Bokanmeldelse – Book review

Ho, A. (2023). *Live like nobody is watching: Relational autonomy in the age of artificial intelligence health monitoring*. Oxford University Press. https://doi.org/10.1093/med/9780197556269.001.0001

# Relational autonomy, privacy, epistemic injustice, and institutional governance

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Ingrid is an older adult with heart failure who lives alone. She feels fine most mornings, but fluid builds up gradually before she notices symptoms. She may not notice it right away but by the time she realizes that she is experiencing shortness of breath, it may be too late to get urgent care.

This problem can be avoided if Ingrid can use an Artificial Intelligence (AI)-powered health-monitoring device to detect patterns earlier than she can notice. Some health problems, like what she is experiencing, are continuous, subtle, and time sensitive.

In episodic health care visits with a physician (e.g. every few weeks or every few months), measurements are taken depending on what patients remember to report. Such episodic monitoring could miss what the patient forgets, especially any deterioration that may happen between visits.

When set to monitor health changes in real-time, AI health-monitoring can observe everything and nothing will be missed including changes that happen gradually, patterns too complex for quick human review, conditions needing frequent follow-up, and situations where in-person monitoring is difficult or expensive. If AI is set to track weight, pulse, oxygen levels, activity, sleep, glucose, or symptom patterns over time, it may detect deterioration sooner than a patient would be able to notice on their own. This is particularly helpful in cases of:

- heart failure,
- respiratory disease,
- diabetes,
- medication side effects,
- and post-surgical recovery.

AI can be used to avoid delays in starting life or health-saving intervention. The patient does not have to suffer health crisis before they access clinical interventions.

AI can also help reduce the need to visit healthcare facilities. This is particularly relevant to:

- older adults living at home,
- people with chronic illness,
- patients recovering after discharge,

- people with cognitive decline,
- and patients in rural or underserviced areas.

When AI-supported monitoring is set to observe health changes remotely, it can help clinicians notice crucial health events without necessitating the patient to travel more frequently than needed.

This AI-assisted approach could also reduce the need for clinicians to review more data than needed. Medical devices can collect continuous raw measurements that the clinician does not need. AI can, therefore, help by:

- identifying unusual patterns,
- filtering noise,
- prioritizing alerts,
- and showing which changes may matter clinically.

This can be done when AI is set to combine many data points over time to detect:

- subtle shifts in gait that may predict falls,
- sleep and activity changes that may signal decline,
- medication adherence patterns,
- and combinations of biomarkers that suggest worsening disease.

In many systems, there are not enough clinicians to provide close follow-up to everyone who might benefit from it. AI monitoring is often introduced because:

- doctors and nurses are overstretched,
- specialist access is limited,
- and health systems want to monitor more patients without proportional staffing increases.

This approach to using AI in health-monitoring saves time as well as improves the use of raw data gathered by monitoring devices. It could address the following practical needs of patients:

1. Earlier detection - spot deterioration before a visible crisis,
2. Continuity - observe health between clinic visits,
3. Efficiency - help clinicians manage many patients,
4. Accessibility - support care at home or from a distance,
5. and Pattern recognition - find meaningful trends in complex data.

## When AI use goes wrong

The race-biased calibration of pulse oximeters has been found to bias machine learning algorithms as well thereby providing inaccurate, overly optimistic oxygen readings for Black individuals (see Martens et al. 2025). When healthcare providers rely on this type of AI-assisted health-monitoring without critically examining its bias, it can run the risk of pursuing interventions that can harm patients. If that happens, it also becomes unclear who is at fault, the physician who used AI or the designers who set AI to detect patterns in a biased way?

AI-assisted analysis of collected health-data in wearable devices and smartphone apps is often sold to third-party advertisers, and patients are rarely given a clear, understandable way to opt-out of this continuous monitoring.[1]

Unless regulation becomes stronger, there is the risk that AI algorithms can automatically cancel a user's upcoming prescription delivery or changes their treatment plan without the user consulting a physician. This is particularly true with consumer health apps since actual clinical use of AI remains to be closely supervised by physicians.[2]

## Relational Autonomy in AI Health-monitoring

Anita Ho's 2023 book *Live like nobody is watching* is hailed as "deeply informed analysis"[3] that leads to new understanding of what's at stake in using AI in health-monitoring. The book presents a careful assessment of the potential benefits as well as the ethical challenges they raise, especially in relation to patients' autonomy. Reviews have noticed the argument that for AI to truly enhance autonomy, it should complement, and not substitute, the healing relationship.

