Introduction to Ambient Scribes

Ambient Scribes are one of the most exciting developments we've seen in clinical workflows in years. They promise less typing, less burnout, and more meaningful connection with patients.

And for many physicians, that alone feels like a long overdue shift in the right direction. But here's the question. Are they actually capturing the full clinical and financial story of The Visit?

Because what I'm seeing across practices of all sizes is that while ambient scribes are incredibly helpful, they're not the entire answer. Welcome to Medical Money Matters, the podcast where you can find experts, answers, and resources so that you achieve mastery over the financial and business aspects of your practice.

Hello, everyone. I am your host, Jill Irina. I began my career in accounting and finance and I have more than 30 years of experience running medical groups.

I own and operate a national healthcare consulting and revenue cycle company and am the author of Physician Heal Thy Financial Self. In 2020, I co-founded the Physician Leadership Project, and in 2025 I released Physicians Edge, the first of its kind CME-accredited online business education for physicians.

My passion is to increase financial and business literacy for Physicians. Episode 178. If you didn't say it, it did happen. The hidden risk of ambient scribes.

Ambient Scribes are one of the most exciting developments we've seen in clinical workflows in years. They promise less typing, less burnout, and more meaningful connection with patients.

And for many physicians, that alone feels like a long overdue shift in the right direction. But here's the question. Are they actually capturing the full clinical and financial story of The Visit?

Podcast and Host Introduction

Because what I'm seeing across practices of all sizes is that while ambient scribes are incredibly helpful, they're not the entire answer. And this isn't a knock on the technology.

In fact, I think it's one of the most important tools we've added to the clinical environment in a long time. But like any tool, its value depends entirely on how it is used and what we assume it doing for us.

So let's start with what ambient scribes do really well, because there's a lot to appreciate here. They reduce the physical and cognitive burden of documentation.

Instead of turning your back to the patient and then typing onto a screen, you can stay engaged, make eye contact, and actually listen. That alone changes the dynamic of the visit in a meaningful way.

They also improve efficiency. Notes are often generated quickly, sometimes even in real time, which reduces the amount of after hours pajama time charting that so many physicians have come to accept as normal.

For some practices, that's been transformative. And they can help with recall.

The Hidden Risk of Ambient Scribes

The system is capturing the conversation, Which means fewer missed details, fewer forgotten elements, and a more complete record of what was said in the room.

So yes, this is a powerful tool. But it's still just a tool, and where things start to break down is in the gap between what is said and what it thought.

Because if you think about how you practice medicine, so much of your value is not in what you say out loud. It's in, what's happening internally. During a typical patient visit, you're constantly processing information.

You're building a differential diagnosis. Your weighing risk. your deciding what matters and what doesn't. you are considering what could go wrong, even if it's unlikely.

Making judgment calls based on years, sometimes decades, of training and experience. This is probably benign, but I can't ignore the possibility that it is something more serious.

Or, I'm going to treat this conservatively, but I need to keep a close eye on it. Or given this patient's history, this is actually higher risk than it appears.

Those are sophisticated clinical decisions. But here's the problem. Ambient scribes are only capturing what is spoken. And what has spoken is often a simplified, patient-friendly version of what you're actually thinking.

So what ends up in the note looks much less complex than the actual visit. And that has real consequences. Because from a coding perspective, from compliance perspective and from financial perspective complexity matters.

Medical decision-making is one of the core drivers of E&M coding, and medical decision making is based on things like the number and complexity of problems addressed, the amount and the complexity data reviewed, AND the level of risk.

If those elements aren't documented, they don't count. So if you're thinking through a complex differential diagnosis, but only verbalizing a simplified conclusion, the note may reflect a lower level of complexity than what actually occurred.

And over time, that leads to under-coding. Not once in a while, consistently. And consistent undercoding is not a small issue. As we've discussed in previous episodes, it's a slow, steady erosion of your revenue.

It's an underrepresentation of the work you're actually doing. And in some cases it can even create compliance concerns in the opposite direction, because your documentation doesn't match the true acuity of you patient population.

Let me give you a simple example. A patient comes in with chest pain. In your mind, you're thinking through a range of possibilities. Musculoskeletal pain, sure, but also cardiac causes, pulmonary embolism, maybe even something gastrointestinal.

You're weighing risk factors, history, presentation. But what you say out loud might be something like, this is likely musculoskelital. Let's treat it conservatively and monitor.

That's appropriate communication for the patient. But if that's all that gets captured in the note, it tells a very different story than what actually happened cognitively.

And that difference matters. So now we're in a new reality where documentation is no longer just about what you type. It's about you say. And that creates a challenge.

Because you may now need to say things out loud that you used to simply think. You may need verbalize your differential diagnosis. you need articulate your risk assessment.

Explicitly state what your ruling in or ruling out, what data you reviewed, and why you made the decisions you make.

Documenting Clinical Reasoning Out Loud

That's a shift. And it's not always comfortable. Because not everything you think is something you want to say in front of a patient. There are moments in clinical care where your internal thought process includes possibilities that are serious, sensitive, or even alarming.

You might be considering a diagnosis that would worry the patient unnecessarily if presented without context. you might thinking about concerns related to compliance, behavior, psychosocial factors that require nuance and care.

And now, with an ambient scribe listening, the question becomes, how do you document those thoughts appropriately without creating unintended consequences in the room?

This is where things get more complex. Because on one hand, you need accurate documentation. You need to capture the full scope of your clinical reasoning.

you Need to support appropriate coding and protect yourself from a legal standpoint. On the other hand you, need, to maintain trust with your patient. You need To communicate in a way that is clear, compassionate, and appropriate for the situation.

So there's a tension here. And the solution is not to abandon the tool. It's to evolve how we use it. One of the most important skills that physicians will need to develop in this environment is intentional phrasing.

