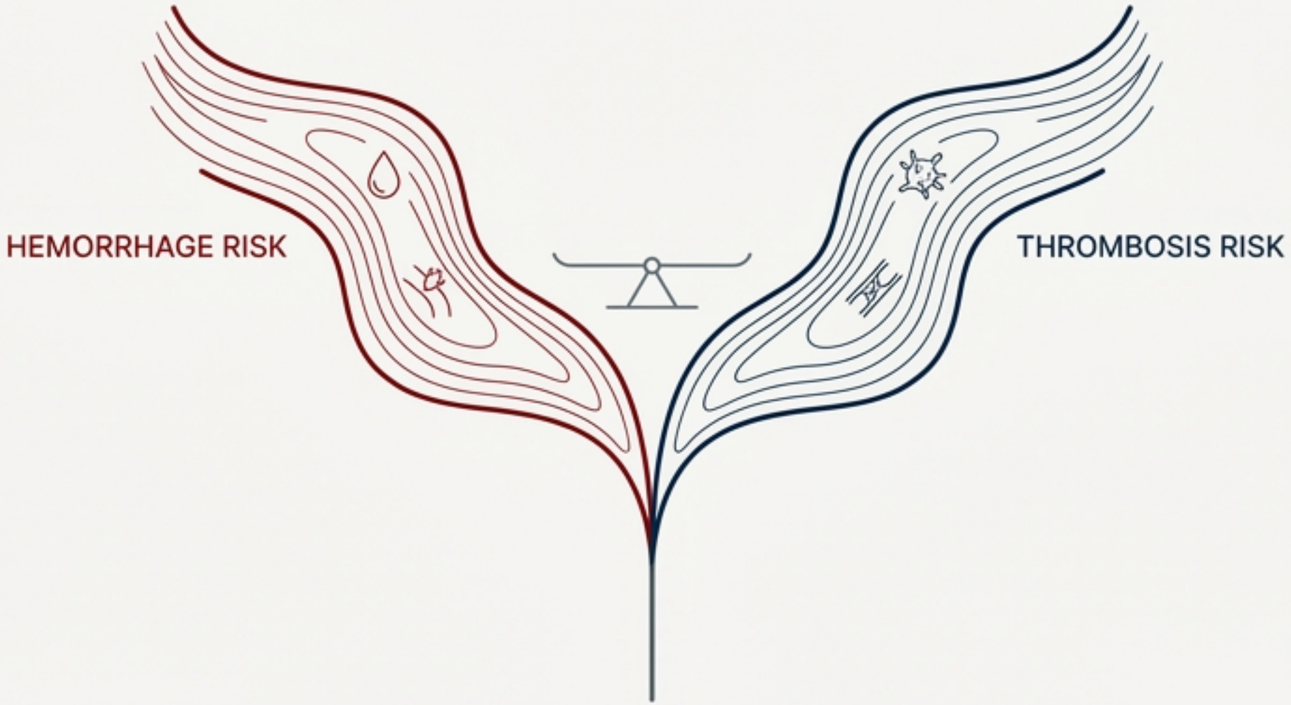
Navigating Competing Harms

A Cognitive Framework for the Anticoagulated Patient with Active Bleeding



Based on the work of William Aird

The Paradox: Same Numbers, Different Worlds

Active bleeding is not a diagnostic category. It is a context-dependent signal.

Scenario A: Low Urgency

Hemoglobin 8.2

- Anticoagulated for remote DVT (3 years ago)
- Patient stable
- Bleeding is capillary/slow

Implication: High Uncertainty Tolerance

Scenario B: Competing-Harms Terrain

Hemoglobin 8.2

- Anticoagulated for recent high-risk PE (1 week ago)
- Active GI bleed
- Falling trajectory

Implication: High Urgency, Brittle Reserve

Fact: The lab values are identical. The Danger is not.

Moving from Diagnosis to Judgment

 The Diagnostic Stance	 **The Competing-Harms Stance**
The Goal: Unify findings into a single cause. **The Question:** “What is causing the bleeding?” **The Failure Mode:** Treats evolving physiology like a static puzzle. Ignores the cost of time.	**The Goal:** Manage trade-offs under uncertainty. **The Question:** “Which danger is weightier right now?” **The Success Mode:** Managing both bleeding and thrombosis safely as biology declares itself.

