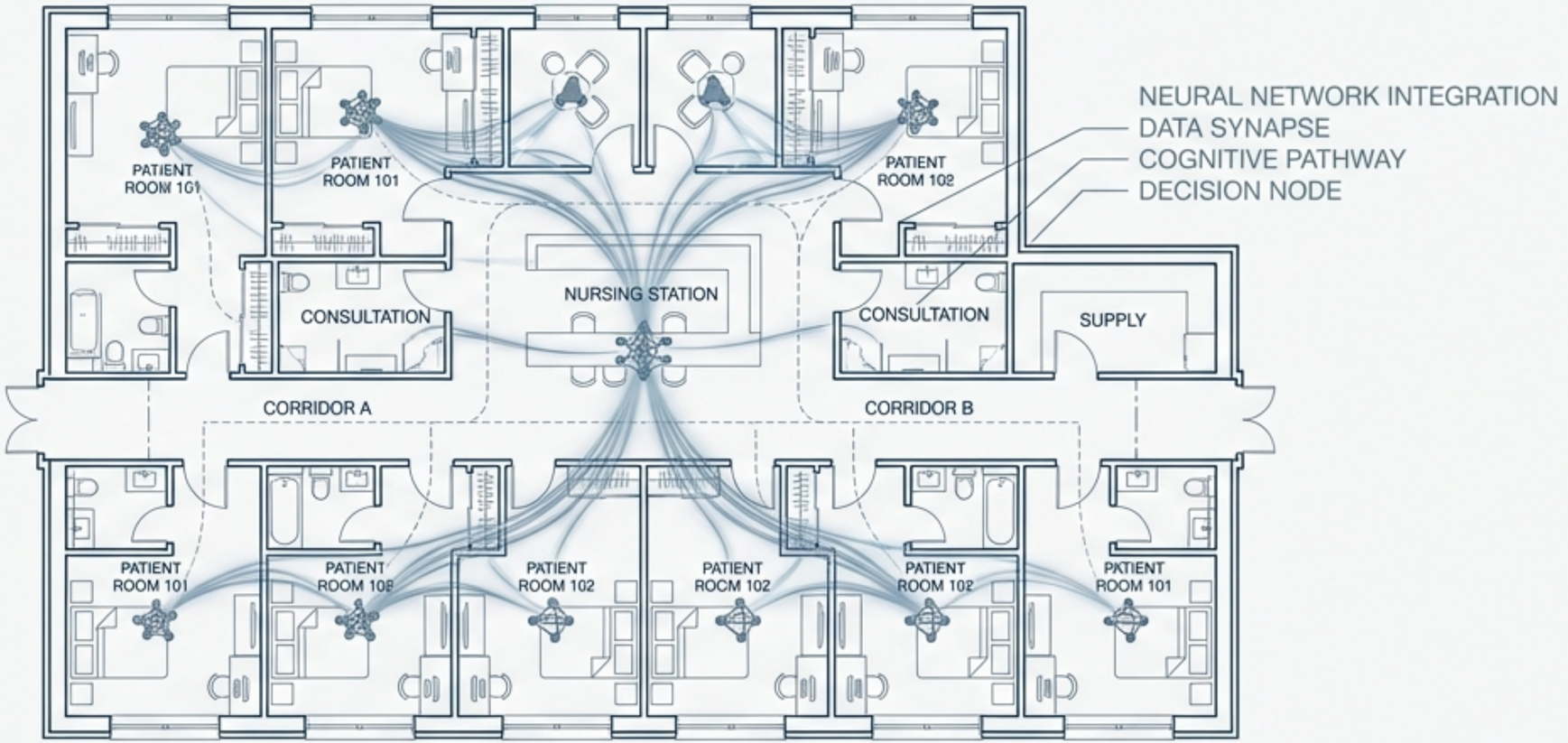
