambient scribes

In an exam room, a family physician discusses a patient's worsening right knee pain. Across the room, a tablet quietly listens, running ambient scribe software. By the time the encounter ends, a polished progress note appears – seemingly ready for the medical record.

But hidden in the text is a small error: the patient is documented as having left knee pain instead. The mistake then migrates, copied onto an X-ray requisition and eventually into a surgical referral.

As hospitals and clinics increasingly turn to ambient scribes – artificial intelligence tools that automatically draft clinical notes based on conversations – a new category of clinical risk is emerging. These tools promise to save time, reduce burnout and improve documentation quality. Yet they can also introduce subtle but significant errors.

### **Omission errors: What isn't captured can hurt**

One of the most common and dangerous errors is the omission of critical information. As ambient systems become more prevalent, clinicians are finding that key clinical details – particularly in complex cases – are sometimes left out. Omissions often occur because ambient scribes prioritize conversational flow over clinical nuance, missing when important points are mentioned briefly or casually.

### **Commission errors: inserting false details**

A resident dictated "patient denies chest pain" during an annual exam. The ambient scribe misheard and recorded "patient reports chest pain," a mistake that, if unnoticed, could trigger unnecessary referrals and propagate through subsequent encounters. Commission errors – where the system inserts incorrect information – often stem from misheard words, background noise, accents or multiple speakers.

### **Contextual errors: misunderstanding the story**

Recently, a patient mentioned surviving a stroke "years ago." The AI system, unable to grasp the timeline, documented it as a current diagnosis. Contextual errors arise because ambient scribes lack a true understanding of time, nuance and clinical reasoning. Historical conditions, hypothetical scenarios and family medical history are easily mistaken for active medical problems, potentially leading to unnecessary tests or treatments.

## **Formatting and structural errors: breaking the flow**

Some notes generated by ambient scribes have misplaced elements: physical exam findings under the history of present illness or investigation results improperly listed under assessment and plan.

While less immediately dangerous than factual errors, poor formatting can create cluttered, confusing documentation. Disorganized notes obscure clinical reasoning and complicate multidisciplinary care, which increases the risk of miscommunication among health care teams.

## **The bottom line: Trust, but verify**

Ambient scribe technologies are evolving rapidly, and early results show they can significantly reduce documentation burden. For physicians spending hours daily on paperwork, these tools offer a promising path toward reclaiming time for direct patient care. Yet despite these advantages, ambient scribes remain imperfect. Errors of omission, commission, context and formatting are common.

For the modern physician, the message is clear: the ambient scribe may be listening, but the final word remains yours.

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Editor's note: The views, perspectives and opinions in this article are solely the author's and do not necessarily represent those of the AMA.