

REHEARSAL REPORT

TIER 0 TABLETOP REHEARSAL 1

Synthetic Desk Exercise: Safe Transition Home
Hospital-to-Community Discharge Coordination

A subordinate implementation aid to the deposited Transformational Laboratories Protocol v1.0

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STATUS

Synthetic Tier 0-format interface stress test. No real person, record, institution, service or material intervention was involved. No qualification, independent review, clearance, authorization or empirical validation is claimed.

Contents and reading pathways

Use the document navigation pane or the links below. The layers are designed for progressive disclosure; read only as deeply as your decision and role require.

[Executive finding](#)

[Method and claim boundary](#)

[Synthetic Candidate Note](#)

[Tabletop sequence](#)

[Illustrative G0 qualification profile](#)

[Risk, red lines and responsible urgency](#)

[AI and data stress tests](#)

[Rupture-and-repair stress test](#)

[Operational metabolism results](#)

[Unresolved disagreements](#)

[Companion changes confirmed by rehearsal](#)

[Decision record and next evidence](#)

[Canonical record and AI disclosure](#)

Executive finding

ILLUSTRATIVE REHEARSAL VERDICT

The synthetic candidate would require remediation and would remain preparatory. No qualification, clearance or material action is authorized. The rehearsal itself remains Tier 0; a real intervention of this kind would be provisionally at least Tier 2 and could reach Tier 3 if consequential clinical AI or partly irreversible health exposure were introduced.

The central design insight is that patients and unpaid caregivers must not become the system's default boundary institution—reconciling instructions, carrying records, resolving medication gaps, coordinating appointments and absorbing delays generated across otherwise competent organizations. A legitimate Laboratory would shift coordination labour toward institutions with authority and resources while preserving affected people's decision rights.

Five separately prompted AI-assisted passes—affected-community/caregiver, duty-bearing and boundary coordination, safeguards, AI/data stewardship, and Protocol-fidelity audit—converged on the same course: protect through established duties, constitute authority and safeguards, price the burden, and repeat the rehearsal with actual affected people before material action.

WHAT THIS RESULT IS

An interface and governance stress test that surfaced implementation hypotheses, conflicts and missing conditions.

WHAT THIS RESULT IS NOT

Affected testimony, consent, community authority, independent review, human comprehension evidence, safety evidence, effectiveness evidence, site qualification or a G3/G4 decision.

Method and claim boundary

Exercise design

The exercise applied the Field Companion's progressive-disclosure cards, role pathways, Q1–Q10 profile, risk-tier logic, administrative-burden matrix, responsible-urgency rules, active AI controls, dual-channel rupture pathway and Operational Metabolism Ledger to a wholly fictional scenario.

Dimension	Method
Setting	Synthetic hospital-to-community discharge pathway for medically complex adults facing medication, transport, housing, language, disability or follow-up barriers.
Mode	Document-based, AI-assisted adversarial role simulation; no interaction with a real institution or person.

Dimension	Method
Perspectives	Affected/community; responsible institution/boundary; safeguards/non-domination; data/AI/external challenge; Protocol-fidelity audit.
Episodes	Affectedness and duties; G0 criteria; urgency; AI failure modes; rupture/repair; paperwork and burden; illustrative disposition.
Evidence coding	Directly observed in this desk exercise / scenario-estimated / proxy-derived / not measured.
Decision limit	Qualification and later gates are not available to a synthetic exercise; only an illustrative remediation finding is recorded.

Non-substitution rule

- AI-simulated perspectives possess no standing, authority, consent or review independence.
- No fictional participant may be cited as affected testimony or evidence of comprehension, safety, trust, burden acceptability or legitimacy.
- The exercise may test instruction clarity, role conflicts, document sequence, failure modes, workload assumptions and measurement feasibility.
- Any later human tabletop requires ethical/privacy/representation protections, accessibility, compensation and independent support appropriate to Tier 0.

Protocol fidelity

Protocol v1.0 remains unchanged and controlling. Q1–Q10 are qualification criteria applied at G0, not ten gates. G0 qualification does not mean safe-to-act; G3 and G4 remain distinct. Living coordination is necessary but insufficient and is not a score, work, level, gate, tier or third grammar.

