During a morning report session, I presented a case of a patient with abdominal pain and was asked to justify my differential diagnoses.For example, when evaluating a patient with chest pain, I learned to quickly assess for "can't miss" diagnoses like MI, PE, or aortic dissection before considering GERD or musculoskeletal pain. This approach helped me present more focused differentials during rounds and during oral case presentations. However, I still sometimes struggle with anchoring bias--becoming overly attached to an initial diagnosis and overlooking contradictory findings. Once, I prematurely concluded a patient had gastroenteritis, only to later discover their symptoms were due to an atypical presentation of appendicitis. This was a humbling experience that reminded me to stay open-minded and reevaluate when the clinical picture doesn't fit. To improve, I've started reviewing missed or challenging cases from our department's M&M conferences and discussing them with peers to identify cognitive pitfalls. Moving forward, I plan to incorporate more deliberate reflection into my practice, asking myself, "What's the worst thing this could be?"