<table>
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<th>Cognitive Bias</th>
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| Anchoring              | Locking onto salient features in a patient’s initial presentation too early in the diagnostic process; failing to adjust this impression in the light of later information | • Tell me how you came to this diagnosis.  
• How did you incorporate (*insert additional data trainee may have disregarded*) into your decision-making? |
| Ascertainment bias     | Physician’s thinking is shaped by prior expectation; stereotyping             | • As physicians, we sometimes let prior experiences influence our thinking in one direction – do you think that might have happened here?  
• Do you think this patient is susceptible to stereotyping? Why? |
| Availability           | Judging things as being more likely if they come readily to mind              | • Why did you think this diagnosis was more likely than others?  
• Were there other diagnoses you considered that would be more likely epidemiologically? |
| Blind obedience        | Excessive deference to authority or over-reliance on technology              | • I understand (*insert service/name*) thought this was the most likely diagnosis. Did you think so also? Why?  
• How accurate is this (*test/diagnostic modality*)? |
| Confirmation bias      | Looking for evidence to support a diagnosis, rather than for evidence to refute it, despite the latter often being more persuasive and definitive | • Were there available data that would have pointed you in a different direction or argue against the diagnosis you made?  
• How did you interpret all of these available data points? |
| Diagnostic momentum    | Once diagnostic labels are attached to patients, they tend to become stickier and stickier. | • Do you think the patient has diagnosis (*insert potential wrong diagnosis*)?  
What data support or negate such a diagnosis? |
| Framing effect         | How physicians see things may be strongly influenced by the way the problem is framed. | • Was there a way the case was presented to you that led you to the diagnosis?  
• If (*insert parts of case that led to framing effect*) weren’t present, would you have come to the same conclusion? |
| Fundamental attribution error | Judging and blaming patients for their illness, rather than examining the circumstances that might be responsible. *Psychiatric patients, minorities, and other marginalized groups particularly at risk. | • Are there other factors that contributed to the patient’s ongoing difficulties? Social factors? Healthcare system issues? Physician decisions? |
| Gambler's fallacy      | Believing that the pretest probability a patient will have a particular diagnosis is influenced by preceding, but independent events | • What aspects of this patient’s case led you to this diagnosis? Do you think these are related to his/her current presentation? If you did not have that information, would you have come to a different conclusion? |
| Hindsight bias         | Knowing the outcome may profoundly influence the perception of patient events and prevent a realistic appraisal of what actually occurred. | • If you had not known that (*insert outcome*) occurred, would you have come to the same conclusion? |
| Overconfidence bias    | Believing we know more than we do                                          | • Do you feel like you have a good grasp on what you might not know about (*insert diagnosis*)?  
• Did you have any uncertainty that might have led you to ask for help? |
| Premature closure      | Stopping the decision-making process and accepting a diagnosis before it has been fully verified | • Is it possible that you made the diagnosis before having available or processing all of the needed information? |

Cognitive Bias: The 3 R’s

Steps for Trainee Reflection:

Recall
• Trainee thinks through process that led them to diagnosis

Recognize
• Attending assists trainee in recognizing possible bias in reasoning

Revisit
• Attending and trainee develop at least one strategy to mitigate bias in future similar case