
Zen-Medical:

Clinical AI with Diagnostic Reasoning

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Abstract

We present **Zen-Medical**, a clinical AI system specialized for multi-modal diagnostic reasoning, differential diagnosis generation, drug interaction checking, and clinical decision support. Zen-Medical is *not* a model trained from scratch: it is a supervised fine-tune of the openly licensed **Qwen3-8B** base model (developed by Alibaba and released under the Apache-2.0 license), adapted to the clinical domain with components that integrate patient histories, laboratory results, medical imaging, and clinical guidelines into structured diagnostic reasoning. The system introduces three engineering components layered on this base: (1) a **Clinical Reasoning Chain (CRC)** framework that mirrors the diagnostic workflow of experienced physicians—chief complaint analysis, history synthesis, differential diagnosis generation, investigation planning, and management recommendation—with explicit uncertainty quantification at each stage, (2) a **Multi-Modal Clinical Encoder (MMCE)** that pairs the fine-tuned language model with modality-specific medical-image encoders for chest X-rays, CT scans, dermatoscopic images, ECG tracings, and pathology slides alongside textual clinical data, and (3) a **Drug Interaction Knowledge Graph (DIKG)** that aggregates drug-drug and drug-condition interactions from FDA labels, DrugBank, and peer-reviewed literature, queryable in real time during clinical reasoning. We deliberately do not report headline accuracy figures or comparisons against other systems in this report; instead we describe the clinical adaptation qualitatively and name the public benchmarks (MedQA/USMLE, PubMedQA, MedMCQA, CheXpert, and others) against which clinical language models should be evaluated under transparent, reproducible protocols. Critically, Zen-Medical is designed for HIPAA-compliant deployment with on-premise inference, audit logging, and explicit uncertainty communication that flags cases requiring human physician review. All outputs include structured citations to clinical evidence and are intended as decision support tools, not autonomous diagnostic systems.

Keywords: Clinical AI, Diagnostic Reasoning, Differential Diagnosis, Drug Interactions, Medical Imaging, HIPAA Compliance, Uncertainty Quantification

1 Introduction

Clinical decision-making is among the most demanding cognitive tasks undertaken by humans. A physician evaluating a patient must integrate heterogeneous information—subjective symptoms, physical examination findings, laboratory values, imaging studies, medication history, comorbidities, and family history—into a coherent diagnostic hypothesis, while simultaneously considering dozens of possible diagnoses, their relative likelihoods, and the potential consequences of diagnostic error. This process requires both deep medical knowledge and sophisticated probabilistic reasoning under uncertainty.

Artificial intelligence has demonstrated significant potential in clinical applications, from medical image interpretation (Rajpurkar et al., 2017; Esteva et al., 2017) to clinical note generation (Abacha et al., 2023). Large language models have shown impressive performance on medical licensing examinations (Nori et al., 2023; Singhal et al., 2023a), suggesting substantial clinical knowledge. However, several critical gaps remain between benchmark performance and safe clinical deployment:

1. **Reasoning transparency:** Black-box predictions are insufficient for clinical use. Physicians need to understand *why* a system recommends a particular diagnosis, what evidence supports it, and what alternative diagnoses were considered.
2. **Uncertainty communication:** Medical AI systems must communicate their confidence levels accurately, flagging uncertain cases for human review rather than presenting all outputs with equal confidence.
3. **Multi-modal integration:** Clinical reasoning requires joint analysis of textual, visual, and numerical data. Most medical AI systems are unimodal, handling either text or images but not both in an integrated reasoning framework.
4. **Safety infrastructure:** Clinical AI requires HIPAA-compliant data handling, comprehensive audit trails, and fail-safe mechanisms that prevent harmful recommendations.

Zen-Medical addresses all four gaps through a comprehensive clinical AI system designed for deployment as a physician decision-support tool. The Clinical Reasoning Chain framework produces transparent, step-by-step diagnostic reasoning with explicit uncertainty quantification. The Multi-Modal Clinical Encoder enables joint reasoning over text and medical images. The Drug Interaction Knowledge Graph provides real-time safety checking. And the deployment architecture ensures HIPAA compliance with on-premise inference and audit logging.

Critically, Zen-Medical is not designed to replace physicians. It is designed to augment clinical decision-making by providing structured differential diagnoses, evidence-based

recommendations, and safety checks that can help physicians catch diagnostic errors, consider overlooked diagnoses, and verify drug safety.

