Dweve
Weaving Intelligence

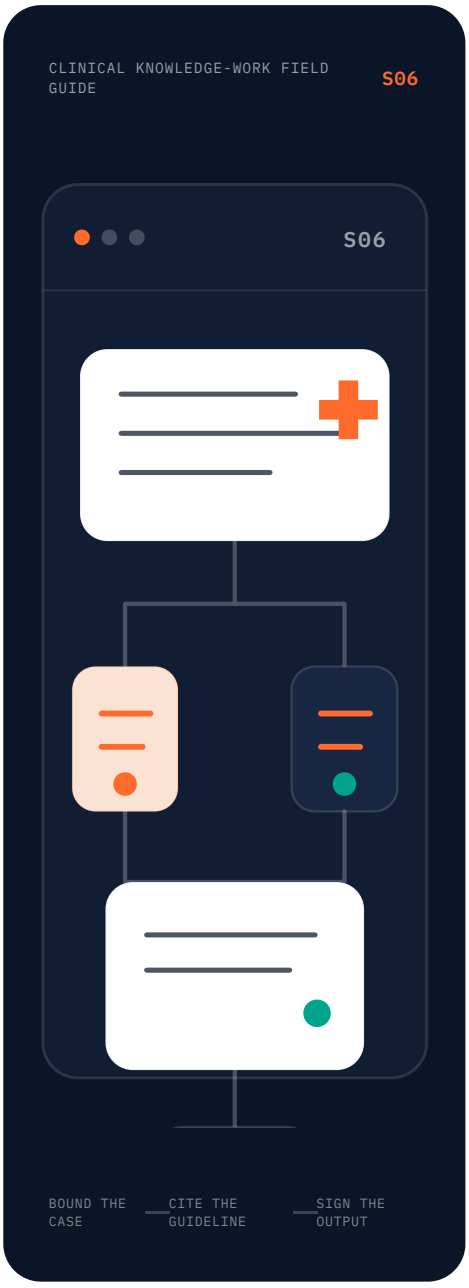
ENGLISH SOURCE EDITION · JULY 2026

CLINICAL KNOWLEDGE-WORK FIELD GUIDE · S06

The clinical knowledge-work field guide

One prior-authorisation recommendation, followed from the minimum case snapshot to the clinician signature and offline replay.

GUIDELINE LINEAGE
MINIMUM PATIENT DATA
CLINICIAN SIGN-OFF
OFFLINE REPLAY



Not a diagnostic promise. One prior-authorisation output with its case boundary, guideline version, clinician, rights path, and replay packet kept together.

S06

CONTENTS

The clinical output, from case boundary to signed packet

This field guide stays with illustrative case 7b2a from March. The minimum snapshot, guideline version, recommendation, clinician state, and repatriation record remain connected.

PRIMARY READERS	READING DEPTH	DECISION THIS SUPPORTS
clinical knowledge-work field guide domain, operations and assurance teams	Sector specialist	A healthcare working book for clinical governance, clinicians, hospital IT, DPOs, quality and safety, integration, procurement, and oversight teams.

HOW TO USE IT

Replace case 7b2a with one approved knowledge-work output. The hospital, clinical governance body, DPO, and responsible clinician supply the real care pathway, source authority, safety rules, and legal position.

SOURCE DISCIPLINE

Dweve-specific facts are taken directly from the English website text audited 2026-07-20; web-navigation wording is humanised for print. Evaluation guidance is editorial, and scenarios and derived visuals are illustrative. Unsupported synthesis is replaced by canonical copy or omitted.

THE REPATRIATION DEADLINE

Six months after the output, the question is not “what did it say?”

The hospital must recover the clinical reasoning context without reopening the entire live patient record or trusting a chat transcript.

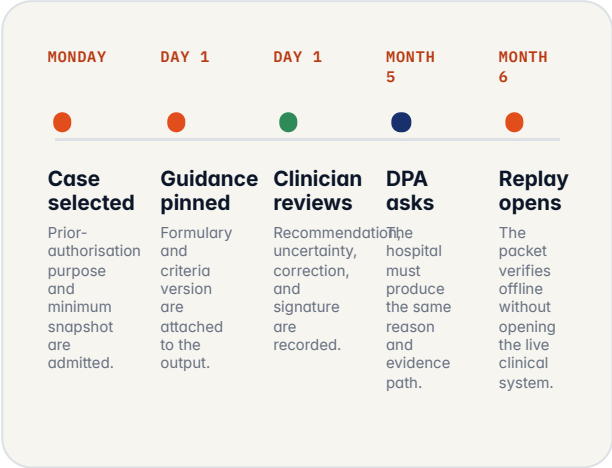
An output can look clear when it is new. Six months later, governance needs to know which guideline and version were in force, which minimum patient factors entered the work, what the model or solver returned, which clinician reviewed it, and whether the same packet verifies on infrastructure the hospital controls.

