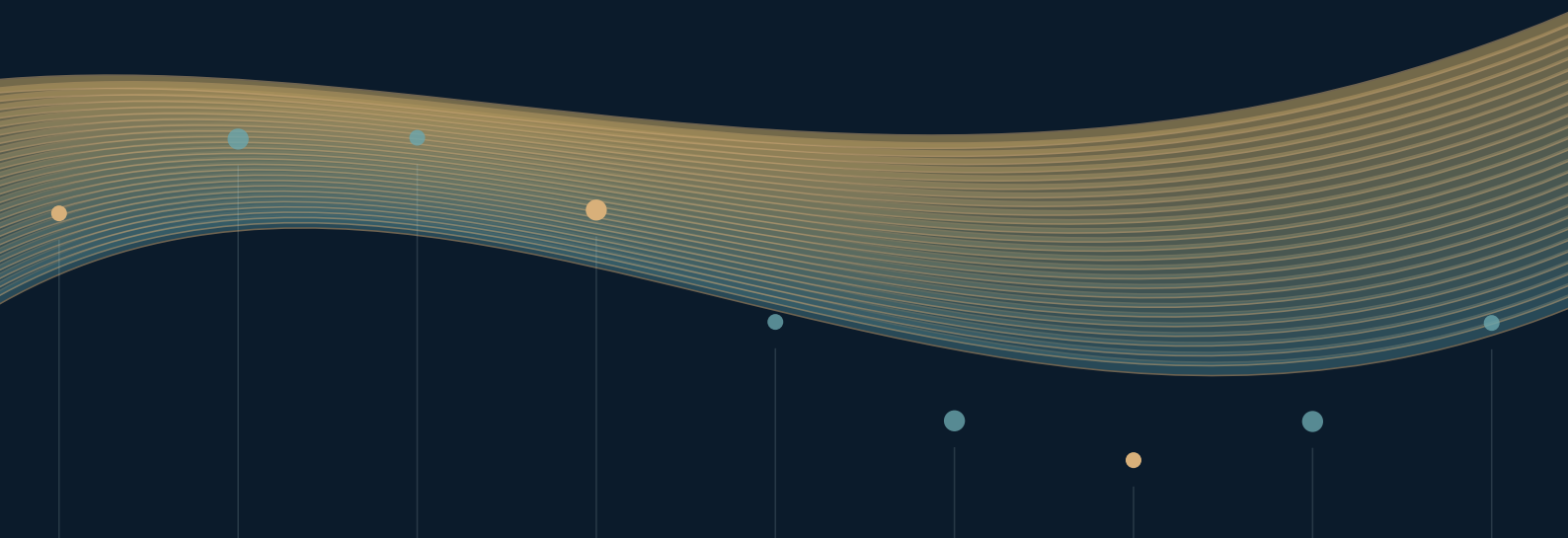




HEALTHCARE

Evidence at the point of care

Clinical and administrative workflows, responsibility and the boundaries of deployment.



ORIGINAL MAYDEN GRAPHIC / EVIDENCE IN MOTION

01 / THE EXECUTIVE VIEW

Start with the operating evidence.

Clinical and administrative workflows, responsibility and the boundaries of deployment.

10

selected entity records

32

recorded claims

27

eligible claims

3

unranked records

01 / WHAT THE RECORD SHOWS

Follow documentation into clinical review. Dallah reports ambient AI supporting clinician documentation. Ask who verifies each note, how errors are corrected and what share of eligible encounters uses the workflow.

Claims: [HLT-006](#)

02 / WHAT THE RECORD SHOWS

Separate throughput, validation and patient benefit. M42 reports daily screening activity and a large radiograph-validation study. Evaluate each evidence layer separately; neither alone establishes improved patient outcomes.

Claims: [HLT-012](#) / [HLT-013](#)

03 / WHAT THE RECORD SHOWS

Test the clinician's final authority. HMG describes imaging support and a responsible-AI framework retaining clinical authority. Request an example of a disputed output, the intervention made and the subsequent review.

Claims: [HLT-001](#) / [HLT-002](#)

Public-evidence review. Selected entity scopes. No company participation, population inference or independent assurance implied.

Read the argument, inspect the exhibits, then use the leadership questions to identify the next evidence your organisation should produce. All report bodies are in English; Arabic executive summaries are available online.

EXHIBIT 01 / SCOPED CASE COMPARISON

Three evidence layers in healthcare AI

Activity, model evaluation and clinical authority answer different questions. Cases are not pooled into a clinical-quality score.

