

In the AI era, Where do We Need More Humanity in Healthcare?

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Abstract



As Artificial Intelligence (AI) is being rapidly introduced across healthcare, many clinicians are enthusiastic about its potential to improve diagnostic accuracy, decision making, operational efficiency, and personalised patient care. However, in this article the author asks the question of where it may deskill or cause harm, and where there is no substitute for real humanity in healthcare. If AI can indeed free clinicians up from some tasks, where should we “dial up” the level of human engagement, not replace it? How can we use AI as a supportive tool rather than a substitute for the therapeutic relationship between clinicians and patients? Here the author discusses 6 domains from his own field. In so doing, he describes training interventions that may be helpful to clinicians moving between South Asia and Europe.

Keywords: Artificial Intelligence; Shared decision making; Non-technical skills; Debriefing; Ethical leadership

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I liked Joanna Maciejewska's quote, "I want AI to do my laundry and tax returns so that I can do art and writing; I don't want AI to do my art and writing so that I can do my laundry and tax returns."

There are many current concerns amongst clinicians about Artificial Intelligence (AI) in medicine: concerns about whether it will be driven to meet the real needs of our patients and our societies or those of commercial empires, concerns about how it might hallucinate plausibly but without responsibility, and concerns that it might deskill us by making clinical reasoning optional. Worse than deskilling of current clinicians, could be "never-skilling" of the next generation [1].

But there is also excitement about its potential to enhance our healthcare, including promises that it can free us up from our administrative tasks (promises which are being counted upon by some workforce planners). Could we see an end to the era of clinicians spending most of their time at computers?

Whatever our thoughts about AI in healthcare, if we suppose for a moment that it will indeed free up our capacity as human professionals, then where should we better deploy that human capacity? Rather than firing people, where should we make sure in healthcare that we have more authentic humanity, not less?

Let me suggest four examples from my own field - surgery and surgical training. The reader can surely think of many more.

Consulting with Patients

My first example is the art and science of consulting with patients; and the training of clinicians in these skills. Because I have an interest in this, I am often asked to consider using AI-driven avatars for trainees to practise clinical consultation skills. But in advanced skills training for postgraduate surgical trainees and experienced surgeons, with nuanced challenges, we have resisted this, and use instead live real or simulated patients.

The reason is simple: what patients and surgeons both want to achieve, is an authentic relationship of

interpersonal trust. The kind of standard, set-piece responses or ways-of-being that AI will perform (and people can too) are subtly off-putting for most patients. They are artificial, and patients sense it. By definition, there is not the interpersonal trust that can carry a patient through, especially in the event of complications.

In the Royal College of Surgeons of Edinburgh (RCSEd), we have developed a modular training series in "Consultation Skills that Matter for Surgeons" (COSMOS, rcsed.ac.uk/cosmos).

The first module centres on Shared Decision Making. In the UK in recent decades there has been a shift from paternalistic decision making ("doctor knows best") to shared decision making ("no decisions about me without me") [2]. This can take some adjustment for clinicians moving into the UK health service from some other countries, perhaps especially rural settings. Though we have moved away from the paternalistic end of the spectrum, neither are we recommending the other extreme – pure informed consent where the patient carries the whole burden of the decisions (Figure 1).

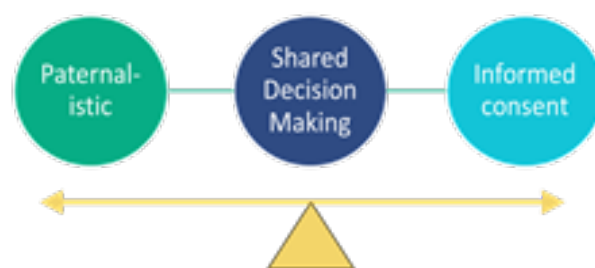


Figure 1. The spectrum of shared decision making

Rather we aim to function on that spectrum, according to the nature of the situation. We use a "three talk model": Team talk, Options talk and Decision talk, [3] and we pay attention to how each phase works for different patients, and how it can be covered in a time-efficient way. We consider carefully how people understand risk and benefits, and how best to communicate these. Through the whole conversation, we encourage the clinicians to "be themselves".