2 Background and Related Work

2.1 Medical Language Models

Early medical NLP focused on clinical named entity recognition (Lee et al., 2020) and relation extraction. Med-PaLM (Singhal et al., 2023a) demonstrated that a fine-tuned PaLM model could approach human-level performance on USMLE-style questions. Med-PaLM 2 (Singhal et al., 2023b) improved further with instruction tuning and self-consistency. GPT-4 achieved 86.7% on USMLE without medical-specific training (Nori et al., 2023). However, these models lack the structured reasoning, uncertainty quantification, and multi-modal capabilities required for clinical deployment.

2.2 Clinical Decision Support Systems

Clinical Decision Support Systems (CDSS) have a long history, from rule-based expert systems like MYCIN (Shortliffe and Buchanan, 1975) and DXplain (Barnett et al., 1987) to modern machine learning approaches. Isabel Healthcare and VisualDx provide differential diagnosis generators based on symptom matching. These systems complement neural approaches by providing structured, evidence-based reasoning but typically lack the flexibility and knowledge breadth of large language models.

2.3 Medical Image Analysis

Deep learning has achieved specialist-level performance on medical image classification tasks, including chest X-ray interpretation (Rajpurkar et al., 2017), skin lesion classification (Esteva et al., 2017), retinal disease detection (de Fauw et al., 2018), and pathology slide analysis (Campanella et al., 2019). However, most systems operate on single images in isolation, without integrating clinical context. Recent work on multimodal medical AI (Moor et al., 2023; Tu et al., 2024) has begun addressing this limitation.

2.4 Drug Interaction Checking

Drug interaction databases such as DrugBank (Wishart et al., 2018), the FDA Adverse Event Reporting System (FAERS), and clinical pharmacology references provide structured drug safety information. Knowledge graph approaches (Zitnik et al., 2018; Lin et al., 2020) have been applied to predict novel drug-drug interactions. Zen-Medical integrates these approaches into a unified knowledge graph queryable during clinical reasoning.

2.5 Uncertainty Quantification in Medical AI

Reliable uncertainty estimation is critical for clinical AI safety. Bayesian neural networks (Gal and Ghahramani, 2016), ensemble methods (Lakshminarayanan et al., 2017), and conformal prediction (Angelopoulos and Bates, 2021) provide different approaches to uncertainty quantification. In the medical domain, calibrated confidence estimates enable appropriate triage of uncertain cases to human experts (Jiang et al., 2012).

3 Architecture

Zen-Medical consists of four integrated components: the Clinical Reasoning Chain framework, the Multi-Modal Clinical Encoder, the Drug Interaction Knowledge Graph, and the Uncertainty Quantification Module.

3.1 Clinical Reasoning Chain (CRC)

The CRC framework structures diagnostic reasoning into five stages that mirror the clinical workflow:

Stage 1: Chief Complaint Analysis. Given a clinical vignette or patient presentation, the system identifies the primary complaint, onset, duration, severity, and relevant contextual factors:

$$\mathbf{h}_{cc} = f_{CC}(\text{presentation}) = (\text{symptom, duration, severity, modifiers}) \quad (1)$$

Stage 2: History Synthesis. The system integrates all available patient information—past medical history, medications, allergies, social history, family history, review of systems—into a structured clinical summary. Laboratory values and vital signs are normalized to standard ranges and flagged as normal, borderline, or abnormal:

$$\mathbf{h}_{syn} = f_{Syn}(\mathbf{h}_{cc}, \text{PMH, meds, labs, vitals, imaging}) \quad (2)$$

Stage 3: Differential Diagnosis Generation. Based on the synthesized history, the system generates an ordered list of differential diagnoses with associated probabilities:

$$\mathcal{D} = \{(d_i, p_i, \mathbf{e}_i)\}_{i=1}^K, \quad \sum_{i=1}^K p_i \leq 1.0 \quad (3)$$

where d_i is a diagnosis (mapped to ICD-10 codes), p_i is the estimated posterior probability, and $\mathbf{e}_i$ is a structured evidence summary listing supporting and contradicting findings. Probabilities are calibrated using temperature scaling on a held-out validation set.

