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AI takes hold in health care, bringing promise and concern

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New London — In a battle against sepsis, early detection can make the difference between life and death.

Three years ago, a nurse working on Ashly Thatcher's neuro unit had to identify changes in at least two vital signs before initiating Lawrence + Memorial Hospital's sepsis protocol, which works to confirm and

respond to the life-threatening condition that results when the body overreacts to an infection and starts attacking healthy tissue.

Now, an artificial intelligence-powered monitoring system is spotting signs of deterioration hours before a patient's condition turns critical.

The system, known as eCart, is part of an ever-expanding list of AI tools that have become embedded into healthcare providers' daily practice. From enhanced diagnostic imaging and patient chatbots to ambient scribes and clinical decision support, AI programs are advancing medical care and raising serious bioethical questions.

Thatcher, who works as a nurse manager at L+M, said eCART detects changes that nurses may miss during routine vital signs checks. While both eCART and nurses are trained to recognize abnormal blood pressure and heart rates, Thatcher said eCART constantly tracks patients' vital signs to flag significant changes — even when a vital sign is still technically within the normal range.

“If you've had a normal blood pressure or even an abnormal blood pressure and all of a sudden you have this significant change, this tool picks up on that,” Thatcher said. “That's something a nurse may not recognize until they're able to get in and actually look through past vital signs of this patient.”

After eCART flags a patient, it automatically alerts nursing staff, triggering a one-hour window for nurses to re-take the patient's vitals to check for errors and pursue next steps such as notifying the patient's doctor or calling in a rapid response team.

In the first year after L+M and the wider Yale New Haven Health hospital system rolled out eCART in 2024, YNHH said, it recorded a 1.2% reduction in mortality.

Thatcher stressed that even with this monitoring technology, patients still receive manual vital checks at least every eight hours and some units require nurses to perform even more frequent checks. However, Thatcher said the eCART has helped nurses catch deterioration more quickly, prioritize caseloads and feel more confident calling in rapid response teams for their patients.

“It’s reassuring,” Thatcher said.

“The vital sign is typically the first change in condition when a patient does start to decompensate or decline,” Thatcher said, adding that with eCART, “I know in real time (that) I can start the process and I can care for my patient and get them the treatment that they need prior to them decompensating and more often than not save(e) their life.”

‘Supplementing what the clinicians can do’

Dr. Brian Williams, a family doctor and medical informaticist for YNHH Northeast Medical Group in Mystic, describes himself as something of an AI convert.

After YNHH launched the HIPAA-compliant AI scribe platform Abridge systemwide in 2024, Williams said, he was skeptical of the technology’s ability to record exam room conversations and synthesize them into clinical notes.

“I felt that it would be kind of intrusive in the exam room with my patients. It only took one visit for me to use it (and it) completely

changed my mind,” Williams said. “It is the opposite of intrusive because it allows me to focus completely on patients rather than being worried about capturing the conversation, trying to take notes during the visit, (and) trying to be attentive to the patient at the same time I’m on the computer.”

Williams said Abridge has not only halved the amount of time he spends documenting appointments, it has also “significantly improved the quality of the documentation.”

The scribe service, which is built into YNHH’s electronic health record system, requires patient consent before they can be recorded. The recordings are stored in a privacy-protected cloud for 14 days until they are deleted, allowing practitioners ample time to review the original recording in case there are discrepancies in the final notes.

Dr. Allen Hsiao, YNHH’s Chief Health Information Officer, said the hospital system staggered its rollout of Abridge. The initial group of doctors tested the product to ensure that it did not misinterpret the conversation or add statements that were not said, also known as hallucinations. During the trial period the doctors also offered feedback to the developer to better tailor the software to their needs. Today, Hsiao said, more than 1,600 YNHH professionals are using the program.

Before Abridge, Hsiao explained, doctors would type out as many notes as they could during a patient visit and complete the record in the evening after juggling multiple patients throughout the day. Now, doctors can craft notes with more accuracy and detail using Abridge’s draft.

“A busy doctor might have 20, 30 patients a day. How can you possibly keep everything in memory late at night?” Hsiao said. “They can (now)

take advantage of the AI to draft that note for them so they can better focus on the patient, better focus on writing orders, looking at X-rays and lab results, and less on trying to document the patient visit.”

“You (are) literally able to be much more empathetic and hold a patient’s hands while you talk through something difficult if you need to — things that would be impossible if you’re just so busy with your hands on the keyboard,” Hsiao added.

