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2ND BIENNIAL DUQUESNE-PENNWEST

CONFERENCE ON GLOBAL BIOETHICS

NOV 12 - 14, 2026

PennWest Edinboro
Baron-Forness Library
Edinboro, PA



**DUQUESNE
UNIVERSITY**

McAnulty College and
Graduate School of Liberal Arts

Center for Global Health Ethics

**PennWest
UNIVERSITYSM**

The James F. Drane
Bioethics Institute

**Second Biennial
Duquesne–PennWest
Conference on Global Bioethics**

Organized by:
Center for Global Health Ethics, Duquesne University
The James F. Drane Bioethics Institute, PennWest University

**November 12–14, 2026
Baron-Forness Library, PennWest Edinboro
Edinboro, Pennsylvania**

PennWest.edu/bioethics-conference

MESSAGE FROM THE INTERIM PRESIDENT AND HONORARY CHAIR



On behalf of PennWest University, I am honored to welcome scholars, students, and professionals to the Second Duquesne–PennWest Conference on Global Bioethics at our PennWest Edinboro campus.

PennWest University is proud to host one of the oldest organizations dedicated to bioethics in the United States. The Bioethics Institute, founded in 1969 by Dr. James F. Drane, one of the pioneers and leaders of the field, is nearly as old as the discipline itself. For decades, the Institute has brought together scholars from PennWest (then Edinboro University), across the United States and around the world to explore the ethical dimensions of medicine, science, and public policy.

Bioethics addresses some of the most urgent questions of our time. With rapid advances in biomedical science and emerging technologies, the ethical dimensions of healthcare and research are increasingly significant.

The James F. Drane Bioethics Institute of PennWest University, in collaboration with Duquesne University's Center for Global Health Ethics, launched this conference series to address global bioethical challenges. The inaugural conference in November 2024 at Duquesne University was a great success, featuring leading international scholars and outstanding student participation. We were especially proud of PennWest students whose work earned the Dr. Russell B. Roth Prize.

We are pleased to host this year's conference at the Baron-Forness Library on our Edinboro campus. The 2026 theme, bioethical aspects of health pseudoscience, comes at an important moment, given contemporary challenges in knowledge, technology, and the growing influence of generative AI. I invite scholars to contribute their work and encourage PennWest University faculty and students in particular to participate, share their research, and engage with colleagues from around the world.

It is my pleasure to welcome you to PennWest during the beautiful Pennsylvania fall season.

A stylized, handwritten signature in black ink, appearing to read 'J. Fisher'.

James Fisher, J.D., Ph.D.

Interim President, PennWest University

Honorary Chair, Second Duquesne–PennWest Conference on Global Bioethics

AGENDA

Thursday, Nov. 12, 2026

12:30-2 p.m.

2-3:30 p.m.

Registration

Opening Ceremony

Dr. James Fisher
Interim President, PennWest University

3:30-4 p.m.

4-5 p.m.

Coffee Break

Keynote Lecture

Governance Ethics for Healthcare Organizations?
Professor Gerald Magill

5-7 p.m.

7-9 p.m.

Dinner Reception

Dr. James Drane Lecture Series on Religion and Culture

Knowing Truth in the Age of AI:
Spiritual Awareness in Human Knowledge and Its Normal Correlates
Professor Lisa Miller

Friday, Nov. 13, 2026

9-10 a.m.

Keynote Lecture

Not a Bug. An Empirical Bioethics Case Against (Supposed) AI Neutrality
Professor Giovanni Spitale

10-10:30 a.m.

10:30 a.m.-12:30 p.m.

Coffee Break

Oral Presentations

Dr. Joris Gielen, Chair

1. *Informational Justice and Health Misinformation in High-Volume Kidney Care*
Joris Gielen and Komal Kashyap
2. *Routine Tests and Sensitive Findings*
Megan Kitts
3. *Rebuilding Trust Through African Communitarian Bioethics:*
An Empirically Informed Ethical Framework for Addressing Health Misinformation
Uchenna E. Okaa-Onwuogu
4. *The Role of Global Bioethics in Determining Minimal, Universal Health Standards for Commercial Space Flight Participants*
Adrianna Hynson
5. *Organ Allocation and Distributive Justice: Addressing Racial and Ethnic Disparities in Global Bioethics*
Francis Sarpong
6. *Sickfluencers': Disability Ethics and Social Media*
Isabelle Toler
7. *Beauty, Poison, and Consent: The Ethics of "Botox Parties"*
Sophie Hintzen
8. *Public Transparency of Biobank Governance Policies in Europe: Implications for Health Misinformation*
David Appiah
9. *A Global Bioethical Evaluation of Allocation Out of Sequence Organ Transplantation*
Ellen Resek
10. *Trust Whom? Kuhn and the Rhetoric of "Trust the Science"*
Jacob Cherry

12:30-2 p.m.

2-3 p.m.

Lunch Break

Keynote Lecture

Creating Your Own Reality with AI:
From Stochastic Parrots to Synthetic Truth with AI and Global Health and Bioethics
Professor Jennifer Camille Dempsey

3-3:30 p.m.

3:30-5:30 p.m.

Coffee Break

Oral Presentations

Dr. Federico Germani, Chair

1. *Social Media Screenshot Battles: Information Literacy Failures Amidst Google AI Overviews*
Tameishia Olden
2. *The Political Justification of Immunization Policy Under Conditions of Widespread Misinformation and Conspiracism about Vaccines*
Amitabha Palmer

AGENDA

3. *From Misinformation to Epistemic Infrastructure: Bioethics and the Governance of AI-Mediated Health Information*
James Hearn
4. *The Law of Medical Misinformation: When Bad Health Information Becomes a Legal Wrong*
Arash Aramesh
5. *An Ethics Overview of Artificial Intelligence Generated Audiovisual Content Representing Experts and the Potential for Digital Global Health Misinformation*
Benjamin Collins
6. *Ethical and Legal Considerations for the Restoration of USAID Global Health Aid Programs*
Kalen Fredette
7. *The Global Bioethics Implications of Clinical Decisions Surrounding Cesarean Deliveries*
Laila Burrell
8. *The Role of Ethics Education in Reducing Health Misinformation*
Ercan Avci
9. *Obsessive-Compulsive Disorder, Risk, and Misinformation*
Benjamin Campbell
10. *Synthetic Medical Authority: The Ethics of AI-Generated Doctors on Social Media*
Dina Siniora
11. *The "Infodemic" and its Consequences for Global and Public Health*
Samuel K. Danso

5:30-7 p.m.

Dinner Reception

Saturday, Nov. 14, 2026

9-10 a.m.

Keynote Lecture

Ethical Strategies for Managing Misinformation During Public Health Crises

Professor Federico Germani

10-10:30 a.m.

Coffee Break

10:30 a.m.-12:30 p.m.

Oral Presentations

Dr. Giovanni Spitale, Chair

1. *From TikTok to Primary Care: The Bioethical Responsibility for Adult ADHD Recognition in the Age of Health Misinformation*
Hande Atalay
2. *Capital's Impact on Global Bioethics*
Richard (Ricky) V. Pazer Jr.
3. *The Ethics of an Infodemic: Information Inequality, Patient Autonomy, and Justice in Healthcare*
Fahmida Hossain
4. *The Ethical Dimensions of the Infodemic*
Ali Shareef
5. *The Ethics of AI-Generated Health Advice: Are Current Guidelines Enough to Protect Patients?*
Kylie Mettrick
6. *Misinformation on Contraception Amidst the Abortion Debate*
Poet Perry
7. *Would You Trust AI? A Narrative Review of the Reliability of AI-Generated Medical Information and Its Bioethical Implications*
Fatima Hernandez Ortiz, Romina Molina Cruz, and Renata Flores
8. *The Appeal to Nature Fallacy*
Khayleigh Sterling-Smith
9. *Supernatural Explanations of Psychiatric Illness: The Bioethical Implications and Role of Clinicians*
Parastoo Aramesh
10. *Embryo Personhood in In Vitro Fertilization: An Ethical Question Without Clear Boundaries*
Michael Donlon
11. *The Role of Autonomy in Patients with Both Physical and Mental Health Needs*
Helena Sweitzer-Bush

12:30-1 p.m.

Closing Ceremony

KEYNOTE SPEAKERS



Professor Gerard Magill, Ph.D.

Professor Gerard Magill, Ph.D., holds the Vernon F. Gallagher Chair for the Integration of Science, Theology, Philosophy, and Law at Duquesne University (appointed in 2007), where he is a tenured professor in the Center for Healthcare Ethics. In 1987, he graduated with his Ph.D. from Edinburgh University in Scotland. From 1987, he developed his scholarly career at Saint Louis University, where in 1996 he was appointed department chair of the Center for Healthcare Ethics. As executive director of that Center from 1999, he held multiple appointments including being a member of the Council of Deans for the university's health sciences campus, a division director in the Department of Internal Medicine at the University Hospital, a member of the university's Institutional Review Board, a member of the Hospital Ethics Committee, a professor in the School of Medicine (secondary appointment), and a professor in the School of Public Health (secondary appointment). He has authored, co-authored, or edited 17 books, including a recently co-authored book on Governance Ethics in Healthcare Organizations (Routledge 2020). He has published over 85 scholarly and professional articles and given over 250 scholarly presentations at conferences. He is a member of 17 professional associations. He has extensive experience on institutional review boards, hospital ethics committees, and ethics consultation services.



