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MEDICINE MEETS MACHINE LEARNING: REAL-WORLD AI IN PRACTICE WITH DR. JOSHUA LOWENTRITT

David Mandell:

Hello folks, Dave Mandell, host of the podcast. We've got a terrific episode, a really interesting topic and doc that I've known for a couple of years.

But before we get to that, for the very few of you who are watching on YouTube, and I know the vast majority of you listen on the podcast platforms, you will see a different background for me. You'll see OJM Group and Earned. And for those of you who get our newsletter or for certainly our investment and insurance clients, you know about this, but I want to take two minutes and talk about it. So OJM Group in the fourth quarter was acquired by Earned, we're part of Earned Wealth. And I'm going to read something then I'm going to give you my 2 cents on it.

So OJM is now part of Earned, a comprehensive tax and wealth firm built specifically for doctors, their families and their practices. Earned brings tax planning, investing, retirement strategies, practice level advice, plus insurance and legal coordination all under one roof. So your entire financial life works together. And I think as of when I checked with the folks just a couple of days ago, we were at about 20,000 clients, the vast majority of which are doctors. We manage about three and a half billion dollars as an investment piece, but we do a lot of things.

And on this podcast over time, we're going to start to have some of my colleagues, and I met a bunch of them over the last couple of months. We've got a healthcare law firm and a really smart guy, Ali, who runs that. We've got four or five CPA firms around the country who do work for medical practices, dental practices and docs and their families, everything from returns and tax planning to payroll and accounting and M&A and all of that. And then we've got a retirement plan services firm. And I think the first guest who I'm going to have on in a couple of episodes is actually a physician out of the Philadelphia area who became disabled, OBGYN, and could not practice and was so frustrated with her experience that she formed a insurance firm to help fellow docs who need disability insurance. And she's been very successful with a partner in helping thousands of physicians that way. And I thought she would be a great first guest from the Earned family to have on.

So a lot of exciting stuff. If you are a client already, you know about this. If you're not, we'd love to talk to you. And now our expertise and our breadth and depth of services are really much greater than we were at OJM and we always did a great job at OJM. So that is a little intro in what's coming, and for those of you watching, you understand why now I have this different kind of Zoom background.

Okay. Now let's talk about our guest Dr. Josh Lowentritt. He is someone we've known and worked with for a number of years now. He gave me kind of a bullet pointed informal bio, which I will sort of go through and we're going to talk a lot about this and we're going to be talking a lot about AI today, which is pretty exciting. I've wanted to have somebody on to talk about AI in medicine and he raised his hand, so I'm really happy to have him.

But a couple of Josh's highlights. He's still seeing patients. He's been in practice over 25 years as a primary care provider and in nephrology. He's been office-based, hospital-based, worked in skilled nursing facilities and nursing homes, hospice, house calls, dialysis, kind of done almost everything you can do in medicine. We'll get that in from his words. He's been a managing partner of a multi-specialty 25 physician practice for 15 years. He

started Louisiana's first physician-owned, physician-governed ACO and helped them grow to be taking over $15 million, but started with very lean years. So we might touch on that.

He had a senior medical director role with Aledade, I think I wrote that down, for six years, focused on clinical engagement, rolling out company-wide clinical programs in 2000 practices. He stepped back from that role a bit, now practicing still consulting with AI's companies, giving leadership workshops nationally, writing peer review journal articles with the goal of making healthcare better for physicians and patients. And we're certainly going to talk about that. He's an angel investor, he's part of some startup volunteer boards, and maybe most important of all of this, he had his first grandchild last summer. So with all that, Josh, welcome to the program.

Joshua Lowentritt:
Thanks Dave. So glad to join you. And yes, first grandson named after my father and his father.

David Mandell:
That's awesome.

Joshua Lowentritt:
Great start to the year.

David Mandell:
Yes, for sure.

Okay. So I gave it in bullet point form a lot there. We've got a bunch to cover and what we want to do in 30 minutes or so. But just give us some highlights or some things that, if I say describe your medical career before this stage, we're going to talk about this stage and your interest in AI. I went through a bunch of bullet points. You've done a lot, but give us a couple of minutes summary of what you've been doing with this.

