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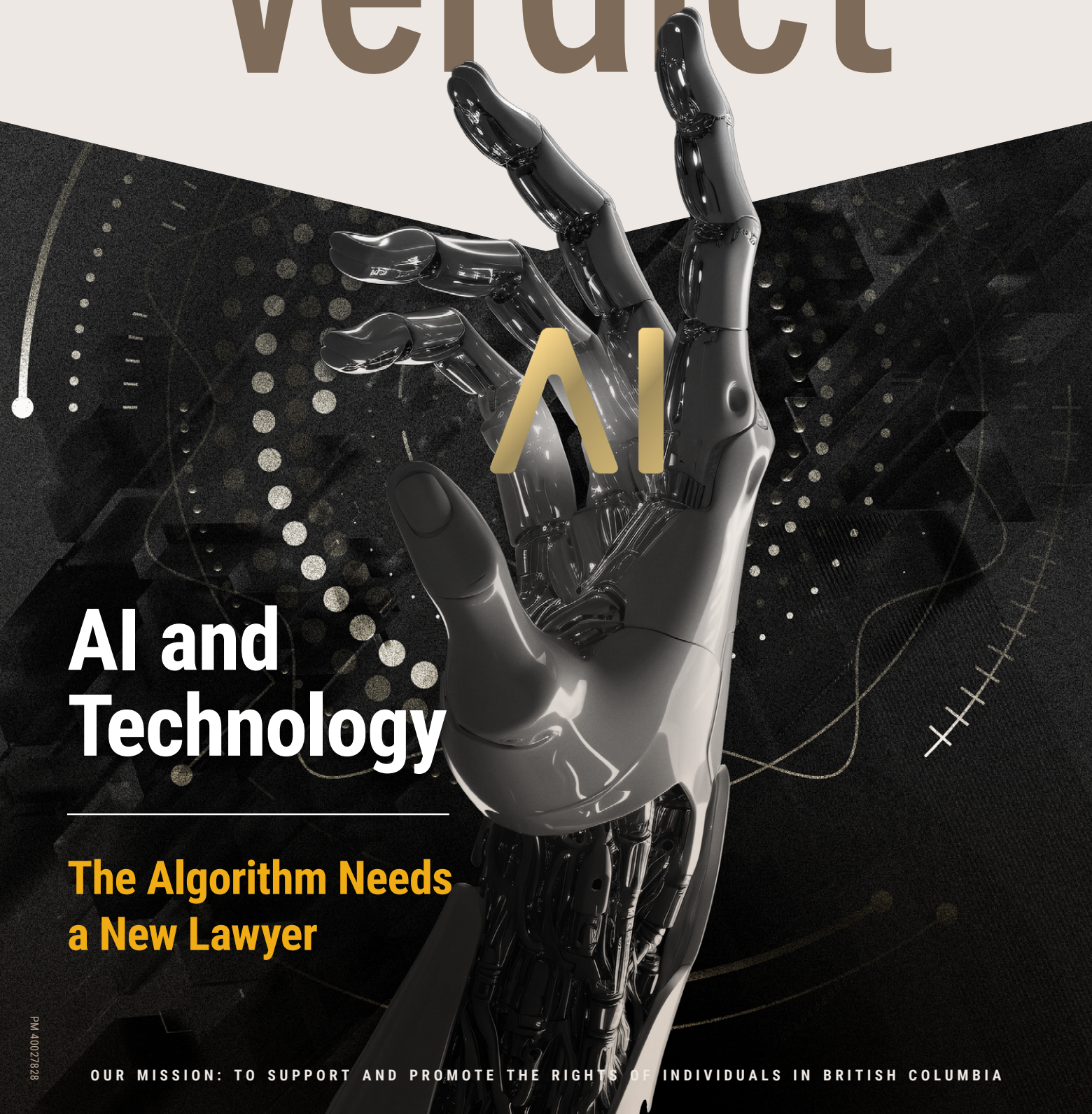

