THE ETHICS OF NUDGING IN THE PHYSICIAN-PATIENT RELATIONSHIP:
MAXIMIZING AUTONOMY WHEN IT REALLY COUNTS

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Abstract

Human behavior is guided largely by our cognitive biases, which can sometimes lead to suboptimal decision-making. Nudges exploit these cognitive biases in order to steer decision-makers towards their best interests without limiting their freedom of choice. In the context of clinical medicine, nudging has come under scrutiny for its potential to undermine patients’ autonomy. Although it is a form of external control over their choices, nudging is an ethically acceptable way for physicians to try to influence patients’ behavior in the context of everyday medical decisions (EDs) because both parties have a shared goal of maximizing the patient’s health and wellbeing. However, for more consequential, life-altering decisions (LADs), physicians are obligated to attempt to maximize patients’ internal control over their choices due to the deeply personal nature and high-stakes consequences of LADs. One way they might do this is by employing de-biasing techniques in order to engage patients’ deliberative, conscious cognitive processes. Beyond the increased likelihood of producing an outcome that aligns with the patients’ actual values and preferences, this tactic is likely to have multiple other benefits for both the physician and the patient.

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Introduction

Nudging is a behavioral economics concept brought to the mainstream by economists Thaler and Sunstein that has recently infiltrated the fields of medicine and medical ethics. A nudge is a gentle push or guidance towards a choice, and in the context of Thaler and Sunstein’s idea of “libertarian paternalism,” it is a freedom-preserving form of choice architecture that steers people towards the option that would serve their best interests in a way that is transparent, publicly defensible, and easily avoidable. In medicine, in the process of trying to improve patients’ physical and mental health, clinicians constantly nudge their patients towards the choices that would best achieve that outcome. In doing so, however, they have run up against accusations claiming that steering patients in this way is too paternalistic (Ploug & Holm). Others have defended the practice of clinical nudging by arguing that physicians are obligated to protect their patients’ best interests and that nudging is an effective way to accomplish this (Munoz et al.).

To start with, human cognition is governed by two main systems. When we consider all the decisions we make on a day-to-day basis, most are influenced by “System 1,” or unconscious, rapid, gut-reaction judgments. It requires much more cognitive effort for us to switch over to “System 2,” our slower, conscious, deliberative thoughts. System 1 encompasses our cognitive biases, such as default effects\(^1\), framing effects\(^2\), optimism bias\(^3\), and priming\(^4\),

\(^1\) People are more likely to stay with preset options than they are to actively change those options, e.g. the default settings on your computer or smartphone.
\(^2\) People will respond differently to equivalent information depending on how it is presented, e.g. people will purchase more fuel if the gas prices are discounted for those paying with cash rather than up-charged for those paying with credit.
\(^3\) People tend to believe they are better off than they actually are, e.g. smokers tend to believe that they are less likely to develop cancer than non-smokers do.
\(^4\) People are more likely to recall certain things or act certain ways when subtly prompted to do so, e.g. people who read a list of words related to old age are likely to perform a subsequent task more slowly than they would have otherwise.
among others, and may lead to suboptimal decision-making (Thaler & Sunstein). These types of intuitive cognitive biases can steer us wrong in many ways (e.g. optimism bias may lead us to engage in riskier behavior, if we believe that we are less likely to suffer any consequences for it), and so they are a prime target for interventions like nudging, especially in clinical medicine. Manipulation of default settings is one of the most common forms of nudges (e.g. requiring people to actively opt-in, rather than opt-out of organ donation when registering a license). Use of the framing effect can also be an effective nudge (e.g. patients may choose different treatment options if the prognosis is described as 90% survival rather than 10% mortality). Nudgers also take advantage of priming effects by inducing subtle change in the context or environment, such as increasing the salience or visibility of an item (e.g. placing all the healthy snacks near the register makes a person more likely to purchase them) (Ploug & Holm). Nudges exploit these and our many other cognitive biases, and physicians employ these techniques (defaults, framing, etc.) in order to guide their patients into the decisions they believe are best for them without, of course, actually limiting any of their options.

