Relational Ethics in AI-Mediated Healthcare: Revisiting the Implications of Patient, User, Consumer, and Client Labels

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Abstract

The role of patients in medical encounters —and the labels they assigned to them or preferred by them— has been a subject of debate in medical ethics over the last few decades. While historically the arguments in favor of a certain label have centered on an increased importance of patient autonomy and the commodification of healthcare services, the integration of artificial intelligence (AI) into healthcare introduces new complexities. AI tools mediate relationships at epistemic, material, and relational levels, introducing uncertainties about the roles and identities of people seeking and receiving care. This paper explores the implications of the labels of 'user', 'client' and 'consumer' through a relational lens, arguing that terminological choices are not neutral: they can both reflect and reshape the underlying moral and institutional structures of the provision of medical care. The conclusion calls for a critical and deliberate conversation about how the choice of a label reveals the kinds of relationships we prioritize in medicine, and how AI mediation is shaping these choices.

Keywords

Artificial Intelligence, healthcare, normative framework, relationality

1. Introduction

The delivery of health care is increasingly mediated by the use of digital tools driven by artificial intelligence (AI) at different levels of abstraction. This mediation is affecting the roles and identities of people in healthcare contexts and is influencing the way in which relationships form and develop in these spaces.

The sociocultural conceptualization of the role of the patient, traditionally understood as the recipient of healthcare services provided by medical professionals, encapsulates the relationship between ethical obligations of healthcare institutions and medical professionals and the rights that patients have a claim to. This conceptualization is justified by aspects like the nature of the provision of medical care, the fiduciary quality of the relationship between patients and their physicians, and the existence of deontological codes and strict regulatory frameworks in the medical profession. However, the implications of what it means to be a patient in normative and practical terms are also influenced by external factors such as advancements in socioeconomic conditions and cultural shifts.

One of such factors is the emergence and introduction of AI technologies in healthcare spaces and the possibilities afforded by them. Although the individual person's access to general medical information was already made possible by search engines —for instance, the phenomenon colloquially known as asking 'Dr. Google' [1]—, the shift towards AI-powered medical chatbots or the use of Large Language Models (LLM's) like ChatGPT or DeepSeek has been positively received by some clinicians, who argue that these tools have the potential to increase the patients' health literacy by providing information in an understandable format [2][1]. Additionally, AI-driven wearables and digital applications have heightened

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[1]It should be noted that many other clinicians have raised concerns about the ethical and medical risks of using these tools, among which are the still prevalent issue of LLM's hallucinations, and the more systemic issues regarding fairness and

the sense of control of individuals over their own medical data, thus empowering them to take greater responsibility for their health choices [4]. These affordances, however, do not originate from established health companies or clinical institutions. Many of the platforms and tools that provide access, control or even the possibility of generating personal health data are designed by technology companies that do not adhere to the deontological codes of the medical profession or to health regulations. In this sense, these companies do not establish the same types of normative relationships with the individuals using their products as do physicians with their patients. However, AI-driven health tools still intervene in the medical sphere of the individuals in ways that have become meaningful. There are, for instance, an increasing number of people turning to AI chatbots to manage their medical care including requesting guidance about symptoms and treatments [5]. As such, the role of patients as recipients of medical care, —broadly defined as the provision of services by licensed medical professionals with the objective to diagnose, treat or prevent disease or illness— has expanded. It is necessary to consider alternative roles as receivers of medical services in relation to their interaction with non-clinical health tools developed and marketed by technology companies but also AI tools that medical professionals are using to assist them in the praxis. These roles reopen the discussion about using the labels of 'client', 'user', and 'consumer' to describe the role of a patient that had already emerged in the medical field against the background of the shift from physician paternalism to patient autonomy in the late 20th century.

The use of these alternative labels raises relevant ethical questions about the normative implications regarding moral obligations and the rights of the individuals as patients. This paper aims to explore these implications in two directions and using a relational lens. First, it explores the normative implications of AI tools as mediators at three levels of abstraction: epistemic, material, and relational. Second, it seeks to analyze from a normative perspective how these labels might reshape moral responsibilities and impact the rights and protections of patients, traditionally guaranteed within medical contexts.

