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On clinical judgment in intensive care

Dear colleagues,

I founded SIJILL with a particular concern about how decisions are reviewed in intensive care. At morning rounds, the chart may show a laboratory result beside the time the specimen was drawn, although the result reached the unit hours later. A physician accounting for an overnight decision deserves a record that preserves that distinction.

That principle informs how we present clinical guidance. Before acting on a recommendation, a physician should be able to read the source passage, identify the findings that brought it into consideration and judge whether it applies to the patient. If the physician defers a proposal, the reason should remain available to the colleague who next reviews the patient.

Responsibility for follow-up deserves the same precision. A pharmacist may read a preliminary culture report while final susceptibilities are outstanding. In our current stewardship build, the pharmacist records acceptance of the follow-up separately. If a later report changes the basis for the original decision, the task stays open for clinical reassessment. We have tested this sequence locally on controlled data. Hospital integration and clinical validation remain ahead of us.

I would welcome correspondence from colleagues who have had to settle these questions in their own units. I am particularly interested in how your service records an exception to protocol and how the incoming team learns when that decision should be reconsidered.

Yours sincerely,

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