Content strategy for Instagram stories

Stories = Recency + Micro-Engagement

Stories are our most immediate content layer — designed to capture attention through timeliness and sustain habit through micro-engagement.

At their core, stories are defined by two principles:

1. Recency

Stories must reflect what is currently happening in medicine.

They serve as a real-time lens into the evolving clinical world, responding to:

- Global and national health awareness days (e.g., World Hypertension Day)
- Disease-specific months and campaigns (e.g., Breast Cancer Awareness Month)
- Emerging outbreaks and endemic patterns covered in the news
- Newly published society guidelines and consensus updates
- Recent breakthroughs, trial results, or practice-changing recommendations

Stories ensure that clinicians are always anchored to the present — not studying medicine in isolation, but in synchrony with the real clinical and public health landscape.

2. Micro-Engagement

Stories are intentionally lightweight, fast, and repeatable.

They are not meant to overwhelm, but to create small cognitive moments:

- A single question that triggers recall
- A quick decision point that mimics bedside thinking
- A short guideline update that reshapes practice
- A micro-vignette that sparks curiosity
- A high-yield clinical pearl that stays memorable

This makes stories the perfect daily touchpoint — low effort, high relevance, habit-forming.

Stories as the Frontline of Clinical Cognition

Stories are not standalone posts. They are the entry layer into deeper clinical reasoning.

Each story will be structured across different formats depending on the cognitive layer being targeted — from awareness and recall, to decision-making, to guideline integration.

Over time, stories function as:

- A daily pulse of modern medicine
- A micro-learning loop for residents
- A bridge between updates and real-world clinical application
- The first step in building augmented clinical thinking

Stories are where clinical cognition begins — fast, current, and engaging.

Orris Does Not Teach — Orris Reminds

At every point, Orris stories must avoid the feeling of instruction, coaching, or authority-based teaching.

The tone is never:

- "Here's what you should know"

- "Let us explain"

- "This is the correct answer"

Instead, Orris functions as a cognitive copilot:

- Quietly surfacing high-yield knowledge

- Reinforcing existing clinical memory

- Triggering recall through micro-prompts

- Helping residents stay sharp without feeling lectured

The experience should feel like:

- "Oh right, I remember this."

- "Good reminder."

- "That's useful to keep in mind today."

> "From Knowledge to Clinical Wisdom: The Doctor's Cognitive Journey"
>
> Facts → Understanding → Observation → Pattern Recognition → Supervised Practice → Independence → Teaching → Continuous Refinement
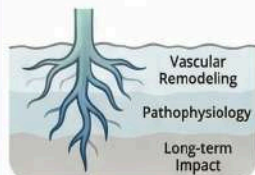
Lets deep dive into each facets one by one.

Facts - Memory

(information)

Facts - Memory: 5 Clinical Recall Strategies

SECTION 1 - FOUNDATION WITH DEPTH

Vascular Remodeling
Pathophysiology
Long-term Impact

- One Core Concept
- One Depth Layer
- Why It Matters

"HTN = years of vascular remodeling underneath"

Use: Awareness days, guideline shifts

SECTION 2 - SIMPLIFYING FACTS

Complex Web → Clean Single Line

- One-Line Truth
- Minimalist Reduction
- High-Speed Retrieval

"'-pril' → RAAS + kidneys + potassium

Use: Exam facts, ward decisions

SECTION 3 - MICRO-MNEMONICS

Patient Scenario Box → Memory Hook: FAST

- Scenario-First
- Clinical Bookmark
- Natural, Not Gimmicky

"Confused + sweaty + tachy → FAST check glucose"

Use: Emergency patterns, diagnostic reflexes

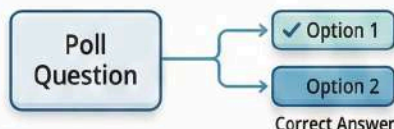## SECTION 4 - DRUG RECALL

- 🔒 MOA
- ✅ DOC
- ⚠️ Caution

- Drug → Why Today
- DOC vs Alternative
- One Key Caution

"Metformin: anchor. CKD limits it → SGLT2 next"

Use: OPD essentials, ICU drugs

SECTION 5 - RAPID RECALL QUIZ

Poll Question → ✓ Option 1 / Option 2
Correct Answer

- One Question
- 2-4 Options
- One-Line Reasoning

"Most common 2° HTN in young adults? → Renal artery stenosis"

Use: Diagnostic pivots, reflex checks

"Your brain, but faster — Not a teacher, but shorter"

✅ Short ✅ Clinically grounded ✅ Reminder-first ✅ Resident-native ✅ Triggers recall

1. Foundation with Depth (Single Anchor Concept)

Goal: Reinforce one core clinical concept with subtle depth — not as a lesson, but as an anchor.