Joshua Lowentritt:
Sure. So I started practice and it started to mature right around 2005. And then Kirk and Hurricane Katrina came in, knocked me out of New Orleans, just about killed the practice. And then when I came back to town to resume the practice in 2006, I kind of had a choice. Did I want to be a leader or a follower? And I really decided that I wanted to really make a difference. If I was going to come back to the New Orleans community, I wanted to be a leader in my firm to help it move forward and also bring a nursing home back to 5-starred status. And then obviously start building the practice that I wanted, but also just to be honest, trying to build investments in entrepreneurial areas that I would need to then count on later in retirement years.

David Mandell:
Yeah. I mean we had a colleague of yours, Shammi, on a number of years ago, and for any of you folks in New Orleans, I mean that's the year that changed everything. And so it is kind of like a reset to say, "How do I want my practice in life to be?" And again, there's an attorney that we've had on here who is a New Orleans two or three generations and left and went to Dallas and didn't come back. And I think there's some sadness there, but that was just a big event that give you ... You were sort of describing a crossroads. There are different ways to go.

You mentioned as you did that and came back and it obviously was in my summary bio. Before we start digging into AI, I think the docs on this platform would love to hear about some of the entrepreneurial things that you looked at or participated in over the last 20 years.

Joshua Lowentritt:
Sure. So my group always tried to own its own commercial medical real estate offices. So we still do, and that's a challenge when you don't fully occupy them. So I'll just give that as something to the audience that if you're not going to be fully occupying your medical real estate, you've got a problem.

David Mandell:
Let me just drill down on that for a second. Are you saying that you don't want to be a landlord when you say that we are going to, meaning the practice if you're going to own it and you're going to have empty space, you've got to try to fill it and deal with tenants and all that nonsense.

Joshua Lowentritt:
Yeah, basically. If your practice downsizes or it gets split apart and you're not fully occupying medical real estate that you used to, it takes some work and you need to have reserves and be patient.

Other things, I developed a joint venture Davita, dialysis unit with Davita about 10 years ago. Learned a lot about business that way. The ACO was probably the biggest thing, building a network across the state of independent position and holding it together when it didn't make money. So holding together an organization of physicians who are paying in but not getting paid out for almost five years. Now they're very happy with it. They're all being paid out. The shared savings are there. It moves around a bit in terms of the amounts each year, which is, it does create some challenging cashflow situations, especially if you're in an LLC and a limited partnership where you need to zero out your income for the year, but you get a big bolus at the end of the year, makes it interesting how you manage your cashflow.

And then I've enjoyed doing angels investing the last five years in about 18 companies. I work with really one of the largest angel investing group, Gulf South Angels. We have members in 19 states, more than 150 individuals, a lot of them doctors in fact. And about half of our investments are in healthcare, but I've also now have shares in a rocket company, a space company, all sorts of things.

David Mandell:
Interesting.

Joshua Lowentritt:
Just some of the different things I've done. Keeps me very busy, I guess, outside of all the other things that I'm doing.

David Mandell:
That's right. Well, that is busy. And I love the fact that you're part of an angel group. We have had certain physicians part of study groups. In fact, I think there was a doc, I want to say Seattle, this is maybe 15 years ago who said, "I'm part of a study group or an angel group," and we wanted one of your books for all the people in the group who aren't even physicians, but they were interested in asset protection or tax, whatever the topics were. And he said, "I've got your book and I think it's valuable, would you send us a box?" And I said, "Obviously, sure, we would do that." So that's great.

All right, so let's get into what the main topic at hand, which is AI. How did you first start using it in your practice and life?

Joshua Lowentritt:
So ChatGPT version 3.5 came out a few years ago. And I didn't jump in right away, but my son-in-law who is in medical school and looking to do radiation oncology, he started asking questions of could this could ChatGPT answer medical questions related to the treatment of cancers. And he found that it didn't do such a great job.

