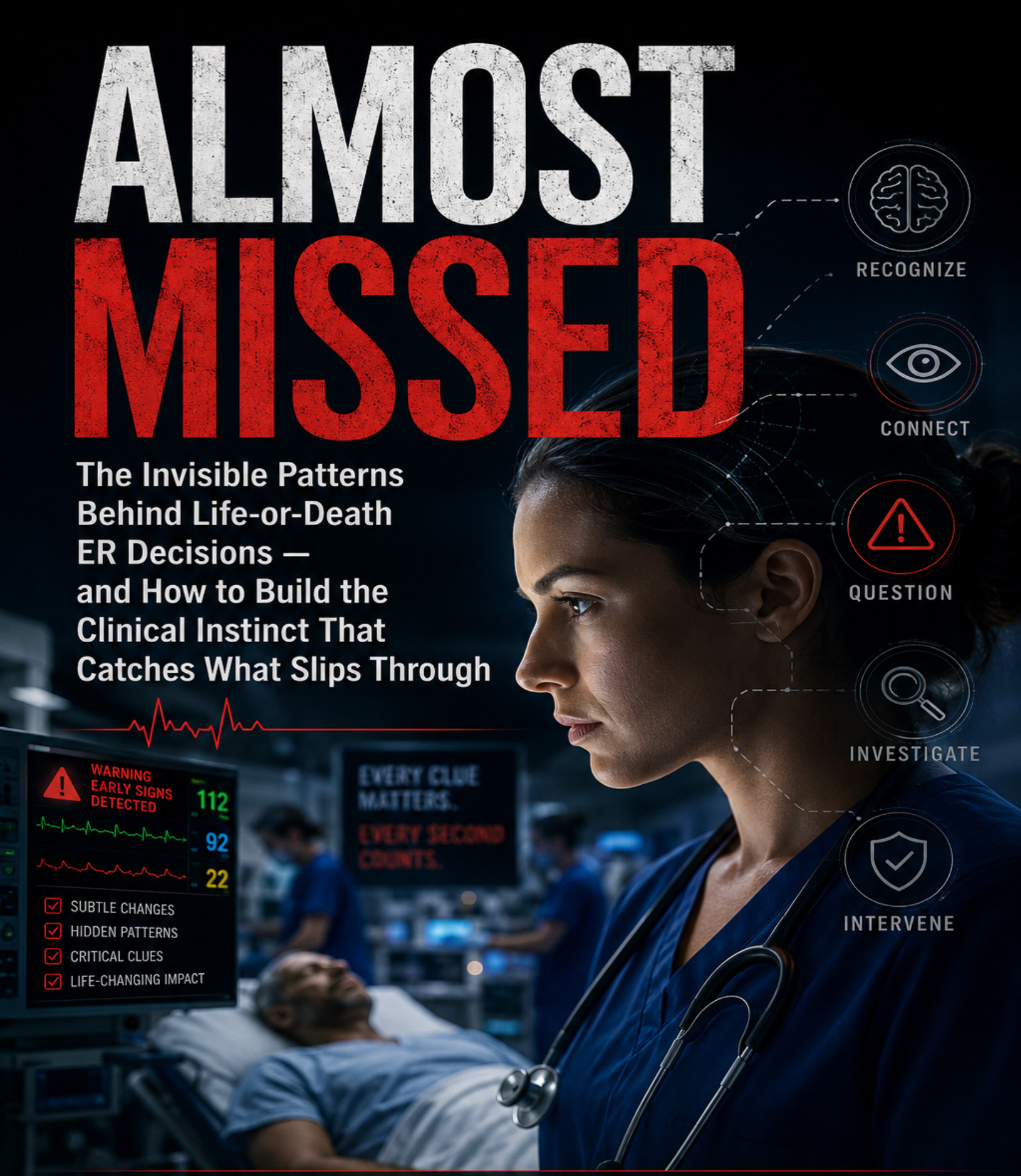
ALMOST MISSED

The Invisible Patterns Behind Life-or-Death ER Decisions — and How to Build the Clinical Instinct That Catches What Slips Through



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SEE MORE. THINK FASTER. SAVE LIVES.