Synthetic Candidate Note

NON-CANDIDATURE NOTICE

This note exists only to exercise the interface. It is not a real Candidate Note and must not be used to invite, recruit, collect data, alter service or represent institutional commitment.

Field	Synthetic entry
Working name	Safe Transition Home
Provisional injury	Avoidable post-discharge harm produced by discontinuity among hospital, patient/caregiver, primary care, pharmacy, home care, transport and social support.
Provisional claim	A patient-controlled transition summary plus explicit duty acceptance, a closed-loop handoff, a time-bounded confirmation process (48 hours used only as a tabletop assumption) and a human escalation route may reduce unowned needs and avoidable harm.

Field	Synthetic entry
Serious rivals	Additional staffing, medication access, transport, housing, primary-care capacity, selection effects or ordinary quality-improvement compliance may explain outcomes better than the proposed coordination architecture.
Optional AI role	Drafting, missing-information prompts, translation/accessibility and pattern surfacing on synthetic material only; no diagnosis, ranking, eligibility, resource or gate decision.
Provisional boundary	One hospital service and a defined receiving network; exact population, institutions, duration, data perimeter and consequence horizon remain unspecified.
Status-quo harms	Medication discrepancies, missed or unaccepted referrals, lost follow-up, caregiver burden, preventable deterioration, emergency use, readmission and frontline moral distress.
Action risks	False assurance, privacy/group harm, alert fatigue, burden shifted to patients/community providers, hospital-centric metrics, stigmatizing labels, vendor dependence and hidden reviewer overload.

Tier 0 exclusions

- No real patient, caregiver, worker, institution or community participation.
- No identifiable, clinical, institutional or community-held data.
- No change to care, discharge timing, eligibility, staffing, responsibility or resource allocation.
- No automated diagnosis, prioritization, risk ranking, monitoring or service decision.
- No withholding of established care or protection to create comparison conditions.
- Any AI use confined to synthetic sandbox material; no product or provider evaluated.

Tabletop sequence

Episode	Prompt	What the interface exposed
1 • Invitation / affectedness	Who is affected, who bears new work and who is absent?	A transient, internally diverse population cannot be replaced by an institution-selected representative; patients/caregivers risk becoming the boundary institution.
2 • Qualification	Apply Q1–Q10 and red lines.	Several required conditions are absent, especially affected authority, duty ownership, protective margins, remedy, boundary mandate and independent review.
3 • Responsible urgency	Status-quo harm continues while governance is built.	Established care and no-regrets protective duties continue; experimental components remain gated; both delay and premature-action harms need owners and clocks.
4 • Consequential AI	A polished summary influences handoff decisions.	Source-linked critical-field checks, reconstruction, protected reviewer time, non-AI equivalence and change control are required; AI may be unnecessary.
5 • Rupture / repair	A person receives an infeasible plan and is asked to narrate the failure again.	Immediate protection and formal remedy must coexist with any voluntary relational response; repeated telling is itself a burden.
6 • Burden allocation	Who completes and pays for each record?	Institutional support can own the records while affected constituencies retain authorship, correction, concurrence and authority.

Episode	Prompt	What the interface exposed
7 • Disposition	Qualify, remediate or decline?	Illustratively remediate and remain preparatory; no real gate decision is possible without real parties and evidence.

Illustrative G0 qualification profile

INTERPRETATION

The colours below describe what the present fictional record would show if brought to G0. They do not constitute a real review. Q9a and Q9b are recorded separately although Q9 is one numbered criterion.

