When AI Targets Core Tasks: Medical Secretaries and Role Repositioning in AI-Driven Documentation Systems

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Abstract. *AI-driven documentation systems such as ambient scribes are marketed with claims to perform clinical documentation. In many healthcare settings this work belongs to an established profession, the medical secretary. Drawing on 26 interviews across six healthcare regions, this interpretive qualitative study examines how medical secretaries respond to such claims. A replacement narrative first took hold but gave way as the secretaries learned more and engaged with the technology. They saw its limits, brought their expertise forward, and began to imagine a repositioned role, still relevant, focused on oversight and quality assurance. The article contributes the concept of anticipatory occupational sensemaking.*

Keywords. Human-AI collaboration, ambient scribes, automation, healthcare, medical secretaries

1 Introduction

AI systems are increasingly entering professional domains where core tasks have long depended on human judgement, situated knowledge, and occupational expertise. Ambient scribes offer a clear example of this development. Built on large language models, they capture clinical conversations in real time and generate structured medical records without manual transcription (Palm et al., 2025). In healthcare they are being introduced as an efficiency solution (Sanchez et al., 2026; Tierney et al., 2024), but the work they are entering is more complex than that framing suggests, and their consequences extend beyond the physicians they are designed to support.

In settings where doctors manage their own documentation, ambient scribes and advanced speech recognition tools promise a welcome reduction in workload. "*Medical notes that write themselves*" reads a tagline from a Swedish provider of ambient scribes (Tandem Health, n.d.).

However, clinical documentation is not organised this way everywhere. In Sweden, clinical documentation is supported by a distinct and formalised documentation profession, "medicinsk vårdadministratör" or "medicinsk sekreterare", translated here as medical secretary. Approximately 20,000 people are employed in this occupational category (Swedish National Agency for Higher Vocational Education, 2025) and many handle physicians' dictations across a broad range of healthcare settings, supported by their specialist expertise in medical terminology, clinical coding, and patient-facing readability.

For medical secretaries, therefore, the introduction of AI-driven documentation tools carries a fundamentally different meaning. The technology is positioned as capable of performing core tasks that have historically formed the backbone of their professional role, raising questions about what happens to professional roles when AI systems are introduced with claims to perform core occupational work.

This study focuses on this second documentation model at a critical moment, when organisations still have the opportunity to shape the transition before roles and responsibilities become stabilised.

What medical secretaries are facing is not unique. Learning algorithms increasingly enter work domains by producing responses, classifications, and summaries that resemble knowledge work with consequences for expertise, occupational boundaries and coordination (Faraj et al., 2018). Concerns of this kind have a long lineage in research on automation and deskilling (Thompson, 2024), where a central argument has been that the reorganisation of work around new technology can leave an occupational role with less skilled content and less room for professional judgement (Braverman, 1974).

This study examines the case of medical secretaries as an instance of this broader development and asks: *How do medical secretaries make sense of AI-driven documentation systems when these systems are positioned as capable of performing core parts of their work?*

The Swedish case of medical secretaries offers an unusually clear empirical window into a broader IS concern. It illustrates how human actors make sense of and respond to agentic IS artefacts introduced with

claims to perform core occupational work (Baird & Maruping, 2021; Faraj et al., 2018). Baird and Maruping (2021) argue that increasingly agentic IS artefacts require attention to how rights and responsibilities for task execution and outcomes are redistributed between humans and information systems. In this study, that concern is examined from the position of an affected occupational group in an early implementation phase. The case should therefore be read as *one* observable trajectory within a wider transformation in which AI systems enter cognitive work previously organised around human judgement, situated expertise, and established divisions of labour.