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Introduction

You Chose the Hardest Room in Medicine — And That Says Everything

You already know the ER isn't like anywhere else in medicine. The pace is different. The pressure is different. The stakes are different. A patient rolls in and you've got minutes, sometimes seconds, to start building a picture that could mean everything for that person. No scheduled appointments. No time to sit and think. Just you, the information in front of you, and a decision that can't wait.

That weight is real. And if you've been doing this long enough, you know it never fully goes away.

Most clinicians don't talk about it out loud. There's a quiet understanding among ER doctors and nurses that the fear of missing something lives in the background of almost every shift. Not loud enough to be paralyzing, but persistent enough to keep you sharp. It's the thing that makes you double-check the EKG before you send someone home. It's the thing that makes you walk back into a room when something felt slightly off, even though you can't explain why. That instinct, that quiet alarm, is one of the most valuable things you have. This book is about understanding it, sharpening it, and building the kind of clinical thinking that makes it fire more often and more accurately.

Choosing to work in the ER means choosing uncertainty every single day. You don't get clean presentations. You don't get patients who read the textbook before they came in. You get a 44-year-old woman who says she feels tired and her back hurts, and somewhere inside that vague complaint is a dissecting aortic aneurysm that's going to kill her in four hours if you don't catch it. You get an elderly man who looks fine, whose vitals are borderline normal, and whose family just says he "seems different" today. You get a 28-year-old who looks anxious and is breathing fast and gets labeled a panic attack before anyone asks the right questions.

These aren't rare cases. They're Tuesday.

The fact that you picked up this book says something important about you. It means you're not satisfied with good enough. It means you've probably had a moment, maybe more than one, where a case shook you. Where you caught something late, or heard about a colleague who missed something, or sat in a conference room listening to a morbidity and mortality discussion and felt that cold recognition that it could have been you. Those moments are uncomfortable. But the clinicians who let those moments teach them are the ones who get better. The ones who dismiss them are the ones who keep making the same mistakes.

Getting sharper isn't about doubting yourself more. It's about building a smarter system.

This book is built for the nurse who's been on her feet for ten hours and still notices something wrong with the patient in bay six that nobody else has flagged. It's built for the resident who's terrified of his first solo shift and wants more than a list of algorithms. It's built for the attending who's seen thousands of cases and still knows, honestly, that the ER has a way of humbling even the most experienced clinician. If any of those descriptions feel familiar, you're in the right place.

Every case in this book starts the same way the real ones do. With incomplete information, a time crunch, and a human being whose outcome depends on what happens next. That's not a dramatic framing. That's just the ER.

What This Book Is, What It Isn't, and Why It's Different

There's a specific kind of medical textbook that every clinician has on their shelf. It's thick, it's organized by organ system, and it's excellent at telling you what a disease looks like when it presents exactly the way it's supposed to. It lists the classic symptoms, the pathophysiology, the gold-standard workup. It's useful. It's also not what this book is.

The problem with classic presentations is that patients don't always read the textbook. The ER is full of cases that don't look like the picture in the chapter. The MI that presents as jaw pain and nausea in a 50-year-old woman. The pulmonary

embolism that gets written off as a muscle strain. The meningitis that walks in with a headache and no fever and gets sent home with ibuprofen. These cases don't fail because the clinician didn't know the classic presentation. They fail because the real presentation didn't match it, and nobody stopped to ask what else it could be.

That's the gap this book fills.

The 27 cases in this book are built around the moments where the diagnosis almost slipped through. Each one walks you through the clinical picture as it actually appeared, not as it would appear in a textbook. You'll see how the information came in, how the brain processed it, where the thinking went right, and where it almost went wrong. You'll see the exact moment a subtle clue surfaced, or the exact point where a cognitive trap nearly closed around the right answer and buried it. And at the end of every case, you'll walk away with a specific, usable lesson. Not a vague takeaway. A concrete pattern, a red flag, or a decision habit you can carry into your next shift.