Operating activity / Screening examinations	
Source account. M42 reports AIRIS-TB conducting 2,000 AI chest-X-ray examinations per day. Boundary. Issuer-reported throughput; staffing/comparator details incomplete. Evidence: HLT-012	Mayden question. How many eligible examinations reach a reviewed clinical decision?
Retrospective evaluation / Radiographs assessed in a study	
Source account. The original AIRIS-TB study evaluates 1.04 million chest X-rays from January 2022 to January 2024 in an observational retrospective analysis. Boundary. M42/CHSC-affiliated research; model evaluation is not prospective patient benefit. Evidence: HLT-013 / L34	Mayden question. Does performance hold in the intended workflow, population and prevalence?
Clinical authority / A clinician's accepted or rejected output	
Source account. HMG says its Responsible AI Framework retains clinician final authority and includes fairness monitoring. Boundary. A different provider and evidence layer; no assurance result supplied. Evidence: HLT-002	Mayden question. Can an actual disagreement show how review, intervention and follow-up operate?

Source: selected claims in PE-2026.10-v4. Company and supplier reports are attributed accounts. The questions are Mayden editorial interpretations, not measured sector results or independent assurance.

EXHIBIT 02 / PUBLIC EVIDENCE

Inspect the operating profile, not only the total

Highest eligible anchor per theme; U = no qualifying evidence located

	Core	People	Partners	Interface	Lineage	Testing	Authority	Knowledge	Control	Points
PureHealth	3	2	U	3	U	1	U	2	1	44
Dallah Healthcare	3	1	2	3	U	U	U	U	2	41
Dr. Sulaiman Al Habib Medical Services Group	3	U	1	2	U	U	U	U	3	33
Hamad Medical Corporation	2	2	U	U	U	1	U	U	3	30
M42	3	U	1	U	U	3	U	U	U	26
Bahrain Specialist Hospital	U	U	U	3	U	U	U	U	U	11
Primary Health Care Corporation	2	U	U	U	U	U	U	U	U	7
Kuwait Hospital	U	U	U	U	U	U	U	U	U	U
Royal Bahrain Hospital	U	U	U	U	U	U	U	U	U	U
Taiba Hospital	U	U	U	U	U	U	U	U	U	U

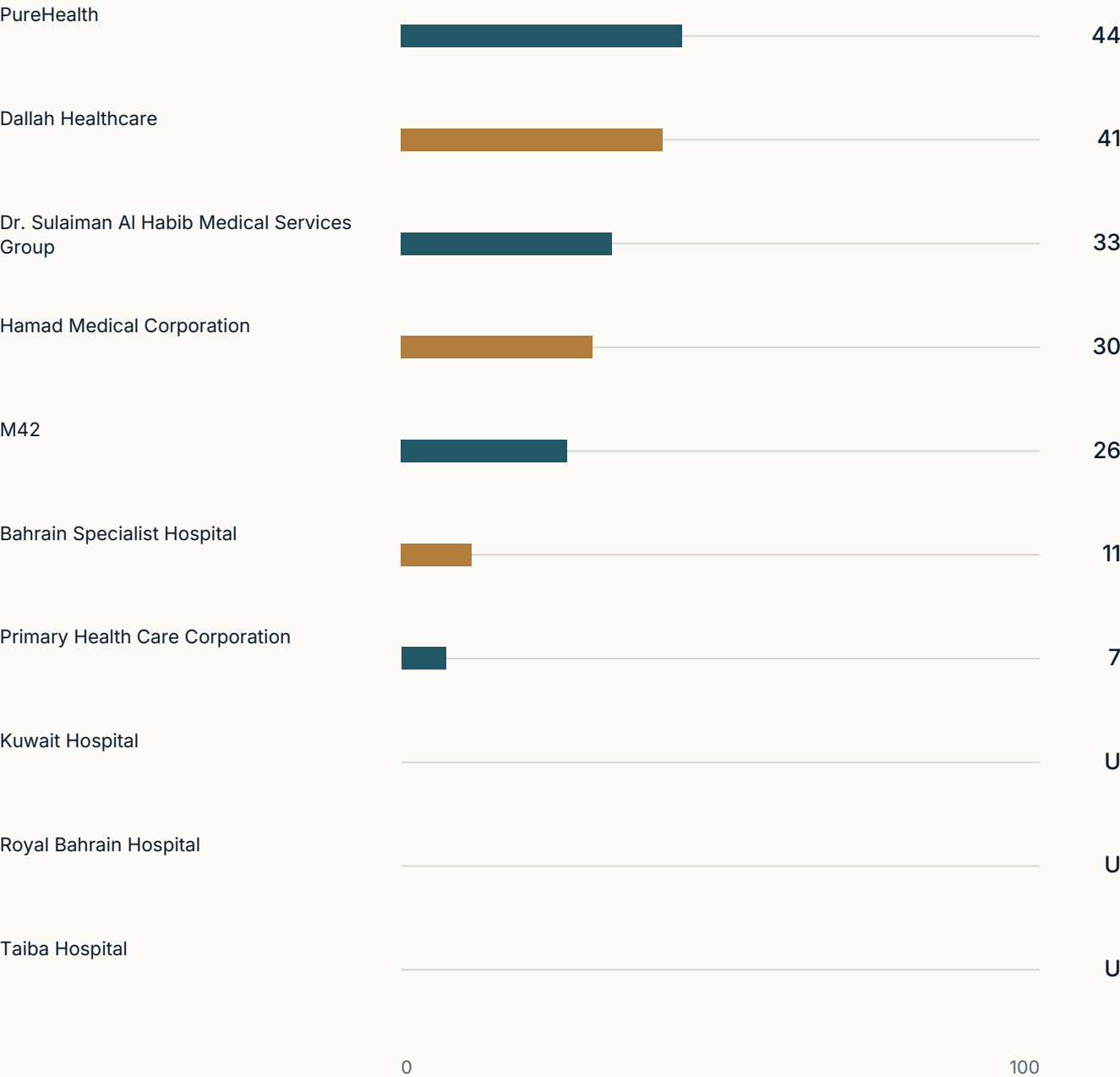
Unknown
Commitment / pilot
Implemented
Operating detail