The clinical boundary is narrow by design

The knowledge-work layer is not the patient record and it is not the clinician. It receives the minimum typed case needed for the approved task, cites the source it used, exposes missing or conflicting material, and stops at recommendation, draft, or review state until the responsible clinical role acts.

REPATRIATION TEST

If the hospital must reconstruct the patient context, guideline, output, and clinician decision from four disconnected systems, the evidence path was never closed.

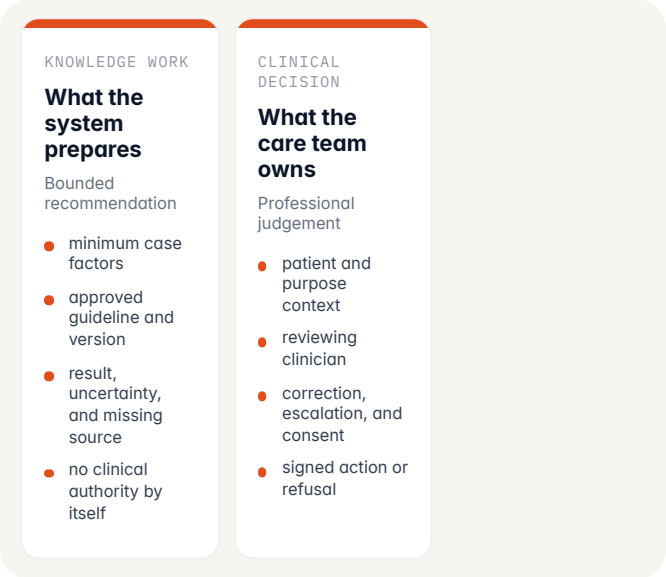


The time between care work and review is part of the clinical control design.

KNOWLEDGE WORK VERSUS CARE AUTHORITY

A recommendation is not a clinical act

A sourced output can support a clinician. It cannot silently become the person who accepts responsibility for care.



The output and the clinical act need a visible handover, not a blurred "AI decided" label.

The illustrative prior-authorisation path may retrieve a criterion, compare approved case factors, and prepare a reason. It does not approve care, deny care, write back an unreviewed conclusion, or convert a probability into a diagnosis. The responsible clinician and the approved governance pathway determine what happens next.

Keep four states separate

- source: which guideline, formulary, or criterion was admitted
- output: what the knowledge-work layer produced
- review: what the clinician accepted, changed, or rejected
- action: what the authorised clinical or payer workflow recorded

NO CLINICAL IMPERSONATION

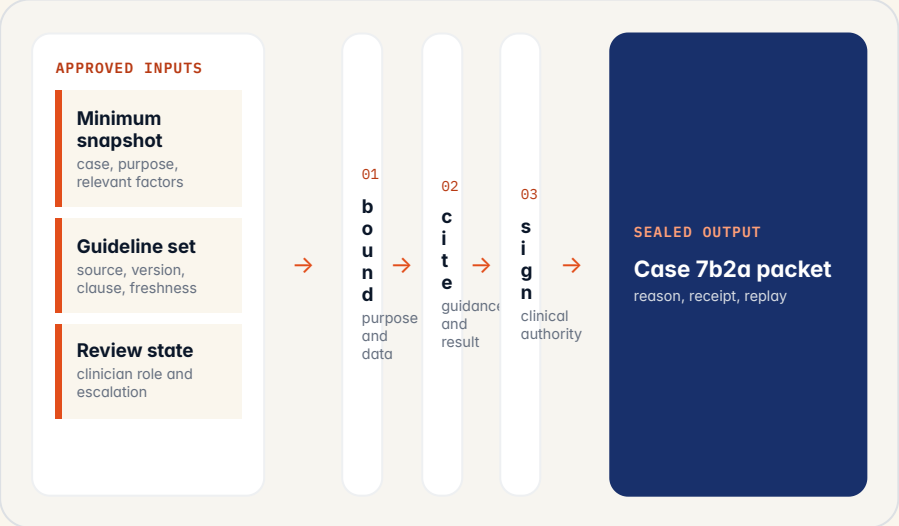
A confident sentence is not a clinician signature. The record must show the person, role, time, review state, and permitted next action.