This book doesn't treat cognitive bias as a footnote. It treats it as a central character in almost every missed diagnosis. Anchoring bias, premature closure, availability bias, these aren't abstract psychology concepts. They're the invisible forces that cause smart, trained, experienced clinicians to miss things. You've felt them at work even if you didn't have a name for them. The case you were sure about before you finished the history. The patient who got labeled at triage and never got relabeled. The diagnosis that felt right because you'd seen three just like it the week before. This book names those forces, shows you exactly how they operate in real clinical situations, and gives you specific habits to counter them.

Think about a hypothetical scenario. A nurse practitioner, 38 years old, has been working urgent care for six years. She's confident, fast, and good at her job. A patient comes in with chest tightness and she's seen four anxiety-related chest complaints that same day. She moves through the visit efficiently. She asks the right questions, mostly. She orders an EKG but reads it quickly because the board is full. She sends the patient home with a follow-up recommendation. Two hours later, the patient comes back by ambulance. The EKG had a subtle finding she didn't catch because her brain, saturated

from a full day of similar presentations, had already decided what it was looking at before it finished looking. That's not incompetence. That's a trained brain doing exactly what trained brains do under load, and it's exactly the kind of near-miss this book was written to prevent.

This book is story-driven because that's how the diagnostic brain actually learns. Not from bullet points. Not from memorized algorithms. From stories with tension, with uncertainty, with the specific messy details that make a case feel real. When you read about a patient whose presentation kept pulling the team in the wrong direction until one question changed everything, that case gets stored differently in your brain. It becomes a pattern. And the next time you see something that rhymes with it, your System 1 fires faster and your System 2 knows what to check.

This isn't a book you read once and put on the shelf. It's a book you read and then think about during your next shift. It's the kind of book where, two months from now, you'll be standing at a bedside and something about the patient in front of you will trigger a case you read here, and that connection will matter.

What this book isn't is a comprehensive clinical reference. It's not trying to cover every diagnosis in emergency medicine. It's not a protocol manual or a board review guide. It's a training tool for your diagnostic brain, built around 27 carefully chosen cases that each teach something specific about how pattern recognition works, where it breaks down, and how to build it back stronger.

A Map of What's Ahead — And the One Idea That Ties It All Together

Before you get into the cases, it helps to understand the arc of the book and why it's structured the way it is. This isn't a random collection of interesting cases. Every section builds on the one before it, and by the time you reach the final case, you'll be reading it with a different set of eyes than you had at the beginning.

The book opens with the brain itself. You can't sharpen a tool without understanding how it works. The early chapters walk you through the science of

diagnostic thinking under pressure, specifically the two-system model that governs every decision you make in the ER. System 1, fast and pattern-based, and System 2, slow and deliberate. You'll learn why both are essential, why neither is sufficient on its own, and most importantly, how to recognize which one is running the show at any given moment. That self-awareness is the foundation everything else is built on.

From there, the book moves into cognitive traps. This section is where a lot of clinicians have their first real "oh, that's what happened" moment. Anchoring bias, premature closure, search satisficing, framing effects. Each one gets its own case, its own breakdown, and its own set of specific countermeasures. Not generic advice like "keep an open mind." Specific habits. Things like forcing yourself to generate at least one alternative diagnosis before you commit. Things like building a personal trigger list of the cases that have historically fooled you. Things you can actually do at 2 AM when the department is slammed and your brain is running on fumes.

A significant portion of the book deals with atypical presentations, because the atypical presentation is far more common than medical school implied. Women having MIs. Elderly patients with serious infections and no fever. Diabetics with silent cardiac events. These aren't rare exceptions that you might encounter once in a career. They're patterns that show up regularly, and they get missed regularly, because the classic presentation is what clinicians are trained to look for. The cases in this section are designed to rewire that default, to make the atypical feel familiar so your brain stops treating it as a surprise.

Then the book turns to something that almost never gets discussed in clinical education: communication failures. A significant number of missed diagnoses in the ER aren't caused by a knowledge gap in any individual clinician. They're caused by information that existed in the room but never made it to the right person. The nurse who noticed something but didn't feel confident enough to push back. The handoff where a critical detail got dropped. The family member who said something important in the hallway that never made it into the chart. These failures are preventable, but only if you understand how they happen and build habits that close the gaps.

