

The Shared Agency Framework (SAF): Bridging the Agency Gap in Modern Healthcare

Moving Beyond Consultation-Only Shared Decision-Making (SDM) to Co-Executed Longitudinal Care · By Cat Clark

1. Executive Summary: The Structural Collapse of Episodic Care

Modern metabolic healthcare is experiencing a structural breakdown of the traditional doctor-patient relationship. The rapid expansion of virtual-first care, direct-to-consumer telehealth platforms, and 15-minute episodic encounters has dismantled the longitudinal continuity that once anchored clinical medicine. In this decentralized landscape, patients are handed 100% of the daily operational responsibility for navigating complex pharmacotherapy, titration schedules, gastrointestinal adaptations, nutrition sequencing, and insurance prior authorizations, yet receive 0% of the professional-grade operational infrastructure required to execute that responsibility.

The **Shared Agency Framework (SAF)** bridges this divide. Moving beyond legacy models of Shared Decision-Making (SDM), which focus strictly on the initial consultation choice, SAF treats metabolic care as a continuous, co-executed operational partnership. It transforms the patient from an isolated ticket in an asynchronous queue into an active Lead Project Manager of her own biology, equipped with structured data instruments that make 15-minute clinical encounters decisive and productive.

2. Diagnosis of the Current System: Three Structural Failures

- **The Disintegration of Continuity:** In high-volume telehealth and overextended primary care, the single physician holding a comprehensive lifelong map of a patient's physiology has been replaced by fragmented, asynchronous touchpoints.
- **The Responsibility Paradox:** Patients carry 100% of the day-to-day execution burden between appointments—interpreting vagal nausea signals, preventing lean-mass catabolism, and fighting pharmacy benefit manager (PBM) step-therapy denials—without structured diagnostic checklists or communication templates.
- **The Willpower Fallacy in Clinical Culture:** When patients struggle to execute complex metabolic directives in an infrastructure vacuum, legacy clinical culture defaults to blaming "patient non-compliance" or "lack of willpower," ignoring the absence of operational support in the white space between visits (cf. Singh Ospina, JGIM 2019; PMID: 29968051).

3. Core Architectural Shift: Shared Decision-Making (SDM) vs. Shared Agency Framework (SAF)

Traditional Shared Decision-Making (SDM) is confined to a single moment in time—selecting a treatment option during an office visit. Once the prescription is transmitted, SDM ends. The Shared Agency Framework re-architects the entire longitudinal interaction model across the treatment lifecycle:

Architectural Dimension	Legacy Shared Decision-Making (SDM)	The Shared Agency Framework (SAF)
Primary Temporal Focus	The Consultation (The Moment of Choice)	The Full Treatment Journey (Continuous Daily Execution)
Clinical Power Dynamic	"Here are the options; you pick one."	"We are a synchronized two-person team executing a protocol."
Clinician Time Allocation	Consumed by unstructured symptom recounting and EHR clerical load (Sinsky et al., PMID: 27595430).	Optimized via pre-completed 7-day patient signal logs and structured biomarker checklists.
Symptom Interpretation	Side effects tolerated passively or treated as grounds for abrupt discontinuation.	Sensations logged as objective physiological data (Ileal Brake, Vagal Defense, Signal Volume 1-10).
Primary Success Metrics	Scale weight and crude Body Mass Index (BMI) thresholds.	Lean mass retention, HOMA-IR, ApoB, visceral adiposity, and hypothalamic stability (Rubino et al., Lancet 2025).
Operational Scope	Terminates when the informed consent form is signed.	Governs the entire "white space" between appointments across multi-year maintenance.

4. The Three Pillars of Agency Infrastructure

For patients and clinicians to operate as a synchronized unit across virtual and hybrid care environments, the Shared Agency Framework establishes three operational pillars:

- 1. Capability (Biological & Pharmacological Literacy):** Replacing dense medical jargon and moralizing diet handouts with mechanistic protocols covering HPA-axis stress remodeling, the Ileal Brake, the 2.5g to 3.0g Leucine Anchor, and hypothalamic set-point defense.
- 2. Visibility (Structured Shared Telemetry):** Providing standardized, one-page tracking instruments (Signal Volume Tracker, Second Brain Calibration Log, Protein & Muscle Worksheet, 4-Step Stall Diagnostic) so both patient and prescriber view the same objective metrics.
- 3. Continuity (White-Space Governance):** Sustaining protocol alignment between formal clinical encounters so that dose titration, lab monitoring, and prior-authorization renewals survive provider turnover or platform transitions.

5. Strategic Impact Across Stakeholders

- **For Patients:** Replaces medical shame, isolation, and titration anxiety with an actionable operational playbook and word-for-word consultation scripts.
- **For Prescribers & Care Teams:** Eliminates unorganized portal messages and rushed 15-minute guesswork by equipping patients to arrive with structured, quantifiable physiological logs.
- **For Healthcare Systems & MSO Partners:** Establishes a repeatable standard of care that improves treatment persistence, protects lean skeletal muscle mass, and reduces avoidable emergency visits for unmanaged gastrointestinal distress.

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