Stage 4: Investigation Planning. For cases where the differential remains broad, the system recommends targeted investigations (laboratory tests, imaging studies, procedures)

Algorithm 1 Clinical Reasoning Chain

Require: Patient presentation P , clinical data D , imaging I

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1:  $\mathbf{h}_{cc} \leftarrow \text{ChiefComplaintAnalysis}(P)$ 
2:  $\mathbf{h}_{syn} \leftarrow \text{HistorySynthesis}(\mathbf{h}_{cc}, D)$ 
3: if imaging available then
4:    $\mathbf{h}_{img} \leftarrow \text{MMCE}(I, \mathbf{h}_{syn})$ 
5:    $\mathbf{h}_{syn} \leftarrow \text{Merge}(\mathbf{h}_{syn}, \mathbf{h}_{img})$ 
6: end if
7:  $\mathcal{D} \leftarrow \text{DifferentialDiagnosis}(\mathbf{h}_{syn})$ 
8:  $\mathcal{D} \leftarrow \text{CalibrateUncertainty}(\mathcal{D})$ 
9: if  $H(\mathcal{D}) > \tau_{\text{uncertain}}$  then
10:   investigations  $\leftarrow \text{PlanInvestigations}(\mathcal{D})$ 
11:   Flag for physician review
12: end if
13: management  $\leftarrow \text{ManagementPlan}(\mathcal{D}[0], \mathbf{h}_{syn})$ 
14: interactions  $\leftarrow \text{DIKG.Check}(\text{management.drugs}, D.\text{medications})$ 
15: if interactions.severity  $\geq \text{MODERATE}$  then
16:   Flag drug interaction alert
17: end if
18: return ( $\mathcal{D}$ , investigations, management, interactions)
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that would most effectively discriminate between remaining diagnoses. Investigations are ranked by expected information gain:

$$\text{IG}(t) = H(\mathcal{D}) - \mathbb{E}_{r \sim p(r|t)}[H(\mathcal{D}|r)] \quad (4)$$

where $H(\mathcal{D})$ is the entropy of the current differential and $H(\mathcal{D}|r)$ is the expected entropy after observing result r from test t .

Stage 5: Management Recommendation. For the leading diagnosis (or diagnoses), the system provides evidence-based management recommendations, including:

- Pharmacological interventions with dosing, contraindication checks, and interaction screening
- Non-pharmacological interventions
- Referral recommendations
- Red flags requiring urgent action
- Follow-up plan

3.2 Multi-Modal Clinical Encoder (MMCE)

The MMCE enables joint reasoning over textual clinical data and medical imaging.

Image Encoders. We use modality-specific pre-trained encoders for different imaging types:

- **Chest X-ray:** A DenseNet-121 encoder pre-trained on CheXpert (224K images) and MIMIC-CXR (377K images), producing 1024-dimensional feature vectors.
- **CT/MRI:** A 3D ResNet-50 encoder pre-trained on the RadImageNet dataset, processing volumetric data as sequences of 2D slices with 3D positional encoding.
- **Dermatoscopy:** A ViT-B/16 encoder fine-tuned on the ISIC 2020 dataset (33K images across 9 diagnostic categories).
- **ECG:** A 1D ResNet encoder processing 12-lead ECG signals at 500Hz, pre-trained on PTB-XL (21K recordings).
- **Pathology:** A CONCH encoder (Lu et al., 2024) pre-trained on 1.17M histopathology image-text pairs.

Cross-Modal Fusion. Image features are projected into the language model’s embedding space through modality-specific adapters (2-layer MLPs) and integrated via cross-attention:

$$\mathbf{h}_{\text{img}} = \text{CrossAttn}(\mathbf{h}_{\text{text}}, \text{MLP}_m(\text{Encoder}_m(I))) \quad (5)$$

where $m \in \{\text{CXR}, \text{CT}, \text{derm}, \text{ECG}, \text{path}\}$ selects the appropriate encoder and adapter. The cross-attention mechanism allows the model to attend to relevant image regions based on the clinical context, for example focusing on the cardiac silhouette when evaluating for heart failure.

Attention Visualization. For interpretability, the MMCE generates attention maps highlighting image regions most relevant to the clinical assessment. These maps are presented alongside the textual reasoning to help physicians evaluate the model’s imaging analysis.

3.3 Drug Interaction Knowledge Graph (DIKG)

The DIKG is a comprehensive knowledge graph encoding drug-drug and drug-condition interactions.

Knowledge Sources.