In the second module, "when things go wrong", we

learn how best to walk the difficult path with patients through complications and adverse events [4]. As trainees work through a series of video enacted examples, a patient's story and some challenging simulations, they build a list of do's and don'ts. Figure 2 shows an example of such a list, generated by one group of trainees. It includes tips and pitfalls

<u>Tips (dos)</u>	<u>Pitfalls (don'ts)</u>
Pause for breath	Rushing to address everything
Rapport, trust	
Address their current concern 1st	Defensiveness
Pacing. Give info in stages.	Catastrophising
CBT - show that you Care, do your Best & tell the Truth	Cover-up
Follow-through	Over-attentiveness
See outwith the ward round	Avoidance
Say sorry. "Sorry you are having to go through this"	"Sorry you feel that way"
Take responsibility. Use "I"	Implied blaming of patient
"I discussed your case with my colleagues"	"The M&M decided ..."

Figure 2. A typical list of tips and pitfalls for speaking with patients during complications or adverse events, generated by one group of surgical trainees in COSMOS module B.

that can otherwise take surgeons a lifetime to learn, if they learn at all.

It re-emphasises the importance of authenticity, trust and mutual respect. We teach that patients are generally very understanding even of errors and complications, if they are convinced that the surgeon and their team "Care, do their Best and tell the Truth". We call that "CBT" [5]. We also cover the "2nd casualty" phenomenon and peer support [6].

Third and fourth modules (still in development) cover palliative surgical care, childhood, and medicolegal aspects.

So talking with patients is one domain that we must not delegate to AI, but where else must we "dial up" our humanity in surgery? What about the more technical environment of the operating room?

In the Operating Room

The non-technical skills for surgeons (NOTSS)

taxonomy helps us understand the cognitive and social skills that underpin optimal surgical performance, and is well validated [7]. There is no doubt that AI can assist us with the cognitive skills - situation awareness and decision-making. In fact, we already use it in modern endoscopy stacks where it helps us detect adenomas. However endoscopists who routinely used AI to detect polyps saw their accuracy drop when they performed colonoscopies without AI assistance [8].

Grantcharov's group propose that we should insist that AI tools in the operating room are confined to "explainable AI", rather than including the kind of machine learning AI which can make predictions about the patient without explaining its reasoning [9]. We need the surgeon and the team to be engaged with the reasoning, able to weigh up the information provided by AI and determine if they agree with the decision making, and then to execute the necessary social skills-communication, teamwork and leadership. Experience tells us that in a driverless car, or even one with adaptive cruise control, we feel less alert and engaged with driving than in a standard car. So in the operating room, we need AI to enhance our attention, not to diminish it, and we need our surgeons and teams to be trained in optimising these non-technical skills using training resources such as the RCSEd NOTSS masterclasses (rcsed.ac.uk/notss).

Feedback and Ebriefing

Thirdly, in surgical training, what about feedback and debrief? This is said to be the "trainers' superpower", whether during or after a consultation, a ward round, operation or other clinical event.

There is no doubt that AI can help give immediate feedback, especially by processing and presenting performance data, as is already done in some professional sports. This is a subject of intense interest to the Edinburgh Surgical Sabermetrics Lab (saberlab.org).

However, debrief is a different thing from mere feedback. It can be defined as a facilitated

conversation which engages with the adult cycle of learning (Figure 3) [10], including the learners' conceptualisation of the episode. If that conversation

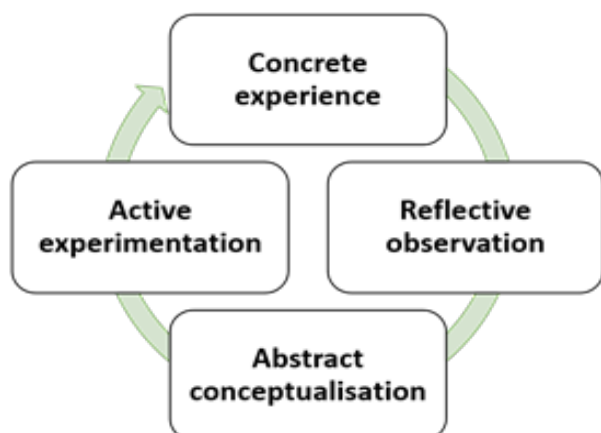


Figure 3. Adult learning cycle.

is to tackle the fundamental assumptions and beliefs upon which learners build their conceptual understanding, then it needs to be the kind of self-actualisation that is at the top of Maslow's hierarchy of needs (Figure 4).