Format Style:

- One statement clinicians already recognize
- One additional layer that sharpens it
- A quiet "why it matters" cue

Story Example Tone:

> "Hypertension isn't just a BP number — it's years of vascular remodeling underneath."

Key Design Rule:

- No full explanation
- Just one extra depth layer that stays with them

Use When:

- Awareness days
- Guideline shifts
- Common conditions with hidden nuance

2. Simplifying Facts (Make Recall Effortless)

Goal: Convert complex clinical detail into a clean mental shortcut.

Format Style:

- One-line clinical truth
- Minimalist reduction
- High-speed memory retrieval

Story Example Tone:

> "If it ends in '-pril'... think RAAS + kidneys + potassium."

Key Design Rule:

- Never oversimplify into inaccuracy

- Keep it as a reminder, not a lecture

Use When:

- Exam-relevant facts

- Common ward decisions

- Frequently forgotten associations

3. Micro-Mnemonics for Clinical Scenarios

Goal: Provide quick recall hooks tied to real patient contexts.

Format Style:

- Scenario-first, mnemonic-second

- Designed like a mental bookmark

Story Example Tone:

> "Confused + sweaty + tachy → don't forget: FAST check glucose."

Or:

> "COPD exacerbation?
> Think: O_2 + Nebs + Steroids + Cover infection."

Key Design Rule:

- Mnemonics must feel clinically natural, not gimmicky

Use When:

- Emergency patterns

- Ward-based rapid decisions

- Diagnostic reflex building

4. Drug Recall for Clinicians (MOA, DOC, 2nd Line)

Goal: Strengthen prescribing memory through rapid pharmacology resurfacing.

Format Style:

- Drug → Why it matters today

- DOC vs alternative

- One key caution or association

Story Structure Template:

- Drug

- Core Mechanism (1 line)

- Where it's first-line

- If not, what next

Story Example Tone:

> "Metformin: still the anchor.
> Works through insulin sensitivity.
> If CKD limits it → think SGLT2 next."

Key Design Rule:

- No long drug lectures

- Just prescribing reflex reinforcement

Use When:

- Common OPD drugs

- ICU essentials

- Frequently confused drug pairs

5. Rapid Recall Quiz (Poll → Answer Follow-Up)

Goal: Active retrieval practice through micro-testing.

Format Style:

- One question

- Two to four options (poll)

- Next story reveals answer with one-line reasoning

Story Flow:

Story 1 (Poll):

> "Most common cause of secondary HTN in young adults?"

Story 2 (Answer):

> "Renal artery stenosis — good to remember when HTN appears too early."

Key Design Rule:

- Never frame as "test prep"

- Frame as clinical reflex check

Use When:

- High-yield differentiators

- Diagnostic pivots

- Common resident mistakes

Design Principle Across All Memory Stories

✅ Short

✅ Clinically grounded

✅ Reminder-first

✅ Resident-native tone

✅ Triggers recall, not passive reading

Orris stories should feel like:

"Your brain, but faster."

Not: "A teacher, but shorter."

Cognitive Layer 2: Concepts (Cause → Effect Understanding)

Concept Stories = The Clinical "Click" Layer

After facts and recall comes the deeper cognitive shift:

understanding why something happens.

This layer is not about memorizing more information.

It is about linking:

- symptom → mechanism

- lab → physiology

- sign → consequence

- disease → system response

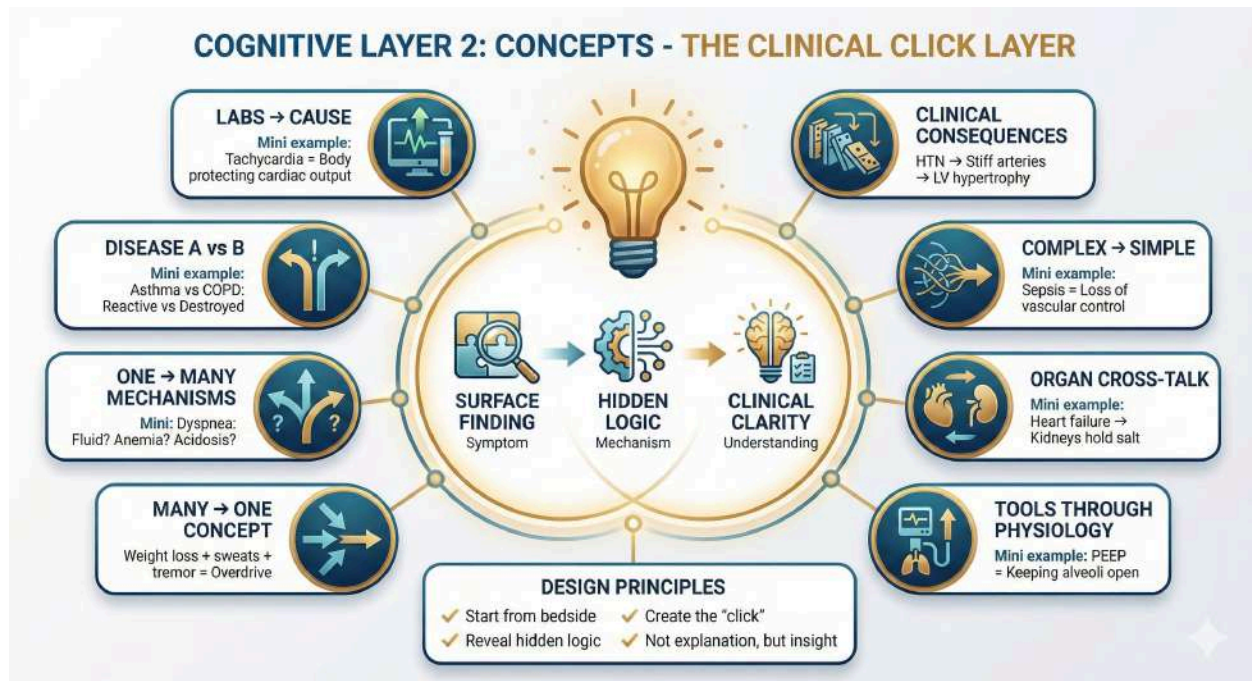Concept stories should create that moment of sudden clarity:

> "Oh... that's why the patient looks like this."
> "Now the lab makes sense."
> "This connects everything."

The goal is not to teach a mechanism, but to make the clinician see the logic underneath.

Orris remains subtle — not explanatory like a textbook, but reflective like a cognitive copilot.

Formats & Content Strategies: Concepts Layer

1. Labs, Vitals, Signs & Symptoms → Underlying Cause

Goal: Turn surface findings into physiological meaning.

Format Style:

- Present a common clinical finding
- Reveal the hidden driver beneath it
- Make the body's response feel logical

Story Tone Example:

> "Tachycardia isn't just a number…
> It's the body trying to protect cardiac output."

Use When:

- confusing vitals

- common OPD/ward signs
- early disease clues

2. Clinical Consequences (What This Leads To)

Goal: Show how one mechanism evolves into downstream harm.

Format Style:

- Start with the process
- End with the consequence clinicians see

Story Example Tone:

> "Chronic HTN stiffens arteries...
> That's why the LV eventually hypertrophies."

Key Design Rule:

- Always connect to bedside outcomes
- No deep path lecture, just the chain

3. Simplifying Complex Mechanisms into One Clean Concept

Goal: Compress complexity into an intuitive mental model.

Format Style:

- One mechanism → one metaphor-like simplification

Story Example Tone:

> "Sepsis isn't just infection...
> It's loss of vascular control everywhere."

Use When:

- residents know the words but not the picture
- ICU physiology

- endocrine pathways

4. Organ Cross-Talk (Systems Affect Systems)

Goal: Reveal how organs communicate through disease.

Format Style:

- One organ triggers another
- The clinical picture suddenly makes sense

Story Example Tone:

> "Heart failure isn't just fluid in lungs...
> It's kidneys sensing low perfusion and holding salt tighter."

Use When:

- cardio-renal
- hepato-pulmonary
- gut-immune axis
- endocrine feedback loops

5. Simplifying Tools (Ventilator, Dialysis, Inotropes) Through Physiology

Goal: Make complex machines feel like applied physiology.