AI and Technology

The Algorithm Needs a New Lawyer

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Medical Malpractice

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Digital Scribes, Legal Signatures: **AI-Generated Records in Medical Malpractice**

THIS IS THE THIRD ARTICLE OF OUR SERIES DISCUSSING PRACTICAL AND EVIDENTIARY ISSUES IN MEDICAL MALPRACTICE. EACH ARTICLE WILL EXAMINE RECENT MEDICAL MALPRACTICE CASE LAW AND FOCUS ON PRACTICAL AND EVIDENTIARY ISSUES WITHIN THEM. THE GOAL IS TO PROVIDE SOME USEFUL INSIGHT INTO THE OBSTACLES THAT OCCURRED IN HOPES THAT FUTURE CASES CAN ADAPT AND DEVELOP NEW WAYS TO OVERCOME THESE CHALLENGES.

Artificial intelligence ("AI") has the potential to radically transform the way healthcare is delivered in Canada. From interpreting imaging to streamlining workflows, AI tools are quickly becoming a routine part of clinical practice. Many see this as a positive shift: by reducing human error and alleviating administrative burdens, AI has the potential to address many of the underlying causes of adverse patient outcomes, including poor documentation and communication breakdowns.

This transformative potential, however, carries a host of legal uncertainties. While much has been written about how courts might address novel uses of AI in diagnostics and clinical decision-making,[1] far less attention has been given to the more routine, administrative uses of AI.

> Unlike diagnostic tools, administrative applications of AI remain unregulated in Canada.

According to the Royal College of Physicians and Surgeons of Canada's Task Force Report on Artificial Intelligence and Emerging Digital Technologies, such tools have the potential to "liberate physicians from repetitive tasks, allowing time for more patient care, including compassionate care, and improving the safety and quality of patient care."[2] Yet, from a medical malpractice perspective, these seemingly low-risk technologies may pose significant and immediate risks to both patient safety and the integrity of the litigation process.

This article explores the complex interplay between AI and medical malpractice, with a specific focus on digital scribes: AI-powered systems that transcribe and summarize clinical encounters. While digital scribes offer the promise of reduced administrative burden, they also raise significant legal risks that medical malpractice lawyers must be alert to in reviewing documents and litigating lawsuits.

AI in the Canadian Healthcare Landscape

Artificial intelligence is notoriously difficult to define. For this reason, the Canadian Medical Protective Association ("CMPA") does not offer a single definition of AI, but instead enumerates the fundamental features shared by all technology under this umbrella term. The CMPA characterises AI as technology which is designed to achieve specific objectives; operates with a degree of autonomy in pursuing those objectives; requires the input of data; and produces output in the form of information, ranging from a recommended solution to a problem to a command directing a robotic device.[3]

In both legal and medical discourse, a distinction has emerged between clinical and administrative uses of AI.[4] Health Canada, along with the CMPA, draws this line explicitly.

AI tools that serve a clinical or medical purpose — such as assisting in diagnosis, monitoring vital signs, or interpreting medical imaging — are regulated as "software as a medical device" (SaMD). These tools are subject to oversight under the *Food and Drugs Act* and related Health Canada guidance.[5] To qualify as SaMD, the AI in question must either replace or inform clinical judgment in a way that impacts individual patient care.

By contrast, administrative or operational AI tools, which do not directly influence clinical decisions, are not regulated as SaMD. These include systems designed to automate scheduling, manage billing, or — most relevant here — generate documentation. Health Canada's regulatory regime excludes software that merely supports healthcare providers by organizing, transmitting, or displaying information, as long as it does not analyze medical images or provide clinical interpretation.[6]

Much of the public and professional attention around AI in healthcare has focused on AI regulated as SaMD, and for good reason. Diagnostic AI raises significant legal, ethical, and safety concerns. One frequently cited issue is the so-called "black box" problem, whereby AI systems produce outcomes that cannot be easily explained or audited by human users. This opacity may obscure sources of error and promote systemic biases.[7] How these technologies may affect a medical malpractice lawsuit has not yet been tested in Canada, though the experience abroad indicates it is only a matter of time before courts in this country have to grapple with these thorny issues.[8]

Despite this focus, however, the implementation of clinical AI in Canada remains limited. While high-profile pilot projects and academic studies suggest a future where AI may play a greater role in diagnostics and decision-making, in practice, most healthcare settings continue to rely on traditional methods. The everyday presence of AI in Canadian medicine is far more likely to be found in administrative systems — tools that quietly support, rather than direct, clinical care. One successful and routine implementation of AI are digital scribes, which will be the focus of the remainder of this article.