So I started to using it for simple things, the clinical questions to help write the first draft of an essay or a presentation. Now I use it to help write presentations, it helps me in my consulting jobs. I help do research for peer review journals, articles that I'm preparing. I found that it works faster than even the traditional online resources that we would use to look up clinical questions or for board review questions. It's just much faster.

David Mandell:
Interesting. And something I have that you mentioned was an ambient AI scribe. Tell us about that.

Joshua Lowentritt:
Sure, so an ambient scribe, it's a software program that's listening to me talk to patients, and it helps generate the notes that would become the progress notes. Because I got very good at doing clinical documentation. I started using EHR fully in 2009. I've used it since, that's more than 15 years. And I could finish my note and get everything done before I walked out of the room with the patient. Now I don't think that was such a great experience for my patients.

David Mandell:
You're on the screen, you're listening, but you're typing.

Joshua Lowentritt:
Yeah, right. What a dumb idea to take people with the highest licensure, the most training and do keypunch and take dictation and stenography. So now you really don't have to do that. So now when I see patients, it's doing the listening, it generates a great note, I'm very impressed. Then when I'm interacting with the patient, I'm just looking right at them. There's no one in between anymore. It's such a better experience. Like lowers my feelings like burnout, lowers my feeling of being a provider. And now I think I'm back to being a physician and counseling patients and be able to explain, since I'm not trying to figure out whether to put a pause or a comma or a double space or correct a misspelling.

Interesting. So a year ago I had to get a tendon repair in my shoulder, and so the surgery was on a Thursday and I had clinic scheduled on Friday. So because I've been doing heroics all my career, I didn't think of canceling patients, but I began using an AI scribe the next day, learned to use it, and I saw 10 patients the next day. I haven't looked back. I'm never going back.

David Mandell:
So I want to tease out a couple of things you said, but before I get to that, I just want to ask a very logistics question. So do you have a recorder that comes

around with you? Is it through your phone? What is the mechanism around your patient in there with you? Do you have a device? How does it work?

Joshua Lowentritt:
Right, so there's probably two versions. One is you use your phone and it's listening through your phone through an app. For me, I use a Mac. And so I pull up my EHR on one window and I pull up the scribe on another window. And so what I practically do is I will start outside the exam room reviewing the patient's chart, what their last appointment was, last lab work, what we did at the last appointment, medication changes. So I'll dictate in about two minutes of prep work, diagnoses, disease states, statuses, look up the labs, dictate them in.

And then I'll literally take my laptop and go into the exam room. I'll literally say to my laptop, "Let's go see the patient." And then the patient and I will have our time together, and then afterwards, this scribe Freed, F-R-E-E-D, it'll generate the note and I'll spend a minute and a half per note editing it and dropping it into the right spot in my EHR. And you have to edit it because it misspells names and it sometimes doesn't quite get it right. But I feel like I'm a doctor again, not a typist.

David Mandell:
So if it can work well in New Orleans where you guys have crazy accents, then probably can work anywhere.

Joshua Lowentritt:
There you go.

David Mandell:
You have to put a little setting on it, this is a New Orleans Cajun accent. But I mean, first of all, your main point, which I thought was great, which is a recurring theme by the way in this podcast over six seasons and a hundred plus episodes, which is highest and best use. It is not your highest and best

use to be typing. You might have to do a tiny bit still just to edit whatever, but it's certainly better.

I just saw my GP this week, my PCP, and it was kind of like that. He would listen and type looking at the screen and then kind of look at me and then type for a while. I could see how the second piece isn't so obvious to me. But now that you say it, I think most docs go into practice because they want to help people. And interacting with people is going to give them a better experience and lessen burnout and frustration than coming in and staring at a screen and typing and being stressed about did I get everything.

Joshua Lowentritt:
That's exactly it.

David Mandell:
Trying to be a doctor and trying to be a typist and going back and forth.

Joshua Lowentritt:
It reduces the cognitive load of the visit. And so that extra load of editing, typing, remembering, putting it into words, it all gets to the patient now. So everything I'm doing there is being focused in on the patient, their treatment plan. I have more time to explain things, to give context to an unusual result, to pause and have that heart-to-heart conversation. It just brings me back to what I went to med school for, why I became a doctor, and why I still really treasure clinical time.