Criterion	Illustrative status	Finding	Required repair
Q1 • Life-grounded problem	Red	Plausible injury, but no affected testimony or local evidence. Institution-centred proxies such as readmission cannot define the injury alone.	Fund plural affected testimony and credible local baseline inquiry without presupposing the solution.
Q2 • Bounded setting	Amber	Hospital discharge is identifiable; population, receiving institutions, duration, data, permitted change and consequence horizon remain unbounded.	Specify one pathway, explicit inclusion/exclusion, named institutions, time, data and permeable observation boundary.
Q3 • Affected authority	Red	No legitimate, plural, compensated and resourced affected body exists.	Constitute standing, representation, advice, burden concurrence, pause, remedy, renewal and recall.
Q4 • Duty-bearing institution	Red	No institution has accepted the cross-boundary authority, resources, liabilities and residual duties.	Execute a duty/resource compact with named officers, acceptance events, escalation and orphan-case ownership.
Q5 • Inquiry/intervention fitness	Amber	Plausible mechanism; incomplete rivals, no-intervention path, thresholds and falsifiers.	Co-author and register the claim, rivals, feasible action, indicators and stop/falsification evidence.
Q6 • Protective margins	Red	No funded staffing, access, service, relational, data, remedy or delayed-harm reserves.	Quantify and fund margins, non-AI capacity, independent advice, transition and remedy before action.
Q7 • Refusal/exit/remedy	Red	Routes are conceptual only; no demonstrated safety, independence, accessibility or service continuity.	Create free assisted/non-digital routes, interim protection, appeal, anti-retaliation and ring-fenced remedy.
Q8 • Living coordination	Red	No real relationship, safe contradiction or affected-person profile exists.	Authorize only a protection-first preparatory phase and test conditions with actual people without blaming mistrust.
Q9a • Boundary fitness	Red	No funded body carries records, duties, corrections and dissent across boundaries; patients risk filling the gap.	Constitute an accountable boundary mandate that cannot certify or adjudicate itself.
Q9b • Independent review	Red	No independent reviewer with funding, direct access, appeal and temporary-pause authority.	Appoint and protect a legally and operationally independent function.
Q10 • Corrigibility/public learning	Amber	A versioned record is feasible, but no institution has committed to adverse publication, dissent, repair, closure and correction.	Name custodian, publication/correction rules, minority report route and closure record.

Preserved reviewer disagreement

The simulated reviewers differed on whether Q1, Q4 and Q8 should be red or amber. The conservative synthesis records red where required evidence or authority is absent. The minority view—amber because a plausible condition or protection-first path can be described—remains attached here. Neither view would authorize material action.

Risk, red lines and responsible urgency

Risk classification

Object	Provisional classification	Reason
This rehearsal	Tier 0	Synthetic mapping and simulation only; no real person, data, service or material change.
A real coordination pilot	At least Tier 2	Health, essential services, vulnerable or dependent groups, cross-institutional duty and sensitive data could be affected.
Clinical/consequential AI or serious exposure	Could reach Tier 3	If outputs influence diagnosis, medication, discharge timing, eligibility, prioritization or partly irreversible health consequences.

No final live tier can be assigned without actual evidence. Missing evidence cannot lower a tier; credible serious or irreversible uncertainty raises it. Tier 3 is not eligible as an initial Minimum Viable Laboratory.

No-go conditions in the fictional record

If this fictional note were treated as a real candidate, absent affected authority, remedy capacity, independent review, safe refusal and protective margins would block material action. The exercise itself did not expose anyone to the Protocol's automatic prohibited practices because no intervention occurred.

Responsible urgency outcome

Proceed now under existing duty	Remain gated as novel/experimental
Correct known medication or identity errors; maintain ordinary clinical response; provide understandable discharge information; use qualified interpretation; fulfill existing privacy, referral, complaint and emergency duties.	New data linkage; consequential AI; altered discharge timing, eligibility or resource priority; experimental reassignment of responsibility; additional monitoring; withholding ordinary practice for comparison.

CANDIDATE-SPECIFIC PAUSE RULE

Pause the experimental layer—never the care or protection already owed. Wrong-person/medication information, urgent follow-up failure, unauthorized disclosure, ignored refusal, discriminatory access loss, overload degrading ordinary care, unsupported AI content, retaliation or a breached margin would require protection and review.

AI and data stress tests

Seven synthetic perturbations were applied. Their value is conceptual: the controls made hazards visible. No AI product was validated and no harm-prevention claim follows.