Digital Scribes in Canadian Healthcare

Physicians in Canada have both a legal and ethical responsibility to maintain accurate, timely, and complete records of all medical care provided. These clinical records not only facilitate continuity of care, but also offer a source of accountability and legal protection. In medical malpractice litigation, charting often becomes the central piece of documentary evidence — sometimes, it is the only record available to reconstruct what transpired during a clinical encounter. Contemporaneous chart entries are routinely considered by the court to be business records admissible in evidence as *prima facie* proof of the facts stated therein.[9] As articulated by Justice Marzari in *Gilmore v. Love,*

> "It is well established that documents created at the time of the events themselves can be helpful in providing an accurate reflection of what occurred, in addition to, or even in preference over, the memories of the participants that have aged with the passage of time, hardened through litigation, or been reconstructed."[10]

As such, documentation quality has a significant impact on the analysis of whether the defendant's conduct met the standard of care.

Against this backdrop, digital scribes — AI-powered tools that generate clinical documentation — are emerging as a promising solution to reduce the administrative burden on healthcare providers. Digital scribes, like DeepScribe and MEDITECH, typically function by recording the clinician-patient interaction, transcribing the audio into text, extracting key clinical information, and summarizing the encounter into a structured note for the medical record.[11] These tools are often embedded within or integrated into electronic health record platforms, offering the potential to improve physician efficiency and "presence" during clinical encounters.

In Canada, such applications are considered "lower risk" from a regulatory perspective. The CMPA categorizes administrative AI, including digital scribes, as posing fewer immediate clinical dangers than diagnostic tools.[12] Similarly, the College of Physicians and Surgeons of British Columbia ("CPSBC") does not impose specific restrictions on digital scribe use, requiring only that patients provide informed consent if their encounters are to be recorded for the purposes of AI-driven documentation.[13]

Proponents of digital scribes have endorsed these tools as a way to rebalance the demands of modern practice. In a recent article published by the University of British Columbia, three physicians and a

medical student praised the use of such "conversational AI" in family medicine. They argued that such tools do not replace physicians' judgment or expertise, but instead "empower them to focus on their primary mission [of] delivering exemplary care," by alleviating the "burden of documentation" that contributes to physician burnout and inefficiency.[14] Similarly, a Canadian study examining the needs of emergency medicine physicians found that "automated charting" and "report generation" were the top-ranked AI applications of interest.[15] On a much larger scale, Fraser Health, a regional public health authority in BC, is currently part of a pilot project that uses Google Cloud's generative AI tools to produce an initial draft of a patient's hospital course and discharge summary.[16] These examples signal a growing institutional and professional enthusiasm for AI-driven documentation solutions.

Medical Records Produced by Digital Scribes: Potential Medical Malpractice Implications

Sections 3-5 to 3-7 of the Bylaws pursuant to the *Health Professions Act* impose obligations on physicians regarding medical record management.[17] Yet, despite the growing integration of AI in clinical documentation, neither the Bylaws, nor guidance from the CMPA or the CPSBC, currently requires that records generated or assisted by AI be explicitly identified as such. In other words, there is no obligation to identify that a medical document was generated, in whole or in part, by AI.