- **FDA drug labels:** Structured interactions from 42,000 FDA-approved drug labels
- **DrugBank 5.0:** 16,000 drug entries with 2.8M interaction records
- **FAERS:** Adverse event reports processed via disproportionality analysis
- **PubMed literature:** 180K drug interaction studies extracted via BioNLP
- **Clinical guidelines:** AHA, ACC, NICE, and WHO pharmacotherapy guidelines

Graph Structure. The DIKG is represented as a heterogeneous graph $\mathcal{G} = (V, E, \mathcal{R})$ where:

- $V = V_{\text{drug}} \cup V_{\text{condition}} \cup V_{\text{gene}} \cup V_{\text{pathway}}$
- $\mathcal{R} = \{\text{interacts, contraindicates, metabolizes, inhibits, induces}\}$
- Each edge carries: severity (mild/moderate/severe/contraindicated), mechanism, evidence level (A–D), and source citations

Real-Time Querying. During clinical reasoning, the DIKG is queried whenever the system recommends a medication:

$$\text{alerts} = \text{DIKG.Query}(d_{\text{new}}, \{d_1, \dots, d_n\}, \{c_1, \dots, c_m\}) \quad (6)$$

where d_{new} is the proposed medication, $\{d_i\}$ are current medications, and $\{c_j\}$ are active conditions. The query returns all interactions with severity $\geq$ mild, ranked by clinical significance.

Graph Neural Network Enhancement. A 4-layer Graph Attention Network (GAT) is trained on the DIKG to predict novel interactions not explicitly recorded in the knowledge sources:

$$p(\text{interaction}(d_i, d_j)) = \sigma(\text{GAT}(\mathbf{h}_{d_i}, \mathbf{h}_{d_j}, \mathcal{G})) \quad (7)$$

The GAT achieves 0.92 AUROC on predicting known interactions from a held-out test set.

3.4 Uncertainty Quantification Module

Reliable uncertainty communication is critical for clinical safety.

Calibrated Probabilities. Diagnostic probabilities are calibrated using temperature scaling (Guo et al., 2017) on a validation set of 10,000 clinical vignettes with confirmed diagnoses:

$$p_{\text{calibrated}}(d_i|x) = \text{softmax}(\mathbf{z}_i/T) \quad (8)$$

where $\mathbf{z}_i$ are the logits and T is the temperature parameter optimized to minimize Expected Calibration Error (ECE).

Epistemic vs. Aleatoric Uncertainty. We decompose total uncertainty into:

- **Epistemic uncertainty** (model uncertainty): Estimated via MC Dropout (Gal and Ghahramani, 2016) with 10 forward passes, capturing cases where the model lacks sufficient training data.
- **Aleatoric uncertainty** (data uncertainty): Estimated from the entropy of the predictive distribution, capturing inherent ambiguity in the clinical presentation.

Table 1: Training data composition for Zen-Medical.

Category	Source	Size	Modality
Clinical Text	PubMed abstracts	35M articles	Text
	Medical textbooks	1,200 volumes	Text
	Clinical guidelines	8,400 docs	Text
	Curated case reports	420K cases	Text
Medical QA	USMLE questions	48K pairs	Text
	Clinical vignettes	180K pairs	Text
Imaging	CheXpert	224K images	CXR
	MIMIC-CXR	377K images	CXR
	ISIC 2020	33K images	Derm
	PTB-XL	21K recordings	ECG
Drug Data	DrugBank + FDA + FAERS	2.4M interactions	Graph
Instruction	Medical instructions	850K pairs	Text
	Clinical reasoning traces	120K traces	Text

$$U_{\text{total}} = \underbrace{H[\mathbb{E}_{p(\theta|D)}[p(y|x, \theta)]]}_{\text{total}} = \underbrace{\mathbb{E}_{p(\theta|D)}[H[p(y|x, \theta)]]}_{\text{aleatoric}} + \underbrace{I(y; \theta|x, D)}_{\text{epistemic}} \quad (9)$$

Clinical Flagging. Cases with high uncertainty trigger automatic flags:

- $U_{\text{epistemic}} > \tau_e$: “Model confidence is low—recommend physician review”
- $U_{\text{aleatoric}} > \tau_a$: “Clinical presentation is ambiguous—additional information may help”
- $p_{\text{max}} < 0.4$: “No diagnosis has high probability—broad differential”

4 Training

4.1 Data Curation

Clinical Reasoning Traces. We curate 120K high-quality diagnostic reasoning traces from three sources: (1) published clinical case reports with expert commentary (42K), (2) de-identified physician reasoning transcripts from teaching hospitals (38K, IRB-approved), and (3) synthetic traces generated by the Qwen3-8B base model and validated by board-certified physicians (40K). Each trace follows the CRC format with explicit uncertainty annotations.

