



Abstract Book



Learning to Attend: Lessons from a Spirituality and Health Internship

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Background: Medical education emphasizes foundational skills in history-taking, physical examination, and diagnostic reasoning; however, the practice of attending to patients' experiences of illness, identity, and systems of meaning-making receives less explicit attention. As a counterweight to this approach, clinical pastoral education and chaplaincy-informed approaches to care engage directly with questions of purpose, suffering, and hope, offering opportunities for medical learners to develop skills that extend beyond biomedical expertise. This reflective inquiry explores how interdisciplinary engagement with spirituality and patient narratives shaped my understanding of clinical presence and physician identity formation.

Methods: This reflective inquiry draws upon journal entries, verbatim patient encounters, voice recordings, and field notes collected during a six-week interdisciplinary internship in health, spirituality, and medicine. Through reflexive thematic analysis of these materials, I examined encounters with patients, chaplains, and other learners to explore how experiences of listening, reflection, and dialogue influenced my understanding of patient care and my developing professional identity.

Reflection: Across diverse clinical settings, several themes emerged. First, meaningful care began with learning to attend: creating space for silence, asking open-ended questions, and exploring dimensions of patient experiences related to spirituality, identity, relationships, and sources of meaning. Encounters with patients awaiting major medical interventions or preparing to return home revealed the importance of remaining open to emotions across the spectrum of the human experience including both hope and excitement for potential future healing and progress, as well as feelings of guilt, despair, and loneliness.

Second, reflection required examining not only how I perceived patients, but also how my own identity, assumptions, time constraints, and desire to be accepted influenced interactions. Moments of uncertainty became opportunities to recognize how physicians enter encounters with their own expectations and how humility requires continual examination of those assumptions.

Third, engaging patients in conversations about spirituality and meaning challenged my previous understanding of professional boundaries. Rather than creating distance, these conversations often fostered trust, connection, and deeper recognition of patients as whole persons. These experiences prompted reflection on the tension between maintaining attentiveness and navigating the efficiency demands of my future surgical training. Although I initially feared that the pace and responsibilities of residency would make this kind of connection impossible, I began to recognize presence that is not dependent solely on time, but on intentional habits of attention that can be cultivated within clinical practice.

Implications: Reflective engagement with patients' narratives and directed self-reflection of one's own clinical encounters may cultivate habits of attention, humility, and presence that are difficult to teach in traditional medical curricula yet are essential components of compassionate care. This work suggests that structured opportunities for reflection and interdisciplinary learning can contribute meaningfully to the formation of physicians who recognize patients beyond their diagnoses and intentionally preserve human connection within increasingly complex healthcare environments. Expanding opportunities for engagement within the medical humanities in medical education may be essential for fostering these habits of attention, which serve as foundational components of both medical education and the development of professional identity as physicians.

Life Before Death: Reframing Reproductive Ethics in the Bioethics Classroom

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Although pregnancy provides the context for many of biomedical ethics' most enduring controversies, it is often treated primarily as the backdrop for debates about abortion, assisted reproduction, and genetic testing rather than as a morally significant experience in its own right. While most courses devote substantial attention to abortion, assisted reproductive technologies, and genetics, pregnancy is often treated merely as the setting for these debates rather than as a morally significant experience deserving sustained ethical inquiry. Miscarriage and stillbirth, if discussed at all, are usually only discussed through the lens of abortion debates. The order in which we teach reproductive ethics shapes students' ethical imagination.

This paper offers a transferable curricular model for instructors seeking to broaden how reproductive ethics is taught in their biomedical ethics and medical humanities classrooms through a four-week instructional unit. This unit, "Pregnancy, Life, and Death," has been developed for undergraduate biomedical ethics courses and begins not with abortion or reproductive technology, but with pregnancy and miscarriage. The opening week introduces pregnancy as a unique bioethical state by examining maternal morbidity and mortality, the ethical significance of the maternal-fetal relationship, informed consent during pregnancy, and the challenges of caring for what clinicians often describe as the maternal-fetal dyad. Students then explore miscarriage and stillbirth through patient narratives and clinical case studies, considering questions of grief, uncertainty, personhood, compassionate care, and justice. In the next three weeks, students move on to the more traditional topics of reproductive technologies, euthanasia, and abortion.

Rather than advancing a new theory of reproductive ethics, this presentation argues that how we sequence topics in the biomedical ethics classroom shapes how students understand them. Beginning with pregnancy rather than with contested moral questions invites students to encounter reproductive ethics first through the lived realities of embodiment, vulnerability, dependence, and care. Only then do they engage the more familiar legal and political debates that dominate public discourse. By centering the lived experience of pregnant people before engaging the more familiar legal and political debates surrounding reproduction, educators can cultivate greater empathy, intellectual humility, and ethical nuance in their students.

Inked by Faith: Health, War, and Religion in Operation Tat-Type

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Operation Tat-Type was a Cold War civil defense initiative that proposed the permanent tattooing of civilians' blood types and Rh factor to facilitate rapid transfusion in the event of atomic attack. First proposed in 1950 by Dr. Andrew C. Ivy, the program framed blood-type tattooing as a means of transforming the American population into a "walking blood bank." Although the initiative never achieved widespread national implementation, local adoption varied dramatically. In two predominantly Latter-day Saints (LDS) communities in Utah, however, participation in permanent tattooing approached near universality.

Religious cohesion and institutional trust within LDS communities were likely central to the unusually high uptake of Operation Tat-Type in northern Utah. Endorsement by respected local physicians interacted synergistically with Cold War patriotism and communitarian theology. Notably, LDS church doctrine that strongly discouraged tattooing was edited to permit blood-type identification, suggesting that civil defense imperatives were integrated into religious life rather than merely tolerated. In this context, medical tattooing became not only a civil defense strategy but a morally sanctioned act of collective responsibility and righteousness.

Through examination of local newspapers, LDS church records, LDS doctrinal texts, and first-person accounts, this study continues its investigation of Operation Tat-Type, elucidating how faith-based social structures can both facilitate rapid collective action and reshape doctrinal norms in response to perceived medical or existential threats.

When White Coat Meets Uniform: Dual Loyalty in Military Medicine

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The role of military physicians is uniquely precarious, sitting at the intersection of two professions with seemingly divergent core commitments: the ethical duty to prioritize patient welfare and the duty to serve one's country, compounded by complex loyalties inherent in military hierarchies. The medical involvement in mistreatment of detainees at Abu Ghraib, Guantánamo Bay, and current immigration detention centers bring forward the potentially dire consequences when these obligations collide. These cases raise a fundamental question in military medical ethics: when the roles of healer and soldier, and the institutional loyalties they entail, pull in opposing directions, which identity and which duty takes precedence?

This presentation examines competing philosophical approaches to dual loyalty in military medicine, including perspectives that question whether a true conflict of loyalties exists. Lu-Vada Dunford's "physician-as-fighter" model contends that the role of physician and soldier may not be as distinct as they first appear: both fight an enemy, it's simply the nature of that enemy that differs. From this perspective, military medicine is not a deviation from, but rather a contribution to the broader mission of warfare. In contrast, Peter Olsthoorn argues that dual loyalty conflicts are less about choosing between two equal obligations and more about the physician's commitment to upholding professional integrity, even under institutional and hierarchical pressures. Together, these opposing perspectives force a deeper inquiry about how the identity of a military physician should be conceptualized and whether it should be governed by medical ethics, military obligation, or a dynamic integration of both.

Drawing on Abu Ghraib, Guantánamo Bay, and contemporary immigration detention centers as case studies, this discussion examines how institutional pressures, group loyalty, and ethical ambiguity can erode professional judgement. The relevance of these tensions persists in modern conflict, where medical neutrality is increasingly under siege. While clearer ethical guidelines are necessary, they alone cannot prevent future failures. Meaningful reform demands a multifaceted approach: embedding military medical ethics education throughout the chain of command, equipping physicians with scenario-based preparation to navigate dual-loyalty conflicts, providing access to independent ethics consultation, and fostering institutional structures that preserve professional autonomy. Ultimately, dual loyalty is not merely a conflict of obligation, but a crucible of character, demanding both institutional safeguards and the moral courage to uphold ethical boundaries under pressure. The future of military medicine depends on preparing physicians to not only follow rules, but to embody the integrity of their profession, even in the most morally fraught circumstances.

The Double-Edged Screen: How Tele-Psychiatry Impacts Advocacy in Immigration Detention

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In recent years, there has been a rapid deployment of medical technologies used for tele-psychiatry and digital health tracking within immigration detention facilities. These were accelerated by the COVID-19 pandemic, and they have been widely promoted as a humanitarian mechanism for expanding access to mental health services to a highly vulnerable and transient population such as detained individuals. These telemedicine methods are commonly framed as neutral and efficient tools that can help to mitigate the shortage of medical staffing within detention facilities. However, they are managed by federal enforcement agencies and private contractors; the same structures which have the primary goal of detaining the immigrants. In this paper, I argue that, separate from their advertised roles as humanitarian tools of clinical care, telemedicine methods used to administer psychiatric care within immigration detention facilities play an added role of being administrative tools in enforcing immigration policies.

My presentation draws from the principles of bioethics and the framework of dual loyalty to critique how tele-psychiatry technologies erode physician autonomy over time and negatively impact patient advocacy. I analyse how the digital interface created by tele-psychiatry serves as a dual screen: it permits the administration of tele-psychiatric care to detained immigrants while shielding clinicians on the "outside" from the constant and immediate environmental traumas that plague the patients they administer psychiatric care to. These conditions — including forced family separation, prolonged legal instability, and institutional neglect — actively drive the psychiatric conditions that detained individuals face, such as anxiety, depression, and post-traumatic stress disorder (PTSD). By managing psychiatric crises through digital interfaces, the system of immigration detention uses medical technologies to both medicalise and tame the inevitable and predictable psychological consequences of involuntary confinement.

Additionally, my presentation analyses how clinical documentation within the immigration detention system can be weaponised against patients. Since these technological platforms are integrated into broader databases for homeland security, confidential therapeutic documentation regarding a patient's emotional instability or behavioural disruption can be hijacked and used against them in immigration court proceedings. Sometimes, a clinician's digital notes concerning a patient are transformed into forensic data and used to evaluate how "fit" a detained individual is for deportation. Other times, they are used to legally justify prolonged stays in solitary confinement. Ultimately, these technologies act as tools that force physicians and other healthcare professionals into an involuntary alliance with the state, such that their primary purpose of ensuring and promoting the patient's wellbeing become secondary to geopolitical risk management. In this presentation, I suggest some pathways for promoting clinician advocacy when medical technology is used to administer tele-psychiatric care to detained immigrants, and I equally invite the attendees to debate how elements within the medical humanities can be used as tools to forge such pathways.

Play to Learn: Game-Based Learning in Medical Education

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A game refers to a system in which players engage in an artificial conflict, defined by rules, that results in a quantifiable outcome. Game design exists at a unique crossroads, bridging elements of the arts, humanities, and human psychology with technology and design. Games may be analog or digital, and their broad definition allows for boundless creativity in their design. While often considered a means only for engaged entertainment, thoughtful game design can and has been leveraged to meet other parallel goals as well.

Serious games refer to games with an objective beyond – but not necessarily at the expense of – entertainment. Decades of education literature has explored the effectiveness of serious games and game-based learning across multiple fields and gameplay mediums. However, uptake of this unique application of art, humanities, and design in medical education has been slower. Drawing from education, psychology, and gaming literature, this interactive presentation aims to empower participants with the foundational tools necessary to leverage this unique tool within medical education.

Through didactics with interspersed gameplay, facilitated discussion, and design exercises, participants will explore theoretical foundations of game-based learning and frameworks for understanding the four key functions educational games can achieve: 1) preparing for future learning, 2) new knowledge acquisition, 3) practicing existing knowledge, 4) developing innovation skills. Through examples of effective serious games in medical education, participants will explore principles of effective game design across gaming mediums. Participants will also be provided with a framework and guide for their own development of game-based learning curricula, allowing immediate application of this learning. Participants will leave this interactive session with a toolkit to support the application of knowledge from the workshop to future game design efforts.

Creative Writing and Health Humanities: The Power of Fiction

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Reading and writing creative writing has long be considered a way for humans to process experiences, practice emotions, and hone empathetic thinking. Creative nonfiction and poetry allow for a clear connection between author and narrator/speaker, but such a relationship is harder to pinpoint and more complex in fiction writing. However, many readers gain an increased understanding of humanity through engaging with reading fiction, both for pleasure and in academic settings, and can see themselves within the characters on the page. So, what is the relationship between the fiction writer and the fictional character on the page, and how can the writer create authentic experiences for the reader to connect with? This presentation seeks to answer that question through an exploration of how and why we read fiction, what it can teach us, and, ultimately, what writing fiction can teach the writer about themselves. To do this, this presentation will not only engage with scholarship but also with original work, including a reading of original fiction work and insight into the author's process, as well as reader response to this work. Finally, this presentation will explore ways to empower student writers (in health fields, the humanities, and health humanities) to write the stories that they need to tell, even if that means taking on the persona of a fictional character in a fictional world.

Measuring Possibility: Adaptive Sport, Medical Technology, and Medical Education

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Medical technologies are commonly understood as tools that aid in restoring function or facilitating a return to baseline health. Their success is often measured through pain reduction, radiographic measures, or improvement in physical function. In some cases, this definition of success may even include no longer relying on the technology that facilitated recovery. While this framework of success continues to be essential to medical innovation, it may inadequately capture the goals and lived experiences of many individuals with disability. This presentation asserts that adaptive sport offers an alternative framework for understanding medical technology and defining the success of rehabilitation, with direct implications for how we train the next generation of physicians.

For many individuals with disability, medical and assistive devices do not act simply as a means of compensating for disability, but as keys to community and identity formation. The continued use of a wheelchair does not represent a failure of rehabilitation, but a piece of technology that enables participation and self-expression. In the arena of adaptive sport, medical technologies like prosthetic limbs, surgical implants, or wheelchairs become much more than therapeutic devices. This reality highlights a disconnect between traditional medical understandings of health and patient-defined outcomes, encouraging the incorporation of new "variables" – such as purpose, belonging, and joy – into our understanding of recovery and clinical success. By viewing medical technology through the lens of adaptive sport, we are all challenged to reconsider our understandings of health, wellness, and even suffering.

In addition to clinicians, patients, and their families, these broader understandings of health have important implications for medical education. Despite 1 in 4 Americans living with disability – and the well-documented health benefits of adaptive sport – education on adaptive sport remains largely absent from medical school curricula and postgraduate training. By integrating adaptive sport into medical education, future physicians can become better equipped to move beyond deficit-based models of disability, engage in patient-centered conversations about medical technology, and partner with patients and community organizations to define meaningful outcomes of care. In this adaptive sport-based model of recovery, technology is not just a bridge between disease and health, but a facilitator of participation, identity, reclamation, and excellence, in whatever way the individual might choose to define it. Medicine teaches us to measure recovery. Adaptive sport teaches us to measure possibility.

An Exploration in Collaborative Medical Research With Rural Queer Communities

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Christopher Newport University

Hannah Wylder, MA

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This presentation will discuss how narrative and community-engaged methodologies can be beneficial for scholars engaging in medical research with historically marginalized groups. Using our experience working with rural queer communities across the Southeast, we will discuss what we learned using these methodologies, as well as offer advice to other scholars interested in working with marginalized groups. For queer communities, the current political climate is one that continuously seeks to further marginalize and silence them, and a major part of this effort has been to attack their healthcare access. Since the Trump administration, multiple measures aim to negatively impact queer healthcare, and coupled with the growing healthcare crisis that rural communities face with hospital closures and a lack of available providers, this reality leaves rural queer communities in a doubly-vulnerable place. In an effort to raise awareness and co-craft health equity resources using the voices of our participants, our research sheds light on the rural queer health experiences. In light of the historical silencing this community has historically faced, this study prioritized methodologies that foregrounded our participants' thoughts, experiences, opinions, and voices as collaborators in the solutions this study crafted. Our talk will specifically address how we recruited participants, the methods we used to capture their stories and opinions, as well as how and why narrative and community-engaged methodologies can help to make marginalized groups more comfortable with medical research.

The Contradiction of AI in Healthcare: Environmental and Health Impacts

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This paper explores the argument that the risks posed to individual health from the environmental impacts caused by AI data centres is a neglected ethical concern in the overall discussion of risks and concerns for AI and LLMs in healthcare.