It does a couple ... Sometimes if I'm telling a story, like the first couple of weeks of using the scribe, just about all my patients had had shoulder surgery when they-

David Mandell:
And Josh, by the way, if you're on audio, he's touching his shoulder right now. So he's just showing that. Referencing back to when you were post-op.

Joshua Lowentritt:
Yeah, so just about all my patients had shoulder surgery, so I had to edit that out. And sometimes if I tell a story, it'll put it in the patient's voice and I'll edit that out, but-

David Mandell:
Not perfect, but saving you time.

Joshua Lowentritt:
It's not perfect. But it will always pick up the patient's concerns that previously when I'm sitting there cutting and pasting and typing, I may not have had time to pick up on. Now it'll pull in a patient concern that maybe wasn't on my top list of things to work on with them. And sometimes I may not see it until I see the transcription later, but then I'll call the patient back and say, "Hey, you told me also you're having bad headaches, and I didn't address it in your visit. Let's talk about it." So it will pick up on things that maybe wouldn't have fit into the normal visit.

David Mandell:
So last question, we'll move on. But if a doc is listening to this and they say, "Hey, I'd like to incorporate it." I imagine when you decided to do that, there were some, this is my lawyer thinking, tweak to your informed consent or something that just maybe it was already covered, but it got looked at to say the patients are okay with this because it's PHI and all that.

Joshua Lowentritt:
So you should definitely, whatever company's software you're going to use, you need to read through all their privacy notices. You need to understand what they're going to do with the transcriptions, that recordings, do they retain them for 30 days, do they send them off for learning or not? They'll have a standard consent that you can print out, that your patients should give consent.

I think all of these have a pause button. When your patient starts telling you some of these stories that are very personable, please hit the pause button. The software will pick up that they have a challenge and you can always type in something later, but you have to be sensitive to that. But my impression is that most of the companies handle data very, very, very, very professionally, ethically, because I mean that would kill a company if these got out.

David Mandell:
Yeah, makes sense. So just do your compliance work beforehand, but it sounds like a real time and stress reducer and helps you practice better and more enjoyable.

So all right, let's move on to some use cases. What are some other ways you're using AI in the practice?

Joshua Lowentritt:
Sure. So I'm on Epic, which is one of the big EHRs and we now have chart summaries. So if I haven't seen a patient in a long time or I know they've been in the hospital or in another hospital system, I can just click hospital summary or a chart summary and I'll get about a really good detailed paragraph of what's been going on. It helps to catch me up before I walk in and see a patient. I'll sometimes dictate that into my scribe.

I use a company, Natera, that provides genetic testing for patients. They take a patient sample and they can screen for 370 kidney diseases. It's incredibly valuable. I felt like I was blind in the first 20 years of practice. I would say, "Well, you have progressive kidney disease." I didn't know why. Now I know. I know now a third of my patients or more that it's not bad luck. It's certain genes and there are beginning to be treatments for them. And so I try and use genetic testing where it's appropriate. They're starting to put clinical decision support into some of the EHRs such as, "Is your patient on an ACE or an ARB? Have you checked in A1C lately?"

So there's things in clinical decision support that are going to come forward and be more prominent. And it would really help because when you get distracted, patient comes in because they're hurting, but you haven't seen them in six months. Sometimes you have to remind yourself or be reminded, also do these other things that the patient needs to stay well. And one of the most powerful things that AI and machine learning does is it helps look at, say, your panel of patients and prioritize who needs a phone call today. So many of these software packages will look at who just got out of the hospital, who has missed refills on important medications, who had an ER visit, and it will rank those by an algorithm so that if your medical assistant can only make five phone calls that day, it makes the five most important phone calls.

David Mandell:
Very interesting.

Joshua Lowentritt:
So the patient is going to benefit because ideally your patient may be trying to reach you, but maybe they're not all so good at reaching us sometimes, or maybe our phones are not working that day, or maybe we're overloaded with messages. But if we know the patients that in my practice need to be outreached to prospectively, it's better for the patient. And that's one of the ways AI helps people's medical practices.

