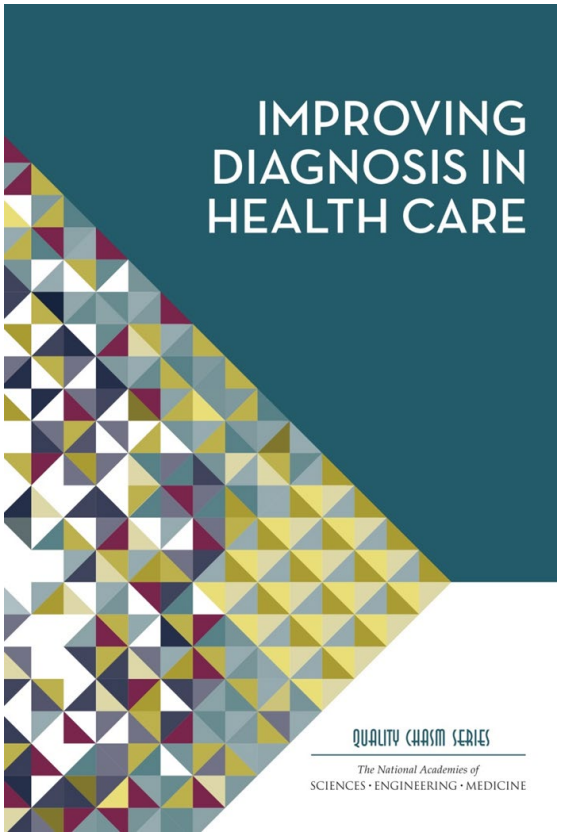
Flawed NAM Definition



- Patients so desperate for recognition of importance of patients and communication…. went for a low bar.

- Dx communication needs to be a ***two-way street***
- Fails to recognize and operationalize ***uncertainty***

Levels of Support for Patient Dx Engagement

I. Listening, non-dismissive, empathetic

II. Communicating meaningful assessment
Shared grappling with diagnosis, uncertainties
Transparent, non-defensive

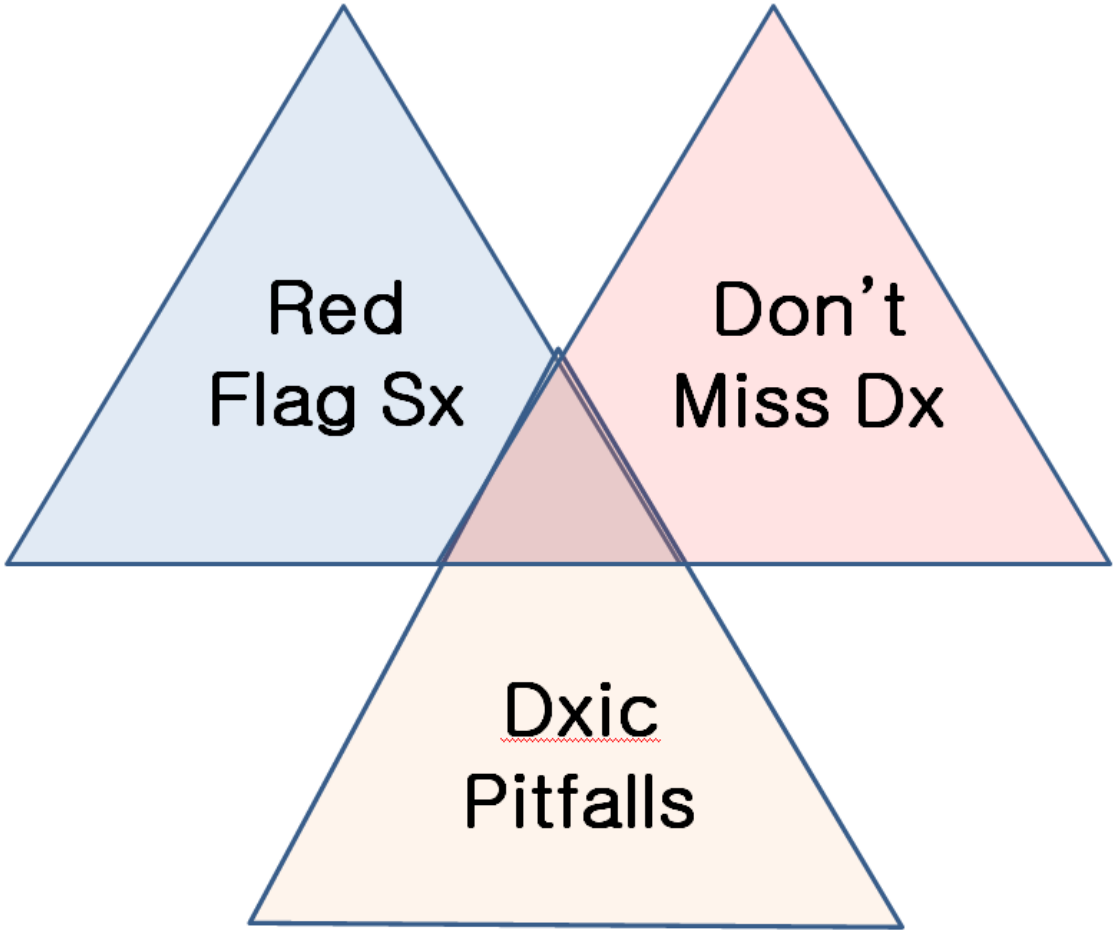
Diagnostic Assessment:
Not just slapping on a label