To answer concerns about how “libertarian” this form of “soft” paternalism really is, there are three different types of freedom we might be interested in protecting. First and foremost, we would want to ensure that patients are free from coercion and strong barriers to legitimate options. Neither of these are at issue in nudging – it necessarily protects freedom of choice, and it excludes any influence that is not easily overcome. Second, we may worry that nudges are a form of external control – a manipulation that, while not necessarily coercive or option-limiting, may be problematic or autonomy-limiting. I argue in the next section that while nudges may be a form of manipulation, they are not problematic (at least not for everyday medical decisions). Patients are people who are vulnerable to making poor choices, and it is a
physician’s duty to steer those under her care towards their best interests. Finally, as a society that places great value on autonomy and self-determination, we might also worry that, by exploiting these cognitive biases, we might be preventing patients from exercising internal control over their own choices. I will argue that for most decisions, this is 1) unavoidable, 2) obligatory for everyday decisions (EDs), and 3) only problematic in high-stakes, life-altering decisions (LADs), where we hope that the patient’s subjective values and preferences will be the guiding factor in the decision. I will make the case that for these LADs, physicians are obligated to take the extra step of attempting to “de-bias” their patients in order to ensure their values and preferences are aligned with their decisions.

The Unavoidability and Appropriateness of Nudging in Everyday Medicine

To be clear, though System 1 can sometimes steer us wrong, our cognitive biases and the heuristics we use to make thousands of decisions daily are incredibly useful to us. These cognitive “traps” are evolutionarily preserved – they are meant to guide us through our everyday life so that we do not become overwhelmed by continually engaging our System 2 deliberative reasoning (Kahneman). If, every time a person had to make a choice, they engaged in a deliberative process that took time, effort, and cognitive resources, they might never get through their day! Instead, our everyday actions and choices are influenced by our environment and the choice architecture around us. Because heuristics and cognitive biases are necessary to everyday decision-making, the triggering of these flawed cognitive processes is inevitable. This leaves us

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As Daniel Kahneman, one of the founding members of the field of behavioral economics, states in his book *Thinking, Fast and Slow*, “the phrase ‘pay attention’ is apt: you dispose of a limited budget of attention that you can allocate to activities, and if you try to go beyond your budget, you will fail.”
with choice architects (in clinical medicine, these are physicians) who are able to help shape the context in which we make these intuitive choices. Without this guidance, patients would still be influenced by these external forces, but they may not necessarily benefit from them. If the choice architecture were not organized around beneficence, then some other force (e.g. randomization\textsuperscript{6}) would take over as the influential factor in the patient’s decision-making process. In other words, there is no “neutral” choice architecture (Thaler & Sunstein). Physicians require that patients participate in their own care, however, and to that end, they have an interest in triggering these biases in a deliberate, systematic way that will benefit their patients’ wellbeing – nudging.

As mentioned, the triggering of cognitive biases and heuristics is unavoidable, especially in clinical medicine. How can a clinician engage in any type of information-sharing without presenting it in some kind of order, or framed in some way? How else can one present survival statistics, for example?\textsuperscript{7} The limitation of the options presented to only the non-absurd, evidence-based ones is itself a nudge – this type of “decisional antecedence” on the part of the provider frames the patient’s choices in terms of the acceptable best practices (Munoz et al.).\textsuperscript{8} Studies have shown even the littlest details, like how a physician introduces herself or the type of clothes she is wearing (e.g. scrubs vs. a white coat) can make a difference in how the information she presents is perceived by a patient (Cohen). If we agree that many nudges are unavoidable (i.e. that for some decisions, there is no form of neutral choice architecture), then certainly patients ought to be guided towards the most beneficial option (Thaler & Sunstein).