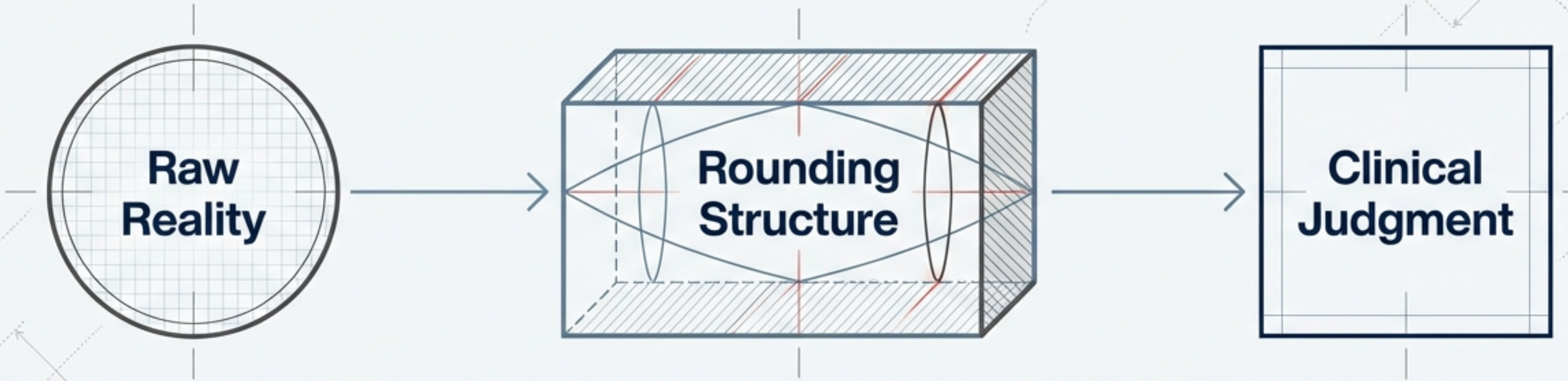
THE ARCHITECTURE OF CLINICAL JUDGMENT

