Blog of the Month

Dr Hannah Rowley is an FY1 in the North East of England, currently working in Gastroenterology. Before medicine she studied French then worked as an editor at a children's publishing company. This month, Dr Rowley gives us a brief guide into different forms of confirmation bias that may be encountered within Palliative Care.

Cognitive bias in end-of-life scenarios

Having graduated from medical school with an interest in palliative care, I probably dread conversations with dying patients and their families less than the average foundation doctor. I had always assumed that the most difficult aspect of these discussions would be navigating a person's emotional response to receiving bad news: the unpredictability of how they will react; the perceived intrusion into their personal distress; the desire to show genuine empathy while maintaining professional distance. As I have gained more experience, I have realised that cognitive biases add an additional layer of complexity to these conversations.

Cognitive bias is the unintentionally flawed interpretation of facts or events, which leads to judgement that deviates from rational objectivity. A common example is anchoring: we afford disproportionate weight to the first piece of information introduced when making decisions, e.g. these shoes are 50% off, therefore they must be a good deal.

Many human emotions are universal, meaning that even if we are not experiencing the same emotion at the same time as someone else, we are often able to recognise and name it; this is the foundation of empathy. Cognitive bias is another innate human tendency, but our individual heuristic shortcuts are based on personal experience, and are therefore less easily recognised and understood by others. This increases the possibility of misunderstandings and conflict, which is particularly lamentable in the context of end-of-life care. Below are a few examples I have seen in my brief experience so far.

Optimism bias: the tendency to over-estimate the likelihood of good outcomes.
A female patient in her late 50s with metastatic breast cancer is admitted to the assessment suite with hypercalcaemia. Looking through her clinic letters, I see that her oncologist has written that she was "keen" to be started on a third-line chemotherapy agent last month. They have broached the subject of palliative care involvement, but I wonder how likely she is to engage meaningfully in this if she believes that she will be in the minority of patients who have a good outcome from the treatment, rather than the majority who do not.

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Confirmation bias: the tendency to find and remember information that confirms our perceptions.
It is Saturday afternoon and I am speaking to the family of an elderly, frail patient who has deteriorated acutely. He is still receiving active treatment for his pneumonia, but my registrar has explained that his outlook is not good. After she leaves, the patient's daughter and wife relay to me the details of his three previous admissions with pneumonia, from which he recovered. They tell me that "He's been this ill before and got better, so there's no reason why he won't this time." In subsequent conversations, they focus on blood results and observation parameters that are stable or improving rather than the visible deterioration of their loved one. Despite the team's best efforts to paint a realistic picture, they continue to have a selective approach to the facts, sadly leading to a very difficult conversation when the patient's consultant decides that continuing antibiotics is not in his best interests.

Availability bias: the tendency to rely on information or examples that are immediately available when making judgements.
A patient is admitted to our gastroenterology ward. He has known metastatic rectal cancer causing chronic diarrhoea, but his symptoms have now become unmanageable. His most recent scan showed disease progression and he is for best supportive care. He has an Emergency Health Care Plan stating his preferred place of care is home, but he is willing to be admitted for treatment of reversible illnesses. Because there is an obvious explanation for his symptoms, it is not until day 3 of his admission that a stool sample is sent for culture and C. Difficile confirmed. In the context of his limited prognosis, that delay in initiating appropriate treatment and getting him home seems inadmissible.

It is not feasible to undo the evolutionary and developmental processes that culminate in a cognitive bias. The best we can do is be aware of them, both in ourselves and others, in order to mitigate the impact that they have on patient care.

Event of the month
This month the APM is holding its Palliative Care Congress between 25-26th March. Due to COVID-19 this will be held online, with the opportunity for those attending to access sessions for up to a month after the event has taken place.

*More information can be found **here.***
Discounted rates available for Junior Doctors and medical students.