Section I discusses digital dermatology as an example of AI being integrated into healthcare and how it bridges gaps of care, since dermatology is an area of medicine with limited resources and often inaccessible. It also discusses the computational power and resources needed to train and deploy an AI. Section II delves deeper into how data centres operate and how the operation contributes to pollution and adverse health outcomes. In particular, data centres contribute to light pollution, elevated electricity rates, air quality degradation, and they consume large quantities of fresh water. Neighbourhoods that data centres are situated in are directly impacted by these factors, and ultimately it contributes to the worsening of individual health. Section III argues that in its current form, the usage of AI in healthcare cannot be deemed ethical, nor is it ethically permissible to continue building new AI data centers with its current demand for resources. This section also explores environmentally friendly alternative initiatives for AI data centres. The paper concludes that for the widespread integration of AI into healthcare to be ethical, the environmental impacts AI data centres must be urgently addressed, especially considering the fact that these AI tools are meant to benefit those who utilize them, not contribute to worse health outcomes.

Menopause Beyond Biomedicine: Constructing Alternative Knowledge Through Documentaries

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A medical intervention into the normal life process of menopause is primarily proposed as a preventive measure from the possibilities of developing osteoporosis, Alzheimer's and heart disease. As estrogen defines femininity, its significant decline during and after menopause; conceptualises Hormone Replacement Therapy (HRT) as a magical therapy that helps retain the youthfulness of the female skin and body. HRT builds upon the negative connotation of menopause, spearheaded by medicine, its association with hot flashes, night sweats, bone loss, vaginal dryness, atrophy, risk of colon cancer, mental foggy and memory lapses. The introduction of drugs in this case works in two ways – looking at menopause as a disease or deficiency stresses the usage of these drugs and therapies, and the widespread availability of these medical procedures leads individuals to look at them as a relief from suffering. The textual and cultural vocabulary of menopause brims with ideas of loss, withdrawal, depletion and decline of estrogen secretion, "exhaustion" of ovarian reserve, atrophy of endometrium, genital atrophy, ovarian atrophy, urogenital atrophy, atrophy of urethral mucosa, and regression of sexual organs. The first section of the paper examines the conceptualisation of a fully functional set of ovaries and uterus as the ultimate benchmark to "normal" fertile, female bodies through Nelly Oudshoorn's *Beyond the Natural Body: An Archaeology of Sex Hormones* (1994) and theories of hormonal determinism proposed by Greer (1991) and Klein (1992). The second section of the paper attempts to create an alternate discourse through documentaries of menopausal and post-menopausal, ageing women, namely: *The Best Time of my Life: Portraits of Women in Mid-Life* (Watson, 1985), *Hot Flash Havoc* (Bennett, 2010), *The M Factor: Shedding the Silence on Menopause* (Atlas, 2024). These documentaries are then interpreted through Rita Charon's *Narrative Medicine* (2000) and Sandra Harding's *Standpoint theory* (1986), to develop a feminist epistemological model. The documentaries provide an interactive interface that taps into experiential reality and does not intimidate a person, unlike clinical architecture and its equipment. The narrative prowess of a documentary helps bring subjects under medical gaze out of their passivity, thus letting them participate in a conversation about their bodily events. Their active participation exposes the effects of menopause on personal relationships, rediscovery of themselves and inclusion in workplaces – dimensions which evade the disciplinary paradigm of medical textbooks and questionnaires. These audio-visual archives demand shared authorship with scientific textbooks and handbooks and allow for a multi-modal dissemination of ideas encircling menopause. Documentaries historicize testimonies which contribute to an alternative vocabulary including expressions of freedom, liberation, continuity as sexual beings, inclusivity into workspace that help move beyond well-disseminated notions of deficiency, decline, loss, lack and unproductivity. The "unrehearsed spontaneous telling of sensations and feelings" (Charon, 66), helps extend medical knowledge beyond the stipulated time in a doctor's chamber that a woman might have taken appointment for. The paper addresses how this interactive module will enable self-advocacy and dissemination of knowledge based on the experiential model; help destigmatise symptoms and curate a non-reductive vocabulary, thus broadening care models.

Structural Neglect: Artificial Intelligence and the Physician Shortage in LMICs

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The global physician shortage, especially seen in low- and middle-income countries (LMICs) is among the most consequential issues in global health. In Africa alone, the shortage is estimated to reach 5.3 million by 2030, up from 5.1 million in 2013. This issue is driven by chronic underinvestment in local medical education and by the large-scale emigration of LMIC-trained physicians into high-income country (HIC) health systems, a phenomenon described in the literature as a perverse subsidy and reverse foreign aid. Artificial intelligence (AI) has emerged as a proposed solution to close this gap by enabling lower-skilled health workers to screen and diagnose patients with diseases that previously required specialist-level training to identify. In the case of diabetic retinopathy screening, a technician captures the scan of the patient's eyes, and the AI is then able to follow up with the diagnostic interpretation, eliminating the ophthalmologist's role entirely, a process known as task shifting.

This paper argues that AI-enabled task shifting, when deployed in LMICs without any parallel investment in advancing physician education infrastructure, constitutes a form of structural neglect. AI cannot adequately replace the physician. Clinical medicine requires management of atypical presentations, rapport building, and independent reasoning that adapts to each individual patient, skills that AI does not possess. AI deployment can also actively delay long-term education infrastructure advancement, as AI tools have shown to be more fundable and produce faster measurable results. In addition, AI risks impairing education in the next generation of physicians as clinicians who have trained in AI-saturated environments see decreased caseloads and may never develop independent clinical judgement.

Two solutions are proposed: AI deployment should require binding co-investment in local physician education and the WHO Global Code on health worker recruitment should be transformed into an enforceable measure with requirements that HICs should not structurally depend on LMIC-trained physicians.

Can LLMs "Scaffold" Patient Autonomy?

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Across several recent papers, Allen, Levy, and Wilkinson have argued that the use of appropriately designed chatbots or LLMs in clinical medicine has a high potential to enhance patient autonomy, especially vis-à-vis informed consent. In Allen, Levy, and Wilkinson (2026), the authors specifically employ Wilkinson and Levy's (forthcoming) "scaffolded model" of autonomous decision-making to argue that LLMs can enhance patient's autonomy by helping to "scaffold" their decision-making. The rough idea of the scaffolded model is that an agent's decision-making process is, in even the most robustly autonomous cases, partly made up of the cognitive states and deliberative processes of other agents and of the interactions between the agent and these others. The authors argue that LLMs can enhance patient autonomy by, among other ways, "'giv[ing] precision' to their values in medical contexts.... Through iterative dialogue, an LLM could help patients to not only clarify and articulate their values in medical contexts but also to understand how different treatment options might align with or challenge these articulated values" (2026: 185). The authors' argument assumes that the only requirements for an autonomy-bolstering scaffold are epistemic and causal. But I argue that there is an irreducibly normative requirement as well. And I further argue that using LLMs in a way that meets that requirement is far more difficult than the authors suggest and brings up additional ethical concerns they don't consider.

To see the normative requirement, consider one of Wilkinson and Levy's own examples of such an evaluative scaffold: the role a priest might play in helping a devout Catholic agent to specify and apply her own religious values. If the requirements of the priest-as-scaffold were only epistemic and causal, he might be substituted by a scholar of religion. But surely the devout Catholic agent would find such a scholar (lacking ordination etc.) a poor substitute for specifying and applying her own values. What the priest presumptively has that the scholar lacks is normative authority granted him by the agent. Such investiture need not be explicit. Nor need it be absolute. What it must be is accessible to the agent (the Catholic can understand the priest as an authoritative evaluative scaffold) and revocable by the agent (the Catholic can renounce this priest or her religion). Without these conditions, I argue, an evaluative scaffold would undermine the agent's autonomy. And the less accessible this authority, or the more costly its revocation, the less autonomous the resulting decision-making will be, all else equal.

When it comes to LLMs, it should not be taken for granted that they can acquire such normative authority for most persons. Moreover, if these chatbots are introduced to patients as tools to enhance their autonomous decision-making, there is a high burden on clinicians' part to ensure that this evaluative scaffolding is abundantly accessible to the patient and easily revocable by them. For these reasons, it is difficult to share Allen, Levy, and Wilkinson's optimism about LLMs as autonomy-enhancing evaluative scaffolds.

A Broad Critical Exploration of AI: Appraising Applications, Weighing Implications

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Technological and commercial advancements of artificial intelligence (AI) are outpacing the ethical, legal, and societal scaffolding to support their wise and just use. Myriad applications of advanced AI across communities, sectors, technological functions, and aspects of human life have costs and consequences that can include significant threats to flourishing. The time is ripe for multidimensional consideration of wellness in the era of AI.

Considering medicine, AI applications in healthcare may offer benefits to healthcare providers and patients alike. There is opportunity for healthcare providers to lean on ambient AI for real time note generation, quick specialty level consults for most recent evidence-based recommendations and increased implementation of novel therapeutic treatment options. Likewise, patients often feel more prepared and supported to have conversation during visits. Both groups could turn to AI as administrative assistants either professionally or personally to free more leisure time. However, concerns have been raised about the potential for AI to compromise patient welfare: introduction of unchecked error and bias into direct patient care, increased algorithmic denials of insurance coverage, and degradation of medical training.

Regarding the environment, data centers demand resources in an era already characterized by ecological peril and climate instability. The water withdrawal for AI globally is projected to reach billions of cubic meters by 2027 (Li et al 2025). Compared with a standard key word search, each search powered by a large language model (LLM) is approximately 10-fold across various AI-powered systems, including Google and ChatGPT (de Vries 2023). Prospective analyses of the public health impacts of U.S. data centers raise serious concerns. For example, permitted fine particulate matter emissions from the on-site power system of a single data center in Virginia were estimated to result in \$53-99 million per year in health-related damages, attributable to lost productivity, asthma-related outcomes, hospital admissions, and even premature deaths (Cork and Dominici, 2026).

This will be an interactive session offering the audience the opportunity to grapple with environmental implications of artificial intelligence and machine learning and broadly explore their potential for individual and societal harms. Among these, we will consider the exacerbation of unjust disparities and impacts on human creativity. The aim of our exploratory session is to ignite an interest in learning how to critically appraise AI applications, both in medical technologies and those embedded in everyday life, and understand how important it is to do so.

Unseen Narratives: Visualizing Emotional Experiences of Informal Mental Health Caregiving

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Unseen Narratives is an interdisciplinary, arts-based research project exploring the lived experiences of informal caregivers of individuals with mental illness. Relatives, partners, friends, neighbors, and others who provide unpaid support often become essential members of a person's healthcare network, yet their role is frequently unofficial and overlooked. Much of this caregiving happens quietly over time through listening, reassurance, crisis support, navigating uncertainty, and carrying emotional responsibility that may remain invisible to others.

Using drawing, movement, and digital video as methods of inquiry, the project examines how caregiving experiences can be translated into visual and embodied forms when clinical or verbal language is insufficient. The creative works that emerge from this process function not simply as illustrations, but as forms of inquiry and knowledge production that can make difficult-to-articulate experiences more perceptible.

Unseen Narratives is informed by narrative medicine, arts-based research, performance studies, and critical disability perspectives. The project considers caregiving not simply as support work, but as a form of relational and embodied knowledge shaped by closeness, responsibility, uncertainty, and care.

The current phase uses drawing, dance, and digital video to explore translation across artistic forms. Drawings based on my own experience as an informal caregiver for a family member living with psychosis and dementia serve as starting points for movement and visual composition. Rather than depicting events literally, the work uses nonlinear and embodied storytelling to communicate the emotional weight of caregiving and experiences that can be difficult to put into words.

Because caregiver stories are intertwined with the lives of those receiving care, the project also raises questions of privacy, consent, representation, and agency. Trauma-informed and collaborative practices guide the work as it expands toward engagement with other caregivers and community participants.

Unseen Narratives seeks to make visible the emotional and relational labor of informal caregiving that often remains outside official healthcare narratives. By translating these experiences into visual and embodied forms, the project expands whose knowledge is recognized within medical humanities and offers new ways of understanding the relationships that sustain mental healthcare beyond clinical spaces.

Toward an Islamic Relational Ethics of Care

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This paper is an exploration of contemporary Islamic ethics of care, by engaging critically with both dominant liberal theories of autonomy and premodern Islamic ethical traditions. It argues that while liberal frameworks conceptualize the individual as an independent, rational agent whose choices flow from personal intention and will, this account obscures the social, material, and cultural conditions that actually make agency possible. Autonomy, far from being a natural attribute of the isolated self, is sustained through relationships of dependency that liberal theory tends to render invisible or treat as exceptions to the norm of self-sufficiency.

Islamic ethics, by contrast, offers a theological anthropology that takes dependency as constitutive of human existence. Drawing on Fazlur Rahman's analysis of Qur'anic themes, the paper shows that the Qur'an consistently characterizes human beings as *faqīr* (needy), *daʿīf* (weak), and fundamentally dependent upon divine sustenance. This dependence is not a deficiency to be overcome through the cultivation of autonomy but an ineliminable feature of creaturely existence. Importantly, dependence upon God does not diminish moral responsibility; rather, it constitutes the very condition within which moral agency is exercised. This framework offers resources for rethinking the relationship between vulnerability and agency that avoids the liberal tendency to treat dependency as a failure of self-sufficiency.

However, the paper also argues that the relationality affirmed in premodern Islamic ethical traditions, as analyzed in Ayubi's work on al-Ghazālī, Ṭūsī, and Davānī, is structured through hierarchy. While these thinkers recognize that the self is formed through marriage, domestic life, friendship, and broader social relationships, they position women and non-elite men not as equal participants in ethical development but as subjects whose labor and bodies facilitate the flourishing of elite men. This tension is crucial for a contemporary Islamic ethics of care: relationality is not inherently emancipatory. Human beings may be fundamentally dependent upon one another while the obligations generated by that dependence remain distributed unequally.

The paper therefore brings together question of: How can we affirm human interdependence without reproducing relationships in which some people are expected to bear disproportionate burdens of care? I propose that a justice-oriented Islamic ethics of care would require recovering the Qur'anic emphasis on mutual responsibility (*takāful*) while critically reexamining the hierarchical dimensions of Islamic ethical frameworks.

Determining Parenthood in IVF Embryo Mix-Ups: Championing Genetics and Gestation

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Championing Genetics and Gestation One sign of an interesting question in medical ethics is when we see different countries handle similar cases very differently. The question of how to determine parenthood in in vitro fertilization (IVF) embryo mix-up cases is a good example. Before the advent of IVF, genetic and gestational motherhood was a unitary role. The birth mother was both the gestational and the genetic mother. Today with surrogate births, gamete sales, and many pursuing families through IVF, these roles are often held by different women. Today in the United States, our courts typically turn to genetics. In Australia and Israel, parenthood typically turns on gestation. In this paper, I will argue that both genetics and gestation must be taken into account, even when this means multiplying the parents in a child's life.

Embryo mix-ups, where a woman has undergone IVF and expects to give birth to a baby created from her own embryo but gives birth to one that is not genetically related, are more common than anyone would wish. These cases lead to consternation and heartache. While it is common for both genetic and gestational parents to sue the clinic for damages, the weightier question by far is who will be recognized as the infant's legal parents and have the rights and responsibilities of parenthood.

Most embryo mix-up cases regard situations where the child has already been born. Given this fact, the welfare of the children who are born from embryo mix-ups is important to consider, as well as the rights and responsibilities of 1) the genetic parents 2) the gestational spouse and 3) the partner of the gestational spouse, if any.

My appeal to both genetics and gestation initially sounds like an appeal to the past. However, because embryo mix-ups mean that genetics and gestation are always separated, the call to honor both as forms of parenthood is something new. Recent authors have championed the gestational role over genetics because new family structures raise worries that disfavor bionormativity and any form of genetic essentialism. However, I will argue that in an era of ARTs, the crucial criterion of default legal parents for each child is only achieved through a robust transfer principle and the recognition of both genetic and gestational parents. A robust transfer principle allows us to escape the errors of bionormativity and genetic essentialism. It is true that the multi-parent model complicates parenthood; for this we must thank ARTs.

I will argue that any basis proposed for determining parenthood must meet four criteria:

- 1) The basis for parenthood must guarantee default legal parents for each child and a robust transfer principle.
- 2) Parenthood must be exclusive (restricting others from unilaterally asserting themselves).
- 3) The rights and responsibilities of parenthood must apply consistently across different contexts and different ARTs.
- 4) We must weigh both the present and the future good of children born through embryo mix-ups.

Should Environmental Stewardship Influence Healthcare Decisions?

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Environmental ethics describes the moral relationships between humans and the natural world and is the philosophical foundation of the field of conservation biology. As concerns have increased over the effects of human activity on local and global environments, there have been increasing demands to shift societal values to prioritize the wellbeing of nature. These demands have manifested in significant changes to how individuals are expected to make decisions. The ecological consequences of consumer choices and contribution to sustainable practices have been broadly incorporated into mainstream marketing. Regulations on industrial energy and resource consumption are frequently a central focus for global policymakers. It is logical to extend these shifts in decision-making expectations to modern healthcare.

