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Tea Break Decisions: Informal Clinical Judgment in Orthopaedic Practice

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Learning Point of the Article:

Informal clinical discussions are an important part of orthopaedic decision-making, but experience and intuition should complement, rather than replace, evidence-based practice and professional accountability.

Not every orthopaedic choice is made in a quick succession.

Some emerge in more subdued settings, over a cup of tea, in the few minutes between cases, or in an unplanned discussion with a coworker. A straightforward question like "What would you do?" can sometimes start a conversation that is just as beneficial as a comprehensive set of rules [1].

These kinds of situations are not unusual. They frequently occur in routine orthopaedic practice without being officially acknowledged as a component of clinical decision-making.

Orthopaedic practice decisions are sometimes influenced by intuition and gut feeling rather than logic alone. Many are formed in informal settings... corridors, scrub rooms, post-round breaks and, quite often, tea breaks. Although they may seem light-hearted, these exchanges have deeper meanings. They depict a form of clinical judgment which is rapid, experience-based and highly contextual. Studies investigating surgical decision-making have found that clinicians often combine the evidence, experience, and contextual interpretation instead of following a protocol strictly alone [1,2].

It is simple to doubt the legitimacy of such decisions. Modern evidence-based medical practice calls for standardization and documentation. Theoretically, every decision should be a data decision, literature-supported, and reproducible in a different setting. Actually, that is not always permissible in orthopaedics. The fracture patterns can vary, patient variables will change, and intraoperative findings will seldom follow a script. In these cases, experience starts to do the work of evidence. Heuristics and cognitive shortcuts play a vital role in medical decision-making, particularly in time-sensitive and complex environments.[3]

The nature of these informal conversations is not some wild speculation. It is all about recognizing patterns. Surgeons have a mental picture of other cases, their successes, their complications, and the little tweaks that are never formally recorded. During a conversation, a suggestion will be given. This suggestion is a culmination on an enormous clinical memory. Thus, it only requires a few words to condense this message. Clinical knowledge is usually applied through internalized experience rather than the active recall of guidelines [2].

There is a social aspect, too. Orthopaedic practice is a group endeavor where discussions; however informal, permit the rapid transport of ideas without hierarchy or structure. A junior might create a problem. An elderly may supply a cursory commendation. Some individuals may incorporate alternations. These relationships shape not only choices, but also learning. They shape judgment more so than formal teaching sometime can. The frameworks of shared decision-making in orthopaedics

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highlight the important role of dialogue and context in clinical decisions [4].

Surgical decision-making is seldom governed by intuition or analytical reasoning alone. Experienced surgeons frequently move between these two approaches, drawing upon pattern recognition when situations are familiar and adopting more deliberate reasoning when unexpected findings arise. Crebbin et al. describe this interaction as an important characteristic of expert surgical judgement, particularly when decisions must be made despite incomplete information [5]. This reinforces the importance of recognising clinical experience as a valuable component of surgical decision-making without allowing it to replace critical evaluation.

Nonetheless, this method carries some risk. Bias, personal preference and authority weight impact informal decisions. A confident opinion may be accepted with little or no questioning. Discrepancies between surgeons may lead to differing solutions to the same problems. What works in one context often does not work in another. Lack of evidence makes it difficult to analyze or criticize such decisions. Recent qualitative analyses show that variability in orthopaedic decision-making has significant implications [1].

The goal is not to take these instances away but to acknowledge their positioning. Guidelines do not reduce orthopedics. Other factors necessitate informal clinical judgment. At the same time, it must remain anchored to sound principles and to evidence. Let experience guide you, not override you. Evidence ought to inform, not restrict.

It may be the catch … !

A slide is not necessary for every decision.

Nevertheless, responsibility must still be borne for each choice.

Ultimately, things that are said in a short gap between cases may not come on record, but often they enter practice. Once it has been done, it becomes the surgeon's mode of thinking; quiet, unrecorded, yet permanent.

Declaration of patient consent: The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given the consent for his/ her images and other clinical information to be reported in the journal. The patient understands that his/ her names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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