01

PRIOR-AUTHORISATION CASE 7B2A

Keep the clinical knowledge-work boundary narrow and visible

The case is small enough to protect and specific enough to expose every assumption about source, patient context, authority, and replay.



The evidence packet is assembled as the work moves, not rebuilt when the DPA asks.

TYPED PATIENT AND PURPOSE BOUNDARY

The minimum case is still a case

Data minimisation is not the absence of identity. The output needs the correct case, purpose, relevant factors, and review state without copying the whole chart.

Case 7b2a is an illustrative prior-authorisation request. A production contract binds the pseudonymous work identity to the hospital's authorised case system, admits only the factors required by the approved pathway, and records why those factors were sufficient. The packet should not become a shadow EHR.

Admit the context that changes the answer

- case identity, purpose, requested knowledge-work pathway, and output time
- minimum clinical factors with source, freshness, unit, and quality
- consent, access, care relationship, and disclosure boundary
- guideline-selection rule, required evidence, and missing-data state
- clinician role, review requirement, escalation, and writeback destination

`case.identity` BOUND

Case

7b2a · prior-authorisation recommendation

`case.purpose` SCOPED

Purpose

Approved prior-authorisation knowledge-work pathway

`case.snapshot` ADMITTED

Factors

Minimum authorised factors with source and freshness

`guidance.version` PINNED

Guidance

formulary-march-2026-v3.pdf and cited criterion

`review.state` PENDING

Clinician

Review, correction, escalation, and signature required

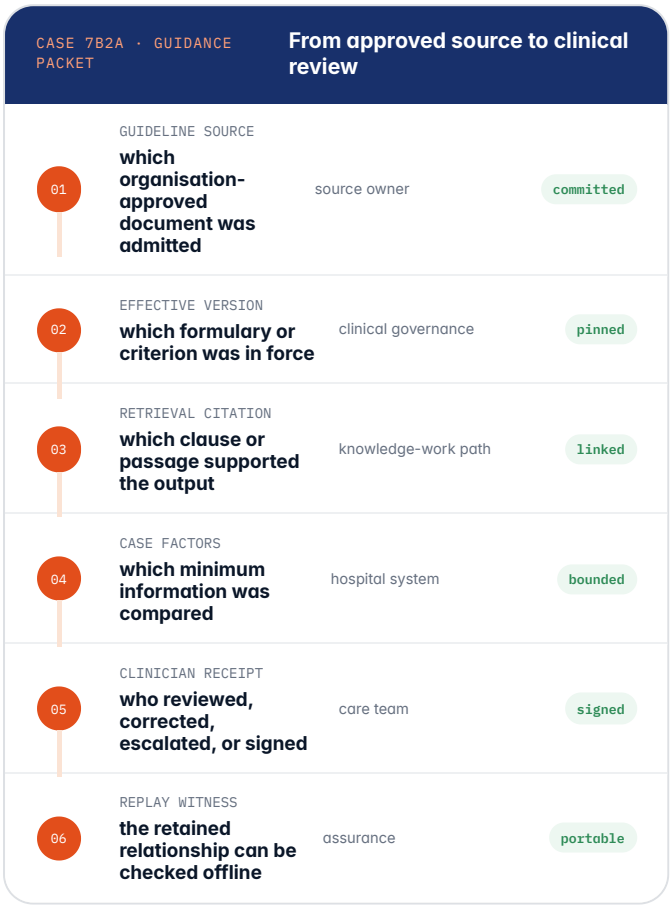
MINIMUM-DATA RULE

The record should prove why the output was made without retaining unrelated chart material merely because the integration could fetch it.

SOURCE FIDELITY AND EFFECTIVE DATE

The guideline is a versioned input

A citation that points to the current document is not enough when the output was made under an earlier formulary or governance rule.



The source, case, result, and professional review remain one chain without becoming one undifferentiated blob.

Spindle can preserve source lineage and effective versions. Loom can keep retrieval, reasoning, and constraints visible. The clinical owner still decides which guidance is approved, which citation is sufficient, and what the workflow must do when sources disagree or are stale.

