

Avoiding bias in judgements, decisions and outcome

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In this module, we have considered the various biases common to most – if not all – processes involving human activity.

We have looked specifically at bias involving overconfident judgements, reflex decisions, heuristic misuse, escalation of commitment, groupthink, emotional biases and finally bias in analysing outcome. It is interesting that most of the research has not involved medical and other health service practitioners, perhaps due to the aura of professional competence ('it can't happen to us'). There has been a similar attitude amongst the financial industry, with the well-known effects of this demonstrated recently.

There is a specific professional role (indeed a duty) to select appropriate safeguards when a decision is being considered. This includes persuading the organisation (and managers) not to overuse safeguards which can be counterproductive, for example delaying discharge. Medical managers need to be sensitive when reviewing decisions made by clinical colleagues, balancing safety with freedom to practice (and to learn from outcome). I believe this is a key leadership competency for both medical managers and educational supervisors.

Being aware of potential bias in judgements, decisions and outcome analysis, it is likely that a professional will develop true and consistent reflective practice and 'think about their thinking'. Furthermore, reflective practice could well improve the professional's conduct as perceived by patients, carers and referrers (as evidenced by considered and considerate communication).

Take-home messages

- When providing diagnoses attend particularly to information which 'does not fit' and utilise collateral information (including GP notes). If in doubt, make a provisional (working) diagnosis, pending more experience during the episode of care.
- When considering risks, think of items outside your usual considerations, such as child protection, driving, exploitation, malnutrition and poor adherence of treatment.
- When deciding on action, consider alternative scenarios (what if... happens), so decisions are modifiable, given interim outcome feedback. Keep the red flags flying!
- When working in multi disciplinary groups, remember risks of groupthink; pay attention to the lone voice of uncertainty or dissent.
- Seek regular feedback about your diagnoses, risk assessments and decisions. Outcome audit is probably the most effective tool – for example, an audit of all your mental health act assessments over a three-month period or a similar audit of your risk assessments – in order to check the accuracy of your judgements.
- Think clearly about potential outcomes before decisions and action. In clinical practice, outcomes (including the duration before review) need to be negotiated

with patients, carers and other stakeholders (such as ward staff), needing considered and considerate communication from you.

- Finally, get into the habit of 'reflective practice' – thinking about your thinking – and be courageous in being open with your peers about lessons you have learned in this process. You might well become a 'change agent' in your clinical and managerial culture!

Reflection questions

(1.6) Can you define the terms 'judgement', 'decision' and 'outcome' any better [than the author]? Similarly, can you pick flaws in these definitions? How would you define bias?

(2.4) A 74-year-old man attends an A & E department with alcohol intoxication and irritability. Put yourself in the doctor's shoes. What kind of overconfident judgements might you make about the patient?

(2.5) What solutions might there be to avoid overconfidence in judgements and decisions?

(2.7) Can you think of recent examples of overconfidence you have observed, either in yourself or others? Think of the consequences and how these could have been avoided or moderated.

(3.4) A 23-year-old man attends a walk-in clinic. He has a three-month history of voices telling him to harm others. What might the doctor's reaction be when faced with this patient? What might cause him to make a reflex decision here?

(3.5) Subsequent access to past records reveals that this is a common presentation for this patient, associated with interpersonal difficulties. How do you think this situation might have been prevented? What solutions might there be to avoid reflex decision-making?

(3.7) Think of a recent decision you made and its consequences. Are intuitive decisions (at least in the British sense) always negative actions? Think of some positive outcomes following an intuitive decision.

(4.4) A 42-year-old woman with a long history of self-harm presents with a further overdose. What do you think you should look for when assessing this patient?

(4.5) The subsequent risk assessment concludes a continuing mild risk of completed suicide, despite changes of life circumstances including a move to a different area with a new partner. What do you think was the heuristic that was used here? What might be some safeguards for heuristic modes of thinking in psychiatry?

(4.7) Think of some examples of heuristics as defined above. Particularly think of your personal availability heuristics stemming from previous untoward incidents. How much do these memories influence your day-to-day practice?

