Managing Bias in Palliative Care: Professional Hazards in Goals of Care Discussions at the End of Life

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Abstract

Background: In the setting of end-of-life care, biases can interfere with patient articulation of goals and hinder provision of patient-centered care. No studies have addressed clinician bias or bias management specific to goals of care discussions at the end of life. **Objectives:** To identify and determine the prevalence of palliative care clinician biases and bias management strategies in end-of-life goals of care discussions.

Design: A semi structured interview guide with relevant domains was developed to facilitate data collection. Participants were asked directly to identify biases and bias management strategies applicable to this setting. Two researchers developed a codebook to identify themes using a 25% transcript sample through an iterative process based on grounded theory. Inter-rater reliability was evaluated using Cohen k. It was 0.83, indicating near perfect agreement between coders. The data approach saturation. **Setting/Participants:** A purposive sampling of 20 palliative care clinicians in Middle Tennessee participated in interviews. Results: The 20 clinicians interviewed identified 16 biases and 11 bias management strategies. The most frequently mentioned bias was a bias against aggressive treatment (n¼9), described as a clinician's assumption that most interventions at the end of life are not beneficial. The most frequently mentioned bias management strategy was self-recognition of bias (n ¼ 17), described as acknowledging that bias is present.

Conclusion: This is the first study identifying palliative care clinicians' biases and bias management strategies in end-of-life goals of care discussions.

Strengths: All participants were board-certified in hospice & palliative medicine and all of them had minimum of 1 year experience in palliative care (more than 70% had >5 yr experience). Good coding and inter-coder reliability during analysis.

Weaknesses: Study was conducted in Tennessee and palliative care physicians outside Tennessee were not interviewed, thus this study may just represents biases and bias management strategies of clinicians in Southeast US. This study relied exclusively on physician's self-identification to exhibit the biases and bias management strategies relevant to these conversations.

Applicability to palliative care: In the final stages of a serious life-threatening illness, many patients die, in settings where these patients do not receive care designed to address suffering in the last hours of life. Providing medical care to actively dying patient presents challenges for the physicians. Patients in their final days need cautious symptom management, and their families need solace and education as death approaches. Given the contexts of palliative care practice, these biases should not be surprising and cannot be easily educated out of existence. This highlights the importance of bias management strategies. Further studies should engage palliative care clinicians from other regions and other nations and should use more exhaustive methods to identify both biases and bias management strategies.