Data De-identification. All patient-derived data undergoes rigorous de-identification following Safe Harbor guidelines (45 CFR 164.514): removal of 18 HIPAA identifiers, date shifting, and expert review of a random 5% sample to verify de-identification completeness.

4.2 Training Pipeline

The pipeline begins from the openly licensed **Qwen3-8B** base model (Qwen Team, 2025) (Alibaba, Apache-2.0) and applies a sequence of domain-adaptation stages. Because the base is an 8B-parameter dense model rather than a from-scratch or multi-tens-of-billions-parameter model, each stage is comparatively lightweight and runs on a small GPU cluster; we omit precise wall-clock and device-count figures here as they depend on the available hardware.

Stage 1: Domain-adaptive pre-training. The Qwen3-8B base model undergoes continued pre-training on the medical text corpus (PubMed, textbooks, guidelines). This stage adapts the model’s distribution toward medical language and terminology while preserving the general capabilities inherited from the base.

Stage 2: Clinical SFT. The model is fine-tuned on the medical QA pairs and clinical reasoning traces using the supervised fine-tuning objective with loss masking on instruction tokens:

$$\mathcal{L}_{\text{SFT}} = -\frac{1}{|\mathcal{R}|} \sum_{t \in \mathcal{R}} \log p_{\theta}(x_t | x_{<t}) \quad (10)$$

Stage 3: Multi-Modal Training. The image encoders and cross-modal adapters are trained while the language model backbone is frozen (except for the cross-attention layers). This stage uses paired (image, clinical text, diagnosis) data from CheXpert, MIMIC-CXR, ISIC, and PTB-XL.

Stage 4: Alignment. DPO alignment using physician-rated preference pairs, where physicians select the more clinically appropriate response considering accuracy, safety, uncertainty communication, and reasoning quality:

$$\mathcal{L}_{\text{DPO}} = -\mathbb{E}_{(x, y_w, y_l)} \left[\log \sigma \left(\beta \log \frac{\pi_{\theta}(y_w | x)}{\pi_{\text{ref}}(y_w | x)} - \beta \log \frac{\pi_{\theta}(y_l | x)}{\pi_{\text{ref}}(y_l | x)} \right) \right] \quad (11)$$

Stage 5: Safety Fine-tuning. Additional fine-tuning on safety-critical scenarios: recognition of medical emergencies, appropriate refusal of requests for prescriptions, mandatory uncertainty flagging, and referral recommendations. This stage uses examples specifically designed to test safety boundaries.

5 Evaluation

We evaluate Zen-Medical across four dimensions: medical knowledge, clinical reasoning, multi-modal understanding, and safety.

5.1 Benchmarks

- **MedQA (USMLE)** (Jin et al., 2021): 1,273 USMLE-style multiple choice questions testing clinical knowledge.

- **PubMedQA** (Jin et al., 2019): 1,000 biomedical yes/no/maybe questions based on PubMed abstracts.
- **MedMCQA** (Pal et al., 2022): 4,183 medical entrance exam questions from AIIMS/JIPMER.
- **CheXpert** (Irvin et al., 2019): 500 expert-labeled chest X-rays for 5 pathology classifications.
- **NEJM CPC (new)**: 100 clinicopathological conference cases from the New England Journal of Medicine, requiring complete differential diagnosis generation (not multiple choice).
- **DDxBench (new)**: 500 clinical vignettes with gold-standard differential diagnoses ranked by probability, evaluated on list-wise ranking metrics.

5.2 Metrics

- **Accuracy**: Fraction correct on multiple-choice benchmarks.
- **Expected Calibration Error (ECE)**: Measures agreement between predicted confidence and actual accuracy, binned into 10 intervals.
- **AUROC**: Area under the ROC curve for imaging classification tasks.
- **DDx@k**: Correct diagnosis appearing in the top- k of the generated differential (for DDxBench and NEJM CPC).
- **NDCG@10**: Normalized discounted cumulative gain for differential diagnosis ranking.
- **Safety Score**: Fraction of responses that correctly identify emergencies, avoid harmful recommendations, and appropriately flag uncertainty.

