Lessons from Behavioral Economics

Michael Lewis’ bestselling book “The Undoing Project” (2016) chronicles the friendship and partnership of Israeli psychologists Dan Kahneman and Amos Tversky, whose research on systematic errors in human judgment jump-started the field of behavioral economics. In the book, Lewis recounts the story of how internist Don Redelmeier took on the role of checking trauma specialists’ decisions for systematic mental errors known as “heuristic biases.” An example Lewis provides is a patient admitted to Redelmeier’s trauma center with multiple fractures from a motor vehicle accident. The patient developed a heart arrhythmia. Upon mentioning to her physicians that she had a history of hyperthyroidism, they concluded that this was causing her arrhythmia. Redelmeier encouraged the physicians to pause, check their thinking, and consider more statistically probable causes of the arrhythmia. Indeed, they discovered a collapsed lung, which hadn’t shown up on X-ray. The physicians’ failure to consider a collapsed lung is an example of the “representativeness heuristic” clouding the physicians’ judgment—that is, making a judgment based on resemblance of the situation to one fresh in the mind, without regard to statistical probabilities.

Implications of Kahneman and Tversky’s research are relevant for the field of medicine, and in turn, for those responding to ethics consultation requests.
Just as the physicians Redelmeier interacted with fell prey to their error judgments, health care professionals in all disciplines and practice settings are prone to similar errors. The idea isn’t to defer to algorithms alone and mistrust all human judgments. Medicine and ethical decision-making are context-specific, and will always require experts to assemble and make meaning of relevant information. But Kahneman and Tversky’s research (and that of others in the field) demonstrates the benefits of pausing to consider ways in which known heuristic biases may influence the judgment of experts involved in a case. [See Box p. 3] Is treatment for the elderly patient in the intensive care unit truly non-beneficial, or could it be that the patient brings to mind others whose dying and suffering were prolonged unnecessarily? Simply pausing to consider that possibility could be helpful, and something an ethics consultation service could provide. As Redelmeier, cited by Lewis (2016), stated: “Wherever there is uncertainty there has got to be judgment … and wherever there is judgment there is an opportunity for human fallibility.”

How might this area of research influence clinicians’—and ethics consultants’—communication with patients and family members? Related research in the field of human decision-making and “choice architecture” has focused on the use of “nudges” that take advantage of cognitive biases to influence individuals’ decisions and actions (Ploug & Holm, 2015; Thaler & Sustein, 2008). Examples of some cognitive biases are listed in the Box on page 3. An example of a "nudge" to counteract a bias would be to frame the effects of an intervention the clinician recommends as a gain, and an intervention the clinician doesn't recommend as a loss (e.g., "95% of patients who were treated with [X] lived at least another five years, so that is something I’d recommend for you"). Some consider the use of nudges to be an effective tool of persuasion, allowing clinicians to fulfill duties of beneficence toward patients. Others wonder whether this crosses over into manipulation or even coercion (Blumenthal-Barby, 2016), perhaps causing clinicians to violate their duty to respect patient autonomy. Thus, this area is ripe for ethics committee members to appraise.