Professor Jennifer Camille Dempsey, Ph.D.

Professor J. Camille Dempsey is director of the PennWest Center for Artificial Intelligence and Emerging Technologies and a professor of Educational Technology at PennWest University. She holds a doctorate in instructional technology and leadership from Duquesne University, a master's degree from Teachers College, Columbia University, and a bachelor's degree from the University of Pennsylvania. Dr. Dempsey has received numerous honors, including being named a Faculty Research Fellow in Artificial Intelligence by the International Society for Technology in Education and an EDSAFE AI Alliance Catalyst Fellow. She also serves as a Google/Technovation Women Techmakers Ambassador, an ISTE Community Leader, and a Pennsylvania Keystone Technology Integrator. Additional honors and work include being recognized as one of ISTE's "20 to Watch" awardees in educational technology, and she received the Educational Technology Impact Award from the Pennsylvania Association for Educational Communications and Technology for her article, The Spirit of the Times: Virtuality Culture and Technology-Mediated Human Presence. Camille was also the recipient of the Ero W. Davidson State Award for Outstanding Accomplishments in Technology and Communications from PAECT. Dr. Dempsey was invited to serve on the Pennsylvania Joint State Government Commission AI Advisory Committee and contributed to the state report on AI ethics, safety, workforce development, and education. Most recently, she completed a professional development series in Morocco, delivering seven workshops to support university faculty in integrating ethical and responsible AI practices into teaching and learning.



Professor Federico Germani, Ph.D.

Professor Federico Germani is the co-director of the ITE Lab at the Institute of Biomedical Ethics and History of Medicine, University of Zurich, Switzerland, and associate professor at the Institute for Data Science and Artificial Intelligence, Boğaziçi University, Türkiye. He previously served as rapporteur for the World Health Organization expert group on the ethics of infodemic management and social listening. He builds evidence and tools to manage misinformation, focusing on how AI-driven information ecosystems shape beliefs and how ethical, evidence-based interventions can strengthen trust and public discourse.



KEYNOTE SPEAKERS



Professor Giovanni Spitale, Ph.D.

Dr. Giovanni Spitale is a postdoctoral fellow at the Institute of Biomedical Ethics and History of Medicine (IBME), University of Zurich, and since 2025, co-director of ITE Lab. He has served as a rapporteur for the World Health Organization panel on ethical considerations in social listening and infodemic management. His research sits at the intersection of empirical ethics, public health ethics, and the ethics of emerging technologies, with a particular focus on disinformation, infodemic management, and AI. In terms of methods, he likes to dip into multiple bowls, combining natural language processing, computational linguistics, qualitative research, statistics, and philosophical analysis into mixed-methods approaches. AI can fit both in the themes and in the methods box. His recent empirical work on AI-generated disinformation and large language model bias has been published in *Science Advances*.

He has published in journals including *Nature*, *Science Advances*, *NEJM Catalyst*, *The American Journal of Bioethics*, and *JMIR*. His work has been featured in *The Times*, *The Verge*, *Wired*, *MIT Technology Review*, *El País*, *Süddeutsche Zeitung*, and *SwissInfo*. He has been a TEDx speaker.



Professor Lisa Miller, Ph.D.

Lisa Miller, Ph.D., is the New York Times bestselling author of *The Spiritual Child* and *The Awakened Brain*. She is a full professor in the Clinical Psychology Program at Teachers College, Columbia University, where she founded the Spirituality Mind Body Institute, the first Ivy League graduate program and research institute in spirituality and psychology. She has also held more than a decade of joint appointments in the Department of Psychiatry at Columbia University Medical School.

Her innovative research has been published in more than 200 peer-reviewed articles in leading journals, including *Cerebral Cortex*, *The American Journal of Psychiatry*, and the *Journal of the American Academy of Child and Adolescent Psychiatry*.

Dr. Miller is editor of the *Oxford University Press Handbook of Psychology and Spirituality* (Editions 1 and 2), founding co-editor-in-chief of the APA journal *Spirituality in Clinical Practice*, an elected fellow of the American Psychological Association (APA), and a two-time president of the APA Society for Psychology and Spirituality. She is a graduate of Yale University and earned her doctorate from the University of Pennsylvania under Martin Seligman, founder of the positive psychology movement.

Dr. Miller speaks extensively for higher education, business, government and military organizations, creative endeavors, medical, health and wellness centers, universities, and faith-based initiatives.



KEYNOTE ABSTRACTS

Creating Your Own Reality with AI: From Stochastic Parrots to Synthetic Truth with AI and Global Health and Bioethics

Jennifer Camille Dempsey, Ph.D.

PennWest University

In an age where artificial intelligence enables the creation of increasingly convincing realities, the nature of truth in global health is fundamentally reshaped. From early critiques of large language models as “stochastic parrots” to the rise of generative AI, deepfakes, and voice cloning, AI systems are no longer simply tools for information retrieval but active participants in knowledge production. These technologies generate persuasive medical content at scale, often without clear markers of accuracy or authority, challenging how individuals and societies determine what is credible and trustworthy.

This keynote examines the ethical, social, and epistemic implications of AI-driven misinformation within a global bioethics framework. As synthetic media blurs the boundaries between authentic and fabricated information, the session moves beyond a focus on correction toward human-centered approaches that address trust, interpretation, and meaning-making in AI-mediated environments. It highlights the responsibilities of higher education, healthcare systems, and policymakers in advancing AI literacy, ethical standards, and equitable access to reliable information, offering a framework for navigating health knowledge in an increasingly synthetic and algorithmic world.

Not a Bug. An Empirical Bioethics Case Against (Supposed) AI Neutrality

Giovanni Spitale, Ph.D.

*Institute of Biomedical Ethics and History of Medicine (IBME),
University of Zurich*

The dominant narrative about AI and health misinformation runs roughly as follows: AI is a powerful tool for generating disinformation, but it can also be deployed to detect and counter it. Both halves of this narrative are empirically wrong in ways that matter for bioethics.

In this keynote I will present insights from three studies that, taken together, dismantle the assumption of AI neutrality: first on the production side, then at the level of adversarial exploitation, and finally, most uncomfortably, on the evaluative side.

First: AI language models produce disinformation that is more persuasive than human-generated content, and humans cannot reliably distinguish it from authentic text (Spitale et al., 2023). The obvious response — improve the safeguards — turns out to be insufficient. Second: emotional prompting bypasses those safeguards systematically. No technical expertise required; emotional manipulation of prompts reliably amplifies disinformation generation even in guarded models (Vinay, Spitale et al., 2025). The natural next move — use AI to evaluate and flag content — reveals the third and deepest problem: when LLMs are tasked with evaluating narrative statements, they exhibit systematic source-framing bias. E.g., attributing content to Chinese sources consistently lowers agreement scores across four state-of-the-art models (Germani & Spitale, 2025). The judge is not neutral. It never was.

The pattern across these findings is not a sequence of fixable bugs — it is structural. And it points to something bioethics has been slow to say plainly: the epistemic infrastructure of the information age is being built without us, on assumptions we have not examined, by actors who do not share our commitments. Drawing on Potter’s third bioethics — the conviction that survival requires a bridge between knowledge and human values — this talk argues that governing AI in the epistemic ecosystem is not a technical problem with ethical implications. It is a political contest over who designs the architecture of credibility. Bioethics has a seat at that table. But only if it claims one.

Ethical Strategies for Managing Misinformation During Public Health Crises

Federico Germani, Ph.D.

*Institute of Biomedical Ethics and History of Medicine (IBME),
University of Zurich*

Health misinformation is a persistent challenge for global health systems, particularly in digitally mediated information environments where rumors and misleading claims can spread rapidly. Policy responses have often focused on content moderation and censorship; however, these measures raise ethical concerns related to freedom of expression and public trust. Moreover, reactive censorial approaches frequently address symptoms rather than the underlying conditions that enable misinformation to emerge and circulate. This keynote lecture proposes an ethical perspective on addressing health misinformation that shifts attention from reactive control to proactive resilience. It examines how information voids create fertile conditions for rumors and misleading narratives to proliferate, and explores how ethically grounded social listening practices can help identify emerging concerns while incorporating meaningful forms of community engagement. The talk will also consider the limits and risks of censorial approaches, arguing that sustainable responses to misinformation require long-term investments in societal resilience. These include strengthening information literacy and promoting AI literacy in the context of generative technologies, as well as developing communication infrastructures capable of responding effectively to emerging informational gaps.

ORAL PRESENTATION ABSTRACTS

Knowing Truth in the Age of AI: Spiritual Awareness in Human Knowledge and Its Normal Correlates

Lisa Miller, Ph.D.

What best might come for humanity in our new era of AI? What can humanity be, that is not feasible for AI? AI might offer a gentle shove to recall who we really are as humanity, distinct from machines, foremost naturally spiritual beings. AI might encourage our realization of the unique and profound capacity in humans for spiritual perception and its application to our ethical and moral lives.

It appears based upon neuroscience that there exists a mode of perception underlying spiritual awareness that is not replicated by AI. Specifically, there exists differences in neural correlates and function between

- 1) Achieving Awareness, with tactical and strategic calculations, versus
- 2) Awakened Awareness, as a receptive form of perception which is a spiritual form of knowing.