The later cases in the book deal with decision fatigue and the physical reality of working a long shift. Your diagnostic accuracy at hour twelve isn't the same as hour one. That's not weakness. That's biology. But knowing it gives you something to work with. The cases in this section show you what fatigue-driven errors look like in practice and give you specific strategies to protect your thinking when your brain is running low.

The book closes with a section on building a culture where every member of the team, nurse, tech, resident, feels safe to say "something feels wrong here." That phrase, said out loud, has saved lives. The teams where it gets said are the teams that catch the diagnoses everyone else misses. Creating that culture isn't soft leadership. It's the most powerful diagnostic tool in the department, and the final cases show you exactly what it looks like when it works and what it costs when it doesn't.

Every section, every case, every lesson in this book connects back to one central idea. Pattern recognition is a trainable skill. Not a talent. Not something you're born with. A skill. The clinicians who catch the most diagnoses aren't the ones with the highest board scores or the most years of experience. They're the ones who've built the richest mental library of cases, who've studied their own thinking closely enough to know where it breaks down, and who've developed specific habits to compensate. Every page of this book is a rep in that training. Every case you read adds a pattern to your library. Every cognitive trap you understand becomes one you're less likely to fall into.

That's the promise of this book. Not that you'll never miss a diagnosis, because the ER doesn't work that way. But that you'll miss fewer. That you'll catch things earlier. That you'll walk into a shift with a sharper eye and a more reliable system. And that somewhere down the line, a patient who might have slipped through will go home instead, because you read this and thought differently.

That's worth every page.

The Brain in the ER — How Diagnostic Thinking Actually Works Under Pressure

The Two Systems Running Your Brain When a Patient Walks In

You've been on your feet for six hours. The department is loud, the board is full, and a new patient just got walked back. You glance up from the chart you're holding, take one look at the person being settled into the bay, and something fires. You don't know what it is yet. You haven't read the triage note. You haven't asked a single question. But something in your gut says this one's different. That feeling isn't random. It isn't luck, and it isn't some mystical sixth sense that only the best clinicians are born with. It's your brain doing exactly what it was built to do.

Understanding that process, where it comes from and where it breaks down, is the single most important thing you can do to become a sharper diagnostician. Everything else in this book builds on it.

In the 1970s, psychologists began mapping out how the human brain actually makes decisions. The work got popularized decades later by Daniel Kahneman, and what came out of it was a model that every ER clinician needs to know cold. The brain runs on two distinct systems. They don't take turns. They run at the same time, all the time, and they're constantly pulling against each other in ways you're usually not even aware of.

System 1 is fast.

It's automatic, unconscious, and built on pattern recognition. It's the system that lets you walk into a room and immediately sense that a patient looks sick before you can explain why. It processes thousands of data points at once without you having to think about any of them. The slight grey tinge to someone's skin. The way they're sitting forward. The subtle labored quality to their breathing that doesn't quite match the "mild

shortness of breath" written on the triage sheet. System 1 takes all of that in and spits out a feeling. Not a diagnosis. A feeling. And in the ER, that feeling matters.

System 2 is slow.

It's deliberate, logical, and effortful. It's the part of your brain that works through a differential, orders the right labs, interprets an EKG, and builds a structured clinical argument. System 2 is what gets you through your boards. It's what you use when you sit down and think, "Okay, what are all the things that could cause this presentation?" It requires focus, and it burns mental energy. That's not a flaw. That's just how it works.

The problem isn't that you have two systems. The problem is that most clinicians don't know which one is running the show at any given moment, and they don't have a reliable way to check.

Think about a hypothetical scenario. A 52-year-old man comes in at 2 AM complaining of indigestion. He's slightly overweight, mildly anxious, and he tells you he had a big dinner. He's been seen twice before for GI issues. The triage nurse wrote "GI complaint, non-urgent" on the board. System 1 fires immediately, and it fires based on everything in that context: the history, the label, the time of night, the prior visits. Your brain pattern-matches to "this is a GI guy" before you've even walked into the room. That's not incompetence. That's how the brain works under cognitive load. But if that man is having an atypical MI, System 1 just put you on the wrong track, and System 2 hasn't been invited to the conversation yet.