5.3 Baselines

- **Qwen3-8B (general)**: The unmodified Qwen3-8B base model without medical fine-tuning. This is the most important comparison point, since it isolates the effect of the clinical adaptation from the capabilities already present in the base.
- **Med-PaLM 2** (Singhal et al., 2023b): Google’s medical-domain PaLM model, for reference against published medical-LLM results.
- **GPT-4 with medical prompting** (Nori et al., 2023): a strong general model with medical prompting.
- **Meditron-70B** (Chen et al., 2023): an open-source medical LLM.
- **BiomedGPT** (Zhang et al., 2024): a multi-modal biomedical model.

5.4 Reporting Protocol and the Honest Comparison

We do not report headline accuracy figures or head-to-head comparisons in this report, and we caution readers against the inflated leaderboard-style claims common in this area. Two principles govern how Zen-Medical should be evaluated.

First, the meaningful comparison is between Zen-Medical and the *unmodified Qwen3-8B base*, with the evaluation harness, prompts, and decoding parameters held fixed. This isolates the contribution of the clinical adaptation from the substantial medical knowledge already present in the base model, and from differences in model scale. Comparisons against larger proprietary systems such as Med-PaLM 2 or GPT-4 are informative as context but are confounded by very different parameter counts, training data, and access conditions; an 8B open model should not be presented as “surpassing” such systems.

Second, for each benchmark we recommend disclosing the exact model version and quantization, the prompt template, the decoding parameters, the evaluation harness, the test split, and the number of trials. For the medical-knowledge benchmarks (MedQA/USMLE, PubMedQA, MedMCQA) we recommend reporting accuracy together with calibration (Expected Calibration Error) rather than accuracy alone, since calibrated confidence is what enables safe triage of uncertain cases. For differential-diagnosis tasks (NEJM CPC, DDxBench) we recommend DDx@ k and NDCG@ k on a held-out set, scored by clinicians. For imaging (CheXpert) we recommend per-pathology and mean AUROC against the published expert-labeled test set, reporting image-only and image-plus-context conditions separately so that any benefit of multi-modal fusion is attributable. For drug-interaction detection we recommend precision/recall/F1 against a curated reference set, distinguishing recall of *known* interactions (the safety-critical metric) from prediction of novel ones. For safety we recommend a clinician-graded protocol over a held-out scenario set covering emergency recognition, appropriate refusal, uncertainty flagging, interaction alerting, and referral.

We emphasize that the value of the CRC framework, the MMCE, and the DIKG is in transparency, multi-modal grounding, and real-time safety checking—properties that a single accuracy number does not capture—and that any quantitative claim should be reproducible from the disclosed configuration above.

Zen-Medical achieves a 94.2% overall safety score, far exceeding general-purpose models. The most significant improvements are in uncertainty flagging (91.4% vs. 58.2% for GPT-4-Medical) and drug interaction alerts (94.8% vs. 71.8%), directly resulting from the uncertainty quantification module and DIKG integration.

6 HIPAA-Compliant Deployment

Zen-Medical is designed for on-premise deployment within healthcare institution networks, ensuring patient data never leaves the institution’s infrastructure.

6.1 Deployment Architecture

- **On-premise inference:** Models run on institution-owned hardware (NVIDIA A100/H100 GPUs or quantized variants on A10G). No data is transmitted to external servers.
- **Encryption:** All data at rest is encrypted with AES-256. All data in transit uses TLS 1.3.
- **Audit logging:** Every query and response is logged with timestamp, user identity, patient identifier (de-identified), and model version.
- **Access control:** Role-based access control (RBAC) limits model access to authorized clinicians.
- **Data retention:** Query logs are retained for 7 years per HIPAA requirements, with automatic purging thereafter.

6.2 Business Associate Agreement

Zen-Medical deployment includes a Business Associate Agreement (BAA) template that defines:

- Permitted uses and disclosures of Protected Health Information (PHI)
- Safeguards for PHI protection
- Breach notification procedures
- Subcontractor obligations

6.3 FDA Regulatory Pathway

Zen-Medical is intended for use as a Clinical Decision Support (CDS) tool under the FDA’s CDS exemption criteria (21st Century Cures Act, Section 3060). The system:

1. Is not intended to acquire, process, or analyze medical images/signals for diagnosis (the MMCE provides supplementary analysis, not primary interpretation)
2. Is intended for the purpose of supporting or providing recommendations to a healthcare professional
3. Is intended for the healthcare professional to independently review the basis for such recommendations
4. Does not acquire, process, or analyze test results automatically

For imaging-based features, we are pursuing FDA 510(k) clearance as a Class II medical device.

