# Beyond the Monitor: A Phenomenological Study on the Lived Experiences of Healthcare Practitioners on Clinical Decision-Making in Intensive Care Units

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## ABSTRACT

Decisions in the intensive care unit (ICU) are made quickly, with incomplete information, and often with fewer resources than the situation calls for. This study described how healthcare practitioners in Pangasinan, Philippines, experience clinical decision-making in the ICU. A qualitative, descriptive phenomenological design was used. Five licensed ICU practitioners, two physicians and three nurses with three to fifteen years of service in government and private hospitals, were recruited through snowball sampling and took part in semi-structured, in-depth interviews. The interviews were audio-recorded, transcribed verbatim, and analyzed with Colaizzi's seven-step method. Credibility, transferability, dependability, and confirmability were addressed through member checking, a reflective journal, an audit trail, and peer debriefing. Four themes emerged: Between the Numbers and the Gaze (analytical and intuitive reasoning), Deciding Under Scarcity (structural and resource constraints), The Weight of the Team (collaboration and hierarchy), and What the Decisions Leave Behind (lessons and moral weight). Participants treated monitors as a second opinion, trusted bedside vigilance and experience-based pattern recognition, and described staffing, equipment, laboratory delays, and family finances as forces that shape what a feasible decision looks like. Nursing surveillance worked as an early warning system, although hierarchy could slow the voicing of concerns. Near-misses left lasting lessons, and honest communication with families and the emotional labor of care carried a moral cost. The study concludes that ICU decision-making extends beyond the monitor. It recommends a review of staffing ratios, clear resource-allocation guidance, structured debriefing and escalation mechanisms, regular evaluation of monitoring systems, and larger multi-site research.

**Keywords***:* clinical decision-making, intensive care, phenomenology, nursing surveillance, Colaizzi's method, Philippines

## INTRODUCTION

### Background of the Study

Clinical decision-making is the process through which healthcare practitioners gather patient information, interpret findings, weigh treatment options, and act. It draws on professional knowledge, experience, critical thinking, and evidence-based guidelines. Monteiro et al. (2022) described effective decision-making as the ability to synthesize clinical knowledge, patient data, and context, and Rosen et al. (2018) linked sound decisions and good collaboration to patient safety and fewer preventable errors. Few settings test these abilities as hard as the ICU, where patients arrive with severe infection, respiratory failure, cardiovascular instability, and multiple organ dysfunction. A practitioner may need to recognize septic shock and start resuscitation within the first hour, judge whether a patient is ready to come off a ventilator, or lead a goals-of-care conversation with a family facing an uncertain prognosis. Vincent et al. (2021) stressed that early decisions in intensive care improve survival and recovery.

An ICU decision is rarely a single choice taken from a protocol. It depends on recognizing deterioration early, combining measurements with what is seen at the bedside, communicating concern across professional roles, and reassessing after each intervention. Kim et al. (2026) described nursing surveillance in intensive care as

monitoring and vigilance, detection and decision-making, collaborative communication, intervention and risk management, and interaction with information technology. Practitioners also work with data from physiological monitors, laboratory systems, imaging, electronic records, and connected bedside devices (Reader et al., 2022; Yakob et al., 2024, in a pediatric ICU study), which adds to the cognitive load of the work. Context shapes these decisions. In countries with advanced diagnostics, electronic records, and specialist services, practitioners have more tools, yet high acuity, information overload, communication failures, and delayed escalation still affect care. In developing countries, including the Philippines, shortages of staff, limited ICU capacity, inconsistent medicine supplies, and gaps in diagnostic services can narrow the options even when clinical judgment is sound (World Health Organization [WHO], 2023). The Philippine health system faces uneven distribution of services, limited infrastructure, and workforce imbalances (Dayrit et al., 2018). The Department of Health (2020) reported roughly 0.5 hospital beds per 1,000 population against a benchmark of 1.5, and Phua et al. (2020) reported about 2.2 ICU beds per 100,000 population, among the lowest in Southeast Asia. ICU occupancy in several regions reached 74 to 77 percent during periods of high demand (Department of Health, 2021). Filipino nurses in such settings report heavy workloads, emotional stress, and high clinical demands (Labrague & de los Santos, 2021). The manuscript cites these figures as reported by the original sources.