Perturbation	Failure	Control that changed the analysis
Medication omission	Polished AI draft omits a high-risk medication; generic sign-off misses it.	Source-linked critical-field verification and independent reconstruction.
Person-blaming compression	Missed appointment becomes 'non-adherence,' erasing transport, access and unaccepted referral.	Mandatory institutional/infrastructural rivals and affected correction.
Translation distortion	Symptom or care preference changes meaning.	Qualified interpretation, teach-back and correction; fluency is not verified meaning.
Silent model change	Provider update alters behaviour.	Version visibility, deployment control and automatic suspension pending renewed Appendix K review.
Non-equivalent opt-out	Manual path exists but is slower because no staff time is funded.	Compare time, access, quality and consequence; fund equivalent non-AI capacity.
Collective/inferential harm	De-identified pattern stigmatizes a neighbourhood or group.	Collective-harm review, community data authority and purpose limits.
Rubber-stamping	Clinician approves output under discharge pressure without reconstruction.	Protected review time, workload ceiling and authority to delay the AI output—not established care.

AI control disposition

Control	Synthetic result	Status before real use
Named human/institutional authority	Can be described but no actor has accepted it.	Absent
Protected reviewer time	Substantial workload surfaced; no staffing commitment.	Absent
Rival mechanism prompt	Prevented premature person-blaming attribution.	Demonstrable on paper
Source sampling/reconstruction	Necessary to detect critical omissions.	Conditional on access/staffing
Override/correction propagation	Required across hospital/community records; workflow unspecified.	Conditional/absent
Synthetic known-answer tests	Can expose omission, staleness, contradiction and translation failures.	Demonstrable on paper
Equivalent non-AI route	Nominal opt-out would be coercive if slower or unstaffed.	Absent
Material-change control	SaaS auto-updates conflict with suspension unless versions are visible/contracted.	Conditional/absent
Independent counter-capacity	Affected people need accessible explanation and funded expertise.	Absent
Privacy/collective authority	Individual permission cannot resolve group or cross-boundary harms.	Absent

AI CONCLUSION

The key risk is institutional choreography masquerading as neutral assistance: a polished summary may make fragmentation more efficient while concealing who failed to carry a duty and who absorbed verification labour. The valid question is whether responsibility and usable remedy cross the boundary with the person—without making that person the quality-control worker.

Rupture-and-repair stress test

SYNTHETIC RUPTURE

'I was discharged with a plan nobody checked I could carry out, and now I am being asked to explain the failure again.'

Immediate protection/formal channel	Optional relational channel	Required structural repair
Correct the record and unsafe plan; restore care/access; independent intake; one assisted telling; interim protection; investigation; reasons; remedy/appeal; anti-retaliation.	Only if the person chooses: confidential advice, acknowledgment, sense-making, changed commitments or safe separation. No forced contact, mediation, apology, forgiveness or recording.	Assign and fund the duty; change the handoff rule; compensate burden where warranted; prevent recurrence; preserve unresolved disagreement and external remedies.

Complaints about the convenor bypass the convenor. Serious harm, retaliation, data misuse, rights loss or a mandatory pause condition enters the formal channel even if relational work also occurs. Choosing one route never waives the other.

Operational metabolism results

MEASUREMENT INTEGRITY

This first rehearsal deliberately separates what was observed, estimated and not measured. Its failure to instrument exact desk-review start/stop time before the first role pass is itself an operational finding: the next rehearsal must open with a live time, ownership and burden log.

Required measure	Evidence status	Rehearsal result	Interpretation / next measure
Time	Not reliably measured; scenario-estimated	Exact AI desk-review elapsed time was not instrumented. Human-equivalent plan: 40–46 compensated person-hours across eight roles.	Next rehearsal logs preparation, contact, session, correction, synthesis and waiting by role.
Cost	Directly observed / not measured	No external participant, venue or travel expenditure; compute/platform cost unavailable. No valid live-site cost.	Apply local loaded rates and record compensation, access, interpretation, care replacement, advice, review, tech, opportunity and remedy costs.
Comprehension	Not measured	No human participant. Simulated reviewers flagged three likely confusions: attendance≠authorization; boundary role≠gate authority; review≠permission to delay ordinary care.	Independent explain-back at 30-second, 3-minute and role-path depths; disaggregate; redesign unclear items.