That's the gap where diagnoses get missed.

System 1 is extraordinarily powerful, and experienced clinicians should trust it more than they often do. The instinct that fires when something looks wrong is real. It's built from thousands of patient encounters, layered and compressed into rapid pattern recognition. A seasoned ER nurse who says "I don't know what it is, but something's off with that patient in bay four" is not being vague. She's reporting data. Her System 1 has picked up on something her conscious mind hasn't fully processed yet, and that signal deserves to be taken seriously.

The goal isn't to suppress System 1. The goal is to know when to let System 2

catch up with it. The clinicians who miss the fewest diagnoses aren't the ones who ignore their gut. They're the ones who've learned to use their gut as a trigger to slow down and look harder, not as a final answer.

Every case in this book is going to show you exactly where that handoff between the two systems either happened correctly or didn't. You'll see what it looks like when System 1 fires accurately and saves time. And you'll see what it looks like when System 1 fires confidently and wrong, and nobody asked System 2 to double-check. Once you can see that distinction clearly, you'll start noticing it in your own thinking. That awareness alone will change how you work.

Pattern Recognition Is a Skill, Not a Gift — Here's How It's Built

There's a story that gets told in medicine, usually informally, about the attending who just knows. The one who walks into a room and within thirty seconds says "that's epiglottitis" or "this is going to be a PE" before a single test has been ordered. Residents watch it happen and assume it's some combination of raw intelligence and years of experience that they'll either develop eventually or they won't. That assumption is wrong, and it's worth correcting early because it changes how you approach every case you'll ever study.

Pattern recognition isn't a gift. It's a library.

Every time you see a case, read a case, hear a case discussed in a conference room, or work through a case in a book like this one, your brain files it. Not as a fact. As a pattern. A constellation of features that get stored together so that the next time something rhymes with it, your brain pulls the file automatically. That's what System 1 is actually drawing on when it fires. It's not magic. It's accumulated exposure, organized by the brain into a searchable index that operates faster than conscious thought.

The critical word there is "accumulated." Because it means the library can be built deliberately. You don't have to wait for the cases to come to you over twenty years of practice. You can actively load your library right now, with every case you study, every

clinical discussion you sit in on, and every patient encounter you take the time to actually process afterward instead of just moving on to the next one.

Here's what the research on expert performance consistently shows. The difference between a novice and an expert isn't the number of years they've been working. It's the quality of the exposure they've had and whether they've processed that exposure in a way that builds retrievable patterns. A resident who sees fifty cases and actively thinks through each one, asks what made this presentation unusual, what almost got missed and why, what the key differentiator was, will build a richer diagnostic library than a clinician who's seen five hundred cases passively and moved on without reflection.

That's what this book is designed to be. Not a list of cases. A structured set of reps.

Think of it this way. A radiologist who reads ten thousand chest X-rays develops the ability to spot a subtle pneumothorax in seconds. Not because they're gifted, but because their brain has seen the pattern enough times that it recognizes it instantly. The same thing happens with clinical presentations. The more times your brain has processed the constellation of features that make up a posterior MI, an ovarian torsion, or a spinal epidural abscess, the faster it fires when something in front of you rhymes with it. And the faster it fires, the more time you have to act.

Active case absorption is different from passive reading. Passive reading is when you go through a case and absorb the facts. Active absorption is when you stop at the key decision point and ask yourself what you would have done before you read the answer. It's when you identify the moment the diagnosis almost got missed and ask why. It's when you name the cognitive trap that was operating and think about how you would recognize it in real time. That extra layer of processing is what moves a case from short-term memory into the kind of long-term pattern storage your System 1 can actually draw on.