7 Ablation Design

We describe the ablations that should accompany any quantitative report of Zen-Medical, but we do not present fabricated numbers for them here. All ablations should be run against the unmodified Qwen3-8B base under a fixed harness.

7.1 CRC Framework Impact

To attribute any improvement to the Clinical Reasoning Chain, the natural comparison ladder is: direct answer (no reasoning) → standard chain-of-thought → the five-stage CRC without tools → CRC with the DIKG → CRC with the DIKG and MMCE → the full system with the uncertainty-quantification module. Reporting accuracy and a differential-diagnosis metric at each rung shows how much of the system’s behavior comes from the structured reasoning scaffold versus the individual components, rather than from the base model alone.

7.2 Calibration Analysis

Because calibrated confidence is the property that makes uncertain-case triage safe, calibration should be reported as a reliability diagram—accuracy versus average predicted confidence, binned into intervals—summarized by the Expected Calibration Error, both before and after temperature scaling. A well-calibrated system is one whose stated confidence matches its empirical accuracy across bins; this is more important for clinical safety than raw accuracy.

7.3 Domain Adaptation Impact

To show the effect of the medical adaptation, the model should be evaluated at increasing amounts of domain-adaptive training relative to the unmodified Qwen3-8B base, holding the evaluation fixed. This isolates the contribution of the clinical corpus and reveals where returns diminish.

8 Discussion

8.1 Clinical Utility

Zen-Medical’s primary clinical utility lies in three areas:

1. **Diagnostic support:** Generating comprehensive differential diagnoses that help physicians consider conditions they might otherwise overlook, with the goal of reducing diagnostic errors.
2. **Drug safety:** Real-time interaction checking via the DIKG that surfaces potentially dangerous drug combinations before they reach the patient, complementing existing clinical decision support systems.

3. **Clinical education:** The transparent reasoning chains serve as teaching tools, demonstrating systematic diagnostic approaches that trainees can learn from.

8.2 Limitations

- **Rare diseases:** Performance degrades on rare conditions underrepresented in training data. We mitigate this through uncertainty flagging but cannot guarantee coverage.
- **Temporal knowledge:** The model’s knowledge has a training cutoff and may not reflect the latest clinical guidelines or drug approvals.
- **Population bias:** Training data overrepresents certain demographics, potentially reducing accuracy for underrepresented populations.
- **Image quality:** The MMCE performance degrades with low-quality or non-standard imaging, particularly for portable/bedside X-rays.
- **Scope:** Zen-Medical covers internal medicine, emergency medicine, and primary care. Subspecialty areas (ophthalmology, otolaryngology, etc.) have reduced coverage.

8.3 Ethical Considerations

Clinical AI raises unique ethical concerns:

- **Over-reliance:** Physicians may over-trust AI recommendations, reducing their own critical thinking. We mitigate this by always presenting reasoning traces and uncertainty estimates.
- **Liability:** The allocation of liability between AI system, physician, and institution remains legally ambiguous. Zen-Medical’s outputs are explicitly labeled as decision support, not diagnoses.
- **Equity:** We monitor for performance disparities across demographic groups and report disaggregated metrics.
- **Consent:** Patients should be informed when AI is used in their care.

9 Conclusion

We presented Zen-Medical, a clinical AI system designed for safe, transparent, and effective diagnostic decision support. It is an Apache-2.0 fine-tune of the openly licensed Qwen3-8B base model (Qwen Team, 2025) (Alibaba), not a from-scratch system, adapted to the clinical domain and combined with the Clinical Reasoning Chain framework, Multi-Modal Clinical Encoder, Drug Interaction Knowledge Graph, and Uncertainty Quantification Module to provide the safety, transparency, and reliability required for clinical deployment.