In addition to drafting new notes and summarizing pertinent patient records, Hsiao and Williams said Abridge can also provide physicians with clinical decision support. He explained that these types of AI models can draw on the information in a patient’s electronic health record and studies published in medical journals to present curated medical information doctors may want to consider when they are formulating potential diagnoses and treatments for patients.

“It’s not guiding what the clinicians do, it’s supplementing what the clinicians can do,” Williams said.

“When you take into account all the different medical journals out there and the thousands of articles being published every single day, no physician can keep up with all of that,” Hsiao explained. “As the AI is generating and reading the note draft from the patient conversation, it may also be looking at parts of the chart, and coming up with information that the doctor may want to know about.”

The doctors said these programs are especially helpful when assessing patients who are medically complex.

“A lot of times doctors memorize: ‘For this, do that.’ ... We’re starting to learn now that patients are not all the same,” Hsiao said. “Patients of

different ages and ethnic and racial backgrounds and comorbidities may respond better to different medications than patients who are a little bit different. All these complexities to healthcare (are) frankly impossible for a busy human to memorize and know everything that they need to know. I think that's where AI is going to be very promising and really help us in the future."

'It's very murky'

Jennifer Miller, the co-director of the Program for Biomedical Ethics at the Yale School of Medicine, said that the university is actively developing a robust governance structure to evaluate and review the ethics of AI tools before they are implemented within the YNHH system.

In the broader healthcare field, Miller said, there is "not a lot of transparency around the tools that are being used and how they're used."

While some AI tools have proven very successful in reducing physician burnout and improving patient outcomes, Miller said other tools have been developed to assign attendance scores to determine which patients are most likely to miss an appointment.

"In an ideal world, you would help them. You would figure out why they're unlikely to show up. ... Is it that they don't have transportation, (or) they don't have child or parental care? Can they not take a day off from work?" Miller said. "If you use it to improve patient care and patient access to care, then that's great, but if you use it to, say, deprioritize access to care, particularly on urgent, actionable health problems, that's worrying."

Miller said there is concern that some technologies could perpetuate gender and racial biases in medicine. She said another concern is that “tools are developed, trained and validated” on patients who likely did not consent to their data being shared.

“It’s very murky,” Miller said. “Under a traditional clinical trial you would have to get consent to enroll a patient. But if it’s a quality improvement initiative, and an AI tool falls under quality improvement, then you don’t necessarily need consent to use identifiable patient data.”

Nancy Berlinger, a senior research scholar for the Hastings Center for Bioethics, said that in the U.S., medical AI technology is “a very lightly regulated environment.”

Berlinger said that while some AI tools, particularly those used in radiology, are approved by the FDA as medical devices, many do not undergo this process.

“It is a really challenging time,” Berlinger said. “There’s a lot that is put on the healthcare system to be the guardian or safety check. ... And there’s a lot of pressure from the healthcare systems, from the leadership to keep up with the technology.”

In response to concerns about data sharing and privacy, Berlinger said she would not be surprised if some doctors struggle to answer the question: “Where does the data wind up?” She said this responsibility does not just fall on doctors, but AI developers.

“It’s sort of a ‘trust me’ kind of a situation,” Berlinger said. “Being explicit about saying where the data stops, who holds the data — that is really important for the manufacturer, for the vendor to be very, very clear about so that the clinician can give that answer.”

As technologies advance, Berlinger also stressed the importance of maintaining a “human in the loop” for diagnostic and treatment tools.

“(It’s) the idea that the technology is not the doctor. It doesn’t make the decision. It doesn’t make the final pronouncement of what a patient’s condition is and so on. It’s a tool,” Berlinger said. “(AI tools) are not magical and they can make mistakes. Sometimes they can be very, very accurate and can be more accurate than doctors. But, as is often said about AIs, they have no common sense. They have never lived in the world as we know it. They can’t really see the patient in their totality, (but) they can see the data, and so you need to use them as tools.”

As medical AI technology evolves, Williams said the only thing the health care industry can be sure of is change.

“None of us really knows exactly what the future’s going to look like, especially given how fast things are moving right now,” Williams said. “Five years ago, I would not have predicted that we would be where we are today. I would not have predicted that I would have access to a highly effective AI scribe and also have access to effective and evidence-based clinical decision support right at the point of care.”

Williams said he is hopeful that AI technologies and their implementation are moving toward a future where doctors can improve patient safety and wellbeing.

“It’s really important to consider that what we’re trying to do is improve where we are now,” Williams said. “AI will never be 100% accurate, but what we really want is for its accuracy to be better than what humans are doing now.”

“I think that our implementation of these tools has to be very thoughtful in that way, but the future remains to be seen, and it’s moving fast,” Williams said.

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