



Evaluating Artificial Intelligence (AI) Scribes to Reduce Administrative Burden and Enhance Data Interoperability in Canadian Primary Care

Centre for Digital Health Evaluation,
Women's College Hospital Institute for
Health System Solutions and Virtual Care

An evaluation among primary care clinicians across Canada who participated in Canada Health Infoway's AI Scribe Program.

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In partnership with:



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Acronyms

AB	Alberta
AI	Artificial intelligence
ASR	Automatic speech recognition
BC	British Columbia
CDHE	Centre for Digital Health Evaluation
DOI	Diffusion of Innovations
EMR	Electronic medical record
Infoway	Canada Health Infoway
LLM	Large language model(s)
MB	Manitoba
NB	New Brunswick
NL	Newfoundland and Labrador
NLP	Natural language processing
NP	Nurse practitioner
NS	Nova Scotia
NT	Northwest Territories
ON	Ontario
PAN	Patient Advisors Network
PCC	Primary care clinician
PPE	Patient Partner Evaluator
QC	Québec
RAG	Retrieval-augmented generation
RN	Registered nurse
SK	Saskatchewan
SOAP	Subjective, objective, assessment, and plan
WCH	Women's College Hospital
WIHV	Women's College Hospital Institute for Health System Solutions and Virtual Care
YT	Yukon

Operational Definitions

Active user: A clinician who uses an artificial intelligence (AI) scribe at least 10 times within a given month as part of the AI Scribe Program. Active use is calculated independently for each month of the evaluation period and reflects ongoing monthly engagement. This threshold was selected to distinguish routine use from occasional or exploratory use, consistent with digital health literature that defines engagement based on frequency and intensity rather than single interactions.¹ The threshold was chosen to approximate a minimum level of integration into clinical workflows (e.g., use across multiple clinic sessions within a month), while minimizing misclassification of clinicians who may have only trialed the tool. It also reflects variability in clinician practice patterns, recognizing that some clinicians may have fewer clinic days or lower patient volumes.

Artificial intelligence (AI) scribe: AI technology that uses machine learning models, such as automatic speech recognition and natural language processing, to summarize conversations between patients and clinicians into written text. AI scribes can produce a transcript of the conversation, a medical note, referral letters, and patient-facing documents.²⁻⁴ In this report, AI scribes may be referred to as a product or solution if referencing a specific AI scribe vendor.

Artificial intelligence (AI) scribe vendor: A company that has developed an AI scribe.

Clinical copilot: AI-enabled tools that assist clinicians across documentation, decision-making, and workflow tasks by integrating functions such as summarization, information retrieval, and clinical decision support within clinical systems, while preserving clinician oversight.^{5,6} AI scribes may form one component of a clinical copilot, as many emerging clinical copilot systems incorporate scribing capabilities alongside additional features, reflecting a shift from single-purpose documentation tools toward more integrated, multifunctional AI support systems. Clinical copilots may be delivered through direct integration within clinical systems (e.g., electronic medical records) or via second-screen applications, which operate alongside primary systems to provide real-time information, prompts, or decision support during patient encounters.

Electronic medical record (EMR): A digital collection of medical information about an individual, including information about a patient's medical history, such as diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and laboratory test results.

High-intensity user: A clinician who uses an AI scribe at least 160 times within a given month. This measure reflects monthly engagement and is assessed independently for each month. This threshold is based on a pragmatic assumption of a clinician working four days per week, seeing approximately 20 patients per day, and using an AI scribe in 50% of encounters, which corresponds to approximately 160 encounters per month where an AI scribe was used.

Inactive user: A clinician with no recorded AI scribe use for three consecutive months. For the purposes of the semi-structured interviews, inactive users were considered **non-adopters**.

Live user: A clinician who has completed at least one encounter using an AI scribe and whose status in the AI Scribe Program is activated. Live users represent a cumulative count over the evaluation period.

Medical note: A summary of essential information about a patient that is unique to each patient encounter. A medical note typically includes critical elements about a patient's health status and concerns, information that supports the treatment or procedure provided, and any other pertinent details that may be useful for the clinician and other healthcare professionals using the medical note to get a synopsis of the patient's health.

Primary care clinician (PCC): A clinician (i.e., family physician; nurse practitioner; registered nurse practicing in remote communities; pediatrician providing longitudinal, community-based care) who provides primary care services.

Survey respondent: A PCC participating in Canada Health Infoway's AI Scribe Program who completed at least one survey administered as part of the evaluation.

Executive Summary

Background

Primary care clinicians across Canada spend a significant amount of time on administrative tasks, which can contribute to burnout and reduce the time available for patient care. Artificial intelligence (AI) scribes, tools that help generate medical notes, have emerged as a solution to reduce documentation workload and improve clinical efficiency. While early studies have shown promise, evidence to date has largely come from small-scale or regional implementations.

In 2025, Canada Health Infoway (Infoway) launched a nationwide [AI Scribe Program](#), providing more than 10,000 fully funded, one-year licenses for AI-powered documentation tools to eligible PCCs across Canada. This created a unique opportunity to understand how AI scribes perform in real-world clinical settings across the country.

Objective

To evaluate the impact of AI scribes on administrative workload and clinical practice among primary care clinicians across Canada who participated in Infoway's AI Scribe Program.

Methods

A mixed-methods evaluation was conducted with clinicians enrolled in the AI Scribe Program. A total of 12,019 clinicians participated, with surveys collected at onboarding (n=3,678) and again after three- (n=2,667) and six-months (n=1,899) to assess clinician experience. Semi-structured interviews were conducted with users (n=37) and non-adopters (n=10) to capture a range of perspectives. Additional analyses drew on AI scribe usage data, a retrospective chart review, and consultations with subject matter experts and patient partners.

Key Takeaways

- Infoway's AI Scribe Program represents the largest national implementation and evaluation of AI scribes in primary care worldwide. It included 12,019 clinicians across Canada, with 7,447 classified as active users (≥ 10 uses/month) by the end of the evaluation period.
- AI scribe use scaled rapidly, with total monthly encounters increasing from 244,631 in June 2025 to more than 1.22 million by February 2026. Adoption was concentrated among highly engaged primary care clinicians, with one-third of users accounting for 85% of total encounters, demonstrating meaningful integration into clinical workflows.

- Nearly 70% of clinicians reported reduced administrative burden, and almost 80% reported a reduced cognitive load.
- Efficiency gains were evident early and increased with continued use. After six months, clinicians reported saving an average of 1.11 hours per week during work hours (95% CI: -1.73 to -0.48; $p=0.0005$) and nearly one hour per week after hours (95% CI: -1.29 to -0.45; $p<0.0001$). Greater gains were observed among pediatricians, nurse practitioners, and registered nurses, with some reporting savings of upwards of five hours per week.
- Time saved was commonly reinvested: over 50% of clinicians redirected time to complete other administrative tasks; over 20% increased same- or next-day appointment availability; and 20% reallocated time to facilitate better work-life balance. Some clinicians also reported improved clinic flow, including reduced in-clinic wait times.
- Reductions in documentation burden meaningfully changed clinical encounters. More than 80% of clinicians reported feeling more engaged during patient visits, and 60% perceived improvements in the quality of care they provided.
- AI scribes improved documentation quality and consistency. More than 75% of clinicians reported that AI-generated notes were accurate, and nearly 70% reported improved note completion. A retrospective chart review supported these perceptions and showed a modest increase in overall documentation completeness (92.9% pre-implementation to 95.5% post-implementation), along with reduced variability in note quality across clinicians.
- Reviewing and editing medical notes generated by an AI scribe remained an important part of clinical use, with over 75% of clinicians reporting that they regularly reviewed notes to address errors or structural issues. This reflects appropriate clinician oversight and highlights opportunities for further improvement in AI scribe performance and customization over time.
- AI scribes were widely perceived as valuable to clinical practice, with more than 90% of clinicians agreeing they added value and over 80% reporting satisfaction with performance. Benefits varied by clinician and workflow, with some primarily gaining time, others experiencing reduced cognitive load and improved engagement with patients, and others noting improvements in documentation quality.

Overall, findings indicate strong impact and future potential for AI scribes to meaningfully transform clinical workflows and improve work-life balance for primary care clinicians across Canada. Continued evaluation remains important to assess long-term use, variability across tools and contexts, and to ensure accuracy, effective workflow integration, and equitable access and outcomes.

1.0 Introduction

1.1 Background and Context

Clinical documentation is widely recognized as a major contributor to clinician burnout.^{7,8} Documentation-related burden arises from several factors, including the significant time and effort required to complete medical notes during and after patient visits,^{8,9} the disruption that documentation tasks create during patient-clinician interactions,¹⁰ and usability challenges associated with electronic medical record (EMR) systems.¹¹ As documentation requirements have continued to expand, clinicians spend increasing amounts of time entering and managing information within electronic systems, adding to the overall administrative workload in clinical practice.⁸ Many clinicians are also spending significant time working afterhours due to documentation requirements.^{8,9}

Artificial intelligence (AI) scribes have emerged as a solution to reduce administrative burden by automating aspects of clinical documentation.^{3,12,13} Using automatic speech recognition (ASR), natural language processing (NLP), and large language models (LLM), these tools capture, transcribe, and summarize patient-clinician conversations.¹⁴ Early studies suggest that generative AI improves clinician workflow and reduces documentation workload.¹³ However, most evidence comes from implementations in non-Canadian contexts, particularly the United States,^{4,12} or from regional deployments and small-scale pilots.¹⁵ To date, the impact of AI scribes when implemented at scale across diverse primary care settings is largely unknown.

1.2 The AI Scribe Program

Canada Health Infoway (Infoway) launched the nationwide AI Scribe Program to support responsible AI scribe adoption within primary care. With more than 50,000 primary care clinicians (PCCs) practicing in Canada,¹⁶ the Program provided a one-year AI scribe license to more than 10,000 PCCs. Infoway's AI Scribe Program was designed to reduce administrative burden at scale and improve data completeness and quality at the point of care, thereby strengthening clinical documentation and supporting broader health system data strategies.

1.3 Purpose and Objectives

The Centre for Digital Health Evaluation (CDHE) at the Women's College Hospital Institute for Health System Solutions and Virtual Care (WIHV) led the evaluation of the implementation and impact of AI scribes among PCCs across Canada who participated in Infoway's AI Scribe Program. The specific objectives were as follows:

1. To explore the direct impact of AI scribes on:
 - a. PCCs' experiences and perceptions (e.g., satisfaction, burnout, work-life balance).
 - b. Administrative load and workflow (e.g., cognitive load, capacity, productivity, integration, care coordination, EMR integration).
 - c. Engagement with patients (e.g., patient-clinician relationship, communication).
2. To evaluate the indirect impact of AI scribes on data completeness and quality, as well as clinicians perceived impact on data accessibility and portability at the point of care.
3. To identify enablers and barriers to AI scribe adoption across different primary care settings, and to inform best practices for scaling and optimizing AI-driven solutions in support of data standardization and interoperability.