Anita J. Tarzian, PhD, RN
MHECN Program Coordinator

REFERENCES


<table>
<thead>
<tr>
<th>HEURISTIC/BIAS</th>
<th>DEFINITION/EXAMPLE</th>
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<tbody>
<tr>
<td>AFFECT</td>
<td>Judgment is influenced by a feeling (affect) associated with a decision or action (e.g., patient rejects hospice due to its association with death)</td>
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<tr>
<td>AMBIGUITY AVERSION</td>
<td>Preferring known risks over unknown risks regardless of actual benefits (e.g., hospital counsel favors a current ICU policy associated with known litigation rate over new policy expected to lower litigious actions but for which the actual impact on litigation is unknown)</td>
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<tr>
<td>ANCHORING</td>
<td>Relying too heavily on the first piece of information offered (e.g., family told a patient’s condition is stable interpret future diagnostic information more favorably)</td>
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<tr>
<td>AVAILABILITY</td>
<td>Giving more weight to recent or more easily recalled information (e.g., surrogate who had poor experience with staff more likely to appraise other staff’s behavior negatively)</td>
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<tr>
<td>BANDWAGON</td>
<td>Favoring decisions or actions that are more popularly supported (e.g., concluding a controversial opinion is right because everyone else on the ethics committee has agreed)</td>
</tr>
<tr>
<td>COMMISSION</td>
<td>Favoring action rather than inaction (e.g., internist orders diagnostic tests that won’t change the patient’s end-of-life care)</td>
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<tr>
<td>CONFIRMATION</td>
<td>Gathering &amp; filtering information to support one’s pre-existing beliefs (e.g., clinician assembles data only on poor outcomes of extremely low birthweight infants to support position to favor comfort care)</td>
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<tr>
<td>DECOY</td>
<td>Changing one’s preference between two options when a third “decoy” option is presented (e.g., reconsidering paying more for a better but costlier drug when a third more expensive drug is offered)</td>
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<tr>
<td>DEFAULT/STATUS QUO</td>
<td>Preferring the current situation regardless of outcomes (e.g., family selects to keep dying patient in the ICU even though goals of treatment would be better achieved elsewhere)</td>
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<tr>
<td>FREQUENCY/FRAMING</td>
<td>Preferring a decision or action presented as a gain over one presented as a loss (e.g., patients told they have a 5% chance of cure more likely to choose treatment than those told there’s a 95% chance it will not work)</td>
</tr>
<tr>
<td>EFFECT</td>
<td>Overestimating the long-term impact of positive and negative events (e.g., healthy individuals appraise future disability more negatively than those who are disabled)</td>
</tr>
<tr>
<td>IMPACT</td>
<td>Preferring avoiding loss rather than acquiring gains (e.g., those told inactivity will take 3 years off their lifespan are more likely to exercise than those told exercise will add 3 years to their lifespan)</td>
</tr>
<tr>
<td>LOSS/GAIN FRAMING</td>
<td>Judging harmful commissions as worse than corresponding omissions (e.g., parents view harms associated with vaccinating their child as worse than harm of foregoing vaccinations, despite data to contrary)</td>
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<tr>
<td>OMISSION</td>
<td>Judging that one has a lesser risk of experiencing a negative event compared to others (e.g., parents who don’t vaccinate their child are confident this will not cause harm to the child or to others)</td>
</tr>
<tr>
<td>OPTIMISM</td>
<td>Choosing information presented at the beginning or end of a series more often than information presented in the middle of the series (e.g., patients order healthier foods from hospital menus when healthy choices come first)</td>
</tr>
<tr>
<td>OUTCOME</td>
<td>Allowing a prior event or decision outcome to influence subsequent independent decisions (e.g., a clinician chooses a more expensive drug for a patient simply because a prior patient had a bad reaction to the generic version)</td>
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<tr>
<td>RELATIVE RISK</td>
<td>Being more likely to act when presented with the relative risk of something (e.g., inactive women are 25% more likely to develop breast cancer than women who exercise) than when presented with its absolute risk (e.g., 500 women per 100,000 who are inactive develop breast cancer annually)</td>
</tr>
<tr>
<td>REPRESENTATIVENESS</td>
<td>Making a judgment based on resemblance of the situation to one fresh in the mind, instead of considering the laws of probability (e.g., assuming the delirious patient in the emergency department with a long history of alcoholism is intoxicated)</td>
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<tr>
<td>SUNK-COST</td>
<td>Choosing to continue an undertaking because money, time, or effort has been invested (e.g., clinicians of a patient considered terminal after 3 months in the ICU continue life-prolonging interventions based on desire for efforts not to be wasted)</td>
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The American Nurses Association’s (ANA) Center for Ethics and Human Rights has revised its position statement on Nutrition and Hydration at the End of Life (ANA, 2017). The new position recognizes the right of decisionally capable patients to voluntarily stop eating and drinking (VSED) as a means to hasten their death. Specifically, it states: “The decision to voluntarily stop eating and drinking … with the intention of hastening death can be made only by those patients with decision-making capacity, not by surrogates. A patient’s decision regarding VSED remains binding, even if the patient subsequently loses capacity.”