Historical guidance questions

- Which formulary, guideline, or criterion was effective at output time?
- Did the source owner withdraw, amend, or supersede it later?
- Can the reviewer open the exact cited passage and its surrounding context?
- Was the output withheld when the required guidance or evidence was missing?

NO CURRENT-DOCUMENT SUBSTITUTION

Replay must resolve the guidance in force when case 7b2a was processed, not silently attach the document current today.

REVIEW, CORRECTION, AND ESCALATION

The clinician signs the boundary

The clinician is not a decorative approval step. The review changes the state of the knowledge-work output and determines whether it can enter the authorised workflow.

A clinical team can distinguish a sourced recommendation, a professional judgement, and a recorded care or payer effect.

The signature needs context

- which minimum case factors and source quality were visible
- which guideline and clause supported the output
- what uncertainty, missing evidence, or contraindication was shown
- whether the clinician accepted, corrected, rejected, or escalated
- what authorised workflow or communication received the signed state

Nexus can represent the task, role, challenge, escalation, and receipt. Clinical governance and the responsible clinician define the permitted action; the product does not assume medical responsibility.

INTEGRATION AND RESIDENCY

Do not copy the whole chart to make the output explainable

A hospital can keep the clinical system authoritative while attaching a narrow, inspectable knowledge-work record to it.

Explainability improves when the boundary is smaller and more authoritative, not when every record is copied into the model context.

Integrate through the hospital's typed interfaces and trust boundaries. Document purpose, minimum fields, source references, retries, idempotency, role mapping, writeback state, communication channel, and what happens when the EHR or guidance repository returns an unknown result.

Keep effects explicit

- no cross-patient context after a retry or stale session
- no payer or EHR writeback before required clinician review
- no clinician confirmation mistaken for patient or payer receipt
- no PHI or packet export beyond the approved deployment boundary

RESIDENCY ACCEPTANCE

"On-premises" or "EU-pinned" is not proof until the hospital can inspect PHI paths, keys, model packages, support, telemetry, updates, and restore behaviour.

EXPLANATION AND RIGHTS

A patient-facing reason has a different audience

The governance packet can be detailed while the patient-facing explanation remains clear, relevant, and limited to the authorised care relationship.

Plain language is a disclosure design choice, not an excuse to remove the evidence behind the result.

Where the workflow calls for a patient-facing explanation, it should state the material factor and the responsible review path without exposing unrelated chart content, protected security controls, or a false claim that the system made a clinical decision on its own.

Rights and safety questions

- Can the person ask what guideline or criterion was applied?
- Can an authorised clinician review or correct the result?
- Can consent, access, correction, or disclosure events be located?
- Does the explanation distinguish recommendation from clinical action?
- Does the communication channel have a receipt and retention state?

NO PREMIUM HUMANITY

A correction route, clinician review, and readable reason belong to the approved care workflow; they are not optional polish around an opaque answer.

THE CLINICAL FAILURE CORPUS

Missing source, missing person, wrong purpose

Healthcare safety is defined by what the system refuses to do when context, authority, identity, or source quality is uncertain.

TEST SLICE	INTRODUCE	EXPECTED OBSERVATION
Normal review	Case 7b2a, approved guideline, clinician sign-off	signed recommendation and packet close together
Guidance gap	missing, superseded, or conflicting formulary/source	hold, cite gap, and route to governance
Minimum-data breach	unneeded chart field or broad context request	refuse request and record containment
Identity boundary	wrong patient, purpose, role, or care relationship	no output disclosure; incident state opens
Clinical uncertainty	insufficient evidence or contraindication	recommendation stops or escalates
Clinician absence	reviewer unavailable, impersonated, or privilege changed	no signature or writeback
Writeback uncertainty	EHR or payer receipt missing after retry	reconcile without duplicate effect
Repatriation	offline restore and exact packet verification	same source, result, reviewer, and verdict

A green clinical path is one test case. The safe boundary is visible in the refusals and escalation states.