Expert consultation is not about choosing bleeding OR thrombosis. It is about managing the trade-offs.

The Three-Layer Framework

Expert execution relies on separating three distinct cognitive jobs.

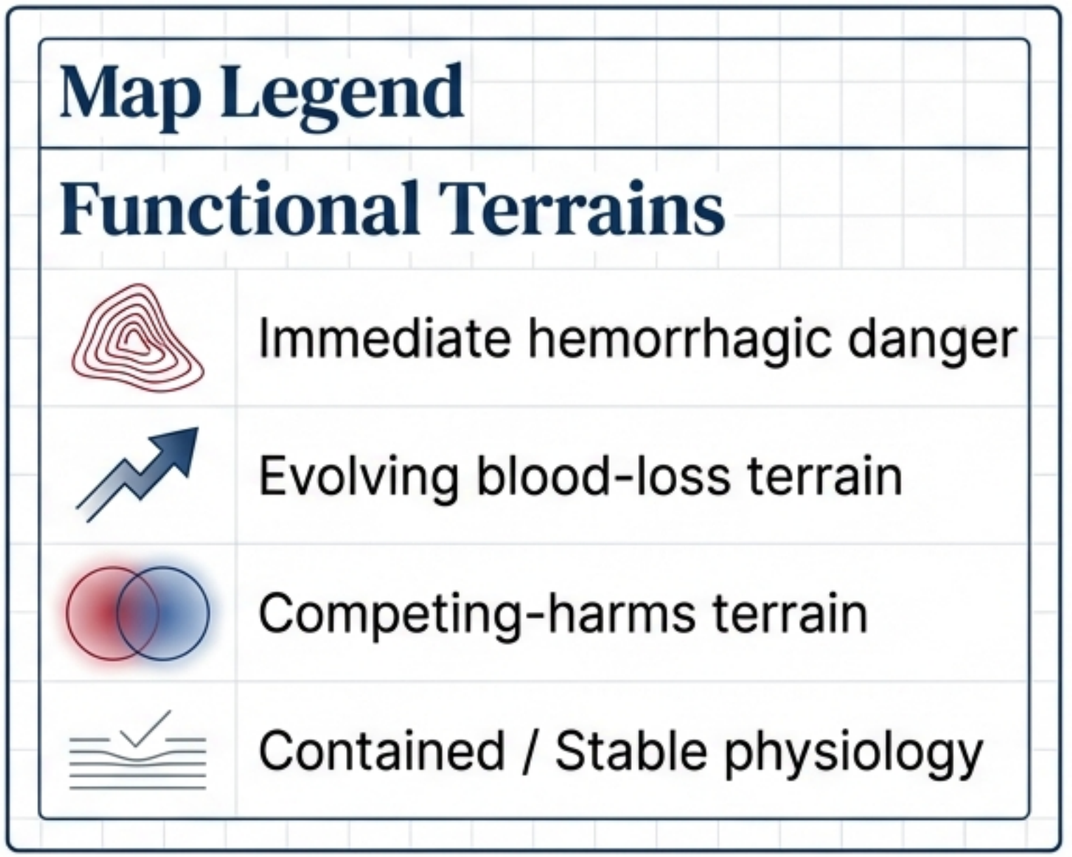
Define the terrain.
Assign the weight.
Make judgment visible.

Layer 1: Orientation Defines the Map

“Orientation is not diagnosis. It is terrain definition.”

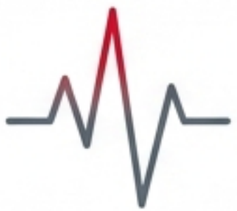
The Goal: Constrain 3 Variables

1. **Urgency:** How dangerous could this be right now?
2. **Trajectory:** How fast is it evolving?
3. **Uncertainty Tolerance:** How much ‘not knowing’ can be safely carried?



The Five Orientation Lenses

Questions to scan the patient and define the terrain.



Hemorrhagic Instability

How dangerous is the bleeding *right now*?