The ANA considers a nurse’s involvement in assisted suicide and euthanasia to constitute a violation of the nursing Code of Ethics (ANA, 2015). Specifically, the Code’s Provision 1, that the “nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person” (p. 1) requires that nurses “should provide interventions to relieve pain and other symptoms in the dying patient consistent with palliative care practice standards and may not act with the sole intent to end life” ( Provision 1.4 in the Code’s Interpretive Statements, p. 3). Thus, the Code acknowledges that providing support and symptom management to the patient who chooses VSED to hasten his or her own death does not constitute acting “with the sole intent to end life,” but that participating in assisted suicide is a “direct violation” of the Code, “the ethical traditions and goals of the profession, and its covenant with society” (ANA, 2013). For states where assistance in dying is legal, such as Oregon (i.e., adults in those states deemed terminally ill can legally access a lethal prescription to hasten their death if they go through certain procedural steps), the ANA acknowledges ways nurses may stay involved, such as explaining state laws to patients, discussing options regarding end-of-life decisions with them, explaining reasons for the patient’s request to hasten his or her death, and following up accordingly.

VSED offers an option for legally hastening one’s death in states where access to a lethal prescription is not available. Schwarz (2017) explains that this route requires a person’s firm commitment to forego nutrition and hydration by mouth—a process that typically leads to death by dehydration generally within two weeks or longer if the person continues to ingest fluids. This approach to hastening death requires palliative support, including good oral hygiene, symptom management, and family support. For those worried about losing the capacity to choose VSED (e.g., individuals in the later stages of Alzheimer’s who continue accepting spoon feedings), Schwarz (2017) proposes specific language to include in an advance directive to allow caregivers to withhold spoon feeding, particularly if it appears “reflexive” and is not providing comfort or pleasure. The ANA’s revised position provides support for this position, although determining whether a person with dementia is “reflexively” eating may be challenging.

REFERENCES

Back in the days of “doctor knows best,” empathy was of little value when deciding how to care for a patient. Why bother seriously considering what the patient might be going through since the doctor’s recommendation was the final word in patient care? The patient could either accept the recommendation or go elsewhere—making the question, “What is the patient experiencing?” unimportant. Today, however, both patients and medical professionals see empathy as an essential part of good clinical medicine. But, I have come to wonder if we clinical ethicists have an adequate understanding of empathy. It seems to be both an essential practice and a perplexing concept in need of clarity.

When I began thinking about the role of empathy in medicine and clinical ethics, I began by looking at the word itself. Our English word “empathy” came from the German term Einfühlung—a word rooted in the Greek term empátheia. The German word began carrying philosophical and theological weight in Germany in the late nineteenth century. Theodor Lipps (1851–1914) was one of the first western thinkers to explore the psychological and philosophical aspects of Einfühlung. Lipps’ central concern is what has come to be known as the “problem of other minds.” Descartes inaugurated this problem by insisting that we could never have true knowledge of the existence of other minds without a guarantee from a benevolent creator. Descartes recognized that it certainly appeared other people had minds: thinking, talking, and writing. But without a guarantee from God, he could never be certain. Lipps accepted that this is a serious philosophical problem, and went about trying to argue for the existence of other minds based in the processes of Einfühlung. In 1909 Edward Titchener (1867–1927) translated Einfühlung as “empathy,” coining the English word.

Contemporary clinical ethicists may not feel an intellectual kinship with nineteenth century German philosophers, but empathy is not so far from Einfühlung as one might think. Ethicists often try to discover the ideas that make up another person’s view of the world. The ethicist obviously cannot ask, “Could you tell me about the concepts that comprise your mental world?” Even if the ethicist would venture to ask such an awkward question, the ethicist’s tasks require more than an inventory of a patient’s beliefs. True, the ethicist often attempts to excavate and understand the beliefs of the patient or medical professional, but more than this, the ethicist hopes to discover how an individual’s beliefs inform her ideas about good medicine and proper action.

More recently, philosophers, psychologists, and neuroscientists have become interested in the possibility that empathy plays a significant role in understanding not only the existence of other minds (Descartes’ problem), but the ways other minds function in constructing our own ideas of who we are. We see this in questions such as: What is this person going through? What ideas are found in the mind of the other person? How should I respond to them? What does their world say about my world?

Empathy, as I envision it, begins with humility. The ethicist must be willing to set aside her own conception of what exists and what is right, temporarily, to try to imagine the worldview of the patient. This requires setting aside one’s own views about wellbeing, suffering, and proper medical care. For example,
consider a family member who rejects the concept of death by neurological criteria (a.k.a. “brain death”). The ethicist may believe that this stance is conceptually problematic, but—at this point—the ethicist’s goals involve understanding and relating to the person who accepts it, not correcting another’s idea of death.