Based upon 25 years of peer-reviewed science, spirituality is not seen to be a belief, but rather an innate human capacity for perception. In this talk, we examine the implications of a renewed understanding of a foundationally spiritual humanity.

ORAL PRESENTATION ABSTRACTS

November 13, 10:30 a.m.-12:30 p.m.

Informational Justice and Health Misinformation in High-Volume Kidney Care

Joris Gielen and Komal Kashyap

Duquesne University

If patients want to participate in decision-making regarding their healthcare, they need access to accurate and understandable health information. In high-volume clinical environments, patients may sometimes struggle to gain access to this kind of information. This lack of information leaves them vulnerable to misinformation. This study examines how adults receiving kidney care obtain and process information about kidney disease and treatment options and explores the bioethical implications of the observations, using ethnographic data from a nephrology department at a large tertiary-care hospital in India.

Analysis revealed that obtaining trustworthy information was a demanding quest for the patients. Three interrelated dimensions shaped this process: the sources patients used to obtain information, the quality and comprehensibility of that information, and patient-, provider-, and system-level barriers to effective communication. Patients often struggled to get reliable information due to time pressures caused by high patient volumes, fragmented care, inconsistent communication by nephrologists, and limited opportunities for questions during consultations. When patients felt that explanations from nephrologists were incomplete or difficult to understand, they frequently sought information from family members, peers, the internet, and practitioners of alternative medicine. While these sources sometimes filled important gaps regarding kidney disease and its treatment options, they also exposed patients to conflicting claims, unverified recommendations, and misinformation.

These findings highlight how misinformation can flourish due to structural and organizational limitations. The data show that misinformation is often not due to individual failure, either in the form of clinicians' unwillingness to provide accurate information or the patients' and their family members' lack of interest in pursuing reliable information. Structural limitations force patients to search for information outside the clinical encounter. Promoting informational justice requires structural changes to improve communication, continuity of care, interdisciplinary collaboration, and support of health literacy.

Routine Tests and Sensitive Findings

Megan Kitts

Duquesne University

Clinical workups typically involve a series of screenings and tests on patients' biospecimen, like blood or urine, which assess the quantities of compounds that are instrumental in forming a care plan. While many results from routine tests on biospecimens are socially benign, others may have serious social implications for those being tested, including pregnancy tests and tests that assess the presence of illicit drugs or alcohol. While patients must agree to provide their biological samples, patients are often not told what tests will be run on those samples or treatment is withheld until they agree to testing. Practitioners justify these practices by citing the risks of treating without knowing the tests' status.

In this presentation, my first aim is to tackle *whether* and *how* sensitive tests are a matter for consent. I argue that consent to potentially sensitive biospecimen testing is an extension of the right to make decisions about personal property, rather than an extension of the right to bodily autonomy. I then show that generalized consent forms and general verbal agreements are ethically insufficient to exercise this right. Finally, I consider whether a clinician's refusal to proceed with treatment given a patient's refusal to be tested constitutes coercion.

My second aim is to identify a principled way to determine *which* tests require consent. Without a principled reason to distinguish between tests, one might be inclined to say that *all* tests or screenings are a matter for explicit consent. However, this is both impractical and nonintuitive. There must be a way to identify which tests that require a more rigorous consent standard. I post that, while personal sensitivity is individually subjective, social sensitivity may be easier to identify though still relative. This may inform which tests carry greater risks to patients, particularly in performing them without patients' explicit agreement.

ORAL PRESENTATION ABSTRACTS

Rebuilding Trust Through African Communitarian Bioethics: An Empirically Informed Ethical Framework for Addressing Health Misinformation

Uchenna E. Okaa-Onwuogu

University of Mary, Bismarck, North Dakota

Health misinformation is a bioethical problem concerning trust, responsibility, autonomy, justice, and health-related decision-making. Although conventional responses often prioritize fact-checking and correcting misleading claims, less attention has been given to the relational conditions through which health information is received, trusted, and acted upon. This research addresses this gap by exploring an African communitarian framework grounded in relational personhood, solidarity, communal responsibility, and accountable moral leadership in addressing health misinformation.

A published exploratory study of 50 purposively sampled participants of African descent in Nigeria, Malawi, South Sudan, Italy, and the United States used structured questionnaires, descriptive analysis, and interpretive inquiry to identify relational and moral resources relevant to trustworthy health communication. The study did not measure misinformation exposure, belief, dissemination, or intervention outcomes.

Relational understandings of persons, health, and moral responsibility emerged as resources for building trust and resilience in health communication. Community was unanimously recognized as shaping individual thought and decision-making, while substantial majorities valued the extended family system (70%), supported sharing relevant medical information with family members (70%), and affirmed family participation in medical decision-making (76%). Most participants (90%) understood justice in interpersonal terms, associating it with respect for others and harmonious communal life. Taken together, these findings suggest that health communication and decision-making are relational practices embedded in family, community, mutual responsibility, and social harmony.

While safeguarding informed, voluntary, and confidential individual decision-making, a bioethical response can also engage communities to enhance transparency, evidence-responsive community leadership, participatory dialogue, and family-inclusive communication where desired by patients. The task is not merely to correct false claims, but to rebuild the trust conditions in which reliable health information can be heard, assessed, and responsibly acted upon. This research offers an empirically informed African contribution to building resilience to health misinformation.

The Role of Global Bioethics in Determining Minimal, Universal Health Standards for Commercial Space Flight Participants

Adrianna Hynson

Duquesne University

Commercial Space Flight is a rapidly evolving, globally expanding industry with globally operating companies, and with the growth of the industry comes the growth of ethical concerns on passenger criteria. Space flight is always going to be hazardous and negatively impact the health of those participating. Therefore, the question of what health standards of space flight participants inevitably must be addressed. This presentation will not only acknowledge the developing questions but also identify the global bioethical concerns underlying them. Several important questions arise: Can passengers with certain health conditions, such as pregnancy, disabilities, diminished capacity, or mental health conditions, safely and ethically participate in space flight? Who should be responsible for screening participants and determining whether they are medically fit to fly? What level of health information should passengers be required to disclose, and what expectations of privacy should they have? These questions become increasingly complex as commercial space flight expands beyond highly trained astronauts to include private citizens with diverse medical backgrounds. Ultimately, determining appropriate health standards requires balancing the participant's autonomy and right to access space travel with principles of beneficence, nonmaleficence, liability, and privacy. Examining these competing considerations can help establish global bioethical approaches to passenger screening while recognizing both individual rights and the unique risks associated with space flight.

Organ Allocation and Distributive Justice: Addressing Racial and Ethnic Disparities in Global Bioethics

Francis Sarpong

Suffolk Community College, Brentwood, NY

The continual scarcity of organs for transplantation presents a question to global bioethics. This problem raises fundamental questions about justice in scarce medical resources allocation. In the existing organ allocation measures, racial and ethnic minorities are disadvantaged in the distribution of organs compared to non-minorities. Organ distribution organizations, health systems, healthcare providers, patients, and the transplant information environments contribute to the disparity in organ allocation. This essay examines the relationship between health misinformation and organ allocation in culturally and ethnically diverse societies. It analyses the impact of misinformation and unequal access to reliable health information about organ donation and transplantation may contribute to disparities in donation and allocation. The paper argues for a normative framework to the production, communication, and dissemination of health information about donation and allocation. The problem addressed in this essay concerns the possibility of a normative approach that can adjudicate who should have scarce medical resources when not all in need can have them, amidst health misinformation, racial and ethnic healthcare disparities. The essay applies descriptive, metaethical, and normative approaches to propose a distributive standard that can potentially strengthen public confidence in organ allocation systems. Bringing to the fore the link between misinformation and the problem of distributive justice, the paper underscores the role of bioethics in responding to the informational and structural aspects of the global organ shortage.

ORAL PRESENTATION ABSTRACTS

Sickfluencers': Disability Ethics and Social Media

Isabelle Toler

Duquesne University

The rise of social media has allowed people with disabilities to share their lived experience with a wider audience. In tandem, social media has also opened the disability community to more public scrutiny. Consider a recent article in The Daily Telegraph called "How having a disability became cool." Author Poppy Coburn critiques social media influencers who post about their disabilities online and says, "A class of young women - somewhat cruelly dubbed as "sickfluencers" - want to tell you about their conditions." She goes on to explain how social media has led to overmedicalization and overdiagnosis of rare conditions such as POTS (postural orthostatic tachycardia syndrome). While 'sickfluencers' may be a trendy term to grab attention from viewers, it represents a larger problem of ableism in contemporary media. I argue that social media risks exacerbating longstanding assumptions that disability is something to fear. The misrepresentation of disability online can contribute to real world barriers for people with disabilities including loss of accessibility accommodations, decreased funding for research, healthcare policy changes, social discrimination, and even violence. However, social media is also an opportunity to center disabled voices and organize advocacy efforts. Virtual communities have social power. We must wield it to challenge assumptions about disability and contribute to larger institutional change.

Beauty, Poison, and Consent: The Ethics of "Botox Parties"

Sophie Hintzen

University Hospital Hamburg Eppendorf, Germany

The willingness to trade health risk for aesthetic enhancement seems deeply rooted in history. Roman women reportedly used *Atropa belladonna* («beautiful lady») to dilate their pupils despite its toxicity. Today a comparable dynamic appears in the popularity of botulinum toxin, a substance that, like digitalis or cocaine, is poisonous in larger doses and therapeutic or enhancing in small, carefully controlled doses. This paper examines the question of whether the so-called «Botox parties,» where injections are given in homes, salons, or hotels amid music, alcohol, and promotional discounts, are ethically permissible since they are turning a medical procedure into social events. Risks might be downplayed, and botulinum toxin seems to be framed as a beauty product rather than a pharmaceutical; these events could be seen as a form of health misinformation. This calls for a bioethical response.

