

## LETTER

## Beyond the algorithm: Reclaiming humanism in the Age of Al-powered healthcare

**JAYASHREE RAVIKUMAR** 

The stethoscope once defined the physician. Today, it shares symbolic space with something more elusive: data. Artificial intelligence (AI), machine learning, and predictive algorithms are reshaping healthcare systems around the world. Al promises increased diagnostic accuracy, standardisation of care, and efficiency in overburdened clinical environments. However, the growing influence of AI raises urgent ethical and professional questions, chief among them the risk of losing the human connection in care.

Al excels in pattern recognition. Its ability to process large datasets with speed and consistency allows for rapid triage, image analysis, and risk stratification. Studies have demonstrated promising diagnostic accuracy when algorithms are used in dermatology, radiology, and ophthalmology [1]. In primary care, chatbots and symptom-checkers increasingly serve as a first point of contact for patients. A recent web-based survey by Yun and Bickmore reported that a substantial proportion of individuals now seek health information online before consulting a physician [2]. While this trend reflects greater patient engagement and empowerment, it also exposes users to misinformation, heightened anxiety, and misinterpretation of medical data.

Yet, Al lacks context. It does not hear hesitation in a patient's voice, notice the tremor of a hand, or ask follow-up questions rooted in compassion. Algorithms operate on probability; humans live in complexity. As clinicians, we are expected to interpret algorithmic outputs and apply them to patients who may not conform to textbook patterns. A misapplied Al recommendation, even when statistically sound, can lead to delayed diagnoses or missed nuances.

Equally concerning is the emotional distancing that can occur when clinicians begin to rely more on digital inputs than interpersonal cues. In resource-limited settings, where patient volume and time pressure dominate, AI can seem like a lifeline. But it may also reinforce a transactional model of care that undervalues presence, patience, and empathy. The human element is not an optional supplement to care; it is a core requirement.

Medical education must also adapt to this shifting landscape. While digital competence is essential, it must not replace critical thinking. The diagnostic reasoning process — the ability to formulate hypotheses, weigh probabilities, and consider outliers must remain central. Overreliance on Al tools can erode clinical instincts. A 2015 audit revealed that

common symptom-checkers varied widely in accuracy and were prone to over triage [3]. Students exposed to these tools early may begin to defer judgment instead of developing it.

There is also an ethical imperative. Algorithms are only as unbiased as the data on which they are trained. Racial, gender, and socioeconomic biases have already been documented in commercial health algorithms [4]. Clinicians must remain vigilant, serving as stewards of justice and equity in healthcare. Ethical education should include digital literacy not just how to use tools, but how to critique them.

What is needed is not resistance to AI but planned integration. Reflective practice, ethics discussions, and patient narrative training should be prioritised alongside algorithmic literacy. Digital decision support systems should be viewed as collaborators, not substitute for human care. Importantly, the system must reward relational competence, not just procedural efficiency.

Healthcare cannot afford to become purely mechanistic. Patients are not datasets. They arrive with stories, fears, and expectations that extend beyond algorithmic capture. The physician's role is not simply to interpret numbers, but to hold space, provide context, and affirm dignity.

Preserving humanism in the AI age requires that we:

- recognise the therapeutic relationship as central to healing
- equip trainees with both technical and narrative skills
- challenge biases in digital tools and push for inclusive design
- value presence as much as precision.

Al may assist in diagnosis. But only a human can understand the complexities.

**Author: Jayashree Ravikumar** (dr.jayashreeravikumar14@gmail.com, https://orcid.org/0009-0002-6497-232X), Kilpauk Medical College, Chennai, Tamil Nadu, INDIA.

Conflict of Interest: None declared Funding: None

**To cite:** Ravikumar J. Beyond the algorithm: Reclaiming humanism in the Age of Al-powered healthcare. *Indian J Med Ethics*. Published online first on October 24, 2025. DOI: 10.20529/IJME.2025.080

**Submission received:** June 6,2025 **Submission accepted:** June 27,2025

Copyright and license

©Indian Journal of Medical Ethics 2025: Open Access and Distributed under the Creative Commons license (CC BY-NC-ND 4.0), which permits only non-commercial and non-modified sharing in any medium, provided the original author(s) and source are credited.



## References

- Esteva A, Robicquet A, Ramsundar B, Kuleshov V, DePristo M, Chou K, et al. A guide to deep learning in healthcare. *Nature Med.* 2019;25(1):24– 29. https://doi.org/10.1038/s41591-018-0316-z
- 29. https://doi.org/10.1038/s41591-018-0316-z
  Yun H, Bickmore T. Online Health Information–Seeking in the Era of Large Language Models: Cross-Sectional Web-Based Survey Study. J Med Internet Res. 2025;27:e68560 https://doi.org/10.2196/68560
- Semigran HL, Linder JA, Gidengil C, Mehrotra A. Evaluation of symptom checkers for self-diagnosis and triage: audit study. *JAMA Intern Med.* 2015;175(3):420–422. https://doi.org/10.1136/bmj.h3480
- Norori N, Hu Q, Aellen FM, Faraci FD, Tzovara A. Addressing bias in big data and Al for health care: A call for open science. *Patterns (N Y)*. 2021 Oct 8;2(10):100347. https://doi.org/10.1016/j.patter. 2021.100347