

PLAIN LANGUAGE SUMMARY



SPOR Evidence Alliance
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Do AI “scribes” reduce clinicians’ documentation burden?

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Summary

Clinical documentation takes substantial time and contributes to stress and burnout in healthcare. In this systematic review, we examined whether AI “scribe” tools (systems that can transcribe and help draft clinical notes) improve documentation burden, clinician outcomes, documentation quality, efficiency, and patient-related outcomes. We included eight intervention studies and summarized findings narratively. Overall, AI scribes showed promising but mixed improvements in documentation time and workflow experience, while evidence for reducing burnout was limited. Larger real-world evaluations are still needed to confirm benefits and understand risks for patients.

What does this mean?

AI scribes may help some clinicians spend less time documenting and feel more supported in their workflow, but the current scientific evidences is small and varies widely across technologies and settings. Implementation should be approached as a change-management and safety initiative: plan onboarding, integration with electronic health records, and ongoing monitoring of documentation quality and errors. Decisions to scale should ideally be paired with local evaluation (workload, quality, patient experience, and equity impacts).

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For more information, please contact
Maxime Sasseville, PhD
(masas27@ulaval.ca)

What is the current situation?

Clinicians face a heavy and increasing documentation workload, which contributes to stress and burnout and reduces time available for patient care. This is a major issue and human scribes can help but have practical limitations (cost, training needs, turnover), motivating interest in AI-based approaches.

What questions did we aim to answer in our research?

Do AI scribe tools used to support clinical documentation improve outcomes for clinicians (e.g., burden, stress/burnout), documentation quality, healthcare efficiency, and patient outcomes compared with usual practice?

How did we approach these questions?

We conducted a systematic review following Cochrane methods and PRISMA guidance. Two reviewers independently selected studies and extracted data. We included intervention and mixed-methods studies of AI documentation tools (e.g., transcription, summarization, structured note generation, EHR entry) across clinical settings, and summarized findings narratively.

What answers did we find from our research?

Across eight included studies, AI scribes generally showed positive outcomes for clinician workflow experience/engagement and some improvements in documentation time or burden in some settings. Concerns remained about training needs and documentation quality, and the effect on burnout appeared limited in the available studies evaluating it. We also identified recurring factors that were linked with successful clinical implementation: training/support, organizational preparation, technical considerations, workflow integration/evaluation, ethics, and future research needs.

How confident are we in these findings?

Confidence is cautious because the evidence is based largely on small studies in specific settings, with heterogeneous technologies and outcomes, so results may not generalize well to the Canadian setting. Accuracy and consistency may vary by system and implementation approach, and broader real-world clinical evaluations are needed before firm conclusions about effectiveness and safety can be made.