From medical drift to predictive medicine

Medical vigilance and chronicity: systemic diagnosis and architectural properties of a sustainable regime

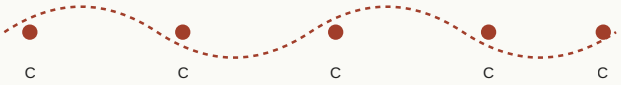
THESIS

Medical drift is not the failure of insufficiently attentive actors; it is the structurally expected effect of an intermittent vigilance regime confronted with trajectories that have become longitudinal, multifactorial, and dynamic.

Five ideas 5

INTERMITTENT REGIME (CURRENT)

trajectory off the observation field



CONTINUOUS REGIME (PROPOSED)

trajectory visible; clinical judgment preserved

Structuring distinction: shifting to a continuous regime is not an instrument question, it is an architectural question.

1 **Chronicity changes the nature of what the system must govern.**

13.8 million patients holding ALD status (long-term condition registry, *affection de longue durée*) on January 1, 2024. Nearly two-thirds of reimbursed expenditure concentrated on these trajectories, with a projection close to 75% by 2035. This is no longer a quantitative challenge; it is a change in the nature of the burden.

2 **The French system has remained optimized for acute care.**

Architecture historically designed for discrete, standardizable, short-temporality events. The epidemiological transition toward long, silent trajectories exposes a structural inadequacy that no marginal improvement corrects.

3 **Wandering and drift are two pathological regimes of the same system.**

Wandering designates uncoordinated over-utilization without longitudinal piloting; drift designates the progressive invisibility of a patient to the system. The two phenomena are not independent: they are the two states of an observation device that has become inadequate.

4 **Increasing the number of consultations does not correct the architectural property.**

Multiplying observation points improves certain capacities without modifying the regime's fundamental property: a primarily discrete observation of trajectories that have become continuous. The question is not quantitative; it is architectural.

5 **Predictive vigilance is an architectural property, not a technology.**

A limited hypothesis: certain degradations become statistically detectable earlier when a partial longitudinal trajectory is rendered interpretable in time. Neither a promise of algorithmic accuracy, nor an automation of clinical decision. The governability of uncertainty trumps performance.

Four political arbitrations not delegable to the technical level 4

Q1 Who governs alert thresholds?
Every predictive device operates on thresholds. Calibration is not a technical decision but a political one (a low threshold multiplies signals, a high threshold accepts false negatives). Without a public authority named for this arbitration, thresholds are set by default by technical designers, without mandate or transparency.

Q2 Who bounds the uses of longitudinal trajectories?
A vigilance infrastructure produces trajectories of considerable economic value to insurers, employers, and platforms. The countermeasure cannot be only legal. It must be architectural: bounded retention, granularity degraded at export, technical impossibility of profile reconstitution outside strict clinical use.

Q3 Who arbitrates prioritization under medical scarcity?
The device can rank patients by criticality; it cannot decide who will actually receive care. That decision belongs to care operators and supervisory authorities. The technical output is a proposal of hierarchization, never an allocation decision.

Q4 What form of State governs without drifting toward actuarial surveillance?
A philosophical, non-technical question: implicit doctrine of public good, partial inalienability of data, collective governance of interpretive frames, political bounding of health visibility. The arbitration cannot be circumvented, even though it exceeds the perimeter of a decision-support note.

Three principal risks 3

R1 AI conflation: the device perceived as a technological platform.
Risk that the architectural perspective is read as an « AI infrastructure in healthcare », which immediately triggers the political antibodies (CNIL, public liberties, behavioral surveillance). Mitigation: explicitly position as architectural property, not as technical product.

R2 Actuarial surveillance: unbounded extra-clinical extension.
Risk that longitudinal trajectories, initially collected for clinical purposes, are progressively reused by peripheral actors (insurers, employers, banks). Mitigation: explicit doctrine of informational minimization built into the design, not retrofitted. This mitigation requires an upstream political decision, not downstream regulation.

R3 Non-decision: cumulative aggravation of the current lock.
Risk that inaction is perceived as prudence, when in fact it preserves a structurally reactive system whose costs (between €2 and €3 billion in annual avoidable hospitalizations, drift of trajectories) increase mechanically with epidemiological pressure. The status quo is not a neutral point; it is a point of cumulative degradation.

CONCLUSION · ONE DECISION

The political gesture required is not to authorize or prohibit a predictive vigilance infrastructure. It is to set, upstream of any deployment, the explicit governance framework within which this infrastructure will be bounded: thresholds, uses, prioritizations, State doctrine. Without this framework, the technical device will deploy regardless; it will simply deploy without mandate or transparency, and its historical trajectory will be that of actuarial surveillance rather than that of sustainable medical vigilance.

Reference documents for further reading: PREDICARE Policy Brief v2 (13 pages); Medico-economic Note (17 pages); Clinical Note v3 (15 pages); Twingital Institute monograph From medical drift to predictive medicine (~90 pages, 128 references).