Applying Beauchamp and Childress the four principles, this analysis argues that respect for participants' autonomy should be scrutinized against the context in which "choice" occurs. Social Media, peer pressure, group dynamics, and limited opportunity for private consultation could undermine voluntary, informed consent. Non-maleficence is implicated when screening for contraindications (neuromuscular disorders, allergies) seems abbreviated, injector qualifications are opaque, and emergency equipment or follow-up care might be far away or even unavailable. Beneficence is compromised when commercial incentives outweigh patient welfare. Justice concerns arise where low-cost, unregulated offerings of botulinum toxin disproportionately reach individuals unable to afford regulated care.

In conclusion, a regulatory and educational response is suggested: a clear legal separation between medical treatment and commercial sales events; minimum standards for consent and screening; restrictions on influencer marketing of prescription drugs; and health literacy campaigns that reframe botulinum toxin as a pharmaceutical with a genuine risk profile. Finally, it addresses the question of liability when complications occur in these settings.

Public Transparency of Biobank Governance Policies in Europe: Implications for Health Misinformation

David Appiah

Duquesne University

Background: As genomic research becomes increasingly transnational, transparency regarding how biobanks govern access, sharing, secondary use and participant protections is an important component of ethical research governance. Limited public visibility of these policies may create uncertainty about how genomic resources are managed, weakening accountability and public trust, and leaving information gaps in which health misinformation can circulate. This study examined the availability and transparency of publicly accessible data governance policies among European biobanks.

Methods: A quantitative content analysis was conducted using the BBMRI-ERIC Directory of Biobanks. Following screening, 268 European biobanks were eligible; preliminary results are reported for 120. Publicly available governance materials were coded using a predefined deductive framework covering nine domains. Transparency was operationalized as public disclosure of substantive, biobank-specific information. A Transparency Coverage Score (0–100) was calculated as the proportion of domains disclosed.

Results: No public governance materials were available for 11 biobanks (9.2%). Disclosure was highest for access and sharing models (90.0%), oversight structures (66.7%) and access processes (56.7%), and lower for de-identification (45.0%), withdrawal procedures (43.3%), material transfer/data use agreement terms (39.2%), cross-border transfer (30.8%) and commercial use (26.7%). Only 5.0% described breach-response procedures. The mean Transparency Coverage score was 44.8 (SD 30.0; median 44.4, IQR 19.4–66.7); 55.0% (n=66) of biobanks disclosed four or fewer domains, and 2.5% (n=3) disclosed all nine.

Conclusion: The preliminary results suggest that access & sharing arrangements are frequently disclosed, but important information concerning cross-border transfer, commercialization, participant withdrawal procedures, data protection, and breach response is less visible. Transparency of data governance policies should not be understood as a direct solution to health misinformation; rather, it constitutes an ethical condition that can support accountability and sustain trustworthy health information environments.

ORAL PRESENTATION ABSTRACTS

A Global Bioethical Evaluation of Allocation Out of Sequence Organ Transplantation

Ellen Resek

Duquesne University

In 2025, the New York Times published an article uncovering potential misconduct within the organ donation system: a new practice called “out of sequence organ transplantation” (AOOS). This article presented OPOs and transplant centers as maliciously engaging in unethical practices such as unfairly skipping recipients who are entitled to be offered the organ first due to their place in the match-run. Since then, new policy regulations and clarifications have led to a near prohibition of the practice in the United States of America despite its generally consistent use in several European countries. The public consensus and subsequent policy interventions have damaged the ethos of the organ transplantation space holistically. However, much of the concern and frustration regarding AOOS usage is based on a fundamental misunderstanding of the Organ Donation Allocation process. This presentation will clarify widespread misinformation about AOOS usage and provide an evaluation of viable considerations for and against the practice from the perspective of global bioethics. It will provide potential avenues for how the practice can continue ethically in the US. I will argue that there are definite concerns with current US procedure surrounding AOOS usage; however, the prohibition of the practice is similarly detrimental. An ethical implementation would require specific and thoughtful initiatives, grounded in global examples of successful AOOS regulations.

Trust Whom? Kuhn and the Rhetoric of “Trust the Science”

Jacob Cherry

Duquesne University

In the months preceding the deaths of her three children, Lindsay Clancy sought psychiatric treatment from multiple clinicians and institutions while experiencing a rapidly deteriorating mental state. Over approximately four months, she was prescribed thirteen psychiatric medications through more than thirty prescriptions, with medications repeatedly introduced, discontinued, and adjusted. Her subsequent civil litigation alleges that failures to coordinate care, recognize warning signs, and properly diagnose her condition contributed to the tragedy. The Clancy case therefore presents a difficult bioethical question that extends beyond whether an individual clinician followed accepted medical practice: what does it mean to trust scientific medicine when the institutions entrusted with interpreting and applying scientific knowledge can disagree, fragment care, and fail?

This paper uses the Clancy case to interrogate the increasingly common injunction to “trust the science.” Philosophically, the phrase commits a category error. Science is not an agent that can be trusted. Science comprises methods, theories, practices, institutions, and communities whose conclusions remain open to revision. When the public is instructed to “trust the science,” it is being asked to defer epistemic judgment to the people and institutions authorized to determine what counts as legitimate scientific knowledge.

Thomas Kuhn’s account of paradigms and scientific communities provides a framework for understanding this distinction. For Kuhn, scientific knowledge does not develop through the simple accumulation of neutral observations. Normal science occurs within paradigms that determine which questions warrant investigation, which methods are legitimate, what constitutes relevant evidence, and which problems require resolution.

Scientific consensus therefore carries substantial epistemic authority without becoming synonymous with immutable truth. Appeals to “the science” can obscure the human and institutional structures through which scientific knowledge acquires authority.

The Clancy case illustrates the consequences of collapsing scientific knowledge into institutional authority. Her treatment involved numerous medications, clinicians, diagnostic judgments, and changes in treatment, raising questions about polypharmacy, continuity of care, diagnostic uncertainty, and the ethical responsibilities created when patients defer to medical expertise. The issue is not whether psychiatric science should be rejected, but whether appeals to scientific authority can become substitutes for examining how scientific knowledge is interpreted and applied within actual systems of care.

The paper extends this analysis to gain-of-function research, where disagreements concerning risk, terminology, oversight, acceptable uncertainty, and potential social benefit further complicate appeals to a singular “science.” In both contexts, scientific evidence cannot itself resolve questions concerning acceptable risk, institutional responsibility, or the conditions under which epistemic deference is warranted. These are partly normative questions and therefore properly within the domain of bioethics.

I argue that bioethics should move beyond the rhetoric of “trust the science” toward an account of justified epistemic trust. The relevant question is not whether one trusts science, but whom one has reason to trust, concerning which claims, under what institutional conditions, and with what degree of uncertainty. Scientific authority remains indispensable. Yet precisely because patients and the public must often defer to expertise they cannot independently verify, bioethics must examine the communities, institutions, and practices in which that authority resides.

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November 13, 3:30-5:30

Social Media Screenshot Battles: Information Literacy Failures Amidst Google AI Overviews

Tameishia Olden

PennWest University

Every day, one can find users on various social media platforms sharing screenshots of Google AI Overview results for their queries. One may even find individuals debating, using screenshots of Google AI answers to support their positions. But how reliable are these AI answers, and is this a display of good information literacy? Two studies published in 2026 found that Google AI Overviews are approximately 89% to 90% accurate, but due to the sheer number of queries, this results in millions of inaccurate answers per hour. Another 2026 study on clinical MRI safety found that only 50% of Google AI Overview answers were clinically usable. In a 2026 study using physician queries of Google, reviewers noted incomplete information and safety-critical omissions. Additionally, answers from Google AI Overviews received a lower average score than those from Gemini 3.1 Pro. In current defamation lawsuits, Google has argued that the onus is on the user to read the provided sources to verify the accuracy of Google AI Overviews. However, expert witnesses testified that, regardless of the accuracy of the answer, the sources Google cites for its overviews align with the answer only half the time. More concerning is that Google AI Overviews frequently cite Reddit discussions, which poses a public health risk for users who do not know that they should verify Google AI Overview answers by reading the cited sources and those who do not know how to judge the sources' credibility.

The Political Justification of Immunization Policy Under Conditions of Widespread Misinformation and Conspiracism about Vaccines

Amitabha Palmer

UT MD Anderson Cancer Center

This presentation addresses the philosophical challenge of justifying coercive immunization policies in liberal democracies when significant portions of the population endorse false beliefs about vaccines. Public reason political philosophy holds that for a coercive law to be politically legitimate, it must be justifiable to epistemically idealized versions of those subject to it. However, proponents of public reason disagree over the appropriate degree of idealization: full or moderate. Using non-medical exemptions (NMEs) to the MMR vaccine as a case study, I argue that public reason views which adopt moderate idealization face a serious problem: they leave room for poorly justified empirical beliefs, including those advanced by conspiracy theorists and science denialists, to block otherwise legitimate policy. To address this problem, I propose the exclusion principle: empirical beliefs that both survive moderate idealization and contradict a consensus of relevant experts in a mature natural science should be excluded from the domain of public reason. This amendment preserves the advantages of moderate idealization while avoiding its permissiveness. The result is a version of public reason that both respects pluralism and justifies science-based policies such as mandatory vaccination and the closure of non-medical exemptions.