- The *diagnosis*
  - Most likely diagnosis, Differential diagnosis
  - Probabilities, degree of certainty

Diagnostic Assessment:
Not just slapping on a label

- The *diagnosis*
  - Most likely diagnosis, Differential diagnosis
  - Probabilities, degree of certainty
- Underlying etiology (organism, exposure)
- Severity, Evolution
  - Better/Improving, Worse, Stable
    - Tempo- need to act quickly
    - Early vs. late stage
- Consideration of Don't miss, Red Flags, Pitfalls
- Impact on patient
  - In distress, pain; very stressed vs. coping well
- Stage related to ameliorability, intervention
  - Active inflammation vs, permanent fibrosis
- Best test choices
  - In sync with patient views, values, available resources

Key, Often Missing Elements of Diagnostic Assessment



Olson, Linzer, and Schiff JGIM 2021
Schiff et al JAMA Open 2022

Patient-Doctor-AI Computer

Doctor Now the Least Smart Person in the Room

- Calls for radically reimaging/redesigning MD role
  - No longer the "all knowing" overconfident
- Enhanced/new skills, role, training, expectations
  - Navigator (Weed: "travel guide")
  - Advocate
  - Listener (non-judgmental, non-defensive, open door/access)
  - Narrative skills (notes, verbal communication)
  - Translator (language, information accuracy)
  - Sentry (on lookout/situational awareness)
  - Negotiator (critical reading of AI, going ½ way w/ patient)
  - Information Manager (including for learning, research)

Thinking critically about AI documentation quality in primary care

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The introduction of artificial intelligence (AI)-driven clinical documentation has taken healthcare by storm. According to many leaders and clinicians, there has never been a technology that has been so impressive and rapidly adopted by clinicians.[1] Arising on the soil of widespread clinician burnout and frustrations, including with the time consumed by charting clinical encounters, AI vendors have developed modules that facilitate clinical documentation.[2] These tools work by recording the encounter (with patient consent) as a digital audio file, which is then transcribed using speech-recognition technology, and then processed by AI to produce a formatted note for the clinician to review and sign. This perspective piece is written by a primary care clinician and patient safety researcher using AI documentation in our own practice. We share our work with AI-documented notes, as well as touch on broader issues raised by this new technology.

In 2021 two key developments threw the doors wide open for rethinking outpatient clinical notes in the USA and beyond. The first was a revision of coding requirements by the US Centres for Medicare and Medicaid which previously required documentation of a specific number of history and physical examination components. The new regulations simplified note-writing, making notes less about check-box documentation, thereby providing flexibility for more meaningful narrative and recording of medical decision-making. This liberated notes from prior constraints and provided an opportunity to rethink and improve