1.4 The Evolving Landscape of AI Scribe Products

While this evaluation was designed to assess AI scribes as documentation-focused tools, the product category evolved over the course of the AI Scribe Program. Many AI scribe vendors expanded functionality beyond core documentation features to include capabilities such as information retrieval, clinical guidance, and workflow support, reflecting a broader shift toward clinical copilot capabilities. Although the objectives of this evaluation remained focused on documentation-related outcomes, the study design and data collection activities also captured emerging patterns in how AI scribes were being used in practice, including changes in functionality and their impact on clinician workflows. Findings should therefore be interpreted in the context of a rapidly evolving product category.

2.0 Methodology

2.1 Study Setting and Timeline

AI SCRIBE VENDOR IDENTIFICATION

In February 2025, Infoway issued a Request for Pre-Qualification for the AI Scribe Program. Following a rigorous national selection process, Infoway pre-qualified a group of nine trusted vendors whose solutions met national standards, supported secure data exchange, satisfied clinical practice needs, and aligned with the [Shared Pan-Canadian Interoperability Roadmap](#).¹⁷ Provinces and territories could further refine the pre-qualified list based on jurisdiction-specific requirements (i.e., privacy, security, and system integration considerations), resulting in vendor availability and rollout varying by jurisdiction. A full list of pre-qualified vendors and their jurisdictional availability is provided in Table 1. Prince Edward Island and Nunavut are excluded as the AI Scribe Program launched later in these jurisdictions and data were unavailable at the time of evaluation.

Table 1. AI scribe vendor availability by jurisdiction.

AI Scribe Vendors	Jurisdictions										
	BC	AB	SK	MB	ON	QC	NB	NS	NL	YT	NT
Autochart.ai	✓	✓	✓	✓	✓	✓				✓	
Autoscribe	✓	✓	✓	✓	✓	✓ [†]	✓			✓	
CareWay	✓	✓	✓	✓	✓	✓ [†]	✓			✓	
Empathia	✓	✓	✓	✓	✓	✓				✓	
Mikata	✓	✓	✓ [*]	✓	✓	✓		✓	✓	✓	✓
Nexus.AI	✓	✓	✓	✓	✓	✓				✓	
Pippen	✓	✓	✓	✓	✓	✓				✓	
Scribeberry	✓	✓	✓	✓ [*]	✓	✓				✓	
Tali	✓	✓	✓	✓	✓	✓ [†]	✓		✓	✓	

^{*}Saskatchewan Health Authority only offered Mikata and Shared Health Manitoba only offered Scribeberry following their respective procurement processes.

[†]In Québec, the certification requirements associated with the Global Verification Toolkit (GVT) for health technologies have reduced the range of AI transcription solutions to those that have successfully met the required certifications.

PARTICIPANT ELIGIBILITY CRITERIA AND RECRUITMENT

On June 10, 2025, Infoway launched the nationwide AI Scribe Program (herein referred to as the “Program”), which was made available to the following PCCs across Canada: family physicians; nurse practitioners (NPs); registered nurses (RNs) practicing in remote communities; and pediatricians providing longitudinal, community-based care. PCCs could access the Program by visiting the Program website, selecting their province or territory, and following a guided process to review available solutions, confirm eligibility, and complete registration.

Participation in the Program was actively monitored by Infoway to support equitable distribution of available licenses and ensure the opportunity could reach as many eligible PCCs as possible. Participants were expected to remain active users, defined as 10 or more uses per month, of their selected AI scribe solution. Between June to September 2025, licenses assigned to PCCs with no recorded use (i.e., inactive) for three consecutive months were returned for redistribution, resulting in approximately 3,000 licenses being reallocated to support additional enrolment. Short-term declines in usage did not result in removal.

This reallocation process should be understood within the broader context of the Program’s design and operations: a large national initiative with rolling enrolment, strong demand, and varying implementation timelines across jurisdictions and practice settings. Infoway’s structured reallocation approach was intended to ensure unused licenses could be made available to other PCCs ready to begin use, with the goal of extending access, supporting ongoing enrolment, and maximizing Program reach across jurisdictions.

2.2 Overview of Evaluation Activities

The CDHE at WIHV conducted a structured mixed-methods evaluation of PCCs enrolled in the Program. The evaluation integrated Program metrics, clinician-reported data, and additional data sources to assess implementation, usage patterns, and outcomes. Figure 1 illustrates how the evaluation’s data collection activities aligned with the Program’s design and operations, including the phased enrolment structure. A description of each data collection activity is also provided below.

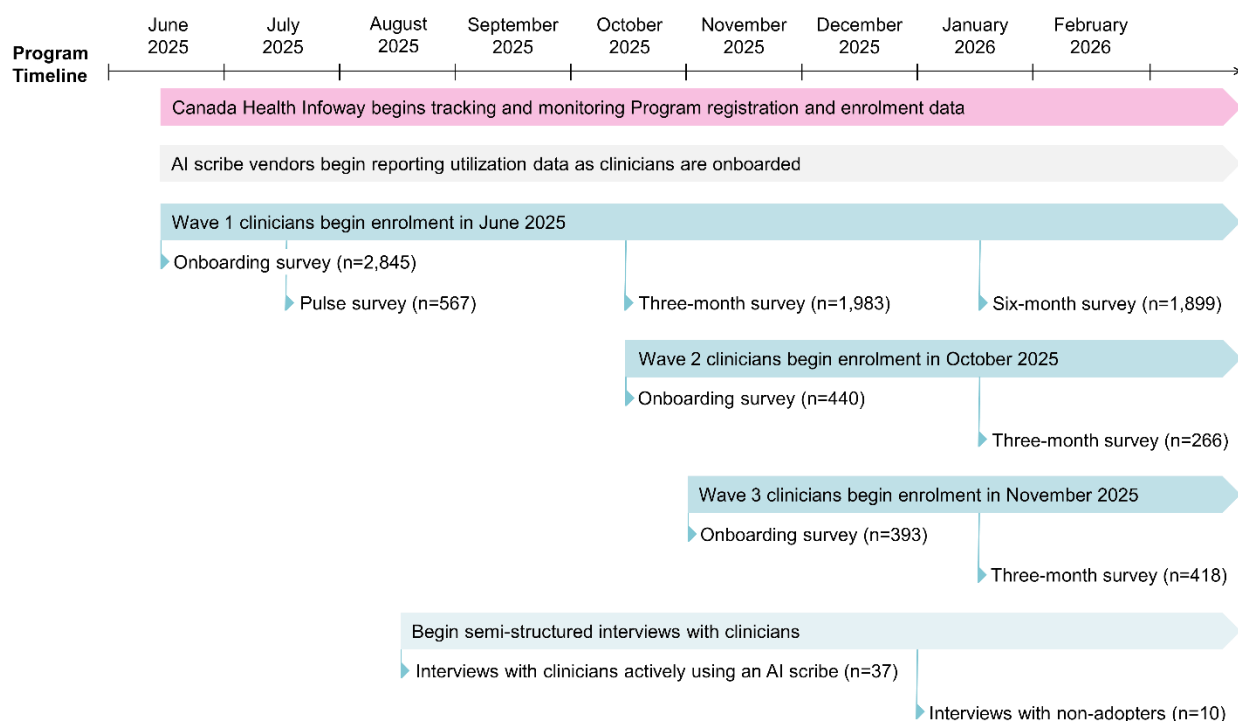


Figure 1. Program implementation timeline, enrolment waves, and data collection activities.

PROGRAM METRICS

Program metrics were used to characterize patterns of AI scribe use across the evaluation period.

- **Program registration data** were analyzed to describe enrolment patterns, which occurred in three main waves (June, October, and November 2025).
- **Vendor utilization data**, collected from June 10, 2025, to February 28, 2026, were analyzed to assess adoption, frequency, and intensity of use, and to examine patterns of engagement over time.

CLINICIAN-REPORTED DATA

Upon enrolment in the Program, clinicians were invited to voluntarily complete surveys and participate in interviews, resulting in clinician-reported data from a subset of enrolled participants.

- **Experience surveys were administered at onboarding, three-, and six-month timepoints** to assess the impact of AI scribes on administrative burden, workflow, cognitive load, data quality, ease of implementation and use, and user satisfaction. Survey administration was aligned to clinician enrolment, resulting in rolling cohorts across timepoints corresponding to the three enrolment waves. Survey data were analyzed using a repeated cross-sectional approach across all timepoints (onboarding, three-months, and six-months) to assess overall trends in clinician experiences and outcomes. Where

possible, responses were linked at the individual level to examine changes over time among clinicians who participated in multiple survey waves.

- **Semi-structured interviews were conducted with users** after approximately two months of active use to explore their experiences with AI scribes, including impacts on administrative burden, documentation quality, and workflows. **Interviews were also conducted with non-adopters** upon inactive use to understand reasons for non-use or discontinuation. All interviews took place between August 2025 and February 2026.
- To supplement these data collection activities, **a pulse survey** was distributed by Infoway on July 15, 2025, to all active users in the Wave 1 cohort to capture early experiences with AI scribes, including impacts on administrative burden and cognitive load.

ADDITIONAL DATA SOURCES

To complement Program-level metrics and clinician-reported data, a **retrospective chart review** was conducted to assess the impact of AI scribes on medical note completeness. The review was done in collaboration with The Centre for Advanced Computing at Queen's University, which hosts the Queen's Family Medicine Restricted Data Environment, a central repository with de-identified electronic medical records. The analytic sample included 173 medical notes from four family physicians who used an AI scribe at least 10 times between January 1, 2024, and January 1, 2026, ensuring sufficient familiarity with the tool. Eligible encounters included both in-person and virtual visits, while administrative or non-clinical documentation was excluded. For each clinician, up to 30 pre-implementation notes (within one month prior to first AI use) and a minimum of 30 post-implementation notes were randomly selected. Notes were independently reviewed by two reviewers. The primary outcome was documentation completeness pre- and post-implementation of an AI scribe.

THE EVOLUTION OF AI SCRIBES OVER THE STUDY PERIOD

The definition of an AI scribe evolved substantially over the course of the evaluation. While the evaluation was initially designed to assess automated scribing of a medical note, this functionality quickly proved to be only one component of a broader and expanding set of capabilities. Over time, AI scribes have increasingly functioned as “clinical copilots,” supporting a wider range of administrative and clinical tasks such as drafting referrals, consult letters, and patient summaries; generating patient education and self-management materials; and supporting clinical decision making. Accordingly, data collection activities captured both documentation-related outcomes and emerging changes in functionality and use, including impacts on clinician workflows and experiences.

3.0 Results

3.1 Participant Demographics

This section describes the demographic and clinical characteristics of all PCCs enrolled in the Program, as well as the subset of PCCs who participated in the surveys and interviews.