Required measure	Evidence status	Rehearsal result	Interpretation / next measure
Paperwork ownership	Directly assessed on paper	Thirteen core work items assigned to institutional support, duty-bearers or independent functions; affected people retain correction/authority rather than default authorship.	Measure actual fields, handoffs, duplication, rework and affected/uncompensated share.
Participant burden	Not measured; scenario-estimated	No human participants. Planning ceiling of about three hours per role before access and debrief was proposed, not validated.	Measure meetings, retelling, work/care disruption, access, emotional load, attrition and compensation; affected people judge acceptability.
Reviewer workload	Scenario-estimated	Concise complete packet: about 5–6 hours; evidence dispersed through full appendices: 9–12 hours.	Log sources/pages, active time, context switches, queue, rework, protected time and quality risk.
Gate latency	Not measured	No constituted authority, complete submission or real gate; therefore latency cannot be validly estimated.	Timestamp submission/completeness/queue/review/repair/decision; name owner, delay bearer, escalation and expiry.
Safeguard value	Directly observed as design contribution	Rehearsal shifted the imagined course from rapid pilot to remediation and surfaced ten pre-action design requirements plus seven AI failure modes.	No claim that ten harms were prevented. Record severity, decision changed, protection added, false alarms, cost and affected judgment.
Unresolved disagreement	Directly generated, not real-party evidence	Eleven material governance disagreements preserved below; reviewer differences on Q1/Q4/Q8 remain visible.	Actual parties record positions, standing, power, evidence, decision effect, duration and next review.
Harm caused by delay	Directly observed / not measured	No real-world harm was caused by the desk exercise. Status-quo injury and any future procedural delay harm are unmeasured.	Track ongoing harm, interim protection, exposure, duration, distribution and causal uncertainty without treating 'inaction' as nothing.

Scenario-estimated human rehearsal workload

Component	Planning estimate	Status
Pre-read and session participation	24 compensated person-hours across eight roles	Scenario-estimated
Preparation and synthesis	10 person-hours	Scenario-estimated
Accessibility / translation preparation	3–4 person-hours before delivery costs	Scenario-estimated
Independent review	3–6 person-hours with concise complete packet	Scenario-estimated
Total	40–46 person-hours	Planning range only; must be replaced by measured human data

Cost formula: total operational cost = compensated participant hours + institutional staff hours + accessibility/translation + independent advice/review + coordination/documentation + venue/technology + opportunity cost + repair or delay cost. No currency total is defensible until local rates and support needs are supplied.

Safeguard contribution—ten design corrections

1. Constitute legitimate affected authority.

2. Bind an accountable duty-bearing institution and cross-boundary duty chain.
3. Appoint a funded, accountable boundary institution.
4. Establish independent safeguards and review.
5. Fund protective margins, service continuity and remedy.
6. Differentiate alerts, temporary pause, suspension and termination.
7. Allocate paperwork and compensate participation/care labour.
8. Bound data and AI use, protected review time, change control and an equivalent non-AI route.
9. Operate voluntary relational repair alongside formal protection/remedy.
10. Track Protocol burden, gate latency, status-quo harm and procedural delay harm as evidence.

Unresolved disagreements

These are governance questions, not misunderstandings to facilitate away. No synthetic exercise can settle them for real parties.

1. When does hospital responsibility end and receiving-institution responsibility begin?
2. Is the proposed workflow ordinary quality improvement, research, service redesign or a material Laboratory intervention?
3. Who belongs to the affected constituency, and how are patients, caregivers, priority subgroups and community workers represented through differentiated standing?
4. Does a patient-controlled summary enlarge agency or transfer clerical and safety labour to the patient?
5. Should the boundary function sit inside the hospital, in an independent intermediary or in a jointly governed hybrid?
6. What minimum data are necessary, and who may create, access, correct and rely on them?
7. Which protective improvements may proceed immediately under existing duties?
8. Do readmission and follow-up metrics conceal safety, dignity, recovery, caregiver sustainability and community burden?
9. Who funds community providers, affected representatives, reviewers and accessibility for coordination and governance work?
10. Is AI necessary, and would its verification, governance and data burden exceed any coordination value?
11. How are liability, remedy and residual duties divided when harm emerges across institutions?