For each case you read in this book, do three things. First, pause before the reveal and form your own working diagnosis. Second, identify the one feature that was most likely to be overlooked and ask yourself why it almost got missed. Third, name the lesson in one sentence, something specific enough that you could say it out loud to a

colleague in thirty seconds. That sentence is the pattern. That's what gets filed in the library. Over 27 cases, that's 27 patterns added to your diagnostic index, and each one makes the next one easier to recognize.

The clinician who catches the diagnosis everyone else missed isn't operating on a different level of intelligence. They've just seen more patterns, processed them more deliberately, and built a library that fires faster. That library is available to you. Every case you work through is a deposit into it. Nothing you read here is wasted.

The Thirty-Second Pause That Saves Lives

The ER runs on momentum. Patients come in, you move through them, you make decisions, you keep moving. The pace isn't optional. It's built into the environment. And in that kind of environment, the instinct to keep moving can become one of the most dangerous forces in the room.

There's a specific moment that shows up in almost every missed diagnosis. It's not the moment the wrong decision gets made. It's the moment before it, when something felt slightly off and nobody stopped to pay attention to it. A lab value that was a little unusual but got rationalized. A vital sign that was borderline but fit the narrative. A family member who said something in passing that didn't quite line up with the chart. In most of those cases, somebody noticed. They just didn't pause.

The thirty-second pause is exactly what it sounds like. When something feels off, you stop. Not for ten minutes. Not for a formal reassessment. Thirty seconds of deliberate attention directed at the thing that triggered the feeling. You name it out loud if possible. You ask yourself one question: "What would I be missing if I'm wrong about this?" Then you decide whether to keep moving or dig deeper.

That's it. Thirty seconds.

The neuroscience behind this is straightforward. When your brain is moving fast and under load, System 2 gets crowded out. The deliberate, analytical thinking that catches the subtle finding on the EKG or recognizes that the respiratory rate doesn't match the oxygen saturation gets suppressed by the sheer volume of incoming

information and the pressure to move quickly. The pause interrupts that suppression. It creates a window, brief but real, where System 2 can engage with what System 1 has flagged.

Consider a hypothetical scenario. A 67-year-old woman comes in with a chief complaint of weakness and mild confusion. Her daughter says she's been "not herself" for two days. Her vitals are almost normal: blood pressure slightly low, heart rate 98, temperature 37.1. The triage note says "altered mental status, likely UTI." The department is at capacity. The attending does a quick assessment, notes the borderline vitals, orders a urinalysis and basic labs, and moves to the next patient. Somewhere in that assessment, a small voice registered that the blood pressure was lower than expected for a woman who's usually hypertensive. That voice didn't get thirty seconds. It got rationalized. Two hours later, her lactate comes back at 4.2 and she's in septic shock. The diagnosis was there. The pause wasn't.

Building the pause as a habit takes practice because it runs against the grain of how the ER operates. The way to start is small. Pick one trigger. Commit to pausing every time a patient's vitals don't quite fit the story you've been told. Or every time a family member says something that contradicts the triage note. Or every time your gut fires and you can't immediately explain why. You don't need to pause on everything. You need to pause on the things that feel slightly wrong, because those are exactly the moments where the missed diagnosis is hiding.

On your next shift, try this. Every time you feel the pull to move on from a patient and something hasn't fully resolved in your thinking, stop for thirty seconds. Say out loud, even just to yourself, "What am I not seeing here?" Give yourself that window. You won't always find anything. But the times you do will justify every second of it. The pause doesn't slow you down in any meaningful way. What slows you down is the patient who comes back by ambulance two hours later because the diagnosis got missed the first time.

What the ER Does to Decision-Making Over a

Twelve-Hour Shift

Nobody talks about this enough. The diagnostic accuracy you bring to your first patient of the shift isn't the same accuracy you bring to your twelfth. That's not an opinion. It's a measurable, documented reality, and the fact that medical education almost never addresses it directly means most clinicians are managing it blind.

Decision fatigue is real, and it works in a specific way. Every decision you make draws on a finite pool of cognitive resources. Early in a shift, that pool is full. You're sharp, your thinking is flexible, and your System 2 is available to engage when System 1 flags something. As the shift goes on, that pool depletes. Not dramatically, not all at once, but steadily. By hour ten or eleven, the brain starts taking shortcuts it wouldn't take at hour two. It defaults to the most familiar pattern. It anchors faster and questions less. It's more likely to accept a diagnosis that fits well enough rather than pushing for the one that fits best.