AI SCRIBE PROGRAM COHORT

More than 14,000 PCCs signed up for the AI Scribe Program, of whom, 12,019 completed the full registration and enrolment process required to activate their accounts. Figure 2 displays the characteristics of the 12,019 PCCs enrolled in the AI Scribe Program.

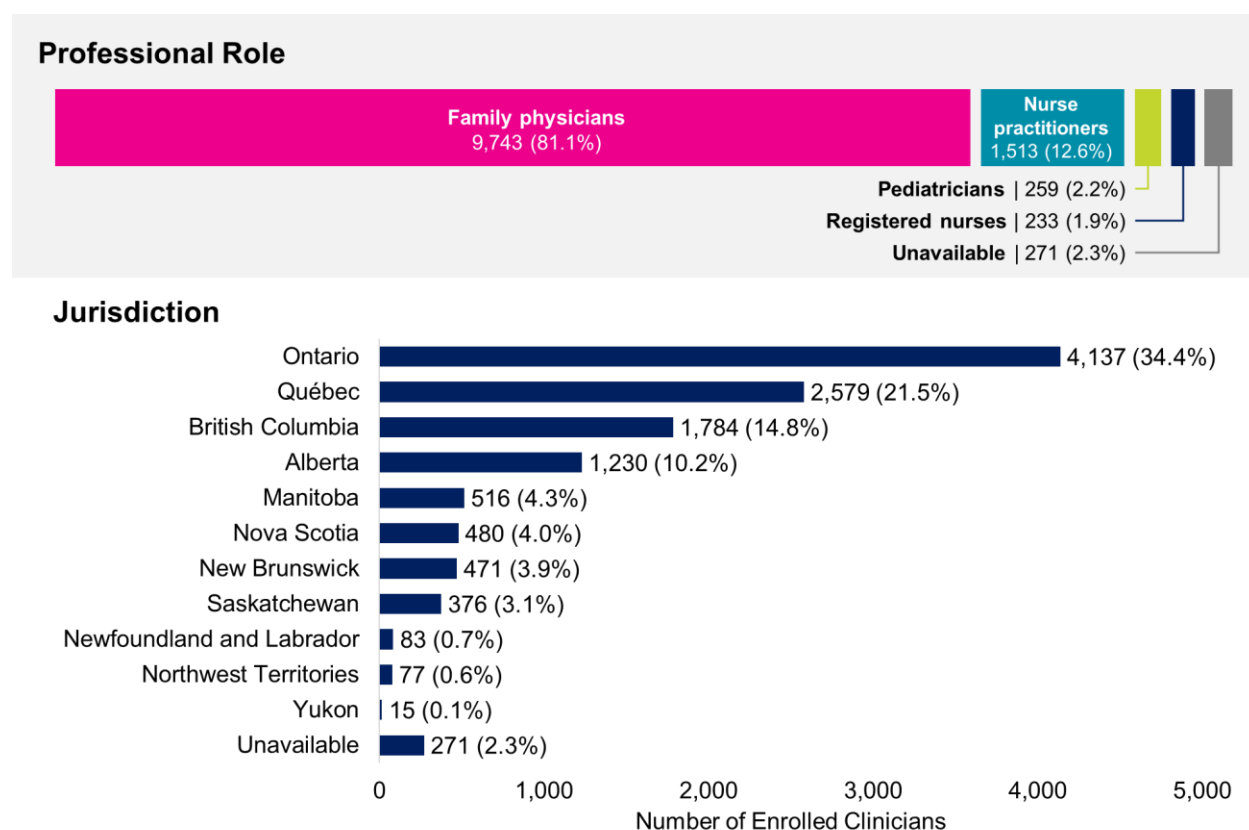


Figure 2. Characteristics of clinicians enrolled in the AI Scribe Program (n=12,019).

The majority of PCCs were family physicians (81.1%), followed by NPs (12.6%). Participants were primarily located in Ontario (34.4%), Québec (21.5%), British Columbia (14.8%), and Alberta (10.2%), reflecting the Program's allocation approach in which AI scribe licenses were distributed proportional to the number of PCCs in each province or territory across the country.

ONBOARDING AND THREE- AND SIX-MONTH SURVEYS

A total of 3,678 respondents completed the onboarding survey (response rate: 30.6%), with 2,667 (response rate: 22.2%) and 1,899 (response rate: 23.8%) respondents at the three- and six-month timepoints, respectively. Further, a total of 567 (response rate: 30.0%) clinicians responded to the pulse survey by Infoway.

Figure 3 presents the demographic and practice characteristics of the 932 PCCs who responded at all time points, providing a cohort for longitudinal comparison. Most PCCs were family physicians (85.4%) followed by NPs (10.2%), and 60.5% identified as women. Respondents represented eight out of 11 participating jurisdictions, with the largest proportions practicing in Ontario (36.1%) and Québec (29.1%). Respondents spanned a range of practice experience with more than one-third practicing for more than 20 years (36.3%), followed by 11-20 years (30.8%), 6-10 years (20.3%), and 0-5 years (12.6%). The majority of PCCs (86.3%) worked in team- or group-based settings. Most practiced in communities with populations between 100,000 and 999,999 people (30.3%) or urban centres of more than 1 million people (29.3%).

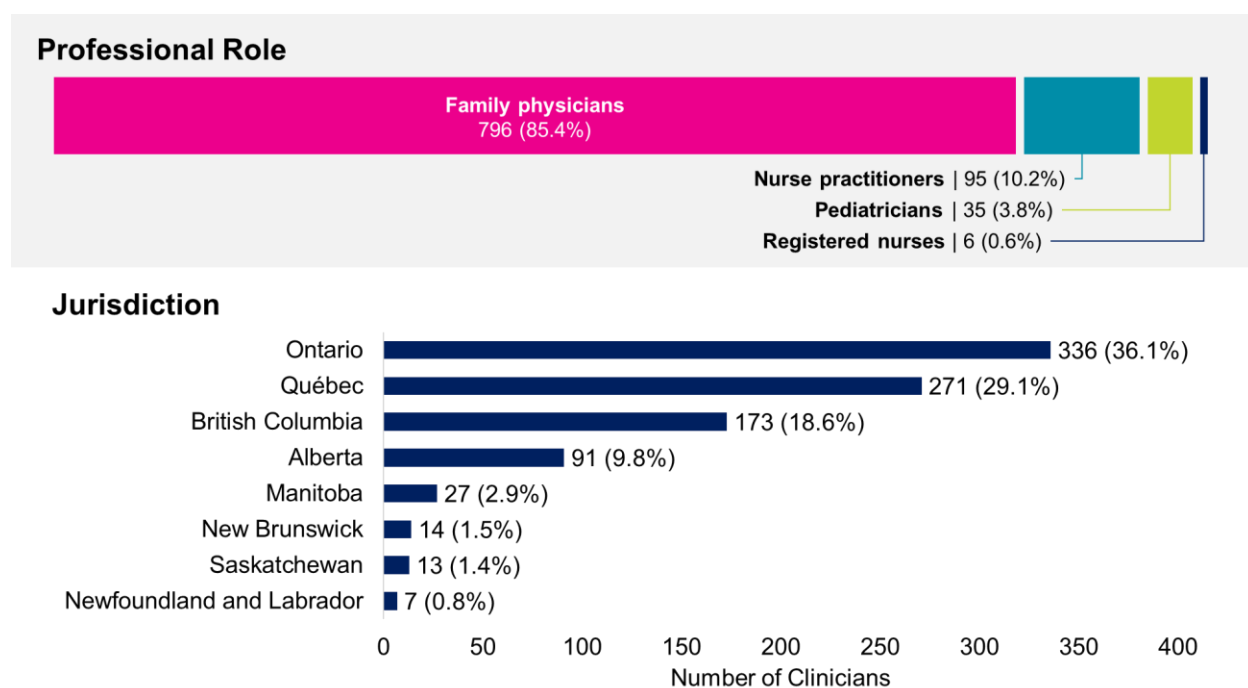


Figure 3. Demographic characteristics of PCCs with linked responses across onboarding, three-month, and six-month surveys (n=932).

SEMI-STRUCTURED INTERVIEWS

Figure 4 summarizes the characteristics of the 47 PCCs who participated in semi-structured interviews, including 37 AI scribe users and 10 non-adopters. Most participants were family physicians (57.4%) or NPs (31.9%), with additional representation from pediatricians providing longitudinal, community-based care and RNs working in remote communities. Participants represented 10 jurisdictions, with the largest proportions practicing in British Columbia (23.4%), Ontario (23.4%), and Québec (19.1%). Among users, 48.6% identified as women.

Interview participants represented a wide range of clinical experience, from early career (0-5 years, 18.9%) to more than 20 years in practice (24.3%). Most worked in group- or team-based settings (70.3%). Care delivery models varied, including attached (54.1%), non-attached or walk-in (40.5%), and mixed approaches, with panel sizes ranging from approximately 600 to over 2,400 patients. Work patterns and clinical workloads also varied, with appointment lengths ranging from 15 to 40 minutes and daily patient volumes differing accordingly. Most participants worked between two and five days per week, with some in part-time or shared practice arrangements. In addition to general primary care, several PCCs reported focused areas of practice, including addictions medicine, gender-affirming care, chronic disease management, care for unattached and unhoused populations, and student health.

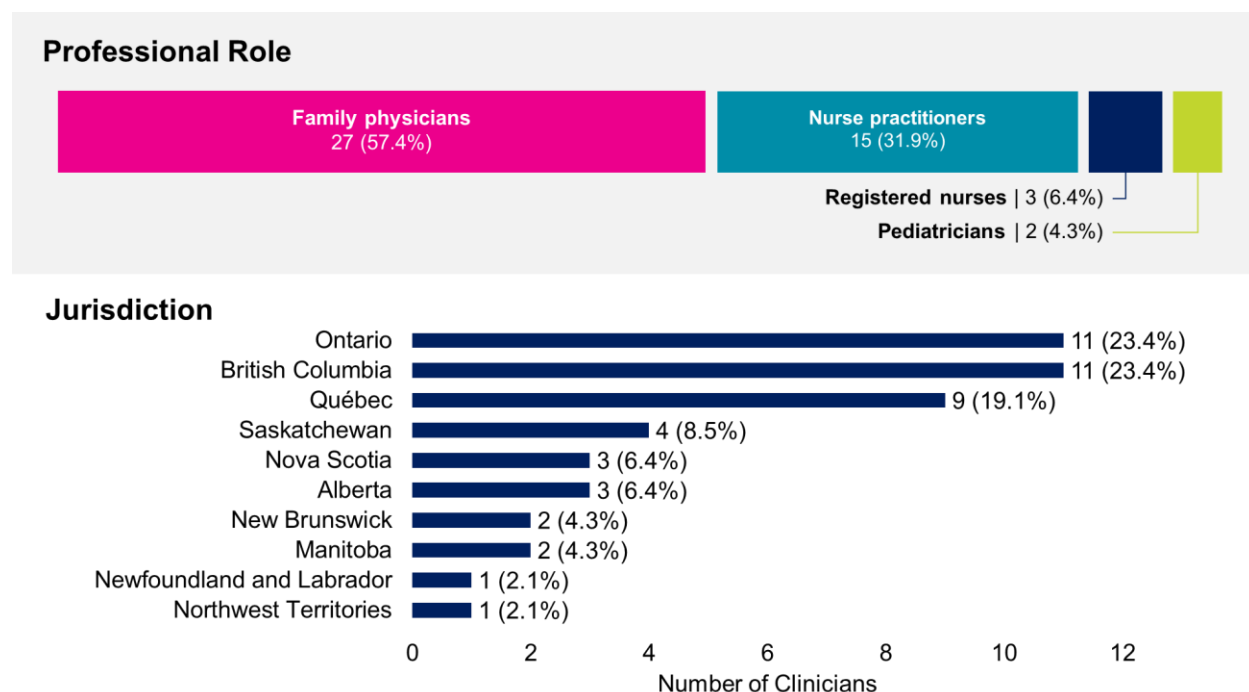


Figure 4. Demographic characteristics of PCCs that participated in an interview (n=47).