This lack of transparency poses significant concerns, particularly because AI-generated content may describe a clinical encounter that did not occur as documented. This issue is not limited to instances of AI "hallucination" — a phenomenon where AI presents incorrect information as accurate.[18] Even when the AI-generated summary appears accurate, it may subtly misrepresent the flow or emphasis of the interaction. In extracting key clinical information, it may overlook signs and symptoms that ultimately end up being important. In such cases, the resulting documentation risks becoming a deceptive fiction rather than a reliable record. For example, in the case of *Pinch v. Morwood*, the pregnant plaintiff attended hospital complaining of neck pain which extended into her head but which she described as "neck pain."[19] One of the issues in the case was whether the physician was negligent for failing to elicit that her neck pain included headache, a red flag for pre-eclampsia, which ultimately led to an eclamptic seizure and a brain injury to the infant. In similar circumstances, if an AI-generated scribe without the medical sensitivity to understand the implications of head pain for this particular population subset was used to summarize the encounter and failed to note the extension of pain into the head, it could have serious implications for any subsequent legal proceedings.

The courts have acknowledged that medical documentation need not be perfect. In *Brito et al. v. Woolley et al.*, the court held that "the law does not impose a standard of perfection on medical personnel in their preparation and maintenance of medical records," recognizing that "[o]ccasional inconsistencies, inaccuracies, and/or omissions are tolerated."[20] This precedent assumes, however, that the records were generated by the treating physician or someone under their direct supervision, not by a third-party algorithm that may incorporate biases, import false information, or misrepresent the encounter.

This assumption becomes even more critical when considering evidentiary rules. Section 42 of the British Columbia *Evidence Act* governs the admissibility of medical records as business records in legal proceedings.[21] Among other requirements, this section stipulates that the weight to be given to such documentary evidence is affected by whether it was created by a person with personal knowledge of the matters being recorded. If AI is used to generate content that the physician has not verified or that does not accurately reflect a direct recollection or observation, the reliability and the weight to be accorded to such documentation may be challenged.

It follows, then, that medical malpractice lawyers must be vigilant when reviewing medical records that may have been generated by digital scribes. It is essential to assess whether the documentation reflects the physician's direct observations and clinical reasoning, or whether it has been shaped by algorithmic structuring that misrepresents the actual encounter. Lawyers should inquire whether the record was created using AI, whether informed patient consent was obtained for recording and transcription, and whether the physician thoroughly reviewed and verified the AI-generated content before signing off. In cases where the record appears central to the alleged negligence, counsel should consider whether the document meets the evidentiary requirements under section 42 of the *Evidence Act*.

Conclusion

As the use of AI in charting becomes more common, scrutiny of how these tools are deployed and documented will become an increasingly important aspect of effective malpractice advocacy. Medical malpractice lawyers must be alive to this fact and should actively investigate whether AI-generated notes were properly reviewed and supervised by the treating physician, whether clinical decisions were unduly influenced by algorithmic outputs, and whether the documentation faithfully reflects both the patient's condition and the physician's own clinical reasoning.

Incursions by artificial intelligence are no longer a distant or hypothetical concern for the medical malpractice lawyer; they are a present and pressing reality. Understanding the role that AI may have played in the generation of a medical record is now essential not only to assessing liability, but also to safeguarding the integrity of the record itself as a piece of legal evidence.

1. See, for example, Yue Fei and Pablo Tseng, "The liabilities for AI in healthcare" The National (2 September 2022), accessed at https://nationalmagazine.ca/en-ca/articles/law/opinion/2022/the-liabilities-for-ai-in-healthcare; Dimitri Patrinos, "The Virtual Physician: Clarifying Medical Liability Issues in the Use of Remote Patient Monitoring" (2024) 62:1 Alberta Law Review 205; Bradley Henderson, Colleen Flood, and Teresa Scassa, "Artificial Intelligence in Canadian Healthcare: Will the Law Protect Us from Algorithmic Bias Resulting in Discrimination?" (2022) 19:2 Canadian Journal of Law and Technology 475.
2. Richard K. Resnik et al, Royal College of Physicians and Surgeons of Canada's Task Force Report on Artificial Intelligence and Emerging Digital Technologies (2020) at p. 3 and 34, accessed at https://www.royalcollege.ca/content/dam/document/membership-and-advocacy/2020-task-force-report-on-ai-and-emerging-digital-technologies-e.pdf.

