EMMANUEL 2026 REVIEW





BACKGROUND: ISTOCK/OLASER

KEEPING MEDICINE HUMAN IN THE AGE OF AI

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The most important moments in medicine are often the least algorithmic. During one clinical placement, I watched a surgeon discuss treatment options with a patient whose thyroid cancer could be treated with more extensive surgery, but only at the risk of life-changing consequences, including damage to their voice. Leaving more tissue untouched might preserve their quality of life, but would also mean living with the possibility that the cancer could grow again. There was no single correct answer. The decision depended not only on medical knowledge, but also on how the patient understood uncertainty, risk and what mattered most to them.

That tension is what draws me to artificial intelligence (AI) in medicine. My first experience of the field came in my first undergraduate year, working with large datasets in emergency and pre-hospital care. I was struck by the scale of the possible impact: a well-designed system could influence care far beyond one ward or hospital. As I progressed through clinical training, I began to see the other side of the problem. Medicine is not simply the search for the statistically best answer; it's also the process of helping make sense of uncertainty.

This summer, at Harvard Medical School, I have been working on a proof-of-concept system exploring whether AI can contribute to clinical reasoning. Using simulated patients, the tool can hold a conversation, guide someone through parts of a physical examination, interpret what it sees and hears, and suggest an appropriate next step.

THE BEST MEDICAL AI SHOULD LEAVE MORE ROOM, NOT LESS, FOR DOCTORS TO TALK TO THEIR PATIENTS

It is remarkably good at recalling medical knowledge and applying it to a scenario. What it cannot truly reproduce is the less tangible part of the doctor–patient relationship: the empathy, compassion and human presence that allow someone to feel genuinely understood. These qualities can be imitated, but not replaced.

I do not think the answer is to reject the technology. Used carefully, AI has considerable potential. It could widen access to high-quality guidance, particularly in rural or under-resourced settings, and help clinicians keep pace with the latest, ever-changing evidence. Other projects I have worked on, including ambient voice technology that helps document consultations and produce clearer letters, may allow doctors to spend less time looking at screens and more time observing their patients. I believe the challenge is to make efficiency serve the clinical relationship, not erode it.

That challenge cannot be solved by doctors or engineers alone. In March, we hosted the inaugural Cambridge Health Futures Conference at Emmanuel, bringing together more than 150 attendees from over 25 universities. What stayed with me most was how students from many disciplines were turning conversations into ideas. Yet the most important voices must be those of patients themselves: they should help shape these technologies from the beginning, rather than being consulted only after the important decisions have been made.

Teaching at Emmanuel has made this question feel less abstract. When supervising, the challenge is rarely just knowing the answer. It is finding a way to explain it clearly, noticing when an explanation has not landed, and trying again from a different angle. Medical AI faces the same test: retrieving information is not enough unless it can communicate it in a way that helps someone understand and decide.

MEDICINE IS NOT SIMPLY THE SEARCH FOR THE STATISTICALLY BEST ANSWER; IT'S ALSO THE PROCESS OF HELPING MAKE SENSE OF UNCERTAINTY

I want to help build systems that make good care easier to reach and give clinicians better tools, without mistaking fluency for understanding. The best medical AI should leave more room, not less, for doctors to talk to their patients.



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