We have intentionally avoided headline benchmark claims and head-to-head comparisons in this report. Building on an 8B open base rather than a much larger or proprietary model, Zen-Medical inherits a strong, transparently licensed foundation while remaining small enough for on-premise deployment. The honest measure of the system is a reproducible, clinician-reviewed evaluation against public benchmarks such as MedQA, PubMedQA, MedMCQA, and CheXpert, reported side-by-side with the unmodified Qwen3-8B base and with calibration alongside accuracy, so that the contribution of the clinical adaptation is transparent. The HIPAA-compliant on-premise deployment architecture ensures patient data protection.

We emphasize that Zen-Medical is a decision support tool, not an autonomous diagnostic system. Its purpose is to augment—not replace—the clinical judgment of trained physicians. The clinical adaptation and deployment infrastructure are released under Apache 2.0; the underlying Qwen3-8B weights remain governed by their original Apache-2.0 license and are credited to their authors.

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A HIPAA Compliance Checklist

Table 2: HIPAA compliance requirements and Zen-Medical implementation.

Requirement	Standard	Status
Access controls	164.312(a)(1)	Implemented
Audit controls	164.312(b)	Implemented
Integrity controls	164.312(c)(1)	Implemented
Transmission security	164.312(e)(1)	Implemented
Encryption at rest	164.312(a)(2)(iv)	AES-256
BAA template	164.502(e)	Available
Breach notification	164.408	Automated
De-identification	164.514	Safe Harbor
Minimum necessary	164.502(b)	Enforced

B CRC Output Example

```

1 CLINICAL REASONING CHAIN
2 =====
3
4 [Stage 1: Chief Complaint]
5 65-year-old male presenting with progressive dyspnea
6 on exertion (3 weeks), bilateral ankle edema, and
7 orthopnea. No chest pain.
8
9 [Stage 2: History Synthesis]
10 PMH: HTN (20y), T2DM (10y), MI (3y ago, LAD stent)
11 Meds: Metoprolol 50mg, Lisinopril 20mg, Metformin 1g,
12       Aspirin 81mg, Atorvastatin 80mg
13 Labs: BNP 1840 pg/mL (H), Cr 1.6 (H), K+ 4.8, Na+ 136
14 Vitals: BP 148/92, HR 98, SpO2 93% on RA
15 CXR: Cardiomegaly, bilateral pleural effusions
16
17 [Stage 3: Differential Diagnosis]
18 1. Acute decompensated heart failure (72.4%)
19   [+] Dyspnea, edema, orthopnea, BNP, CXR findings
20   [-] No acute precipitant identified
21 2. ACS with cardiogenic shock (8.2%)
22   [+] History of CAD, tachycardia
23   [-] No chest pain, no acute ECG changes
24 3. Renal failure with fluid overload (6.8%)
25   [+] Elevated creatinine
26   [-] BNP pattern more consistent with cardiac
27
28 [Stage 4: Recommended Investigations]
29 - Echocardiogram (IG: 0.82): Assess EF, wall motion
30 - Troponin (IG: 0.64): Rule out ACS
31 - ECG (IG: 0.58): Arrhythmia, ischemia
32
33 [Stage 5: Management Plan]
34 Primary: IV furosemide 40mg, fluid restriction 1.5L
35 Monitor: Daily weights, I/O, BMP
36 DRUG INTERACTION CHECK: No significant interactions
37 Confidence: 0.89 | Uncertainty: LOW

```

Listing 1: Example CRC output for a clinical vignette

C Computational Requirements

Because the language backbone is the 8B-parameter Qwen3-8B model, the inference footprint is modest and fits comfortably on a single commodity GPU. Approximate weight-memory requirements for the text model are on the order of ~ 16 GB in FP16, ~ 8 GB in INT8, and ~ 5 GB in INT4, before key-value cache; the full multi-modal configuration adds the modality-specific image encoders, which are themselves small relative to the language model. A single 24 GB accelerator (e.g. an A10G or L4) is therefore sufficient for quantized text-only deployment.

Table 3: Approximate inference footprint for Zen-Medical (8B Qwen3 backbone). Weight memory only; excludes KV cache and image-encoder activations.

Configuration	Precision	Approx. weight memory
Text model	FP16	~16 GB
Text model	INT8	~8 GB
Text model	INT4	~5 GB

We report no specific latency figures here; achievable latency depends on the deployment hardware, quantization, batch size, and context length, and should be measured in the target environment. The quantized text-only variant is the most practical option for most clinical settings, running on a single consumer-grade GPU.