The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Using AI scribes for consultation notes

Guidance for College members and wider primary care teams.
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AI scribes capture the verbal aspects of a consultation, convert the conversation to text, and use AI to generate a draft clinical note for you to review, amend, and add to the patient's record.

Used well, AI scribes can reduce the administrative burden of clinical documentation and allow more attention to the patient during a consultation. However, they also introduce new risks around accuracy, consent, privacy and handling of health information.

This guidance sets out practical steps for using AI scribes safely and it should be read alongside the Medical Council of New Zealand Guidance on using artificial intelligence in patient care (March 2026), which includes AI scribing tools within its scope.

Your responsibilities when using an AI scribe

- **Obtain informed consent:** Before recording begins, explain that you would like to use an AI scribe and obtain the patient's consent. Document whether consent was obtained. If a patient declines, continue the consultation without the scribe.
- **Remain accountable:** AI supports documentation; it does not replace clinical judgement. You remain responsible for the accuracy and appropriateness of the clinical record and decisions made during the consultation.
- **Review the clinical note:** Check the AI-generated note before it is added to the patient record. Speech recognition can mishear symptoms, medicines, doses, names or speakers. The generated note can also omit important information, introduce information that was not said, misstate negatives or certainty, or place information in the wrong context. Add relevant findings that were not spoken aloud, including examination findings and non-verbal observations.
- **Use an appropriate clinical scribe service:** Do not enter patient information into a general-purpose or consumer AI service unless you are satisfied that its privacy, security and contractual protections are appropriate for health information. Check whether patient data is used for model training or product improvement, whether vendor staff may access it, and what third-party sub-processors are involved.
- **Understand where information goes:** Know what the service records, where audio, transcripts and generated notes are processed and stored, including any processing outside New Zealand,

and how long each is retained. Check deletion settings before first use and periodically afterwards, as providers can change services, terms and defaults. There is no expectation that the transcripts are kept and it is recommended that transcripts are only retained for as long as needed for the clinical notes to be checked. If the transcript is going to be kept, then it is important to correct any hallucinations, making it clear what these corrections are, and then file the corrected copy of the transcript in the patient notes.

- **Use pause and stop controls:** Pause or stop the scribe when information should not be captured, such as an unrelated third-party conversation or if the patient changes their mind about having the consultation recorded.

Talking to patients about AI scribes

For an AI scribe that records a consultation, the Medical Council requires informed consent. Keep the explanation proportionate and practical. Patients should understand:

- **What it does:** The scribe records or captures the conversation, creates a transcript and uses AI to prepare a draft clinical note. You will review and edit that note before adding it to their record.
- **What is captured:** Audio-based tools only capture what can be heard. They may also capture the voices of whānau, interpreters or other people present. Explain how you will manage this and obtain consent from others where appropriate.
- **Where their information goes:** Explain where audio, transcripts and generated content are stored and processed, whether this occurs outside New Zealand, and which organisations may receive or process the information.
- **How their information is used:** Explain whether information is used only to provide the scribing service or may also be used for purposes such as product improvement, quality assurance, human review or AI model training.
- **How long information is retained:** Explain what the service retains and for how long. Do not promise that a transcript or audio file is deleted immediately unless that is how your chosen service and settings operate.
- **Accuracy and review:** Explain that AI-generated notes can contain errors or omissions and that you will review and amend the draft clinical note before it becomes part of their patient record.
- **Their choice:** The patient can decline the use of the scribe. Explain how you will document the consultation instead. A patient can also ask you to stop using the scribe during the consultation.
- **Language and cultural safety:** Consider how well the tool performs with te reo Māori, and the accents and languages of your patient population, interpreters, and whether the language used in the generated note is appropriate for the patient and whānau.

Record keeping, transcripts and patient access

The final clinical note must meet the usual requirements for clear and accurate patient records. Health information collected or held through the scribe is also subject to the Health Information Privacy Code 2020, including requirements covering storage and security, access and correction, accuracy before use or disclosure, retention, use, disclosure and overseas disclosure.

Do not assume that audio or a raw transcript sits outside those obligations simply because it is an intermediate step in producing the note. Practices should decide, with reference to the Privacy Code, applicable record-retention requirements and the terms of their scribe service, what intermediate material needs to be retained and when it should be securely deleted.

If a patient requests access to audio, a transcript or other information held about them, treat this as a request for health information and follow your usual process for access requests. Do not alter the original material to make it appear accurate. If context or correction is required, provide this separately or deal with it under the usual correction process.

Choosing a scribe

Before using an AI scribe for patient consultations, confirm that it is suitable for clinical use by checking:

- what is recorded and whether audio is retained;
- where data is processed and stored;
- whether identifiable patient information leaves New Zealand;
- whether patient information is used to train AI models or improve the product;
- which sub-processors can access or process the data;
- retention and deletion settings for audio, transcripts and generated notes;
- security arrangements, contractual privacy protections and breach processes;
- how the tool performs for the languages, accents and patient groups in your practice; and
- how easily clinicians can review and correct the generated note before it enters the clinical record.

More information

- Medical Council of New Zealand: Guidance on using artificial intelligence in patient care
- Office of the Privacy Commissioner: Health Information Privacy Code 2020
- Health New Zealand: Using generative AI and large language models
- For medico-legal or privacy advice, contact your indemnity provider or the Office of the Privacy Commissioner.