How Rounding Structures Shape Medical Reality



BASED ON THE WORK OF WILLIAM AIRD

Structure Is Not Neutral



Rounds are not just a way to visit patients; they are a way of organizing reality.

The structure privileges certain information and backgrounds others.

Over time, these logistics shape not only workflow but judgment itself.

The Inversion of Discovery

Historical Model (Discovery)

We enter to discover.

Modern Model (Verification)

We enter to verify.

In modern consult practice, high-resolution data precedes the bedside. Before entering the room, the consultant already knows the CBC trends, smear description, Ferritin/LDH/INR, and unit location.

Impact: We no longer enter the room to discover the problem. We enter to test, humanize, or challenge a terrain we have already defined. The exam shifts from discovery to confirmation.

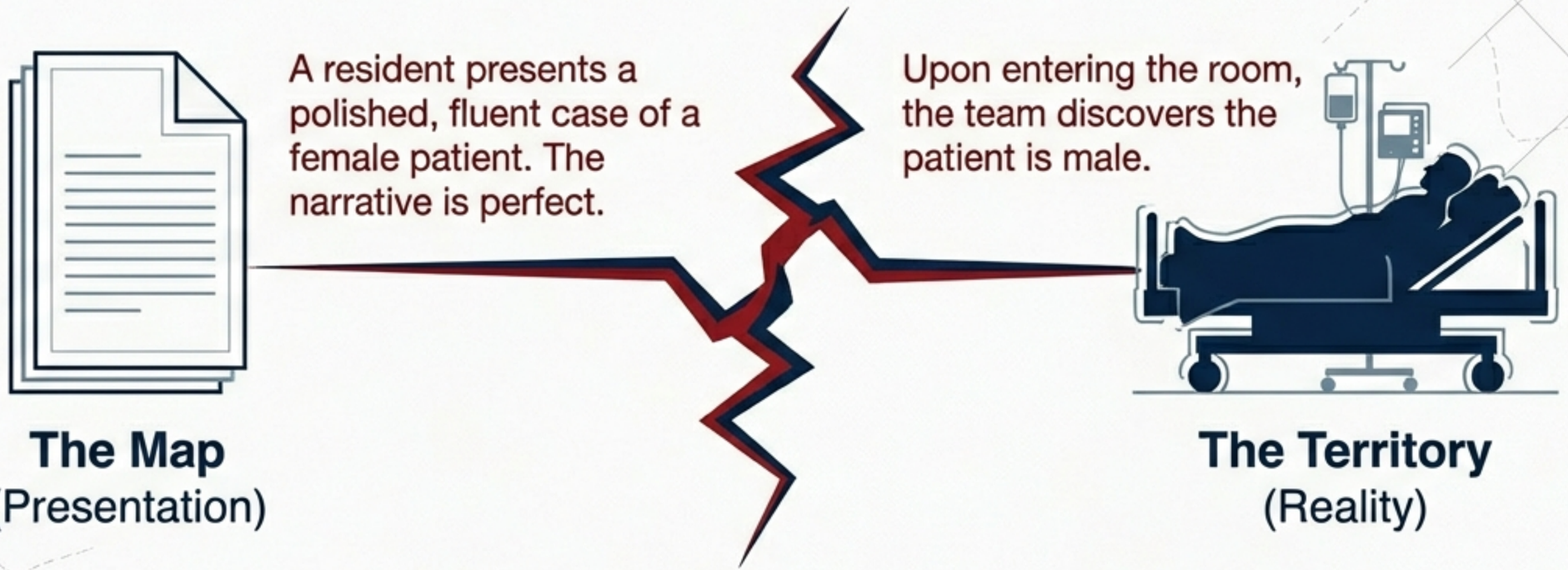
The Terrain of Attention

Computer-First vs. Bedside-First

Bedside-First Rounds	Computer-First Rounds
Privilege • Gestalt assessment • Human connection / Trust • Shared reality • Detecting subtle instability	**Privilege** • Lab trends • Temporal patterns • Physiological trajectories • Early signal detection
Risk • Underweighting silent trends • Anchoring on appearance • Delayed integration of trajectory	**Risk** • Distancing from context • Overconfidence in numbers • Missing discordant bedside clues

The danger is not choosing one style, but failing to recognize the blind spots of the one you choose.

When Presentation Replaces Presence



This was not dishonesty; it was structural drift. The presentation had become a surrogate for presence; the chart had become a proxy for reality.

Key Insight: In some structures, seeing the patient becomes optional. When the narrative is too polished, we risk mistaking the map for the territory.

Expertise as a Filter

The Student (Epistemology)