2 AI Documentation as Socio-technical Transformation

2.1 Clinical documentation as distributed, quality-critical work

Clinical documentation is often treated as a matter of producing clinical text, yet IS and health informatics research has shown that records form part of a wider organisational infrastructure. They support clinical reasoning, coordination, accountability, reimbursement, management, research, and other secondary uses of data (Berg, 1999; Bossen et al., 2019; Pine & Bossen, 2020). Documentation quality therefore depends on more than whether information from the clinical encounter has been captured. Records must also be complete, accurate, codeable, legally usable, and understandable across different organisational and patient-facing contexts (Kariotis et al., 2025; Pine & Bossen, 2020).

This broader view is important because clinical documentation is produced through situated work across roles. In many Swedish healthcare settings, physicians dictate or provide the clinical content, while medical secretaries prepare, structure, code, and quality assure the record. As introduced above, this occupation is supported by specialised higher vocational education for medical care administrators (occupational titles may vary across regions). During the period relevant to this study, MYHFS 2022:1, a national agency regulation issued by the Swedish National Agency for Higher Vocational Education, specified programme content in areas such as medical terminology, medical documentation, diagnosis classification, healthcare law, digital systems, confidentiality, and IT and e-health (Swedish National Agency for Higher Vocational Education, 2022, Appendices 1 and 2). This makes the Swedish case analytically useful: it shows a documentation arrangement in which quality, readability, coding, and accountability are already distributed before AI enters the setting.

For this reason, AI-driven documentation tools do not enter an empty space. They enter an existing division of documentation work. When such tools are framed primarily as text-generating technologies, important forms of human expertise risk becoming less visible. The question is therefore how such systems become connected to the social and organisational arrangements through which documentation quality is produced.

2.2 AI-driven documentation systems and human-AI role reconfiguration

Speech recognition systems and ambient AI scribes (hereafter ambient scribes) represent two related but distinct forms of AI-driven documentation technology. Speech recognition systems convert dictated speech into text and may include functions such as templates, structured fields, or language support. Ambient scribes go further by capturing clinician-patient conversations and generating draft clinical notes using machine learning and natural language processing (Tierney et al., 2024). They therefore shift the technical artefact from transcription support towards automated drafting, summarisation, and preliminary structuring of clinical documentation.

Recent research on these systems has mainly examined physician-centred outcomes, including documentation burden, time use, EHR efficiency, note quality, and technical performance (Oettl et al., 2026; Pearlman et al., 2025; Tierney et al., 2024). This literature helps explain why ambient scribes attract organisational interest. They promise relief from administrative workload and a more efficient clinical workflow. At the same time, emerging studies point to persistent risks. Comparative evaluations of clinical AI scribes have identified omissions and other errors in generated summaries, while studies of LLM-based medical summarisation have reported hallucinations and missing information (Asgari et al., 2025). Topaz et al. (2025) therefore warn that adoption is moving faster than validation and oversight.

These findings matter for human-AI collaboration. If AI-driven documentation systems generate drafts that require review, correction, and contextual adaptation, then implementation is not simply a question of replacing human writing with automated output. It becomes a question of how organisations configure responsibility around AI-generated documentation. This raises practical questions about who verifies the record, checks omissions, adapts language for patients, and ensures that coding, templates, and local documentation routines still work.

A socio-technical perspective is useful here because the consequences of AI documentation technologies depend on how technical capability is configured with human judgement, organisational routines, and professional responsibilities (Leonardi, 2011; Orlikowski, 1992). In healthcare, this is especially important because digital technologies affect coordination, accountability, and patient safety, not only task execution (Papoutsi et al., 2020; Sittig &

Singh, 2010). The present study therefore examines AI-driven documentation as an early socio-technical transition in which medical secretaries begin to interpret, evaluate, and reposition their role within emerging human-AI documentation arrangements.

3 Method

This study adopts an interpretive qualitative design (Klein & Myers, 1999) to examine how medical secretaries make sense of AI-driven documentation technologies in Swedish public healthcare. This design is suitable because the study focuses on an early stage of technological change, where roles and routines are still being negotiated and many consequences are not yet stabilised in everyday practice.