From Misinformation to Epistemic Infrastructure: Bioethics and the Governance of AI-Mediated Health Information

James Hearn

Kansas City University College of Osteopathic Medicine

Generative artificial intelligence is transforming the problem of health misinformation. The ethical challenge is no longer limited to false claims from individuals, social media platforms, or unreliable sources. AI systems increasingly generate, summarize, rank, personalize, and transmit health information, becoming part of the epistemic infrastructure through which patients, clinicians, and institutions encounter medical knowledge. This shift requires bioethics to move beyond reactive strategies centered on fact-checking, correction, and media literacy.

This paper argues that information integrity should be treated as an ethical property of healthcare AI systems. When AI mediates access to health knowledge, questions of provenance, uncertainty, validation, authority, correction, and accountability become matters of bioethical governance. A system may disseminate technically accurate information while still causing epistemic harm through omission, false confidence, decontextualization, selective amplification, or the obscuring of uncertainty. Conversely, trustworthy systems require more than accurate outputs; they require institutional mechanisms that make knowledge claims traceable, contestable, corrigible, and appropriately qualified.

The paper proposes a framework for embedding epistemic responsibility in healthcare AI governance through five functions: source provenance, uncertainty disclosure, validation standards, correction mechanisms, and accountable human oversight. It further argues that bioethics has a distinctive role in shaping these functions because misinformation is not merely an informational failure but a threat to autonomy, informed consent, professional integrity, distributive justice, and public trust.

The central claim is that bioethics should not merely respond to misinformation after it appears. It should help design the infrastructure that makes health information trustworthy in the first place.

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The Law of Medical Misinformation: When Bad Health Information Becomes a Legal Wrong

Arash Aramesh

Aramesh Law

Medical misinformation is usually discussed as a public-health or communications problem. But when inaccurate, incomplete, or misleading medical information causes real-world harm, it also raises a more difficult question: When does medical misinformation become legally actionable, and who should bear responsibility for it?

This paper examines the fragmented legal framework governing medical misinformation in the United States through several prominent case studies. The Theranos prosecutions illustrate how knowingly false claims concerning medical technology can become criminal fraud—while also demonstrating the significant evidentiary hurdles involved in proving that misinformation directed at patients constitutes fraud. *Wyeth v. Levine* presents a different problem: medical information need not be literally false to cause harm; incomplete or inadequate warnings about a drug's risks may instead produce liability through products-liability and failure-to-warn doctrines. More recent disputes involving hospital safety ratings raise yet another problem: efforts to characterize health information as false or misleading can collide with First Amendment protections for opinion, methodology, and editorial judgment.

Together, these examples reveal an important gap in how American law conceptualizes medical misinformation. There is no unified “law of medical misinformation.” Instead, the legal system addresses essentially the same underlying harm—people making consequential healthcare decisions based on unreliable information—through an assortment of criminal fraud, tort, products-liability, consumer-protection, regulatory, and constitutional doctrines.

The paper asks whether this fragmented framework adequately addresses modern medical misinformation and explores where the law should draw the line between actionable deception, inadequate medical communication, scientific disagreement, and protected speech.

An Ethics Overview of Artificial Intelligence Generated Audiovisual Content Representing Experts and the Potential for Digital Global Health Misinformation

Benjamin Collins

Vanderbilt University Medical Center

The digital divide has served as a barrier to the digital spread of health information. There are ongoing efforts to reduce this disparity. However, alongside improved access to health information, the digital spread of health information also introduces a higher risk for health misinformation, especially in social media posts that may contain artificial intelligence generated content that is presented as real content. With the increased capabilities over the past several years to use AI tools to generate realistic images, video, and audio, and for that content to contain false information whether intentional or unintentional, it is more possible to generate contents representing experts of science and medicine that consumers of this content misinterpret as real content. As the digital divide is addressed across the globe, many people will be introduced to realistic digital health misinformation content alongside real accurate digital health information. How well will this work when introducing people to digital health information without prior access in a time when even people who have experience with digital health information may have difficulty distinguishing real from fake content? This session will provide background on AI generated content and their potential role in communication of global health (mis)information when utilizing content generated to represent well-known experts, examples of generated content, and an overview of relevant ethics concepts. Concepts covered include freedom of speech with global distribution of content, governance of AI-generated content from an international perspective, and control of identities at a global level. This will all be contextualized through ethical principles, for example, in terms of autonomy wherein individuals may decide to allow or request removal of publicly available AI generative models of their person and regulation could remove some of this autonomy for healthcare providers and biomedical researchers.

Ethical and Legal Considerations for the Restoration of USAID Global Health Aid Programs

Kalen Fredette

Legacy Health System

The Trump Administration dismantled USAID and halted much of its associated global health aid (GHA), by arguing that GHA cessation was necessary to “put America first”, stop foreign dependency, and end wasteful, fraudulent or “woke” spending. Such rhetoric starkly contrasts George W. Bush’s statements championing PEPFAR as an opportunity to address the AIDS epidemic internationally—both a life-saving act of mercy and a prophylactic against disease transmission into the US.

Responding to GHA cuts, critics cite the abruptness of cuts as causing avoidable mortality/death, while lauding a transition to foreign states self-sufficiency. Other critics have predominantly lamented the loss of the GHA’s life-saving role and/or its “soft power” utility. Placing GHA on an ethical foundation of mercy and pragmatism both failed to accurately describe the US’s ethical obligation to GHA recipients and arguably left GHA broadly susceptible to the Trump Administration’s dismantling attacks. Rather, the equality of persons and international interdependence create clear justice-based ethical obligations on the US to provide GHA to recipient nations. Historical and current harms perpetrated by the US against many former GHA recipients made them specifically vulnerable to many of the health problems that GHA sought to remedy. This presentation will argue that fully attending to its ethical obligations strongly favors the US restoring GHA to many, if not all, former recipients.

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However, the new geopolitical reality, described by Canadian PM Mark Carney as a dynamic in which global integration can be “weaponized” by advantaged countries to “subordinate” disadvantaged countries, arguably makes the return to the status quo both undesirable and unsustainable. Accordingly, a less-vulnerable GHA model must be instituted. This presentation outlines how restoration of GHA and eventual transition to foreign state self-sufficiency should be guided by established legal principles (i.e., detrimental reliance and gross negligence) that insulate GHA from future, disruptive geopolitical shifts.

The Global Bioethics Implications of Clinical Decisions Surrounding Cesarean Deliveries

Laila Burrell

Duquesne University

Cesarean delivery can be lifesaving, yet its use is not distributed equally across racial groups. Although cesarean delivery can be medically necessary, it is associated with greater maternal risks than vaginal delivery. In the U.S, Black women experience higher rates of cesarean delivery than non-Hispanic White women, raising questions about how clinical information, risk, and race shape obstetric decision-making. Studies found that Black mothers undergoing a trial of labor were 25% more likely than non-Hispanic White mothers to deliver by cesarean, with the disparity persisting after adjustment for medical risk, sociodemographic characteristics, hospital, and physician/medical practice group (Corredor-Waldrón et al., 2026).

The history of the vaginal birth after cesarean (VBAC) calculator illustrates how racial assumptions can become embedded within clinical decision-making. The original calculator incorporated race, assigning Black women a lower probability of successful VBAC (Vyas et al., 2020). Vyas et al. (2020) argue that although racial differences were observable, incorporating race as a clinical predictor could reinforce disparities without a clear biological rationale. The misinformation is the assumption that race itself provides clinically meaningful information about a patient's likelihood of a successful VBAC.

This history is significant because racial disparities in cesarean delivery persist alongside growing examination of race-based clinical algorithms. Rather than assuming race explains differences in delivery, this paper argues that persistent disparities warrant ethical scrutiny of less measurable influences on obstetric decision-making, including provider discretion, practice patterns, and assumptions embedded within clinical care. This is a global problem. Hence, Global Bioethics can help address this problem through justice and autonomy: justice requires critical assessment of unequal patterns of care, while respect for autonomy requires that patients receive individualized, evidence-based information that supports meaningful participation in decisions about delivery. Examining how race enters clinical reasoning may identify and challenge practices that perpetuate inequity in maternal health.

The Role of Ethics Education in Reducing Health Misinformation

Ercan Avci

Duquesne University

The increase in the prevalence of social media has significantly prompted the prevalence of health misinformation. Health misinformation not only negatively impacts individuals' health but also destroys public trust in the health governance and causes growing public health issues. Healthcare institutions and healthcare professionals should show an active effort in fighting misinformation to mitigate such undesirable outcomes. From this perspective, as an essential component of contemporary healthcare, bioethicists may play an important role by encouraging individuals to seek accurate health information through ethics education. At that point, this oral presentation proposes providing patients and their family members with ethics education to improve their health literacy in ethics, which can help them access reliable sources and health information. Ethics consultation departments should expand ethics education services to patients in order to enhance their knowledge in ethics and build trust in their relationship with healthcare professionals. Ethics education for patients can increase patients' awareness of major ethical matters, including the significance of their values, preferences, and decisions; promote their knowledge of decision-making processes, such as the need for accurate and adequate medical information; and foster effective communication between patients and other pertinent parties. In this view, rather than explaining what constitutes correct and incorrect medical information, the role of ethics education is to support patients in accessing accurate information and in creating a trustworthy relationship with healthcare professionals.