(Immediate vs. Evolving vs. Contained)

Thrombotic Recency

How recent is the history?

(PE last week vs. DVT years ago defines the 'cost' of stopping meds)

Proportionality

Is bleeding disproportionate to context?

(Catastrophic vs. Expected)

Broader Pattern

Is this isolated or systemic?

(Check for thrombocytopenia, coagulopathy)

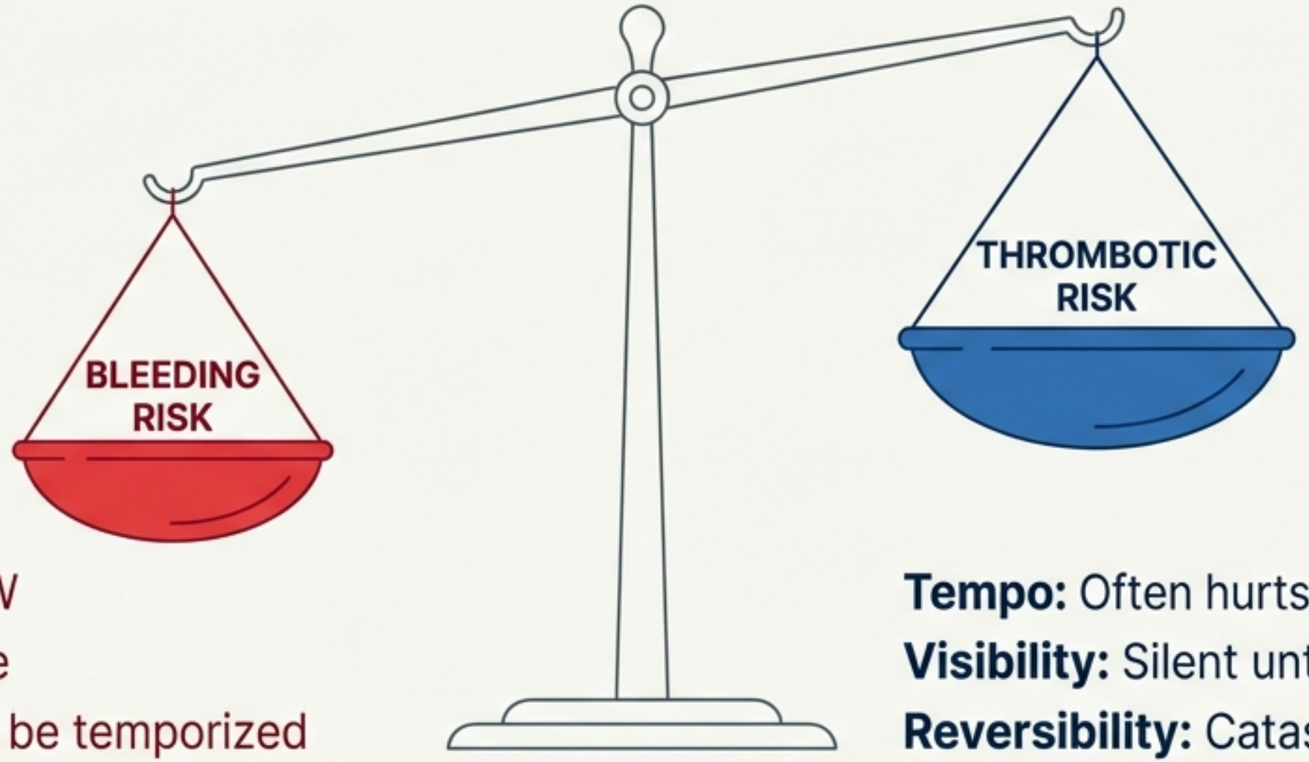
Trajectory & Tempo

What does the *rate of change* suggest?

(Falling Hgb vs. Stable Low Hgb)

Layer 2: Thinking and Asymmetric Harms

Bleeding and Thrombosis are not equal risks. They behave differently.