3.1 Research setting and participants

Swedish healthcare is a decentralised, publicly funded system in which 21 regions are responsible for medical care, delivered by both public and private providers. The study is based on empirical material from six of these regions. Participants had experience of speech recognition systems, ambient scribe demonstrations, pilot activities, or organisational discussions concerning AI-driven documentation. A separate survey of regional uptake was used to situate the interview material within broader developments across Swedish public healthcare.

The study includes 26 participants: 13 medical secretaries, 8 managers, 2 physicians, 1 project leader, and 2 vendors. Medical secretaries constituted the main participant group, while the additional interviews provided perspectives on implementation, clinical use, management, and vendor positioning. Most managers had a background as medical secretaries or equivalent documentation roles. Participants were recruited through snowball sampling, supplemented by direct contact with regional organisations. This enabled variation in how the technologies were introduced, discussed, and experienced across settings.

Participants' engagement with the technologies ranged from direct use of speech recognition systems in daily work and participation in ambient scribe pilots to familiarity based on demonstrations, internal communication, and colleagues' accounts, as summarised in Table 1. Quotations are labelled by role (MS for medical secretary, MAN for manager), and participants with hybrid backgrounds are labelled according to their current role. As snowball sampling relies on referrals, the sample may over-represent participants with an active interest in AI-driven documentation, a potential self-selection bias that should be kept in mind when interpreting the findings.

Table 1. Overview of data sources

Data source	n	Engagement and role in the study
Interviews: medical secretaries	13	Direct use, pilots, demonstrations; primary material for the thematic analysis
Interviews: managers	8	Oversight and direct use; pilots, demonstrations
Interviews: physicians	2	Direct use, pilots
Interviews: project leader	1	Head of implementation
Interviews: vendors	2	Product demonstrations and development
Regional uptake survey	17 of 21	Two questions on uptake of speech recognition and ambient scribes (Nov–Dec 2025); contextual mapping
Pilot documentation	3	Two evaluation reports, one slide deck (2024–2025); context and triangulation
Public web material	–	Vendor and regional communication; terminology and positioning

The 24 interviews with regionally based participants were distributed across the six regions as follows: Region A: 8; Region B: 7; Region C: 4; Region D: 3; Region E: 1; Region F: 1. The two vendor representatives operated across regions and were not affiliated with a single region.

3.2 Data collection and analysis

Data were collected through semi-structured interviews conducted in Swedish via Microsoft Teams in 2025, each lasting 30 to 50 minutes. The interview guide covered participants' experiences of speech recognition and ambient scribe technologies, their perceptions of how these systems might affect documentation work, and their expectations for future roles. Interviews were recorded with consent, transcribed using an AI-based transcription service, and checked against the recordings. The study does not fall under the approval requirement of the Swedish Ethical Review Act (SFS 2003:460), as it involves neither sensitive personal data nor any physical intervention or influence on participants. This research adheres to the standards stipulated by the European Code of Conduct for Research Integrity (ALLEA, 2023) and the Swedish Research Council's guidelines for good research practice (Vetenskapsrådet, 2024). All participants were informed about the purpose of the study and the handling of their data, that participation was voluntary, and that they could withdraw at any stage. Participants were anonymised through role-based labels and personal identifiers were removed from the transcripts. Interviews were recorded within

institutional Microsoft Teams environments; recordings were automatically deleted after transcription and verification in accordance with the applicable retention policies, and anonymised transcripts were retained for analysis. Interview quotations were translated from Swedish into English by the author and checked against the original transcripts.

The analysis followed a reflexive thematic approach (Braun & Clarke, 2021). All transcripts were imported into Atlas.ti, where coding was initially inductive and focused on how participants described the technologies, their own expertise, and the future of documentation work. In a subsequent interpretive phase, codes were iteratively grouped and regrouped into themes around replacement-oriented narratives, visible documentation expertise, and role repositioning towards oversight and human-AI collaboration, with earlier coding decisions revisited as the interpretation developed. The interviews were conducted and analysed by the author, whose position as an informed outsider, familiar with the organisational and digital context of Swedish public healthcare but without a background in the profession studied, provided contextual understanding while preserving analytical distance. The main themes were derived from the interviews with medical secretaries, while the interviews with managers, physicians, vendors, and the project leader were used to contextualise implementation, clinical use, management, and vendor positioning rather than to generate themes.