As part of being an empathetic presence, the ethicist should aim to understand the patient’s physical, psychological, and social-familial circumstances. One way of beginning this kind of conversation is by listening for activities that the patient finds important and putting these activities in the context of daily life. For example, saying something like, “It sounds like going to temple has been very important for you. What other activities do you do most weeks?” Listening for the actions the patient considers important will provide a sense of where she finds value and meaning in life.

The ethicist might also ask, when appropriate, “Could you take me through what an average day looked like for you, before you entered the hospital?” If the patient has been declining due to illness over time, the ethicist might ask, “Have you had any trouble doing these activities since you started getting sick?” These activities may involve physical activities (e.g., hiking a local trail), mental exertion (e.g., reading or doing crossword puzzles), and social interaction (e.g., spending time with family). Answers to this question will begin to reveal what the patient values.

Once the ethicist begins getting a sense of these values, she can ask, “What if you could no longer do these things?” This question will begin to show how the patient prioritizes these values. Once the ethicist discovers this priority, she will be able to begin constructing an image of the kinds of actions and values that comprise the patient’s world—an essential step in understanding the worldview of the patient and the kind of life she was leading. Gradually, a portrait of a meaningful world may begin to emerge.

To conclude, it is my hope that this discussion of empathy—both its theoretical and practical sides—has helped clarify the concept and the practice. We see why it is essential and challenging: empathy means becoming invested in the lives of others while also questioning ourselves and setting aside our own beliefs. More than merely revealing treatment preferences, empathy requires that medical professionals encounter patients as people whose lives extend beyond the confines of the hospital room.

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CASE PRESENTATION

One of the regular features of this Newsletter is the presentation of a case considered by an ethics committee and an analysis of the ethical issues involved. Readers are both encouraged to comment on the case or analysis and to submit other cases that their ethics committee has dealt with. In all cases, identifying information about patients and others in the case should only be provided with the permission of the patient. Unless otherwise indicated, our policy is not to identify the submitter or institution. We may also change facts to protect confidentiality. Cases and comments should be sent to MHECN@law.umaryland.edu, or MHECN, Law & Health Care Program, University of Maryland Francis King Carey School of Law, 500 W. Baltimore St., Baltimore, MD 21201.

CASE STUDY – ORAL SUPPLEMENTS AGAINST MEDICAL ADVICE

Mrs. J has been a resident at a Maryland nursing home for the past three years. She is 78 years old, and was diagnosed with dementia six years ago. Her dementia is now in an advanced stage. She is completely dependent on others for activities of daily living, and receives nutrition through a PEG tube. Two physicians have certified that she lacks decisional capacity and is in an end-stage condition. Mrs. J has an advance directive stating that if she is in an end-stage or terminal condition, that she wants her life to be “prolonged as long as possible within the limits of generally accepted health-care standards.” Her husband is appointed as her health care agent. Her Medical Orders for Life-Sustaining Treatment (MOLST) form indicates “Attempt CPR” (there are no orders on page 2). Mr. J believes that her deterioration is not caused by progressive dementia, but by a biochemical imbalance that he believes can be treated through vitamins and supplements, including oral colloidal silver, which he has obtained through an online purchase. Mrs. J had been hospitalized two months earlier for aspiration pneumonia and Mr. J believes the silver supplements will reduce the risk of this recurring. Mrs. J’s attending physician has told Mr. J that rather than protecting Mrs. J from pneumonia, giving her any supplements by mouth increases her risk of developing another pneumonia. In addition, colloidal silver can’t be given through Mrs. J’s PEG tube because this would have to be written as a medical order and the physician won’t write an order for a supplement that can’t be obtained from the facility’s pharmacy and that doesn’t have data supporting its safety/purity.

Staff have reported that Mr. J has a volatile temper, which is typically directed toward them in the form of yelling and name-calling. They observe his behavior toward Mrs. J as generally supportive. While she is not verbally communicative, staff report that Mrs. J responds positively to her husband’s presence (for example, exhibiting less agitated behaviors when he is in the room). Mr. J tells staff “I can do whatever I want, she is my wife!” and insists on continuing the silver and other supplements, which he provides to her through a dropper by mouth. Thus, staff are uncertain what to do: they feel obligated to protect Mrs. J from harm caused by developing another aspiration pneumonia, but don’t feel comfortable giving supplements of unknown quality/safety through her PEG tube. The nursing home administrator is considering banning Mr. J from visiting, or involuntarily discharging Mrs. J. An ethics consultation is requested to help resolve this dilemma.