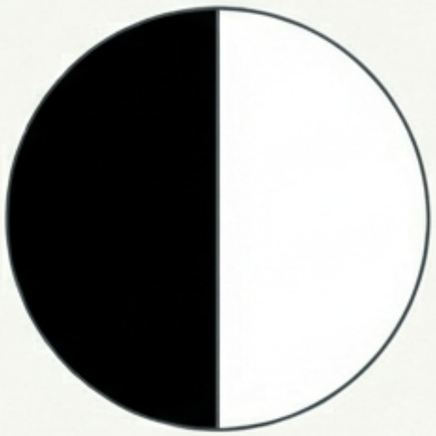
Tempo: Often hurts NOW
Visibility: Usually Visible
Reversibility: Can often be temporized

Tempo: Often hurts LATER (upon withdrawal)
Visibility: Silent until it strikes
Reversibility: Catastrophic / Permanent

The Task: Assign “Provisional Weight.”
Hold both truths, but decide which drives the bus right now.

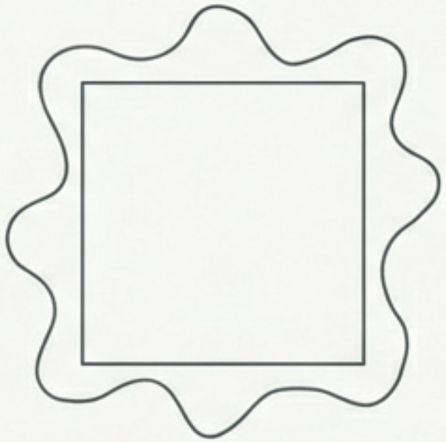
Avoiding Cognitive Traps

Binary Framing



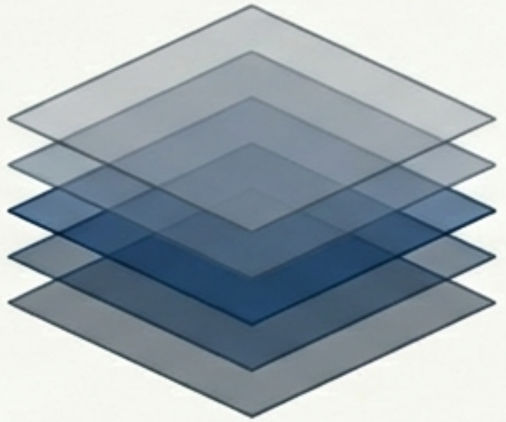
Thinking it is EITHER a bleed problem OR a clot problem. Reality: It is a dynamic balance of both.

Forced Elegance



Prematurely simplifying a messy situation because a single answer feels satisfying.

Ranked Posture / Trade-off Discipline



Holding two opposing truths. “Right now, hemorrhagic instability outweighs thrombotic risk. We will reverse if bleeding stabilizes.”

Layer 3: Execution is Judgment Made Visible

Execution is not a checklist. It is translating stance into behavior.

1. Visible Restraint

Deliberately holding anticoagulation while clearly communicating *why*. It is an active decision, not an omission.

2. Protective Escalation

Acting to stabilize *before* the crash. Transfusing early, engaging GI/Interventional teams immediately.

3. Protective Deferral

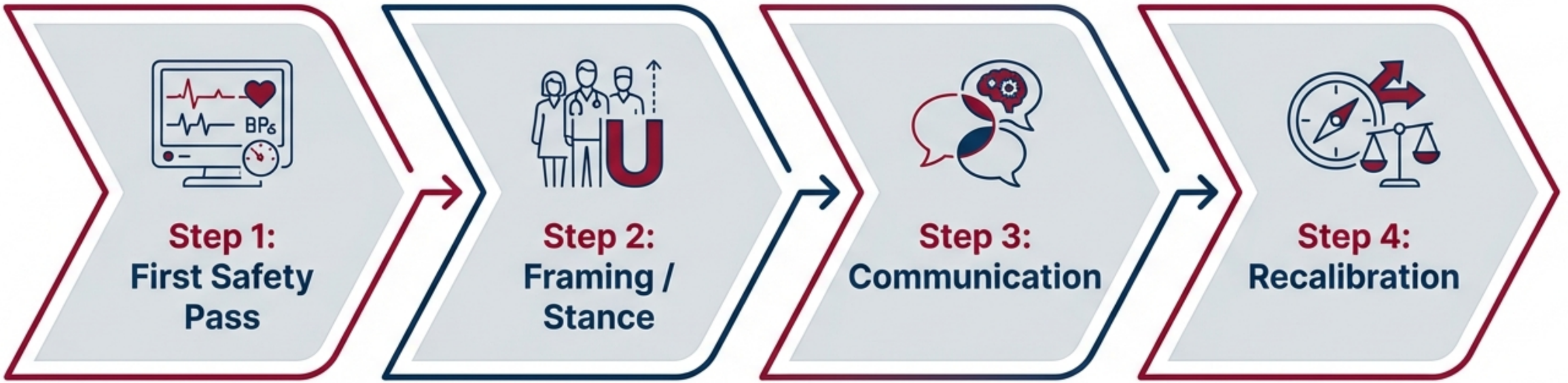
Postponing non-urgent testing to focus entirely on stabilization.