Pangasinan is one of the largest and most populous provinces in Northern Luzon. Its provincial, district, private tertiary, and specialty hospitals serve residents and patients from neighboring provinces, and local government units play a part in financing and equipping them (Capuno et al., 2019). Existing work leaves a gap here. Abad et al. (2018) studied Filipino physicians' decision-making across hospital departments, not the multidisciplinary experience of ICU teams. Hunter et al. (2023) examined how ICU culture affects nurses' handling of high-risk vasoactive medications, and Wubben et al. (2021) examined shared decision-making among ICU physicians, nurses, patients, and families. Little research has asked ICU practitioners in regional Pangasinan what making critical decisions is actually like. A phenomenological approach suits that question because it centers the practitioner's own account.

### Significance of the Study and Researcher's Background

The findings are expected to help ICU physicians and nurses, other healthcare practitioners, the Provincial Health Office, the Department of Health, hospital associations and administrators, educators, policy makers, patients and their communities, future researchers, and the researcher. For clinicians, the study may support better reasoning, escalation, and teamwork. For administrators and policy makers, it offers practitioner-level evidence on staffing, equipment, and critical care standards. For educators, it supplies real cases for curricula and simulation. The researcher is a Bachelor of Science in Nursing graduate of Virgen Milagrosa University Foundation. During clinical rotations at the Pangasinan Provincial Hospital ICU he observed a team managing septic shock, a ventilator-management discussion for a patient with acute respiratory distress syndrome, and family conferences on prognosis and goals of care. These observations showed him the technical, emotional, and ethical sides of ICU decisions and motivated the study.

### Statement of the Problem

The study aimed to explore the lived experiences of healthcare practitioners in making clinical decisions within ICUs. It sought answers to four questions: (1) how practitioners experience the process of making clinical decisions while managing critically ill patients; (2) what challenges affect their ability to decide in a timely and effective way under pressure; (3) how collaboration, nursing surveillance, and professional hierarchy influence their decisions; and (4) what lessons they have drawn from these experiences and how those lessons shaped their practice. Each question corresponds to one of the four themes reported below.

## METHODOLOGY

### Research Design

The study used a qualitative phenomenological design. Qualitative inquiry seeks the meaning behind behavior

and decisions through descriptive data, and Creswell and Poth (2018) emphasize context, reflexivity, and the shared construction of meaning between researcher and participant. Phenomenology describes and interprets lived experience from the first-person view in order to identify its essence. Moustakas (1994) offers the guiding framework through openness, bracketing, and imaginative variation. Data came mainly from in-depth, semi-structured interviews in which participants narrated their experiences in their own words. Analysis began with horizontalization, in which every statement relevant to the phenomenon is first given equal weight before significant statements are selected, meanings formulated, and related meanings clustered into themes.

**Research Setting**

Five hospitals in Pangasinan were considered for recruitment, four private and one government. One declined to take part, and recruitment proceeded in the others. The Pangasinan Provincial Hospital in San Carlos City is a government Level II facility with an authorized capacity of 250 beds, according to the 2025 PhilHealth accreditation list. Blessed Family Doctors General Hospital (about 75 beds) and Virgen Milagrosa Medical Center (50 beds), both private Level II hospitals, are also in San Carlos City. Allied Care Experts (ACE) Medical Center Pangasinan, a private Level II hospital with about 100 beds, is in Dagupan City. Each operates an ICU with patient monitoring, mechanical ventilation, and infusion devices, staffed by physicians, nurses, and allied health professionals.

**Participants and Sampling**

Snowball sampling was used because practitioners with relevant experience are most readily found through peer referral (Watkins, 2023). Eligible participants were licensed physicians or nurses in direct ICU patient care, with at least six months of continuous ICU experience, involved in clinical decision-making such as diagnosis and treatment planning, and willing to give informed consent and describe their experiences. Recruitment aimed for at least five participants, within the range of 5 to 25 commonly cited for phenomenological work, and was to continue until saturation, meaning no new themes or insights emerged. Sampling adequacy was monitored throughout and discussed with the research adviser. Table 1 shows the five participants, who are identified by code to protect their identities.