Source: Mayden PE-2026.10-v4. Each row is a named entity scope. U does not mean absent capability. Anchors are ordinal evidence-specificity judgements; scopes and disclosure access differ.

EXHIBIT 03 / PUBLIC EVIDENCE

Documented evidence points in the selected cohort

Fixed denominator of 27; normalized to 0-100; ties use unrounded totals



Source: frozen release calculation. These are public-evidence points, not a maturity percentage, operational audit or population ranking. No-evidence records stay unranked.

02 / ANALYSIS

Mayden AI Native Index - exploratory public-evidence research. Cutoff: 10 October 2026. This is a purposeful sample of ten healthcare organisations, not a clinical-quality ranking or an estimate of national adoption.

The meaningful question for a healthcare executive is whether AI changes how work gets done while preserving accountable clinical judgement. A hospital can acquire advanced equipment, sponsor conferences and announce technology partnerships without changing a routine workflow. Another can implement a narrow, well-supervised intervention that makes a real difference to documentation, screening or patient access. Those situations should not receive the same interpretation.

Our reviewed material makes the distinction concrete. It contains operating accounts of AI-assisted imaging, clinical documentation, insurance administration and appointment support. It also contains pilots, future organisational plans, broad supplier promises and statements whose entity scope cannot be established. Mayden retains these differences in the evidence register. An attractive narrative is useful only if a reader can inspect the passage, understand whose operation it describes and see why the claim qualifies.

This edition examines Dr. Sulaiman Al Habib Medical Services Group and Dallah Healthcare in Saudi Arabia; M42 and PureHealth in the UAE; Hamad Medical Corporation and Primary Health Care Corporation in Qatar; Taiba Hospital and Kuwait Hospital in Kuwait; and Bahrain Specialist Hospital and Royal Bahrain Hospital in Bahrain. Selection was purposeful, with two organisations headquartered in each market. Qatar's two organisations are public providers and are labelled accordingly. PureHealth and M42 are integrated international groups. The sample therefore supports comparison of public evidence, not a contest between equivalent hospitals.