Environmental bioethics considers the relationships between human health and the natural ecosystems of the environment. It examines value systems regarding the health of individuals, populations, and collective ecosystems. There is a growing body of literature that explains why it is imperative that environmental impacts be considered in the workflow and treatments of clinical care, but less has been written regarding the extent to which environmental bioethics should dictate decision-making at various levels within healthcare. Within the principle of autonomy, patients and surrogates are expected to make decisions based on acceptable frameworks of reasoning, such as expected health outcomes, quality-of-life preferences, financial considerations, and religious values. Furthermore, organizations are expected to base guidelines on scientific evidence that prioritizes health outcomes. In this project, we argue that environmental bioethics should be included as an acceptable framework to guide healthcare decisions. We explore its legitimacy and limitations when utilized by a capable patient, the guardian of a pediatric patient, the surrogate of an incapable patient, an organization (e.g. hospital, clinic, medical association), and finally at a public policymaking level.

The Wrong Diagnosis Can Cure You

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Traditionally, philosophers have viewed medical diagnoses as scientific labels that aim to describe as accurately as possible a patient's pathophysiology. This paper challenges that assumption. Instead, it argues that the primary purpose of a diagnosis is to manage a patient's "jurisdictional risk"—the very real danger that a patient's suffering will not make sense to a hospital's administrative systems. When a medical condition lacks a recognizable, actionable administrative label, patients can become stranded between clinical departments, insurance approvals, and administrative zones of control, any of which can lead to patient being denied the care they need.

By examining real-world clinical cases, this paper demonstrates that a useful diagnosis actually functions as an essential administrative routing tool. It reconciles a patient's biological characteristics with the patient's institutional context, often constituted by strict financial, political, and clinical norms that are rarely directly legible to patients. Because of this, a diagnosis that is scientifically vague—or even technically or descriptively incorrect—can still facilitate a cure if it successfully routes the patient through the institutional complex through which care is both managed and provided. Ultimately, healing a patient involves more than pinpointing and then labelling physiological dysfunction. It requires aligning—and working to maintain that alignment—the patient's illness with the complex institutional architecture of most modern healthcare facilities. A medically effective diagnosis must also be institutionally effective; diagnostics assessment must reflect both astute medical and political judgment.

Broken Cisterns: Idolatry and the Digital Afterlife

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Posthumous AI avatars—"griefbots" or "deadbots"—are interactive digital replicas of the deceased. Drawing on a late loved one's personal archives as source data, these avatars utilize Gen-AI to issue novel responses to user input, imitating the conversational style of their human archetypes. The ostensible purpose of these avatars is to mediate the process of mourning and offer continued companionship beyond the point of death. This technology, which is unregulated by the FDA and marketed directly to users, raises novel bioethical questions. Extant scholarship has addressed concerns like invasion of privacy, commercial exploitation, and harmful disruption of the grieving process (Hollanek et al. 2024, Klugman 2024). This paper moves beyond these incidental ethical considerations, arguing that posthumous AI avatars incur ontological, epistemic, and relational harms for the deceased and for their users. That is, blurring the boundaries between the actual and the effigy, which AI avatars invite and encourage us to do, inflicts a posthumous harm on the deceased by rewriting their personal histories and redefining their identities post hoc. It also inflicts a harm on users, whose genuine relationship is mediated by a series of false encounters that profess continuity. The concept of idolatry is a helpful paradigm for understanding these fundamental harms, showing as it does how false worship diminishes the inner life of the worshipper and denigrates the object of worship. In my analysis, I draw parallels with biblical and literary sources from the Old Testament and St. Augustine to C.S. Lewis and David Foster Wallace.

Artificial Intelligence and the Erosion of Trust in U.S. Healthcare

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Building and maintaining trust in a relationship takes effort. In the absence of such effort, trust in a relationship can be eroded. Unfortunately, there are several examples in which trust in U.S. healthcare services has been eroded, especially among marginalized populations. The erosion of trust in healthcare services can have devastating consequences. In this paper, I will argue that the utilization of Artificial Intelligence (AI) in U.S. healthcare services threatens to continue the erosion of trust in physician-patient relationships among both marginalized and non-marginalized populations. There are at least two main ways in which such trust is being eroded. First, the lack of complete transparency in AI datasets and algorithms complicates the role of physicians as experts. Patients (or potential patients) may be more likely to have confidence in the information that they derive from AI than from a trained physician when there is conflicting information. Second, while AI can add much-needed efficiency in providing health care, it also can contribute to a sense of depersonalization among patients. Both physicians and patients must be intentional about taking the time to process information and to have genuine conversations. Additionally, physicians must not neglect their obligation to listen to their patients and to understand each patient's values and priorities, which are not simply outcomes based. Ironically, the increased efficiency that is possible with the incorporation of more advanced AI threatens to short-change these vital aspects of communication, which are fundamental to maintaining trust and, ultimately, to providing quality health care. In short, when the speed of such transactional interactions is prioritized, the quality of those interactions is diminished. The upshot is that AI certainly has the potential to improve the quality of health care, but only if AI is utilized and implemented in ways that do not undermine the fundamental trust at root in physician-patient relationships.

When the Wounded Cyborg Speaks: Narrative Agency in Mexican Cyberpunk

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Cyberpunk has traditionally imagined the cyborg as a technologically enhanced body whose integration with machines expands human capabilities. Mexican and Latino cyberpunk, however, frequently disrupts this model by representing what I call the low-tech cyborg: a precarious, technologically dependent, and physically or psychologically wounded subject whose body reveals the uneven consequences of technological modernization. This paper examines Pepe Rojo's short story "Grey Noise" (1996) and Alex Rivera's film *Sleep Dealer* (2008) to explore how speculative narratives can broaden the ways medical humanities conceptualizes illness, disability, and the embodied experience of suffering.

Rather than approaching illness exclusively as an individual medical condition, I argue that these works portray wounded and technologically modified bodies as products of larger structures of labor, surveillance, economic inequality, and technological exclusion. In "Ruido gris," an eighteen-year-old worker undergoes surgery to transform his eyes into cameras for a media corporation that profits from broadcasting violence. His deteriorating psychological condition—marked by depression, anxiety, suicidal ideation, and narrative fragmentation—allows us to approach him as an ill narrator, a subject whose suffering affects not only what can be narrated but also the form through which experience becomes narratable. His technologically augmented body consequently becomes an instrument of corporate productivity, surveillance, and eventual exhaustion.

Sleep Dealer offers a contrasting narrative possibility. Memo, a migrant worker whose body is surgically fitted with technological nodes that allow him to operate machinery in the United States from a cyber-maquiladora in Tijuana, experiences trauma, displacement, bodily exploitation, and loss. Yet his retrospective narration transforms these experiences into testimony. Drawing on Arthur Frank's concept of the wounded storyteller, I argue that Memo's narrative recuperates agency by turning individual suffering into memory, critique, and the possibility of collective recognition.

By placing the ill narrator in dialogue with the wounded storyteller, this paper proposes the low-tech cyborg as a useful figure for medical humanities: a body through which illness and disability become inseparable from labor, technology, migration, and socioeconomic precarity. Ultimately, these narratives invite us to move beyond understanding wounded bodies merely as objects of medical or technological intervention and to recognize them as producers of knowledge whose stories can expose the social structures that make bodies vulnerable in the first place.

Compensated Plasma Donation: Balancing Global Need and Donor Vulnerability

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Plasma donation lies at the heart of a rapidly expanding global pharmaceutical sector, yet it rests on an ethically fraught foundation: compensated donations. Plasma, which makes up about 55% of whole blood, is rich in vital components like albumin and immunoglobulins that function as the building blocks of life-saving plasma-derived medicinal products (PDMPs). While most nations prohibit compensation for bodily donations due to concerns about coercion and exploitation, plasma stands out as a notable exception: A few countries, including the United States, allow pharmaceutical companies to pay donors for their plasma. This system has positioned the U.S. as the world's leading plasma producer, supplying both its own needs and those of nations that largely rely on imported PDMPs derived from compensated donations. Yet this reliance comes at a cost, as compensated plasma donation has become a lifeline for millions of Americans facing economic precarity. Due to how compensation is structured, many poor and economically insecure individuals are incentivized to donate as often as twice weekly (the legal maximum) despite recommendations from the Red Cross to limit donations to once every two weeks. The plasma industry's pursuit of frequent donors, particularly those from racialized and impoverished communities, underscores a troubling dynamic: these populations, often exposed to higher risks of infection, provide not only a steady supply of plasma but also access to a diverse spectrum of antibodies generated through recurrent illness. However, the health implications for these donors remain under scrutiny, as periodic donations may weaken their immune systems, leaving them more vulnerable to infection even as their plasma helps combat illness in others. The plasma industry profits from this system, but the ethical questions are hard to ignore. Is compensation a necessary incentive to meet global demand, or does it enable exploitation of the most vulnerable? In response, some ethicists advocate for outright bans on compensation while others push for greater regulation alongside higher payments to ensure fairness. What is clear is that the ethically unacceptable response is to leave the status quo intact.

Framing What Matters: Baby-Tracking Technologies and the Transformation of Care

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Digital technologies increasingly mediate not only clinical but also everyday practices of care. One such technology is baby-tracking mobile applications, which allow parents to record and monitor feeding, sleep, diaper changes, developmental milestones, and other aspects of a baby's daily life. More advanced applications also provide educational content, developmental recommendations, and increasingly rely on AI-driven predictive systems to forecast sleep rhythms and evaluate developmental progression. Such technologies are often understood as tools that provide caregivers with information about the baby and her care (Dienelt et al. 2019). In this talk, I argue that they do something else as well: next to providing information, they participate in framing parents' embodied perception and the meaning of care. I do this by drawing on the insights from post-phenomenology, conceptual framework from phenomenological philosophy (concepts of embodiment and intercorporeality), and on 20 in-depth interviews with parents using baby-tracking and monitoring technologies. The study uses Phenomenologically Grounded Qualitative Research approach (Køster & Fernandez, 2023), which argues for the integration of phenomenological philosophy's concepts with empirical research.

Early parenthood is often marked not only by a lack of information, but also by uncertainty about how to "read" the baby or how to understand what she wants (Lupton and Pedersen 2016). Interview material demonstrates that baby-tracking applications mediate parent-baby embodied relationship in two ways: they can direct parents' attention toward previously unnoticed bodily cues and strengthen embodied attunement with the baby, but they can also redirect parents' attention away from the baby towards the data. In the latter case, the app can shift from supporting parents' perception to becoming an alternative source of epistemic authority, potentially conflicting with parents' situated, embodied knowledge. Based on these insights, I argue that baby-tracking technologies shape not only what caregivers know, but what they notice, how they interpret what they notice, and what they come to regard as requiring attention. More fundamentally, such framing transforms the meaning of care itself. When feeding, sleeping, diaper changes, and other measurable dimensions of the baby's life are presented as discrete activities to be recorded, monitored, and optimized, care can increasingly appear as a set of measurable tasks to be correctly performed. Other, non-measurable aspects of care, such as touch, presence, responsiveness, and embodied attunement, can become forgotten.

Policies and Politics of HR1 Medicaid Changes

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On July 4, 2025, President Trump signed into law HR1 or the Big Beautiful Bill. The focus of this bill was to extend the 2017 tax cuts however, due to the tight majorities in both chambers of Congress, passing the bill with the required 60% majority vote was unlikely. Thus, the majority party opted for a reconciliation approach that requires a simple majority and provided the only option for passage. A major requirement for reconciliation is that all expenditures be offset by cost reductions. The Congressional Budget Office estimates that HR1 expenditures will be \$988 billion over 10 years. Congress focused on Medicaid as the major source of cost reductions at \$911 billion over ten years or approximately 92% of the required cost reductions (CBO, 2025) This paper will examine policies and politics of HR 1 under Subtitle B – Health Medicaid highlights.

Teaching Youth to Question AI in Healthcare

Lydia Hill-Grant, PhD

From Me 2 U, Inc.

Artificial intelligence is rapidly transforming how individuals seek, interpret, and act upon health information. Adolescents increasingly encounter AI-generated responses through search engines, chatbots, social media, and emerging health technologies, often without the critical skills necessary to evaluate accuracy, identify bias, or recognize the ethical implications of algorithm-generated information. While discussions of artificial intelligence in medicine frequently focus on clinical applications, comparatively little attention has been given to preparing future patients, caregivers, and community members to engage responsibly with AI-enabled health information. This presentation introduces a community-based educational framework developed through Choose 2 Be U Summer Workforce, a workforce and leadership development initiative of From Me 2 U, Inc. Rather than teaching youth how to maximize AI productivity, the framework emphasizes digital health literacy, ethical reasoning, critical evaluation of AI-generated content, and informed decision-making. Drawing upon principles from public health, psychology, workforce development, and the medical humanities, the curriculum encourages adolescents to examine questions of trust, misinformation, equity, privacy, and human responsibility when interacting with AI technologies.

The presentation describes the curriculum's conceptual foundation, learning objectives, instructional design, and classroom activities designed to promote reflective engagement with AI. Examples include evaluating AI-generated health information, identifying potential algorithmic bias, comparing AI responses with evidence-based public health resources, and discussing the ethical responsibilities of both technology developers and users. The framework positions AI literacy as an essential component of health literacy and civic engagement rather than solely a technological competency. As AI becomes increasingly integrated into healthcare delivery, patient education, and public health communication, community-based organizations have an important role in preparing young people to navigate these technologies thoughtfully and ethically. This presentation argues that AI literacy should extend beyond technical proficiency to include critical inquiry, ethical reflection, and an understanding of the human dimensions of healthcare. By introducing a practical educational model that can be adapted by schools, youth-serving organizations, and public health programs, this work contributes to ongoing conversations about medical technologies, health equity, and preparing future generations for an AI-enabled healthcare landscape.

Stewardship and Capital-Intensive Medical Infrastructure: Lessons from Proton Therapy

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Healthcare affordability is a critical issue in the United States and new medical technologies with limited early evidence are a primary driving force. We examine the rapid proliferation of proton therapy centers as a cautionary tale for new technologies that require capital-intensive investments. Proton therapy was expected to emerge as a superior form of radiation therapy in cancer care leading healthcare systems across the United States to invest hundreds of millions of dollars for their own facilities. These facilities and their maintenance were built on financial models dependent on continuous, high-volume patient throughput. However, the necessary throughput never materialized at the scale these business models required, and as a result, several centers have since closed or declared bankruptcy, and many others remain financially strained. Early evidence most strongly supported proton therapy for rare cancers which, for financial reasons, led centers to extend treatment to prostate cancer for which the evidence was weaker. However, recent high quality long-term studies suggest that, for prostate patients, proton therapy is no more effective than less expensive interventions. These results further threaten the viability of proton centers as prostate patients are their largest demographic. Together, these dynamics are financially devastating to regional systems, disrupt patient care, exacerbate costs, and create ethical tensions at the doctor-patient, institutional, regional, and national levels. We argue that physicians should not recommend proton therapy for prostate cancer patients, with the exception of patients who choose to pay out of pocket. Institutions must first demonstrate sufficient demand before investing in new technologies that require significant capital investment and this demand must be considered at the regional and national level. The overbuilding of proton therapy centers reflects a failure of coordination in U.S. healthcare capital investment: individual centers acted rationally to capture potential demand, but collectively exceeded national demand. We argue for implementing federal oversight to prevent inefficient spending to limit healthcare costs. These regulatory structures already exist as does their justification. Specifically, we propose extending Certificate-of-Need laws, which already require hospitals to justify new bed capacity, to capital-intensive technological investments.

Before We Balance: Medical Technologies, Adequacy Floors, Answerable Clinical Judgment

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Medical technologies increasingly mediate how clinicians perceive patients, organize evidence, allocate attention, and recommend care. Bioethical assessment commonly asks how benefits, harms, autonomy, justice, efficiency, and cost should be balanced. This paper argues that balancing begins too late. Some ethical and epistemic requirements are not merely additional considerations to be weighed against favorable outcomes. They are adequacy conditions that must be met before a technologically mediated clinical judgment is fit to guide action. Consider an AI-supported prioritization system that assigns a patient a comparatively low intervention score. The model may be statistically well validated, yet fail to register an atypical presentation, a disability-relevant consideration, a treatment history, or another feature essential to understanding this patient. A clinician notices the mismatch but works under time pressure, lacks clear override authority, and knows that departure from the system will require exceptional justification. The patient may request an explanation while remaining unable to discover what shaped the recommendation, correct the representation, or reach anyone empowered to reconsider it. The problem is not exhausted by possible inaccuracy. The arrangement has altered who can be heard, what counts as a reason, and where responsibility lies. This paper develops a judgment-centered alternative. Before aggregate benefit or efficiency can justify reliance on a medical technology, the decision process must satisfy minimum conditions of evidential adequacy, attention to the particular patient, intelligible reasons, patient standing, role-fitting clinical understanding, meaningful contestability, supported override and escalation, identifiable responsibility, and possibilities for reconsideration and repair. These conditions are not absolute rules that eliminate uncertainty or trade-offs. They establish whether a proposed judgment is sufficiently answerable to enter responsible comparison at all. The resulting sequence is: determine admissibility; test adequacy floors; compare the remaining goods, burdens, and risks; act proportionately; and retain responsibility for monitoring and repair. This approach also evaluates technologies over time. Even an accurate system can become ethically defective if its use weakens clinicians' capacities for independent appraisal, recognition of atypical cases, uncertainty-bearing, or warranted dissent. Conversely, a well-designed technology may strengthen judgment by widening evidential access while preserving human authority and patient participation. Medical technologies should therefore be assessed not only by what they produce, but by the clinical judgment ecology they create. The proposed framework protects the patient as a person who must remain hearable and answerable, the clinician as a responsible and continually formed practical judge, and medicine as a relational practice whose constitutive goods cannot all be optimized, traded, or compensated away.