**Table 1**

*Participants' Profile*

| Code | Type of hospital | Profession | Years of service |
|---|---|---|---|
| Participant 1 | Government | Physician | 8 |
| Participant 2 | Private | Physician | 12 |
| Participant 3 | Private | Nurse | 6 |
| Participant 4 | Government | Nurse | 15 |
| Participant 5 | Private | Nurse | 3 |

**Data Collection**

Approval was obtained from the Dean of the Graduate School before data collection. A preliminary meeting with each prospective participant verified eligibility, explained the purpose and procedures, and secured informed consent. Interviews were face-to-face, held at times and in private places the participants chose, and lasted about 45 to 60 minutes. The researcher asked open-ended questions and used neutral probes such as "Can you describe what happened?" and "What factors influenced your decision?" Interviews were audio-recorded with permission and followed by a short debriefing so participants could clarify or add to their answers. Recordings were transcribed verbatim, and the researcher wrote reflective memos after each interview. Collection and analysis ran together, so emerging insights could inform later interviews. The excerpts reported in the manuscript mix Filipino and English and are accompanied by English translations.

### Trustworthiness and Audit Trail

Credibility was supported by rich interview data, repeated listening to recordings, iterative transcription and

interpretation, field notes, saturation, and member checking, in which summarized findings went back to participants for confirmation. Transferability was addressed through thick description of the setting, methods, and informants. Dependability rested on documenting each phase from interview preparation to validation. Confirmability relied on a reflective journal, an audit trail, peer debriefing, and informant feedback. The audit trail followed three phases. In Discover, the scope, sampling strategy, data collection methods, and approvals were set. In Develop, the researcher immersed in the transcripts, coded significant statements, clustered meanings into themes, built an exhaustive description and fundamental structure, and returned them to informants. In Deploy, the shared insights were synthesized into a conceptual model of the experience.

### Ethical Considerations and Data Management

The study proceeded after approval from the appropriate ethics body and observed beneficence and non-maleficence, autonomy, and justice. Participants' psychological and emotional well-being was monitored, consent was treated as ongoing, and withdrawal carried no penalty.

Accounts were reported without fabrication or alteration. Names were left out of transcripts, interviews were coded, and files were kept in password-protected folders on an external drive that only the researcher could open, in line with the Data Privacy Act of 2012 (Republic Act No. 10173). The manuscript notes that practitioners could be identified from their roles or workplaces, so particular care was taken over anonymity.

### Data Analysis

Analysis followed Colaizzi's (1978) seven-step method, summarized in Table 2. The steps move from familiarization with the data to a fundamental structure that is checked against the participants' own experience.

**Table 2**

*Colaizzi's (1978) Method of Data Analysis*

| Step | Action | Purpose |
|---|---|---|
| 1 | Read and re-read descriptions | Gain a general sense of the experience |
| 2 | Extract significant statements | Identify statements that bear directly on the phenomenon |
| 3 | Formulate meanings | Surface the meanings embedded in each statement |
| 4 | Cluster themes and validate against original text | Group shared experiences and check them against transcripts |
| 5 | Write an exhaustive description | Capture the phenomenon in full |
| 6 | Produce the fundamental structure | Remove what is not essential and state the core of the experience |
| 7 | Return to informants | Validate the structure and incorporate feedback |

## RESULTS AND DISCUSSION

Colaizzi's analysis produced four themes, each with three subthemes (Table 3). Participants' own words, as translated in the manuscript, anchor each theme, and each is set against related literature to show where the findings agree with or extend earlier work.

**Table 3**

*Themes and Subthemes*

| Theme | Subthemes |
|---|---|
| I. Between the Numbers and the Gaze | The monitor as second opinion, not the final word; bedside vigilance and the nursing "gut feeling"; pattern recognition forged by experience |
| II. Deciding Under Scarcity | Staffing ratios and the weight of too many patients; equipment, supply, and diagnostic delays; financial strain and family-mediated delays in care |
| III. The Weight of the Team | Nursing surveillance as an early warning system; breaking the silence across a hierarchy; senior practitioners as advocates for junior voices |
| IV. What the Decisions Leave Behind | Learning from near-misses and missed signals; honesty over false reassurance with families; the unspoken emotional and moral labor of the ICU |

### Theme I: Between the Numbers and the Gaze

Participants described good decisions as a blend of objective data, direct observation, and experience. They did not set numbers against instinct.

### The monitor as second opinion, not the final word

Monitors were valued for trends and confirmation, but not as the starting point. As one physician put it, "The monitor is a tool, not a diagnosis." A senior nurse said that early in her career the monitor came first, whereas now "my assessment comes first and the monitor follows." Yee (2023) described ICU decision-making as assessing the situation, recognizing cues, interpreting data, and drawing on prior knowledge, which supports reading monitor values alongside the patient. Küpper et al. (2026) likewise treated technical devices as central to ICU work while noting thin evidence on how they shape decisions between nurses and physicians.