2. The Debate About Labels

Terminological choices in fields such as healthcare are not neutral. They frame the narrative around values and norms and influence the perceptions of people regarding the moral standing of others. As such, as sociocultural narratives change, the terminological choices employed in certain contexts might require revision [6]. It should be clarified that in this paper the notion of 'label' defines the term used to describe or identify each of the roles ascribed to or contemplated in reference to the notion of patient. It should not be confused with labels used as descriptors in medical prescriptions or with the practice of data labelling in AI development.

The implications of using certain labels to describe people receiving medical care have been a subject of interest to medical researchers, particularly since the late 20th century, due to the convergence of several factors. First, the strengthening of ethics committees in medical research as a result of high-profile scandals such as the Tuskegee studies in the United States [7]. Second, the shift from a paternalistic approach to the practice of medicine to one in which patient autonomy and the need for informed consent are of greater relevance, and in which the patient plays a more active role in the medical decision-making process [8]. Third, the strengthening of the socioeconomic phenomenon of consumerism, and with it the emergence of the role of the consumer as able to acquire goods and services according to his or her individual preferences and financial capacity [9].

These factors gave way to an increased interest in considering whether the term 'patient' was still the most appropriate and desirable way to refer to people receiving medical care, or whether an alternative term was needed. Literature since the late 1980's and 1900's, both empirical and conceptual, acknowledged the problematic undertones and potentially misleading assumptions associated with this term [10]. The main arguments were rooted in the etymology of the word (from the Latin *patiens*, meaning 'the one who suffers') and its portrayal of a passive, waiting and suffering figure, at odds with the shift towards a more autonomous person, actively engaging with medical professionals in making decisions over his or her own medical care. Authors argued that the traditional concept of the patient

discrimination of health datasets used to train the tools. For more on this see: [3].

suggested an unequal status in the relationship with medical professionals and could risk objectifying the person by setting social expectations of meekness and blind acceptance [11].

However, despite these arguments, empirical research with patients on their own preferences for how they should be described showed a strong preference for retaining the label 'patient' and in some studies, they also expressed strong opposition to proposed alternatives such as 'client' or 'consumer'. The reasoning pointed at the undesirable associations of the medical encounter with a transaction [12] and with the commodification of medical services [13]. An interesting caveat to this trend was observed in studies conducted on individuals receiving care at mental health facilities, which showed a slight tendency to prefer being referred to as 'clients' [14], [15]. Although not conclusive, one study argued that these results could likely point at the social stigma of being classified as 'mentally ill' when attending a mental health facility as patients and thus the label of 'client' was seen as more neutral and advocating for a more agentic role [16].

3. Normative Implications of AI Mediation

The main motivation behind reevaluating the appropriateness of the 'patient' label in the 1980's and 1990's was to reflect the changes in the sociocultural conceptualization of the role and identity of people seeking and receiving medical care. In the present day, however, the rapid introduction of AI technologies in healthcare provides new arguments for revisiting the importance of clarifying the implications of existing and emerging conceptualizations and the attached labels. This paper argues that this mediation is changing the way healthcare is delivered and the way individuals interact with others in health settings at least at three levels of abstraction.

3.1. Epistemic Mediation

In the first place, there is the matter of the epistemic implications of AI technologies as intermediaries. Tools like chatbots or open-access LLM's are being used as symptom checkers or as sources of information and recommendations to manage health conditions. As explained in the introduction, they are said to make medical knowledge more accessible (in terms of material availability) to a broader public and to improve patient literacy. However, there are two epistemic implications to consider. First, there is still no reliable way to detect inaccuracies and so-called 'hallucinations' in AI-generated medical information [17]. The communication of uncertainty plays an important role in shared decision-making for health management processes because it enables the patient to make informed decisions and engage with the clinicians in a more transparent and active manner, which has been shown to strengthens the physician-patient relationship [18]. However, LLMs and chatbots are designed to sound reliable and confident in their recommendations and not so much at communicate uncertainty, which fuels the tendency of people to overestimate their accuracy and place their trust in the information they are receiving [19]. This is concerning because if people are unable to discern false or inaccurate information and become trusting of it, they will likely act upon that information. For health management, this could lead to patients following potentially harmful or even fatal recommendations [17].