Key Insight:

If you finish the Orientation guide knowing exactly what to do, it has gone too far.

Execution requires recalibration as biology evolves.

The Four Phases of Execution



Stabilize

Clarify Hgb trajectory, hemodynamic stability. What must be protected **right now**?

Define Urgency

Is bleeding active or slowing? Align team on reversibility. Does this still deserve urgency?

Align the Team

State what is dangerous, what is uncertain, and what triggers a change.

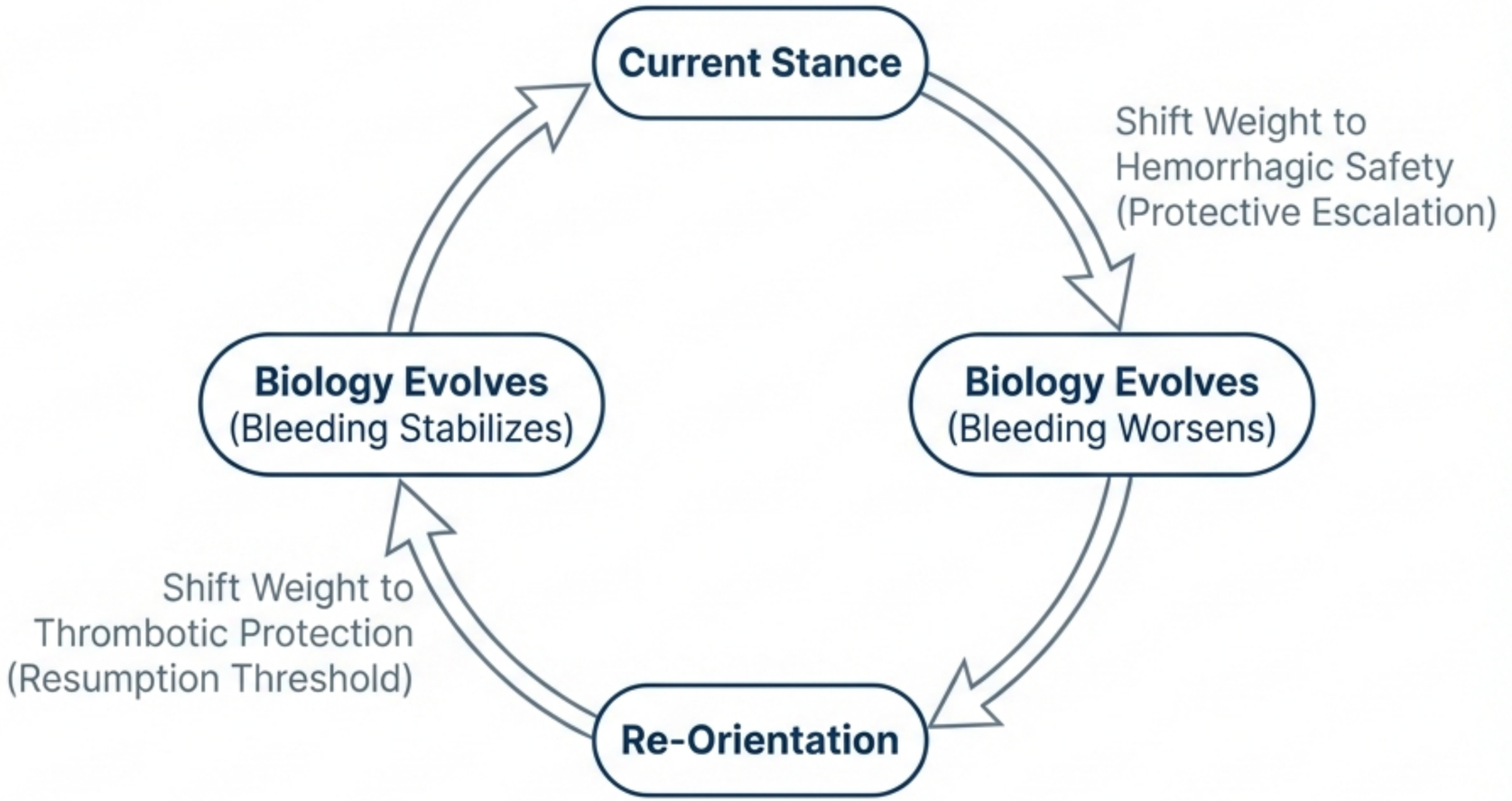
Adjust

As info appears (bleeding stops vs. worsens), visibly shift the plan. Revision is judgment.

The Engine of Care: Tempo and Trajectory

Tempo: The speed at which the situation is changing.

Trajectory: The direction (falling, stable, fluctuating).



“Revision is judgment, not reversal.”

Communicating Uncertainty Without Paralysis

How to align the team around vigilance using explicit triggers.

"Right now, the priority is stabilizing the bleeding. We are holding anticoagulation **while active**."

"We will reassess thrombotic risk **when bleeding is controlled**."

"Please notify us **immediately** if [Specific Trigger] happens."

The Strategy: Define explicit **triggers** for revision, rather than giving a static order that might become dangerous in 6 hours.

