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RCH Rounds – April 22, 2020

Topic: Decision Making in the ED

Summary Points:

1. A “diagnosis” is really just a high probability of a disease being present
2. We will miss diagnoses and make incorrect diagnoses
3. A missed diagnosis does not always equate to patient harm, nor does a correct diagnosis equate to patient benefit
4. There are two primary modes of thinking: System 1 (intuitive, fast, pattern recognition) and System 2 (analytic, slow, deliberate)
5. Our brains prefer to operate in System 1
6. System 1 is prone to error through heuristics and biases
7. We make more errors than we think we do
8. Cognitive errors can be avoided by recognizing cognitive stressors, biases, and using cognitive forcing strategies
9. Feedback is systematically lacking in emergency medicine, and can cause solidification of biases and errors in practice
10. Seek out feedback from colleagues and consultants, follow-up routine as well as extraordinary patients, and engage in M+M/PSQR processes to improve group feedback