David Mandell:
That's interesting. Yeah, I never thought of that. That's really cool.

So in the bio that I summarized there, it looks like you're doing some consulting too with some AI companies. So let's hear about that. What are a couple of the things you're, beyond just your practice, obviously this is the area you're interested and passionate about. What are some of the companies and what are they working on that you'd like to the audience to know?

Joshua Lowentritt:
Sure. I'm also working with a company called Koda Health, K-O-D-A. They help patients who are higher risk, more vulnerable with advanced care planning. So they have a program that's both a set of videos that helps you write your advanced directives and helps pull them together, but they also use machine learning algorithms, AI algorithms to find the highest risk patients and reach out to them for in-person one-on-one facilitations. And they can do this at scale. So we all know that-

David Mandell:
So this company, part of what they're doing is helping folks put together their legal documents. I mean, not that it's practice of law or anything, but there's plenty of AI groups in the field on state planning. And part of that would be a durable power of attorney or healthcare proxy or whatever the state requirement is. But this is specific in healthcare and trying to get to people who don't have those documents in place and have them get done.

Joshua Lowentritt:
Yeah. So what's really helpful is it will bring up certain situations that a patient may not think about or a lawyer may ... I know you're a lawyer, but you may not say ... So when my dad did a program like this, thankfully he's still well and still with us. My dad, I was surprised, he's a retired surgeon. He said, "Oh yeah, you can do a trach, you could put a feeding tube, you can do experimental treatment, cancer treatments until it's to a point." And then I would say stop. So then one of the situations was, "Well, Dr. Lowentritt, what would happen if you were in a nursing home? Would you still want all that?" He said, "No, if I'm too weak to go home, I don't want all that. I just want to be kept comfortable."

So being able to prepare beyond just the simple would you want CPR, would you want a feeding tube, to your situations really helps. And it's very well-informed and helps draft documents in plain language, which is critical so that a patient can share it with their family members, with all their care team. And ideally Koda Health, if it's implemented, the patients get more of the care they want and less of the care they don't want. So really critical.

David Mandell:
It's brain on the system. I mean if nobody has these documents or they don't understand et cetera, they're not making choices. Again, there's some statistic that … And I don't know exactly, but it was some overwhelming number, terrible number of how much healthcare dollars are spent in someone's last year of their life when they might not even want that or a portion of it they don't want. So why are we spending all that on someone who doesn't even want it? Well, because they never got the documents together so no one can make that judgment for them.

Joshua Lowentritt:
About a fourth of healthcare dollars go to folks in their last year of life.

David Mandell:
Yeah, And a big portion of that fourth may be unwanted.

Joshua Lowentritt:
Some of it is definitely unwanted.

David Mandell:
And this is helping people to make those decisions.

So back to the physicians, you had mentioned one of the guardrails that we were … You already brought it up, which is, on the recording when it comes to the scribe notes, if they're going into a real personal situation, know, pause that, et cetera, if it's not key to the diagnosis and patients. And I know clients sometimes can go off into a tangent. You want to listen to them and be respectful and then guide them back to what we're here for, but if it's being recorded, you want to make sure that you avoid that. What are some other things that docs should be thinking about if they're going to be using AI more in their practice just in terms of smart guardrails?

Joshua Lowentritt:
Sure. So these LLMs, these large language models are trained on millions or billions of pages of material. And sir, they've read all the journals that are public access. But they're also reading all of the blogs they've scraped off the internet, and you don't know what is in those blogs. And so you have to be aware that evidence may be pulled in if you ask a clinical question and you don't know if the AI LLM that you're using is going to weigh a blog or a bunch of blogs, maybe it's from folks that are skeptical of vaccines and you're trying to figure out what's most important for this 3-year-old or 30-year-old. You want to be careful to understand where the evidence comes from. The good LLMs will give you the notation, it came out of JAMA, it came out of Journal Lancet or somewhere else. And so you want to just know that they may come up with things, it may not weigh evidence the way that you would.

