College of
HEALTH AND CARE
PROFESSIONALS OF BC

Physical Therapists

Using a Digital Scribe for Documentation

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With the advent of digital scribe (automated clinical documentation) technology, you may be considering using this form of artificial intelligence (AI) to improve both efficiency and patient care. Before you do, you will need to consider what the literature says about both the advantages and the risks of using a digital scribe, as well as your regulatory obligations, which you should review whenever you use new or emerging technologies in practice.

There are many potential benefits to digital scribing, including increased ability to focus on the patient (as you do not have to take notes during the patient encounter), increased efficiency, and increased accuracy in capturing the patient's voice. In addition, some practitioners have found that they are more likely to have a fuller discussion of their findings with their patient, articulating thoughts and observations aloud so that they can be captured.

However, AI and digital scribe technologies are not infallible. It is important to remember that digital scribes are intended to assist with documentation (and in some cases clinical decision making), not to replace clinical judgement or clinical reasoning. It is important to remember that data produced by digital scribes may be inaccurate or demonstrate inherent bias.

Currently, there is no regulation specific to the use of AI or digital scribing in physical therapy practice in BC; however, if you use these tools, you must still meet all of the existing College requirements. For example, you must follow the College Practice Standard related to records regardless of the documentation method which is used (paper-based, electronic, digital scribe, or other method). Likewise, there are regulations and a Practice Standard related to privacy and consent which must be adhered to when collecting and documenting personal information.

What Does a Digital Scribe Do?

Digital scribing is more than transcribing audio to text for use in a clinical record. Essentially, a digital scribe takes an audio recording of the encounter you have with your patient, converts audio to text, and extracts the information it decides is important from

the text. It may offer differential diagnoses or hypotheses based on the information it captures, refining it as the conversation continues, and it summarizes that information into what it determines is the correct section of your documentation template.

There are multiple digital scribe options/companies—before selecting a scribe for your practice, be sure to compare features, ask for a demonstration, and explore whether it meets your needs based on the advice below.

Ensure Privacy, Confidentiality, and Data Security

As with any software or technology used in practice, it is your professional obligation to be aware of the privacy safeguards within the system, to ensure that they comply with provincial privacy legislation. When utilising digital scribe technology, you must ensure that appropriate security protocols and the necessary privacy measures are in place.

These might include factors such as understanding how patient information is anonymized or de-identified, being able to apply end-to-end encryption, confirming where and for how long the data are stored, and understanding whether the patient's data will be accessible to the digital scribe model for use as part of the data cache of the system (which can be used for training the model for enhanced accuracy and capacity over time). It is important that this feature can be disabled.

It is also important to know what other security measures are built into the system (for example, what safeguards or options do you have if the digital scribe accidentally records a conversation that wasn't supposed to be captured?). You should also know how to protect your patient's personally identifiable data (such as date of birth or ICBC case number) from being captured by the scribe. Completing a privacy impact assessment may be helpful to review the implications of using the tool and the safeguards required (more information on privacy impact assessments can be found at https://www.oipc.bc.ca/documents/guidance-documents/2246#:~:text=A%20PIA%20should%20indicate%20the,and%20stores%20the%20personal%20information).

Obtain Informed Consent

You are required to obtain informed consent from your patient to use a digital scribe during your session with them. You will need to explain what the digital scribe does, why you would like to use it, and any potential risks (for example, inaccuracy or data breaches) and how these will be mitigated. Include an explanation of how privacy is assured. Be clear that they may decline the use of the digital scribe without compromising treatment, and that the digital scribe will be turned off if they do not consent to its use.

Review the Output for Accuracy

You must review and edit the documentation produced by the digital scribe to ensure accuracy and to ensure that it meets the requirements of the Practice Standard: Records. As a licensee, you are responsible for the accuracy of your documentation—not the digital scribe. It is the physical therapist who is accountable for the quality, accuracy, and comprehensiveness of the patient record. Ensure your clinical judgement and assessment findings, as well as your physical therapy diagnosis, treatment, goals, and plan, are accurately reflected in the final record.

In the clinical record, note what technology (including version number) was used to capture the chart note.

Risk of Bias in the Output

Be aware that current AI tools (including digital scribes) evolve and learn by reviewing large datasets; these datasets can include or reflect bias, and therefore the output of the tools will apply these biases. This could result in an incorrect interpretation or documentation of the conversation you have with your patient.

The digital scribe needs to understand both your and your patient's speech (consider factors such as accents, medical terminology, ambient noise, other nearby conversations) and it will miss the nuances of non-verbal communication. It may not convert to text correctly, and then its documentation and diagnostic suggestions may be inaccurate. It can summarize the salient pieces of the conversation to suggest hypotheses based on the learning it has done as a result of multiple previous patient encounters with multiple other clinicians—if the dataset it has been trained on does not include data on rare conditions or red flag indicators, the scribe may not suggest these conditions or identify a concern when you, a physical therapist, would. The digital scribe is developed to recognize patterns and will default to the most frequent pattern it finds in its training dataset. The scribe may not suggest this as a differential diagnosis, or it may suggest a diagnosis that is entirely incorrect or implausible.

It is important to be mindful when reviewing scribed notes as the outcome may include bias leading to inaccuracies or gaps and may not reflect how you would have captured the clinical interaction independently.

In Summary

Digital scribes, along with other AI technology, have the potential to be beneficial tools for patient care. While there is currently no regulation related specifically to physical therapists using digital scribing, as with any new tool, it is incumbent on licensees to ensure that the use of digital scribes adheres to all College Practice Standards, as well as other legislation such as the Personal Information Protection Act (PIPA).

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