3.2 Utilization

Among the 12,019 PCCs enrolled in the Program between June 2025 to February 2026, utilization data were available for 11,321 PCCs; the remaining 698 PCCs (5.8%) had no observed use during the study period. Since enrolment occurred on a rolling basis, with most clinicians joining in June 2025 and smaller groups joining in October and November 2025, utilization trends were examined in two ways. First, trends were analyzed across the entire Program to understand overall growth and scale over time. Second, use was examined at the individual clinician level, based on when each person enrolled into the Program, to better understand patterns of engagement over time.

PROGRAM-LEVEL TRENDS IN AI SCRIBE ADOPTION AND USE

AI scribe use scaled rapidly over the evaluation period. Total monthly encounters increased nearly fivefold, from 244,631 in June 2025 to over 1.22 million by February 2026 (Figure 5a). Over the same period, the cumulative number of clinicians using the AI scribe at least once (“live users”) rose from 2,494 to 11,321.

This growth was accompanied by increased intensity of use. The number of active users, defined as clinicians who used an AI scribe ≥ 10 times per month, increased from 2,216 to 7,447. By February 2026, approximately 65% of PCCs who had ever used the AI scribe (i.e., live users) were active users. At the same time, the number of monthly encounters per active user rose, indicating that active users were using the AI scribe more frequently over time.

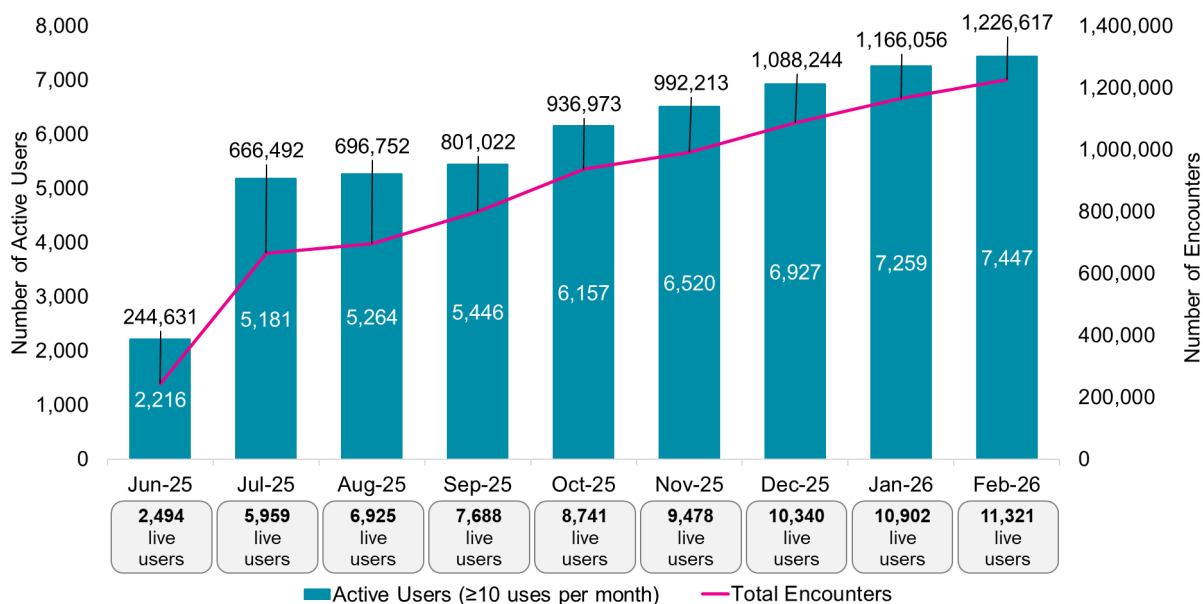


Figure 5a. Program-level trends in AI scribe use over the course of the evaluation period.

CLINICIAN-LEVEL ADOPTION AND USE FOLLOWING ENROLMENT

Clinician adoption was rapid, with most users initiating use shortly after enrolment and maintaining consistent use over time. A total of 82.3% of PCCs began using the AI scribe within the month immediately following enrolment (Month 1), of which, nearly half of clinicians (45.6%) began using the tool in the same month they enrolled (Month 0) (Figure 5b). The number of encounters where an AI scribe was used increased sharply from Month 0 to Month 1 (507,978 to 988,890), then stabilized in a range of 775,000 to 1 million per month.

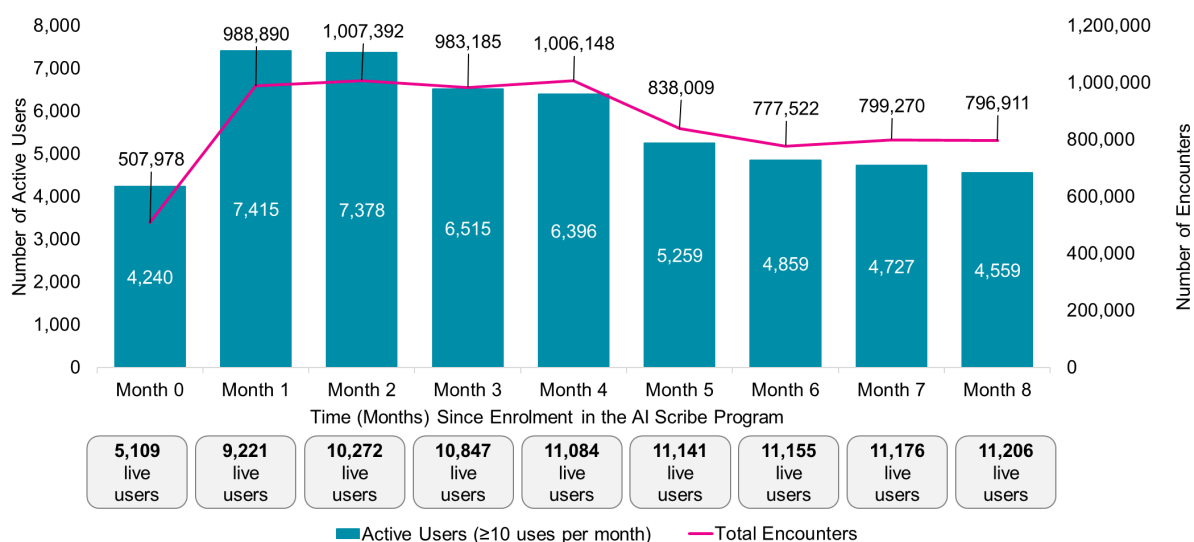


Figure 5b. Clinician-level trends in AI scribe use relative to month of enrolment.

Importantly, Figure 5a and Figure 5b show two different but complementary views of AI scribe use. Figure 5a shows overall Program activity by calendar month, demonstrating that active users and total encounters increased steadily across the evaluation period, reaching 7,447 active users and more than 1.22 million encounters by February 2026. Figure 5b shows clinician-level adoption patterns by tracking use relative to individual PCC's month of enrolment, providing insight into how individual clinicians begin and continue using AI scribes after joining the Program.

Further, Figure 5b demonstrates rapid individual PCC uptake following enrolment, with active use increasing sharply in the first month after clinicians joined the Program. However, because clinicians enrolled in different waves, fewer participants have reached the later follow-up months in Figure 5b, which can make later months appear lower. This should be understood as a staggered enrolment and follow-up effect, rather than evidence of declining overall Program activity or disengagement. This distinction is important because Figure 5b helps explain clinician

adoption behaviour after enrolment, while Figure 5a provides a measure of overall Program activity and growth. Together, the findings reflected in both figures show both Program growth and early integration into practice.

VARIATION IN AI SCRIBE USE AMONG CLINICIANS

Consistent with common patterns of technology adoption,^{12,18} use was highly concentrated among a subset of clinicians (Figure 6). By February 2026, one-third of PCCs accounted for 85% of all encounters (6,692,105 of 7,819,000), while the remaining two-thirds contributed 15%.

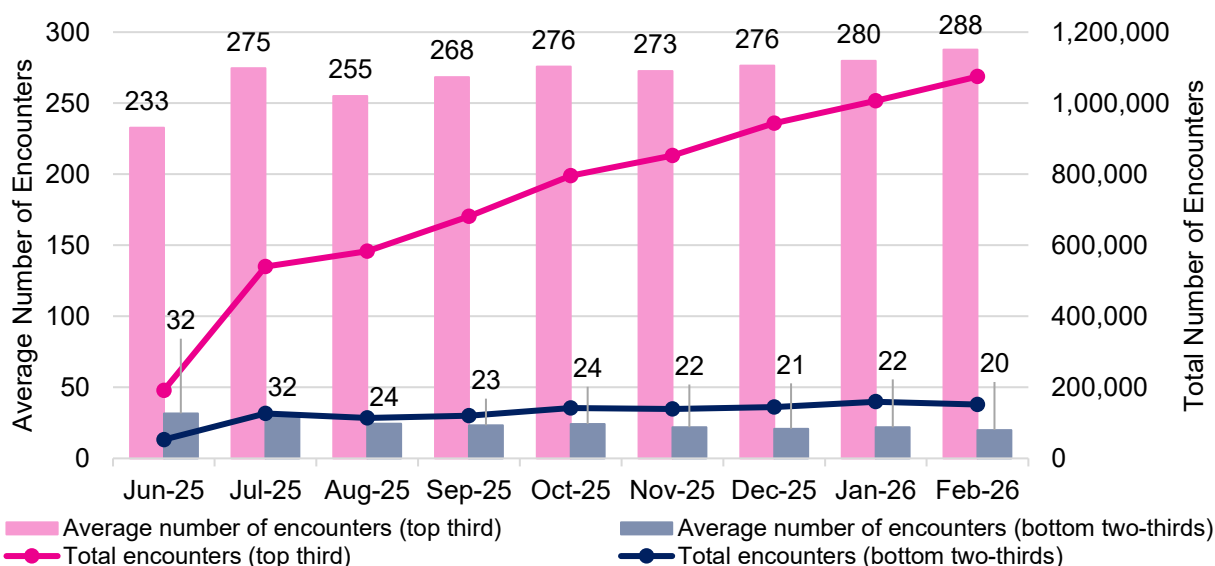


Figure 6. Total usage and average encounters comparing the top one-third and bottom two-thirds of live users in the Program from June 2025 to February 2026.