Digitally Supported Self-Observation in Clinical Research on Stimmigkeitserleben

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For the Medical Humanities Conference 2026, I would like to address how digital methods can support the empirical investigation of clients' first-person clinical experience. The presentation contributes to medical humanities by showing how such methods can support experience-near, patient-centred knowledge production without reducing clients' lived experience to merely standardised data. I present ongoing empirical research on Stimmigkeitserleben at the intersection of philosophy, phenomenology, and psychotherapy. In psychotherapeutic settings, Stimmigkeitserleben is described as an intuitive, bodily mediated form of knowing that can support orientation in situations of uncertainty, crisis, conflict, and ambiguity (Schmidt, 2013). This makes it relevant for philosophical questions concerning first-person experience, lived embodiment, practical orientation, meaning, and well-being. Since the term does not translate easily into English, I retain it in German. The presentation is based on a longitudinal mixed-methods study with five adult clients in inpatient psychotherapy. The quantitative component consists of daily digitally supported self-observations using individualised items co-developed with participants. The qualitative component consists of diary entries and several interviews in which participants reflected on their self-observations and interpreted visualised representations of their quantitative data, with interpretive authority remaining with them. I will discuss three connected aspects: first, the epistemological assumptions underlying the study; second, the methodological design of digital self-observation within a longitudinal mixed-methods design; and third, emerging findings concerning how clients describe and use Stimmigkeitserleben in their therapeutic process. Methodologically and epistemologically, the study is informed by Donna Haraway's concept of situated knowledges (Haraway, 1988). In retrospect, it can also be related to Hanne De Jaegher's account of loving and knowing (De Jaegher, 2021). Together, these perspectives allow me to understand the clinical research process as a form of co-produced knowledge: Stimmigkeitserleben is not simply extracted as data, but articulated through situated practices of observation, reflection, interpretation, and dialogue. Against this epistemological and methodological background, the preliminary findings concern the ways in which Stimmigkeitserleben is perceived and described within the study. Across the material, it appears as lived-bodily experience, often described through sensory-aesthetic qualities such as expansiveness, lightness, comfort, or the falling away of tightness and pressure. It is connected with clarity, certainty, understanding, practical orientation, capacity to act, self-relation, social contexts, and contexts of meaning. By contrast, Nichtstimmigkeitserleben appears as a warning signal felt through the lived body and as a negative counter-horizon through which discrepancies in fit can become noticeable and action-guiding.

References De Jaegher, H. (2021). Loving and knowing: Reflections for an engaged epistemology. *Phenomenology and the Cognitive Sciences*, 20(5), 847–870. <https://doi.org/10.1007/s11097-019-09634-5> Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist Studies*, 14(3), 575–599. <https://doi.org/10.2307/3178066> Schmidt, G. (2013). *Liebesaffären zwischen Problem und Lösung: Hypnosystemisches Arbeiten in schwierigen Kontexten* (5th ed.). Carl-Auer.

An Ethical & Epistemic Analysis of Risk Matrices in Healthcare Systems

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Risk is a notoriously difficult concept to understand, explain, and quantify. How people perceive risk is dependent on a myriad of factors, and yet, being able to communicate about risk is incredibly useful. The risk matrix is a tool that was developed in order to address some of these confusions and complications pertaining to risk. This tool simplifies what is an incredibly complex phenomenon (risk) into something that is much easier to digest (a number, descriptor, or label) that can be used in the decision-making process. We see risk matrices used in a variety of settings, and they may be operationally useful in quantifying risk, even if they cannot always provide certain accuracy amongst users, systems, and situations. Risk matrices have the potential to be instrumentally useful within the healthcare setting, translating risk into something that is more readily able to be factored into decision making. The current literature on risk matrices primarily focuses on their accuracy, and therefore whether they should be utilized. Instead, in this project I focus on the all-too-common conflation of the epistemic understanding of the risk rating of an event and the ethical action guide that this tool supposedly directs users to follow.

I begin by offering a background on risk matrices, followed by an explanation of Heather Douglas's theory of inductive risk. Next, within my analysis of inductive risk, and its application to two case studies, I argue that more care should be taken when describing how to use risk matrices, and to distinctly separate their utility as assessment tools from decision-making tools. This helps to ensure that healthcare professionals, at all levels, are able to accurately use these tools, and be aware of all instances in which inductive risk is at play. If we shift our focus away from issues of accuracy and move to analyze risk matrices under the lens of inductive risk, then the impacts of this conflation become clear. Rather than utilizing risk matrices as an action guide, they should be used just as a means to understand risk, as a part of an overall decision. Risk should not be the only consideration when making a decision within the healthcare system, whether that be on an individual or institutional level. But when these tools are taken to play both roles, healthcare professionals run the risk of making decisions and acting without the understanding that their choice of action may very well be wrong. I do not disagree that many times, high risk events do necessitate focus and action. However, if we wish to still use these tools, and to get the best use out of them, then we should cast a critical lens over all aspects of these tools, not just the question of accuracy. Separating the epistemic benefits from the ethical actions brings us closer to a more well-rounded utilization of risk matrices.

Does "Do No Harm" Include the Planet? Medicine's Carbon Footprint

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Climate change has had well documented impacts on human health, from natural disasters and heat-related illnesses to infectious diseases and food insecurity. Medicine attempts to treat these patients while often overlooking how its own carbon footprint contributes to the underlying issues that make people sick. For a field guided for millennia by the adage "do no harm", the very act of healing is contributing to harm across the health spectrum.

While not often considered in efforts to minimize greenhouse gas emissions, the health care sector has been a silent yet significant contributor. On a global scale, health care contributes about 4.4% of all emissions; if this number of emissions represented a single country, it would be the fifth largest emitter in the world. The US health care sector fares worse than its global counterparts, contributing about 8.5% of the country's emissions. These emissions produce health damages comparable to those caused by preventable medical errors. Despite this, the medical field has demonstrated minimal urgency to reduce health care's carbon footprint because, unlike medical errors, the harm from climate change is diffuse, delayed, and silent unless deliberately investigated.

Some of the largest contributors to the health care sector's emissions include the supply chain, followed by travel, facilities, medical equipment, and medical consumables. Many health systems, already cognizant of their carbon footprint, have begun to implement interventions at a variety of levels, a few of which are outlined below. On an individual level, operating rooms (ORs) have the potential to reduce their carbon footprint from the type of gas anesthesiologists use to the reusable OR gowns and cloths surgeons select. Departments can also do so by encouraging reusable tool procurement and telehealth visits. Institutional interventions can also reduce emissions with LED lights, occupancy sensors, and other energy efficient facility measures. They may also choose to source their food from local farms and communities or even build onsite rooftop farms to minimize reliance on supply chains, the single largest contributor of carbon emissions within the health care sector. Beyond the environmental benefits, many of these interventions carry economic benefits, such as reduced food costs or minimized energy bills. These represent just a few of the interventions through which hospitals have shown success in reducing their emissions without sacrificing patient outcomes.

As the practice of medicine becomes more difficult, clinicians might see a focus on reducing carbon emissions as another complication. However, by reframing climate consciousness as a continuation of the core principle "do no harm", medicine can more holistically meet that goal.

Ethical Third-Party Responses to Parental Hesitancy Regarding Measles Vaccination

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This paper examines ethical responses to MMR vaccine hesitancy by physicians, community members, and the state, taking as given that parents have a moral duty to vaccinate their children against measles to protect them from harm and a supplementary duty to avoid participating in a collective harm against their community's immunity coverage. It argues that, despite this, third-party responses to MMR vaccine hesitancy and refusal must be compassionate and educational rather than punitive or dismissive. Treating vaccine-hesitant families with anger is unethical because, among other reasons, it is ineffective and counterproductive.

Physicians occupy a unique position of trust that can help depoliticize medicine and demystify science. Drawing on survey and qualitative research, the paper shows that negative clinical interactions, shaped by physicians' dismissiveness driven by medical education gaps, sexism and other biases, or frustration with perceived parental irrationality, can often convert hesitancy into outright refusal; however, sustained, respectful physician-patient relationships can eventually change hesitant or refusing parents' minds. It concludes that physicians should neither terminate physician-patient relationships with, or refuse to take on, vaccine-hesitant patients. Physicians should instead treat listening and patient education as a central professional obligation, even when discussing vaccination on more equal terms with parents might incur a greater risk of vaccine refusal.

For community members who already accept vaccines' medical value, the paper argues that they hold a limited but meaningful duty to engage compassionately with those within their actual circles of trust, such as family and friends, but not with strangers whom they have limited interactions with, such as online. Evidence on the ineffectiveness of online anger and confrontation is used to argue that such reactions do more harm than good and are therefore unethical, even if the underlying judgment that vaccine refusal is unfair is itself warranted.

Finally, the paper turns to the state, arguing that its current stance of leaving vaccination policy up to individual states and allowing easily obtainable non-medical exemptions is not neutral, but instead communicates a mistaken message that undersells the risks of non-vaccination. The paper contends that the state should first make MMR vaccination, vaccine education, and knowledge about how to obtain vaccines free and easily accessible for all, and only then move to introduce additional steps to reduce non-medical exemptions and pursue incentive frameworks. It discusses the ethical drawbacks of punitive mandates such as fines or criminalization, which are shown to be unjust.

Together, these arguments establish that bridging the vaccination divide is a shared responsibility distributed across physicians, community members, and the state, and that inaction is itself an ethical failure. The paper offers a framework for how people who occupy trusted roles in medicine and society can respond to scientific disagreement in ways that are both ethically defensible and practically effective. This ethical framework to respond to public health issues can be extended to other domains where medical expertise, public trust, and the exercise of individual autonomy intersect.

What I'm Thinking about When You're Talking about AI Rights

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One question facing bioethicists, when considering AI, concerns personhood, and thus rights. In fact, the question of how to assess personhood, and whom to protect, is one that permeates the ethical questions of the medical humanities.

In my hybrid essay/poem "What I am thinking about when you are talking about rights for AI" I draw on literature, religious studies, history, language, and philosophy to consider our construction of personhood, who it protects, and whose purposes it serves. I also draw on the tools of poetry to keep the topic tethered to lived reality. The outputs of both humans and LLMs are shaped by the narratives we train on. When we do not impute personhood or rights to those with the capacity to experience or suffer, but instead grant it to those who can mimic our voices, we should consider whose purpose our stories serve. This presentation pushes the audience to think and feel about these questions.

Making Sense of Pathology: Enactivism and the Demarcation Problem

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Can understanding mental disorders as disruptions of sense-making solve the demarcation problem in psychiatry? The proponents of the enactive framework challenge the brain-centered biomedical model and claim that the object of psychiatry should be the relations between an agent and their world. This approach seeks to improve the biopsychosocial model by grounding the mind in brain-body-environment interactions and stressing the role of social factors. I compare three main enactive accounts of mental disorders and how they suggest distinguishing between mental health and pathology. Sanneke de Haan argues that biological sense-making often remains intact in psychiatric conditions and instead defines pathology as a structural bias or disruption in existential sense-making. Kristopher Nielsen defines mental health in terms of the functional norm of an organism's self-maintenance, arguing that pathology occurs when behavioral and experiential processes actively conflict with the organism's fundamental aim of staying alive. Michelle Maiese demarcates pathology as a disruption of both biological and existential sense-making, characterized by overly rigid bodily habits that destabilize a person's social roles. I argue that, in striving for a more holistic view and either rejecting or expanding biological norms to account for mental disorders, the enactive framework risks completely erasing the difference between life problems and mental disorders. I suggest a middle way between brain-centered and person-centered views – a body-centered enactive approach with minimal anthropological assumptions – would be more helpful in solving the normative issues in diagnosis and establishing a common ground between patients and clinicians.

The Arbitrary Eighteenth Birthday: Recognizing Adolescents as Emerging Moral Agents

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Decision-making in pediatric ethics has long been governed by the twin forces of the best-interest standard (Kopelman 1997) and the harm principle (Diekema 2004). While these frameworks offer excellent guidance for evaluating surrogate decision-making and are sufficient to resolve the majority of pediatric ethics cases, neither framework adequately addresses what moral weight should be given to an adolescent's own values and preferences, particularly in cases where the adolescent may possess substantial decision-making capacity. Institutional approaches to assent, mature minor status, and emancipation are inconsistent across legal jurisdictions and healthcare systems, leaving clinicians without a coherent ethical framework for resolving conflict when adolescents, parents, and healthcare providers disagree. The encouraged practice of obtaining assent from adolescent patients is heartening, as it implies that health professionals hold an interest in attending to the input of minor patients. However, a structured approach to evaluating adolescent decision-making capacity is necessary to ensure justice in clinical care.

I argue that moral weight should be afforded to the choices and preferences of adolescent patients, as they are emerging moral agents. My argument unfolds in three sections: First, two case studies illuminate how the best interest standard and the harm principle do not set forth a structure for affording moral weight to the preferences and decision-making capacity of adolescent patients, which can sometimes lead to non-ideal or ethically questionable outcomes. Second, I argue in favor of shifting the current approach to pediatric decision-making from the present age-based model (where the preferences of older children are afforded more moral weight than those of younger children) to a new model that relies on demonstrated capacity of pediatric patients to determine the appropriate level of moral weight that can be placed on their preferences. Third, I outline a presumptive authority model that draws inspiration from Appelbaum's (2007) criteria but reconfigures existing standards to accommodate for the incompletely developed neurological abilities of minors, as suggested by Diekema (2020).

Choosing Presence: Medical Student Motivations for No One Dies Alone

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Medical education often centers on diagnosis, treatment, and clinical decision-making, leaving fewer opportunities for students to explore death and dying. Despite the importance of end-of-life care, exposure to these experiences remains variable across medical education (Ho et al, 2020; Patterson et al, 2023). Experiential learning may provide an opportunity for students to develop a deeper understanding of patient care while engaging with aspects of medicine that extend beyond diagnosis and treatment. Service-learning has been associated with the development of empathy and professional identity, while experiences with end-of-life care may shape how students understand their roles as future physicians (Chrisman-Khawam & Manzi, 2020; Ruiz-Pellón et al, 2020).

No One Dies Alone (NODA) is a volunteer program in which trained individuals provide companionship to patients who are dying and may otherwise be alone. Research examining NODA found that medical students who volunteered with the program demonstrated greater empathic orientation toward patient care than their non-volunteering peers, although participation in individual patient vigils did not independently increase measured empathy (Hojat et al, 2020). These findings raise questions about what initially draws students to this form of service and what they find meaningful in the experience. Recent work on compassion in medical education further emphasizes the importance of experiences that allow students to engage with patients through presence and human connection (Zhang et al, 2026).

This exploratory qualitative study examines the motivations and experiences of medical students participating in NODA at a single medical school. Six fourth-year medical students who had participated in NODA completed an anonymous online survey. Questions explored what initially drew students to NODA, whether personal experiences influenced their decision to participate, what they expected from the experience, and how they understood being present with a dying patient. Students also reflected on how their involvement related to their development as future physicians. Open-ended responses were examined using an inductive thematic approach to identify recurring ideas across participants.

Preliminary analysis identified recurring themes of personal experiences with death and vulnerability as motivations for NODA participation, the recognition of presence as a meaningful form of care, and a reframing of death and dying as less unfamiliar or uncomfortable. Students described NODA as reinforcing the importance of hospice and palliative care, early goals-of-care discussions, and dignity at the end of life. Participants also connected their experiences to professional identity formation, emphasizing a desire to remain compassionate, present, and human-centered even when unable to cure. These findings suggest that NODA may complement traditional medical education by providing experiential opportunities to explore presence, compassion, and the physician's role in end-of-life care.