3. CMPA, "The medico-legal lens on AI use by Canadian physicians" (2024) accessed at https://www.cmpa-acpm.ca/en/research-policy/public-policy/the-medico-legal-lens-on-ai-use-by-canadian-physicians.
4. CMPA, ibid; see also CMPA, "Considerations for adopting and implementing artificial intelligence (AI) in healthcare" (2024) accessed at https://www.cmpa-acpm.ca/en/education-events/good-practices/the-healthcare-system/considerations-for-adopting-and-implementing-artificial-intelligence-ai-in-healthcare.
5. See Health Canada, "Guidance Document: Software as a Medical Device (SaMD): Definition and Classification" (2019) accessed at https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/guidance-documents/software-medical-device-guidance-document.html; Health Canada, "Pre-market guidance for machine learning-enabled medical devices" (2025) accessed at https://www.canada.ca/en/health-canada/services/drugs-health-products/medical-devices/application-information/guidance-documents/pre-market-guidance-machine-learning-enabled-medical-devices.html.
6. Ibid; see also Michael Da Silva, Colleen Flood, and Matthew Herder, "Regulation of Health-Related Artificial Intelligence in Medical Devices: The Canadian Story" (2022) 55:3 UBC Law Review 635.
7. See Mirja Mittermaier, Marium M. Raza, and Joseph C. Kvedar, "Bias in AI-based models for medical applications: challenges and mitigation strategies" (2023) Digital Medicine, accessed at https://www.nature.com/articles/s41746-023-00858-z.
8. Consider, for instance, the coroner report for Stephen Pettitt, a retired music teacher who died in Newcastle, UK, after a routine heart surgery was performed using a DaVinci device: https://www.judiciary.uk/wp-content/uploads/2019/05/Stephen-Pettitt-2019-0037_Redacted.pdf. For a more recent example from the United States, see Re: Acclarent, Inc., Court of Appeals of Texas (Fort Worth) June 7, 2024, 2024 WL 2873617.
9. *Gilmore v. Love*, 2023 BCSC 1380, para. 55
10. Ibid., para. 54
11. Juan C. Quiroz et al, "Challenges of developing a digital scribe to reduce clinical documentation burden" (2019) Digital Medicine, accessed at https://www.nature.com/articles/s41746-019-0190-1.
12. CMPA, supra endnote 3.
13. College of Physicians and Surgeons of BC, "Interim Guidance: Ethical Principles for Artificial Intelligence in Medicine" (April 11 2023) accessed at https://www.cpsbc.ca/files/pdf/IG-Artificial-Intelligence-in-Medicine.pdf.
14. Rohit Singla et al, "Talking Smart: Conversational AI Streamlines Clinical Practice" (February 14 2024) accessed at https://thischangedmypractice.com/conversational-ai-streamlines-clinical-practice/.
15. Kyle W. Eastwood et al, "Needs and expectations for artificial intelligence in emergency medicine according to Canadian physicians" (2023) BMC Health Services Research, accessed at https://pmc.ncbi.nlm.nih.gov/articles/PMC10369807/.
16. MEDITECH, "Fraser Health to leverage generative AI for clinical documentation in MEDITECH Expanse EHR" (December 7 2023) accessed at https://ehr.meditech.com/news/fraser-health-to-leverage-generative-ai-for-clinical-documentation-in-meditech-expanse-ehr#:~:text=Fraser%20Health%20Authority%20(Surrey%2C%20B.C.,large%20language%20models%20(LLMs).
17. Accessed at https://www.cpsbc.ca/files/pdf/HPA-Bylaws.pdf.
18. See Rami Hatem, Brianna Simmons, and Joseph Thornton, "A Call to Address AI 'Hallucinations' and How Healthcare Professionals Can Mitigate their Risks" (2023) Cureus, accessed at https://pmc.ncbi.nlm.nih.gov/articles/PMC10552880/.
19. 2016 BCSC 938
20. 2005 BCSC 443, para. 62.
21. RSBC 1996, c 124