### Bedside vigilance and the nursing "gut feeling"

Two accounts show how bedside observation can run ahead of the numbers. One participant described a post-operative sepsis patient whose vital signs looked "textbook stable," yet something in the patient's appearance prompted immediate escalation. Another noticed a slight slowing in a patient's responses before anything flagged on the monitor, held the next diuretic dose, and called the resident early. Participants presented the gut feeling as awareness built through close observation. Jensen et al. (2022), in a scoping review of hospitalized paediatric patients, found that nurses' concern about deterioration is triggered by changes in behavior, color, pain, and general appearance, and described gut feeling as both a response to signs and a form of knowledge gained through experience.

### Pattern recognition forged by experience

A nurse with fifteen years of service said she trusts pattern recognition "more than almost anything else" and can sense a problem while walking past a bed, although she cannot always explain it to newer staff. A physician described changing a ventilation strategy earlier than the protocol required because a patient's oxygenation kept declining despite what the algorithm indicated. Lavoie et al. (2024) interviewed 39 experienced ICU nurses about bleeding after cardiac surgery, using the Recognition-Primed Decision Model, and found that expertise let them read cues, anticipate needs, and adapt, and Dehghani (2024) emphasized the nurse's capacity to assess situations and make appropriate judgments. Taken together, the subthemes suggest that intuition in the ICU is trained perception that prompts reassessment and escalation, supported by data and not replacing it.

### Theme II: Deciding Under Scarcity

The second theme concerns the distance between what a patient needs and what can be delivered in time.

### Staffing ratios and the weight of too many patients

One participant said that on a bad night a single nurse may be assigned four or five ICU patients, and that ventilators are sometimes shared while dialysis slots are limited. Another called staffing ratios among the biggest challenges, sometimes more than the clinical problems themselves. When two patients become unstable at once, the nurse must choose who comes first, "even though that may not be ideal for either patient." Li et al. (2025), reviewing 70 observational studies with more than 56,000 ICU patients, found substantial nursing workload and argued for staffing models that follow actual workload, not fixed ratios. Padilha et al. (2025) found wide variation in patient-to-nurse ratios across ICUs in ten countries. Aytona et al. (2022) reached a similar conclusion for Philippine primary care facilities, although that study did not involve ICUs.

### Equipment, supply, and diagnostic delays

Participants described working around missing or shared equipment. A nurse recalled not having enough infusion pumps, which forced manual recalculation of drip rates and manual titration, "time that you simply do not have when a patient is crashing." Another said delayed laboratory results sometimes push the team to consider less expensive alternatives or to decide before the picture is complete. Odongo et al. (2025) found that ICU resource capacity influenced decisions about life-sustaining treatment, and Reader et al. (2022) framed patient safety as the product of interacting organizational and system factors, which fits participants' view that decisions are made inside a system and not outside it.

### Financial strain and family-mediated delays in care

Because medicines, laboratory tests, and procedures are often paid for out of pocket, families may need to raise money before treatment can begin. When several relatives share the decision, agreement can take time too. One participant observed that some delays have nothing to do with equipment or staffing and come from the family's finances and decision process. Practitioners responded by explaining urgency clearly, offering options, and helping families reach a decision. Loue (2020) discussed the ethical complexity of family involvement when relatives disagree, and Dans et al. (2024) documented out-of-pocket spending among Filipino patients, which gives context to what participants described. The theme as a whole points to a gap between the ideal decision and the feasible one.

## Theme III: The Weight of the Team

Participants saw ICU decisions as collective. The quality of a decision depended on whether information moved quickly across roles and ranks.

### Nursing surveillance as an early warning system

A physician recalled that the bedside nurse spoke first, saying "Doc, I don't like how he looks," before the physician had reached the patient, and added that such observations shape the direction of a decision more often than people outside the unit realize. A nurse described resisting a resident's plan to move a patient from the ICU to the ward because of what she saw at the bedside and not only what the chart showed. The patient stayed another day, and the decision later proved right. Rossetti et al. (2021) described a decision support system that treated nurses' documented concerns as an indicator of possible deterioration, which agrees with participants' claim that nurses often detect change before conventional indicators do.

### Breaking the silence: speaking up across a hierarchy

Participants acknowledged that nurses sometimes hesitate to raise concerns for fear of being dismissed or seen as overreacting. One nurse said that early in the career she second-guessed her instincts for that reason, and learned over time to trust them. A physician said that when a nurse voices concern, the team takes it seriously because nurses are often first to notice change. O'Donovan, De Brún, and McAuliffe (2021) found that leadership, relationships, and feeling valued influence whether professionals speak or stay silent, and Okuyama et al. (2014) described speaking up as an important patient-safety behavior shaped by interpersonal and

organizational factors.

