

Using AI to train and support medical staff **under pressure**

What is safe to deploy now, what needs a slower path, and the risks hospital leaders must control.

Three questions for hospital leaders

- 1** Where can AI take load off clinicians today?
 - 2** How can it help train doctors and nurses?
 - 3** Which risks grow when the wards are full?
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2 hrs

of records and desk work for every hour with patients

Plus one to two hours after hours each night. Sinsky et al., Annals of Internal Medicine, 2016. WHO projects a shortfall of 11 million health workers by 2030.

9.5%

less time writing notes with the better of two AI scribes

The second scribe's 1.7% was not significant. Inaccuracies appeared "occasionally". UCLA randomised trial, 238 physicians, NEJM AI, 2025.

Drafts a clinician can check

- 1 Clinic notes, discharge summaries, referral letters
- 2 Record summaries and shift handover notes
- 3 Simulated patients for training
- 4 Search over approved protocols, with citations

A named clinician checks every output.

Judgements a tired clinician cannot easily check

Patient message replies

Edited before sending, never sent unedited

Triage and early-warning alerts

Tested on your own patients first

Diagnosis and treatment suggestions

Regulatory status checked, second read only

80%

80%



20%

thinsp;

80%



20%

rarr;

80%



20%

Six risks to control

- 1 Clinicians follow wrong suggestions
 - 2 Errors carried into the record
 - 3 Unsafe drafts sent unedited
 - 4 Skills fade when the tool does the looking
 - 5 Models that fail on your patients
 - 6 Patient data in unapproved tools
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Five steps for hospital leaders

- 1 Approve one documentation tool properly
 - 2 Name a senior clinician owner per tool
 - 3 Train staff on where the tools fail
 - 4 Write the surge rules in advance
 - 5 Test decision support on your own data
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The busiest week of the year is the wrong time to find out which safeguards only worked when people had time.



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