Figure 4. Maslow's hierarchy of human needs.

It is therefore dependent on having the other needs met first, including safety (physical and psychological), love and belonging and esteem. This is therefore a field where we need skilled humans, not AI, to be facilitating the debrief, whether it is one-on-one or small group debrief.

Surgeons are traditionally fond of simple feedback-giving models like Pendleton's rules, but in our experience these can obstruct trainees' train of thought and learning. We have therefore moved to a more nuanced debriefing model described by *Oliver*

et al, where trainees can react freely, set an agenda for discussion, have a safe exploratory discussion, be stimulated by "advocacy inquiry" and reach their own take-home messages (Figure 5) [11].



Figure 5. The Scottish Centre debrief model

We will not be delegating this to AI anytime soon. In this reference there is a link to a podcast explaining more [12].

There is a stereotype that implies surgeons are generally not gifted in these non-technical skills. However this is not what the literature tells us. In Bisset's systematic review, in 4 studies assessing UK abdominal surgeons' personality using a "five factor model", they demonstrated higher levels of extraversion (sociability, emotional expression), openness (creative, conventional) and conscientiousness (self-discipline, thoughtfulness) in surgeons versus population norms [13]. We have used this to encourage our faculty, we should be good at this.

Leadership and Policy

There is a tendency for large organisations to default to using transactional leadership (rules and deals) to change culture and behaviours. However, in healthcare settings we know that a transformational style of leadership (attentive, motivational and stimulating) is usually more effective in engaging teams and bringing about meaningful change, than a transactional one. This has been demonstrated, for example, in a Belgian vascular surgery team, where leaders' styles and team behaviours were

observed through black box video surveillance [14]. Leadership was classified as transformational, transactional or passive. Positive team behaviours were team collaboration, knowledge sharing and speaking up. The only leadership style that correlated with all three positive team behaviours, was the transformational one. By definition, this requires humanity in leadership.

Ethics

My final example of where we need to maintain and enhance our humanity, is in the field of ethics. Until recently we were assured that medicine and surgery transcend politics. For example in the Geneva Convention, healthcare facilities and workers are explicitly protected from being targetted or used as weapons of war. However, in recent conflicts in Gaza, Iran, and Sudan, these rules have been flouted and hospitals and healthcare professionals in local civil healthcare systems have been targetted. In these conflicts AI is reported only to have assisted the most technologically advanced combatants in their warfare, and to be operating on the edge of, and overstepping, the rules of war. Furthermore, healthcare professionals have been finding themselves to be key witnesses to these events, especially where journalists are banned, and so needing to speak out in an ethical

way, notwithstanding the norms of neutrality in humanitarian healthcare aid. Such ethical challenges surely cannot be outsourced to AI.

Clinician Wellbeing

Acting in accordance with our values benefits not only our patients and our society, but our own wellbeing. Known protective factors against burn-out are: agency and control, patient feedback, lack of moral injury, community, fairness, and realistic medicine. The author can reflect that his 2-year post in Nepal seemed manageable and satisfying despite lower resources and a higher patient-to-surgeon ratio than back home in the UK, and even a civil war, probably due to some of these protective factors being in abundance, especially community and realistic medicine.

Conclusions

So let us have AI do what we need it to do, not just what it can do. Let it be our servant and not our master. Let us continue to work within our Hippocratic Oath to “do no harm”, and so let us refuse to let AI “deskill, mis-skill or never-skill” us. If it can free up our capacity to do so, let us be clear where we need to “dial up” our humanity instead of withdrawing it.

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