This pattern suggests that, although early uptake was widespread, integration into clinical workflows was concentrated among a smaller group of highly engaged users. At the same time, the remaining two-thirds of users continued to demonstrate consistent, lower-intensity use over time, indicating that AI scribes were still being used across a broader group of clinicians, though at different levels of frequency.

Differences in practice model, workflow fit, platform functionality, and individual comfort with the technology likely contributed to this variation. Future evaluation should examine whether lower-intensity use reflects intermittent or selective use cases, differences in clinical workload or workflow integration, adoption barriers that may be addressed through additional training or technical improvements, or clinicians using the tool only where it adds the greatest value within their existing workflow (i.e., lower-frequency use may be sufficient for some clinicians, particularly if they use AI scribes for specific appointment types, complex encounters, or documentation

tasks). Understanding what distinguishes high-intensity from lower-intensity users should be a key focus of the next phase of evaluation.

ADOPTION PATTERNS ACROSS PROFESSIONAL ROLE

The observed patterns of AI scribe use in the Program are characterized by rapid early uptake followed by stabilization.¹⁸ As of February 2026, approximately 17.0% of Canadian family physicians, 12.3% of NPs, 6.0% of pediatricians, and 0.04% of RNs were actively using an AI scribe through the Program. These proportions were estimated by comparing the number of active users within each clinician group in the Program to national workforce estimates for each role.¹⁹

Interpreted through the Rogers' Diffusion of Innovations (DOI) theory,¹⁸ these patterns indicate that clinician groups are at different stages of adoption (Figure 7). RNs align with the innovator group, while NPs and pediatricians more closely reflect early adopters who often act as clinical champions. Family physicians appear to be transitioning into the early majority, where adoption extends beyond champions to clinicians who require demonstrated value before integrating new tools into practice. Given that the Program is still within its first year, uptake across PCCs may accelerate as awareness grows, tools mature, and integration into clinical workflows scales. Implementation strategies should be tailored by practice model; thus, supporting innovators, amplifying early adopters, and reducing friction for the broader majority.

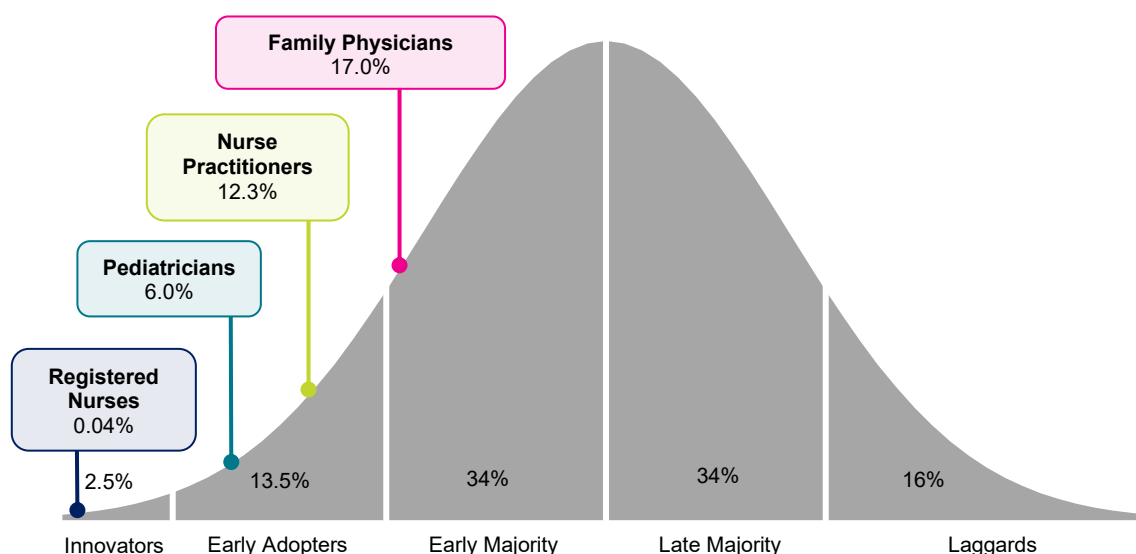


Figure 7. AI scribe adoption across Canada according to the Diffusion of Innovations framework, representing active users from June 2025 to February 2026 in the AI Scribe Program.

Importantly, Program estimates likely represent only part of the total AI scribe adoption landscape across Canada. Over half (55.3%) of survey participants reported prior experience with AI scribes, among whom 27.3% reported using an AI scribe product not included in the Program. This suggests that Infoway's AI Scribe Program is playing a role in supporting national adoption, while broader market activity and clinician interest in AI-enabled documentation tools are also growing in parallel.

3.3 Implementation and Change Management

Survey and interview findings provided important context for the observed utilization patterns. Specifically, why uptake was rapid, why use stabilized early, and why sustained, high-intensity use remained concentrated among a subset of clinicians.

CATALYSTS FOR ADOPTION

Rapid early uptake was driven by a clear and pressing need to reduce administrative burden, combined with enabling conditions that lowered barriers for adoption.

- **Administrative burden as the primary driver:** At baseline, 89.2% of survey respondents reported symptoms of stress or burnout, often describing their administrative workload as “unmanageable” or “unsustainable.” Several clinicians reported reducing their in-clinic hours or retiring early as strategies to cope with burnout.

“I cut back majorly on the amount of hours I do because of administrative burnout, including working many hours writing notes after my kids went to bed each night... I would consider increasing my patient office hours if I was able to be more efficient with note taking or admin time.”

– Family Physician, Nova Scotia

- **Peer influence and champions:** Adoption was reinforced through informal peer networks and word-of-mouth, highlighting the role of social influence in accelerating early uptake.¹⁸
- **Free license for an extended period:** No-cost access allowed PCCs to quickly assess value within their own workflows.
- **Vendor validation:** Confidence in adoption was further supported by Infoway's national vendor validation and procurement process, which confirmed that selected products met Program requirements related to privacy, security, clinical usability, EMR integration, and alignment with pan-Canadian interoperability priorities. In some jurisdictions, this confidence was further reinforced through additional review or validation by regulators and local health authorities.

*“Canada Health Infoway has been great. They narrowed it down. They can just continue to just help us, come along with us on the journey... The other thing that helped is that they gave us a **one-year free trial where we could just spend our time and get to know [the AI scribe] a bit before we commit.**”*

– Family Physician, British Columbia

EARLY IMPLEMENTATION EXPERIENCES

The rapid uptake observed in the utilization data was mirrored in early implementation experiences reported by clinicians. Most PCCs were able to begin using AI scribes quickly, with 91.3% reporting rapid uptake of basic functions (e.g., SOAP note generation). When moving beyond initial use to more tailored, workflow-integrated use, additional time and effort was required, particularly when they wanted to refine templates and adapt the technology to their documentation style. Nearly one-quarter of PCCs (24.3%) sought additional support for this type of optimization.

IMPLEMENTATION SUPPORTS AND CHANGE MANAGEMENT

Sustained and high-intensity use was often constrained by gaps in implementation support, highlighting clear opportunities for targeted action.

- **Fragmented peer learning and limited formal supports:** PCCs relied on informal networks (e.g., professional Facebook groups) to share templates and workflow strategies. While valuable, these channels were unstructured. Establishing formal communities of practice locally could provide more consistent, scalable support for optimization.
- **Inconsistent vendor support:** Many PCCs experienced delays or gaps in vendor responsiveness. In some cases, this contributed to discontinued use, highlighting the importance of reliable and responsive vendor support to sustain use. This finding should be understood as part of the broader implementation experience for a rapidly evolving technology category, where reliable onboarding, timely troubleshooting, and ongoing optimization are important to helping clinicians integrate AI scribes into routine practice.
- **Desire for greater customization support:** While basic functions were easy to learn, optimizing AI scribes for individual workflows required additional work. PCCs expressed a desire for one-on-one training and efficient asynchronous resources (e.g., short videos) to support customization and ongoing learning.
- **Low transparency in data use and model behaviour:** Uncertainty regarding how AI scribes use data to learn, adapt, and update outputs reduced PCC confidence, particularly

when outputs changed unexpectedly. Greater transparency and education around model behaviour and data use, alongside mechanisms for PCCs to provide feedback, could strengthen trust.

- **Infrastructure gaps:** In some settings, effective use was limited by inadequate infrastructure (i.e., microphones, hardware, private spaces for conducting virtual visits). Ensuring baseline technical readiness is essential for successful integration and scale.

3.4 Workflow Integration

BASELINE DOCUMENTATION PRACTICES

Before using an AI scribe, 80% of PCCs rated their note quality as high, although documentation styles varied widely, ranging from detailed narratives with verbatim patient quotes to concise entries focused on clinical essentials. Many PCCs reported completing documentation outside of work hours, with some finalizing notes days, weeks, or even months later, and a small proportion acknowledging that some notes were never completed. Delays in documentation were also perceived to affect note quality, as details became harder to recall over time.

“... and then occasionally, a week later finding that either your note didn’t save or you didn’t write the note... and then having to really think, wow what did I even see the patient for? ... Then often having to phone the patient, which is time consuming and a little bit embarrassing and maybe decreases the patient’s confidence as well in their providers, right? And having to say, ‘I’m just doing your charting now. Can you remind me what we did? What happened?’”

– Family Physician, Saskatchewan

Workflows and documentation practices varied considerably across clinicians, and these baseline differences played a key role in shaping how AI scribes were integrated into practice. The following section examines their impact on workflow integration and documentation processes.

NEW WORKFLOWS AND ASSOCIATED CHALLENGES

Nearly 90% of survey respondents reported that the AI scribe was easy to use, consistent with Infoway’s pulse survey, in which 96% of early adopters reported ease of use. However, using an AI scribe also introduced new tasks for clinicians, though many are likely transitional and reflect the early stages of adopting a new technology. Specifically:

- Most PCCs (85.4%) found the consent process straightforward and were comfortable discussing AI scribe use with patients. However, reliance on vendor-developed consent processes and a lack of national and regional standardized policies introduced

inefficiencies, highlighting opportunities to streamline workflows (e.g., clinic-wide consent models).

- Most PCCs reported that reviewing and editing AI-generated notes took less time and cognitive effort than writing notes from scratch. A smaller subset, however, experienced minimal time savings, particularly when editing disrupted documentation workflows.
- Some PCCs reported variability in AI scribe performance, including note generation delays and recording interruptions, which occasionally resulted in incomplete documentation.
- Challenges with EMR integration were also common: products were not always fully integrated as advertised, and even when integration was available, it was sometimes slow, cumbersome, and disruptive to workflows. Reliance on internet connectivity and additional login steps (i.e., two-factor authentication) further compounded these issues. At present, it remains unclear whether these issues stem from the AI scribes, the EMR systems, or their interaction.