Contextual material was used to situate the findings but was not analysed with the same depth as the interviews. The regional uptake survey, conducted in November–December 2025, comprised two questions on the use of speech recognition systems and ambient scribes and was answered by 17 of Sweden's 21 regions. The responses showed an uneven and early-stage national landscape: six of the 17 responding regions reported broad use of AI-supported speech recognition while seven reported none (several noting that they used speech recognition without AI support), and no region reported ambient scribe use beyond the pilot stage in its own services, although broader use among private providers was noted. The pilot documentation consisted of two formal evaluation reports and one slide deck from regional pilots conducted in 2024–2025. Together with selected public web material, these sources were used to corroborate uptake and implementation status and to clarify how the systems were positioned in official communication, not to generate additional themes.

4 Findings

The findings are organised around three connected movements in how medical secretaries made sense of AI-driven documentation technologies. First, the technologies appeared through replacement-oriented narratives. Second, medical secretaries evaluated the systems against the practical demands of documentation work and made their own expertise visible. Third, they began to reimagine their role around oversight, quality assurance, and human-AI collaboration.

These three movements represent analytical patterns identified across the material rather than stages through which individual participants necessarily progressed. Participants moved between these positions, and several remained primarily concerned about replacement throughout. The movements should therefore be read as coexisting orientations in the material rather than as a uniform sequence.

4.1 AI first appeared through replacement-oriented narratives

Medical secretaries first encountered AI-driven documentation technologies through claims that the systems could take over tasks long associated with the core of their work. Speech recognition systems and ambient scribes were therefore not interpreted as neutral administrative tools. They were understood as technologies directed at writing, transcription, and documentation processes that had historically defined the medical secretary role.

This interpretation was reinforced by how the technologies were presented. One vendor tagline promised "Medical notes that write themselves" (Tandem Health, n.d.). One respondent recalled how a similar idea circulated around speech recognition: that no one should have to write anything and that medical secretaries would no longer be needed. She then laughed and added, "then some time passed…" (MAN-7). The remark captures the initial force of the replacement narrative, but also its later weakening as participants became more familiar with what the technologies could actually do.

Organisational signals made this interpretation more acute. One medical secretary described how the timing of AI discussions coincided with workforce uncertainty: "There was a redundancy notice and a hiring freeze at the same time. It made us think that management believed this [AI] would take over much of the work" (MS-9). Another participant stated the concern more directly: "Of course, you were worried that we might not have jobs left, that we would somehow be completely replaced" (MS-11).

In this first phase, AI was mainly encountered through a language of substitution. The concern was therefore shaped less by stable use of the systems and more by the expectations attached to them. Ambient scribes and speech recognition systems appeared as technologies that could change who was needed in documentation work, and on what terms.

4.2 Medical secretaries made documentation expertise visible

As participants engaged more closely with the technologies through demonstrations, pilots, colleagues' accounts, and direct observation of outputs, their assessment became more specific. The perceived threat did not disappear. Several participants still expected AI to reduce parts of the work and perhaps reduce the number of medical secretaries over time. Yet their evaluation increasingly focused on the gap between AI-generated documentation and what high-quality documentation requires in practice.

Readability was one area where this expertise became visible. Participants described how documentation must often be reshaped so that it works for patients, clinicians, and organisational use. One medical secretary explained: "We act as a filter between the clinician and the patient. We adapt the record so it becomes readable. Some doctors are very good, but often it would be unreadable if we just wrote things exactly as they are said" (MS-7). Another described the work of clarifying local or individual abbreviations: "There are both established and local abbreviations, sometimes even ones used by individual physicians. I therefore often write out the abbreviation and clarify it in parentheses" (MS-6).