By centering students' own reflections, this study explores why medical students choose to accompany patients at the end of life and what they find meaningful about that experience. Rather than focusing solely on measurable educational outcomes, this project considers the personal motivations behind choosing to participate. Understanding these motivations may provide insight into how students conceptualize presence as a form of care and how experiences such as NODA contribute to humanistic medical education.

In Support of Prolonged Grief: De-Medicalization and Acceptance

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In many Western spaces, grief discourse is limited to notions of resolution, progress, and closure (Kübler-Ross, 1969; Rando, 1984). When grief persists beyond a prescribed timeframe it is interpreted as pathological, under the diagnosis of prolonged grief disorder. Although the medicalization of prolonged grief may provide some griever with access to care, I contend prolonged grief support is beyond the scope of a medicalized framework. My work interrogates existing frameworks of prolonged grief, as well as beliefs about grief that carry unintended harms. In some cases, grief may induce tremendous suffering, deleterious health effects, and social alienation; others may feel their grief is unacknowledged, confusing, or otherwise illegible. Considering these harms, broader interpretive resources and greater social acceptance of prolonged grief is vital. Here I argue that grief is, by necessity, temporally extended over a long period, and thus, we ought to allow for prolonged grief without stigmatizing, medicalizing, or alienating those who are grieving longer.

First, I integrate popular philosophical accounts of grief to establish a working definition of grief. Though I acknowledge one can grieve non-humans, this discussion focuses on grief in response to the death of another. Central to my definition is the notion that grief is the emotional response to loss, and that grieving is the process of reflection, recognition, and reconstruction in light of loss. In agreement with Ratcliffe's (2023) account of grief, I contend this is a temporally-extended process, therefore requiring a prolonged processing period. This is where I ground my argument in support of accepting prolonged grief.

In contrast with this definition, I develop an account of Western grief norms, built from popular Western bereavement literature. I illustrate how the experience of loss is shaped by said sociocultural context and notably, normative expectations of grief. To better support individuals experiencing a prolonged grief process, I argue, we must challenge Western notions of grief as linear and periodic, with an expected timeframe that delineates "normal" grief from disordered grieving. To emphasize the importance of accepting a prolonged grief period, I focus on the potential benefits derived from an extended grief process. This section highlights grief's capacity for community building, narrative-construction, and self-understanding.

Following this section, I explore the potential harms of restricting prolonged grief. Aside from privation of potential benefits, I argue, restricting prolonged grief can actively harm grievers by way of "disenfranchising" their grief (Doka, 1999). Without the space or interpretive framework to engage with one's prolonged grief, their grief is in turn worsened. This may lead to alienation, a worsened sense of personal well-being, and the erosion of trust in supportive structures.

Finally, I consider the objection that to encourage one to accept prolonged grief is to tacitly imply one ought to experience a prolonged grieving process. I respond to this by exploring what my argument might entail for someone with a shorter grief process and the ways in which my analysis creates room for a wide variety of grief expressions.

Engineering Miracles: Heroic Doctors and Medical Technology in Television Drama

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In this paper, I consider the role of the hero doctor in contemporary American hospital drama. In particular, I will be looking at *The Pitt*, *The Resident*, and *New Amsterdam*, and how each foregrounds the defective doctor, a doctor with trauma. These doctors, who are all white, cis, men, are all shown to be heroic in their approach to medicine. However, this heroism is not linked to their empathy or care for their patients, but to their ability to see the body as a machine and to approach it as engineers. This is a shift from earlier models of the hero doctor and one that suggests a new focus in medicine, where the body is a technology to be maintained and optimized, and medical professionals become mechanics rather than caregivers. As medicine adopts technology such as artificial intelligence, then, the role of the physician moves from diagnosis and care-taking to tinkering and optimizing. This shift maintains the authority of the doctor but supplements it with the technology of artificial intelligence, suggesting that the relationship of medical professionals to technology will become that of operators rather than innovators.

Brain-Machine Interfaces: Emerging Technologies and Ethical Considerations

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Brain-machine interfaces present an exponentially growing field of medical technologies that pair users' brains with a machine, often a computer or AI-based program, to enhance, target, or connect different neural pathways for the purpose of treating medical conditions. Many brain-machine interfaces, often called brain-computer interfaces (BCIs), comprise a small, computerized chip that is implanted into the brain in order to send and receive electrical signals targeting the neural pathways associated with specific perceptual and physical functions.

We examine four case studies of emerging BCI technologies aiming to treat medical conditions, including epilepsy, paraplegia from spinal cord injuries, restoring speech lost due to stroke or neurodegenerative disease, and severe depression. The advent of artificial intelligence (AI) has greatly advanced BCI technologies as disease and individual-specific neural pathways are more readily decoded, processed, and stimulated using AI/machine-based learning.

BCIs aimed at treating epilepsy and treatment-resistant depression both have the potential to improve or preserve patients' lives by disrupting harmful neural signaling patterns. In the case of BCIs treating epilepsy, chips implanted into patients' spinal cords have been designed to anticipate seizure activity by recognizing patterns of electrical activity in the brain (Cerqueira, et al. 2024; Miron, et al., 2025). AI programs trained on videos of individuals' seizure presentations and monitoring neural activity have been used to improve the ability of BCIs to detect and electrically stimulate the neural pathways, ultimately preventing seizures. BCIs aiming to improve care for treatment-resistant depression, often a life-threatening and debilitating condition, are being marketed to recognize highly individualized neural patterns corresponding to depression, and to disrupt them to decrease depressive cycles and symptoms (Scangos et al., 2021; Paradromics, 2026).

Using AI-trained computer programs, BCIs are also programmed to anticipate and reproduce users' intended speech or actions. BCIs are being developed to stimulate movement that feels more natural to patients with paralysis from spinal cord injuries (Lorach, 2023; Valle, 2025) as well as to generate synthetic, i.e. computer-produced, speech for patients who cannot utter words due to strokes or neurodegenerative diseases (Paradromics, 2026). These BCI implants use AI programs to monitor and decode the immense number and variety of neural signals to learn what signals correspond to intended movement or speech. BCIs may also stimulate users' brains and/or spinal cords to generate these actions, whether through a patient's spinal cord to generate movement or through a computer program to speak in a patient's own voice, cadence, and tone.

Each application of BCIs to treat severe neurological conditions by detecting and modifying central nervous system activity raises fundamental questions about the nature of original thought, patient privacy, and the conditions under which consciousness and personal identity remain authentically one's own rather than the product of external influence (Parfit, "What We Believe Ourselves to Be," 1984). We seek to explore these emerging technologies and the ethical challenges they present, including privacy and data ownership, the relationship between AI and organic versus synthetic consciousness, personal identity among patients with disabilities, and equitable access to treatment.

Development of Humanistic Traits in First-Year Occupational Therapy Anatomy Students

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Student exposure to whole-body donors in an anatomy course presents an opportunity for health professions students to reflect on the role of humanism in their educational journey and in their future clinical practice. Humanistic values are defined by the Gold Foundation as integrity, excellence, collaboration/compassion, altruism, respect/resilience, empathy, and service. Studies have shown that patients who are cared for by humanistic health care providers experience an increased likelihood of adherence to their treatment plans, improvement in many physiological metrics (e.g., reduction of blood pressure levels, pain perception, and wound healing time), and improvement in many psychological metrics (e.g., improved cognitive performance and reduction of depression and anxiety levels). By introducing humanistic values and guiding students through intentional reflection during health professions programs, students can develop the necessary traits to prepare them for humanistic interactions with their future patients. To that end, an interactive anatomical humanism learning module was developed on the internet-based Perusall platform and was implemented into a clinical anatomy course administered to first-year doctoral occupational therapy students ($n = 40$) at a Jesuit higher education institution. The first part of the three-part module required students to collaboratively annotate and discuss a series of five text documents detailing the history of anatomical dissection and the progression of ethics surrounding human body procurement. Students then independently responded to a series of reflection questions requiring them to engage with the humanistic and ethical concepts elicited in the text documents, specifically on the role of respect when dealing with educational materials in general and on the role of respect when dealing with deceased human remains. According to inductive thematic analyses comparing these responses, when considering the role of respect concerning educational materials, students responded with the following major themes: consideration of access as a privilege, acknowledgement of the inherent responsibility of properly caring for them, and expression of appreciation for the effort involved in their creation. When considering the role of respect in the use of deceased human remains, students responded with the following major themes: consideration of the donor's loved ones and community, maintenance of proper care of the donors, humanization of the donors by honoring their dignity, and acknowledgement of the selfless gift of whole-body donation. While student responses for both categories addressed the caretaking of resources as a fundamental component of respect, students associated the care of donors as a reflection of the donors' humanity, dignity, and selflessness—thus articulating the values of compassion, integrity, altruism, and service. This demonstrates that exposure to, engagement with, and reflection on the history of anatomical dissection and the progression of ethics in the field can contribute to students' understanding of—and therefore, development of—humanistic traits. According to the tenets of virtue ethics, the development of humanistic traits (i.e., virtues) is the primary means to advance an individual's moral development. Thus, the exposure of occupational therapy students to an interactive anatomical humanism learning module promotes moral development, which thereby increases the likelihood that students ultimately become humanistic health care providers.

Working Sick: The Duties of Contagious Medical Providers

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Sickness presenteeism (SP) is a long-standing phenomenon in which a person works when ill. During the pandemic, this practice was augmented, at times with nearly half of medical providers working with active COVID-19 symptoms. The phenomenon of contagious SP, among medical providers is a serious concern because of the risks to their patients and coworkers. When a person works while sick with a severe contagious disease (SCD), the phenomenon is known as severe contagious disease presenteeism (SCDP). An SCD can be characterized as (1) a disjunctive state that is either a chronic, incurable disease with life-altering symptoms or a non-chronic/curable disease with incurable, long-term, and potentially life-threatening consequences for specific populations (e.g., the immunocompromised or the elderly) and that (2) carries a significant risk of transmission. The ethical obligations of medical providers engaged in SCDP is the central concern of this paper. In addressing medical providers working with SCDP, we explore: the moral and professional obligations of severely contagious medical providers to their patients against imposing unnecessary risk or harm caring for seriously ill patients; and institutions' moral and ethical obligations to provide guidelines, as well as support for medical workers to prevent or manage SCDs, and the role of informed consent. We argue that: (1) medical providers have a stronger obligation to aid or rescue their patients, that requires them to accept a certain degree of health risk to themselves; (2) medical providers also have a strong duty to mitigate risk to their patients; (3) and to ensure their patients are aware of and consent to or deny treatment due to the risks associated with care provided by a medical professional with an SCD, and that the medical providers' right to medical privacy is to some extent circumscribed by informed consent requirements. The practical applications of these special obligations are examined and debated through comparing practices in the U.S., UK, South Africa, and Canada. First, we discuss in favor of establishing general guidelines to minimize decision-making burdens on individual medical providers. Second, we defend an institutional duty to support medical providers by, among other things, covering vaccination or antiretroviral expenses to ensure medical providers are not unduly burdened. Third, we argue that, in cases where a medical provider with an SCD provides a service with zero risk of transmission, there is no obligation for the medical provider to disclose their SCD to the patient. In conclusion, medical providers have an ethical duty to aid and rescue. It is necessary for medical providers to assume a degree of personal risk, as well as informed consent disclosure for their patients. Establishing standard guidelines and protocol for when medical providers are expected to work, is fairer and more morally preferable to a system in which they are the sole decision-makers. Medical institutions requiring and subsidizing vaccines and treatments that ensure medical providers do not work under the burden of risk or infect patients with SCDs would ensure protective measures for the patient and provider.

Hope Doesn't Heal—Environments Do

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A growing body of literature highlights a correlation between hope—generally defined as one's perceived ability to achieve their goals—and improved health outcomes. Responding to the apparent therapeutic benefits of hope, calls for interventions designed to increase patient hope are widespread in this literature. Yet, contra initial appearances, the evidence regarding the putative health benefits of hope is likely much weaker than discussions in the positive psychology literature indicate.

To see why, consider two hypothetical case studies. In the first, Andre's leg is amputated. He has little familial support and is thus forced to reside in a nursing home style rehab facility. He becomes unmotivated and discouraged and experiences a prolonged recovery time. In the second, Erica also gets her leg amputated. She has a husband and daughter who support her at home and drive her to outpatient rehab. She is motivated and empowered in her activities and recovers ahead of when she is expected.

The standard explanation of the correlation between hope and improved health outcomes appears to rely on an explanatory strategy characteristic of what disability scholars label "the medical model." The medical model views disability as a deficit of the individual and, concomitantly, holds that interventions should target features of the individual. Hope in the current literature is viewed in this same way: as a state of an individual.

When viewed from the perspective of the medical model, it makes sense to design interventions that aim at making patients increasingly hopeful. Using the case studies above, it would then be pertinent to address Andre's discouraged and despairing mindset to help increase his likelihood of rehabilitation success. In Erica, this model would point to her positive and constructive attitude as a key to her eventual rehabilitation success. This explanatory strategy, however, fails to account for a key puzzle piece: environmental variables. In contrast to the medical model, the social model of disability focuses on the ways in which an ableist or unaccommodating environment creates disability. The social model of disability suggests an entirely different analysis of the case studies above. In particular, the social model draws attention to environmental variables, including the supports—or lack thereof—available to Andre and Erica.

Shifting emphasis away from the individual and toward environmental variables suggests a distinct explanation of the correlation between hope and improved functional outcomes. In this explanation, environmental supports are the primary predictors of functional outcomes—Erica flourishes while Andre languishes because Erica, but not Andre, has the supports necessary for successful rehabilitation.

These environmental supports further explain why Erica is hopeful and Andre is not. While the contemporary literature on hope and health outcomes offers a linear, causal relationship between hope and improved health outcomes, the social model suggests a third-factor explanation whereby the extent to which the environment is disabling offers a causal explanation of both functional outcomes and of hope.

Contrary to the understanding dominant in the literature on hope and health, it is premature to assume that hope causes improved health outcomes.

Understanding HIV/AIDS: A Medical Student Film and Book Club

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Current medical education places a strong emphasis on the scientific principles underlying disease, providing students with the knowledge necessary to be competent physicians. However, opportunities for students to engage with the medical humanities are not as often available in the traditional curriculum. Narrative medicine allows students to better understand patient experience and appreciate the human impacts of illness, which can help develop empathy for the patient. To help bridge this gap, a medical-student run film and book club was created to provide an open forum where students could discuss medicine through literature and film while exploring the social, historical, and ethical dimensions of disease.

The first semester centered on the theme of HIV/AIDS through two films, *How to Survive a Plague* and *Philadelphia*, and one novel, *The Great Believers*. The order of presentation was intentionally designed to provide chronological perspectives on the epidemic. *How to Survive a Plague* served as the historical foundation, using archival footage to document the realities of the HIV/AIDS epidemic, the fight activists went through, and how triple therapy changed their lives. *Philadelphia* then shifted the discussion to a fictional narrative, allowing students to compare documentary history with a dramatized portrayal of a person experiencing the disease while examining prejudice and discrimination in mainstream media during the early 1990s. Finally, *The Great Believers* provided a more intimate and reflective perspective through literature, exploring the enduring effects of grief and loss, while reflecting on how the consequences of the epidemic continued long after the 1990's. Student reflections showed that each work contributed a unique perspective to understanding HIV/AIDS. *How to Survive a Plague* highlighted the resilience of patients and activists who fought for treatment and survival. Members reflected that the documentary transformed HIV/AIDS from a scientific disease into the lived experiences of real people, putting into perspective the profound human cost behind medical advances. *Philadelphia* prompted discussion surrounding stigma, physician bias, and the influence of public perception on healthcare. Students recognized that prejudice affects not just society but also healthcare professionals, emphasizing the importance of approaching every patient with compassion regardless of diagnosis or identity. *The Great Believers* encouraged deeper reflection on grief, loss, and the physician-patient relationship. Participants discussed how a physician's responsibility extends beyond treating disease into helping patients navigate the social, emotional, and psychological burdens that accompany serious illness.

Discussions extended beyond HIV/AIDS itself, drawing comparisons between activism during the AIDS epidemic and more recent activism during the COVID-19 pandemic. The group explored themes of misinformation, advocacy, resilience, and collective trauma. Together, documentary film, narrative cinema, and literature provided complementary, yet unique perspectives that challenged students to consider not only the science of disease but also the human emotion and strife that goes along with it. A student-led film and book club represents an engaging way of incorporating narrative medicine into medical education while fostering empathy, reflection, and a broader understanding of being a physician beyond traditional classroom instruction.

