PUBLISHED IN **Visionary Vogues** · Magazine column · web
PUBLISHED 16 September 2026
Recorded by the author. The source carries no date, and nor does the publisher's live page.
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SOURCE https://visionaryvogues.com/ayora-health-precision-medicine
RECORDED 23 November 2026 · record AR-2026-09-001

BOARDROOM REFLECTIONS

The Data Deluge and the Fifteen-Minute Visit

By **Ravi R. Iyer, MD**



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Two physicians are betting that the future of precision medicine begins not with the patient, but with rescuing the doctor.

There is a quiet inversion taking place in American medicine. Never in history have we generated more data about the human body. Hundreds of biomarkers. Genomic panels. Continuous monitoring. Longitudinal records stretching back decades.

And never have physicians had less time, or less clarity, to use any of it.

On one side sits an ocean of information, growing by the day.

On the other sits a fifteen-minute visit.

Somewhere in that gap, patients get lost. But so, increasingly, do their doctors, and it is the second casualty that almost no one is talking about.

That gap is what a recent Boardroom Reflections conversation set out to examine, with two physicians who have known each other since residency and have spent three decades in practice across the Washington–Northern Virginia corridor: Dr. Rajeev Khanna , a board-certified internist and CEO of Ayora Health , and Dr. Gurdeep Chhabra , a medical oncologist and health-technology executive. Their platform, Ayora Health, is not another longevity boutique. It is an attempt to rebuild the economics and the workflow of independent practice itself.

The Million-Dollar Question



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> **DR. RAJEEV KHANNA -- CEO OF AYORA HEALTH**

The origin story is almost too vivid to be true.

Khanna was at breakfast in a friend's oceanfront condo in Miami. The friend, a wildly successful lawyer, a self-made billionaire, had just returned from an elite wellness clinic and dropped a thick stack of lab reports on the table.

Then he made an offer.

- I'll write a million-dollar check to you right now, if you can
- promise me you'll prolong my life by five years.

Khanna could not. No honest physician could. There is no test, no protocol, no algorithm that lets a doctor look at a patient and guarantee the arithmetic of a lifespan.

But the question lodged itself and would not leave.

He went home. He researched the emerging science of longevity and “super wellness.” He found real evidence buried inside it, and, surrounding that evidence, an overwhelming volume of information that no one had figured out how to translate into anything a patient could actually use. He ordered the same advanced panels on himself. He attended seminars on how to interpret them. And he began to build.

The million-dollar question, it turned out, was not about money at all. It was about meaning: how to convert a mountain of data into a single, honest recommendation a patient could understand.

A Long Life Is Not a Good Life

Chhabra approaches the same problem from the other end of the stethoscope.

As an oncologist, he negotiates the boundary between quantity and quality of life every day. Chemotherapy, immunotherapy, the endless calculus of how much time a treatment buys and at what cost, this is his daily vocabulary.

> *There's a difference,” as he frames it, “between a long life and a good life.*

Lifespan is not thrivespan. And the danger he sees in the longevity boom is precisely that it sells the first while implying the second, bombarding patients with promises of more years, thin on the evidence that those years will be worth living.

His response is not skepticism. It is discipline: an evidence-based approach a working clinician can apply to every patient who walks through the door, not merely the one prepared to write a million-dollar check.

The Data Deluge

- Here is the uncomfortable admission at the heart of the
- conversation.

When Khanna took that stack of genomic and gut-lining reports home, he, a board-certified internist with thirty years of practice, struggled to interpret them.

Not the patient. The physician.

The names were familiar; the clinical meaning was not. Pulling it all into a single coherent recommendation would have required a geneticist and a specialist. And the patient? He had received a fifteen-minute phone call with a nurse practitioner from the testing company, and left with more anxiety than answers.

This is the paradox modern medicine has engineered: we have become extraordinary at generating information and abysmal at converting it into intelligence.