What the strongest disclosures explain

HMG's 2025 report describes cardiac-imaging AI and an AI framework that preserves clinicians' final authority and includes fairness monitoring. These are separate questions: where AI assists care, and how its use is controlled. The report also identifies clinical documentation tools. A partnership described as established to support development and research remains a commitment where completed joint work is not demonstrated. Its evidence is narrower than its ambition. [HMG Annual Report 2025, PDF pages 39 and 51](#)

Dallah identifies Sahl ambient documentation, reporting use by more than 175 clinicians, and deployed Thakaa Med radiograph analysis. Its responsible-AI framework is described at a higher level than HMG's specific authority and monitoring account. A training paragraph sits in a forward-looking section and is treated as a planned commitment, not a completed workforce programme. This distinction survived a separate AI-assisted challenge of the initial research coding. [Dallah Annual Report 2025, PDF pages 24-26](#)

M42 reports AIRIS-TB operating at 2,000 chest examinations daily. That issuer-reported throughput is separate from model evaluation. The original AIRIS-TB paper evaluates historical screening images; its estimated automation potential is not a measured reduction in routine clinical workload. Prospective workflow validation remains necessary. Executives should request both technical evaluation and evidence of what changed in care delivery. The GE HealthCare collaboration remains a forward-looking commitment. [M42 operating account, original study, accessible full text.](#)

PureHealth's report connects a shared AI infrastructure to particular operations. Daman's document processing is insurance administration; SEHA Clinics' retinal screening is clinical delivery; HHG's nurse scheduling and executive insights concern overseas operations. These cases belong in an explicitly consolidated group profile. They must not be silently converted into evidence that

every UAE hospital uses the same systems. The physician-documentation pilot and proposed AI Office also retain their own statuses. [PureHealth Integrated Annual Report 2025, PDF pages 29, 31, 36 and 39-41](#)

These examples suggest a practical reporting standard: name the workflow, identify the operating entity, state whether use is live, describe the mechanism and explain the decision boundary. A list of technologies is less informative than a clear account of who does what differently. Executives can use that standard immediately, even before collecting additional quantitative measures.

Historical evidence and current claims need different treatment

HMC provides unusually specific historical material. Its 2021-2022 precision-medicine report describes an imaging AI committee, internal educational sessions and integrated imaging trials. The committee has review and monitoring responsibilities. The Siemens and Koios applications are explicitly trials, even though integration into imaging systems is technically detailed. We retain the pilot cap and label the committee evidence historical. The document cannot confirm that the same arrangements remain active in October 2026. [HMC Precision Medicine Annual Report, PDF page 39](#)

PHCC's March 2025 account says AI was integrated into its 2024 screening programme to assist image interpretation. That supports an implemented practice. It does not identify enough about the model, coverage or evaluation to support a more detailed operating anchor. Its annual report's conference discussion is not automatically an internal workforce-development programme. [PHCC screening account, PHCC Annual Report 2024](#)

Age matters because technology and organisations change. A programme may be replaced, expanded, discontinued or absorbed into another service. Historical evidence can still explain an organisation's development and inform follow-up questions. It should not acquire a false current date

because a researcher accessed the webpage recently. Publication date, reporting period, observation date and research access date are distinct fields.

For a future recurring edition, The next research cycle should ask organisations to reconfirm older operating claims with dated implementation records. The correct question is not simply whether the old claim remains on the website. It is whether the operation, accountable owner, user population and control arrangement remain materially the same. Changes should create a documented update rather than quietly rewriting the historical record.

What the gaps actually mean

The Kuwait and Bahrain searches illustrate why an unknown result needs a visible explanation. Taiba's indexed news points to a doctor's AI-assisted endoscopy demonstration at an overseas conference. The full page could not be recovered through the reviewed access route. Neither an inaccessible passage nor an overseas demonstration establishes routine use at the Kuwait hospital. Kuwait Hospital's official identity and service inventory were checked, but the bounded search recovered no qualifying AI operating claim. This is a research limit, not a judgement about clinical capability. [Taiba source lead, excluded, Kuwait Hospital](#)

Bahrain Specialist Hospital has a named IT director's testimonial on Voiceoc's site describing conversational AI in appointment and call support, including a reported share of traffic. This is direct implementation-participant evidence, but supplier-hosted and undated. General performance claims elsewhere on the supplier page are not hospital results. Royal Bahrain Hospital's MRI page includes a broader KIMSHEALTH FAQ mentioning AI diagnostics; that template does not identify the Bahrain hospital's own implementation. It remains excluded from local scoring. [BSH testimonial, Royal Bahrain Hospital FAQ](#)

A public-evidence index will partly reflect disclosure capacity. Large listed groups produce extensive reports and have communications resources. Smaller private providers may operate effective

systems without describing them publicly. Replacing quiet organisations with easier-to-score ones would make the cohort look more impressive while weakening its integrity. The better response is to preserve the selected entities, publish the search boundary and invite evidence through a standard verification process.

