

The AI scribe and the disappearing hand



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“**Y**ou write like a doctor already” is a familiar refrain in medical training—a tongue-in-cheek recognition of professional assimilation. The trope of the physician’s indecipherable hand is well-worn, yet its persistence invites a deeper inquiry into the phenomenology of the clinic.

If handwriting is, as philosopher Martin Heidegger argued, an embodied act of thought—the hand disclosing how the writer exists in the world¹—then the physician’s

hurried script is not a deficiency but an index: the trace of a body caught in the whirlwind of clinical demands. That trace is now disappearing. What follows is an attempt to reckon with what disappears along with it—not a technical evaluation of accuracy or efficiency, but an accounting of what is encouraged, what is foreclosed, and what is quietly conceded when documentation ceases to be something a physician does and becomes something that happens to an encounter.

Heidegger described the pen as “ready-to-hand” (*zuhanden*), a tool that functions as a direct extension of the body, disclosing how we exist in the world.¹ What handwriting captures—whether elegant or hurried—is the embodied presence of the writer. Loops and smudges may reveal haste; an ink blot can mark pause

for thinking. The physician's handwritten note, however illegible, was indexical: it pointed back to a body situated in time and space, immersed in the demands of care. By contrast, Heidegger argued the typewriter "tears writing from the essential realm of the hand."¹ When script is produced by striking keys rather than the moving, feeling hand, the primordial link between the hand and thinking is severed, and writing becomes a technical operation, rather than an embodied act of thought. The typewriter, he warned, "makes everyone look the same," privileging readability over individual expression, "concealing the handwriting, and thereby the character."¹

We must be honest about the cost of that "character." Illegibly written orders caused medication errors; electronic prescribing addressed this crisis.² But, it is worth noting what this framing ruled out. Illegibility might have been read as a symptom of pace and volume—a signal that physicians needed slower encounters, not better tools. Whether physician busyness actually caused illegible handwriting has never been established; what matters is the institutional response never seriously entertained slowing the encounter. Illegible handwriting was treated as a workflow problem amenable to a technological fix.³ The scrawl was a symptom; the intervention targeted the symptom rather than its cause.

This is the historical current into which the artificial intelligence (AI) scribe now flows. Where the typewriter homogenized the surface of writing—standardizing its appearance while leaving its content untouched—the AI scribe completes the trajectory by homogenizing the content itself. Trained on millions of prior encounters, these probabilistic models do not merely transcribe what the physician and patient say; they translate dialogue into the grammar of the existing medical record. One can imagine an AI scribe that simply produces a faithful transcript. But that is not how the technology is being deployed. It generates the assessment and plan—the very section of the note where clinical reasoning takes shape.

The case for ambient AI scribes is substantial, and in the context of the current burnout crisis, compelling. Physicians spend one to two hours each evening on documentation,⁴ a burden that fuels attrition and erodes the joy of practice.⁵ Meanwhile, the preeminence of the electronic medical record (EMR) introduced a new problem: the screen interposing between doctor and patient, fragmenting attention and diminishing presence. AI scribes promise to remove that barrier. Early adopters report renewed connection: the ability to make eye

contact, to listen without typing, to be fully present in the room.⁶ If AI scribes deliver on this promise, they may restore something medicine has been losing for decades.

And yet, we must proceed with caution. Medicine has a longstanding predilection for defining problems in ways that only technological solutions can address,⁷ a phenomenon referred to as technological rationality—a habit of mind in which problems are met with procedures, whether those procedures are devices, protocols, or frameworks for thought.⁸ When the available tools are technological, problems are defined in technological terms. Illegible handwriting became a workflow issue amenable to electronic prescribing, not a signal that physicians needed more time. Now consider how burnout has been defined, in part, as a documentation problem amenable to a documentation solution, rather than as a symptom of medicine's deeper structural contradictions:⁹ the pressure to see more patients in less time, the commodification of care, the erosion of professional autonomy.

The promise that AI scribes will restore the physician's presence follows the same logic: documentation fragmented the physician's attention, therefore, removing documentation will restore it. This assumes presence was lost because of a tool, and that a better tool can give it back—as if the attention that fragmented under the EMR were a resource waiting to be unlocked rather than a casualty of the conditions that made the EMR necessary in the first place. The framing does not ask what new form those pressures will take once the scribe has absorbed the paperwork. The AI scribe may indeed solve the problem as framed, but the framing itself goes unquestioned.

Beneath that framing lies another unexamined assumption: that writing the note is separable from the thinking it records. Clinical reasoning does not happen all at once. It emerges in the quiet pauses of an encounter—moments in which the physician might dwell with uncertainty, attend to what resists easy categorization, or simply notice something about this particular patient. Writing the note has traditionally extended that process. To compose a note is to reconstruct the encounter, to decide what mattered, what to foreground, what to leave unsaid. It is itself a form of clinical reasoning—a means by which the physician discovers, not merely records, what she thinks. The AI scribe preempts this. As LLMs ingest historical notes, billing codes, and population-level trends, the

clinical encounter is documented before the physician has even finished speaking. The draft of the encounter appears polished, comprehensive, and professional. The physician's remaining task is to review and sign. But composing and reviewing are not equivalent cognitive acts. To review an AI-generated note is to approve a reconstruction already made. The polished, apparently complete document invites assent rather than deliberation—precisely the condition in which automation bias thrives, allowing the algorithm's prior probabilities to stand in for the physician's own judgment.

The cost of this displacement is what might be called clinical particularity: the irreducible specificity of this patient, in this moment, that resists subsumption into pattern. This is not to suggest that physicians approach each encounter as a blank slate. Clinical reasoning depends on pattern recognition—on schemas built from training, experience, and the cases that came before. But the physician's schemas can be interrupted—by a pause in the patient's narrative, a discordant detail, an intuition that the textbook presentation may conceal something else. The model's patterns cannot. It processes; it does not attend. The AI model cannot experience the friction of a case that does not fit.

This is not a call to refuse these tools, nor the benefits they might afford. It is, instead, a call for a deliberative pause, for reflective thinking about the tools we are so eager to adopt. Return, then, to Heidegger's pen—ready-to-hand, disappearing into use, an extension of the thinking body. The AI scribe is something different. It is not an extension of the hand, but a replacement for it. Not a tool the physician uses, but a system that uses the physician's speech as input. Where the pen disclosed the physician's presence, the AI scribe generates a simulation of presence: fluent, professional, and untouched by human hands. In adopting these tools, we must reckon with what is left behind: the composing that was also thinking, the friction of a case that does not fit, the deliberation that the blank page once demanded.

It would be tempting to conclude with a checklist: strategies for reviewing AI-generated notes, safeguards against automation bias, principles for preserving the clinician's voice. But to end there would be to enact the very logic this essay has tried to expose. The answer to a crisis of technological rationality cannot itself take the form of a technological rationality, for that would merely deepen the condition it claims to address.⁷

Physicians are not without agency, though the territory over which it can be exercised has narrowed. Reviewing cannot recover the thinking that composing used to do. But the physician can reconstruct the encounter in her own mind even when she no longer reconstructs it in her own writing. She can notice what the algorithm has smoothed away—the discordant detail, the hesitation in the patient's voice, the clinical particularity that resists the template.

These are not solutions. They are disciplines of attention, and their modesty is the point. But to practice attention in a system that rewards speed is itself a form of resistance. As William Stringfellow wrote, "in resistance persons live most humanly."^{10,11} So too in the clinic.

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