Format Style:

- Parameter → physiological effect
- Tool becomes intuitive, not technical

Story Example Tone:

> "PEEP is not just pressure...
> It's keeping alveoli from collapsing between breaths."

Use When:

- ventilator settings

- ABG interpretation

- ICU decision fatigue

6. Many Consequences → One Common Concept

Goal: Show how multiple clinical manifestations share one root.

Format Style:

- List consequences

- Reveal the single unifying idea

Story Tone Example:

> "Hyperthyroid patients lose weight, sweat, tremble...
> One theme: the body is running in overdrive."

Use When:

- systemic diseases

- endocrine syndromes

- autoimmune multisystem effects

7. One Symptom → Multiple Mechanisms

Goal: Build diagnostic flexibility.

Format Style:

- Start with one symptom

- Show multiple mechanistic pathways

Story Tone Example:

> "Dyspnea isn't always lungs.
> Could be fluid, anemia, acidosis, or panic — different pathways, same
> sensation."

Use When:

- symptom-first reasoning

- emergency medicine

- high-yield differentials

8. Disease X vs Disease Y (Looks Similar, But Here's the Differentiator)

Goal: Teach discrimination, not memorization.

Format Style:

- Two similar presentations

- One key differentiator

- The "why" behind it

Story Tone Example:

> "Asthma and COPD both wheeze...
> But asthma is reversible because the airway is reactive, not destroyed."

Use When:

- common confusions

- exam pivots

- ward diagnostic traps

Design Principle: Concept Stories Feel Like Insight, Not Explanation

✅ Start from the bedside (symptom/sign/lab)

✅ Reveal the hidden logic

✅ End with clarity

✅ No heavy textbook voice

✅ Always aim for the click

Orris doesn't say:

"This is the mechanism."

Orris says:

"That's why this happens."

Cognitive Layer 3: Textbook → Reality (Clinical Complexity & Wisdom)

Reality Stories = The Resident's Awakening Layer

This layer captures the moment every clinician experiences:

> "The book said one thing… but the ward showed me another."

Medicine is not practiced in perfect presentations.

Patients rarely follow clean diagnostic chapters.

Stage 3 stories are not meant to teach facts or mechanisms.

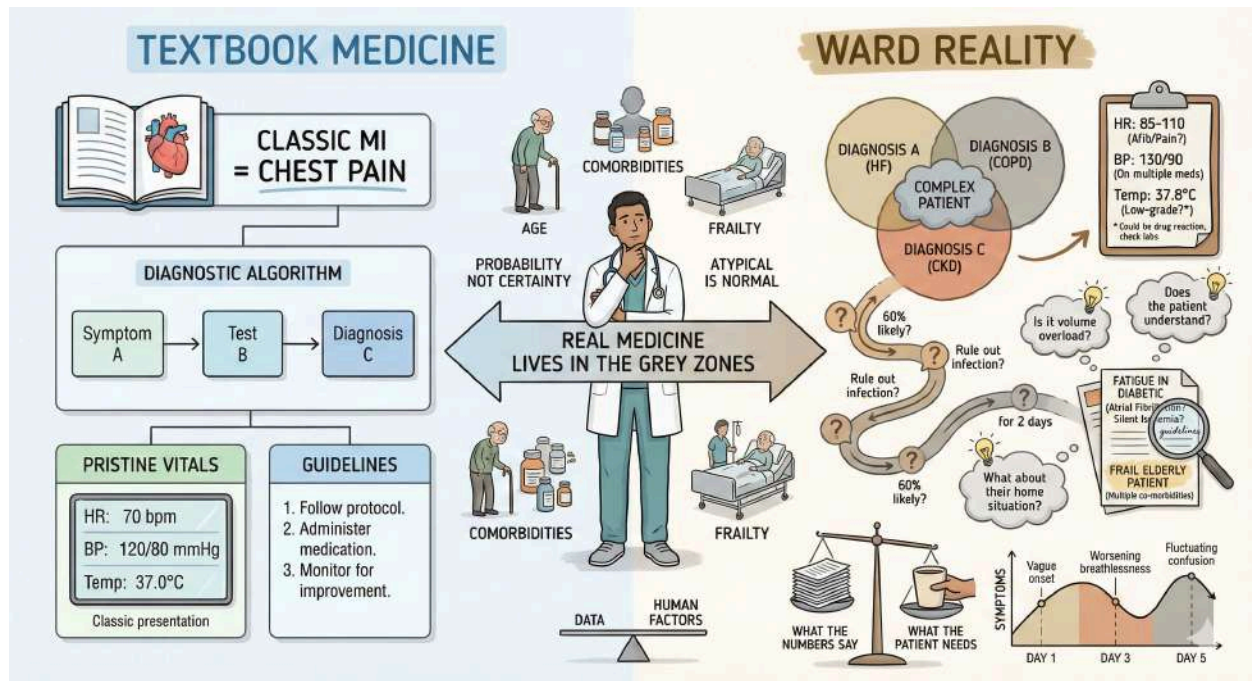They are meant to surface the deeper clinical truth:

- medicine is messy
- presentations are incomplete
- certainty is rare
- probability rules
- humans don't come with single labels

The emotional signature of this layer is:

> "Oh… real medicine is more complex than the textbook."

This is where Orris feels like a senior resident quietly whispering:

> "Welcome to the real world."

Formats & Story Strategies: Complexity & Clinical Reality

1. Textbook vs Ward Reality

Goal: Bridge idealized descriptions with real patient messiness.

Format Style:

- "Textbook says..."

- "Ward reality is..."

- One reflective takeaway

Story Tone Example:

> "Textbook PE is sudden collapse.
> In wards, it's often just unexplained tachycardia for two days."

Purpose:

- Normalize clinical ambiguity

- Build observational sharpness

2. Atypical is Not Uncommon

Goal: Break the assumption that "classic" is the norm.

Format Style:

- Common disease

- Unexpected presentation

- Quiet reminder

Story Tone Example:

> "MI doesn't always announce itself with chest pain.
> Sometimes it's just fatigue in a diabetic."

Resident Effect:

- Prevent anchoring

- Expand clinical suspicion

3. Medicine is Probability, Not Certainty

Goal: Teach medicine as Bayesian reasoning, not binary answers.

Format Style:

- No diagnosis is 0 or 100%

- Medicine is likelihood management

Story Example Tone:

> "We don't 'rule in' pneumonia.
> We decide it's likely enough to treat."

Key Shift:

- From certainty-seeking → risk-balancing

4. Incomplete Presentations Are the Default

Goal: Reinforce that early disease rarely arrives fully formed.

Format Style:

- Symptoms evolve
- First snapshot is partial

Story Tone Example:

> "Appendicitis isn't always textbook RLQ pain.
> Day 1 is often vague discomfort."

Resident Benefit:

- Watchful thinking
- Avoid premature closure

5. Real Patients Usually Have Multiple Diagnoses

Goal: Break the single-disease mindset.

Format Style:

- One symptom
- Two or three overlapping causes

Story Example Tone:

> "The SOB isn't always one problem.
> CHF + anemia + infection often coexist."

Core Message:

- Patients aren't MCQs.

6. Guidelines Are Maps, Not Terrain

Goal: Reframe guidelines as frameworks, not commandments.

Format Style:

- Guideline anchor

- Patient complexity override

Story Tone Example:

> "Guidelines say target BP <130.
> But frailty, falls, and tolerance matter more than the number."

Clinical Wisdom:

- Guidelines guide — clinicians decide.

7. Treat the Person, Not the Label

Goal: Move from diagnosis-first to patient-first medicine.

Format Style:

- Same disease

- Different patient

- Different treatment reality

Story Tone Example:

> "Two patients with COPD exacerbation...
> One needs BiPAP.
> One just needs reassurance and bronchodilator spacing."

Key Principle:

- Context changes care.

8. Treatment Changes Under Complexity

Goal: Show how comorbidities reshape "standard management."

Format Style:

- Classic treatment

- Real-world modifier

Story Example Tone:

> "NSAIDs are simple for pain...
> Until CKD and heart failure enter the room."

Use When:

- polypharmacy

- frailty

- renal/liver constraints

9. The Normal Vital Trap

Goal: Teach that "normal vitals" can hide danger.

Format Style:

- Normal number

- Abnormal context

Story Tone Example:

> "BP 110/70 looks fine...
> Unless their baseline is 180 and they're septic."

Resident Skill Built:

- Relative abnormality recognition

10. Clinical Grey Zones (Where Medicine Lives)

Goal: Normalize uncertainty and decision-making under ambiguity.

Format Style:

- Not clear-cut

- Tradeoffs exist

- Monitoring is management

Story Tone Example:

> "Not every fever needs antibiotics.
> Not every fever can wait.
> The grey zone is the job."