The other thing is, it may pull up evidence that's out of date. So a lot of things move very quickly, we know, and guidelines change pretty often in some fields. So you want to make sure you're getting the most up-to-date resources. And I always say if you're looking up a clinical question for a patient. And it's important not just looking up a fact, you should probably check more than one source. So if you're using OpenEvidence, also check ChatGPT or Claude or UpToDate and use multiple sources.

But I'm telling you, sometimes it's dead on. I have a patient who was referred to me with a change in kidney function after getting chemotherapy, and I kind of knew what it was already just even before he walked in having read his chart. But I asked ChatGPT and they said, "Oh, this is interstitial nephritis from a checkpoint inhibitor. You give steroids, it generally gets better 80% of the time." It had it, had it cold. And that was not that common. It's only a 1% to 2% side effect of certain chemo agents. So it's very helpful.

I think what's interesting, doctors are not known to be rapid, fast adopters of new technology and always a little slow and hesitancy. And historically, they've said it takes 17 years for medical technology to be fully implemented.

As of last December, about 60 plus percent of physicians had used AI in some form in only three years of it rolling out.

David Mandell:
That's just a reflection, I think, of society in general. I mean, I've used it a bit, and even for this podcast. When I want to create the show notes out of this, when we started six years ago, I would actually look through the transcript and literally from word one, kind of write the show notes. Well, I'm not doing that anymore because I can get AI to go through the transcript and suggest show notes and then I added them, and they're pretty good. Now I might change this or that, whatever. And I'll ask for five possible titles and I'll choose one or I won't use any of the five, but it suggests something else to me that I like as a title. So it's just saving me work.

But to your point, if I'm doing something or care on taxes or what have you, or legal, I may use it for some research, but I'm going to make sure I look at two or three places and I'm going to put my stamp of approval on it, not just send it. So obviously, medical it's even more important, you got somebody's lives in your hands. So I mean checking this off in a couple of ways and looking at the sites and all that.

So a couple more questions, then I want to wrap because we're getting time. So one of the things you wanted me to ask you about was, and I don't even know anything about this, so we're going to go into it, Diffusion of Innovations Theory by Everett Rogers. What does that mean? And maybe you were kind of getting into it what you were just talking about, which is the fact that docs have already been acceleratingly using this technology as opposed to others in the past, but what is that about?

Joshua Lowentritt:
Sure. So Everett Rogers was an agrarian sociologist in the Midwest who was trying to figure out why did it take so long for changes in agriculture to go through society. And his dissertation is 1960 Diffusion of Innovations. Well, that theory says that we individuals have different ways of dealing with new

technology. We have our innovators, which are about 2% to 3% of a population, early adopters. They will take something that's been sort of started, prove it and then roll it out. Early majority, late majority, laggards and skeptics. So it's sort of a bell curve of the willingness to innovate and try new things.

And physicians, most of our willingness to innovate gets rubbed out of us in training. You are not going to start doing something that doesn't have evidence behind it because you are trying to save a life. So we have a very high burrow of evidence before we change what we do, and sometimes that could lead us to move too slow. What the theory also says is if the new technology is much better than what we had before, it makes rapid adoption more likely. And social capital is very much ... Social capital helps move an adoption forward.

So if one out of 10 physicians is loudly speaking in the doctor's lounge about how wonderful this is, that shows opinion leadership for that innovator. Folks are going to adopt it more rapidly. I was really shocked to see a physician, 60% within three years are using AI in some capacity, but it just tells you how bad the system was before that we had to look stuff up, to double check things. Look at the PDRs, thousands of pages. Every drug has pages and pages of things to know. The system was not so great into helping support our decision making. And now we have technology that can help us support our decision making information very quick and it's getting much better, and you have to be smart enough to use it in a safe manner.

David Mandell:
So I have a couple thoughts there, then we'll wrap, last question. It's not surprising in general, forget about AI, that physicians are slow adopters. I don't know, again, my brother and father, grandfather and so many of my clients went to med school and training. But the one thing I do know is the saying, first, do no harm. And that's a pretty conservative, not an innovative way to start, first, do no harm. Which makes total sense, especially if you think about the history of medicine where leeches, and I know there are some good uses

for leeches, but the point is that you don't want to make the patient worse by interacting with them. And so I get that it should be a conservative thing. We're not talking about something trivial.