Measure the care boundary

- minimum-data compliance and purpose alignment
- source freshness, citation completeness, and version resolution
- clinician review time, correction, escalation, and override
- writeback, communication, and patient-facing receipt
- refusal, safety, access, rights, incident, and recovery evidence
- offline verification on approved hospital infrastructure

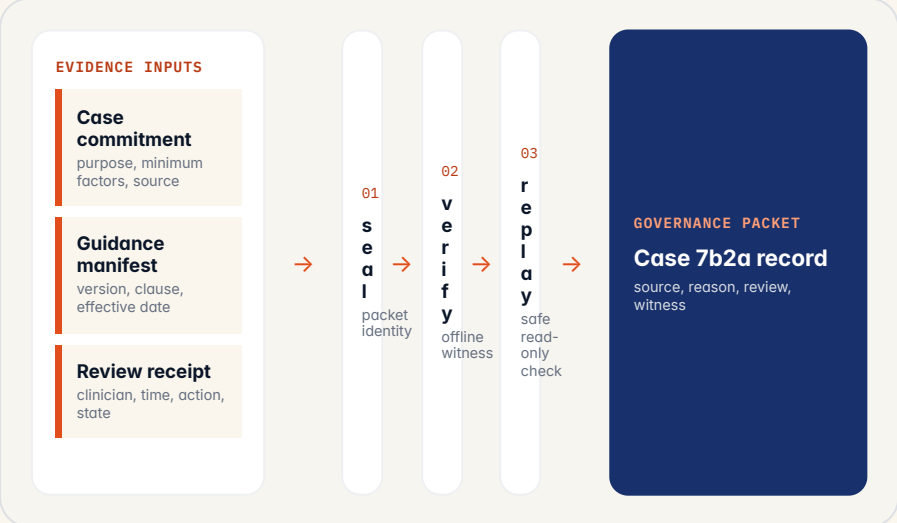
Do not summarise clinical safety with an accuracy percentage alone. Keep the test fixtures, expected refusals, source snapshots, access events, packet contents, and named review owners that demonstrate the supported pathway.

02

THE EVIDENCE PATH

Make the clinical output inspectable without making it a second patient record

The packet carries only the decision context needed for review, rights, safety, and replay, with the hospital's systems remaining authoritative.

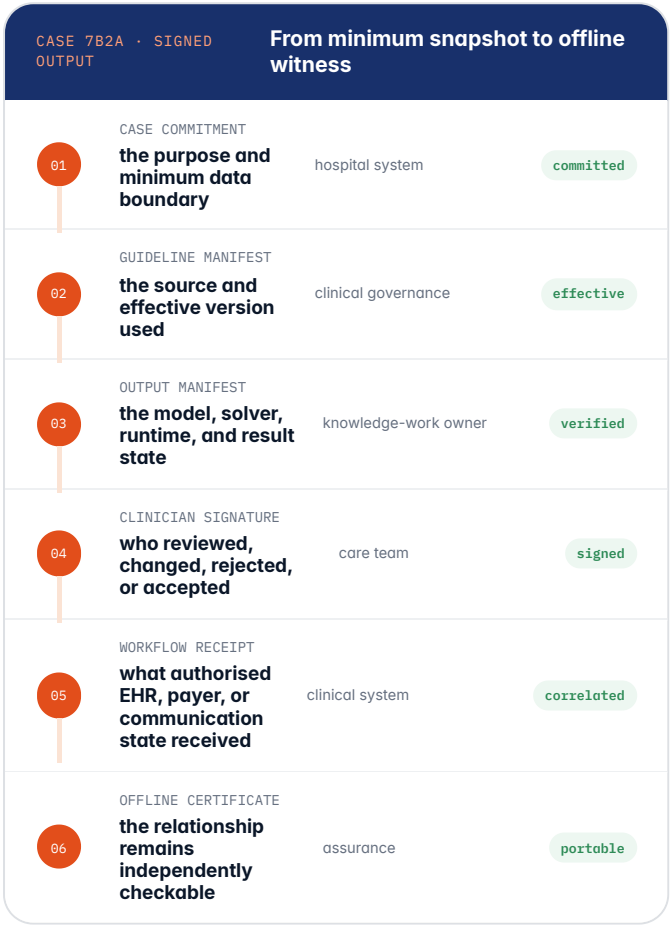


The packet gives governance a controlled answer without granting the verifier a clinical or writeback authority.

EVIDENCE, SIGNATURE, AND REPLAY

The output packet is a clinical governance object

The packet should answer the DPA, clinical governance, quality and safety, and engineering questions from the same retained state.



One packet can serve care governance, rights response, engineering, and oversight without becoming a universal data dump.