Because of the proprietary nature of most AI-assisted technology, patients cannot inspect the systems that shape the information it produces, especially those produced by machine learning, thereby affecting the quality of choices made based on that lack of transparency. The patient cannot really make an informed choice without access to the needed information. Tina Nguyen's 2024 review explains that health-monitoring AI can "undermine rather than promote autonomy" because manufacturers hide how the system actually works (Nguyen, 2024, p. 103). Nguyen's example is that companies provide results in "easily digestible charts" that can "oversimplify the results," leaving patients without "all the pertinent information they need" for making informed decisions (Nguyen, 2024, p. 103).

The patient's digital literacy (sufficient understanding of AI technology used) is central, not peripheral, to the ethics of AI monitoring. Some patient groups are "not afforded the proper resources to have the required expertise and access to these technologies" (Nguyen, 2024, p. 103). This undermines autonomy because a patient cannot meaningfully govern their healthcare if they cannot interpret the system, access it properly, or challenge its outputs. A formal right to choose means little when the practical conditions of understanding are absent.

Patient populations using AI health-monitoring depend on "social relationships" and caregivers (Nguyen, 2024, pp. 101–102). The patient is not the only person affected by AI monitoring-based decisions, therefore we must examine those relationships to frame ethical analysis, especially how it changes the patient's relation to family, caregivers, clinicians, and institutions.

In another review of Ho's book, Tom Sorell (2024) cites the example of elderly home monitoring. AI systems can turn homes into extensions of a "dominating hospital system" (Sorell, 2024, p. 668). When hospitals extend its monitoring through remote AI technologies, the meaning of home, care, and independence is redefined. Sorell notes that these systems may reduce travel burdens and infection risks, but they may also be "data-hungry and intrusive" (Sorell, 2024, p. 668). The problem is when AI health-monitoring "overly medicalize[s]" the home environment and informal carers are forced to become "aides to the medical system" (Sorell, 2024, p. 668).

In the case of AI assisted medication-adherence technologies, Nguyen cites Ho's example of the "digital pill project" where AI tracks whether a patient has ingested medication (Nguyen, 2024, p. 103). When physicians trust AI outputs more than what patients say about their own behavior or condition, AI use contributes to testimonial injustice (Nguyen, 2024, p. 103). Autonomy depends partly on being recognized as a credible knower of one's own life and body. If a patient's report is treated as less reliable than a device's output, then the patient's voice is weakened in clinical decision-making. This technological reordering of trust transforms patients into objects to be managed rather than persons to be heard.

AI health-monitoring can also exacerbate injustice by shifting the burden of caregiving. Since "the duties of caregiving are often expected of the women in the family, and the workforce for caregivers are disproportionately women of color", AI monitoring does not enter a neutral care environment. It is layered onto already unequal social arrangements (Nguyen, 2024, p. 103). This matters for autonomy because the patient's so-called independence may depend on someone else's intensified labor. If caregivers must learn the device, interpret alerts, troubleshoot data, and adjust routines around the system, then the technology may shift burdens rather than reduce them. The broader problem here is that AI health-monitoring can hide social dependency behind a language of efficiency and self-management.

When users are not informed that their data can be sold to third parties for purposes beyond what they associated with the device, this is a clear violation of their autonomy to decide (Sorell, 2024, p. 669). The patient is not using the device solely for their own ends but for commercial purposes they did not knowingly and intentionally choose to support.

The problem does not stop with undermining patients' autonomy. Even "ordinary general practitioners and medical specialists may not have the data science education to understand health algorithms fully" and "they, and not only typical patients, are at a cognitive disadvantage in the AI world" (Sorell, 2024, p. 670). If clinicians themselves cannot fully interpret the system, then both parties may be dependent on unclear outputs they do not fully understand. When neither patient nor clinician fully grasps how a recommendation or alert was generated, decision-making becomes harder to question, contest, or own. These problems show that AI health-monitoring can undermine autonomy not in one single way, but through a complex of mechanisms:

- **lack of transparency** that blocks meaningful understanding of all affected parties (e.g. patients, informal caregivers, physicians),
- **extension of hospital surveillance** that changes the meaning of home and care,
- **shifts in valued testimony** that silence patient voice and credibility,
- and **hidden commercial use of patient data** that turns health management into data extraction.