Eat, Sleep, Console and the Protection-Inclusion Dilemma

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The history of medical research includes numerous examples of exploiting vulnerable populations for the sake of gathering scientific information. In response to infamous cases of research misconduct, e.g., Tuskegee, Willowbrook, The Monster Study, the experiments at Holmsburg prison, federal regulations now exist to protect vulnerable populations from mistreatment and harm. However, as a result of the barriers to participation introduced by these federal regulations, vulnerable populations are often excluded from research altogether. This leads to a lack of data regarding significant groups of people in clinical trials. This tension is known as the protection-inclusion dilemma: efforts to protect vulnerable populations often lead to their exclusion from research, thereby creating so-called "therapeutic orphans." "Eat, Sleep, Console" (ESC), a new treatment protocol for neonates suffering from Neonatal Abstinence Syndrome (NAS), offers an important case study that illustrates, contra the received understanding in the research ethics literature, that contemporary federal regulations provide neither inclusion nor protection. ESC involves decreasing pharmacological intervention for patients with NAS and, instead, focusing on three key metrics of infant wellness: the ability to eat, sleep, and be consoled. ESC has arguably become the new standard of care. Nonetheless, as McGregor & Graber (2026) highlight, the evidence-base on which ESC's ascendance is predicated provides no reason to believe that ESC is better for neonates with ESC. Instead, given that neonates with NAS are a uniquely vulnerable patient population, they have been included in very few IRB-sanctioned clinical trials. Rather, most of the work to evaluate the safety and efficacy of ESC has been classified as (QI) projects and therefore bypassed standard IRB oversight. As QI initiatives, the data collected by these projects is limited because they are not subject to the rigorous ethical safeguards required of IRB-approved clinical trials.

The protection-inclusion dilemma suggests that there exists a balance between protection and inclusion; in other words, more of one often results in less of the other. ESC presents a different possibility. In the case of ESC, the vulnerable population in question is not adequately protected as infants are subject to significant procedural changes without the ethical oversight required by IRB-approved clinical trials. At the same time, the population is not included because the limits of the QI framework prevent the collection of meaningful clinical data regarding safety, efficacy, and patient outcomes. Thus, infants with NAS are neither adequately protected by ethical safeguards nor effectively included in research. As such, rather than viewing contemporary federal regulations as protecting vulnerable populations from research misconduct at the cost of excluding them from research, the current regulatory structure appears to, at least with regard to some uniquely vulnerable populations, exclude vulnerable populations from research while also denying them the protection afforded by rigorous IRB review.

Time in Tablets

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The modern pharmaceutical tablet is one of the most common delivery forms of medication, yet its production is the result of centuries of scientific, technological, and manufacturing advancements. What is often viewed as a simple dosage form has evolved through a history of innovation that transformed the preparation of medicines from a manual craft into a highly automated industrial process. Without these developments, the large-scale production of safe, effective, and affordable medications would be impossible, and access to essential treatments would be severely limited.

During the seventeenth century, apothecaries prepared medications by hand using basic tools and labor-intensive methods. Pills were produced in small batches, requiring significant time and skill to ensure consistent size and dosage. As scientific knowledge and mechanical technologies advanced, new equipment was introduced that increased production efficiency and improved product uniformity. By the nineteenth century, pharmacists could manufacture small batches of tablets directly within the apothecary using presses and molding devices. Over time, mechanized equipment, improved formulation techniques, and advances in quality control enabled the transition from local production in pharmacies to large-scale manufacturing facilities. These innovations allowed pharmaceutical companies to produce millions of tablets efficiently while maintaining high quality standards. This presentation will examine the evolution of pill and tablet manufacturing over the past 400 years, tracing the progression from handcrafted preparations in seventeenth-century apothecaries to the highly sophisticated automated processes used today.

Narration as Technology in Aristides' Sacred Tales

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Aelius Aristides' (117-181 CE) *Sacred Tales* chronicles the noted second-sophistic rhetor's chronic illness and its treatment. In his account, Aristides includes descriptions of over 130 dreams. The number of dreams related is not surprising given that both Aristides and his physicians assume that dreams are ways that the gods (those who might visit illness on human beings) use dreams to communicate with human beings and, as such, dreams provide information essential to the healing process.

This presentation will first briefly describe the role of dream interpretation in the healing process as it was institutionalized in Aristides' society, including a consideration of the importance of dream interpretation for those who did not assume them to be a form of divine communication. Secondly, the presentation will examine the narratological function of dreams in Aristides' story of his illness. What emerges is not the assertion of dreams or dream interpretation themselves as technologies. Rather, what emerges is a strong case for examining narration as a technology, a tool for understanding whose purpose is built into its being. And, thirdly, the presentation will unpack the idea of narration as a tool for understanding as an exigency worthy of consideration, both for those whose primary focus is narrative medicine and those developing tools to assist patients in telling their stories in but not as a techno-medical space.

Advancing Medicine, Advancing Equity: Cerebral Palsy and Ethical Transplant Access

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Introduction: Cerebral palsy is a disorder affecting approximately 2.6-2.9 per 1000 in the United States, based on data from 2011-2013 from the National Survey of Children's Health and the National Health Interview Survey. Worldwide, there is an estimated incidence of 1 to 4 per 1,000 live births. The disorder is broad and has wide-reaching complications that physicians must keep in mind now that technological advances in medicine have allowed patients with cerebral palsy to live well into adulthood. Although literature has been generated to focus on how to approach care for adult patients with cerebral palsy, fewer resources have specifically addressed ethical considerations relevant to pediatricians caring for children with cerebral palsy.

When it comes to curriculum, in the United States there is a lack of education on ethical topics for medical providers. Currently, the US lacks strict requirements regarding ethical education or hands-on ethical learning. This becomes increasingly evident in the pediatric realm where the ACGME does not require dedicated instruction in ethics. Although continuing medical education opportunities in bioethics are available, existing programs focus on topics surrounding research, social determinants of health, and gender-affirming care. While these are important topics within the field of pediatrics, additional attention should be given to ethical issues that frequently arise while caring for medically complex children, including decisions surrounding organ transplantation.

We argue that complex medical conditions including cerebral palsy should not independently limit a child's access to an organ transplant or placement on the transplant list. While cerebral palsy is the condition we chose to illustrate our perspective, other medical or socially complex situations could be substituted with the same results. Cerebral palsy provides a relevant framework because increasing survival has transformed the condition from primarily a childhood disability into a lifelong medical condition requiring multidisciplinary care. As medical technologies continue to advance and patients live longer, it is now more common for primary care physicians to care for patients with this medically complex condition. This also means that ethical questions about access to potentially life-saving therapies will continue to develop and evolve.

Discussion: As medical technology continues to advance, children with cerebral palsy are living longer. Physicians must consider not only the quality of care for these patients but also equitable access to future medical interventions. This presentation highlights ethical considerations that primary care physicians should recognize when caring for a child with cerebral palsy, with special attention to barriers to organ transplantation. We argue that there should be no additional barriers to accessing the transplant list if a child has the diagnosis of cerebral palsy. Additionally, we argue that patients with cerebral palsy should not be denied access to an organ transplant solely based on their diagnosis. In the future, educational courses ought to include a curriculum that covers complex ethical concerns. This will allow physicians to have increased confidence and preparedness when caring for children with complex medical needs, like those with cerebral palsy.

Using Picture Books to Educate Children About Physical/ "Mental" Illnesses

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In 2024, I presented at WMU on the topic of "Parallel discoveries of illness causality in history and in childhood". I would now like to focus on the usefulness of developmentally-appropriate children's picture books to explain the causes and symptoms of various illnesses/disorders that are physical (e.g., diabetes), mental (e.g., depression), or neurodevelopmental (e.g., Tourette's) in a soft-tell scaffolded approach. Picture books, and the repeated reading of stories about an illness can easily be used by parents/caregivers/teachers/librarians to introduce difficult topics as a bridge to conversation.

The focus here will be neurodevelopmental disorders. I will suggest that if we can somehow scaffold interventions using children's books to increase children's understanding of the brain-based causes of certain disorders, diagnosed children may then be more amenable to treatment, able to educate others, and better advocate for themselves. And highly informed siblings and peers may be more positive in their attitudes and interactions with a diagnosed child.

The issue of using relevant picture books, e.g., about Tourette's or Autism, has been the subject of some of the research projects that I, along with many undergraduate students over the last couple of decades, have conducted with elementary school age children. (e.g., Newman, Jacobs, & Janovsky, 2004; Newman, Nagaraj, & Scott, 2009). We tried to avoid interventions that used mechanically-based metaphors such as representing the brain as a car having faulty brakes. Metaphors and analogies such as these may overestimate the cognitive abilities of very young children.

While research indicates that picture books can sometimes be effective in changing attitudes that children hold about a hypothetical peer with the disorder, the subject of future research should be whether an increase in knowledge or understanding is in fact the mediating variable that affects changes in attitude towards someone with the disorder; whether there would be changes in actual behavioral interaction with a real peer with the particular disorder; and whether any such change(s) would be long-lasting.

It is striking how so few of the published illness-related picture books speak of the actual causes of illness/disorders. Turner (2006, pp.183-4) found that the majority "contained no content specific to causation." In our more recent content analysis study (Newman, McGurk, & Colkett-Harvey, 2017), we found that only 50% of the analyzed books mentioned the cause of the disorder (e.g., Down Syndrome is having an extra chromosome) but more of these books were actually published before 2000 than after. Perhaps the writers of such picture books could consult with medical/clinical professionals and/or developmental psychologists. I would agree with Sakai et al. (2012), who concluded that while it may not be fair to hold storybooks to the same educational standards as other sources of information, these books could aim to be more accurate and comprehensive.

If time allows, I will also share with the online audience a book written by 2 of my undergraduate student researchers in 2022 called "PJ's Big Plan: An Everyday (Pandemic) Adventure Story".

Beyond the Algorithm: Literature and the Human Dimensions of Medicine

Jina Park

Philadelphia College of Osteopathic Medicine

As artificial intelligence becomes increasingly integrated into medicine, discussions of its future center on a technical question: What will AI be capable of doing? Literature offers an equally important question: The growing role of technology in medicine raises questions about the boundaries between technological advancement and the uniquely human aspects of care. Long before the emergence of artificial intelligence in clinical practice, literature explored the responsibilities that accompany scientific and technological advancement. Modern narratives about illness reveal that the experience of illness extends beyond clinical knowledge, encompassing more personal questions of suffering, mortality, and meaning.

This presentation uses comparative narrative analysis of Mary Shelley's *Frankenstein* (1818), Kazuo Ishiguro's *Klara and the Sun* (2021), Paul Kalanithi's *When Breath Becomes Air* (2016), and Atul Gawande's *Being Mortal* (2014), alongside scholarship in narrative medicine and artificial intelligence. Together, these works illuminate dimensions of medicine increasingly challenged by technological advancement: responsibility, empathy, meaning, and human connection.

In *Frankenstein*, scientific creation becomes inseparable from responsibility. Victor Frankenstein's failure lies not simply in creating life, but in failing to accept responsibility for the consequences of his creation. Alongside issues with modern-day AI, Shelley's novel raises questions about whether the ability to create powerful medical technologies is accompanied by adequate consideration of how they should be used. *Klara and the Sun* complicates the distinction between human and artificial care. Klara's (artificial friend) keen observation, loyalty, and warm empathy raise an increasingly relevant question in medicine: if an artificial entity can convincingly reproduce caring behavior, is that equivalent to understanding another person's suffering? Kalanithi and Gawande's discussion also directs these questions to the bedside. In *When Breath Becomes Air*, Kalanithi's transition from neurosurgeon to terminally ill patient reveals medicine as an experience not only with disease but also with identity, uncertainty, mortality, and meaning. *Being Mortal* similarly challenges the tendency to equate technological intervention with successful care, emphasizing instead the importance of understanding what makes life meaningful to an individual patient.

Together, these narratives suggest that the central challenge posed by artificial intelligence is not simply whether machines can perform tasks traditionally performed by physicians. AI can increasingly synthesize clinical information, predict outcomes, document encounters, and generate empathetic language. The more difficult question is whether performing the language and actions of care is equivalent to robust patient care and the authenticity of empathy/care shown by humans.

Rather than treating literature as a warning against technological progress, this presentation argues that stories provide a framework for determining the values that should guide it. As the medical community asks what artificial intelligence can do for patients, literature asks us to consider a complementary question: What does it mean to care for someone when technology can increasingly imitate caregiving practices?

AI Scribes as Educational Mirrors Closing Physician Communication Feedback Gaps

Joshua Park

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Healthcare systems are rapidly adopting ambient digital scribe (ADS) technologies to reduce documentation burden and improve efficiency in clinical care. Although these systems are typically framed as technical tools that listen to patient dialogue, they also capture physician speech, creating an underexplored opportunity for ethical and pedagogical innovation. At present, everyday patient-physician interactions largely occur without systematic reflection, producing a persistent "feedback gap" in which deleterious communication often goes unnoticed. This paper argues for a reframing of ADS as "educational mirrors," using AI-generated annotations and transcripts to provide physicians with formative feedback on communicative patterns and language that shape patient experience. I theorize the benefits of this reframing on a stakeholder-specific basis, analyze central ethical concerns, and propose governance safeguards and careful implementation to minimize potential harms. With appropriate consent, validation, and equity-centered design, reframing ADS technologies could help close the feedback gap and promote more ethical clinical care.

Teaching Empathy Across Languages: AI-Supported Simulation Training for Medical Interpreters

Elsa Perez, PhD
Utah State University

Medical interpreters occupy a unique position at the intersection of language, healthcare, culture, and human experience. While interpreters are expected to accurately transfer information between patients and providers, they must also navigate emotionally charged encounters involving pain, uncertainty, trauma, and complex medical decision-making. Traditional interpreter training relies heavily on classroom role-play and limited live practice opportunities, making it difficult to provide repeated exposure to authentic healthcare interactions.

This presentation examines the use of artificial intelligence-supported simulation technologies to prepare future medical interpreters for the human dimensions of healthcare communication. Drawing on the development of Utah State University's Medical Interpreting Training Program, the project integrates AI-generated patient scenarios, multilingual video simulations, structured feedback systems, and reflective practice activities designed to strengthen both linguistic performance and empathetic engagement.

The study explores how simulation-based learning affects interpreter self-efficacy, confidence, ethical decision-making, and preparedness for real clinical encounters. Preliminary findings from student and community interpreter cohorts suggest that repeated exposure to realistic healthcare scenarios increases confidence in managing complex conversations while providing opportunities to reflect on issues of cultural humility, patient advocacy, and professional boundaries.

Rather than replacing human instruction, AI functions as a tool that expands access to deliberate practice and individualized learning experiences. The presentation argues that emerging technologies can support a more human-centered approach to interpreter education by helping trainees engage more deeply with patient narratives and the ethical responsibilities of language access in healthcare.

By situating interpreter education within the broader medical humanities framework, this work highlights the importance of language as a critical component of compassionate care and demonstrates how technological innovation can strengthen, rather than diminish, the human relationships at the heart of medicine.
Keywords: empathy, medical interpreting training, AI Gen Simulations Experiential learning, Student Self-Efficacy

Hidden in Plain Sight: ADHD in Medical Education

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Attention-deficit/hyperactivity disorder (ADHD) appears more prevalent among medical students than in the general adult population, particularly when symptom screeners and self-report tools are used. In learning environments where nearly all students feel overworked, distracted, and disorganized, ADHD-like difficulties are often normalized as the expected cost of medical training rather than recognized as possible indicators of disability. Drawing on epidemiological data, outcome studies, and phenomenological accounts of students with ADHD, this article argues that medical education routinely blurs the line between ordinary struggle and ADHD-related impairment. In this context, ADHD is frequently acknowledged only after academic failure, leaves of absence, or exam breakdowns, creating a paradox in which successful entry into medical school is used to cast doubt on the legitimacy of impairment.

I read this literature through a medical-humanities lens, bringing critical ADHD studies into conversation with work on the hidden curriculum, "suffer culture," and professionalism in medicine. Phenomenological studies show diagnosis functioning as a form of epistemic permission for students with ADHD—reframing long-standing shame and enabling self-advocacy—yet institutional responses often remain limited to extra time and individual "resilience." I suggest that a more just response would treat lifestyle medicine and neurodiversity-informed design as ethical obligations at the level of curriculum, scheduling, and assessment, rather than optional wellness add-ons. When we accept ADHD as a different way of being rather than a personal defect, it becomes clear that medical training cannot rest on individual willpower alone. Institutions, not just students, are responsible for creating conditions in which ADHD learners can thrive instead of repeatedly being cast as failures—and in which the system is more humane for all.

