Avoiding bias: the key to good leadership in practice?

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The propensity to bias is an increasingly recognised phenomenon in professional activity in general, 1 and medical practice in particular.2 It is thought that pressure of time and inadequate knowledge of the various types of bias can increase errors in clinical reasoning and actions. In addition, psychiatric practice often does not have 'gold standard' inves- tigations to confirm diagnoses, or the necessary outcome metrics to validate effectiveness of treatment' The 2008 Tooke report! describes the core role of medical staff (as opposed to other health profession- als) as having to accept ultimate responsibility for decisions in situa- tions of uncertainty and complexity common characteristics of psy- chiatric practice.

Groopman/ describes six 'cog- nitive traps' doctors can fall into. Firstly, 'availability' is judging the likelihood of an event by how read- ily it comes into a doctor's mind; for example, a psychiatrist considering a diagnosis of attention deficit hyperactivity disorder (ADHD) or generalised anxiety disorder (GAD) after attending a conference devoted to these topics. This bias can be enhanced by 'confirmation', whereby the doctor selectively accepts certain facts while ignoring other (inconvenient) data. The third pitfall is 'anchoring', when multiple diagnoses (or co-morbidities) are

1 denied - for example, the existence , of a concurrent problem with sub- stance abuse or with compliance.

The fourth bias of 'affective error' has also been described by other authors! and involves the professional letting subconscious emotions guide judgments (for example risk assessment) or decisions (the preferred treatment option). Dislike of a therapy, *eg* ECf, or a particular therapist can skew decisions, or indeed alter the initial diagnostic formulation due to awareness of the expected decision.

Groopman also describes the risk of 'premature closure'. **In** this, the diagnostic investigation is ter minated soon after a positive finding is detected, often missing an underlying problem, for example picking up an affective disorder, but missing a dementia. Finally, he describes 'diagnostic momentum' - when doctors and other profes- sionals unquestioningly accept the original diagnosis or treatment plan. This has been described by other authors'' as 'group think' and can happen in multidisciplinary teams where challenge is discour-aged, sometimes subtly, to pre- serve group cohesion and goodwill. There are two main solutions to bias. Firstly, bias often reveals itself when outcomes are unexpectedly poor. At that stage it may be possible to rectify the effects of the specific bias by applying a counterbalancing mechanism.

In psychiatry, examples include requesting a second opinion on diagnosis or treatment, or review- ing all the existing data looking for errors in application. The alternative strategy is to pro actively avoid / bias by placing appropriate safe-guards. Psychiatric examples include routinely arranging a col- lateral history, or carrying out a comprehensive risk assessment prior to a patient being discharged.

Professionalism

A professional would pro actively look out for potential bias in any presenting situation or task. He or she would then go on to consider appropriate safeguards and interim reviews, to minimise the harmful effects of bias. However, it needs to be appreciated that an excess of safeguards would also be counter- productive; liable to slow down the decision-making process and reduce effectiveness. Therefore, an effective professional would select the minimum number of appropriate safeguards to deliver the necessary safety from bias.

Furthermore, in my opinion, a true professional has the capacity for reflective practice, *ie* 'thinking about one's thinking and actions'. This is also described as 'meta cognition'.

In order to avoid repetition of errors, a professional would also endeavour to learn from past successes and fail- ures in a systematic manner. Therefore, outcome audits looking at mental health act judgements or effectiveness of hospital discharges would be useful exercises.

A 'no blame' examination of crit- ical incidents (or near misses) would also provide a useful learning experience - especially if carried out by a number of professionals joining together. However, there is a major bias in analysing outcomes, known as recency bias - the prioritising of recent actions over long-term judgments and strategy when determining the cause of an event. The best example of this is the emphasis given to the final contact and interventions when conducting a 'root cause analysis' following a suicide. This bias needs to be compensated for within audit tools, and discussed at the onset of any investigation to determine causality.

Leadership

A true leader, in my opinion, will have the courage to facilitate others in his or her team to make rational decisions; helping them to balance risk and benefit. He or she would also impartially, but saliently, communicate the context in which the decision has to be made, thereby making the choices available to the team clearer. The leader would use prior experience to highlight potential biases and help team members to select appropriate safeguards.

A leader would encourage collaboration to maximise chances of success, including getting his or her hands dirty by taking on an onerous role. Furthermore, a leader would demonstrate concern about the enterprise the team is engaged in, including supportive concern for team members when outcomes are not looking positive. Finally, a leader would provide consistent support to decision makers and be willing to accept overall responsibility for outcome.

Role of consultant psychiatrists

In my experience, bias is still not a recognised topic in medical or other professional curricula - perhaps this needs to change. For consultants to admit to bias even to their peers would be difficult, let alone to team members, trainees or managers. Breaking through this mindset would require courage.

With respect to professionalism, this is expected of consultant staff, along the lines of 'getting it right the first time'. The notion of learning from errors without blame is officially accepted, but not always consistent with actual practice when investigating critical and other untoward incidents.

The leadership role of a consultant psychiatrist might well differ from the model described above, although the general public and GPs might well expect these attributes in us. Most leadership responsibilities have been taken over by team managers, most of whom have not had training in managing propensity to bias either. Consultants, in my experience, are often left to 'advise' as opposed to lead. However, consultants can influence and support a 'no blame' type of learning culture among other team members, which does require courage and consistency.

Finally, I do believe that understanding bias and the appropriate application of safeguards are useful learning activities to be carried out with trainees, and encourage discussion of the potentially abstract ideas of professionalism and leadership. The case-based discussion (CbD) can be an appropriate format to assess the trainee's capacity to identify biases when considering diagnosis, risks and potential treatments. The consultant can help the trainee in selecting suitable safeguards, and think about how to evaluate the plan thereafter.

Conflicts of interest

None.

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