Chhabra recognizes the pattern immediately, because oncology lived it first. In cancer care, next-generation sequencing reveals dozens of mutations in a single tumor, but only a handful are actionable. The art is not in producing the data. It is in knowing which fraction of it matters for this specific patient, today.

Longevity medicine, he argues, is now at exactly that stage. A flood of signal and noise, indistinguishable to the eye, arriving faster than any individual physician can learn to read.

If we don't take this into our own hands and start learning this very quickly, we will lose the respect of our patients.

The Real Crisis Is Burnout



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- [Dr. Gurdeep Chhabra - A Medical Oncologist and Health-
- Technology Executive]

None of this happens in a vacuum. It happens inside a system that is grinding its physicians down.

Ask Khanna whether burnout has become healthcare's number-one problem, and he does not hedge. “You don't have to listen to me,” he says. “Just read the newspaper.”

The arithmetic is brutal. Reimbursements fall. Patient volumes rise. Primary care shortages deepen as new graduates flee toward specialties. And into that squeeze the system pours an ever-growing burden of documentation, box after box to be checked before anyone gets paid.

The result is a profession practicing at the bottom of its license instead of the top.

- Dr. Iyer, hosting the conversation, offered the metaphor that
- framed the whole exchange: the industry has built McDonald's
- medicine, burgers and fries, enough to keep body and soul

The obvious escape is concierge medicine. But it is a door most physicians are afraid to walk through, because going fully membership-based means abandoning the insurance patients, the ones who have waited years, who will sit in the waiting room until their doctor is free rather than see anyone else.

So Khanna built a hybrid instead:

A membership-based track for patients who want, and can support, deeper longevity and wellness care. A continuing insurance-based practice for everyone else, unchanged. Ancillary providers to extend capacity without severing the physician–patient bond.

- It is, in his words, still a moving part. But it points at something
- larger than one practice: a way for independent medicine to
- survive.

AI as Force Multiplier

If time is the one commodity a physician can never buy more of, then the only path forward is leverage.

This is where Chhabra locates artificial intelligence, not as a replacement for judgment, but as a democratizer of information.

The technology will help the physician, rather than the physician working for the technologist.

That inversion is the whole philosophy. The physician must build the AI around patient care, not contort patient care to fit the technology. Used that way, AI becomes a force multiplier: it collapses the hours of literature review and data integration that no clinician has time for, and hands them back as minutes.



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Iyer knows the cost firsthand. Testing the concept on his own patients, he had spent ten days integrating one patient's data and running the evidence-based literature search, then two more hours assembling it into a plan. At that rate, he noted, the work simply cannot be done.

Unless something does the assembling for you.

One Score, Many Signals

That something is the Ayora Score.

Khanna's insight was that the longevity market had it backwards. Dozens of companies now sell biomarker panels at cut-rate prices, 120 markers for $199 in a holiday sale. What almost none of them sell is continuity: the longitudinal hand-holding that turns a number into a decision.

So he built an algorithm that does the clinical reasoning. It takes the domains that actually govern how we age, cardiac, metabolic, inflammatory, hormonal, assigns each a weighted value, and resolves the whole into a single composite score.

The score is not the point. The roadmap is.

Improve your cholesterol and your cardiac inputs; the score rises. Reverse your insulin resistance; it rises again. Restore hormonal balance; higher still. The patient is no longer handed a binder and sent home. They are handed a direction of travel, and a reason to move.

Iyer, who tested the tool, singled out exactly this: the graphical output that shows a patient their trajectory in a way that finally changes behavior. Telling patients something is bad for them rarely works. Showing them the slope of their own decline, and the path back up, does.