Learning how to say what needs to be documented in a way that is both accurate and appropriate. For example, instead of saying nothing about your differential diagnosis, you might say, there are a few possibilities we're considering here, including X, Y, and Z.

Based on what I'm seeing today, I think this is most likely X but we are going to keep an eye on it. That communicates your thinking. It documents your complexity.

And it does so in a way that is transparent, but not alarming. There will also be times when what you need to document is not something you want to say out loud in that moment.

And that's where it's important to remember that the ambient scribe should not be the final version of your note. It should always be first draft. You still have the ability and the responsibility to review, edit, and add to that note before it becomes part of the permanent record.

That might mean adding an addendum. It might meaning refining language. it might means documenting elements of your thinking that weren't verbalized during the visit.

Because again, the goal is not just faster notes, it's better notes. More accurate notes – notes that reflect the true complexity of the care you're providing.

You're listening to Medical Money Matters, a weekly podcast brought to you by Healthy Practices, A healthcare consulting and revenue cycle company dedicated to keeping our clients independent.

If you're looking for more ways to strengthen your business skills, check out Physicians Edge, the first of its kind CME accredited online business education for physicians.

It's a mini MBA online course designed to help you master the financial side of your practice. You can find that and more about how we support practices like yours at healtheps.com.

That's www.healtheps.com And don't forget to follow or subscribe so you never miss an episode. Now, let's zoom out a bit and talk about the operational and workflow implications of ambient scribes, because there's a lot happening here as well.

On the positive side, we're seeing improved efficiency in many practices. Physicians are spending less time charting after hours.

Workflow Benefits and Implementation Challenges

Notes are being completed more quickly. There's a sense of relief that comes from not having to carry that documentation burden into the evening. We're also seeing improvements in patient engagement.

When the physician is not focused on a screen, the interaction changes. Patients feel more heard. The visit feels more human. patients even feel like you spent more time with them, even if you didn't.

They just feel better about the visit and the attention they got from you. And from a staffing perspective, there may be opportunities to reduce reliance on traditional scribes or reallocate resources in a more efficient way.

Those are real benefits, but there are also challenges that need to be acknowledged. One of the biggest is over-reliance. There's a tendency to assume that the technology is handling the documentation completely.

That what's being generated is accurate, complete, and sufficient. And that's not always the case. Without a structured review process, errors can slip through.

Omissions can go unnoticed. Over time, note quality can become inconsistent. There is also a learning curve. Physicians are being asked to shift from thinking internally to speaking externally.

That's not a small change. It requires awareness, practice, and in some cases, coaching. Workflows may need to be adjusted. Time may be built in for review and refinement.

Expectations need be set clearly within the organization about what done looks like when it comes to documentation. Another challenge is variability. Different physicians will adapt to this technology differently.

Some will naturally verbalize their thinking. Others will continue to process internally, leading to differences in documentation quality and coding outcomes across the group.

And that variability can create both financial and operational issues. So what does a best practice model look like? It's not about choosing between ambient scribes or traditional documentation methods.

It is about integrating the technology into a thoughtful system. That system includes physician and clinician awareness, understanding that what you think needs to be reflected in what is documented, and that may require more intentional verbalization.

It includes a structured review process. Notes should not be signed without being reviewed. There should be an expectation that the ambient output is a draft and not a final product.

It include alignment with coding education. Physicians need to understand how their documentation supports, or fails to support, appropriate coding levels in this new environment.

And it includes periodic audits. Looking at note quality, looking at coding patterns, identifying trends, making adjustments. Because what you don't want is a slow drift toward under-documentation and undercoding that goes unnoticed for months or even years.

And this is where the broader message comes in. Technology is moving quickly, faster than most of us expected, and it's solving real problems. But it's not replacing clinical judgment.

It's now replacing the need to communicate that judgment clearly. And it is not eliminating the needs for systems, processes, and oversight. Ambient scribes are solving the problem of documentation burden.

They are not fully solving problems of document accuracy, coding optimization, or clinical storytelling. Those are still your responsibility. So if you're using an ambient scribe or considering one, the question isn't just, is this making my life easier?

It's also, Is this accurately reflecting the care I'm providing? Is the supporting appropriate coding? is improving or potentially compromising my documentation quality?

Best Practices for Accurate Documentation

Because at the end of the day, the goal is not just to get the note done. The goal, is to tell the story of The Visit in a way that is clear, complete, and accurate.

To reflect the complexity of your thinking. to support the financial health of you practice. And to protect both you and your patient. This is a powerful tool.

But like any powerful tool, it needs to be used with intention. It needs be supported by good systems, and it need to understood, not just adopted. And if you're already using ambient scribes, It may be worth taking a closer look at your notes, at you coding patterns, how your workflows have changed.

If you are thinking about implementing this technology, this is the moment to design it well from the beginning. Because when you get this right, you don't just reduce documentation burden, You create better notes, stronger systems, and ultimately healthier, more sustainable practices.

Until next time. Before we wrap up, if today's conversation sparked any questions about whether you're truly capturing all of the revenue you've earned, I want to point you to something we've built specifically for that.

At Healthy Practices, our Code Mastery program is designed to help physicians and medical groups close the gap between the carry they deliver and the Revenue they actually collect.

Because in many cases, it's not about working harder. It's about documenting, coding, and communicating your clinical work in a way that fully reflects its value.

This physician-to-physician training program is delivered via Zoom in four one-hour trainings throughout the year to simplify coding improve accuracy and uncover missed revenue opportunities that are often hiding in plain sight.

So if you're ready to better understand your numbers and take control of your revenue, I'd encourage you to learn more about code mastery. You can visit us at Healthy Practices or check the link in the show notes to get started.