*“When the AI scribe works, it is very helpful. However, **there are reliability issues. The AI scribe fails to generate a SOAP note about 1 out of every 6 encounters.** This is frustrating because **I have to type the whole note from memory after the encounter...** I tend to take fewer notes during the encounter when I am using the AI scribe because I am relying on the AI scribe to generate a note for me.”*

– Survey Respondent, British Columbia

VARIATION IN WORKFLOW IMPACT ACROSS USE CASES

PCCs reported that AI scribes improved efficiency in some situations (e.g., complex multi-reason visits) but were less effective or disruptive in others (e.g., visits already supported by established templates), with no clear patterns by visit type, suggesting that the value of AI scribes is highly dependent on individual practice styles and clinical context. However, improvements in customization, templating, and system performance may enable more consistent use over time. Ongoing AI scribe advancements, such as templating, knowledge integration, and retrieval-augmented generation (RAG), are expected to expand functionality and use cases.

3.5 Time Savings and Efficiencies

PCCs reported substantial reductions in time spent on administrative tasks following AI scribe implementation. At both three and six months, nearly 70% of PCCs indicated that using an AI scribe reduced their administrative burden, and 75% reported time savings.

These reported time savings were observed early and increased over time (Figure 8). By three months, PCCs reported saving an average of 0.80 hours per week during work hours (95% CI: -1.41 to -0.18; $p=0.01$) and 0.76 hours per week outside of work (i.e., afterhours) (95% CI: -1.19 to -0.33; $p=0.0005$). By six months, these savings rose to 1.11 hours per week during work hours (95% CI: -1.73 to -0.48; $p=0.0005$) and 0.87 hours per week outside of work (95% CI: -1.29 to -0.45; $p<0.0001$).

Despite the highly individualized nature of AI scribe use, where perceived value is shaped by clinician-specific workflows, findings on reported time savings indicate that in the overall Program cohort, AI scribes deliver rapid efficiency gains that are sustained over time, with time savings observed as early as three months and maintained at six months.

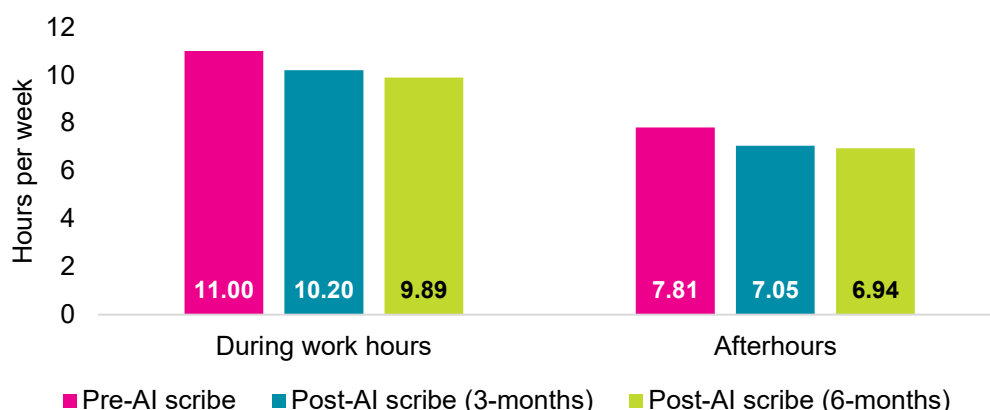


Figure 8. Clinicians reported significantly less time spent on administrative tasks during and after work hours (n=932). All mean differences were statistically significant ($p<0.05$).

These findings further support early results from the Infoway pulse survey, where 94% of respondents reported time savings, of which, 62% reported saving more than 30 minutes per day.

Timeliness of documentation also improved following AI scribe implementation. The proportion of PCCs completing notes on the same day during work hours increased from 55.9% at onboarding to nearly 75% by six months, while delayed documentation (which could be days to months later), declined from 9.8% to less than 3% by six-months. Overall, 82.0% of PCCs agreed that AI scribes

enabled more timely documentation, with more work being able to be completed during work hours, though some afterhours documentation persisted.

Clinicians who reported time savings reallocated this time in several ways:

- Over 50% of PCCs **redirected time to complete other administrative tasks**. However, administrative work remained time-consuming and continued to contribute to after-hours work and burnout. Notably, tasks identified by PCCs as particularly burdensome (e.g., completing referrals and forms) align with features currently being developed by many AI scribe vendors.

“Very handy tool for improving efficiency in clinic. I was able to complete tasks like sending prescriptions, writing referral letters, and creating requisitions during the visits which improved patient flow and helped me make less mistakes and have less call backs or omissions.”

– Survey Respondent, Ontario

- Approximately 20% of PCCs reported **improved work-life balance** and a more positive attitude toward work. Correspondingly, the proportion of PCCs reporting good or optimal work-life balance increased from 22.5% at onboarding to nearly 40% by six months.

“Since starting to use the AI scribe, my stress has gone down, and my symptoms of burnout definitely improved. I have more time to spend on homelife activities that have suffered in the last many years prior to the AI scribe. I no longer dread going to work.”

– Survey Respondent, Alberta

- Approximately one-fifth of PCCs **used the time to see more patients**, primarily by adding same- or next-day visits, phone appointments, or follow-ups. PCCs noted it was too early to determine whether AI scribes alone increased patient attachment, as capacity changes were often influenced by additional factors (e.g., team structure or planned growth).

“My task box now by the end of the week is much lower than what it used to be. I feel it’s gotten me to be able to do my medical forms and my referrals and everything the same week, rather than then trying to squeeze in time. So, it has opened me up to seeing more patients, because I’m not blocking extra time for visits and follow-ups and that sort of thing. If anything, it has helped me be more productive for patient visits.”

– Nurse Practitioner, Nova Scotia

Importantly, although PCCs were asked to identify a primary use of time savings, these categories are not mutually exclusive in practice. Many PCCs described distributing time across multiple activities, noting that there is “always more to do in primary care.”

UNCHANGED OR INCREASED DOCUMENTATION TIME

A subset of PCCs reported little or no time savings from using an AI scribe. Approximately 15% felt no meaningful change in documentation time, and just over 10% reported an increased administrative burden. For these PCCs, limitations in note quality often offset potential efficiency gains. AI-generated notes were described as requiring substantial editing, particularly in multilingual care contexts, and as overly detailed or verbose, increasing review time and cognitive load.

“In addition, it takes me longer to close a note with AI because I have to reread it and make corrections. It takes me 5 to 7 minutes per patient. Before, I closed my notes as I went along and rarely had to take time to finish them. So now I’m always behind on my labs and paperwork.”

– Survey Respondent, Québec

Other PCCs, including fast typists and proficient EMR users, reported minimal added benefit. Some also noted that initial time savings diminished over time due to downstream workload and evolving model performance. In some cases, this led to discontinued use, while others remained open to trying alternative AI scribe solutions.

“I find it very helpful for walk-ins (whom I will never see again), but over time use it less and less for my attached patients due to difficulty synthesizing the key points of visits when I review AI generated summaries later.”

– Survey Respondent, British Columbia

Despite this, some PCCs continued using the AI scribe due to other realized benefits, including reduced cognitive load and stress, improved note quality, better engagement with patients, and physical relief from not having to frequently turn toward the computer or type during a clinical encounter.

“It hasn’t changed my throughput, nor had a huge impact on my documentation time, but the decrease in cognitive load has been huge, both during the appointment and then that needed to create a starting point for my final consult letter.”

– Survey Respondent, British Columbia

IMPACT ON COGNITIVE LOAD

More than 75% of PCCs reported reduced cognitive load related to documentation at both three- and six-months. This was attributed to less multitasking and task-switching during appointments, reduced mental effort when editing notes compared to writing from scratch, and the reassurance of having a reliable documentation “safety net.”

*“I believe AI scribes are an immense benefit to family physicians... I must admit that I have been treading dangerously with burnout for a period of time. **The level of cognitive load and emotional distress that the AI scribe has relieved me of is tremendous. It is not hyperbole to say that the AI scribe arrive just in time to save my sanity.**”*

– Survey Respondent, Ontario

PERCEIVED IMPACT ON ENGAGEMENT AND QUALITY OF CARE

Most PCCs reported positive effects on patient interaction and care delivery after using an AI scribe. Approximately 80% felt more engaged, and 60% perceived they were able to provide better quality of care. PCCs reported that not having to look at their computer or constantly task-switch allowed them to focus more fully on the patient, pick up on non-verbal cues, make direct eye contact, and listen more effectively. In addition, the completeness and accuracy of AI-generated notes were perceived to improve quality of care by reducing the likelihood of missing important information, particularly for complex conditions.

*“What has really helped with the AI [scribe] is that **I catch myself missing some things that the patients have said. I’ve actually had to call the patient and say, ‘hey, I missed when you talked about this and it actually changes our plan.’ which has been very appreciated by the patients. My biggest benefit is not missing things.**”*

– Family Physician, Alberta

Some PCCs (27.8%) also reported shorter in-clinic wait times. While many had previously stayed on schedule by completing documentation outside of work hours, efficiency gains allowed more work to be done during clinic hours. Some PCCs also had more time to collaborate with colleagues and discuss complex cases, supporting more comprehensive, coordinated care.

*“...and then talking more with colleagues, discussing cases, sitting in my colleague’s office and saying, ‘I’d like to talk about a diabetic patient, I’m not sure what to do with them anymore,’ **we have more time to discuss cases with colleagues than before. Before, we were always running around, then saying, ‘Oh no, I have about an hour of notes to take before I leave... I’m sorry, it’ll be fine tomorrow.’**”*

– Registered Nurse, Québec

3.6 Technical Performance

Building on the variability in efficiency gains and PCC experience, the technical performance of AI scribes played a central role in shaping both realized benefits and ongoing challenges.

PERCEIVED ACCURACY AND QUALITY OF AI-GENERATED DOCUMENTATION

In general, PCCs perceived AI-generated notes as accurate and reliable. At three months, 67.3% reported that notes accurately reflected patient encounters, increasing to 70.6% at six months. Confidence in the accuracy of AI scribes remained high over time, with nearly 80% of PCCs reporting they were comfortable relying on an AI scribe to document sensitive patient information.

“The [AI scribe] was generating notes that were a million times superior [to] what I was typing. Way more information, and it was pretty accurate... and it's just they're way safer, especially in team-based care.”

– Family Physician, Northwest Territories

Interview findings aligned with survey results, with many PCCs reporting that AI-generated notes captured key clinical information with reasonable accuracy, especially as they became more familiar with the tool. Several PCCs also noted improvements in note quality over time.