But I think the reason why you may see that adoption accelerated here is that there is a lot of use cases and it can be gradual. You're talking about agrarian economy and you're talking about Roger's thesis here, either you use the new crop duster or you don't. It's not like you have a lot of other uses of a crop duster. Whereas with Chat or AI or LR, you could start with, "Help me do some stuff on the US history. I'm interested in building out itinerary for a trip."

You can start to use it and get comfortable, "Hey, it's giving me some good stuff. I have to check second sources." But you can get into it and then say, "You know what? I have this patient situation, why don't I try putting it in there, but I can look elsewhere." There are multiple ways, and you've even talked about it, scribe, et cetera, ways to get your feet wet and move forward. So that's not surprising to me.

Okay. Last question, and this is a big one, right? Will physicians be replaced by AI? Everybody's asking that. Will lawyers be replaced by AI? Will financial advisors be replaced by AI? What's your take on that?

Joshua Lowentritt:
So if all you do is provide information that can be looked up, you're going to be replaced. If you use information and adapt it to an individual situation, an individual patient, explain it to the patient, give context, give some coaching and be available when things don't work, no, you're not going to be replaced as a physician unless what you were doing really wasn't the highest level of our profession. So AI is going to supplement physicians, not replace us. So if you're a physician that lays hand on people, if you're a surgeon, a cardiologist who does intervention work, if you operate on the eyeball, you're not going to be replaced by a robot. You may have robotics help you be a better surgeon, like knee surgery for now, for sure, knees and hips.

But again, if you're a physician who diagnoses and treats and helps patients, you're not going to be replaced. And hopefully on the patient side, they can look up simple questions on their own and hopefully get balanced and factual information that can help them know, "Do I have a UTI or maybe I'm passing a kidney stone?" Or, "If I have a fever after two days after getting a vaccination, do I need to panic?" But the hardest part with clinical questions that patients really don't have the training for, and what a lot of AI training focuses on is building and creating the right prompts.

So if a patient says, "I have a fever and my shoulder hurts," well that could mean a septic joint. But if they also say, "Well, I had a shingles vaccine two days ago and I'm also feeling a little uncomfortable," it'll say most of the time people with shingles vaccination will get pain in the injection site and you can treat it with ice and seds. So the prompting is what can give good answers to people, but prompting also takes a bit of sophistication, and we're not there yet for the general public to always get the answer they're looking for. I think clinical decision support is going to be very helpful, again, not replacing physicians but helping us do our jobs. We have a lot to remember in those 12 or 14 minutes with a patient.

David Mandell:
That's right.

Josh, I think that's my take on things too, just in general, whether it's advising financially, advising legally, that there's a science part, there's an art part, there's a human connection part where people will take the advice and there is a piece of that that is just informational. And rather than fighting technology, I think the best way to do it is figure out how it can make your job easier and better so you can really spend the time and effort on the areas that you add the most value. And it sounds like you're already doing that in a big way.

Joshua Lowentritt:
Yeah, I just reflect that back in saying that my use of AI in medicine helps me get back to doing what we're trained to do best, which is meet patients where they are and help them out.

David Mandell:
That's right. And that's how we started this conversation. So I really appreciate that.

And thank you for being on because this was a topic I'm sure we'll cover again in the future and maybe have you back on a number of years and you'll be telling us different tools to use. But I wanted somebody on to talk about AI and how to use it in a practice, and I'm glad you were able to join us. Thank you.

Joshua Lowentritt:
Thank you.

David Mandell:
So everybody watching and listening, again, if you have a topic, if you're a physician that you think your colleagues would like to hear about, and Josh was very proactive in saying, "Hey, I could talk to you about this," and I said, "Let's do it." And let me know. Also, if you feel so inclined, give us a 5-star review, give us a good rating, et cetera, et cetera, tell your friends about us. And in another two weeks, we'll have another episode. Thanks for joining.