Framing the analysis using the concept of relational autonomy shows that autonomy is not just about isolated choice, but about whether patients can participate as respected, informed, and socially supported agents within the systems that govern their care.

Moreover, Sorell argues that some of these concerns are not unique to AI. He points out that surveillance, behavior modification, cost-cutting rhetoric, and intrusive monitoring also characterized earlier forms of telecare. His criticism is that Ho does not always distinguish sharply enough between what is newly AI-specific and what is part of a longer history of medical surveillance (Sorell, 2024, pp. 668-669). That is an important finding because it pushes the debate toward greater conceptual precision.

## How to address ethical challenges

In order to strengthen autonomy when using AI health-monitoring, Nguyen states that Ho "advocates for dialogic engagement" that includes patients and patients'

families in ongoing conversations about machine learning systems (Nguyen, 2024, p. 102).

Another recommendation is the use of low-tech or nontechnical alternatives whenever possible and sufficient. Rather than always defaulting to more surveillance technology, one might improve care through something as simple as "better lighting in the hallways" (Nguyen, 2024, p. 102).

As earlier stated, AI health-monitoring use requires a clear and practical strategy to increase digital literacy of patients and caregivers, i.e. their knowledge and understanding of the AI/machine learning technology they are using needs to increase to a sufficient level.

Related to this, more transparency about data practices associated with the AI technology being used is also needed.

Direct to consumer (DTC) devices deserve special scrutiny because they are voluntarily adopted yet still data-hungry and often provide unclear benefit (Sorell, 2024, p. 669).

Clinicians' limited data-science understanding implies a need for institutional safeguards, training, and limits on overreliance on algorithmic outputs (Sorell, 2024, p. 670).

## Beyond relational autonomy

There are other issues that need to be addressed. There is, for instance, a need to sufficiently spell out how the concerns identified should be institutionalized into procurement rules, auditing standards, redress procedures, or post-deployment oversight. This matters because moral critique without governance often leaves practice unchanged.

Sustained attention to liability, regulatory approval, adaptive-system consent, or obligations of vendors and healthcare institutions is also needed. This is important because many harms from AI monitoring are not interpersonal accidents; they are structurally produced.

There is a need to fully explore commercialization, platform incentives, or the economic logic of health-data capture. That is crucial because AI monitoring is not just a medical tool; it is part of a data economy.

We also need to apply conceptual resources from disability theory and disability justice. Disabled people are among the most directly affected by monitoring regimes, and disability perspectives can challenge the paternalistic equation of surveillance with safety.

We need to ask what evidence exists regarding clinical benefit, false positives, caregiver burden, or differential outcomes across social groups. Ethical analysis is stronger when paired with evidence of actual effects on diverse groups.

Further, there is a need to clearly specify how participation can become merely symbolic or even exclusionary in dialogic engagement. That matters because poorly designed engagement can legitimate systems without redistributing power.

Sorell is right that not every case is a life-and-death struggle over practical identity. But repetitive nudging, scoring, and surveillance can gradually reshape how people see themselves and what they regard as normal. That slower

transformation of agency is ethically important even when no single decision looks existential.

These other practical issues matter because AI health-monitoring is not just a question of private choice. It involves institutions, incentives, legal structures, labor, and social inequality. If the analysis stops at conceptual ethics, it risks underestimating how harms are produced and reproduced in practice.

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## Notes

[1] American Academy of Dermatology (AAD) explicitly warns that wearable device data can be shared and sold: "By default, when you click 'agree,' you may unknowingly give a device maker consent to share your data with third parties… Health insurers could buy your data." (Ludmann 2023)

[2] Prescription validation using AI is restricted to decision-support than autonomous process: "AI-powered prescription validation algorithms can identify potential prescribing errors... Clinical Decision Support Systems (CDSS) that use Artificial Intelligence embedded in Electronic Health Records inform nurses in real time about high-risk drug interactions and incorrect dosing." (Alqaraleh 2025)

[3] From the book cover review.

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