\textsuperscript{6} There also exists the possibility for the choice architect to present the options maleficiently or to the benefit of their own selfish interests (Thaler & Sunstein).
\textsuperscript{7} Even if one tried to present both frames (e.g. “90% survival, which means 10% mortality”), one frame would necessarily come first, and ordering also influences the System 1 automatic processes.
\textsuperscript{8} In other words, a patient with high blood pressure may be given a choice between two anti-hypertensives, but not, say, brain surgery. The options are limited to those that are relevant, evidence-based, and likely to benefit the patient. This is an \textit{a priori} judgment on the part of the physician. As long as she does not block her patients from \textit{legitimate} options, it still counts as a nudge.
Though nudging may be inescapable, clinical medicine is also the ideal context for implementing this kind of beneficial choice architecture. As Thaler and Sunstein put it, “it is particularly hard for people to make good decisions when they have trouble translating the choices they face into the experiences they will have.” In making medical decisions for themselves, patients are inexperienced, uninformed, and lack ongoing feedback, making it the perfect scenario for nudging. Medicine is complicated, requiring experts such as doctors to decipher and translate it. It is also true that people (unless they have been unfortunate enough to come into frequent contact with the healthcare profession) are inexperienced at making medical decisions. Finally, there are many decisions to be made without the chance to receive feedback and adjust course – key elements in learning to make good choices for oneself (Thaler & Sunstein).

Not only is medicine an ideal context for nudging, but patients also expect their doctors to steer them in the right direction. In fact, as Munoz et al. point out, it would be inappropriate for a patient to show up at the doctor only for the doctor to respond that they have no suggestions for how to move forward. Patients go to their doctor for advice, not just information, and they rely on their clinical judgment in order to proceed with their medical care. For instance, we don’t just rely on an EKG to diagnose a person with chest pain (even though they are relatively sophisticated machines and do a decent job of flagging important findings) – we want a human with good judgment to guide us towards the correct diagnosis and our ultimate best interests.

One of the reasons patients do expect nudging to occur is that doctors are experts in the field of medicine. They attend four years of medical school, complete anywhere from three to ten years of post-graduate training, and undergo countless standardized and subjective evaluations in order to be able to provide patients with competent clinical care. There is no possible way to make
patients fully informed about each choice, nor should doctors attempt to do so – their job is to provide the relevant information (i.e. to explain the intervention, as well as its risks, benefits, and alternatives), check for understanding of this basic information, and provide recommendations based on their experience, evidence-based medicine, and best practices of the profession. Thus, I would argue that the everyday clinical context aligns well with Thaler and Sunstein’s original idea of when it would be appropriate to apply nudging, as well as patients’ expectations from the physician-patient relationship.

The Obligation to Nudge in Everyday Medicine

To prove the obligation for physicians to nudge their patients, I will employ Clavien’s framework for evaluating nudges. In order for a nudge to be justifiable, we require 1) its goals to be justifiable, 2) the nudge to be effective at achieving those goals, 3) the nudger to be trustworthy, and 4) for any ethical concerns regarding the application of the nudge to be addressed. In medicine, the goals for the nudge are not selfish (in that they do not benefit the physician directly) – they are patient-driven nudges that are guided by beneficence and align with what the patients would actually want for themselves. In studies of shared decision making, around half of people prefer to be guided into which treatment option they should choose. Patients have been noted to say things like, “What would you do if you were me?”, or “I trust you to make the right decision.” In studies of the default effect, for example, many patients do not demonstrate any true preference in the decisions they make, as they do not change their choices either when made aware of the possibility for nudging to influence their decision.

9 In fact, there is lots of evidence to suggest that too much information and/or too many choices result in poorer decision-making (Nagel & Reiner).
beforehand or after the fact (Gorin et al.). Empirically, “people accept being softly manipulated as long as nudgers’ goals are aligned with their own objectives in life,” which in the case of clinical medicine is the patient’s wellbeing (Clavien). This evidence shows that patients are at least aware of their deficits in their ability to reason perfectly about their medical care, and that nudges would be an appropriate and appreciated way for doctors to help them choose the option that would be in their best interests. To the second requirement, nudges are extremely effective at accomplishing their ends. I will not describe the troves of empirical evidence showing the efficacy of nudges (including clinical nudges) for meeting this requirement, but there is plenty available in the literature.