Obsessive-Compulsive Disorder, Risk, and Misinformation

Benjamin Campbell

Duquesne University

Obsessive-compulsive disorder (OCD) is a commonly misunderstood mental health disorder. This is true both with regard to the popular understanding of OCD as well as its promotion by advocates and peer support systems. One common myth about OCD is that, since intrusive thoughts are ego-dystonic, individuals with OCD never engage in harmful or risky behaviors because of their obsessions. Drawing on lived accounts of OCD as well as case studies in the OCD literature, I will point out that two subtypes of OCD – harm OCD and suicide OCD – can, rarely, involve violence toward the self or other. This risk of violence may be missed by clinicians unfamiliar with unusual OCD presentations and can accordingly lead to the dismissing of options like the duty to warn and involuntary hospitalization. I will argue that a virtue now commonly missing from healthcare ethics textbooks is at the core of resolving this problem: competence. Specifically, competence in the differential diagnosis and risk assessment processes. I will moreover highlight the tough balance that healthcare professionals have to strike between the values of autonomy and beneficence/non-maleficence in order to best serve the patient and the population at large.

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Synthetic Medical Authority: The Ethics of AI-Generated Doctors on Social Media

Dina Siniara

Duquesne University

Medical authority is traditionally grounded in education, clinical training, licensure, professional standards, and accountability. Generative artificial intelligence complicates this foundation by enabling the creation of highly realistic representations of healthcare professionals that reproduce the visual, verbal, and behavioral markers of medical expertise without possessing the qualifications or responsibilities from which such authority is derived.

This paper introduces the concept of synthetic medical authority to describe the ethical implications of separating the appearance of medical expertise from the institutional and professional processes through which medical authority is earned. This separation is particularly consequential on social media, where professional appearance, confident communication, and familiar medical cues may influence users' judgments of credibility. The concern is especially significant for users who may be vulnerable to health misinformation or have limited capacity to evaluate the credentials and accountability of online sources.

The paper argues that AI-generated doctors present a distinct bioethical problem because they enable medical authority to be simulated without being earned. Synthetic medical authority raises concerns regarding autonomy, deception, epistemic trust, professional responsibility, and the legitimacy of technologically mediated medical expertise.

At the same time, its persuasive capacity presents an important ethical tension. If AI-generated medical figures can influence health beliefs, synthetic medical authority might also be harnessed to counter health misinformation and expand access to credible health communication. This paper argues that the ethical legitimacy of such uses depends on whether the potential benefits of synthetic medical authority can be realized without exploiting or undermining the trust upon which genuine medical authority depends.

The “Infodemic” and its Consequences for Global and Public Health

Samuel K. Danso

Duquesne University

The “Infodemic” and its consequences for global and public health is a crucial topic in this era of ubiquitous social media platforms. This issue of the infodemic is increasingly impacting life and sustainability, particularly health and well-being. As a portmanteau word from “information” and “epidemic,” infodemic basically has to do with misinformation and disinformation on health-related issues. Infodemic can easily mislead and misguide people’s healthcare decisions. Understanding the infodemic concept and its adverse effects is essential to doing everything ethically possible to combat this canker. Bioethics, with its core principles, offers a strong framework for curtailing the infodemic in healthcare. By championing ethical biomedical research, bioethics helps generate life-saving information that enables key stakeholders in healthcare to make informed decisions. Furthermore, biomedical research provides the foundation for public health intelligence (PHI), ensuring the public has access to reliable and authentic information. To be effective, PHI should focus on all levels of society: global, regional, national, and local. When people are well-informed, misinformation and disinformation have no place in their healthcare decisions. Conversely, when access to reliable health information is limited, speculation thrives, which misguides the public. To effectively curtail the infodemic, ethical biomedical research must be promoted, and its results must be made easily accessible to all people.

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November 14, 10:30-12:30

From TikTok to Primary Care: The Bioethical Responsibility for Adult ADHD Recognition in the Age of Health Misinformation

Hande Atalay

UPMC

The rapid expansion of social media and artificial intelligence has transformed how health information is produced, accessed, and interpreted. While these technologies can democratize medical knowledge, they can also blur the boundary between evidence-based information and pseudoscience, creating challenges that extend beyond factual accuracy into the domain of bioethics. Addressing health misinformation therefore requires not only correcting false claims, but also examining the ethical responsibilities of healthcare systems when patients seek guidance amid competing sources of information.

Adult attention deficit and hyperactivity disorder (ADHD) illustrates this tension. Its increasing visibility on social media has improved public awareness and encouraged previously overlooked adults to recognize symptoms and seek evaluation. At the same time, oversimplified diagnostic content can promote inappropriate self-identification, overgeneralization of ordinary experiences as symptoms, and trivialization of ADHD as a clinical disorder. These competing effects raise questions of autonomy, beneficence, nonmaleficence, and justice: How should healthcare respond when increased access to information simultaneously empowers and potentially misleads patients?

This paper argues that primary care should serve as an ethical bridge between online self-recognition and evidence-based ADHD care. Limited access to psychiatric evaluation leaves many adults without a practical pathway to determine whether information encountered

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online applies to them. This paper proposes a primary-care model that combines clinician education and initial screening tools with an internal referral pathway to designated primary care physicians with expertise in adult ADHD. By expanding access to specialized evaluation within primary care, this model could improve ADHD awareness, recognition, and access to appropriate care in clinical settings without placing excessive burden on individual physicians or patients.

The bioethical response to health misinformation should extend beyond combating inaccurate information. This paper demonstrates how bioethics can move from identifying the problem of misinformation to shaping systems capable of responding to it.

Capital's Impact on Global Bioethics

Richard (Ricky) V. Pazer Jr.

Duquesne University

In Global Bioethics today the dominating framework was born out of the human rights project. This current human rights framework claims to be universal and fair but, in many ways, has simply become a tool for the powerful nations and institutions to maintain such power and influence. The main decision-making force behind these nations is capital. Capital can be understood as the exploitative force that demands a continual increase in profit in perpetuity. This force of capital has captured nearly every decision-making body globally and shapes what problems get identified and how solutions get implanted. A true implantation of the human rights project would be an existential threat to capital. So, capital found it necessary to turn it into a tool used by the developed world for the continued exploitation of developing nations. A global economy based on capital was imagined in order to help produce a universality amongst people and help to provide people with the freedom and resources necessary to realize human rights. However, the reality of capital is far from universal. Thus, it is now imperative of ethicists to develop a new framework for global bioethics that maintains core principles of the human rights project such as justice, solidarity, and vulnerability while leaving behind the exploitative and unequal aspects that come from a system captured by capital.

The Ethics of an Infodemic: Information Inequality, Patient Autonomy, and Justice in Healthcare

Fahmida Hossain

Duquesne University

We are living in the era of an infodemic—a time characterized by a huge volume of health-related information that includes both accurate and misleading content. Due to technological advancement, AI, and the availability of social media platforms, health information and misinformation are now widely available. Once, the availability of information itself was a concern, and bioethicists had to advocate for making information available to patients so that they could make informed choices and exercise their autonomy. Now, the concern has shifted to whether the information patients are receiving is accurate or misleading.

Misinformation from various sources is influencing health decision-making, including treatment refusal, vaccination, reproductive choices, and end-of-life decisions. AI-generated health information is also sometimes replacing or competing with physician advice. This raises a central bioethical concern about informed decision-making, as the information on which patients base their decisions may itself be questionable. Moreover, misinformation is not available to everyone in the same way. Due to exposure and algorithms, misinformation can appear differently within each person's information environment. Patients may have unequal access to trustworthy information and unequal resources to evaluate competing claims. Education also plays a role, as individuals may have different levels of resources and ability to judge what information to trust, what to reject, and how to distinguish accurate information from misinformation. Thus, the wide availability of information may itself contribute to health inequality and raise concerns about justice in healthcare.

The paper argues that misinformation should therefore not only be a concern for public health and health communication; it should also be a concern for bioethics, as it can affect meaningful autonomous decision-making by individuals. Ultimately, the question should be revisited: What conditions are required for information to support meaningful autonomous decision-making?

The Ethical Dimensions of the Infodemic

Ali Shareef

PennWest University

The growth of social media and digital communication has completely changed how people find and share health information. During public health emergencies, large amounts of information can spread quickly, often including misinformation. The World Health Organization describes this as an infodemic. This makes it difficult for people to identify reliable health information, make informed decisions, and maintain trust in health professionals. This problem can be especially serious in areas with limited access to healthcare, lower health awareness, or fewer sources of accurate health information. WHO warns that infodemics can also create ethical concerns involving responsibility, freedom of expression, autonomy, and public trust.

One major issue is responsibility. Individuals who create and publicize misinformation have some responsibility, but social media platforms, health organizations, and governments also play a role in how misinformation spreads and is addressed. Because platforms already regulate what content can be shared, there should also be regulations regarding health misinformation. Another concern is autonomy, which is a person's ability to make their own informed health decisions. Meaningful autonomy depends on having access to accurate information that is understandable. When false or misleading pieces of information spread, it becomes difficult to make an informed decision.