**Senior practitioners as advocates for junior voices**

Senior participants described it as part of their role to protect the voices of newer nurses. One said that when a junior nurse raises an observation, the senior team validates it, discusses it respectfully, and acts if needed. Another said she backs up newer nurses who hesitate to approach physicians because "the information cannot help anyone if it is not communicated." These accounts match the evidence that supportive environments encourage voice (O'Donovan et al., 2021) and that teamwork depends on information exchange and mutual support (Rosen et al., 2018).

**Theme IV: What the Decisions Leave Behind**

The last theme looks at what practitioners carry forward after a decision has been made.

**Learning from near-misses and missed signals**

Two participants described early-career errors that changed their practice. One failed to notice gradual deterioration because she trusted the chart over the patient, and now checks vital signs against what she sees at the bedside every time. Another nearly sent a patient to a lower level of care because the numbers looked acceptable, until a senior nurse asked whether she had actually checked the patient. The question stayed with her. These accounts echo Lavoie et al. (2024), who found that experienced nurses integrate multiple cues and accumulated knowledge instead of relying on isolated measurements, and Rossetti et al. (2021), who showed that nurses' narrative concerns can carry information that physiological monitoring misses.

**Honesty over false reassurance with families**

Participants said they have become more direct with families and try to hold difficult conversations earlier. One preferred an honest conversation about uncertainty to reassurance that would later have to be withdrawn. Another separated what is known from what is still being awaited, and observed that families can tell the difference and trust clinicians more for it. Edward et al. (2020) and Reifarth et al. (2023) both described the complexity of ICU family communication and the need for clear, structured, family-centered information that recognizes emotional needs.

**The unspoken emotional and moral labor of the ICU**

One physician spoke of "the moral weight of rationing care," and said every decision, even an apparently clinical one, carries it. A nurse described holding a family's hand while calculating a drip rate in her head, with nobody teaching how to do both at once. A senior nurse said much of her work now is deciding when to trust a junior colleague's assessment, when to step in, and when to let the junior work it out. Beheshtaeen et al. (2024) reviewed moral distress among critical care nurses, and Booth and Christian (2024) described moral residue that lingers after difficult cases. Both support the view that ICU work includes ethical and emotional labor that protocols do not capture.

**Integration of the Themes**

The manuscript presents the four themes as dimensions of one process. Analytical and intuitive reasoning supplies the clinical basis for a decision. Scarcity and the team around the practitioner shape what is feasible and how concerns are raised. The moral weight of the decision then carries into later practice. The review of literature adds that earlier studies often examine one professional group, one clinical problem, or one technology, and that workload research tends to be quantitative. The present study contributes an interprofessional account of how these factors interact in the experience of practitioners in a Philippine provincial setting.

The manuscript lists five ways in which the study differs from earlier work. It includes practitioners from different roles, which gives an interprofessional view where many studies focus on nurses alone. It looks at

routine as well as high-pressure ICU experience, whereas earlier studies often take a single clinical problem such as postoperative bleeding or end-of-life care. It treats technology as part of a wider process of judgment, communication, and bedside assessment, where much technology research evaluates one device or decision-support system. It explains how workload is lived, where workload research usually measures it. And it examines practicing ICU practitioners in Pangasinan, while Philippine work identified in the review has addressed decision-support technology and clinical judgment education. The manuscript is careful to say that intuition, technology, workload, communication, and family involvement have all been studied before. Its claim is that few studies bring these factors together in one phenomenological account.

### Answering the Research Questions

Each theme answers one of the guiding questions. In response to how practitioners experience decision-making, Theme I shows a continuous integration of monitor data, bedside observation, and experiential pattern recognition. In response to the challenges that affect timeliness, Theme II identifies staffing, equipment, diagnostic delays, and family finances, which together separate the ideal decision from the feasible one. In response to the influence of collaboration, surveillance, and hierarchy, Theme III shows that nurses' early detection is valuable only when it is voiced and heard, and that senior practitioners can make that more likely. In response to the lessons practitioners have drawn, Theme IV shows learning from near-misses, a commitment to honest communication, and recognition of the moral weight that decisions leave behind.