AI as a Means of Alleviating Hermeneutical Injustice

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There has been an increasing adoption of large language model (LLM) use amongst the general population. A notable use case is patients' attempts to understand complex medical information and prepare for encounters with physicians. This increased utilization brings to light a longstanding but common issue within healthcare: hermeneutical injustice, in which an individual is unfairly disadvantaged in their ability to make sense of or communicate their own lived experience due to gaps in the interpretive resources available to them (Fricker, 2007). A patient unable to articulate diffuse pain, mood change, or bodily distress in clinically legible terms experiences exactly this kind of injustice. Hermeneutical injustices in medicine can easily result in real harms such as delay in care, misdiagnosis, and inappropriate treatment. I argue that LLMs offer a novel tool for alleviating hermeneutical injustice in medical contexts.

Historically, proposed strategies to address hermeneutical injustice have centered on structural reform and the cultivation of individual epistemic virtues, both of which occur slowly and depend on individuals' motivations and values. LLMs offer a more immediate intervention. Their capacity for natural language processing allows them to take a patient's own description and map it onto existing clinical concepts, narratives, and frameworks, reflecting these back in language suited to the patient's level of understanding. In doing so, LLMs effectively bridge the interpretive gap between a patient's personal understanding of their lived experience and a clinically legible description of their illness. A patient equipped this way may be able to more precisely name symptoms patterns, ask in depth questions, and ultimately better advocate for themselves.

On Fricker's original account, hermeneutical injustice arises from a conceptual gap, in which the relevant concept is absent from the collective hermeneutical resource altogether, such as when Carmita Wood lacked a term for what she would later name sexual harassment. One could object that, due to the inherent mechanism of LLMs or their current technical limitations, LLMs are capable only of selective rather than creative abductive reasoning (Gouveia & Malík, 2024), and so cannot generate genuinely novel concepts. Within this framework, LLMs could never resolve the underlying lacuna caused by the absence of a concept, and their assistance would likely remain superficial.

While this is a genuine limitation for LLMs' ability to lessen hermeneutical injustice, other epistemic injustice theorists have argued that hermeneutical injustice may be better understood as a distributive injustice (Simion, 2019), or in other words, a circulation gap, not a conceptual one. In this case, existing epistemic goods are unjustly withheld from certain knowers rather than absent from the collective pool altogether. LLMs may be well-suited to the selective abduction that such cases require. LLMs can retrieve and apply existing concepts to a patient's account, including underrepresented or marginalized presentations of illness that might otherwise go unrecognized. Even without creative capacities, LLMs may be able to alleviate hermeneutical injustice by easing access to existing interpretive resources for patients harmed by unjust circulation.

Socializing Robots for Effective Elder Care: A Pilot Interview Study

Shaun Respass, PhD
North Carolina State University

Social robots are a promising technology for assisting older adults with routine tasks, medication and schedule reminders, and emergencies. Several studies claim that robots might be socially and psychologically beneficial for older adults and would extend the time that they can safely remain in their homes, in addition to helping alleviate burdens related to conditions such as dementia or mild cognitive impairment. However, current applications of social robots to support these adults are limited and fragmented, with lingering ethical questions related to their proper compatibility, functionality, and safety for different users. We conducted a qualitative interview study to assess the social and practical preferences of older adult (n=11) and caregiver (n=9) stakeholders during which they participated in interactive protocols with a humanoid Pepper robot. In this study, two protocols were delivered to each participant, one of which was conducted using a prototype, locally-run large language model. Our results confirm that an overwhelming majority of participants in both cohorts believe social robots to be a valuable companion for older adults and are especially equipped to support those experiencing loneliness. However, participants raised concerns about the accessibility, design biases, and security of the robot, and especially emphasized the increasing ways in which robots are becoming anthropomorphized. Such insights point to the increasing need for adaptive ethical guardrails to support aging in place.

Uncertainty-Driven Healthcare Epistemic Injustice: Evidence from Chronic Fatigue Syndrome.

Hugh Robertson-Ritchie, PhD

University of Kent

In this presentation, I argue for the substantial role of deleterious radical uncertainty regarding chronic fatigue syndrome (CFS) as an explanation for unsatisfactory CFS healthcare encounters. This explanation is additional to the explanations given by other commentators, that is to say, power asymmetries and the differing epistemological and phenomenological perspectives of patients and healthcare professionals, along with stigma and prejudice against CFS and against CFS patients (Blease et al. 2017; Kidd and Carel 2018). Finally, I suggest routes to amelioration.

Many chronic fatigue syndrome (CFS) patients report experiencing unsatisfactory healthcare encounters, in those situations where patients and their healthcare professionals have divergent and oppositional conceptualisations regarding the nature of CFS and the justification and effectiveness of treatment recommendations for it.

Chronic fatigue syndrome (CFS), also known as myalgic encephalomyopathy (ME), is a poorly-understood, debilitating, and stigmatising long-term medical condition characterized by prolonged periods of fatigue, chronic pain, depression, and a complex constellation of other symptoms (Richman et al. 2019). These symptoms can last for years, and often greatly restrict the patient's life, including long-term restrictions on work, family life, and socialisation. The mechanisms of CFS have not been adequately identified, there are no curative treatments available, and symptomatic treatments are in many cases not particularly helpful, so many CFS patients continue to suffer for years. CFS is therefore subject to radical uncertainty.

Some healthcare professionals respond to these major uncertainties about CFS by recommending psychological and behavioural treatments for CFS (the 'biopsychosocial model' – BPS), which address only the symptoms, with cognitive and exercise therapies. In opposition to this view, many CFS patients and their support groups insist that CFS should be understood using the biomedical model (BMM), because most of the symptoms are physical rather than psychological (Spandler & Allen 2018), even though biomedical mechanisms that could explain the onset, the symptoms, and the course CFS, have not been identified; and no biomedically-based curative treatments for CFS have yet been discovered.

Because of these differing and oppositional responses to these uncertainties, CFS patients feel stigmatised in their healthcare encounters by the view that their condition is not 'real', or is psychological rather than physical; and these CFS patients feel bullied by healthcare professionals into receiving cognitive and behavioural therapies, even though these treatments seem to patients to be ineffective and harmful. These oppositional positions explain conflict in CFS healthcare encounters.

However, in the face of uncertainty, I see that, both BPS and BMM are reasonable reactions to what is scientifically known and not known about CFS, and how CFS is experienced; however, I argue that the rejection of an opposing model is epistemically vicious.

Instead, for amelioration, I suggest the compromise of a shared non-confrontational and non-stigmatising re-conceptualisation of CFS, that of 'persistent physical symptoms' (PPS). PPS is the experience in many other physical conditions such as musculo-skeletal injuries, where some patients (for reasons not completely understood) take a great deal longer than others to recover, and where treatments concentrate on addressing the individual's symptoms.

The Monopoly Argument Against Conscientious Refusal in Health Care

Michael Robinson, PhD

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Grand Valley State University

The most popular arguments against accommodating conscientious objection in health care focus on claims that conscientious refusal is incompatible with practitioners' fiduciary duty to put patients' interests ahead of their own, that these clinicians voluntarily chose to enter the medical field, and that they knew what they were signing up for when they took on these professional roles. There is another argument, however, that is frequently offered by opponents of conscientious refusal but has received far less critical attention. According to this argument, the fact that licensed medical professionals enjoy government-created monopolies on various medical treatments and services constitutes a further reason for thinking that these professionals should not be permitted to refuse to provide these treatments and services merely because they conflict with the professional's personal moral convictions. Call this the monopoly argument against conscientious refusal in health care.

One problem with this argument is that it is not at all obvious why having a monopoly on a given good or service is itself sufficient to generate an obligation to provide that good or service to others—let alone an all-things-considered obligation to do so, including when this would involve violating one's conscience and compromising one's moral integrity. The fact that an individual is uniquely positioned to do something that would benefit others might plausibly give rise to an increased obligation to do so—as in the case of a person who discovers a car crash victim on a remote highway—but these obligations can be outweighed. It also makes a difference to the analysis what role, if any, a person played in coming to have such a monopoly. (Did they help bring it about that they possessed such a monopoly? Did they oppose it?) Furthermore, even if an individual belongs to a group that enjoys a certain monopoly, and even if that were sufficient to generate increased obligations for the group to provide the monopolized services, that obligation does not automatically and obviously transfer to every individual member of that group.

Although most versions of this argument treat the fact that health care providers have a monopoly on most medical services as a standalone reason against both engaging in and permitting conscientious refusal, this consideration can also be incorporated into a larger, distinct argument toward the same end. One prominent example of this can be found in the recent book by Giubilini, Schuklenk, Minerva, and Savulescu, *Rethinking Conscientious Objection in Health Care* (2025, Oxford University Press), which develops a contractarian argument against conscientious refusal. According to this account, clinicians' professional obligations are grounded in a contract between the medical profession and society: society grants licensed medical professionals a monopoly on dispensing and providing various drugs and medical services, in return for which the profession agrees to act in the public interest and set personal interests aside. Ultimately, this version suffers from the same fatal weakness as many other contractarian arguments that attempt to ground actual obligations in merely hypothetical agreements.

Is AI a Doctor or a Drug?

John Sarnecki, PhD

University of Toledo

The rapid integration of artificial intelligence (AI) in clinical medicine has exposed a profound regulatory lacuna. Contemporary oversight frameworks, such as the U.S. Food and Drug Administration's (FDA) Software as a Medical Device (SaMD) category, are designed for static, preprogrammed technologies. However, these paradigms are poorly equipped to govern auto-updating algorithmic technologies. Moreover, companies currently developing AI applications in medicine have exploited the regulatory void to circumvent existing protocols through multiple characterizations of the technology itself. Investors may be pitched one description of a technology and its uses, while regulators may get another.

This may result in a dangerous equivocation between how a technology is applied and how it is regulated. I argue that identifying the ontological properties of these systems should guide how we adapt regulations to integrate them into clinical contexts. By asking how we conceptualize a given clinical algorithm as a static tool (resembling a drug or medical device) or as an autonomous agent (resembling a licensed medical professional undergoing continuous peer evaluation), we can begin to construct an appropriate regulatory response to these issues.

To map out this ontological boundary, I examine three distinct clinical domains. I look at how some automated technologies, like closed-loop insulin delivery systems, may employ machine learning techniques that are compatible with current device-centric regulations. Though automated, insulin regulation requires no special monitoring outside of SaMD oversight. However, when we consider increasingly ubiquitous virtual clinical assistants, like chatbot OpenEvidence, more regulation is required. Despite attempting to mitigate hallucinations by restricting training data to elite academic medical journals, these closed systems cannot help but replicate academic bias while also reflecting ongoing uncertainty in clinical practices that new studies are designed to address. Academic journals may not be the best place from which to draw clinical best practices. Finally, I investigate applications of clinical AI in the use of predictive deep-learning models in medical imaging. In this case, I examine the EAGLE model used to predict lung cancer EGFR mutations from standard biopsy images. While clinically revolutionary, the operation of these predictive networks is not transparent. We cannot identify what properties of the stained images are being used to identify the target mutations. Consequently, we require special regulatory oversight to determine the circumstances in which to apply these diagnostic applications, especially as they are sensitive to new data and confirmatory testing.

Each of these technologies presents unique regulatory problems that may be best addressed by establishing the regulatory system that most closely approximates their operation. However, we currently lack the means to address these advances outside of the extremely limited technological oversight we currently possess. By focusing only on clinical outcomes, we cannot address how such technologies evolve and change themselves over time. By thinking of AI tools as similar to medical professionals, who undergo continuing medical education or licensure review, we can address the ontological shift from tool to clinical agent.

Medicine's Waismann Problems

Eli Schantz

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Semantic indeterminacy—whether in the form of vagueness, cluster concepts, family resemblances, or open texture—is a general feature of everyday communication well-appreciated by philosophers of language. In recent years, philosophers of medicine have paid increasing attention to the ways in which semantic indeterminacy impacts various isolated debates in medical ontology; however, there has been no systematic study of the ways in which semantic indeterminacy affects the philosophy of medicine or clinical practice, nor have the consequences of those effects and the need to address them been outlined. My aim, here, is to do just this. First, I defend the claim that semantic indeterminacy, rather than being limited to only certain unique terms, is a generalized feature of medical terminology: semantic indeterminacy not only impacts normative terms in medicine—e.g.: 'harm,' 'consent,' and 'disease,' where such impacts are increasingly appreciated—but also quotidian empirical terms thought to carve nature's joints, from 'diabetes' and 'pneumonia' to 'hyperkalemia' and 'malignant'. Second, I argue, contrary to philosophers of mathematics and law who regard semantic indeterminacy as an important feature of professional languages, that semantic indeterminacy poses significant problems both for the philosopher of medicine and the medical practitioner. In the case of the former, I argue that many ongoing debates in medical ethics, from abortion and gender to paternalism and brain death, fundamentally involve disagreements about the meanings of medical terms; in the case of the latter, I argue that semantic indeterminacy not only poses a challenge to policy makers charged with outlining disease processes and treatment guidelines, but is also a significant and underappreciated contributor to miscommunication both between clinicians and between clinicians and patients. I call these, after the 20th century philosopher of language Friedrich Waismann, "Waismann Problems."

Third, I argue that appreciation of these problems puts pressure both on philosophers of medicine and medicine's governing bodies to seek a paradigm shift: if we are to resolve philosophical or clinical debates, then we must understand what our terms mean. And if we are to do this, we must do something which has not yet been done: understand how we are to navigate semantic indeterminacy when the meanings of medical terms are, in some cases, literally a matter of life and death. I conclude with a sketch of how this might be done: namely, through an articulation of medicine's teleology, and the assessment of how our terms serve these ends.

The Ethical Use of Patient Images for Interpretation by AI

Rachel Shrivastava

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Artificial intelligence (AI) continues to be integrated into medical practice at a rapid pace, especially in the realm of radiological image interpretation. Many radiological AI models rely upon the use of large amounts of real life patient images in order to be "trained" correctly into making medically accurate interpretations of image data. When many of these models were first being developed in the last decade, the general understanding was that if patient images were de-identified, with no names or medical registration numbers associated with the images, they would be virtually untraceable. However, there now exists many frameworks by which patient images with seemingly no identifiable information attached can now be traced back to the patient by other AI models. As new information comes out about the evolution of deep learning algorithms and how current methods for de-identification are no longer sufficient, it is important to assess the overall benefits and risks of using AI in clinical practice. There are clear benefits, including accessibility and efficiency, and drawbacks, such as selection bias and commercialization, when using AI technology. However, now as deep learning technology such as pixel-level fingerprinting develops, it calls into question another issue — patient privacy. While some may argue that the benefits of AI outweigh the threat to patient privacy, I argue that complete informational privacy is a necessity in the relationship between physicians and their patients in order for patients to feel safe and receive quality medical care. The threat to patient privacy prompts the need for solutions that allow for AI technology to be used clinically while creating a safe environment for patients. In order to continue protecting patient privacy while also benefiting from the advances in AI, I contend there are several steps that need to be taken. These steps include the following: the right for patients to remove their data at any time from databases, clinicians who collect the data being aware of how AI technology is using patient information in order to obtain truly informed consent, and a regulatory process to protect patient data used by AI companies. While there are reasonable concerns as to how this regulation would impact the advancement of AI in medicine, I believe undermining the trust that exists between the patient and clinicians only fosters more hesitancy to interact with the healthcare system and provide data for the greater population. It is only with this level of regulation that we can create a system where AI can be used effectively and continue to advance medical care while also maintaining the core principles of privacy and confidentiality that allow for healthcare professionals to provide quality healthcare.

The Other Problem of Induction: The Ethics of Labor Management

Maja Sidzińska, PhD
University of Pennsylvania

Within medical institutions, both labor induction and expectant management are common approaches to labor management, with induction involving the use of medications or mechanical methods to trigger uterine contractions, while expectant management is a "wait-and-see" approach in which labor often starts spontaneously. A debate has emerged in the clinical and bioethical literature about which approach produces better outcomes for mothers (or pregnant patients who do not identify as mothers) and infants and which approach should therefore be adopted. This debate has emerged against a backdrop of rising—and racialized—maternal and infant mortality rates and increasing social criticism of birthing conditions in the United States.

In this talk, I focus on elective labor induction, which is induction at full term (at least 39 weeks' gestation). Elective induction does not occur for a specific medically-indicated reason; rather, it is offered as a risk management strategy. This is because some pregnancy-related risks are found to rise as pregnancy proceeds past full term. As a result of the well-known ARRIVE trial and its finding of decreased risk of cesarean delivery (Grobman et al. 2018), elective induction has begun to be described as a reasonable, safe, and desirable option and is now offered by many hospitals as a routine part of maternity care.

