

When the barrier is not intellectual: artificial intelligence, authorship, and academic production in health professions education

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Abstract

Artificial intelligence (AI) did not give this author new ideas. It provided the cognitive infrastructure to turn existing ideas into published text. This commentary describes a first-person experience of using AI as a tool for academic production in health professions education. Four examples are presented: redesigning a psychopathology course; producing large-scale assessment material for a clerkship; formalising connections between art and medical teaching; and mapping a research agenda from scattered ideas. The central argument is that the greatest obstacle to many clinician–educators’ scholarly contribution is not intellectual but logistical — and that AI, by lowering that

barrier, reveals how much of what we call “academic productivity” has always measured infrastructure rather than thought. Predictable objections are addressed directly: the risk of homogenisation, the temptation to accept AI output uncritically, and the particular burden faced by faculty in the Global South who must publish in a language that is not their own. The commentary concludes that AI does not replace authorship, but changes its conditions of possibility; and that whether it does so with integrity depends on the judgement and honesty of those who use it.

Keywords: artificial intelligence (AI), authorship, medical education, academic productivity, Global South

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I discovered artificial intelligence in late 2025, not as a concept but as a tool — by accident, driven by exhaustion rather than curiosity. I am a psychiatrist, faculty member, and emergency physician at a public university in Brazil. I coordinate a health professions clerkship for over 100 students per year, supervise residents, run outpatient clinics, and work nights, weekends, and holidays in an emergency department never designed for patients with severe mental disorders. I have published throughout these 20 years — but less than I perhaps could have. Research happened in the gaps, and the ideas were there: arguments elaborated during late shifts that dissolved by morning, essays outlined in my head that never reached paper. The accumulation of unfinished intellectual work became itself a source of suffering. I experienced episodes of clinical depression requiring psychiatric and psychological treatment — not without irony for someone who works in mental health. What was missing was not thought. It was the cognitive infrastructure to

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transform thought into text. I needed something that could hold the thread while I was pulled elsewhere.

What changed

The examples all come from teaching. AI helped me redesign a weekly psychopathology course from lecture-based to discussion-based, using previously recorded lectures and AI-generated questions calibrated to different learner levels. Following a curricular reform, I produced 240 examination items — all framing the student as a non-specialist managing a psychiatric situation — and 36 complete OSCE stations with scenarios, actor instructions, checklists, and structured feedback, enough for three years of application. The AI produced the skeleton; the clinical and pedagogical judgement remained irreplaceably human. It also made possible what years of lecturing had not: turning connections between art and health professions education into academic text. Pink Floyd’s 1979 album, *The Wall*, and the fiction of Caio Fernando Abreu — a Brazilian writer whose

prose on loneliness, stigma, and finitude renders clinical material with precision — had long informed my teaching. With AI holding the scaffolding, one of those essays has already been submitted internationally. Most importantly, AI organised scattered ideas into a coherent production map, connecting projects I had not seen as linked. From that map, during an intense period, I wrote several authored essays. The AI did not write them; I did — dictating, revising, approving or rejecting each paragraph. Without it, they would still be waiting for conditions that never arrive.

The authorship question

This is where most discussions pause to ask whether AI use is ethical, whether the author is truly the author.^{1,2} These are legitimate questions, but not mine. My prior question concerns education: what did this experience reveal about what the academy was measuring as “productivity”? Every sentence that survived passed through a filter the AI does not possess — 20 years of clinical experience, a particular epistemological stance. What I do with AI output is curation: selection, rejection, rewriting. That confidence may itself be vulnerable to illusion, making reflective scepticism an essential scholarly skill. A related risk is homogenisation: if many authors draft through the same systems, prose may converge towards a shared register, and idiosyncratic voices — often those carrying the most situated knowledge — may be the first to be smoothed away. Writing has always involved cognitive extensions — editors, mentors, translators, dictation. AI differs in scale and immediacy, not in the existence of mediation itself.¹

Academic production has never been a level playing field.³ Publishing in English demands of a Brazilian academic an investment Anglophone colleagues never make. Professional revision is a cost, because imperfect English raises the probability of rejection before merit is assessed.⁴ AI does not resolve structural inequality between Global North and South academies — access to high-capacity systems is itself uneven — but it lowers a concrete barrier. If the barrier between my ideas and their publication was not intellectual, then what was the academy measuring? Capacity for thought, or capacity for infrastructure: time, institutional support, fluency in academic English? AI is revealing that a significant

part of what we call productivity was never intellectual production. It was logistics.

What this means for health professions education

Health professions educators face a silent contradiction: they are asked to teach, supervise, research, and remain clinically active — with the same resources as decades ago. Pedagogical knowledge accumulated in practice disappears before entering collective academic memory. AI does not solve this institutional problem, but it reduces the distance between the educator’s experience and its formalisation. There is an irony worth naming: the people teaching me to use AI better are my own trainees. The resident on call with me as I write this, during a mercifully quiet shift, is one of them. The generation I am training is training me. There is, however, a risk: if AI makes publishing easier, it also makes bad publishing easier.⁵ The responsibility lies squarely on the shoulders of those who use AI as a tool.

The relationship between AI and academic authorship is not primarily a question of ethics or attribution. It is a question of conditions. A significant portion of the scholarly silence among clinician–educators reflects not a poverty of thought, but a poverty of infrastructure. When that infrastructure changes, knowledge that would otherwise disappear has a chance to reach the field. Whether it does so with integrity depends on the judgement and honesty of those who use it. The stethoscope does not hear for the physician. But without it, the physician hears less.

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This article was written with the assistance of Claude (Anthropic, Claude Opus 4.6), a large language model. The AI was used to structure arguments from ideas dictated by the author, to draft passages subsequently reviewed, edited, and

approved or rejected by the author, to organise a research production map, and to translate the manuscript from Portuguese into English. No clinical data, patient information, or identifiable institutional data were shared with the tool. All

intellectual content, arguments, and editorial decisions are the sole responsibility of the author. The AI did not contribute ideas, interpret data, or make editorial decisions; it served as a cognitive scaffold, as described in the commentary itself.

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