Nine operating questions for healthcare leaders

AI in core work. Which recurring clinical or administrative workflow uses AI today? Identify the service, facility, operating owner and eligible population. Distinguish assistance from a system that completes a task. Describe the ordinary workflow after implementation, including what happens when the tool is unavailable. This makes the answer testable without requiring proprietary model code.

Workforce. Which roles have changed, and how is competence checked? Training attendance alone does not establish effective use. Ask whether clinicians and administrative staff understand limitations, escalation and correction. Separate staff training from AI used to allocate staff: both concern work, but they are different organisational practices and need different evidence.

Ecosystem. What does the organisation do with partners beyond signing an agreement? Useful evidence identifies implementation responsibilities, integration work, support arrangements and who controls changes. A partnership announcement can establish a specific commitment. Continued delivery requires a more substantive account, especially when a vendor's software is embedded in a consequential care workflow.

Interfaces. Where does a patient or employee encounter AI, and how is the interaction connected to the underlying service? An appointment assistant should be assessed through completed service transactions, unresolved requests and human escalation. A documentation assistant should be assessed through review and correction in the record workflow. Conversation volume alone does not explain whether work was completed reliably.

Lineage. Can an organisation reconstruct which information, model version and instruction produced an important output? Generic electronic records and cybersecurity controls do not answer this question. The interview should seek a concrete example of tracing an AI-assisted decision or document back through its inputs and changes, with privacy-preserving evidence suitable for review by a named human assessor.

Experimentation. How are new tools evaluated before routine adoption and after material change? A pilot should have a stated question, target population, comparison approach, acceptance criteria and stopping rule. Detailed integration is not a substitute for evaluation. Equally, a completed evaluation should not be confused with proof of general clinical benefit across settings.

Autonomy. What can the system do without a person's approval? This should be answered task by task, with explicit limits, override mechanisms and responsibility. Automatically drafting text differs from submitting a claim, changing a schedule or influencing a clinical action. The label "agentic" does not supply these missing details and should not determine an anchor.

Knowledge. How does the organisation turn AI-assisted information into reusable operational learning? Examples could include evaluated retrieval, reviewed summaries or structured feedback into a clinical protocol. A dashboard described as AI-enabled establishes less than a documented learning loop. Ask who checks the content and how errors alter future practice.

Governance. Who may approve, pause or retire a system, and what evidence informs that decision? Policies become more informative when they specify authority and operating routines. Ask for an example of a model change, an incident review or a rejected use case. This reveals whether oversight is part of ordinary management rather than a document created for external communication.

These questions are a proposed diagnostic instrument, not validated survey scales. The company study must test clarity with clinical, operational and technical respondents before treating answers as comparable measurement.

Some concepts require multiple informants. A chief executive may know strategic ownership while a clinical lead knows exception handling and a technical owner knows model versioning. Disagreement can be useful evidence of an incomplete operating model.

Measurement that executives can trust

The public-evidence layer uses discrete anchors. A specific named commitment or pilot can establish level 1. An explicitly implemented internal practice can establish level 2. Implementation with a concrete mechanism, coverage, evaluation or authority can establish level 3, subject to a separate AI-assisted source challenge. Unknown means that the bounded search found no qualifying evidence. It does not mean that the organisation lacks the practice.

The aggregate must remain a summary of documentation across the nine dimensions. It is not the probability that an organisation is AI-native, a clinical-safety grade or a measure of patient benefit. Repeating the same case in several press releases must not increase its score. The maximum supported anchor within a dimension is retained, and the evidence reader should show the contributing claim rather than a mysterious total.

Outcome claims need a separate ledger. A reported reduction in documentation time, annual document throughput, screening discrimination and appointment traffic are not interchangeable benefits. Each has a different denominator and study design. Before comparing results, record the baseline, time period, sample, exclusions and relevant operating conditions. Where those fields are missing, label the result as an attributed organisational claim. Do not average unlike percentages into a sector impact statistic.

A stronger proprietary assessment would add submitted evidence to the public record while preserving provenance. Mayden could request a workflow map, redacted approval record, role-specific adoption figures and a description of evaluation and monitoring. The organisation should

approve only the factual accuracy and disclosure permissions of its submitted material, not its eventual score. A separate reviewer should decide whether the evidence meets the published anchor.

The first pilot should test respondent burden as well as measurement quality. Start with an executive interview, route detailed questions to the appropriate owners and ask for a small number of useful artefacts. A long questionnaire filled with hypothetical best practice can reward confident language rather than real capability. A shorter interview that follows one implemented workflow end to end can uncover responsibility, exceptions and learning much more clearly.