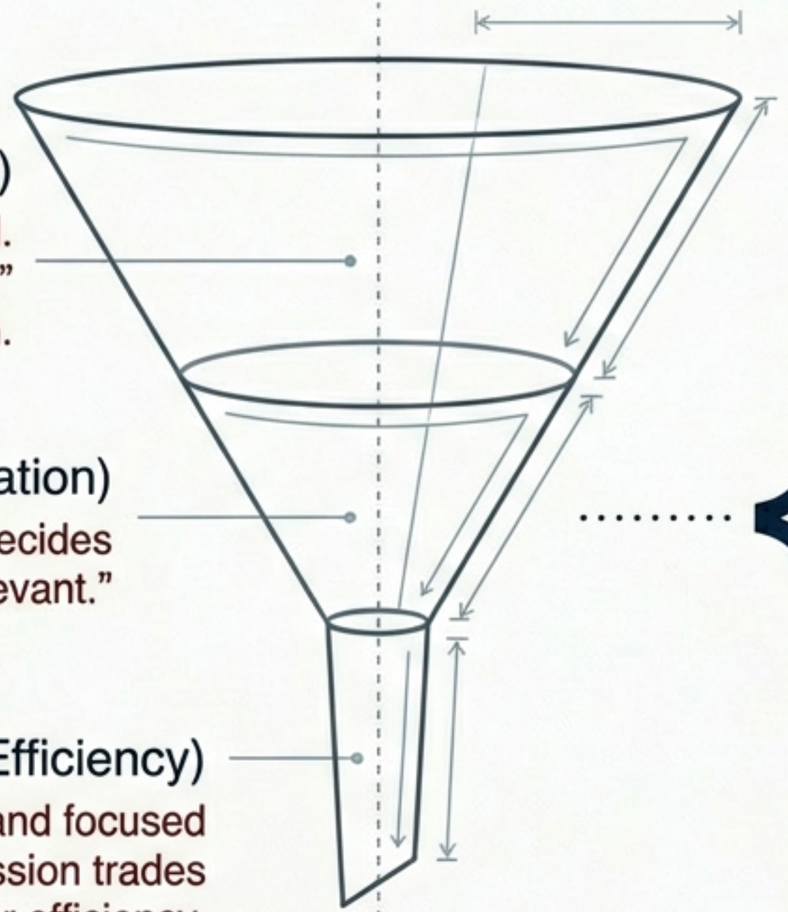
Presents full history & physical. Learning “what might matter.” High breadth.

The Resident (Prioritization)

Summarizes and filters. Decides what is “probably irrelevant.”

The Fellow (Efficiency)

Presents only key labs and focused assessment. Compression trades breadth for efficiency.



The Paradox

Expertise teaches you what to ignore to speed up Orientation.

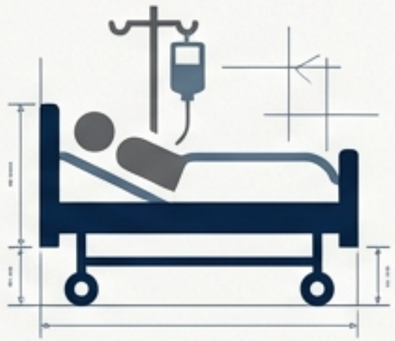
But this compression narrows the field of possible signals.

What is filtered out is possibility.

Geography as Cognitive Terrain

The ICU

Data and trajectory dominate. Bedside exam is for stability, not discovery. Sedation and lines restrict the exam.



The Ward

Appearance matters. Accessible patients allow history to shift the terrain.

The ED

Tempo dominates. Uncertainty tolerance is low; Orientation is provisional.

Labor & Delivery

Access is restricted. Friction points delay presence.

These environments don’t just change logistics; they change how judgment is formed.

The Impact of Time and Barriers

Time as a Force

Rushed Rounds: Favor closure, heuristics, and rapid synthesis.

Unhurried Rounds: Permit revision, second looks, and deliberation.

- **Insight:** Time pressure limits how much uncertainty can be tolerated.

Physical Barriers (PPE)

Impact: Slows entry, limits team size, fragments shared observation.

- **Insight:** Discussion moves outside the room; the bedside becomes less central to collective perception.

The Social Environment

How presence and hierarchy dictate safety.

Family Presence

Changes the performance of confidence.

Trainees may suppress provisional thinking.

It alters what reasoning is ‘socially safe’ to display.

Culture of Deference

Canadian / Oral Exam Model

Adversarial but collaborative.
Errors are tested.

U.S. Deference Model

Polite acceptance.
Errors go untested.

Risk: Deference can quietly replace shared responsibility. A healthy culture requires permission to think independently in the presence of authority.

Technology: The Redistributed Consult

The Microscope

A site where **Orientation** is socially constructed.