As for the trustworthiness of the nudger, I believe that both the obligations of their professional role and the requirements of libertarian paternalism (as set out by Thaler and Sunstein) influence the way we can legitimate physician nudging. From the Hippocratic Oath to the AMA Code of Medical Ethics, the themes of responsibility to the patient and the duty to help the sick are deeply embedded in the medical professional codes of conduct. Knowing how effective nudging can be in achieving these ends, a failure to nudge may actually count as a dereliction of one’s professional duty to act beneficently and to do no harm (Munoz et al.). For example, if a patient required a medical intervention, such as a treatment regimen for his hypertension, and his doctor did not steer him towards the optimal, evidence-based option, she would be derogating her responsibility as his physician. Indeed, Clavien describes a way to think of nudges as a new technology that has the potential for a positive social impact. Like the defibrillator or any other demonstrably effective tool, its potential for benefit creates a moral responsibility for nudgers to at least evaluate their use (Clavien). Additionally, if the nudge
meets all the criteria that Thaler and Sunstein set out (i.e. that the nudge be transparent\textsuperscript{10}, publicly defensible, easily avoidable, and choice-preserving), many of the concerns about whether we can trust physicians to deploy this tactic without trampling on autonomy would be lifted. For example, if patients are more willing to engage in health behaviors (such as applying sunscreen or exercising) when framed as a gain instead of a loss (e.g. “sunscreen will improve the appearance of your skin” instead of “not applying sunscreen will put you at risk for skin cancer”), then a doctor ought to counsel her patients in a way that reflects this information, since the ultimate goal is the wellbeing of patients (Moxey et al.). This example is certainly publicly defensible (who would object to healthier skin?) and could easily be transparent (i.e. the patient received the message at the dermatologist’s office). The doctor does not coerce her patient in any way, nor does she block any of his options, and thus it is easily avoidable and choice-preserving: he can certainly choose not to wear sunscreen, or even to wear suntan oil and use UV tanning booths instead. He is simply more likely to apply the sunscreen (a potentially life-saving measure for those at risk of skin cancer) when the clinician employs this tactic. This is all to say that while the nudge is a form of external manipulation, when guided by professional obligations of beneficence and non-maleficence, as well as the constraints imposed by Thaler & Sunstein, we can trust the physician to act well.

Finally, the main ethical consideration we are concerned with in nudging is preservation of autonomy. While the rejection of “hard” paternalism (i.e. doing what we believe is best for the patient, whether they would agree with it or not\textsuperscript{11}) in medicine is somewhat recent, the notion of

\textsuperscript{10} Transparency is important to autonomy concerns as well – as DiSilvestro puts it, “transparency matters, in part, because we do not want to be mere cogs in someone else’s social machine, cut off from the possibility of knowing that we are being nudged and prevented from finding out how and why and by whom we are being nudged.”

\textsuperscript{11} A common example is the fact that until the later part of the last century, physicians would not inform patients of upsetting diagnoses. They believed they were acting beneficently, but in fact, were deceiving their patients and depriving them of the opportunity to understand what was happening to them (Beauchamp & Childress).
acting in a patient’s best interests is certainly not, and when the paternalism is weak (as it is in libertarian paternalism), they are not mutually exclusive (Thaler & Sunstein). Nudging patients gives clinicians “the power to more effectively protect and promote the best interests of patients by reducing the role that arbitrary and sometimes harmful influences play in their medical decision-making” (Gorin et al.). It exploits the very elements that make humans sub-optimal decision-makers (their cognitive biases) and uses them to advance the patient’s well-being without limiting his freedom to choose otherwise.