The reporting opportunity

The media opportunity is the gap between visible applications and visible operating systems, illustrated through scoped cases and unanswered questions. Two unlike providers cannot establish a country winner. Unknown entries do not mean lagging capability, and international groups do not represent national health systems.

The heatmap shows documented evidence and unknowns. Points summarise that profile under the declared rules; they do not measure clinical quality or enterprise maturity. The evidence-anchor chart separates commitments and pilots from implementation and operating detail, counting claims rather than independent systems. Source-URL removal shows the effect of omitting the most influential retained URL: a large change signals concentrated documentation, not weak capability. None establishes national adoption or patient benefit.

Participants should receive an evidence profile, unanswered operating questions and prioritised verification gaps. Repeated editions can track commitments becoming operations, stopped pilots, improved controls and better-evidenced outcomes. Consistent definitions and traceable revisions make that comparison useful.

Review transparency. Extraction and source challenge were AI-assisted, without human expert sign-off or independent assurance.

EXHIBIT 04 / INSPECT THE ASSUMPTION

Separate a commitment from a deployed practice

Eligible claim records, n = 27; one practice may support multiple distinct themes

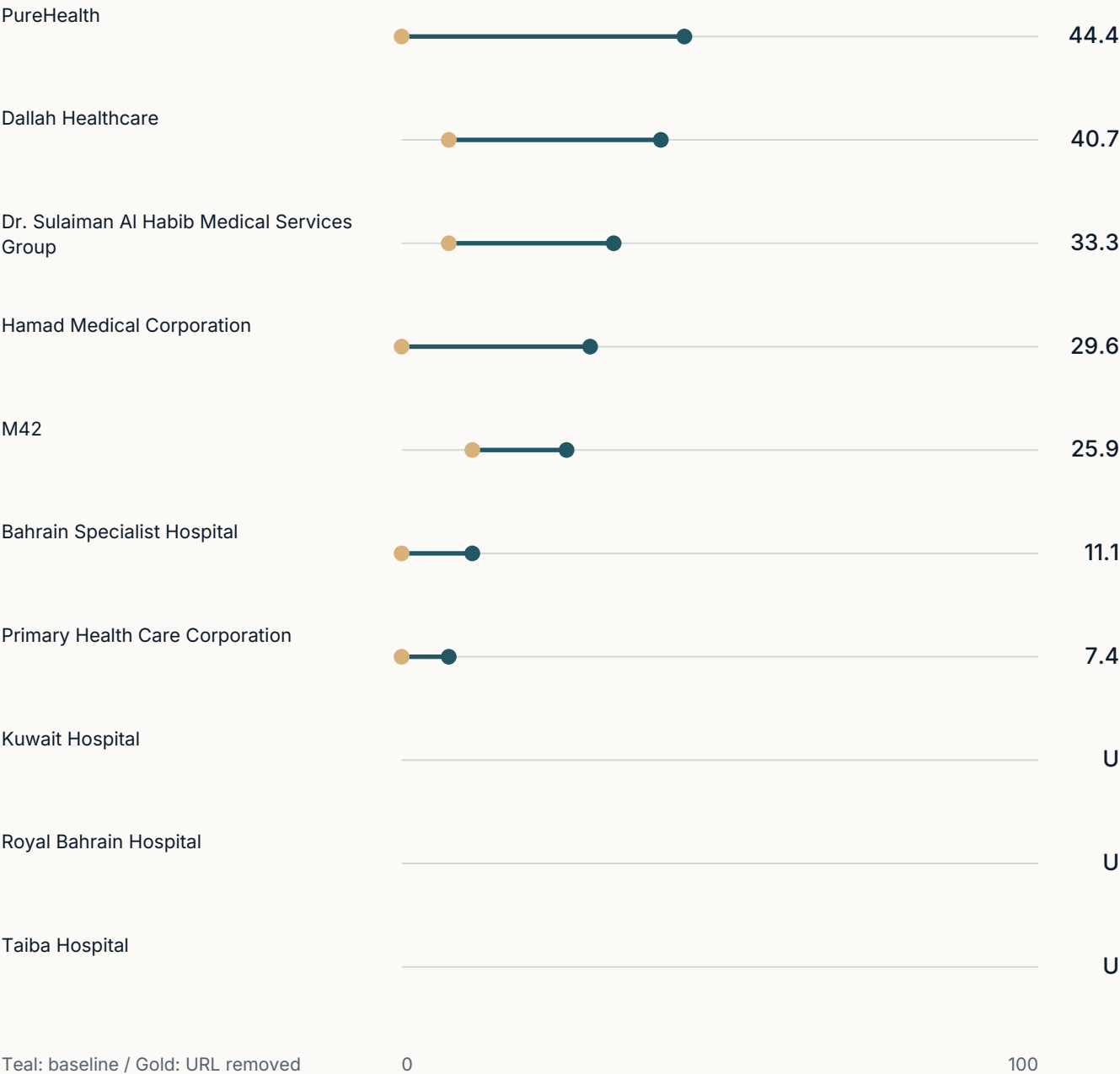


Source: claim ledger. 5 excluded records are outside these bars. Counts are claims, not independent systems, companies or estimates of adoption.

EXHIBIT 05 / INSPECT THE ASSUMPTION

How much of the profile rests on one retained source URL?

Baseline points versus points after removing the most influential primary source URL



Source: deterministic URL-removal check. Remaining URLs can repeat the same disclosure; required corroborating-source dependencies are not removed. This is not a confidence interval or a test of source truth.

03 / A CLOSER LOOK

PureHealth

PureHealth Holding PJSC consolidated group; includes Daman insurance and overseas HHG, not a UAE hospital-only measure.

ELIGIBLE ANCHOR 3 / HLT-016

PureHealth's AI Factory became operational in Q3 2025 and supports document, radiology, pharmacy and claims workflows.

Boundary. Claim scope: PureHealth Holding PJSC consolidated group; includes Daman insurance and overseas HHG, not a UAE hospital-only measure.. Group architecture assertion does not imply uniform adoption across all acquired entities. Application: internal-operating-practice.

Locator. PDF40-41/printed76-79, AI Factory

[Inspect the source](#)