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At the same time, attempts to control misinformation must be careful not to unfairly limit freedom of expression. This creates an ethical issue between preventing harm and protecting individual rights. Bioethics can help address this issue by focusing on reliable communication, cooperation between health organizations and social media, informed decision-making, and trust. As social media continues to play a major role in how people learn about health, managing infodemics will remain an important hurdle for global health.

The Ethics of AI-Generated Health Advice: Are Current Guidelines Enough to Protect Patients?

Kylie Mettrick

PennWest University

Artificial intelligence (AI) chatbots are being used to answer health questions because they are convenient, inexpensive, and available 24/7. While these tools can provide general health information, risks arise when users rely on them for personalized medical advice. For example, explaining that dehydration can cause dizziness is general health information. However, telling someone that their symptoms mean they are dehydrated and don't need medical attention is personalized advice. This difference matters because the second response could influence a healthcare decision. Current ethical guidelines address safety, privacy, transparency, bias, and accountability, but do not fully address the risks of general-purpose chatbots providing personalized health advice.

Existing guidelines recognize that AI can cause harm. A review of chatbot ethics explains, "When such chatbots lack a strong evidence base, this may lead to avoidable harm to people with mental health concerns and thus fail to meet the principle of non-maleficence" (PMC, 2023). It also explains, "The complete or relative absence of trained human supervisors from the chatbot environment can undermine the role of expert professionals" (PMC, 2023). These guidelines establish ethical principles, but they don't always explain how chatbots should respond to individual medical situations. The American Psychological Association further states, "AI should be regulated and implemented as a tool to augment, not replace, professional judgment and the essential human relationship that is the bedrock of quality care" (APA). However, recognizing these principles doesn't explain how a chatbot should respond when an individual asks for medical advice.

The greatest concern is that an AI response doesn't have to be false to be harmful. Duke Medicine identifies the problem of "answers that are technically correct but medically inappropriate because they lack context" (Duke Medicine). A chatbot may not know a person's medical history, medications, diagnoses, or physical examination results. Therefore, information that is accurate in general can still be inappropriate for a person. The APA similarly states, "GenAI chatbots were not created to deliver mental healthcare" (APA), demonstrating that general-purpose chatbots should not be treated as replacements for healthcare professionals.

Accuracy and bias create additional risks. U.S. News reports that AI chatbots can "hallucinate" (make up information) or provide "incorrect/dangerous medical advice," with one study finding consumer-used chatbots were correct in guiding a diagnosis about 34% of the time (U.S. News). *Nature* also warns that "Biased AI algorithms will necessarily cause discrimination and misleading predictions" (Nature). U.S. News adds that "the AI platform may not have been trained sufficiently to provide you with high-quality and accurate advice" for underrepresented populations (U.S. News). These problems show why users can't always be expected to identify inaccurate or biased medical information on their own.

Current guidelines are an important starting point, but stronger consumer-specific protections are needed. AI should use risk-based warnings for serious symptoms, clearly explain its limitations, encourage professional care when appropriate, and establish clearer accountability. AI does not need to be removed from healthcare; instead, it should be designed and regulated so its convenience doesn't come at the expense of patient safety.

Misinformation on Contraception Amidst the Abortion Debate

Poet Perry

PennWest University

Misinformation about contraception, including hormonal birth control, barrier contraception, and emergency contraception is increasingly prevalent. A popular belief spread by religious extremists and anti-abortion political groups is that hormonal birth controls, particularly levonorgestrel emergency contraception pills, act as abortifacients. This is a false belief built around a fundamental misunderstanding of the reproductive process and the mechanism of birth control pills and devices. This misinformation has the possibility led many young people to hesitate or refrain from use of contraception like intrauterine devices (IUD) and "Plan B" emergency contraception (Mundaden et al., 2026).

The conception of a human fetus occurs in three phases. Ovulation occurs, where a viable egg is released from an ovary into a fallopian tube. The egg is then fertilized by a viable sperm and implants in the uterus. An egg that has been fertilized and has implanted is considered a viable pregnancy (Cleveland Clinic, 2022). Legally, abortion is defined as the medical termination of a pregnancy. This means that abortion can only occur after implantation of an embryo. There is a common misconception that levonorgestrel emergency contraception pills, common brands such as "Plan B" and "Julie", act in the same manner as abortion medication like mifepristone and misoprostol. Emergency contraception works to prevent ovulation for up to five days by providing a high dose of synthetic estrogen compounds found in daily combination estrogen and progesterone birth control pills. Emergency contraception pills will only prevent pregnancy, not terminate it.

The idea that emergency contraception methods are abortifacients is intentional disinformation and presents an ethical dilemma about bodily autonomy and access to reproductive care. Religious extremism is on the rise in the United States, and a commonly held belief among religious and right-wing political extremists is that sex should not occur unless it is for the purpose of reproduction (Cleland et al., 2022). Attacking contraception access using medical misinformation allows the real attack on bodily autonomy and personal choice to be shrouded in the abortion debate. The question becomes "Should we allow access to abortion?" instead of "Should people be able to

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control if and when they become pregnant?" Spreading the idea that birth control medications and devices terminate pregnancy violates people's autonomy and right to information about their medical care. Contraception is being used by young people at an all-time high rate, and it is unethical to provide medical care for people who are uneducated about the effect of medications and devices on their bodies.

Would You Trust AI? A Narrative Review of the Reliability of AI-Generated Medical Information and Its Bioethical Implications

Fatima Hernandez Ortiz, Peñalosa Medrano Adolfo Beedxe, Tobón Pérez Verónica, Gopar Díaz Angélica, Jiménez Guendulain Fátima Daniela, Martínez Mendoza Antonio, Flores Pérez Renata, Molina Cruz Romina Medical Intern, Bautista Aguilar Gabriela Alejandra
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Background: Artificial intelligence (AI) and large language models are transforming healthcare by supporting clinical decision-making, emergency triage, and health education. However, the automated generation of medical information introduces critical bioethical challenges regarding data accuracy, systemic biases, and patient safety. A fundamental distinction exists between a system's technical reliability and the moral act of placing trust in its outputs.

Objective: This study reviews scientific evidence concerning the reliability of AI-generated health information and comprehensively analyzes its bioethical implications. The goal is to determine the ethical conditions under which epistemic trust in these technologies is justifiable for patients and clinicians.

Methods: A narrative literature review was conducted using academic databases to explore AI safety, reliability, and ethical healthcare implementation. Selected empirical studies and systematic reviews were synthesized into five core thematic axes: clinical reliability, medical disinformation, determinants of trust, bioethical principles, and responsible AI usage.

Results: Evidence indicates that AI-generated medical responses exhibit variable, context-dependent accuracy. While AI improves accessibility, it poses risks of producing coherent yet clinically inaccurate data, thereby amplifying plausible health misinformation. Trust in these systems demands transparency, explainability, and rigorous validation rather than mere accuracy. Furthermore, assigning medical liability when AI-assisted recommendations cause patient harm remains a complex, unresolved challenge.

Conclusion: Uncritical trust in AI is bioethically unjustifiable. Patient autonomy requires verified data for genuinely informed decisions, while non-maleficence dictates that reliance on AI must be strictly proportional to clinical risk, necessitating robust professional supervision. Justice demands mitigating algorithmic biases and digital literacy disparities. Adopting an anthropocentric approach ensures AI remains a supplementary tool. Trust becomes ethically justifiable only when reflective, risk-adjusted, and transparent, upholding patient dignity without replacing human clinical expertise.

The Appeal to Nature Fallacy

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Now more than ever, the media is a part of each person's life in some aspect. It is found in advertisements online, magazines, newspapers, radio stations, billboards, news channels, or even daily mail. The media has been designed to reach people everywhere, every day. According to a study done by the University of Southern California, on average people are exposed to around 5,000 ads a day. Despite only a fraction of these ads actually being processed in the brain, they greatly influence public perception. A popular advertisement in the media insists on a single, persuasive, widespread assumption that natural is better. To support their claim, the media frequently relies on the appeal to nature fallacy. This is a deep-rooted belief arguing that whatever is deemed natural is inherently better than that said to be unnatural; furthermore, labeling anything unnatural as 'bad'. This belief is especially popular in relation to medicine, claiming that drugs labeled as 'natural' are safer, healthier, and carry less risks than synthetic drugs. With the media's influence, it is second nature to assume that whatever is labeled as 'natural' to be more beneficial. Conversely, research has proven that natural remedies are not always the safest, most effective, or economically friendly option. Agencies like the National Center for Complementary Care (NCCIH) have recognized that, "people will generally prefer a natural drug over a synthetic one even when it is an objectively less safe and/or effective form of treatment" (NCCIH). This paper examines the ethical implications of this phenomenon, arguing that health misinformation regarding natural versus synthetic drugs violates the bioethical principle of autonomy by spreading misleading information. This paper aims to evaluate the moral responsibilities of media platforms and health communicators, using data analysis from peer reviewed articles, research institutes, government health agencies, and scientific organizations. The 'natural trend' in the media is a powerful influencing tactic used to manipulate consumers by entertaining the bias for natural products that have been rooted into our brains. Ultimately, bringing attention to deceptive health narratives serves to encourage individuals to develop critical media literacy and reject systemic misinformation designed to favor cognitive biases.