Participants also pointed to errors that required situated judgement. Speech recognition outputs could misrecognise names, create long blocks of text without clear structure, omit information, or alter meaning. One respondent described how a clinically important distinction could be lost when "right" was rendered incorrectly. Another warned that if AI-generated text went directly into the record, "no one might notice" errors that should have been corrected (MS-3). These accounts show that participants evaluated AI documentation tools against the practical conditions of safe and usable documentation, not against text production alone.

Coding was another area where documentation expertise became visible. Participants described coding as closely connected to reporting, follow up, and financial flows in healthcare organisations. One respondent noted that "Documentation and coding are closely tied to reporting and how organisational performance is monitored, which in turn affects resources and finances" (MS-5). Another emphasised that coding is part of the profession's formal expertise: "Coding is an integral part of the medical secretary profession. During our training, we take courses in coding and in how to think about it. There is a strong focus on this, and there is a sense of pride in the fact that this responsibility rests with us" (MS-6). The stakes could be substantial: "If you miss a code, it can mean a difference of 30,000 kronor on an invoice" (MS-6).

This phase therefore revealed more than technical shortcomings. It showed how medical secretaries used practice-based expertise to evaluate the limits of AI in relation to documentation as it is actually done. Their accounts made visible forms of work that had been obscured in the earlier replacement-oriented narratives: interpretation, structuring, coding, readability, quality assurance, and accountability. The material therefore points to a qualified position. AI was seen as likely to affect the role, but important parts of documentation work were still understood as dependent on human judgement, adaptation, and responsibility.

4.3 The role was reimagined around oversight and human-AI collaboration

As the initial replacement narrative lost some of its force, many participants began to describe a different future role for medical secretaries. This did not mean that uncertainty disappeared. Several still expected writing tasks to decrease and some believed that fewer medical secretaries might be needed in the long run. Alongside this concern, however, the material shows a forward-looking movement in which the role was reimagined around oversight, coordination, quality assurance, and implementation support. This orientation coexisted with continued uncertainty. As one participant, quoted earlier on the fear of being completely replaced, concluded: "I think we are still needed, but perhaps not as many of us" (MS-11).

Participants repeatedly described a future role centred less on producing text and more on reviewing, controlling, and safeguarding documentation processes. One participant summarised this shift: "I do not think the profession will disappear, but that it will become more closely connected to operations and processes, with more control and less monotonous writing" (MS-8). Relief from transcription was also linked to freeing capacity for other tasks: "If we can get some relief, we can do other things better" (MS-8). AI was therefore interpreted as something that could move the human role towards broader oversight and contextual judgement.

This future role was closely linked to collaboration. Participants stressed that AI-generated output would still require human review and that clinicians should not be left to carry the entire documentation burden. One respondent put it clearly: "We cannot put everything on the doctors … they need to be doctors and do what they are good at, and we take care of the rest" (MS-1). The future envisioned here was a more differentiated division of labour in which AI, clinicians, and medical secretaries contribute in different ways.

Participants also connected this role shift to implementation and governance. Several argued that medical secretaries should be involved early when AI documentation tools are introduced, configured, and evaluated. One respondent stated: "I think it is important to include medical secretary expertise in the governance of AI. When is AI appropriate, and when is human involvement needed? Patient records are about patient safety" (MS-1). Another participant

stressed that medical secretaries should help lead implementation work so that documentation knowledge, legal requirements, and regional guidelines are built into how the systems are introduced.

The findings therefore show a shift from acute replacement anxiety towards a more qualified and proactive position. Medical secretaries did not simply defend an existing role. They began to articulate how their expertise could be used in a documentation process increasingly shaped by AI. In this sense, the findings point to an emerging model of human-AI collaboration in which the role of the medical secretary is not removed, but reconfigured.

5 Discussion

5.1 From affected employees to active transformation actors

The study shows that role repositioning can begin long before AI systems are fully implemented in everyday work. In this case, the movement was triggered by replacement-oriented narratives, vendor promises, organisational signals, and uncertainty about the future relevance of the medical secretary role.