ELIGIBLE ANCHOR 3 / HLT-017

Daman deployed in-house AI classification, validation and extraction for documents.

Boundary. Claim scope: PureHealth subsidiary Daman health-insurance operations, UAE.. Insurance subsidiary scope; annual 60 million figure is issuer-reported and not an external performance audit. Application: internal-operating-practice.

Locator. PDF39/printed74-75, Digital Transformation

[Inspect the source](#)

The question for leadership

Identify the exact clinical or administrative task.

Company/group scope follows each cited claim. Headquarters is not the geography of all operations. Public disclosures and search completeness differ; no national or population inference.

03 / A CLOSER LOOK

Dallah Healthcare

Listed Dallah Healthcare Company and hospital operations in Saudi Arabia.

ELIGIBLE ANCHOR 3 / HLT-006

Dallah reports Sahl ambient AI documenting patient encounters for more than 175 clinicians.

Boundary. Claim scope: Listed Dallah Healthcare Company and hospital operations in Saudi Arabia.. No denominator of eligible clinicians; provider-reported scale, not independently verified. Application: internal-operating-practice.

Locator. PDF24/printed46-47, Investing in responsible AI

[Inspect the source](#)

ELIGIBLE ANCHOR 3 / HLT-007

Dallah deployed Thakaa Med machine learning to detect oral pathologies in radiographs.

Boundary. Claim scope: Listed Dallah Healthcare Company and hospital operations in Saudi Arabia.. Sensitivity, validation dataset, override rates and deployment-site count not reported here. Application: internal-operating-practice.

Locator. PDF24/printed46-47

[Inspect the source](#)

The question for leadership

Identify the exact clinical or administrative task.

Company/group scope follows each cited claim. Headquarters is not the geography of all operations. Public disclosures and search completeness differ; no national or population inference.

03 / A CLOSER LOOK

Kuwait Hospital

Private Kuwait Hospital, Sabah Al-Salem, kuwaithospital.com.kw; excludes UAE hospitals with the same name.

No claim qualified in this bounded review. An empty public record is a research gap, not evidence that AI capability is absent.

The question for leadership

Identify the exact clinical or administrative task.

Company/group scope follows each cited claim. Headquarters is not the geography of all operations. Public disclosures and search completeness differ; no national or population inference.

04 / THE LEADERSHIP AGENDA

Ask for evidence that changes the decision.

01 / Identify the exact clinical or administrative task.

Evidence to request: Care setting, patient/workflow scope, decision owner and deployment status.

02 / Separate assistance from clinical authority.