Second, the design choices made during the development of these tools imply that this knowledge is framed and filtered in specific ways, which can make accessible or obscure certain information according to how the models are trained and fine-tuned. In healthcare, the consequences of these design choices can be critical, as it was the case for an algorithm used to manage health population needs that predicted that Black patients required fewer resources although they are sicker [20]. These design choices reflect the priorities and interests of the developers and company owners, which may not always be aligned with certain needs or interests of the individuals using their products[21]. In this sense, the developers have acquired a significant degree of epistemic authority over the information generated by AI tools, which might challenge the long-standing epistemic authority of clinicians and other medical professionals [22]. On the one hand, while this might offer opportunities for a more democratized dynamic of health management that empowers the patient's autonomy, it also demands reflection about how medical knowledge is generated, validated, and distributed to the public. On the

other, it is also imperative to evaluate whether the patient is truly benefiting from this model or if this mediation is used to perpetuate dominant hierarchies of power in the new 'digital media economies' as argued by Lupton [23].

3.2. Material Mediation

The second type of mediation with normative implications is concerned with tools like ambient AI tools or chatbots used as material intermediaries between the patient and the medical professionals. Traditionally, the patient in need of medical care establishes a relationship with a clinician, often in a primary care setting. During these first medical encounters, the clinician performs physical examinations and listens to the patient's concerns. Research has found that patient satisfaction is positively impacted when a physical examination is conducted during a clinical encounter [24], as it is seen as a form of non-verbal communication that helps to foster patients' trust in clinicians, a key aspect of the fiduciary relationship between the two [25]. In scenarios of AI material mediation, however, the clinician may grow to rely on the output of the AI device or app as a proxy for direct engagement with the patient, thus enacting a form of digitally mediated exchange, fundamentally distinct from an embodied form of relational care. For instance, in scenarios where instead of having an in-person consultation with a human physician, the patients must input their symptoms into a platform to be then triaged based on algorithmic configurations, the locus of trust, communication and responsibility that used to belong to the medical professional is now distributed between human actors and technological tools.

3.3. Relational and Affective Mediation

Closely connected in the third form of mediation, framed in this paper as relational and affective mediation. The last years have seen an increase in the development and the popularity in terms of user acceptance of AI mental health companions [26]. They are designed to mimic empathetic responses, and their use-cases include guiding people through crisis episodes or as a tool for self-therapy [27]. However, from a relational ethics lens, the core issue is not whether AI systems can simulate empathy convincingly, but whether these simulations can satisfy the normative conditions of providing care [28]. If care is understood as an orientation toward the needs of another as they are expressed and interpreted in a particular medical context, then this form of affective mediation by AI may fall short in ways that are ethically significant. Thus, this form of AI mediation raises, at the very least, an important question about the meaning of providing medical care, in particular in mental health: Is there a moral distinction between feeling cared for and being cared for? These are not merely semantic or speculative issues, they impact directly on the lived experiences of people who seek care. It is thus of critical importance to investigate how the interaction with these types of AI tools, especially in moments of vulnerability, affects the person's health journey and at other levels.

4. Normative Implications of Labels

The second aspect that this paper seeks to explore is the ethical considerations of the use of labels like 'patient', 'user', 'client' and 'consumer' considering implications derived from the mediations discussed in the previous section. These terminological choices have acquired new meanings and, aside from the dual function of framing and shaping sociocultural norms and values, this is a matter of relevance because they can influence decisions and set priorities in policymaking and governance. For instance, the normative framing around the importance of the autonomy of patients in healthcare settings has translated into policies that seek to ensure that informed consent is given freely and that the interests and values of patients are secured [29]. Similarly, the design of AI systems is influenced by the choices in language used during the development process. These choices, as has been argued, are not neutral and have ethical consequences [30].

In traditional healthcare contexts, the label 'patient' is embedded in a normative framework that makes several assumptions. On the one hand, it considers that the person needing medical attention might be in a position of situational vulnerability and dependence, and from a rights-based lens, justifies a right to receive medical care in an appropriate and timely manner [31]. On the other, given the position of epistemic authority that medical professionals have, it is presumed that he or she must be placed in a position of fiduciary responsibility and, correlative to the right to healthcare of the patient, they have a moral duty of care. It is understood, from both ethical and institutional levels, that patients are not just recipients of services but instead moral subjects to whom certain protections are owed, in part due to the asymmetries of epistemic authority and decision-making power that characterize medical relationships.