(5.3) A 68-year-old man is three months into in-patient treatment of resistant depression in a tertiary centre. He shows increasing evidence of Asbergers-type premonitory traits and his medicine is completely ineffective. What do you think has happened here? What might be some ways to avoid escalation of commitment?

(5.5) Think of an example of escalation of commitment (apart from examples from politics!) How did these decision-makers fare? Did they have to be rescued? If so, how?

(6.4) A 34-year-old woman with borderline personality disorder is being considered for unaccompanied leave (following a bed management meeting). How might groupthink play a role in the team's decision whether to give leave?

(6.5) The ward team is keen to maintain 'team cohesion', and adamant this should take place despite concerns expressed by the community key worker about the woman's tendency to abscond and face vulnerability/neglect. Following leave, she is found by the police in her nightdress near a river, with no money or identity documents, with imminent hypothermia. A complaint is made by the police to the general manager of the hospital. How might this situation have been avoided? What solutions might there be to counteract groupthink?

(6.8) Think of your MDT in the ward and compare it with your CMHT. Which group is more likely to develop groupthink? Which specific features show up? (For example, can you identify a mind guard?)

(7.4) As on-call consultant for the weekend, you are presented with a long standing case for a Section 2, due to the potential risk of self-harm. You are aware that this case is complex, with difficult relationships between the mental health services and the carers due to their perception of inappropriate admissions in the past. What might your decision be in this scenario? What factors might lead to emotional bias around your decision?

(7.5) Despite concerns about the repercussions for long term relationships, you proceed with the section. You are mindful of the situation 'being sorted' for the weekend. Have you ever found yourself in a similar situation? If so, what would you have done differently on reflection? What might be some ways to avoid emotional bias?

(7.7) Have you ever made a decision to avoid a particular therapy, because of feelings of animosity towards this therapy (or a particular therapist for that matter)?

(8.4) A severe untoward incident (suicide) inquiry leads to a contested coroner's hearing with relatives looking to blame the mental health services for lack of care and supervision. The narrative findings identify two staff errors in documentation immediately prior to the suicide. The family barrister identifies these to the attending reporters as causative, suggesting a civil litigation case will be forthcoming. How might hindsight bias play a role in this case?

(8.5) The relevant staff feel undefended and misrepresented. They feel that the patient received good overall care during the whole of the admission, and that it is unfair to highlight two minor omissions immediately prior to his death. Have you ever experienced a similar situation involving hindsight bias? What safeguards might there be for avoiding hindsight bias?

(8.7) Think of discussions you have had with patients and carers about a trial of treatment. How were outcomes agreed? How did you prioritise the target symptoms? How did you agree on the durations for each outcome? Did you consider and discuss the lack of available evidence if the patient was an older adult?

Figures and tables

[Diagram 1: Usual process of decision-making](#)

References

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Edwards W & Newman JR (1982) Multi attribute evaluation, Sage Publishers.

Finklestein S, Whitehead J & Campbell A (2009) Think Again – why good leaders make bad decisions. Harvard. Harvard University Press.

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Staw BM (1976) Knee deep in the big muddy. A study of escalating commitment to a chosen course of action. *Organisational behaviour and Human performance*, **16**: 27–44. [[abstract](#)]

Tversky A, Kahneman D (1974) Judgement under uncertainty: heuristics and biases. *Science*: **185**: 1124–1131. [[abstract](#)]

Further reading

Barron J (2008) Thinking and Deciding. New York: Cambridge University Press. (One of the main texts contains the relevant research and some medical examples) [[Amazon](#)]

Gerstein M (2008) Flirting with Disaster: Why Accidents Are Rarely Accidental, Union Square. (Marc Gerstein discusses how probability theory can be ignored, especially inverse probability. In addition, he explains the research behind the finding on how we feel distress at a loss twice as intensely compared to the pleasure felt regarding a gain.) [[Amazon](#)]

Groopman J (2007) What's the trouble? Professor Groopman is a current author on the various pitfalls for doctors when making diagnoses and deciding on treatments. [[website](#)]