Evidence to request: Clinician supervision, escalation, validation and permitted-use boundaries.

03 / Ask for prospective operating evidence.

Evidence to request: Patient safety, subgroup performance, drift and a comparator appropriate to the care pathway.

Method and boundaries

This is an AI-assisted, bounded public-source review using a purposeful corpus. Nine themes retain their highest eligible anchor: 1 for a specific commitment or pilot, 2 for an implemented practice, 3 for implemented practice with operating detail. U means unknown. Points equal 100 times the sum of anchors divided by 27. Ordinal steps and equal weights are design assumptions, not validated importance estimates.

Reported outcomes, actual company capability and disclosure depth are different objects. Source-linked corporate or vendor statements are not independently assured operations. Deterministic sensitivity tests are not confidence intervals. Sector scopes, reporting periods and access differ; no national rankings, population prevalence or causal inference are made. The confidential company instrument remains a separate development track.

Dated sources run from 2024-12-30 to 2025-08-06. 22 of 27 eligible claim records have undated sources. Publication dates do not confirm continuing operation or a common observation period; undated does not mean stale.

[Inspect the full method](#) / [Reproduce the evidence](#)

05 / SOURCES & PROVENANCE

Follow the argument back to its source.

Sources below include eligible and excluded research leads. Inclusion in this list does not make a source eligible or independently verified. Exact claim decisions, source locators and limitations are retained in the online evidence ledger. Research cutoff: 10 October 2026.

S01 / Integrated Annual Report 2025

PureHealth / Undated / annual-report

Locator: PDF40-41/printed76-79, AI Factory

[Open source](#)

S02 / Annual Report 2025

Dallah Healthcare / Undated / annual-report

Locator: PDF24/printed46-47, Investing in responsible AI

[Open source](#)

S03 / Artificial Intelligence in Dentistry: Enhancing Patient Care and Service Quality

Dallah Hospital / 2024-12-30 / official-implementation-account

Locator: Successful implementation opening paragraph

[Open source](#)

S04 / Annual Report 2025

HMG / Undated / annual-report

Locator: PDF51/printed99-100, Radiology Services

[Open source](#)

S05 / Sustainability2024: Maintain sound business practices

HMG / Undated / sustainability-report

Locator: Innovation and technology, AI applications paragraph

[Open source](#)

S06 / Precision Medicine Annual Report 2021-2022

Hamad Medical Corporation / Undated / annual-report

Locator: PDF39/printed37, CIPAC

[Open source](#)

S07 / M42 and GE HealthCare join forces to advance AI-Enabled Patient Care

M42 / 2025-07-08 / official-implementation-account

Locator: Final AIRIS-TB paragraph, line69

[Open source](#)

S08 / M42 announces breakthrough results for its AI-powered tuberculosis screening

M42 / 2025-08-06 / official-implementation-account

Locator: Study design, results and demographic consistency paragraphs

[Open source](#)

S09 / Voiceoc patient interaction: Bahrain Specialist Hospital testimonial

Voiceoc / Undated / supplier-case-study

Locator: Nadim Navde testimonial, lines222-232

[Open source](#)

S10 / We are working on introducing mandatory annual oral screening for students

PHCC / 2025-03-06 / official-implementation-account

Locator: Breast and bowel screening paragraph

[Open source](#)

S11 / Annual Report 2024

PHCC / Undated / annual-report

Locator: PDF23, conference paragraph

[Open source](#)

S12 / MRI Scan page: KIMSHEALTH FAQs

Royal Bahrain Hospital / KIMSHEALTH / Undated / official-implementation-account

Locator: FAQ: What advanced technologies are available at KIMSHEALTH?

[Open source](#)

S13 / Taiba Hospital proudly recognizes Dr Asmaa Al Kandari's achievement

Taiba Hospital / 2025-03-05 /
official-implementation-account

Locator: Indexed conference passage; full source unavailable

[Open source](#)

S14 / Population-scale cross-sectional observational study for AI-powered TB screening on one million CXRs

npj Digital Medicine; full text in PMC / 2025-07-09 /
original-observational-model-evaluation

Locator: Study methods and results; see institutional affiliations and limitations

[Open source](#)

S15 / Kuwait Hospital

Primary source as linked / See original / Research or official publication

Locator: Linked publication; see cited passage in report

[Open source](#)

About Mayden

Mayden connects senior judgement, research and engineering to help organisations move from strategic choices to working capabilities. This research programme examines how AI changes recurring work, decisions and accountability.

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