The Risk of Anchoring Bias in the Emergency Department

ED is Ripe for Anchoring Bias

Anchoring bias is a cognitive bias where individuals rely heavily on the first piece of information they receive (the "anchor") when making decisions. In the context of medical malpractice, anchoring bias can lead to increased lawsuits through several mechanisms.

Unfortunately, the emergency room is a prime setting for anchoring bias to occur. Physicians are handling communications from several channels that can bias their ability to objectively assess a patient, often in a limited period of time. Patients, family members, EMS providers, law enforcement, and even the internet all add additional channels of communication that can influence a physician's initial evaluation of a patient.

The effect of anchoring bias is all too often seen in malpractice cases. Consider the following malpractice cases:

Real-World Examples

- EMS brings in a patient from home due to mental status change and suspected medication overdose.

- A patient who was recently diagnosed with COVID complained of neck pain and is unable to lay flat.

- The patient presents to the ER due to "sciatica acting up". Also believe she has a UTI as she is urinating frequently.

In each of these complaints, physicians may unintentionally gravitate toward the initial diagnostic impressions, based on test results available and presumed diagnoses being "given" to them in the chief complaint. In these scenarios, a provider may focus on complaints and findings to support this diagnosis, rather than separate this diagnosis altogether and "start from scratch" to form their own independent assessment.

The Anchoring Effect

The effect of anchoring bias is varied. Considering the above examples,

Case 1: The patient was treated as an overdose but was suffering from an intracranial hemorrhage. Anchoring bias in this case led to a delay in CT imaging, as the provider focused on the overdose history rather than ruling out a time-sensitive diagnosis such as intracranial hemorrhage. The patient had a prolonged hospital course and sustained permanent neurologic injuries.

Case 2: In this case the patient presented with a diagnosis with COVID, anchoring any additional symptoms or findings to the sequelae of the virus. However, the patient was suffering from bacterial meningitis. The neck pain and fever were attributed to COVID and the patient was discharged home. She returned to the ER in shock two days later and was diagnosed with meningitis. Due to the delay in administration of antibiotics, she now has permanent neurologic deficits.

Case 3: The patient in this case had a known history of sciatica, therefore anchoring the physician to this diagnosis. The patient was having incontinence due to a spinal cord compression. The patient was hospitalized for pain control and had a long delay for MRI, as spinal cord compression was not at the top of the differential diagnosis. Because of this delay in diagnosis and surgery, the patient had permanent lower extremity paralysis.

Mitigating Anchoring

Overall, anchoring bias poses a significant risk for patients as providers in healthcare, especially in a chaotic environment such as the ER where information is often coming rapidly from multiple sources. Recognizing the reasons for anchoring bias is the first step in addressing it. Considering alternative hypotheses, seeking diverse perspectives, maintaining open communication with patients and families, and focusing on time-sensitive conditions first on a differential diagnosis are all techniques that if deployed consistently, can mitigate the anchoring risk and subsequent litigation.

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