ORAL PRESENTATION ABSTRACTS

Supernatural Explanations of Psychiatric Illness: The Bioethical Implications and Role of Clinicians

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Cultural beliefs shape how individuals understand illness, interpret symptoms, seek support, and approach mental health care. Clinicians work in a delicate balance of respecting patients' cultural beliefs while staying true to their ethical duties as providers when patients' supernatural explanatory models of their illness directly conflict with biomedical understandings, on which treatment of their symptoms are based on. Depending on the cultural lens through which it is understood, mental illness can imply vastly different causes and outcomes. While clinicians are more likely to view psychiatric illness through a scientific lens, patients from diverse backgrounds could have different understandings of their experience through supernatural explanatory models. This clash in perspectives and understandings puts the therapeutic alliance and ethical obligations to the test when treatment approaches are discussed, especially when discussing medication. Mishandling a patients' unique cultural beliefs surrounding their distress can have a significant and potentially detrimental impact on the therapeutic alliance, treatment and medication adherence, and engagement with care; all factors which are key predictors of treatment outcomes.

In forming a therapeutic alliance, there are two cultures in the room, with both clinician and patient, immersed in their own worldviews, traditions, attitudes, and ethical values that guide their approach to treatment. The accepted scientific framework may not be universally adopted by patients whose understanding of illness is shaped by different cultural or spiritual beliefs. While from a clinician's lens of scientific explanatory model, mental illness is not so different from physical ailments such as a broken bone or infection, the patient's supernatural approach to their circumstance could assign a much different etiology and significance onto their situation.

Spiritual understandings of mental illness present symptoms as having supernatural causes such as possessions, divine punishment, karma, or evil eye, and as having equally supernatural remedies such as prayer, repentance, or exorcism. Dismissal of supernatural beliefs faces ethical challenges in weakening the therapeutic alliance and reducing engagement with treatment, which creates barriers to effective, scientifically supported treatment. Highlighting and separating clinicians' worldview from patients can induce alienation and mistrust, which has been identified as a major barrier to mental health treatment among racial and ethnic minority populations. This highlights the importance of culturally responsive care, particularly in building trust between patients and providers. Meanwhile, affirming supernatural beliefs likewise betrays the clinician's ethical duty to honesty and non-maleficence through encouraging patients to seek inaccurate understandings of treatment outcomes and potentially harmful alternatives.

Ethical psychiatric care requires navigating a balance between maintaining a responsibility as clinicians to provide evidence-based information and treatment while respecting a patient's cultural worldview and ensuring patients are informed about their care and that regardless of their and their clinician's worldview compatibility, they benefit from the same ethical principles that guide modern medicine. A culturally responsive approach should therefore seek to understand the patient's explanatory model while maintaining clear communication about evidence-based psychiatric care. Ultimately, this paper considers how clinicians can respect cultural and spiritual perspectives without allowing cultural sensitivity to become a barrier to appropriate mental health treatment.

Embryo Personhood in In Vitro Fertilization: An Ethical Question Without Clear Boundaries

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In Vitro Fertilization is a procedure where gametes-eggs and sperm-are collected and used to create an embryo outside of the body. Typically, embryos are created and later implanted in the uterus and ideally develop as a standard pregnancy. (Harris, 1983) This is a method of fertilization typically used by individuals who have difficulty conceiving naturally, though embryos created in this process may be used for other purposes such as research (Harris, 1983). While IVF is a relatively recent advancement the concept has been worked on and theorized decades prior to the first successful IVF birth. In 1978 Louise Brown became the first person born through IVF, (Keifer, 1980) and in the following 40 years after her birth, roughly 10-13 million more babies have been born through IVF (Chambers, n.d.). Since then, there have been many ethical questions surrounding IVF such as the personhood status of the Embryo, and recent developments have made this issue increasingly relevant. There are many interpretations of this topic yet there is no clear cut, fair, and consistent answers. Additionally, IVF is heavily tied to the abortion debate in many discussions which further complicates answering these questions.

In recent history the personhood status of an embryo is still an evolving topic, that was brought under the spotlight by the supreme court case, Dobbs v. Jackson Women's Health Organization, in 2022, which overturned Roe V. Wade, and eliminated federal protection of abortion rights (Dobbs v. Jackson Women's Health Organization, 2022). While this decision was not focused on IVF, the Dobbs decision shifted authority of reproductive rights to the states. This influenced the Alabama Supreme Court case, LePage v. Center for reproductive medicine, in 2024, where they decided that frozen embryos are considered a minor child, and IVF clinics could potentially be held liable for the accidental loss of embryos under in a wrongful death of a minor case. (LePage v. Center for Reproductive Medicine, P.C., 2024) This led to several IVF clinics suspending their practices in Alabama, and critics saw it as a direct attack on IVF practices.

Abortion being the termination of a pregnancy and IVF being the creation of one, they represent opposite procedures in reproductive choice but remain heavily tied together with the legal and ethical standing of developing embryos. Alabama being 1 of around 13 states that have near total bans on abortion (Livingston, 2026) lawmakers have faced criticism for simultaneously attacking these practices, in the words of Vice President Kamala Harris "On the one hand, the proponents are saying that an individual doesn't have a right to end an unwanted pregnancy and, on the other hand, the individual does not have the right to start a family." (Lim, 2024). This highlights the difficulty in determining legal or ethical boundaries that are consistent when addressing IVF and abortion.

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Shifting laws surrounding embryo personhood have created uncertainty and conflict in abortion and IVF practices. While regulation is important to ensure ethical handling of embryos, these laws often fail to account for the real-world implications they have on individuals' access to IVF and risk limiting reproductive choice. IVF has been incredibly effective and has allowed millions of people to create families that would otherwise not exist -including my own parents who had my twin brother and I through IVF. As regulation develops, it is essential that IVF is protected and is not unfairly restricted while caught in the crossfire of the abortion debate.

The Role of Autonomy in Patients with both Physical and Mental Health Needs

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Throughout history, ethical principles and their applications have procured both analysis and controversy. Traditionally, philosophers have been associated with the study of ethics. Inspired by Socrates, philosophers have scrutinized the application of ethics from two dominant perspectives, Utilitarianism and Deontology. Utilitarianism adheres to the role of context in the application of ethics, whereas as Deontology maintains an absoluteness of ethical principles regardless of context (Fine & Ulrich, 1988). With the increases in mental health awareness and diagnoses in society, healthcare decision making has become increasingly complex, especially for a physician. Cognitive impairments or temporary impaired functioning due to drugs or alcohol may prevent a patient from making sound judgments with respect not only to their health but may also endanger the health/well-being of another. How should a physician proceed when receiving a patient that has both mental health and physical health needs? Should the physician rely entirely on the judgment and choices of the patient regarding their health needs, or should the physician consider the outcomes or consequences that are best for patient or best for others in society?

The Utilitarian approach provides a means for the physician to consider the best outcomes for the individual and for the greater society. Autonomy is a paramount ethical principle that has become increasingly scrutinized in its application and interpretation within healthcare. Its complexity is even more apparent within the context of a patient who presents with both mental and physical health needs. Decision-making is at the core of the argument. Research contends that most mental health patients can make sound decisions with appropriate support (Giannopoulos, 2023). However little research exists when physical health impairments also present. This abstract will examine the interplay of autonomy when healthcare professionals are confronted with dual diagnostic criteria.

Various human rights organizations contend that autonomous decisions should be presumed and advocated for instead of questioned or coerced. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) affirms that every individual, irrespective of disability, possesses legal capacity and is entitled to supportive measures in exercising this fundamental right (United Nations, 2006). In accordance with the CRPD, Drake & Deegan, (2009) assert that mutual decision-making contributes to patient engagement, treatment outcomes, trust, and overall satisfaction. Hence, these findings contend that autonomy is not dichotomous but can exist and thrive within the context of support.

Conversely, a second argument for the foundation of autonomy focuses on the damages incurred from its void. O'Donoghue et al., (2018) noted that restrictive decision-making and coercive treatments have led to hesitance in pursuing future care and contributes to increases in stress. When restrictive practices are linked to the avoidance of healthcare, there is a corresponding decline in both mental and physical health. Hence, active and participatory engagement reinforces the premise that autonomy can be achieved when aligned with physician support, flexibility, and utilization of least restrictive practices.

Counterarguments assert that autonomy must be limited when severe mental illness impairs judgment to the point of endangering the patient's physical health. This premise also implies that paternalistic intervention, rather than autonomy, may be required to prevent harm to self or another (Giannopoulos, 2023). Research however maintains that autonomy be viewed as a qualitative variable, where decision-making is exercised within a supportive environment and in accordance with dynamic changes (Appelbaum, 2007).

In conclusion, the exercise of autonomy in patients with both physical and mental health needs evolves as a dynamic process that is in alignment with the Utilitarian approach. Research recognizes positive frameworks that utilize mutual decision-making, foster trust, minimize coercion and presume competence. However, flexibility and context are noted as paramount strategies to employ should safety concerns arise (Ajluni, 2023). Utilitarianism appears to hold the most value for practicing physicians as it considers the overall "goodness" or benefit of wholistic outcomes or treatments, especially for an individual who has compromised judgement or in consideration of collective healthcare support. Utilitarianism allows for the fluidity of autonomous decision making in accordance with the context and presenting needs of the patient in striving toward life and overall health. Maintaining autonomy may present as a qualitative challenge, but it is one that the healthcare profession must strive to uphold.