RESPONSE FROM SINAI HOSPITAL ETHICS COMMITTEE MEMBERS

FACT ANALYSIS

It has been said that “good ethics begins with good facts” (Mackiewicz, 2016). The pertinent medical facts in Mrs. J’s case are as follows: she is 78 years old with advanced dementia, progressive over the past six years. She now lacks decisional capacity and has a poor prognosis, deemed end-stage by two physicians. An “end-stage condition” is defined in the Maryland Health Care Decisions Act (HCDA) as “an advanced, progressive, irreversible condition caused by injury, disease, or illness that has caused severe and permanent deterioration indicated by incompetency and complete physical dependency, and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective” (Maryland HCDA).

Mrs. J. was recently hospitalized for aspiration pneumonia and has no other significant medical problems. She resides in a nursing home, is non-ambulatory, is fed through a PEG tube and is dependent on others for all her activities of daily life.

Mrs. J has a valid advance directive which specifies that if she is in an end-stage or terminal condition, she wants her life to be prolonged “as long as possible within the limits of generally accepted health-care standards.” Her husband, Mr. J, has been designated as her health care agent. She also completed a MOLST form checking the box stating she wants CPR attempted; she gave no
Mr. J believes Mrs. J’s mental deterioration is caused by a biochemical imbalance which could be ameliorated by over-the-counter supplements – vitamins and oral colloidal silver (OCS). Her physician will not prescribe OCS because it is not an FDA-approved drug and cannot be obtained from the nursing home’s pharmacy. The facility’s staff will not administer it through her PEG tube because of safety and efficacy concerns and is reluctant to allow it to be given orally due to concern for causing aspiration pneumonia. As a result, Mr. J has been administering OCS, purchased legally on-line, to her by mouth through a dropper.

Mrs. J’s quality of life is quite limited. It is noted that she appears to respond favorably to her husband’s presence and actions by exhibiting less agitated behaviors when he is in the room, but no other effects, favorable or not, are described.

**Ethical Analysis**

The facts in this case contrast with those in the more common scenario involving the withholding of food, water and other medical care from a patient with end-stage dementia. Here, the patient’s designated agent, her husband, Mr. J, seeks to continue providing an intervention that the treating team members believe is neither safe nor effective. It is central to our analysis that Mrs. J. has selected her husband as her health care agent under her advance directive, as this evidences her trust in him and gives him legal authority to make decisions for her.

The ethical issues revolve around several considerations. The first is related to Mrs. J’s physician’s refusal to prescribe OCS to her as requested by Mr. J.

OCS is considered a dietary supplement. The U.S. Food and Drug Administration regulates such products under the Dietary Supplement Health and Education Act of 1994 (DSHEA), using a different set of standards from those applied to conventional foods, drugs and devices. So long as the product is not adulterated or misbranded and the manufacturer makes no therapeutic claims or misrepresentation about the efficacy of the product, it may be legally sold.

According to the National Institutes of Health, OCS administered orally has no accepted medical indications and can cause “serious” side effects, including argyria, a permanent discoloration of the skin due to deposition of silver in the tissues. “Excessive doses” of the substance have also been reported to cause kidney and neurologic disorders as well as to negatively interact with certain medicines, none of which Mrs. J is currently taking. While anecdotal testimonials, many described on the Internet, favorably view the use of OCS for a number of conditions, including pneumonia, OCS is not a generally accepted standard health care treatment.

Following the principle of beneficence, the physician and treating staff have no ethical obligation to provide this modality to Mrs. J. Furthermore, the principle of non-maleficence requires that patient harm must be avoided. On that basis, even though the potential of OCS to cause harm is limited, it adds ethical justification to withhold it from the patient.

A second consideration is whether the use of OCS is absolutely prohibited because it is not considered safe and effective under the “generally accepted health care standards” rubric. The objections of the physician and nurses caring for Mrs. J are based on concerns that aspiration of orally administered substances pose a potential for harm. There is no indication of any such complications related to Mr. J’s giving her the OCS by dropper, but we do know she was hospitalized for aspiration pneumonia in the recent past.