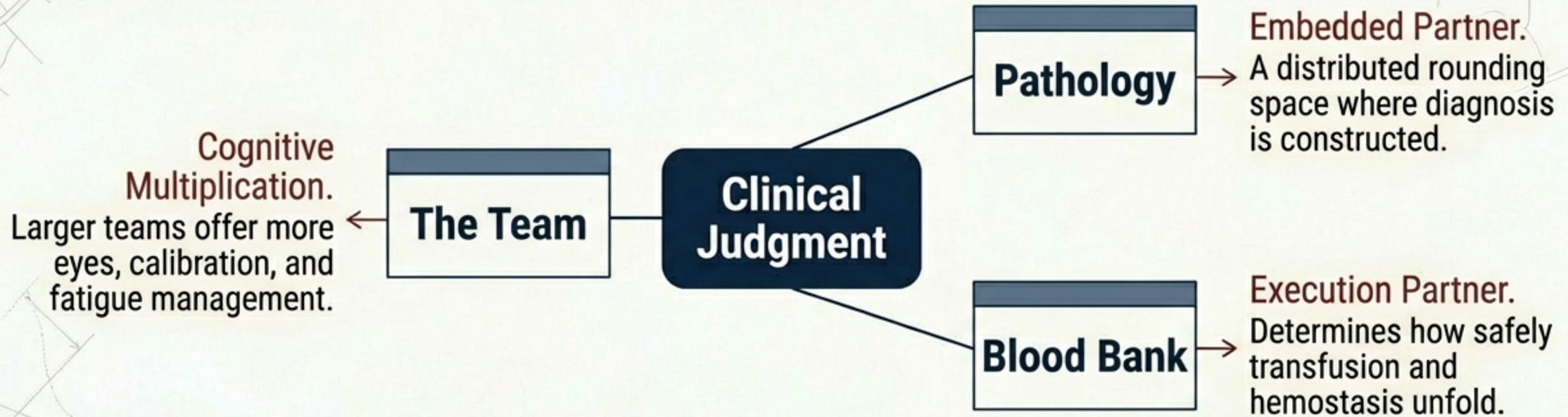
Who drives the scope (Fellow vs. Attending) determines who frames the field and curates attention.

The iPhone

Diagnostic presence becomes portable, but contextual presence recedes. We see the smear, not the patient.

- **Insight:** Technology redistributes clinical responsibility across distance and devices.

Distributed Cognition



These are not ancillary services. They are parts of the "Extended Mind" of the medical team.

The Borderlands

When the map doesn't match the territory.

Hematology

- Iliac Vein Thrombosis
- Massive PE
- Extensive Femoral Clot

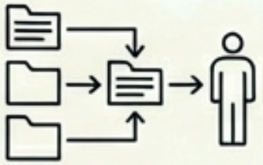
Vascular Medicine

The Problem: The clot has one physiology. The institution has two maps.

- Duplicated data review
- Parallel risk stratification
- Diffuse responsibility
- Ambiguous ownership of anticoagulation strategy

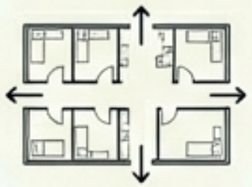
The Invisible Architecture

A Synthesis of the Cognitive Operating System



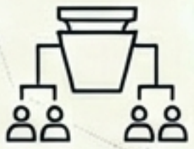
Sequence Does data precede the patient? (Inversion of Discovery)

Format Does presentation replace presence? (Compression)