AION can provide a portable decision certificate for the selected output. Ledger can retain the event chain. Selvedge can preserve runtime evidence where a verified execution transcript is required. Each layer has a different purpose; none substitutes for clinical governance or a clinician's professional responsibility.

Replay must state its domain

- same minimum snapshot, guidance, runtime, and supported verifier
- same result within the declared exactness or tolerance
- same clinician and workflow correlation
- same refusal or unknown state when a source or authorised system is unavailable

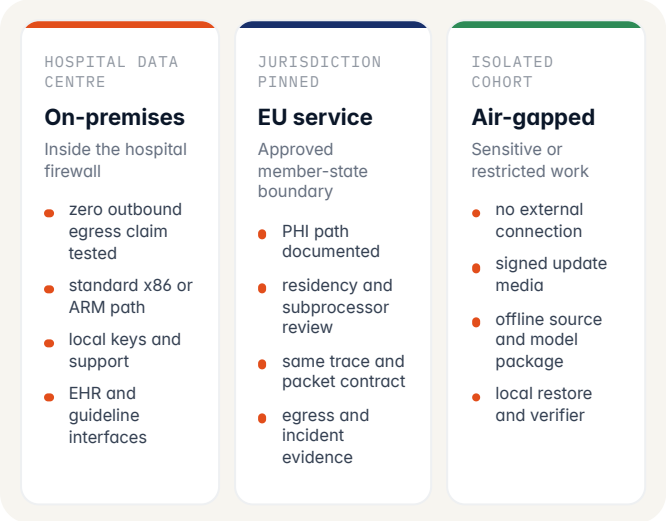
READ-ONLY REPLAY

The verifier should check the packet on approved hardware without opening the live patient record or gaining authority to alter care, payer, or EHR state.

HOSPITAL, EU-PINNED, OR AIR-GAPPED

Repatriation changes the deployment proof

The same knowledge-work proposition must be tested against the actual PHI, key, model, support, update, and recovery boundary in which the hospital will rely on it.



A deployment label is a proposal. The hospital must accept the observed boundary, operating burden, and recovery proof.

Start with synthetic or authorised historical records. Expand only after the clinical governance, DPO, hospital IT, security, quality and safety, and integration owners can inspect the same packet and agree on data, refusal, escalation, writeback, and recovery states.

Posture evidence

- PHI ingress, egress, storage, logs, backups, and deletion
- key custody, identity, role changes, signed packages, and rollback
- guideline, model, solver, and numeric artefact availability
- EHR, payer, and communication receipt after timeout or retry
- offline replay, restore, incident handling, and support without external access

NO RESIDENCY SHORTCUT

"EU data" does not prove that a model package, log, support path, telemetry stream, backup, or packet export stays inside the approved healthcare boundary.

PURPOSE, ROLE, AND PATIENT SAFETY

Access and disclosure are failure modes

The output is unsafe when it reaches the wrong person, uses the wrong purpose, or exposes more than the approved care relationship permits.

A clinical knowledge-work system must be able to refuse a technically possible disclosure.

The access record needs context

- which patient, purpose, care relationship, and role were asserted
- which source and minimum factors were visible
- which output and explanation were disclosed
- which consent, rights, or governance state applied
- what destination acknowledged the communication or writeback

The DPO, clinical safety owner, security team, and responsible clinician own different parts of this boundary. One signed packet makes their evidence meet; it does not collapse their responsibilities into a single role.

03

THE PRODUCTION PROOF

Prove the knowledge-work pathway before relying on it with clinical records

Synthetic fixtures, authorised history, source changes, access failures, clinician authority, deployment, recovery, and the final hospital decision turn the published proposition into evidence.

The proof ends in a reversible clinical and operating decision, not a screenshot of an answer.

THE ACCEPTANCE CORPUS

Run synthetic fixtures before clinical records

The first proof should expose the source, data, authority, rights, and replay boundary without using live patient records.

TEST SLICE	INCLUDE	EXPECTED OBSERVATION
Normal recommendation	approved case, source, clinician review	reason, signature, and packet close together
Version boundary	formulary/guideline changes near output time	historical source remains resolvable
Missing material	source, factor, freshness, or evidence absent	safe refusal or escalation with gap named
Purpose abuse	wrong patient, role, care relationship, or destination	no output disclosure; incident state opens
Clinical override	clinician changes, rejects, or escalates result	final state and rationale remain distinct
Model change	runtime or knowledge package update	manifest and replay verdict change visibly
Writeback timeout	EHR or payer acknowledgement missing	no blind retry or duplicate effect
Offline recovery	restore packet without live clinical system	same evidence and verifier outcome

Synthetic proof is not a substitute for clinical validation. It establishes that the controlled pathway behaves as designed before authorised records enter it.