Emotional Outcome:

- Confidence without false certainty

Design Signature of Stage 3

Stage 3 stories should feel like:

✅ lived experience

✅ clinical realism

✅ wisdom, not information

✅ uncertainty handled calmly

✅ "this is what residency actually feels like"

Orris is not saying:

"This is the answer."

Orris is saying:

> "This is real medicine."

Cognitive Layer 4: Clinical Intuition & Pattern Recognition

Intuition Stories = The Exposure Compression Layer

Clinical intuition is not magic.

It is what happens when repeated exposure creates mental shortcuts:

- syndrome recognition

- early danger sensing

- rapid prioritization

- automatic next-step reflexes

Over time, the clinician stops processing each case from scratch.

Instead, they begin to think in patterns:

> "This looks like adrenal crisis."
> "This patient is quietly crashing."
> "This is septic shock until proven otherwise."

Stage 4 stories are designed to **simulate exposure**.
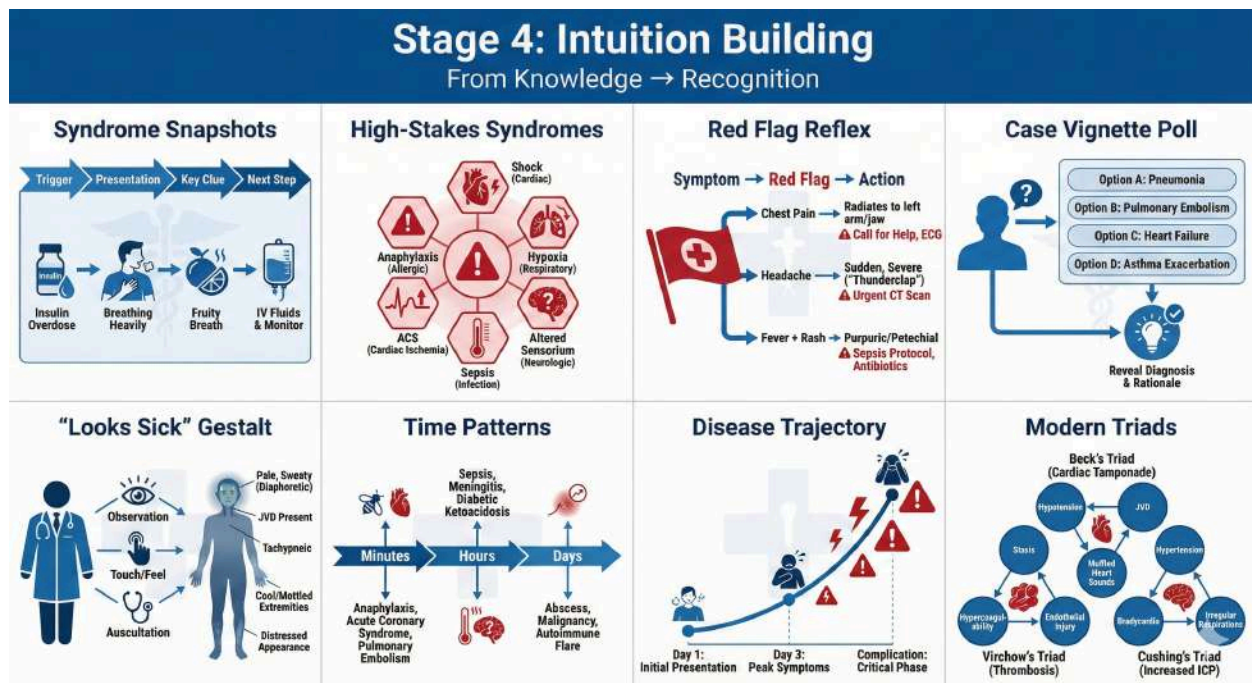
Short, repeated clinical snapshots allow residents to build:

- illness scripts

- heuristics

- red flag reflexes

- time-sensitive instincts

The emotional signature of this layer is:

> "I've seen this before... I know what this is."

Formats & Story Strategies: Intuition Building

1. Syndrome Snapshots (Illness Scripts in 4 Steps)

Goal: Build a compressed mental template for common syndromes.