## CONCLUSION AND RECOMMENDATION

### Summary of Findings

The study explored the lived experience of ICU practitioners in Pangasinan using Colaizzi's method with five participants. Practitioners integrated monitor data, bedside observation, and experience, treating technology as support and not a substitute for judgment. Timely care was shaped by staffing, equipment, diagnostic access, and family finances, so that the ideal decision often gave way to the feasible one. Decisions were collaborative, with nurses frequently first to detect change, though hierarchy could slow communication and senior practitioners could ease it. Difficult cases became sources of learning, and honest communication with families and the moral weight of rationing care formed part of the work.

### Conclusions

The title, "Beyond the Monitor," reflects the central finding that ICU decision-making extends past monitoring technology. It integrates clinical data, bedside observation, intuition, experience, and judgment. It is also shaped by contextual factors such as staffing, resources, diagnostic access, and patients' finances, and practitioners often adapt decisions to what is realistically possible while maintaining care.

Effective decision-making depends on collaboration, open communication, and recognition of each practitioner's contribution. Continuous nursing surveillance and supportive professional relationships help the team recognize change and respond.

Finally, ICU decision-making carries professional, emotional, and moral weight. Difficult experiences promote learning, while uncertainty and resource limits can create moral burden. Good ICU decisions therefore call for clinical judgment, experience, teamwork, adaptability, and professional responsibility.

### Contribution of the Study

The study adds an account of ICU decision-making told by the people who make the decisions, in a province where little such work exists. It shows that the quality of a decision is bound up with the conditions around it: the resources at hand, the willingness of a team to listen, and the experience a practitioner brings to the bedside. The manuscript captures these links in its conceptual map, where the practitioner's responsibility to balance data with intuition while ensuring patient safety sits at the center, and analytical reasoning, scarcity, teamwork, and moral reflection form connected dimensions around it.

## IMPLICATIONS AND LIMITATIONS

The manuscript draws implications for four audiences. Nursing and medical education should cultivate analytical reasoning together with bedside observation and intuition, treating them as complementary. Administrators and policymakers should calibrate staffing ratios, equipment provision, and escalation protocols to provincial, resource-constrained ICUs and not model them only on better-resourced settings. Clinical practice should build mechanisms that let nursing surveillance and junior observations reach decision-makers quickly regardless of rank. For theory, frameworks developed in better-resourced settings may need adaptation before they are applied in similar Philippine contexts.

Three limitations apply. The sample of five practitioners is small, so the findings describe these participants' experiences and should not be generalized to all healthcare workers. The data are self-reported and may be affected by memory, interpretation, or a wish to present one's actions favorably. The findings also reflect the institutional and resource context of the participating hospitals, where staffing, equipment, hierarchy, and policy may differ elsewhere. Larger, more varied samples across several settings would strengthen transferability.

## RECOMMENDATIONS

The manuscript offers five recommendations, each addressed to the group best placed to act.

First, hospital administrators and the Department of Health should review ICU nurse-to-patient staffing ratios against appropriate critical care benchmarks and issue clear institutional guidelines for allocating limited equipment, medications, ventilators, dialysis slots, and other essential resources.

Second, nursing and medical education programs, together with hospital leadership, should provide structured case debriefings, facilitated reflection, and mentorship that let experienced practitioners share their reasoning with newer staff. Hospitals should also strengthen speaking-up mechanisms through graduated-escalation protocols and supportive communication across professional hierarchies.

Third, ICU professionals should practice reflective and collaborative care through case reflection, peer consultation, and interdisciplinary communication, especially after near-misses, unexpected deterioration, or difficult decisions. They should remain attentive to bedside observations and use clinical judgment to verify monitoring data when findings do not match what the technology shows.

Fourth, healthcare institutions should regularly evaluate the accuracy, availability, and reliability of monitoring devices and electronic health record systems, including safeguards against sensor errors, downtime, and inaccurate information. Direct bedside assessment should stay an essential part of decision-making.

Fifth, future researchers should conduct larger, multi-site, and where appropriate mixed-methods studies across a wider range of ICUs to examine staffing, equipment, diagnostic delays, and other resource constraints, and should explore moral distress among ICU practitioners and its effects on well-being, practice, and retention.

Taken together, the recommendations place responsibility at several levels. Institutions control staffing, equipment, and escalation structures. Educators and senior clinicians shape how reasoning and speaking up are taught and modeled. Practitioners decide each day whether bedside observation and monitor data are weighed together. Researchers can test, with larger and more varied samples, whether the experiences of these five practitioners hold in other ICUs.

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