However, as discussed previously, while it might be acceptable to manipulate patients’ actions externally through the use of nudges, this may prevent them from exercising a form of internal control that is essential to leading a self-determined life. Indeed, Ploug & Holm posit that nudging “subvert[s] the patient’s autonomous choice and replace[s] it with a choice that, seen from the doctor’s perspective, is better for the patient.” While I agree that nudging does constitute a form of external control (which, to some extent, violates the principle of autonomy and its requirement of “freedom” from such manipulation), I think that it is appropriate for the principle of beneficence to take precedence in EDs. Additionally, this account does not take into consideration the degree of mental energy and cognitive resources for patients to be able to make each of these everyday medical decisions without the intervention of a physician’s beneficent “subversion,” nor does it properly value patients’ expectations and preferences regarding their clinical care, mentioned above. Clavien’s framework provides us with the “shared preference justification,” (SPJ) which is just that “nudgers pursue goals that are shared by, or in line with the preferences of individuals impacted by the nudge” – a notion that helps us address these concerns of subversion and paternalistic abuse by stating that the nudgees (i.e. the patients) would largely agree with the nudgers’ (i.e. the physicians) goals. For EDs, the goals are patient
health and wellbeing, which can be safely assumed to be shared by both parties in the physician-patient relationship. Patients need help to overcome their cognitive biases and make more optimal medical choices (i.e. ones that lead them closer to their goals of health and wellbeing), and nudges that steer patients towards these choices not only increase the likelihood for good patient outcomes, but they also enhance the therapeutic alliance and strengthen the physician-patient relationship.

**Nudging and Life-Altering Decisions**

While nudging is beneficial for the quotidian clinical situation, patients ought to make important, life-altering decisions (LADs) as autonomously as possible – meaning they ought to make sure these choices are truly their own and not merely the product of a physician nudge. There is a difference between these types of decisions and everyday medical decisions (ED). Asking someone whether he prefers life-sustaining treatment (LST) or comfort measures; or whether he wants to amputate his limb or risk his life; or whether he wants to pick chemotherapy or disfiguring surgery, is *not* the same as asking him to get a flu vaccine or a prostate exam or to stop smoking. Munoz et al., who enthusiastically promote the obligations of the medical profession to nudge, concede that “in cases where there are no agreed upon best practices for a particular medical issue, informed consent should be least like a nudge and more like a fully democratized instance of shared decision making.” This is to say that there are limits to evidence-based medicine – the recommendations for whether one should amputate a limb or risk death and disability through a limb-salvage procedure can certainly be based on data, but it is also a deeply personal decision that physicians should respect – by informing the patient about the relevant factors and then engaging him in a discussion about his values and preferences.
These high-stakes LADs have different consequences than other medical choices – for one, they are long-lasting or permanent, and largely irreversible (e.g. there’s no turning back if you have not been resuscitated or if your leg has already been amputated). They also have a tremendous impact not only on the patient, but also on their family and support network, whereas an ED (such as choosing an appropriate diabetes regimen) does not carry the same power.

To illustrate this point, I will describe different scenarios of the Framing Effect, both in the context of LADs and in the context of EDs:

(A) (Speaking to a patient undergoing surgery for late stage cancer): “If you were to die during surgery, would you want us to pound on your chest and break your ribs to try to bring you back? There is a 90% chance of death prior to hospital discharge if we perform CPR.”

(B) (Speaking to a patient undergoing radical prostatectomy for early stage cancer): “If your heart were to stop on the table, do you want us to do everything in our power to try to save your life? There is at least a 10% chance of survival to discharge if we perform CPR.”

(C) (Speaking to a patient at a PCP appointment): “Do you want us to administer the shingles vaccine? Studies show that it reduces the chance of shingles, an extremely painful condition that can lead to chronic nerve pain, by more than 50%.”

(D) (Speaking to a patient with epilepsy at a neurology appointment): “Do you want to try this new anti-convulsant drug? Studies have shown a 50% lower rate of breakthrough seizures when it’s added to the medication you’re on.”

While exaggerated, it’s easy to see the difference between nudging in the first two situations compared with the second two. While in (C) and (D) the physician is acting appropriately by
guiding her patient towards his best medical interests (a CDC-recommended vaccination and a potentially more efficacious seizure treatment regimen, respectively), it is much less clear that she is doing so in scenarios (A) and (B). With cancer patients about to undergo surgery for an incredibly scary diagnosis, it is not appropriate to nudge patients into either agreeing to CPR and LST or into signing a ‘do not resuscitate’ (DNR) order without engaging the patient further and ascertaining his values and preferences.