Levels of Support for Patient Dx Engagement

I. Listening, non-dismissive, empathetic

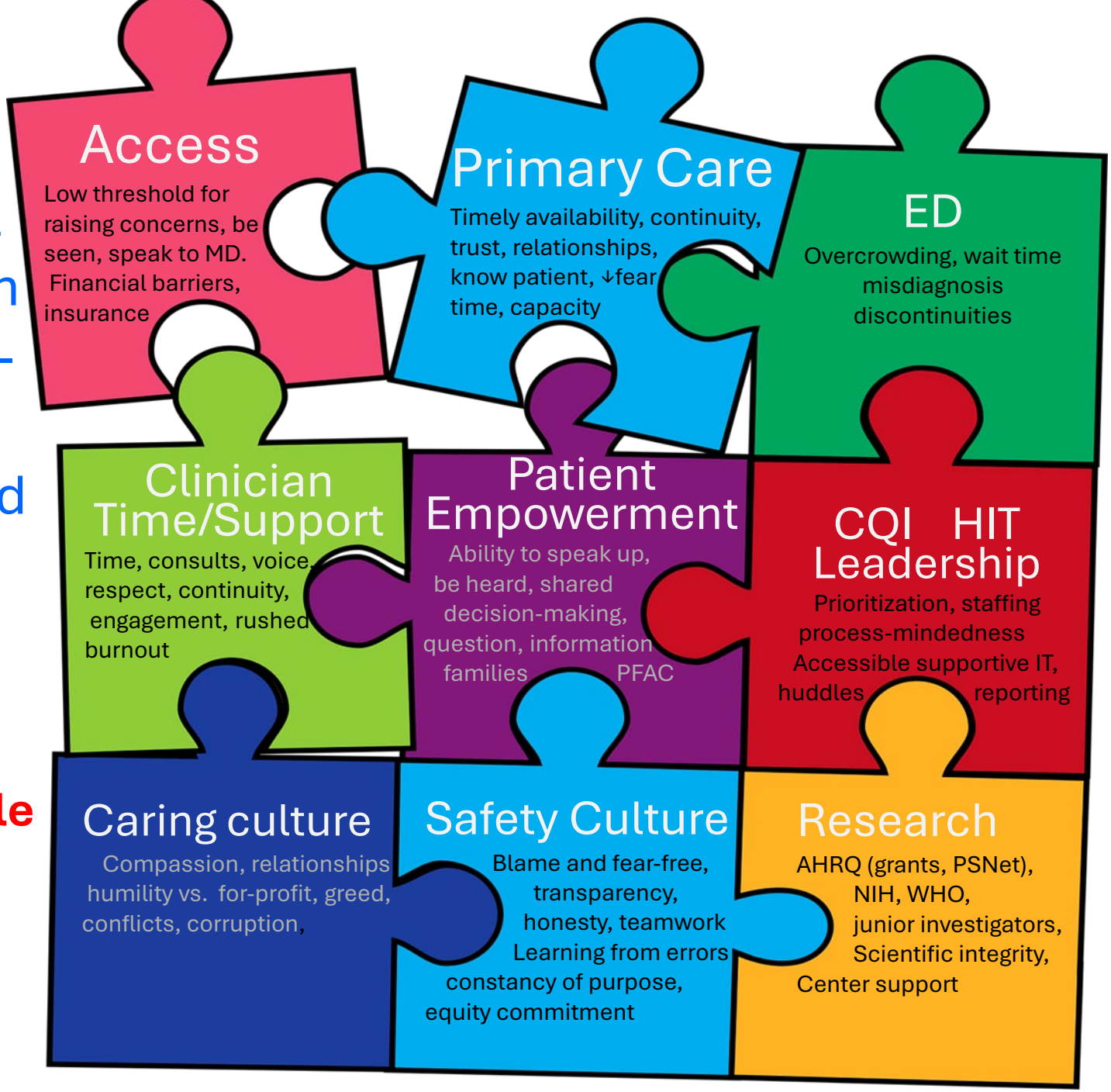
II. Communicating meaningful assessment
Shared grappling with diagnosis, uncertainties
Transparent, non-defensive encouraging of questioning

III. Proactive, systemic co-production redesign
Paradigm shift for patients to play key hypothesis-testing roles related to time course and communication channels especially in reliable follow-up of symptoms, tests, referrals, contingencies
Deepened trust, continuity. Changed power dynamics

IV. Transformed eco-system for diagnosis feedback, learning
EMR pivotal role. Operationalize conservative diagnosis
Working with community for education, trust building

Structural Foundation for Patient-Centered Empowered Diagnosis

Are we fiddling while Medical Home is Burning



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TODAY'S NEJM

Perspective
MARCH 5, 2026

THE CORPORATIZATION OF U.S. HEALTH CARE

Private Equity's Transformation of American Medicine — Implications for Health Equity

Ruqaiijah Yearby, J.D., M.P.H.,[1] and Marcella Alsan, M.D., Ph.D., M.P.H.[2]

In recent years, private equity (PE) firms have gained increasing control of U.S. health care infrastructure. Along with other potential consequences, this growth threatens to undermine progress in health equity, defined by the Centers for Disease Control and Prevention as "the state in which everyone has a fair and just opportunity to attain their highest level of health." PE investors often promise to eliminate inefficiencies in fragmented U.S. health care markets, raise capital for starved systems, and exploit economics of scale and scope. Yet mounting evidence suggests that PE investment in health care has generally resulted in curtailed access, robust regulation and enforcement, the lucrative accounting and operational practices used by PE firms will most likely continue to proliferate, further transforming U.S. health care in ways that harm patients and exasperate many clinicians.