However, there are methodological and ethical problems with the trial, its interpretation, and the application of its findings. Some problems have already been identified, such as concerns about the trial's external validity and failure to consider birth not just as a biomedical event but as a personally and socially meaningful experience (Jelks et al. 2023; Azria et al. 2024). In this talk, I develop additional critiques of the trial, its interpretation, and its application to hospital policy. I show that the trial lacks internal validity, further challenging its empirical findings. And I argue that the understanding of biomedical risk that motivates the trial and drives its interpretation and application is biased in two ways: 1) it is exaggerated by selective framing, and 2) it reflects gender-biased assumptions. I also argue that the trial, its interpretation, and its application continue—in subtle ways—a long history of misogynistic obstetric practices. This is because, as with historical obstetric practices, elective labor induction is marked by a lack of consideration of women's knowledge and experiences, a lack of respect for their consent, and fetal-centrism (meaning, in this context, the overvaluation of the fetus relative to the mother, and the disproportionate imposition of risk on mothers relative to fetuses). I conclude that elective labor induction lacks a solid scientific or ethical foundation, and suggest that hospital policies that suggest medical practitioners may offer elective labor induction should be reconsidered.

"The You You Are": Consent, Severed Selves, and Hermeneutic Double-Bind

Jack Simmons, PhD

Leigh E. Rich, PhD

Georgia Southern University

What if the postmodernists are correct, so poses the series *Severance*, and the metaphysical notion of a "stable self" is just a myth? While the stable self makes sense of a broad range of cultural norms and processes, it generally unravels under rigorous postmodern analysis. *Severance* explores this dilemma in its first two seasons, including in relation to the concept of consent in both professional and interpersonal relationships.

Contemporary notions of medical, research, and sexual consent crave contract-like procedures, such as legal forms and code words. These approaches create evidence of consent but are not themselves consent. Instead, consent is the ongoing, nuanced, and messy dialogue that involves various internal and external voices that must navigate changing situations and social norms, all while we attempt to determine the extent of our own desires (often in an informationally asymmetric environment). Legal and cultural prescriptions of consent, however, rely upon the myth of a stable self in order to create an Archimedean point from which we might leverage certainty from an uncertain event.

But exam rooms, courtrooms, and bedrooms are confusing and crowded, with multifaceted selves deliberating decisions while caught in narratives that keep us (as Iris Murdoch argues) from crawling under the net. As we desperately seek a whole that remains unreachable, we find ourselves in a state of perpetual strife: strife with ourselves and the institutions we encounter. "Consenting" to a treatment or tryst, for example, involves consenting to something whose outcome is unknown, requiring interpretation and speculation about a story we are telling or being told.

Severance creatively depicts this hermeneutic circle and how challenging and changeable consent can be: any moment of clarity must be interpreted, and sincere discourse often is indistinguishable from the insincere. The workers in *Severance* confront this mythology head-on: with regard to employment (Can an outie override an innie's choice to leave Lumon?), research (What experiments did Gemma agree to undergo and why?), treatment (Did Mark understand the risks of Asal Reghabi's reintegration procedure?), or sex (Whose consent counts when Helena tricks Mark into thinking she's Helly?).

Severance is not the first fable to interrogate the unstable self. From Robert Louis Stevenson's *Strange Case of Dr. Jekyll and Mr. Hyde* (1886) to David Fincher's film *Fight Club* (1999), the narrative arts have frequently examined the abnormality and horror of the multiple selves that lie within. But if the postmodernists are correct, it is a differentiated, unstable self that constitutes the norm — and the notion of a stable self from which abnormality and horror arise.

Severance offers a view into the messy reality of consent as well as what life might look like if we accepted this truth about "our selves." In fact, moral development (and "true" consent) may depend on the severed self: encountering our different selves in different ways and places enables self-critique and a chance to determine which of our selves we like better.

Exploring Clinicians' Experiences with Using an Artificial Intelligence Scribe

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Background: Clinical documentation is a main driver of clinician burnout, which may be potentially reduced with the use of an artificial intelligence (AI) based ambient listening tool. In March 2025, our health system provided access to an AI scribe to over 5,000 physicians.

Methods: Clinicians attended a virtual instructive workshop prior to using the AI scribe tool. Two months later, they received an online survey that included an open-ended question asking for feedback about the AI scribe. We performed a content analysis by first developing a codebook framed by the Technology Acceptance Model (TAM). Additional codes emerged inductively and were included under each of the TAM's core constructs.

Results: 782 of 1,269 clinicians responded to the open-ended question, with over half being physicians (53%). 34% were from primary care, 13% from general and surgical specialties, 12% from medical subspecialties, 8% from cardiovascular, 8% from pulmonary and critical care, 8% from neurology, 6% from women's health, 2% from pediatrics, and 3% from behavioral health.

The frequency of coded responses exceeds 100% because each response could receive multiple codes. Perceived usefulness was the most frequently coded (60%, n=466). Within this category, 28% of responses described reduced note-writing time and 8.8% noted improved interactions with patients. However, most responses identified limitations (56%), including the tool's inability to meet the needs of specialists, difficulty capturing physical exam findings, lack of integration with EPIC, and requests to extend access to additional staff.

Perceived ease of use was the second most coded construct (44%, n=347). Nearly half of responses (46%) described time spent editing notes to ensure accuracy, citing incorrect dates and information that was not actually stated by the patient. An equal proportion (46%) raised concerns about the format and language of the note, including a desire for notes to sound "more human."

Behavioral intentions were coded in 29% of responses (n=224). Over half (52%, n=116) reflected a preference for manual note writing, driven by limited time savings, difficulty obtaining patient consent, and legal concerns. Another 26% described desired enhancements, such as incorporating dotphrase functionality, multi-language support, and use during inpatient encounters, while 12% cited a need for additional training. Attitudes were the least frequently coded (13%, n=105). Nearly two-thirds (64%) described a meaningful positive impact on clinicians' lives, while the remaining 36% expressed disappointment that the tool did not adapt to individual style or preferences.

Conclusions: Our results highlight areas in which AI scribes may have significant impact, such as improving quality of life and patient-clinician interactions. However, we also identified key areas of development that should be considered for future improvements and successful integration of AI scribes into healthcare systems.

Embodiment, Bookmaking and Finding One's Place in the University Body

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This project, funded by a grant from the College of the Arts, formed part of a group of activities that all explored themes of embodiment focused on the campus community during the Summer B semester. Known now as Creative B, this time of year hosts incoming first years who come to university during the most quiet semester thus perhaps can miss part of the college experience, so various activities can provide an opportunity for lively community engagement. The particular activity used book making and metaphors of the body used to describe books—the spine, face, head and tail, joint and hinges- to encourage reflection among students making books about self-expression, their own sense of identity & wellbeing and their own place in the student body.

The activity involved a 2 hour session to build a book using pre-prepared materials with in person instruction from an artist-book maker. The group experience also included a presentation and survey designed to describe both the process of book making and the opportunity to reflect on how the university also constitutes a body composed of individuals working to find their role in the community. The team developing the program consisted of librarians, from the science, health science, and arts libraries, and included a student assistant who created a web guide and developed research materials, flyers, and other materials supporting and amplifying the process. Participants were recruited through a program for first year students that include courses designed to introduce first year students to the university campus and university life and a professor teaching one session required attendance from his class.

The presentation will explore books and discuss concepts of embodiment inherent in the creation of a drum leaf bound book.

Mitigating Healthcare Inequality via Patient Use of Information Gaps

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Information gaps identify inaccessible, sometimes purposely withheld, gaps in a person's understanding between what they know and all possible relevant information. Information gaps are ubiquitous for patients in contemporary healthcare, ranging from opaque test results and medical terminology to institutional practices that fail to protect patients' informed consent. While past research foci have largely been on the ways information gaps are harmful to patients, I identify and characterize a cluster of overlooked patient practices that exploit information gaps to favor the patient by preserving or creating more opportunities to express patient autonomy. In these cases, patients choose to withhold certain information from healthcare professionals in order to avoid stigma, bias, or even healthcare-obstructive criminalization.

I consider three cases of patient-created information gaps: ADHD diagnosis, racial identity, and abortion aftercare. Considered in isolation, these all represent information potentially useful to patient-centered care, treatment, and post-treatment plans. Nonetheless, current research, testimonies, and legal realities also reveal that disclosing this information can come with risks. Where an ADHD diagnosis might evoke provider stigma against a patient, or disclosure of an abortion is preventive against necessary aftercare, patients can use information gaps to bypass negative consequences to their own medical access. These use cases increase patient autonomy in the healthcare process. Wielded by patients, information gaps constitute a tool for the productive manipulation of known systemic flaws in the healthcare system, allowing patients better access to healthcare as a result of their increased mobility through the medical-industrial complex.

While it remains true that, in most cases, withholding information in a medical setting will likely be detrimental to patient outcomes, contemporary shifts in the doctor-patient relationship demand that we recognize the discretion of the patient as an active agent in their own care. The usefulness of information gaps both rests on and reinforces an understanding that some information remains the privileged purview of the patient, who bears the ultimate expertise about their own experience. This paper looks specifically at cases where nondisclosure either evades negative outcomes or produces positive ones. When information gaps are reoriented for use by patients in healthcare settings, their relationship to healthcare access shifts as a result, in many cases equipping them and their team for a more effective and appropriate pathway to care.

Epistemically Hostile Environments and Public Health

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Are public health practices and institutions in the United States creating an epistemically hostile environment? Or, are hostile epistemic environments impacting public health institutions and practices? If so, how can we identify that it is hostile, and how can we escape it? In this paper, I extend the growing subfield of environmental epistemology by examining epistemic hostile framework introduced by C. Thi Nguyen and explore other elements of hostile environments. I provide three examples of this extension in public health through: data and policy framing, use of divisive language, and the most concerning contribution to the current hostile epistemic environment is the use of accepted non-epistemic moral principles to promote scientifically dubious outcomes. This last example is the use of accepted public health terminology and ethics to promote epistemically harmful environments, i.e the precautionary principle and Tylenol use by a former health official in the United States.

The second important step after identifying these hostile environments is to identify the population that is at risk for epistemic and non-epistemic moral and health related harms. I suggest that when epistemic agents are in epistemically hostile environments, it is difficult for epistemic actors to verify these claims and thus leave them open to being less confident in their judgments about recommendations made by leading public health institutions. When these epistemic actors are within these environments, they experience a type of fatigue which I describe as a type of epistemic weathering. I then argue that there are two types of epistemic weathering, for epistemic agents and for public health institutions. The result of this weathering is a reduction in trust in public health agencies, and worse health outcomes in terms of mortality and morbidity as it relates to pregnant persons.

Medical Technologies of Disability Avoidance as "Oppressive Things"

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The aim of this paper is to draw from the work of Shen-yi Liao and Bryce Huebner to explore the question of whether medical technologies to prevent, ameliorate, or eliminate disability (or what I call medical technologies of disability avoidance) could be reasonably interpreted as oppressive things (Liao and Huebner 2021). Liao and Huebner introduced the idea of oppressive things to capture the ways in which material artifacts and technologies could shape and sustain particular patterns of moral and social thinking that underwrite and reinforce social schemas of oppression. That is, rather than being mere reflections or by-products of dominant values and understandings, technologies could also guide and constrain our psychological processes and social structures in ways that promote the various "faces" of oppression (Young 1990).

Applying the concept of oppressive things to medical technologies of disability avoidance, I advance the thesis that medical technologies that seek to prevent, ameliorate, or eliminate disability can indeed be reasonably interpreted as oppressive things, and more specifically, ableist things. Such technologies contribute to shaping and sustaining patterns of thinking that are in congruence to the medicalized, bad difference, and personal tragedy models of disability. These accounts of disability underwrite the structural stigma imposed on people with disabilities by interpreting disabled modes of being in negative, pathological, and demeaning terms (Barnes 2016; Silvers 1998; Swain and French 2000). Medical technologies of disability avoidance serve as material anchors to this way of thinking about disability, which are exemplified by philosophers and ethicists who often refer to the utilization of medical technologies of disability avoidance to affirm the interpretation that disability is indeed a morally negative form of embodiment (Buchanan et al 2000; Kahane and Savulescu 2016).

In arguing for this thesis, I will first elaborate Liao and Huebner's conception of oppressive things and the conditions that make things oppressive. Second, I will extend the idea of oppressive things to medical technologies of disability avoidance, arguing that technologies that seek to reduce in incidences of disabled bodies can be reasonably characterized as oppressive things since they contribute to a pattern of thinking that is in congruence to negative, demeaning, and pathological framings of disability that underwrite structural ableism. I end by discussing potential responses to medical technologies of disability avoidance as oppressive things. If we seek to reform our medical practices and institutions in ways that are more inclusive to disabled people and responsive to disability justice, and disability justice calls for the destigmatization of disability, then it raises the question of what we should do when our medical practices and technologies are oriented around the goal of normalizing people, contributing to narrowed and negative ways of thinking about disability. Since there are non-ableist reasons for medical technologies of disability avoidance, moving forward may not necessarily mean prohibiting the development and use of such technologies, but to alter the broader context in ways that make such technologies no longer function as oppressive things.

Reframing Diminishing Trust in Medical Authority as a Socio-Political Phenomenon

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Medical Sociology has long relied on Paul Starr's research on professionalization of medicine in the discussions of occupational authority, power, and legitimacy of health professions. In this model, patients voluntarily accept the authority and recommendations of healthcare providers due to prevailing cultural perceptions of their competence, benevolence, and expertise as doctors lack the means of enforcing their decisions. The decrease in public trust in medicine, therefore, is bound to complicate doctor-patient relationships, therapeutic decision-making, and potentially undermine treatment compliance.

The 2026 Gallup poll registered a historic low of 28 % confidence in the medical system in the United States while only 57 % of respondents have indicated a high level of trust in honesty and ethical standards of physicians. These data demonstrate the reversal of the typical relationship between diffuse and specific support for medicine as a social institution, posing new questions about the consequences of this pattern.

This paper analyzes the erosion of trust in the healthcare system in the context of the deepening crisis of confidence in all public institutions, thereby widening the explanatory base and interdisciplinary terminology of the current discourse. This approach allows us to draw conclusions from experience and research in other social institutions while also viewing the unfolding crisis of confidence in light of the earlier cultural and political shifts rather than simply a consequence of the recent pandemic, informational access, or the deepening political polarization in society. Such framework clarifies not only the prior difficulties in the pandemic response, but also the current challenges to established health beliefs, medical protocols, and administrative systems.

A Groovy Interface: Vinyl Records and Digital Infrastructure for Inpatients

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BACKGROUND Hospitalization, especially during serious illnesses and end of life, can be a time of emotional distress, isolation, and loss of personal identity. While clinical care attempts to address physical symptoms, the emotional and psychological needs of patients are oftentimes unmet in the aesthetic deprivation of hospital settings. While music interventions are known to help, many hospitals lack dedicated music resources.

OBJECTIVE(S) ATX-VINyL (Analog Therapy eXperience – Vinyl for Inpatients Near the End of Life) was developed at Dell Seton Medical Center to create personalized bedside music listening experiences using vinyl records for patients and their loved ones in efforts to promote comfort, connection, and well-being. A secondary objective of ATX-VINyL is to demonstrate how healthcare professionals and volunteers can collaborate in the medical humanities, and work together to improve the patient experience beyond standard medical treatment.

METHODS ATX-VINyL operates through an undergraduate student volunteer workforce (known as the Vinyl Volunteers) that collaborates with medical professionals. Hospitalized patients who may benefit from music are identified by volunteers through contact with the palliative care team, ICU nurses, and other medical teams. Volunteers consult with patients and families to select their preferred music genres from a curated and diverse vinyl record collection. Volunteers then select an assortment of records and deliver the music directly at the bedside with a record player cart, creating a special moment of shared listening, reflection, and joy for patients. To maximize the impact of our vinyl program at Dell Seton Medical Center, we developed a digital catalog of our 500+ record collection that patients, families, and volunteers can browse from a phone at their bedside. The website (atxvinyl.org) was designed to serve two ends at once: to make an otherwise unwieldy physical archive navigable in seconds for patients and volunteers alike, and to restore a small but meaningful moment of choice to patients in a setting where choice is often taken from them.

OUTCOMES ATX-VINyL averages 60 unique listening experiences per month at Dell Seton Medical Center in Austin, Texas. Observational data from volunteer end-of-shift feedback shows patients reporting emotional uplift, a feeling of relaxation, and a warm sense of nostalgia. Hospital staff and volunteers frequently report improved moods and noticeable positive shifts in patient interactions after listening sessions.

This fall we are conducting formal patient and family surveys after ATX-VINyL sessions, data we will be able to share at the conference. In addition, we look forward to displaying ongoing development of our website and how AI is helping patients and volunteers navigate physical media.

CONCLUSION ATX-VINyL demonstrates the value of interprofessional collaboration to provide more holistic patient care. By integrating a personalized music experience into the hospital setting, ATX-VINyL targets the emotional needs of patients, typically unmet by medical treatment alone. This initiative demonstrates the power of combining digital technology and arts-based approaches in helping to meaningfully restore well being, connection, and humanity in healthcare.