Returning to the Clavien framework, LADs require a higher burden of proof for a convincing SPJ. Rather than the general goals of health and wellbeing that were sufficient for nudging in EDs, it is less obvious for LADs whether the doctor and patient truly share the same goals for care. While shared decision making is meant to help doctors and patients get on the same page, it is not a sufficient tool because it does not address the potential for patients to fall prey to their cognitive biases, nor does it address the issue of physicians exerting too much influence over the decision by way of nudging. Thus, we need another means to help these patients through these incredibly important choices.

For these LADs, an increased level of autonomy for the patient is critical, since in these matters, it is much less obvious to the physician what the patient’s “best interests” might be, especially if preferences are not shared between the physician and the patient. The interests of the patient may be non-medical or related to some other element of wellbeing besides their physical health. For example, the patient in (A) might have a strong value placed on staying alive long enough to see his grandchild born, regardless of his physical state, and so DNR may not be the appropriate choice to steer him towards – even if the physician judges the quality of life and chances for recovery for this patient to be poor. Similarly, the patient in (B) could have strong objections to taking “heroic” measures because she sees them as an affront to her deeply held
religious beliefs; in this case, guiding her towards LST might not be appropriate for her, even though the physician judges her to be otherwise healthy and likely to make a full recovery. As we can see, the judgment of the optimal option is much more subjective for LADs, and so there is uncertainty ethically about how to best steer the patient. In scenarios (C) and (D), the stakes are much lower and both nudges were completely appropriate as the patients would clearly benefit from these interventions (while still remaining totally free to decline them). Thus, nudges should be used cautiously in LADs, considering their high stakes and high degree of subjectivity in deciding the best course of action.

As such, it is especially important to determine the decisions that aligns best with the patient’s values and preferences for LADs. Indeed, de-biasing techniques, where the physician engages the patient’s System 2 deliberative thinking processes, may be a way for her to minimize her own power over the patient’s decision and to maximize the patient’s control over his choice. In other words, it may still be appropriate and obligatory to nudge in (A) and (B), but not without undergoing a significant effort to discover if that nudge aligns with what the patient’s beliefs and values are. Taking this step may have benefits far beyond the impact of the decision itself, including the potential to reduce the moral distress of the clinician and the chance to reduce decisional regret on the part of the patient.

**Maximizing Autonomy in Life-Altering Decisions**

Much of this argument is staked in protecting, preserving, and maximizing patient autonomy. While the nudge is necessarily freedom-preserving and easily avoidable, I will argue that for these serious, emotionally fraught LADs, it is absolutely essential that true patient
preferences are elicited and physician influence over the decision is minimized. This notion is rooted in the bioethics principle of respect for persons or personal autonomy, which states that patients (and research participants) should be granted “at a minimum, self-rule that is both free from controlling influences by others and from limitations, such as inadequate understanding, that prevent meaningful choice” (Beauchamp and Childress, p. 58). The concern in the case of nudging is that it might deprive patients of the chance to have full internal control over their medical options, as mentioned above.

Why should we worry about nudging if physicians are just going to steer patients into the option that would be best for them? Why, when until the later part of the last century, we were content to just defer to the physician’s opinion on all things medical, should we care to involve patients more in issues related to their own medical care? If we thought that, objectively, patients with terminal cancer should not be resuscitated (as in (A)), why does it matter that we de-bias patient A? First, I would respond that it is just a part of leading a self-determining life that people be able to make these types of important LADs for themselves based largely on their own values and preferences, rather than the decision being merely the outcome of a clinician’s nudge. In addition to the inherent value of the patient making the decision himself, there is the concern that the physician might not succeed in nudging him into the option that is best for him. The concern is that “only the individual to whom that decision relates can truly appreciate their own values and preferences and thus the best interests that will be unique to them. Therefore any attempt to influence this will result in a decision that is not truly in their best interests” (Aggarwal et al.). While a nudge might align with the patient’s values, it also might not – and the physician is not always privy to the kind of information that would allow her to know whether the nudge aligns with the patient’s values or not. For the purposes of LADs, the burden of determining the
“correct” decisional outcome should lie more on the side of the person whose life course will be forever altered by that decision.