The Consultant's Summary

ORIENTATION
(The Map)

- Hemorrhagic instability?
- Thrombotic recency/severity?
- Is bleeding disproportionate?
- What is the Trajectory/Tempo?

THINKING
(The Weight)

- Which harm is asymmetric right now?
- Avoid Binary Framing.
- Avoid Forced Elegance.
- Assign Provisional Weight.

EXECUTION
(The Signal)

- First Safety Pass.
- Protective Escalation.
- Visible Restraint.
- Define explicit triggers for recalibration.

Shared Vocabulary

Problem Space
The clinical world the patient inhabits (danger plausibility + uncertainty tolerance).

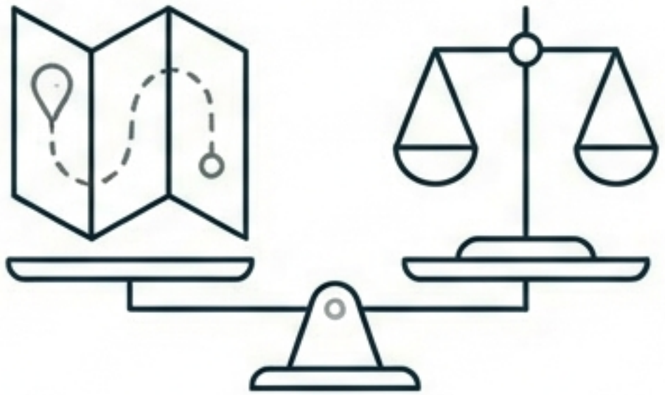
Competing-Harms Terrain
A situation where both bleeding and thrombosis are live, active dangers.

Protective Escalation
Early action to stabilize before full diagnostic clarity is available.

Visible Restraint
Deliberately holding action (like anticoagulation) anticoagulation) and communicating the rationale clearly.

Resumption Threshold
The clinical point where restarting anticoagulation becomes safer than holding it.

The Expert's Role



- **Define the Map.**
- **Assign the Weight.**
- **Make Judgment Visible.**

Anticoagulation with bleeding is not a diagnosis. It is a **signal**. Danger comes from failing to weight the trade-offs as the biology evolves.