However, the response that followed was not limited to anxiety or resistance. As medical secretaries encountered the technologies through demonstrations, pilot activities, colleagues' accounts, and organisational discussions, they began to assess what the systems could and could not do in relation to documentation work as they knew it. Their concern about replacement became a starting point for a more active form of sensemaking. They began to identify where human judgement remained necessary, where AI-generated output would need control, and how their own expertise might remain relevant in a documentation process increasingly shaped by AI systems.

This suggests that affected employees may themselves carry out part of the preparatory transformation work that organisations need, but may not yet have formally organised. By interpreting the technology, testing its implications against everyday work, and imagining possible future divisions of labour, medical secretaries began to translate an uncertain AI-driven change into more concrete organisational questions. This does not remove the need for organisational direction. It does, however, indicate that early employee sensemaking can provide a resource for shaping the transition before roles and routines have stabilised.

This matters for research on digital transformation because it shifts attention from affected employees as recipients of change to affected employees as possible contributors to role and practice transformation. Medical secretaries were not simply reacting to an already defined transformation. They were beginning to work on the transformation itself by exploring possible future scenarios, articulating alternative divisions of labour, and repositioning their expertise in relation to AI. Their response therefore points to an important source of agency in early AI implementation: the people whose work is most directly challenged may also actively be trying to make sense of how the organisation could move forward.

The findings do not support a general claim that all AI-affected groups will reposition themselves in the same way. However, the findings identify one possible trajectory. The broader contribution is to make this trajectory visible as a phenomenon that future IS research should examine across other domains where AI targets established cognitive work.

5.2 Situated expertise as a resource for human-AI collaboration

The case also shows that human-AI collaboration cannot be designed only from a general understanding of what the technology can automate. It depends on situated knowledge of the work into which the technology enters. In clinical documentation, this includes not only drafting text, but also recognising omissions, clarifying language, adapting records for patients, managing coding requirements, and understanding how documentation travels through clinical, administrative, legal, and organisational contexts. The findings suggest that medical secretaries are preparing for a transformation of their role, shifting from text producers to active agents within the AI system's lifecycle. They were beginning to contribute to how the transformation could be understood and organised in practice, where human oversight becomes a prerequisite for bridging the gap between the AI system's technical output and the actual requirements for clinical usability.

Medical secretaries' contribution lies in this documentation expertise. Their assessments of AI were grounded in knowledge of what a usable and accountable record requires.

This allowed them to see weaknesses in a future model built only around physicians and AI, especially where responsibility for checking, structuring, coding, and adapting the record remained unclear. The issue, then, is not whether medical secretaries see the technology better than other actors. It is that they see it from a position embedded in the documentation process. Research on invisible work has long noted that no work is inherently visible or invisible; whether the judgement and coordination embedded in a role are seen is a matter of context and negotiation (Star & Strauss, 1999). The replacement narratives, by reducing documentation to transcription, put exactly this negotiation in motion, and the medical secretaries responded by making the invisible work visible. Employee involvement therefore becomes an organisational resource for configuring workable human-AI collaboration.

Involving medical secretaries early is a way of bringing documentation knowledge into the configuration of human-AI collaboration. Their emerging future role, as described in the material, centres on oversight, quality assurance, coordination, and implementation support. This suggests that affected employees can become active contributors to the design of workable AI-supported practices, particularly when the technology targets tasks that have previously anchored their occupational role.

5.3 Early implementation as a window for proactive role shaping

The early phase of implementation is therefore consequential. Demonstrations, pilot projects, vendor narratives, procurement discussions, and informal organisational signals do not merely prepare the ground for later change. They already shape how employees understand the technology, how they imagine their future role, and what kinds of human-AI arrangements become thinkable. In this case, repositioning began before ambient scribes had become routine practice. That timing is central to the study's contribution.