Format Style:

- Trigger

- Presentation

- Key clue

- Next step

Story Template:

- **Trigger:** What starts it

- **Presentation:** What walks in

- **Key clue:** What reveals it

- **Next step:** What you do now

Tone Example:

> "Trigger: missed insulin
> Presentation: vomiting + deep breaths
> Key clue: fruity breath + high AG
> Next step: fluids first, insulin next"

These become the building blocks of intuition.

2. Pattern Recognition for High-Stakes Syndromes

Goal: Rapid identification of life-threatening states.

Core focus syndromes:

- Shock

- Hypoxia

- Altered sensorium

- Sepsis

- Acute coronary syndromes

- Anaphylaxis

Story Tone Example:

> "Hypoxia with quiet chest + normal wheeze?
> Think PE, not asthma."

These stories train the mind to spot danger before labels.

3. Red Flag Reflex Stories (Fast Danger Cues)

Goal: Make red flags automatic.

Format Style:

- Symptom

- One red flag

- Immediate action cue

Tone Example:

> "Back pain + fever + neuro signs = don't miss spinal epidural abscess."

Key Principle:

Red flags are not trivia — they are survival heuristics.

4. Case Vignette → Poll → Pattern Reveal

Goal: Active pattern completion.

Flow:

Story 1: Vignette + Poll

> "25M, fever, hypotension, rash after antibiotic.
> What's the state?"

Options:

- Septic shock

- Anaphylaxis

- Adrenal crisis

- Cardiogenic shock

Story 2: Pattern Explained

> "Anaphylaxis: rapid onset + rash + exposure trigger.
> Epinephrine is the step, not fluids alone."

This builds intuitive recall through retrieval.

5. "This Patient Looks Sick" Patterns

Goal: Build gestalt recognition beyond numbers.

Format Style:

- Subtle cues

- Overall impression

- Early escalation instinct

Tone Example:

> "Normal BP doesn't mean stable.
> A patient who is diaphoretic, restless, and silent is often pre-collapse."

This trains clinical sensing.

6. Time-Associated Patterns

Goal: Link timing with diagnosis.

Format Style:

- Symptom + time course

- Most likely pattern

Examples:

> "Sudden worst headache → SAH pattern."
> "Fever day 7–10 in dengue → leakage phase risk."
> "Chest pain minutes → ischemia. Hours → infarction. Days → pericarditis."

Time becomes a diagnostic clue.

7. Disease Progression Patterns (Trajectory Awareness)

Goal: Teach residents what comes next.

Format Style:

- Day 1 picture

- Day 3 evolution

- Complication arc

Tone Example:

> "Pancreatitis isn't dangerous on admission.
> The danger is what follows: third spacing → ARDS → sepsis."

This builds anticipation, not reaction.

8. Modern Triads (High-Yield Clinical Groupings)

Goal: Replace outdated textbook triads with real-world clusters.

Format Style:

- 3-part pattern

- Associated syndrome

- Next reflex

Examples:

> "Hypotension + lactate + confusion = occult shock."
> "Tachypnea + agitation + normal SpO_2 = early hypoxia."
> "Fever + cytopenia + organomegaly = think HLH early."

These become bedside mental shortcuts.

Design Signature of Stage 4

Stage 4 stories must feel like:

✅ repeated clinical exposure

✅ compressed mental scripts

✅ fast heuristics, not deep explanations

✅ urgency-aware

✅ resident-real

Orris is not saying:

"Here is the full differential."

Orris is saying:

> "This is the pattern. Don't miss it."

Cognitive Layer 5: Cognitive Traps & Clinical Guardrails (Debiasing in Practice)

Bias Stories = The Safety Layer of Clinical Thinking

Medicine is not only about what you know.

It is about *how your mind moves under pressure*.

Most real diagnostic and management errors don't come from ignorance.

They come from predictable cognitive traps:

- stopping too early

- locking onto the first story

- trusting labels too much

- acting because silence feels uncomfortable

Stage 5 stories are designed as subtle mental guardrails.

Not:

"This is anchoring bias."

But:

> "Quick pause — are we stuck on the first answer?"

The tone is always supportive, resident-native, and practical.

The emotional signature of this layer is:

> "Wait… let me sanity-check my thinking."

Formats & Story Strategies: Debiasing Without Lecturing

Each bias story follows one simple structure:

- **Clinical moment** (real ward scenario)

- **The trap** (unspoken)

- **The reset question** (copilot intervention)

- **The safer next move**

These are not psychology lessons.

They are bedside cognitive nudges.

