**Cognitive Biases List Abridged and paraphrased**

**Anchoring**: the tendency to perceptually lock onto salient features in the patient's initial presentation too early in the diagnostic process, and failing to adjust this initial impression in the light of later information.

**Availability**: the disposition to judge things as being more likely, or frequently occurring, if they readily come to mind. Thus, recent experience with a disease may inflate the likelihood of its being diagnosed. Conversely, if a disease has not been seen for a long time (is less available), it may be under-diagnosed.

**Commission bias**: It is the tendency toward action rather than inaction even when not indicated or out of desperation. Physician feels better doing *something* rather than *nothing*.

**Confirmation bias**: the tendency to look for confirming evidence to support a diagnosis rather than look for evidence to refute it.

**Diagnosis momentum**: once diagnostic labels are attached to patients they become stickier and stickier.

**Framing effect**: how diagnosticians see things may be strongly influenced by the way in which the problem is framed. Is this a patient with "vomiting, weight loss, and urinating well" or is it a patient with "vomiting, weight loss, and *inappropriately* urinating well"?

**Fundamental attribution error**: the tendency to be judgmental and blame patients for their illnesses (dispositional causes) rather than examine the circumstances (situational factors) that might have been responsible. In particular, psychiatric patients, minorities, and other marginalized groups tend to suffer from this error.

**Gambler's fallacy**: the belief that if a coin is tossed ten times and is heads each time, the 11th toss has a greater chance of being tails. Thus if I had two patients today with ACS, no way the next patient has it.

**Omission bias**: the tendency toward inaction and rooted in the principle of nonmaleficence. In hindsight, events that have occurred through the natural progression of a disease are more acceptable than those that may be attributed directly to the action of the physician.

**Outcome bias**: the tendency to opt for diagnoses with a better prognosis. They diagnose what they hope for rather than what the evidence really points toward.

**Overconfidence bias**: a universal tendency to believe we know more than we do. Overconfidence reflects a tendency to act on incomplete information, intuitions, or hunches. Too much faith is placed in opinion instead of carefully gathered evidence.

**Posterior probability error**: occurs when a physician's estimate for the likelihood of disease is unduly influenced by what has gone on before for *a particular patient*. For example, if a patient presents to the office five times with migraines, there is the tendency to diagnose migraine on the sixth visit.

**Premature closure**: a powerful bias accounting for a high proportion of missed diagnoses. It is the tendency to accept a diagnosis before it has been fully verified and stopping the search for alternatives. “When the diagnosis is made, the thinking stops.”

**Representativeness heuristic**: The diagnostician looks for prototypical manifestations of disease: “If it looks like a duck, walks like a duck, then it is a duck.” They are usually correct but this could lead to atypical variants or “mimics” being missed.

**Search satisfying**: reflects the universal tendency to call off a search once something is found. Thus we miss the second foreign body, the 2nd fracture, or the coingestants in a poisoning.