

Selected Biases

Premature Closure Biases – Failure to adequately consider alternative diagnoses

Framing – The way in which a problem is presented has too powerful effect on how the information is interpreted

Anchoring – Relying too heavily on information obtained early in the diagnostic process and allowing that to overly influence the interpretation of new data

Diagnostic momentum - Allowing collective input from prior intermediaries to inordinately influence diagnostic decisions

Confirmation Biases – Selectively using evidence to confirm a diagnosis and not valuing evidence that brings that diagnosis into question

Search satisficing – The “eureka” diagnosis that results in failure to consider other evidence

Overconfidence – Overreliance on one’s own skills or those of an expert

Semmelweis reflex – Rejecting evidence that contradicts the favored diagnosis

Estimation of Probability Biases - Misrepresenting the true prevalence of a disease due previous experiences or perception

Availability – Thinking that the current patient has the same diagnosis as a patient cared for recently or a previous patient whose case had a particularly strong impact on your thinking

Severity – Exaggerating the likelihood of the diagnosis with the worst potential outcome

Base rate neglect - Failing to consider the prevalence of the disease on which you are basing the diagnosis

Representativeness restraint – Illness script does not adequately account for less common presentations

Biases Related to Emotion Biases - Impact of feelings toward a patient or about the circumstances around their care on clinical judgement

Affective/Visceral – Allowing emotions, positive or negative, about your patient, to influence your judgement

Regret - Tendency to follow a pattern of behavior due to discomfort over a previous patient experience