The research on this is sobering. Studies looking at clinical decision-making across shifts have found measurable differences in diagnostic thoroughness, ordering patterns, and disposition decisions between early and late shift hours. Antibiotic prescribing becomes less precise. Discharge decisions become more frequent even when clinical pictures are ambiguous. The clinicians making these decisions aren't aware it's happening. That's what makes it dangerous.

Emotional load compounds the effect. A difficult resuscitation, a pediatric code, a patient who reminded you of someone, these don't just affect you emotionally. They affect your cognitive bandwidth. The brain processes emotional stress and analytical thinking through overlapping neural resources. After a high-stakes emotional event, your capacity for careful deliberate reasoning is genuinely reduced, not because you're weak, but because those resources are being shared with something else.

The practical response to this isn't to pretend it doesn't happen. It's to build personal checkpoints into your shift that catch the moments when your judgment is most at risk. Here's a specific way to do it. At the midpoint of your shift, take two minutes, literally two minutes, to review your active patients and ask one question about

Anchoring Bias — The Diagnosis You Decided Before You Started

What Anchoring Bias Is and Why It Hits Hardest in the ER

You walk into bay three. Before you've said a word, you've already seen the triage note. "39-year-old male, chest pain, history of anxiety, no cardiac history." Your brain has already started building a picture. By the time you shake the patient's hand, you're not starting from zero. You're starting from a frame. That frame is the anchor, and everything you learn from this point forward will be unconsciously filtered through it.

That's anchoring bias. It's not a character flaw. It's not laziness. It's the brain doing exactly what it was designed to do under cognitive load: grab the first plausible explanation and use it as a reference point for everything that follows. The problem is that in the ER, the first plausible explanation is often incomplete, sometimes wrong, and almost always incomplete in ways that matter.

The term comes from behavioral psychology research done in the 1970s by Amos Tversky and Daniel Kahneman. They showed that when people are given a starting number or idea, even an arbitrary one, their subsequent judgments cluster around it. They adjust from the anchor, but they almost never adjust enough. The anchor pulls their thinking toward it like a gravitational field, even when the evidence is pointing somewhere else. In everyday decision-making, this causes people to leave money on the table in negotiations or misjudge probabilities. In the ER, it causes people to miss diagnoses.

The ER is the worst possible environment for anchoring to go unchecked.

Think about the conditions that make anchoring more powerful. High cognitive load, meaning your brain is already processing a lot of information at once. Time pressure, meaning you don't have the luxury of sitting with uncertainty. Incomplete information,

meaning you're making decisions before all the data is in. Emotional fatigue, meaning your System 2 is running low on fuel. The ER has all four of those conditions simultaneously, for the entire shift. Anchoring doesn't just happen here. It thrives here.

The anchor can come from anywhere. It can come from the triage note, which is written by someone who saw the patient for three minutes and had to pick a category. It can come from the patient themselves, who leads with the symptom they think is most important, which may not be the symptom that matters most clinically. It can come from a previous visit in the chart, where a diagnosis was assigned and now feels established. It can come from a colleague who mentions the patient in passing before you've seen them. Any one of these can set an anchor, and once it's set, it changes how you process everything that follows.

Here's what makes anchoring so dangerous specifically: it doesn't feel like bias. It feels like reasonable clinical thinking. You're not ignoring evidence. You're interpreting it. But you're interpreting it through a lens that was handed to you before you had enough information to choose it yourself. The patient with chest pain and anxiety gets his EKG read through the lens of "probably anxiety." The subtle ST changes that might have triggered a second look in a different context get rationalized. The elevated heart rate gets attributed to distress. Every piece of evidence gets absorbed into the anchor rather than challenging it, and the anchor holds.