Around that engine, Ayora Health assembles the rest under one roof:

Advanced diagnostics most community physicians struggle to order, Lp(a) and ApoB for cardiac risk, hormonal and inflammatory panels, gut and food-sensitivity testing, with the lab logistics handled by a single click. Imaging pathways, from total-body scans to coronary calcium scoring and CT angiography. Ancillary services: nutritionists, curated nutraceuticals, and a referral network that surfaces specialized care a patient could not find elsewhere. The business machinery, vendors, ordering, results parsing, abstracted away, so the physician simply orders and interprets.

The clinician's job shrinks back to the part only a clinician can do: sit with the patient, apply judgment, and explain it in words a human being can understand.

The Entrepreneurship Gap

- There is a truth about doctors that the profession rarely says
- aloud.

Most physicians are brilliant clinicians and poor businesspeople. The rare ones who excel at business are seldom the strongest clinicians. Entrepreneurship is not innate to medicine, and after a fourteen-hour day, almost no one has the energy to acquire it.

This is the gap Ayora Health is really built to close.

By running the commercial infrastructure, enrollment, vendor relationships, billing logistics, the platform lets a physician build a financially sustainable longevity practice without becoming an entrepreneur, and without walking away from the insurance-based practice they spent decades building.

It makes the average clinician better than average at the one thing they were never trained for.

Democratizing Precision

Stack these pieces together and the mission comes into focus.

- Advanced diagnostics, longevity protocols, precision
- interventions, until now these have been the province of
- patients able to pay thousands of dollars out of pocket at
- boutique clinics.
- Ayora Health's wager is that the same sophistication can be
- delivered by the community physician down the street.

“We want to make it truly precision,” Chhabra says, “not because it's the sexy way of saying precision medicine, but for that individual, specific patient.” A person with osteoarthritis who cannot walk twelve thousand steps needs a different path to the same goal. The platform is designed to nudge each patient along the route that fits their life, not a generic one.

Precision, in other words, not as a luxury tier, but as a default.

Healing Both Sides of the Stethoscope

For decades, every reform in healthcare has been justified with the same phrase: better outcomes for patients, a better patient experience.

Iyer named what he had never once heard alongside it, that we must do the same for the physician.

This is the quiet radicalism of the whole enterprise. Healthcare that works only for patients is only half a system. A model that heals patients while burning out their healers is not sustainable, however noble its outcomes look on paper.

And artificial intelligence, deployed correctly, is not the threat to that vision, it is the instrument of it. Chhabra tells his residents as much on rounds: he has no quarrel with open evidence, with Claude, with ChatGPT. The point is not to fear the tools but to become better physicians using them, so that a patient never leaves the room wondering whether their doctor missed something knowable.

The physician, restored to the top of their license. The patient, handed clarity instead of a binder. The same tool serving both.

Closing Reflection

Picture the three of them meeting again a decade from now.

If Ayora Health succeeds as its founders envision, what will have changed will not only be measured in patient outcomes. It will be measured in whether the practicing physician can still keep pace, absorbing each new wave of evidence, translating it at the bedside, and evolving as a clinician rather than drowning as a clerk.

- The science of longevity keeps advancing. New cardiac risk
- markers move from obscure to standard within a few years;
- drugs for targets once considered untreatable are already in

late-stage trials. The knowledge will keep arriving. The question is whether the people meant to wield it will still be standing.

The real question was never whether we can generate more data. We have answered that, overwhelmingly.

The real question is whether we can build a system that lets a physician turn that data into health, one patient, one honest conversation, one restored doctor at a time.

And that will be decided neither in the lab nor at the lab-report table.

It will be decided at the boardroom table.

YouTube Podcast Link: https://www.youtube.com/watch? v=p0G8v6S3LuM

ABOUT THE AUTHOR

Ravi R. Iyer, MD, is a physician-scientist, entrepreneur, author, and 5x TEDx speaker who has spent four decades exploring a deceptively simple question: What makes human beings, and the organizations they create, perform at their best? A Harvard-trained physician, corporate strategist, and the founder of multiple healthcare and performance ventures, he is the creator of Neuroalignment, a framework for building high-performance organizations around the realities of human

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