Bias Themes to Cover (With Story Templates)

1. Anchoring Trap (First Impression Lock-In)

Clinical Pattern: First diagnosis sticks too hard.

Story Tone:

> "If the first label disappeared... what else would fit?"

Copilot Reset:

- Re-list 2 alternate diagnoses.

2. Premature Stop Trap (Thinking Ends Too Soon)

Story Cue:

> "The case feels solved... but does anything not explain itself?"

Reset:

- Identify one loose thread.

3. Evidence Filtering Trap (Only Seeing Supporting Signs)

Story Cue:

> "What finding would prove me wrong right now?"

Reset:

- Search for disconfirming evidence.

4. Recent Memory Trap (The Last Case Echo)

Story Cue:

> "Just because you saw it yesterday... doesn't mean it's today."

Reset:

- Return to base rates.

5. Classic Presentation Trap

Story Cue:

> "Real disease doesn't read the textbook."

Reset:

- Ask: "What's the atypical version?"

6. One-Finding Trap (Search Satisficing)

Story Cue:

> "Finding one abnormality doesn't end the search."

Reset:

- Ask: "What else could coexist?"

7. Label Momentum Trap (Diagnosis Carried Forward)

Story Cue:

> "Inherited diagnoses deserve re-earned trust."

Reset:

- Reassess from zero.

8. Framing Trap (Presentation Bias)

Story Cue:

> "If this was presented differently... would I think differently?"

Reset:

- Restate case in neutral terms.

9. Confidence Trap

Story Cue:

> "High confidence is not the same as high accuracy."

Reset:

- Ask: "What am I missing?"

10. Blind Trust Trap (Tests/Authority Over Clinical Sense)

Story Cue:

> "Treat the patient, not the printout."

Reset:

- Clinical picture > single test.

11. Action Pressure Trap (Commission Bias)

Story Cue:

> "Doing something is not always better than doing the right thing."

Reset:

- Pause: "Does this intervention change outcome?"

12. Fear of Harm Trap (Omission Bias)

Story Cue:

> "Avoiding action can also be an action."

Reset:

- Balance risk of waiting vs acting.

13. Probability Blindness (Base Rate Neglect)

Story Cue:

> "Rare things happen... but common things happen commonly."

Reset:

- Start with prevalence.

14. Result-Based Judgment Trap (Outcome Bias)

Story Cue:

> "Good outcomes don't always mean good decisions."

Reset:

- Judge reasoning, not result.

15. After-the-Fact Obviousness Trap (Hindsight Bias)

Story Cue:

> "It's obvious only once you know it."

Reset:

- Focus on information available then.

16. Patient Attribution Trap

Story Cue:

> "Patient identity should not become diagnosis."

Reset:

- Separate behavior from pathology.

17. Emotion Drift Trap (Affect Heuristic)

Story Cue:

> "Strong feelings distort clean thinking."

Reset:

- Slow down when irritated or overly sympathetic.

18. Plan Commitment Trap (Sunk Cost)

Story Cue:

> "Time invested doesn't make the plan correct."

Reset:

- Ask: "What would I do if starting fresh?"

19. Triage Label Trap

Story Cue:

> "The first label is often just a placeholder."

Reset:

- Verify severity yourself.

20. Common Answer Overreach (Frequency Gambling)

Story Cue:

> "Common doesn't mean automatic."

Reset:

- Ensure key clues align.

21. One-Diagnosis Trap (Occam Overuse)

Story Cue:

> "Sometimes it's not one disease... it's two."

Reset:

- Allow comorbidity.

22. Treatment Inertia Trap (Therapeutic Momentum)

Story Cue:

> "Just because it started doesn't mean it should continue."

Reset:

- Daily reassess necessity.

23. Emergency Action Trap (Action Bias Under Stress)

Story Cue:

> "Fast is good. Clear is better."

Reset:

- Stabilize first, label later.

Design Signature of Bias Stories

Stage 5 stories should feel like:

✅ internal resident voice

✅ quick mental checkpoint

✅ clinical realism

✅ supportive correction

✅ never a psychology lecture

Orris is not saying:

"Here are cognitive biases."

Orris is saying:

> "Quick pause — sanity check this step."

Recommended Story Products in This Layer

- "One-Line Trap + Reset Question"

- "Poll: What are we missing?"

- "Ward Moment: Classic Mistake"

- "The Diagnostic Pause Card"

- "Two Diagnoses Can Coexist" Series