

Values and Politics in the HEART Clinic Project

HCD-501

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My intended users are student clinicians working in the HEART Clinic, along with their supervisors who review documentation and the patients who benefit from their care. The student clinicians are the direct operators of the system: they track heart-rate data with Polar monitors, record perceived exertion ratings, and manually transcribe notes into Excel or paper templates. Supervisors indirectly depend on this documentation for oversight and assessment, and patients ultimately rely on accurate, safe, and timely care. Designing in this space means balancing the needs of all three groups, but the primary interface will be for students.

In approaching this design, I am making several assumptions about who my users are and what they want. I assume that student clinicians have at least basic digital literacy and regular access to clinic tablets or laptops. I assume they are motivated to minimize administrative tasks so they can focus more on patient care, and that they trust digital tools to support rather than replace their clinical judgment. I also assume that they want a cleaner, less error-prone process than the current combination of paper forms and Excel sheets. These assumptions carry risks: not all students may be equally comfortable with technology, some may prefer analog methods for learning, and others may feel uneasy about AI-generated summaries. By assuming a “default” user, I risk overlooking the needs of those with diverse abilities, language backgrounds, or levels of tech confidence.

The values of my users likely include safety, accuracy, and empathy. Students want reliable systems that catch heart-rate spikes and prevent miscalculations. They value efficiency, but only when it does not undermine the quality of their patient interactions. Supervisors value consistency and trustworthiness in records, while patients value privacy and the assurance that their data is handled ethically. At a deeper level, students also value feedback and learning; they want documentation systems that help them improve rather than merely check boxes.

Politics are deeply embedded in this design problem. The U.S. healthcare system is shaped by regulation, billing requirements, and institutional standards. Paper and Excel reflect resource limitations and entrenched habits, while cloud-based systems like Zanda or Epic carry their own politics; subscription models, usage billing, data ownership, and AI “black boxes.” On one level, the politics here involve who does the work: students currently shoulder a heavy administrative load, reflecting a broader culture of unpaid or invisible labor in clinical education. On another level, there are politics of surveillance and trust: AI-powered documentation can either support clinicians or become a tool to monitor productivity. There are also equity politics: if algorithms are trained on narrow physiological norms, patients who don’t fit those patterns risk misclassification, echoing structural biases in medicine.

My proposed solution responds to these politics by redistributing labor; automating tedious calculations and standardizing templates so students can devote more energy to patient interaction and learning. It seeks to address inequity by designing with transparency, ensuring patients’ heart-rate data is secure, and allowing manual oversight rather than forcing blind

reliance on automation. It resists the politics of pure efficiency by emphasizing empathy and human agency as central design values. In short, the solution is not just about making documentation faster; it is about reshaping the balance between technology, care, and learning in ways that foreground human needs.