Perceived improvements in accuracy likely reflect a combination of factors. As PCCs gained experience using an AI scribe, they became more adept at integrating them into their workflows, including how they prompt, review, and edit outputs. This increased familiarity may have contributed to greater trust and perceived reliability. At the same time, some AI scribes may adapt to clinician preferences (e.g., via iterative edits within the system that contribute to model learning), which may support both user-specific and broader model improvements.

“Over the year the [AI] scribe has gotten better, and I've just adapted to it... It's just kind of like the new normal. So, overall, I would say it's pretty good. When I first started, I really didn't like it. It was a change; it was different from the way I would've documented.”

– Pediatrician, British Columbia

COMPLETENESS OF AI-GENERATED DOCUMENTATION

PCCs described how AI-generated notes often captured additional details from the clinical encounter, such as symptoms, history, and discussion points, that might otherwise be missed, particularly in visits involving multiple concerns. PCCs also noted that reviewing these notes often prompted them to revisit aspects of the encounter requiring follow-up, effectively serving as a secondary review mechanism that helped identify overlooked details during busy encounters.

“It’s not infrequent that the AI scribe will pick up something that I actually missed... I had a patient who was talking to me about I think six or seven different issues. During this whole visit I had missed that they said they were struggling with some addictions. In the [AI-generated] note it had a section about substance abuse and addiction and I was like, ‘I don’t remember that.’... I went back into the transcript and read back to see where it got this information from and we were talking about one topic and the patient had just thrown in a very clear statement about how they were dealing with addiction and I was focused on the other thing that they were talking about. **That allowed me to go back and address that with them at a later date, which I totally would have just missed.**”

– Family Physician, Saskatchewan

These clinician-reported perceptions were supported by findings from the retrospective chart review. Overall documentation completeness increased modestly, from 92.9% pre-implementation to 95.5% post-implementation, while variability in note quality decreased, indicating more consistent and complete documentation across PCCs. Improvements were most evident in the more complete capture of discrete clinical elements, particularly psychosocial context (88.5% to 96.2%) and vital signs (44.0% to 49.0%).

PCCs also reported that greater note completeness supported care delivery in team-based settings, as more detailed documentation improved care continuity by making it easier for colleagues to understand prior encounters and clinical decisions.

“But some of my colleagues were really delinquent on their charting, and I think that’s something that happens when GPs have like such a cognitive load. Once you accumulate a backup, you’re kind of stuck, like you just accumulate and it’s hard to go back. I think that my colleagues that had difficulty, or had not integrated a way of charting that made sense for them, I’m really grateful they have AI [scribe] because now, their charting – I have enough information to move on from that.”

– Non-Adopter, Family Physician, Québec

RNs specifically reported that AI-generated notes improved documentation of clinical reasoning, supporting clearer communication with clinicians responsible for final assessment and diagnosis. Both survey and interview findings also highlighted accessibility benefits for PCCs, as documentation could be generated through conversation rather than manual entry, supporting clinicians with physical limitations or disabilities.

COMMON ERRORS AND REVISIONS TO AI-GENERATED NOTES

Although most PCCs found AI-generated notes to be accurate and complete, more than 75% of PCCs reported that they had to frequently edit AI-generated medical notes. Interviews identified common types of documentation errors, summarized in Table 2 with definitions and examples.

Table 2. Common types of errors identified in AI-generated medical notes.

Type of Error	Definition	How Errors Commonly Appeared in Medical Notes
Homonym or misspellings	Errors where words that sound similar are transcribed incorrectly or where speech recognition misinterprets spoken terms.	Incorrect spelling of local names such as geographic locations, clinic sites, or the names of specialists referenced in referral letters.
Misplacement errors	Errors where information is documented in the wrong section of the medical note.	Elements of the management plan appearing in the subjective history, or patient-reported symptoms or self-diagnosed conditions being recorded as objective findings or diagnoses.
Speaker attribution errors	Errors where statements made by one individual during the encounter are attributed to a different individual.	Patient statements documented as clinician observations or recommendations, or clinician statements attributed to the patient.
Omissions	Relevant information from the clinical encounter that is not captured in the generated documentation.	Missing physical examination findings, omitted pertinent positives or negatives, or missing qualifiers to clinical questions (e.g., yes/no responses).
Structural or organizational errors	Issues related to how information is summarized, structured, or organized within the note.	Documenting connected symptoms as unrelated issues, or generating separate differential diagnoses for each symptom rather than recognizing that they may reflect a single underlying condition.
Hallucinations or inferred content	Information generated by the AI system that was not explicitly discussed during the clinical encounter and cannot be directly traced to the conversation between the clinician and patient.	Suggestions for investigations or clinical considerations that were not discussed, or content appearing to infer additional clinical information based on the conversation.

COMMON STRATEGIES TO IMPROVE AI-GENERATED MEDICAL NOTES

PCCs adopted a range of strategies to improve the quality of notes generated by the AI scribes, including customizing templates, using structured dictation, and modifying how information was verbalized during encounters. These strategies likely reflect early-stage workarounds for limitations that more advanced templates, model retraining, and RAG functionality could resolve. As AI scribe technology matures, the responsibility of adaptation should shift from the clinician to the technology itself, enabling high-quality documentation without PCCs needing to modify how they naturally communicate with patients.

Many PCCs felt that AI-generated documentation was a step toward a new standard for clinical notes. Compared to traditional documentation practices, often optimized for speed and brevity, AI-generated notes were perceived as more structured and better aligned with documentation and medicolegal expectations.^{20,21} However, opportunities remain to improve quality, personalization, and consistency before these tools can be considered ready for broad, sustained use.

IMPACT ON DATA COMPLETENESS AND PORTABILITY AT THE POINT OF CARE

Looking forward, PCCs noted three key areas that are likely to shape the evolution of AI scribes:

- **Greater flexibility in template customization:** PCCs need the ability to create and refine documentation templates that reflect their specialty, practice context, and individual style, rather than relying on generic formats. Shared template libraries across peer networks could further accelerate adoption and standardization.
- **Model retraining using context-specific clinical data:** Governed secondary use of clinical data would enable AI scribe models to better reflect Canadian practice patterns, specialty-specific workflows, and jurisdictional documentation norms rather than defaulting to generic or trained outputs for other regions, such as the United States.
- **Integration with clinical knowledge sources through approaches such as RAG:** An AI scribe that not only documents what occurred but also highlights relevant evidence-based recommendations may represent a meaningful shift beyond improved transcription, bridging documentation with clinical decision support.

3.7 Risks and Limitations

While AI scribes demonstrated meaningful benefits, PCCs also identified several risks and limitations that may affect their safe, effective, and sustainable use. The following section outlines key considerations related to training, trust, workflow integration, and broader system-level implications.

DESKILLING AND APPROPRIATENESS FOR LEARNERS

Many PCCs emphasized that notetaking is an important component of clinical reasoning and should be developed before relying on AI scribes. While early exposure during training was seen as valuable, there were concerns that overreliance could lead to deskilling. Some early-career PCCs also questioned how AI use might affect patient perceptions of their competence. Others also raised concerns about the potential for AI-generated notes to reflect existing biases.

*“...I’ve gone through a lot of effort to try to minimize my own risks of exposing my patients to [racist, sexist, transphobic, and homophobic] biases **and I wouldn’t want to integrate something that would undermine what is already something that I could potentially have short-sightedness towards...** and then I thought about what I want my practice to be and how I want my patients to think of me and the risks I want to take.”*

– Family Physician, Ontario

TRUST AND ACCOUNTABILITY

Most PCCs reported that they did not fully trust AI scribes to accurately and reliably capture clinical information. As a result, clinicians consistently emphasized the need to review and edit AI-generated notes, actions that are recommended as best practices by medical regulatory and medical protective organizations. Many non-adopters reported observing noticeable errors when reviewing notes written by peers using AI scribes, which reinforced their concerns about adopting the technology.

*“I find a lot of people now are using AI scribe and we get the referral, the letters back from the doctors. They are overly long. **They do not represent what has happened according to the patients.** The doctors will say that they have done examinations but then patients say, ‘Well, they never did look in my ear,’ but there will be things in the [note]... **I find a lot of mistakes because I read them over and I think that people are not reviewing the notes.**”*

– Non-Adopter, Family Physician, British Columbia

PCCs also highlighted the potential for discrepancies between the AI-generated notes and clinician recall, particularly when notes were reviewed sometime after the appointment, creating uncertainty about which source to trust.

*“Another thing I noticed that surprised me actually was I had a consult, telemedicine, with a patient, finished the consult, copy/pasted the generated note and it said that the patient had had three prior episodes of what we were talking about. I said, ‘No, no, it was two.’ but the AI scribe put three... **It’s possible that my memory didn’t capture it, so I trusted that the AI who’s recording the audio transcribed it properly. I have no way to ever check because the audio is deleted by now.**”*

– Family Physician, Québec

Overall, PCCs emphasized that AI scribes are supportive tools intended to support, not replace, clinical judgment. Their value lies in helping reduce documentation burden and improve workflow efficiency, while clinicians remain accountable for reviewing, validating, and finalizing the clinical record.

DOCUMENTATION SUPPORTING CLINICAL REASONING

Some PCCs highlighted that the process of medical notetaking supported their clinical reasoning, helping them work through differential diagnoses and decision-making in real time. For these PCCs, shifting from active notetaking to primarily reviewing and editing AI-generated notes created a sense of cognitive disconnection from the encounter, disrupting their ability to recall important details. In some cases, this led them to discontinue use. Others, however, felt that the time savings and reduced documentation burden outweighed this disadvantage.

*“I do very minimal typing now. It’s more the edits that are needed, and most of it is reviewing the notes and closing it off. **What I have noticed from that, because I am not typing it, is that sometimes I don’t recognize my notes...** When it’s something you’ve written, you can automatically tell and you know exactly where to find the information. When it’s generated by the AI [scribe], you don’t have that kind of same instinct to know where you put something or recognition of your own typing so that it comes flooding back to you. **I have noticed that as a little bit of a downside in my recall, but it’s not enough to make me want to type things out.**”*

– Family Physician, Saskatchewan

VENDOR PROLIFERATION AND INTEROPERABILITY CHALLENGES

A few PCCs expressed concern about the proliferation of AI scribe vendors in the market, noting challenges in determining which products met benchmarks for quality, privacy, and security. The abundance of options made it difficult to make informed choices, although Infoway’s national vendor validation and procurement process helped provide additional confidence by confirming that selected products met Program requirements and aligned with pan-Canadian interoperability priorities. In some jurisdictions, guidance from regulators and local health authorities further supported clinicians in vetting and selecting solutions. Some PCCs also worried that AI scribes could follow a similar trajectory as EMRs, where market consolidation and limited interoperability standards have reduced competitive pressure on vendors to improve integration and data portability.

PRIVACY AND SECURITY OF PATIENT DATA

Some PCCs expressed concern about the privacy and security of patient data, particularly regarding third-party handling, data storage, and the potential for commercialization. These worries were compounded by the large number of vendors in the market and the risk of potential privacy breaches. PCCs also voiced concerns regarding the environmental impact of AI scribe use that may lead to large, long-term consequences.