In the first two decades of the 21st century, the U.S. government made efforts to support progress in health equity by addressing economic and social barriers to health care. During the same period, PE investment increased by a factor of 20 (from $5 billion to $100 billion) between 2000 and 2018. Facing less regulatory oversight than publicly traded corporations, PE firms raise capital from high-net-worth individual and institutional investors, often using leverage to acquire "portfolio companies," with the goal of generating higher returns than those that could be generated in the stock market. Fund managers do not face incentives to improve patient outcomes or health equity.

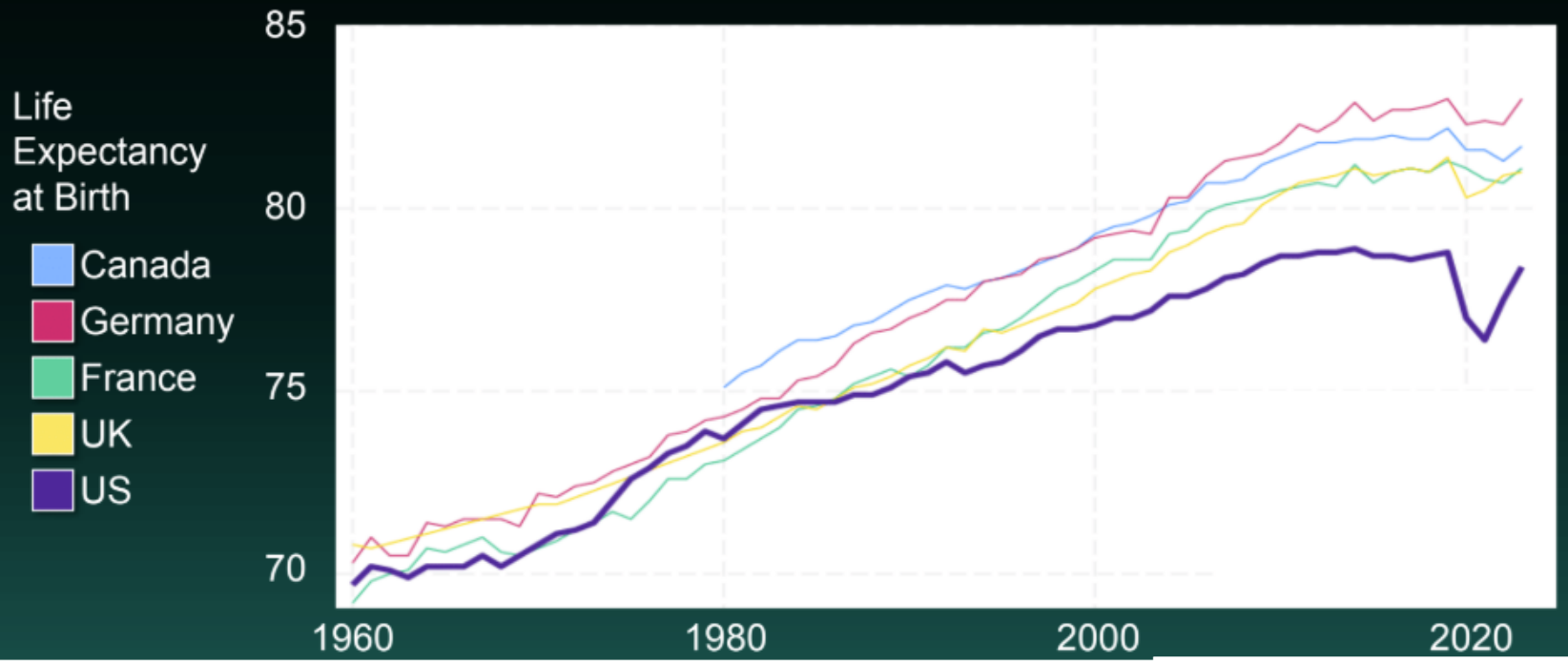
The rapid growth of PE in health care has been fueled by regulatory failures as well as monetary and fiscal policies (see diagram). The number of health care systems in financial distress in-

"Accumulating evidence presented in scholarly articles and government reports indicates that the proliferation of PE in health care has reduced access to care, increased costs, and compromised quality of care."

- Accounting and operational practices run counter to improving access and equity
- Takeover often associated with cutting staff, increase costs, and worsened quality

Life Expectancy in Five Wealthy Nations

US falling further behind even in pandemic's wake



Draft 1.0

Good Diagnosis

PATIENT BILL OF RIGHTS

1. Ensured timely care access
2. Open to raising and answering questions
3. Participation in informed shared decision-making
4. Access to 2nd opinions
5. Honesty regarding uncertainties
6. Open door for accessible follow-up/recontact
7. Ability to bring in family member; advocate
8. Ability to speak to live person when requested
9. Disclosure, transparency when errors
10. Welcomed participation in learning/improvement
11. Financial transparency; accountability