Letters

AI scribes might capture the consultation, but they miss the point ...

Foo et al present an important evaluation of artificial intelligence (AI) scribes in Australian general practice, suggesting comparable or superior performance to human documentation across several domains.[1] Importantly, the authors provide a clear and considered discussion about applications and limitations, in particular about what is meant by 'hallucination' in this setting.

However, in no other area of scientific inquiry would it be acceptable to define the metrics for success as the inherent attributes of just one of the systems being compared. This study (and many others in the AI discourse) are only assessing the marketed features of the AI scribe platforms, such as clarity, comprehensiveness, thoroughness and accuracy, without exploration of how we (clinicians, patients, researchers) should define medical record quality.

In routine practice, we do not produce verbatim transcripts; clinicians synthesise, interpret and translate patient narratives into clinically meaningful records. By contrast, AI scribes are optimised for transcript-faithful summarisation. The result is not a like-for-like comparison.

This reflects a broader issue: the purpose of clinical documentation is not clearly defined. Medical notes serve multiple functions, including communication between clinicians, continuity of care and, importantly, supporting clinical reasoning.[2,3] Treating documentation primarily as a structured summary driven by medicolegal priorities risks overlooking its cognitive role and drives a purely biomedical model of care. This evaluation framework risks privileging what is easily measured over what is most valuable in general practice. Rapport-building, understanding patient context and person-centred care are central to outcomes but less visible in transcript-based assessments.[4]

The act of clinical documentation may also help develop heuristic and pattern-recognition processes, with implications for training. For trainees, writing notes is closely linked to the development of reasoning skills through synthesis and formulation.[5] At present, the impact of removing this process is largely unstudied.

AI scribes may offer substantial time-management benefits. However, claims of superiority should be interpreted cautiously unless evaluation frameworks reflect the full purpose of clinical records. Perhaps the recording of clinical information should be seen as a valuable component of patient care, not an inconvenience.

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References are available online only.

Reply: AI scribes free the consultation; they do not define it

We appreciate the author's engagement with our study.[1] Several points raised, however, warrant clarification.

The assertion that our evaluation assessed only 'marketed features of AI scribe platforms' mischaracterises the instrument employed. The Physician Documentation Quality Instrument (PDQI-9) was developed to evaluate physician documentation quality and was validated well before the emergence of artificial intelligence (AI) scribes.[2] It reflects clinician-defined standards, not vendor-derived metrics.

The author contends that the comparison is not 'like-for-like', given that clinicians synthesise and interpret rather than produce verbatim transcripts. We agree and addressed this directly. Our finding that human-generated notes contained information not verifiable by the transcript, classified as a hallucination under the modified PDQI-9, illustrates precisely this distinction. This finding challenges the assumption that human documentation constitutes a gold standard and exposes a gap between clinical reasoning and its documentation.

The suggestion that AI scribes promote a 'purely biomedical model of care' conflates the documentation tool with the clinical encounter. AI scribes record the consultation; they do not determine its conduct. Reduced documentation burden may instead afford clinicians greater capacity for the rapport-building and reduced interpersonal disengagement the author rightly emphasises.[3]

Regarding trainee development, we acknowledge this warrants investigation. However, framing it as a permanent risk overstates the evidence. Concerns about deskilling have accompanied successive clinical technologies, and medical education has consistently adapted.[4] Current trainees may experience a transitional period, but subsequent cohorts will train in environments where ambient documentation is standard infrastructure, as digital imaging and electronic prescribing are today.

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The challenge lies not in whether to adopt these tools, but in how training frameworks should evolve to integrate them effectively.[5]

We welcome broader evidence-based discourse on the purposes of clinical documentation, and we question the assumption that existing practices are inherently superior.

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'Coercive control: Recognising relational patterns that affect patient wellbeing'; overlaps with patient healthcare experiences

We read with interest Lynch et al's paper[1] on recognising patterns of coercive control in patients; an important topic worthy of attention. However, the descriptions were eerily familiar to us – not from a domestic relationship perspective, but from experience accessing healthcare.

If a person dismissed their partner's illness, told them it is not that bad, refused to give them medications and told them they are 'just anxious', we would rightfully raise red flags that the relationship is abusive. Yet this is akin to many patients' – particularly women's – experiences accessing healthcare.[2] Both scenarios illicit fear, making escape difficult or impossible; medically, patients need to remain engaged for diagnoses/treatments. Lack of diagnosis/treatment can lead to loss of a patient's identity and freedom (descriptions akin to Lynch et al) or even life, including instigating or exacerbating abusive home relationships.

Lynch et al state 'Fear is often covered with polite compliance, sadness or anger'; this rings true of how patients can feel about medical appointments. While medical professionals often encourage patient advocacy, doing so can seemingly be perceived as 'proof' the patient is 'being dramatic', resulting in worse healthcare interactions, or as Lynch et al write: 'They create patterns of subjugation, terror, intimidation, punishment and fear that enable control'.

Lynch et al highlight 'coercive control causes women to be fearful for their own safety, their children and other family members'; this is particularly true for parents who can be perceived as being irrational – a phenomenon that has been recognised for decades[3] – with concerns that repeat medical encounters will trigger safeguarding procedures rather than medical care. Such conversations might be framed as choice, yet non-compliance can be used against the parent. Similarly, 'false friendship' is discussed. Indeed, there are articles dedicated to basically teaching medical professionals this 'trick',[4] failing to recognise the importance of providing quality healthcare.[5]

We are not implying coercive control is necessarily deliberate in healthcare; rather, we hope to raise awareness of the patient experience. Patient freedom and wellbeing are at the mercy of doctors. Remembering this might help doctors re-evaluate their approach, in turn possibly improving patient trust and outcomes.

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Reply

Thank you for the opportunity to respond to this thoughtful letter to the editor.

We are grateful to the authors of this letter for their careful reading of our paper and for their courage in sharing the patient experience that has caused them pain.

We are also thankful to see our paper used as pattern recognition beyond the domestic and family violence setting. Being able to watch for relational patterns of invasion, confusion and isolation in the doctor–patient relationship is important.[1]

We join with the authors in noting that fear, polite compliance and the suppression of distress can characterise the experience of patients who have learned that advocacy may be used against them, or that expressing distress risks being labelled as 'dramatic' or dismissed as 'just anxious'.[1] This can be exacerbated for women, and for those patients who are survivors of childhood trauma or domestic and family violence, whose symptoms are often hard to diagnose and whose pain is often dismissed.[2,3]

This letter to the editor also highlights the need to train clinicians to have overt awareness of the power dynamics in every consultation.[4] As the authors note, many troubling clinical encounters might involve not deliberate manipulation, but instead structural medical and gendered bias against trusting subjective information as evidence, and against uncertainty, emotion, or vulnerability as reliable.[5] When the fiduciary power of medical authority is used rigidly with over-reliance on objective markers, it displaces the patient's lived knowledge and means that patients can feel 'blamed for their own distress'.[6] When a patient's account of their experience is consistently overridden, reframed, or treated as data to be corrected rather than as a perspective to be understood, the clinical relationship is no longer safe for the patient – regardless of whether any manipulation was intended.

Our hope for quality medical care is that both clinicians and patients can hold complexity together. The goal is not agreement for its own sake, but consultation built on mutual respect – one in which a patient's reality is taken seriously even as it is being examined, and in which the limits of medical certainty are acknowledged

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with humility, suffering is validated, and the patient receives empathic interpersonal care.[6,7] The Sense of Safety Theoretical Framework that underpins our paper reminds that clarity, belonging and integrity are human needs – in providing safety in consulting rooms as much as in homes.[8]

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Reply

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