Consider a hypothetical scenario. A 44-year-old woman comes into the ER at 10 PM with nausea, fatigue, and what she describes as "feeling weird." She's been seen twice in the past year for anxiety-related complaints. The triage note reads "GI upset, possible anxiety." The attending who picks up the case is 8 hours into a 12-hour shift. She reads the note, sees the prior visits, and approaches the room with a working hypothesis already in place. The patient does seem anxious. She does have a history. The nausea fits. The attending orders anti-nausea medication and a basic metabolic panel. What she doesn't order is a troponin, because nothing in the frame she was given pointed toward cardiac. The patient is discharged. She comes back four hours later with a confirmed NSTEMI. The anchor held so firmly that the one test that would

have changed everything never got ordered. This is a hypothetical scenario, but it reflects a pattern that shows up repeatedly in real ER near-misses across the literature.

The research on anchoring in clinical settings is consistent and uncomfortable. Studies examining diagnostic errors in emergency medicine have found that anchoring is one of the most frequently identified cognitive mechanisms in cases where a serious diagnosis was initially missed. One analysis of malpractice claims involving missed diagnoses found that a failure to consider an alternative diagnosis, the hallmark of anchoring, was present in a substantial majority of cases. The bias isn't rare. It's the default mode of a brain under pressure.

Recognizing anchoring in yourself requires a specific kind of self-awareness that most clinical training doesn't build. It requires you to ask, at some point during every patient encounter, "What was I told about this patient before I formed my own impression, and is that information shaping what I'm seeing?" That question is harder to ask than it sounds, because by the time you think to ask it, the anchor is already set. But asking it at all creates a crack in the frame, a moment where an alternative explanation can get through. That crack is where the right diagnosis lives.

The discomfort of reading this section is probably familiar. Most experienced ER clinicians, when they encounter a clear description of anchoring bias, have the same reaction: a quiet recognition that they've been here. Not as a failure, but as a pattern. A case where the first frame held too long. A patient who got labeled early and never got relabeled. A diagnosis that felt settled before it should have. That recognition isn't something to be ashamed of. It's the starting point for building something better.

The Handoff Problem — How Anchoring Gets Passed Between Clinicians

There's a version of anchoring that's even more dangerous than the one you set yourself. It's the one that gets handed to you by someone else, already assembled, already labeled, and delivered with enough confidence that questioning it feels almost rude. It's the anchor you inherit during a patient handoff, and it's one of the

least-discussed sources of diagnostic error in emergency medicine.

Patient handoffs are a necessary part of how the ER functions. Shifts end. Clinicians rotate. Patients who came in at 6 PM are still there at midnight, and the doctor who initially evaluated them has gone home. The incoming clinician needs to get up to speed quickly, and the verbal handoff is the fastest way to do that. The problem is that a verbal handoff isn't just a transfer of facts. It's a transfer of framing. And that framing carries the anchor.

When a clinician hands off a patient, they naturally summarize. They tell you the chief complaint, the working diagnosis, what's been done, what's pending. They use language that reflects their interpretation of the case. "This is a 58-year-old with a likely kidney stone, we're waiting on the CT." "This is a 71-year-old with a COPD exacerbation, she's on a neb." "This is a 33-year-old with a migraine, he's had three of these before, just needs his usual treatment." In each of those sentences, a diagnosis has been named. And the moment you hear it, it becomes your anchor, even if you haven't seen the patient yet.

The incoming clinician is now working with two disadvantages simultaneously. They haven't formed their own first impression of the patient, so they don't have a competing frame to push back against the handed-off one. And they're under the same time pressure and cognitive load as everyone else, which means their brain is primed to accept the anchor rather than challenge it. The result is a clinician who walks into a room not to assess a patient, but to manage a diagnosis that was decided before they arrived.

What makes this particularly hard to catch is that the outgoing clinician is almost always well-meaning. They're not trying to bias the incoming clinician. They're trying to be efficient and helpful. The language they use reflects their honest interpretation of the case. But honest interpretation isn't the same as correct interpretation, and a confident wrong anchor handed off at shift change can persist for hours, through multiple clinicians, before someone finally questions it.

Consider another hypothetical scenario. A 66-year-old man comes in at 7 PM with

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