By contrast, the term 'user' draws from a vocabulary often associated with software systems and digital platforms. It suggests a more transactional and functional relationship, centered on access, interaction, and personalized experience. The use of this term in relation to health AI tools reflects a shift from relational forms of care and toward individualized engagement, often with reduced expectations of responsibility. Similarly, 'consumer' and 'client' are terms rooted in market logic that evoke ideas around the preeminence of the client's choice or consumer's preference [32]. The issue with these alternative framings that arguably afford the person a higher degree of freedom in regard to health-related choices is how they might shape the way in which care is imagined and organized, how systems are designed, and how obligations are distributed.

In particular, the matter of the diffused responsibility and accountability allocation is of significant normative weight. An 'user' or a 'consumer' imply an active subject who engages with services or technologies based on preference or convenience. Within the logic of consumer autonomy, the decision-making shifts toward the individual, who is presumed to have access to information, the capacity to evaluate it, and the freedom to act on it. In the healthcare sphere, the patient as consumer is not longer only encouraged to take a more active role but even required to do so, for instance, by needing to choose their health provider or being in charge of initiating communication with the clinicians. However, as pointed by [33], consumers are defined as actors within a market and health care is not a market in the regular sense, and thus do not possess the same power over the markets as in other examples. Similarly, an 'user' is expected to be self-sufficient in navigating the systems he or she is using, and the service providers are not necessarily under a regulatory or moral obligation to make choices that secure their fundamental rights if they compete with other interests. Naturally, this does not mean that products and services deployed to the public are not subjected to regulatory frameworks at all. However, this may vary across the legislation of a specific territory and depending on factors such as the category of the product or service. In many regions in the world, AI tools are not regulated as medical devices, but as consumer products and thus, the strictness and oversight are vastly different [34].

Although technology companies often highlight the potential of AI tools to empower users and consumers by giving them access to data and recommendations, positioning them as autonomous agents in control of their health, it should not be forgotten that AI outputs are shaped by prior design and training decisions, assumptions about user behavior and limitations in data availability and quality . In this sense, the adoption of consumer-oriented framings may prioritize efficiency, access, and customization, but de-prioritize the relational aspects of the provision of medical care, like compassion and humane understanding of each other. The alleged advantage of choice and control of 'consumer', 'client' or 'user' labels may be emphasized at the expense of the right to be supported in making choices and embracing vulnerability, as the label of patient seeks to secure.

5. Conclusion

This paper has sought to explore two general areas of normative interest regarding the introduction and increasing adoption of AI tools in healthcare settings. First, it looked into the ethical implications of three forms of AI mediation and second, it analyzed the implications of the use of labels to describe the roles and identities of people seeking and receiving care. A relational lens reveals that these labels

are not merely descriptive; they actively structure interactions between individuals, clinicians, and technologies. The term 'patient', rooted in fiduciary duty, may safeguard traditional protections but risks inadequately addressing the new dynamics introduced by AI tools in these settings. Conversely, 'user' or 'consumer' labels, while emphasizing autonomy, may obscure asymmetries of power and de-prioritize certain values and attitudes about the importance of acknowledging vulnerability, and dependence in healthcare settings. It can ultimately become an obstacle to achieving more equitable, patient-centered and sustainable delivery of medical care if patient autonomy becomes a strategy to offload the task of ensuring meaningful channels of responsibility.

The debate over labels in healthcare is ultimately a debate about the kinds of relationships we prioritize in medicine. As AI systems increasingly mediate access to care, the choices of how to label these relationships will shape not just how people interact with these systems, but what kind of ethical and institutional commitments follow from those interactions, and what kind of justifications will ground policy recommendations and regulations. In other words, what is at stake is not only how those who receive care are called, but how these names shape our shared understanding of vulnerability, responsibility, and moral standing in healthcare spaces. Normative clarity around these terms will be essential for designing AI systems that support, rather than undermine, the ethical commitments of healthcare professionals and institutions to people receiving care that have long grounded the practice of medicine.

Declaration on Generative AI

The author has not employed any Generative AI tools.

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