Interpreting the Interpretation **April 12, 2026**

Dear Residents,

I am coming off two weeks on the rheumatology consult service, and I was struck by something that feels both familiar and entirely new. I cared for a patient in whom we were navigating a complex inflammatory syndrome, with greatly elevated cytokines. Their interpretation depended not on any single lab value, but on patterns, trends, and clinical context, as did the response to treatment. Several of the relevant tests returned over the course of days. Often on rounds, the patient and family had already reviewed the results in the electronic health record sometimes before I had seen them.

Their questions were thoughtful and engaged but were sometimes anchored to a different timeline. Results that reflected where the patient had been (before we began treatment) were understandably taken to represent where the patient was now (after treatment had commenced) because the labs drawn a few days earlier had just resulted. Much of our conversation became less about how the patient was doing, and more about what the record was saying.

In many ways, this is an extension of changes that began with the Open Notes movement, which was launched in 2010 to improve transparency, strengthen trust, and help patients better understand and participate in their care. What began as an effort to open the chart has gradually reshaped the patient-physician relationship. Patients have greater access, and with that, greater agency. But what feels different now is the immediacy and the interpretive layer. The chart is no longer just visible; it is actively being read, processed, and sometimes explained before we arrive.

This creates a new dynamic at the bedside. We are no longer simply gathering information and offering an assessment. We are entering a space where multiple narratives already exist: the raw data in the chart, the automated flags and comments within the record, and increasingly, interpretations generated by AI tools. The clinical encounter becomes, in part, an exercise in reconciling these narratives.

There is much to welcome in this. Patients are engaged. They are informed. They are asking questions that reflect attention and investment in their care. Patients are using AI tools to understand their symptoms, labs, and diagnoses. It's helping them ask better questions. But it is also creating false certainty, amplifying anxiety, and stripping information from the clinical context.

Data divorced from context can mislead. Time delays in lab processing can distort the relationship between when they were drawn and when they resulted. A result that is clinically evolving may appear static. And a conversation that once began with the patient's experience may now begin with the chart's

output. This does have implications for efficiency. It adds time, and sometimes friction, to our encounters. But more importantly, it calls for a different skill.

We have always been interpreters of data. Now, we must also become interpreters of interpretations. We are not only explaining what we think, we are explaining how to understand what has already been seen, read, and sometimes misread. In that sense, the role of the physician is not diminished, but expanded.

In some ways, this moment feels like a return to an earlier chapter of my own life in medicine. Attending Medical School in Pakistan, in the early 1980's, I recall that patients often carried their own medical story, in a folder containing lab reports, prescriptions, referral notes, and sometimes even radiographs. It was their way of holding on to the narrative of their illness as they moved from one doctor to another. With each visit, more pages were added. The "medical file" as it was commonly referred to, was tangible, portable, and in a very real sense, theirs. What was often missing were the physician's notes. Those were usually brief, handwritten, and kept separately, sometimes in the doctor's office, sometimes not at all. A few physicians would make photocopies for patients, but that was the exception.

Now, decades later, it feels as though we have arrived at a different version of the same idea. Patients once again hold their own medical story, but now in ways that are far more immediate and comprehensive. Today, our patients carry it because the system now allows them to. The medium has changed, from manila folders to portals, but the deeper human impulse is the same: to hold on to the story of one's illness and make sense of it. The patient portal is no longer a narrow window into their medical life; it is a wide-open door.

The chart has always told a story. What has changed is that our patients now read it alongside us, and often before us. Our task is no longer simply to write the story well, but to help make sense of all the stories that now surround it.

Best regards,

Dino Kazi