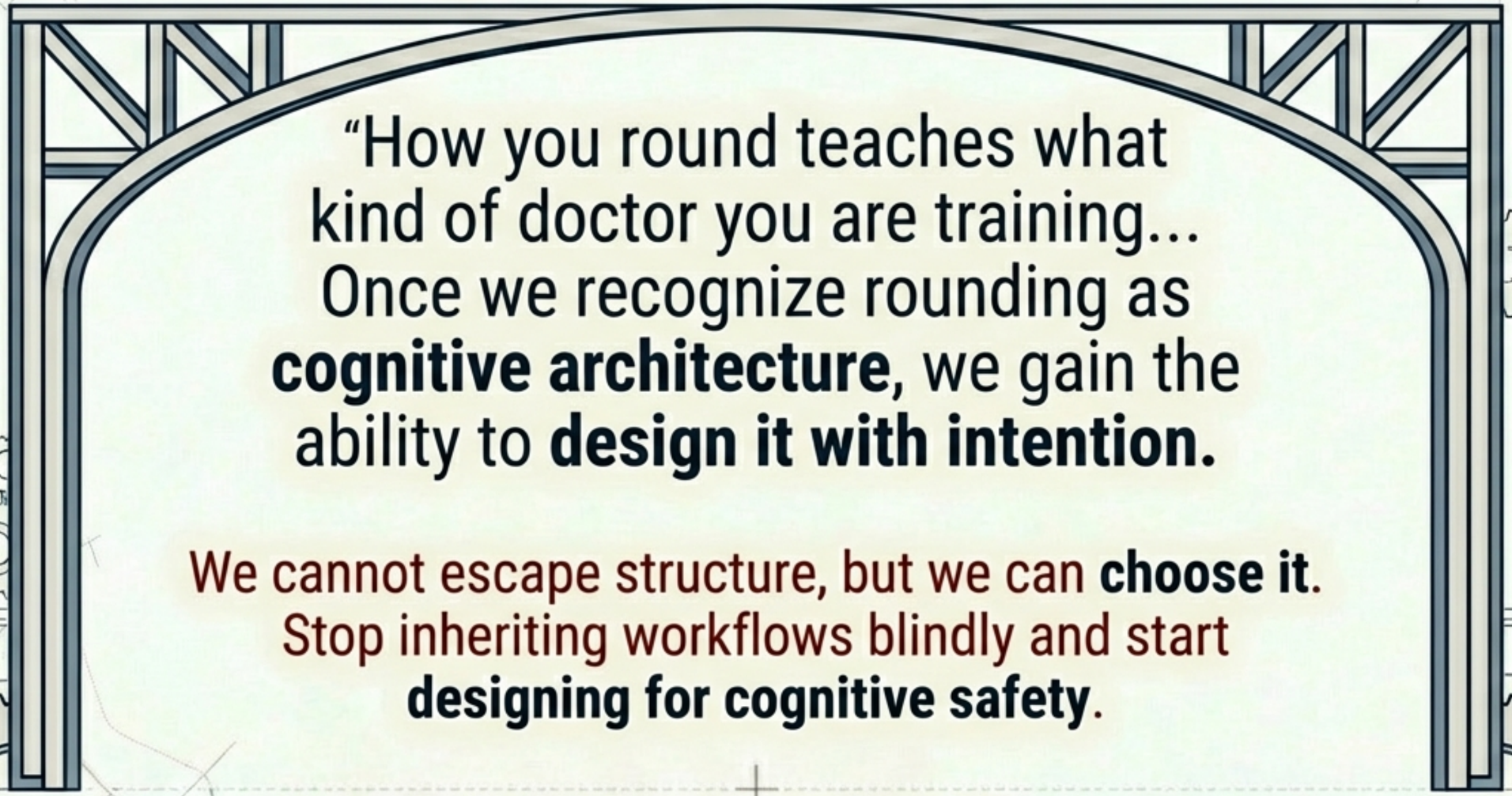
Space Does the unit dictate the thinking? (Geography)

Tools Does the tech redistribute presence? (Microscope/iPhone)



Culture Does deference silence safety? (Social Environment)

Designing with Intention



"How you round teaches what kind of doctor you are training... Once we recognize rounding as **cognitive architecture**, we gain the ability to **design it with intention.**

We cannot escape structure, but we can **choose it**.
Stop inheriting workflows blindly and start **designing for cognitive safety**.

Sources

The Architecture of Clinical Judgment in Consult Practice

By William Aird

Excerpts on How Consult Rounds Shape Clinical Judgment