3.8 Spread, Scale, and Sustainability

Understanding the long-term use of AI scribes requires examining PCC satisfaction, drivers of sustained use, and system-level considerations. The following section explores key factors influencing whether AI scribes are likely to scale and be sustained in routine clinical practice.

SATISFACTION WITH AND VALUE OF AI SCRIBES

Following three- and six-months of use, PCCs reported high levels of satisfaction with AI scribes. More than 90% agreed that the AI scribe was valuable to their clinical practice, and over 80% reported being satisfied with its overall performance. AI scribes received a net promoter score of +41, with 55% of PCCs classified as promoters, 30% as passives, and 14% as detractors. Most PCCs provided high recommendation scores (median = 9 out of 10), indicating a strong willingness to recommend an AI scribe to colleagues.

FACILITATORS FOR SUSTAINED USE OF AI SCRIBES

JOB SATISFACTION AND CLINICIAN WELL-BEING

Clinicians consistently identified improvements in job satisfaction and well-being as key drivers of sustained use. Reducing the cognitive burden of documentation allowed PCCs to focus more on patient care and clinical decision-making. Many described a renewed sense of professional fulfillment, with some noting that AI scribes brought “joy” back into their work.

By easing some administrative pressures, PCCs noted that AI scribes contributed to a more manageable workday and reduced stress. For some PCCs, this shift was described as an important factor in sustaining their motivation to continue practicing.

“The wonderful thing is that [the AI scribe] is allowing me to reorganize my practice in a way that’s – it’s liberated time... I think it’s allowed me to actually sit down and be able to not just be in survival mode... It’s making me like, ‘OK, how can I thrive in my practice and how can I actually plan it so that I’m not like always head above water like this?’”

– Nurse Practitioner, Québec

COSTING

Cost emerged as a key determinant of sustained AI scribe use. At six months, the majority of surveyed PCCs reported a willingness to pay up to \$100 per month out of pocket, although this varied considerably by practice model, reflecting both economic incentives and structural constraints. For example, PCCs working in fee-for-service settings were generally more willing to pay if time savings from using an AI scribe allowed them to see additional patients and offset the

cost. In contrast, PCCs working in salaried, capitation, or fixed budget models, such as NP-led or community clinics, were less likely to view personal payment as feasible, particularly when their compensation was not tied to patient volume. Others noted that the continued use of an AI scribe after the Program was dependent on organizational policies or institutional approval processes.

Across practice contexts, there was strong interest among PCCs in ensuring AI scribes remain accessible to clinicians who can benefit from them. PCCs broadly viewed AI scribes as part of the digital infrastructure that supports better clinical care by reducing administrative burden. From this perspective, many noted that cost was an important consideration for sustained adoption and suggested that long-term funding models could include support from health systems, governments, or professional organizations (i.e., Colleges or regulators).

These considerations highlight important sustainability and equity considerations. Although certain practice models (i.e., capitation and salaried models) were designed to support patient-centred care rather than volume-based incentives, funding structures and limited discretionary budgets may constrain clinicians' ability to adopt and sustain tools that could enhance care delivery. These findings suggest that flexible funding approaches may be needed to support equitable access across different practice environments and ensure that the benefits of AI scribes are not limited by clinicians' ability to pay or by clinical budget constraints.

PCCs also emphasized that their willingness to pay out of pocket could change as AI scribes evolve. Many noted that improvements in performance, reliability, and functionality could increase the perceived value of AI scribes and, in turn, clinicians' willingness to contribute financially. Nevertheless, most participants expressed interest in long-term funding or reimbursement models that could support continued access to AI scribes, including potential support from professional associations, health authorities, or government programs.

SYSTEM-LEVEL FUNDING FOR SCALE

Many PCCs indicated that they would have preferred the opportunity to try more than one AI scribe before making a longer-term commitment to a specific solution. As a result, many expressed interest in testing alternative AI scribe solutions to better understand differences in performance and workflow fit. Even among non-adopters or those who discontinued use, most indicated that they remained open to trying AI scribes again in the future. Several indicated they would be more willing to revisit AI scribes once additional evidence on their impact becomes available and as the technology continues to improve.

This desire for greater trialability also has implications for long-term adoption and funding models. In an emerging technology market, trialability is important for identifying solutions that best fit different practice environments. These findings also suggest that broad interest in AI-enabled documentation tools remains strong as the technology and supporting evidence continue to evolve. Continued early subsidization or system-level support may enable PCCs to experiment with different tools, supporting broader adoption, market competition, and sustainable scale over time.

THE FUTURE OF AI IN PRIMARY CARE

Many PCCs anticipate that AI will play an important role in the future of primary care as a scalable technology to reduce administrative burden and support more sustainable practice. At the same time, PCCs noted that AI scribes in their current form address a single component of workload: documenting the encounter. While highly valued, an encounter still generates a series of downstream tasks that are time-consuming.

The most commonly identified opportunities for expanded capability included:

- Drafting **referrals and specialist consult notes** based on the AI-generated medical note.
- **Inbox management** (i.e., triaging, summarizing, and drafting emails).
- Completing **standardized forms and insurance paperwork** (e.g., disability documentation, insurance forms, etc.).
- **Patient education materials** including personalized handouts to support understanding and shared decision-making.
- **Sharing visit summaries** with patients to ensure accuracy and support self-management.
- **Panel management and population health** by identifying patients due for screening, follow-up, or preventive care.
- **Clinical decision support** to surface potential differential diagnoses or suggested investigations based on the clinical discussion during the encounter.

Some PCCs reported that the AI scribes they were using already included emerging features that extended beyond documentation, including referral drafting, patient education materials, and clinical decision support prompts enabled by RAG. These capabilities were viewed as promising but early in development. PCCs emphasized that expanded functionality requires careful evaluation for clinical accuracy, safety, and appropriate integration into workflow.

4.0 Discussion

4.1 Key Findings

The AI Scribe Program by Canada Health Infoway demonstrated meaningful benefits for PCCs across Canada. PCCs reported measurable reductions in time spent on administrative tasks, improvements in documentation timeliness, and lower administrative burden and cognitive load. These gains appeared within the first few months of use and were generally sustained, and in some cases strengthened, following six months of use. For PCCs who previously spent hours completing documentation outside of work, AI scribes helped restore time during lunch breaks, evenings, and weekends. For others, the primary benefit was reduced cognitive burden during visits and a greater ability to focus on patient care. The successful implementation of a nationwide AI Scribe Program in primary care represents a significant achievement for Canada.

In general, the benefits of the Program were clear, though they varied across clinicians and practice settings. A group of highly engaged users accounted for the majority of AI-assisted encounters, while others used the tools more intermittently. The degree of benefit appeared to depend on how PCCs integrated the technology into their workflows, their existing documentation practices, and their expectations for note quality. In less frequent cases, the need to review and edit AI-generated notes reduced efficiency gains and disrupted established routines. PCC experience was also shaped by technical factors, including inconsistent system performance and EMR integration.

Importantly, these findings should be interpreted in the context of the product generation being evaluated. The AI scribes assessed in this evaluation were primarily defined by documentation-focused features and capabilities, and often required workarounds, manual editing, and clinician-led adaptation. Most operated without access to governed Canadian training data, without RAG in provincial or territorial guidance, and without many of the referral, inbox management, and clinical decision support functions that are now beginning to emerge. In addition, documentation templates were often developed informally by individual clinicians rather than curated through professional or organizational channels. Opportunities for model refinement were also limited, and integration with broader health system data assets was minimal. As a result, the benefits observed in this evaluation likely reflect early-stage impacts, with additional gains expected as these tools continue to mature.

Despite these constraints, PCCs consistently reported less burnout, timelier documentation, reduced cognitive load, more attention available for patient care, and more complete clinical records. These findings suggest that even early-generation AI scribes address a significant and persistent source of administrative burden in primary care: documentation of clinical encounters.

The broader implication is that the current generation of AI scribes should be understood as an early stage in a rapidly evolving product category. Many AI scribe products are already expanding beyond documentation to incorporate RAG, clinical knowledge integration, and broader clinical copilot functionality. Canadian primary care systems now have an initial base of adopters, implementation knowledge, and evaluation experience on which to build.

Overall, the AI Scribe Program by Canada Health Infoway was an early national success on all direct measures and has important implications for Canadian healthcare. The findings from this evaluation shift the central policy and implementation question from whether AI scribes provide value to how they can be effectively implemented, improved, governed, and scaled within a rapidly changing technological and market landscape.

4.2 Study Limitations and Considerations

There are a few study limitations to consider. First, participation in the surveys and interviews was voluntary, and respondents may not fully represent all PCCs enrolled in the Program or the broader population of PCCs practicing across Canada, introducing the potential for selection bias. Survey response rates varied at onboarding (n=3,678; 30.6%), three-months (n=2,667, 22.2%), and six-months (n=1,899, 23.8%), reflecting attrition over time and differences in engagement with the evaluation. While a subset of clinicians (n=932; 7.8% of the AI Scribe Program cohort) responded across all waves and enabled linked longitudinal analyses, most analyses were conducted as repeated cross-sectional assessments, which may limit the ability to attribute observed changes solely to within-person changes over time.

Second, many outcomes in this study were based on clinicians' self-reported perceptions. While these measures provide important insight into clinicians' experiences and workflow changes, they may not fully reflect objective changes in documentation practices or time savings. Although a retrospective chart review was conducted to assess documentation completeness, future research incorporating a more comprehensive independent review of clinical notes or objective measures of documentation time could provide additional evidence on the impact of AI scribes.

Third, this evaluation assumed that clinicians' responses primarily reflected their experiences with the AI scribe assigned through the Program. However, some PCCs may have had prior experience with, or concurrently used, other AI scribe solutions outside of the Program. Although some responses may have been influenced by experiences with other products, the overall trends observed across PCCs and timepoints remained broadly consistent.

Finally, this evaluation focused primarily on PCC experiences, documentation practices, and workflow changes. While improvements in documentation completeness and efficiency may have implications for patient care, the study did not directly assess patient outcomes, safety events, or other downstream clinical impacts. Future research examining how AI-generated documentation influences care delivery, patient outcomes, and patient perspectives would provide a more comprehensive understanding of the broader impact of this technology.

5.0 Conclusion

This evaluation of Infoway's AI Scribe Program demonstrated that AI scribes can deliver meaningful benefits for clinicians across Canada, including reduced administrative burden, improved documentation, and greater capacity to focus on patient care. These benefits were observed as the technology continues to mature, highlighting the potential of AI-enabled tools to address broader administrative challenges that extend beyond documentation of the clinical encounter.

Future work will require a shift from initial implementation to supporting scale, deeper integration with clinical systems, and stronger governance. As AI scribes continue to evolve beyond documentation toward broader clinical copilot capabilities, their long-term value will depend on ensuring they are safe, interoperable, and aligned with clinical workflows across the Canadian healthcare system.

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