One of the important aspects of respect for persons, informed consent, illustrates the issue of nudging LADs nicely. Patients who are at the mercy of their System 1 cognitive biases may make suboptimal decisions (Aggarwal et al.). If we examine the requirements of informed consent (disclosure of information and demonstration of understanding; a consideration of the consequences of the outcomes of the different options; and freedom from coercion, manipulation and undue influence), they aim to ensure that rational deliberation of the decision occurs and to protect its authenticity, or the matching of the decision with the patient’s goals and plans (Faden & Beauchamp; Ploug & Holm). Indeed, Chwang argues that nudging is only permissible in situations where informed consent is not required, and that informed consent is always required in high stakes situations where the doctor has expertise that the patient does not have (2015). By this logic, nudging is not permissible in these LADs, whereas for many EDs (that do not require informed consent), nudging is allowed. While I disagree that nudging needs to (or can) be completely eliminated from LADs, steps (like de-biasing) should be taken to ameliorate the effects of our cognitive biases on these important and consequential choices.

If the goal of maximizing autonomy is to be realized, then the ability to engage with practical reasoning, or goal-directed reasoning that helps one decide how to act, must be realized. In order to do this, the “fundamental task […] is to determine which course of action would optimally advance the agent’s complete set of ends” (Wallace). It would not be enough to decide which actions would achieve any individual ends – the goal is to determine which actions would maximize the patient’s subjective utility holistically (Wallace). One way to engage this type of deliberation and fully engage a patient’s System 2 processes is through the act of de-biasing.
De-biasing Nudges

In order to de-bias patients for LADs, doctors will get them to switch from “fast” to “slow” thinking, or from System 1 to System 2. This will cause them to slow down their cognitive processing of the decision so that they can weigh their choices more considerately. I believe that doing so will allow the outcome of their decisions to more accurately reflect the patient’s own beliefs and values.

For example, in order to de-bias the effect of default options, one way that has been shown to reduce the effect is to ask people to think of reasons for their decision or to have them write the reasons out. Doing so requires people to weigh the alternatives more evenly with the default option. Similarly, for the Framing Effect, studies have demonstrated that asking people to elaborate on their decisions reduces the effect (Almashat et al.). Other de-biasing studies for the Framing Effect showed that people who were primed to engage in analytical reasoning were much less likely to demonstrate a bias than those who were primed to ‘go with their gut’ and that visual aids can help when framing effects coincide with low numeracy (Thomas & Millar; Garcia-Retamero & Galesic). For optimism bias (where people tend to believe their own risk is below average), one study showed that the effect was reduced by increasing awareness about one’s similarities to others at risk (Harris et al.).

In most of these scenarios, the patient was merely asked to consider his options carefully or to elaborate on the reasons for his decision. Asking medical professionals to have their patients elaborate on their reasons for making a certain decision would therefore not be overly burdensome to the clinical encounter. In fact, it may enhance communication and understanding between the clinician and the patient. For example, if in the course of explaining his decision, the patient revealed some important or relevant information (say, about the values he holds or his
preferences for treatment), it would enhance the physician’s understanding of her patient as a whole, which is better for patient care and for the physician-patient relationship. Doing this also reduces potential criticism of nudging as paternalistic, if after the nudge, the physician tries her best to make sure the patient’s decision is aligned with his values.

De-biasing has many possible benefits beyond increasing the potential for the outcome of the decision to align well with the patient’s goals and preferences. If these decisions are well-reasoned by patients and explained in terms of values and preferences, they have the power to reduce the amount of moral distress and burnout experienced by clinicians. As it stands currently, doctors shoulder a lot of the burden for these extremely important life decisions. When they nudge patients in these types of high stakes choices, much of the moral responsibility falls to them. This can lead to feelings of moral distress or moral residue, when the lingering feelings of the problematic situation have passed (Schroeter). If we recall scenario (A) above, if that patient were to die during surgery, the weight of knowing that their nudge influenced his decision to forgo LST might weigh heavily on this physician. If the patient in scenario (B) were to code, and CPR was successful but resulted in long term brain damage and mechanical ventilation requirements, the physician might be similarly burdened that she nudged the patient into accepting LST and feel responsible for the patient’s bad outcome. Physicians under stress and those who deal with end-of-life issues such as these are at high risk for burnout, and distressing situations like the outcomes of these LADs could be a contributing factor (McCue). By de-biasing patients, doctors can shift some of that moral responsibility for the outcome of these LADs to their patients.