For organisations, this creates a window for proactive role shaping. If early sensemaking is ignored, organisations risk missing the point at which employees are already trying to work out how their expertise can remain useful in an AI-supported future. If it is recognised, the organisation can use this moment to clarify responsibilities, involve documentation experts in procurement and evaluation, define appropriate human oversight, and design roles around the work that AI output still requires. The practical implication is therefore stronger than simply involving users early. Affected employees should be treated as transformation resources, not implementation obstacles.

This is particularly relevant in public healthcare, where digital transformation takes place under staffing pressure and high accountability demands. The findings suggest that AI-supported documentation may move medical secretaries towards roles centred on human oversight, verification, quality assurance, and control of AI-generated output. Such roles keep humans in the loop, but they may not require the same number of medical secretaries to perform traditional documentation work. A proactive approach should therefore also consider how this occupational expertise could be further developed or partly reskilled for other organisational needs. Medical secretaries' knowledge of terminology, coding, confidentiality, documentation systems, and patient-facing administration may be valuable beyond the specific task of producing records. This broader use of competence lies beyond the main empirical claim of the study, but the case suggests why the question should be raised early, while roles and routines are still open to shaping.

This repositioning converges with needs identified in the clinical AI safety literature. The auditing of AI-generated content, recognition of error patterns, and quality assurance that Topaz et al. (2025) call for as safeguards correspond in part to the role medical secretaries were beginning to articulate for themselves.

Taken together, the theoretical contribution of this study is to conceptualise role repositioning as anticipatory occupational sensemaking. This denotes an adaptive response through which an affected occupational group reinterprets its expertise in relation to an agentic system before that system is embedded in everyday practice. In terms of Baird and Maruping's (2021) delegation perspective, medical secretaries were beginning to specify which rights and responsibilities could be delegated to the system and which should remain with humans, before the organisation had formally addressed that question. This positions role repositioning as a potential precondition for workable human-AI collaboration rather than its outcome: whether the repositioned role is realised depends on whether organisations recognise and act on this early sensemaking. Whereas sociotechnical accounts have located the reconfiguration of roles and routines in people's ongoing interaction with technologies in use (Leonardi, 2011; Orlikowski, 1992), this case shows that it can be set in motion by anticipated delegation, by what the technology is claimed to do, before patterns of use have stabilised. The study thereby extends research on occupational change in the age of the learning algorithm (Faraj et al., 2018), showing that boundary work over expertise can begin in this anticipatory phase.

5.4 Limitations and future research

This study examines an early phase of AI-driven documentation change. It can therefore show how expectations, concerns, and role repositioning emerge before full implementation, but it cannot determine how these arrangements will stabilise once ambient scribes and related systems become embedded in everyday work. The Swedish setting is also distinctive because medical secretaries constitute a formalised documentation profession, which may limit direct transferability to healthcare systems where documentation work is organised differently. Future research should therefore follow AI-supported documentation longitudinally and compare settings where documentation work is distributed across roles in different ways.

This also raises a need for comparative studies of how occupational groups respond when AI systems are introduced into cognitive tasks that have previously anchored human expertise. Such studies could examine under what conditions anticipatory occupational sensemaking leads to role repositioning, occupational-level deskilling, resistance, or new forms of hybrid work.

5.5 Conclusion

This study has examined how medical secretaries make sense of and reposition their role when AI-driven documentation systems target core documentation work. The findings show that the introduction of AI is not understood only as a technical change, but as a challenge to occupational identity, expertise, and future relevance. In response, medical secretaries begin to reposition themselves around oversight, quality assurance, contextual interpretation, and human-AI collaboration. The study conceptualises this response as anticipatory occupational sensemaking, offering one empirically grounded example of how human actors may renegotiate their role when AI systems enter cognitive work domains previously organised around human expertise. The study does not claim that all occupational groups will respond to AI in the same way. This points to the need for further IS research on how AI reshapes work, expertise, and professional boundaries across organisational settings.

Acknowledgments

The author thanks the interview participants for generously sharing their time and experiences.

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