Companion changes confirmed by rehearsal

The exercise did not revise Protocol v1.0. It confirmed the following implementation features in Field Companion v1.0:

- A non-authorization warning at every short disclosure layer.
- Separate affected-community rights and authority cards, with authority explicitly separated from clerical labour.
- Role pathways that prevent the boundary institution, convenor, sponsor, implementer or AI from acquiring improper authority.
- Tier-specific documentation depth with an invariant constitutional floor.
- An administrative-burden matrix assigning preparer, verifier, approver, payer and burden budget.
- Three visible clocks for protection, authorization and learning, with delay-harm ownership and anti-stall escalation.
- Active AI oversight based on source reconstruction, protected reviewer time, serious rivals, overrides, non-AI equivalence and material-change suspension.
- A dual-channel pathway with immediate protection, voluntary relational choice and independent formal remedy.
- A disaggregated Operational Metabolism Ledger with evidence-status tags and no universal efficiency score.

Decision record and next evidence

Record item	Rehearsal entry
Illustrative disposition	REMEDiate; remain preparatory. This is not an actual G0 decision.
Material action	Not authorized; no G1–G4 claim is made.
Ordinary protection	Continues under existing lawful, clinical, ethical and professional duties.
Protocol v1.0	Unchanged. No v1.1 proposal is opened by synthetic findings.
Next permissible step	A human-informed Tier 0 rehearsal with actual affected participants, no live workflow or patient data, and appropriate representation, compensation, accessibility, privacy, independent support and ethical review.
Evidence needed before reconsideration	Affected testimony; constituted authority; real comprehension; measured burden/time/cost; duty/resource commitments; boundary and review fitness; preliminary remedy; action-inaction evidence; delay-harm and disagreement record.

V1.1 HOLD

Protocol v1.1 is not under consideration on the basis of this rehearsal. Preserve synthetic findings as hypotheses. Only evidence from actual Tier 0 human use and later consequences can justify opening a bounded v1.1 review docket.

Acceptance conditions for the next Tier 0 rehearsal

- Public accessible Candidate Note clearly marked preparatory.
- Paid, plural and accessible listening routes designed with independent community support.
- No use of real patient data or changed care workflow during the tabletop.
- Named institutional duty-holders, boundary support and independent safeguards participants.
- A live Operational Metabolism Ledger opened before preparation begins.
- Explain-back tested without blaming participants; least-understood group results remain visible.
- Actual time, compensation, opportunity cost, paperwork ownership, reviewer load, queue time and delay harm recorded.
- Both rupture channels rehearsed, with refusal and no-contact options protected.
- Dissent and minority positions appended without forced resolution.

Canonical record and AI disclosure

Sahely, B. (2026). *Transformational Laboratories Protocol v1.0: From Civilizational Healing Theory to Bounded, Life-Grounded Praxis—with Living Coordination as the Necessary Affective-Relational Substrate*. Zenodo.

<https://doi.org/10.5281/zenodo.22230642>

The DOI identifies the deposited Protocol v1.0. This rehearsal report is subordinate, synthetic and non-authorizing.

AI DISCLOSURE

This rehearsal report was drafted and stress-tested with AI assistance under human direction. AI supported synthesis, adversarial role rehearsal, structure and document production; it did not provide affected-community testimony, consent, authorization, independent clearance or empirical validation. Bichara Sahely retains responsibility for scholarly judgment, publication and any future use. AI capability confers no political, ethical, legal or gate authority.

Closing question

Can responsibility, resources, understandable authority and usable remedy travel across institutional boundaries with the person—without turning that person or their caregiver into the carrier of the system’s unresolved coordination burden?