Additionally, patients who are nudged without the opportunity to deliberate their decision may have less “buy-in” for the final decisional outcome. According to stakeholder theory, those
decisions where stakeholders are allowed greater participation in the decision-making process are deemed to be fairer and their outcomes are judged more favorably. While this might be favored for normative reasons (as we have been discussing), it might also be favored for instrumental reasons, like achieving “buy-in” (Phillips). By maximizing their autonomy through de-biasing, patients could feel increased ownership over their decisions. This could possibly reduce the chances of decisional regret, since they have thoroughly examined their options and come to the outcome on their own terms.

Finally, de-biasing can increase the strength of the therapeutic alliance. It allows doctors to nudge, giving them the opportunity to steer their patients towards what they believe to be in their best interests (thereby fulfilling their professional duty towards their patient) (Munoz et al.). However, it also allows the patient to take ownership over their decision and to make sure it aligns with their values and preferences, rather than just having the outcome be the result of a doctor’s nudge (Aggarwal et al.). As mentioned, taking the time to have a patient elaborate their reasons for a given decision can enlighten the physician to what his values and preferences are, which helps her understand her patient better, but it also can allow the patient to feel heard and valued as a person. These elements together can increase the strength of the physician-patient relationship.

**Conclusion**

While some may see nudging as an unacceptable form of external manipulation, I maintain that it is an appropriate, and even obligatory portion of the physician-patient relationship in EDs. If patients will be influenced anyway, they should be steered towards the
options that will benefit them the most, especially since they share a common goal with the physician – their own health and wellbeing. Where I believe internal control over each patient’s decisions should be maximized is for important, irreversible LADs. In these cases, it is essential to ensure that the values and preferences of the patients are truly reflected in the outcome of their decisions.

While de-biasing is not necessary for every medical decision, for LADs, patients should be de-biased in order to maximize their autonomy. Physicians should anticipate the ways in which their nudges might affect decisional outcomes and for these LADs, they should attempt to de-bias their patients (Gorin et al.). This simple addition to the physician-patient interaction could have many potential benefits and is feasible for the clinical encounter.

Furthermore, I believe this type of structure could have wider implications and benefit areas other than medicine. The lawyer-client relationship, for example, could be said to have many similarities to the doctor-patient one. If lawyers nudge their clients into the contract, plea deal, or lawsuit tactic that is in their best interests for everyday legal decisions, everyone is likely to be better off. However, for LADs in the legal arena (e.g. if the client is charged with a capital offense or is part of a huge merger or acquisition), the client is better off to be de-biased and made to deliberate adequately for that choice. It is likely to have similar benefits – lower rates of lawyer moral distress, decreased client decisional regret, and greater trust between lawyer and client. We should aim to use this form of switching to our deliberative, System 2 cognition for all our important LADs in order to ensure that our true leanings are captured in the outcomes.
Bibliography


Mitra Haeri was born and raised in the Washington, D.C. area and earned a B.A. from Washington University in St. Louis, where she double majored in Philosophy-Neuroscience-Psychology (PNP) and Biology. After serving in the 2010 Teach For America corps in Baltimore, MD, she went on to do research in neuroimmunology at the National Institute for Mental Health in Bethesda, MD. She continued her research and found her way into the field of medical ethics while enrolled at the University of Maryland School of Medicine, where she earned her M.D. in 2017. After completing her Masters in Bioethics at the Berman Institute, she will complete a preliminary year in internal medicine at Sinai Hospital of Baltimore, followed by a residency in neurology at the University of Maryland Medical Center. Her research interests lie in neuroethics and the ethics of clinical decision-making.