Measure the actual promise

- minimum-data and purpose compliance
- guideline citation and effective-version resolution
- clinician review, correction, escalation, and workload
- refusal, uncertainty, rights, access, and safety incidents
- writeback, communication, packet, and recovery correlation
- offline verification on the agreed hospital, EU, or closed posture

Keep the fixture corpus, expected outputs and refusals, source snapshots, role/access events, model and guideline manifests, raw packets, and verdicts. A clinical claim without its boundary conditions is not an acceptance result.

GO, NARROW, HOLD, OR STOP

The hospital decides whether to proceed

A proof ends with an accountable clinical and operating decision, not with a benchmark or a reassuring demo.

The accountable group decides whether the selected knowledge-work pathway may proceed, for which purpose, population, source set, clinician roles, data boundary, deployment posture, EHR or payer integration, communication route, monitoring, recovery, and stop conditions. Clinical governance, the responsible clinician, DPO, security, quality and safety, IT, procurement, and oversight may each own a condition.

HEALTHCARE PRODUCTION RECORD	Case 7b2a proof decision	
WORKFLOW	**Prior-authorisation knowledge-work recommendation**	BOUNDED
CLINICAL BOUNDARY	**Named purpose, population, case system, and reviewer role**	SCOPED
INPUTS	**Minimum factors + source + effective guidance + manifest**	LINKED
AUTHORITY	**Clinician, governance, destination, and rights route**	REVIEWED
OPERATION	**PHI boundary, access, incident, support, restore**	OWNED
EXIT	**Export, verifier, rollback, and stop trigger**	DATED
DECISION	**Go / narrow / hold / stop**	SIGNED

The record should remain useful when the guideline changes, the clinician leaves the service, or the hospital repatriates the workload.

The smallest credible next exercise

Replay one authorised or synthetic prior-authorisation output, then introduce one boundary failure selected by the clinical team: superseded guidance, insufficient factor, wrong purpose, absent reviewer, writeback timeout, or offline restore. Have clinical governance, the responsible clinician, DPO, IT, security, quality and safety inspect the same packet.

PRIMARY ACCEPTANCE CRITERION

The hospital can identify the exact purpose, minimum data, source and version, output, uncertainty, clinician action, destination state, rights path, and replay verdict for every selected case.

That proves one knowledge-work slice. It does not authorise generalisation to diagnosis, treatment, population analytics, or every clinical workflow.

FIND A SUBJECT

Subject index

Page references point to the substantive explanation, worked example, control, boundary, or decision record, not merely to a passing label.

SUBJECT INDEX CONTINUED

Subject index · P–W

Terms are grouped alphabetically. Consecutive page references are collapsed into ranges.

CLOSING RECORD

Make the clinical output replayable before it enters the record

Choose one approved knowledge-work pathway, name the clinician and governance authority, and prove that its minimum input, source, result, review, destination, and packet agree.

Write the case and purpose identity, minimum factors, source and guideline version, retrieval/citation, model or solver manifest, result and uncertainty, clinician authority, patient-facing explanation, EHR/payer/communication receipt, rights and consent state, deployment posture, recovery, retention, export, and stop conditions.

Then choose the result you most dread explaining: a superseded guideline, an answer produced with too much chart context, a clinician override, a wrong-purpose disclosure, a writeback that timed out, or a packet that cannot verify offline. A clinical field guide is useful when that case can be replayed before governance asks for it.

WORKFLOW

One bounded knowledge-work output

Do not begin with every clinical use

DATA

Minimum case, purpose, role, and source

Every input has a boundary

GUIDANCE

Named document, clause, version, and date

Current is not historical

AUTHORITY

Clinician, governance, destination, and rights owners

Roles must stay distinct

DECISION

Go, narrow, hold, or stop

Signed with safety and replay conditions

THE CLINICAL STANDARD

A recommendation can be useful. A defensible clinical knowledge-work output shows the purpose, minimum data, source, result, clinician action, destination, rights path, and replay state that existed when the work happened.