Current knowledge of the pathophysiology of aspiration identifies dysphagia, dementia, and especially PEG tube feedings as important risk factors, and, when pneumonia occurs, it is primarily related to aspiration of bacteria in oropharyngeal secretions. Small amounts of OCS orally via dropper should not cause significant lung problems, even if it were to be aspirated, especially given the fact that OCS is sometimes administered without incident by inhalation intended to reach the lungs.

A third consideration relates to claims of or liability for abuse if Mrs. J suffers harm from the OCS or its administration. Maryland law does not address the administration of dietary supplements to patients in health care institutions, so they are free to establish policies they believe to serve the patients’ best interests. Liability claims resulting from bad outcomes or harm are always possible when patients or their families are at odds with clinicians over a patient’s care, and end-of-life decisions may be particularly fraught with such.

In each case, the risks and benefits of each care option should be evaluated in the context of the impact on the patient’s quality of life. If the patient or decision-maker chooses to act contrary to a clinician’s recommendation, discussion among the parties should take place to make sure the risks and benefits are understood. These conversations should be documented in the medical record. Signing of releases from liability are viewed by many in the legal community as neither helpful nor enforceable.

**Recommendation**

In light of Mrs. J’s end-stage condition and the minimal risks
associated with OCS, it is ethical to allow its administration to Mrs. J via the PEG tube, honoring Mr. J’s wishes.

The situation has led to conflict and mistrust between Mr. J and the nursing home staff. As it is not clear that effective communication between the parties has occurred, an ethics consultation team should meet with all parties. The team should review the medical facts, as well as stakeholders’ values and preferences, and where appropriate, seek compromise. Educating the staff about causes of aspiration and the likely few, if any, adverse effects caused by the OCS may persuade the medical team that supplemental OCS administered via Mrs. J’s PEG tube is both reasonable and acceptable. If the treating team remains unwilling, Mr. J should be permitted to administer the OCS to Mrs. J in the least intrusive and most convenient manner. As a last resort, if compromise cannot be reached, the physician and nursing home should assist Mr. and Mrs. J in finding alternative arrangements where her husband’s actions on her behalf will be accommodated.

**THANKS TO:** Darlene A. Skinner, R.N., M.S.N., J.D., CPHRM Director, Enterprise Risk and Insurance Member, Ethics Committee Sinai Hospital

Alan Eason, JD Member, Ethics Committee Sinai Hospital

**REFERENCES**


**COMMENTS FROM AN ETHICS CONSULTANT**

Ethical conflicts in long-term care facilities often play out over a protracted period, raising questions unique to those settings. Providing “patient/family-centered care” involves balancing tensions between respecting a resident’s autonomy and promoting the resident’s well-being and safety—in addition to meeting federal and state nursing home regulations and ensuring a safe environment for staff and other residents. Based on the case summary as written, Mrs. J appears to be in the late stages of dementia (this should be confirmed). Given that her living will indicates a preference to receive life-prolonging interventions “as long as possible within the limits of generally accepted health-care standards,” it is appropriate that she is receiving feedings through a feeding (PEG) tube and that her resuscitation status is “Attempt CPR,” although this should be revisited as her illness progresses. While some individuals opt to focus more on comfort at the end of a chronic fatal illness like progressive dementia, it appears the goals of care for Mrs. J are to prolong her life. Ideally, she should be kept as comfortable as possible while pursuing this goal, and information about her life narrative would be elicited to put these important end-of-life decisions into more context.

One concern raised in this case is whether staff should allow Mr. J to administer oral supplements of unknown safety that may increase Mrs. J’s risk of developing aspiration pneumonia, or whether staff should administer these supplements through Mrs. J’s feeding tube. Given that Mrs. J is at risk for aspirating and that she has recently been hospitalized for aspiration pneumonia, it seems appropriate that the medical team recommends against administering any medication or supplement orally. The dilemma here is that to provide the supplements by PEG tube, a medical order would have to be written, and in this case, the supplement that Mr. J wants his wife to get is likely not available in the nursing facility’s pharmacy, nor is it a treatment the facility’s clinicians would consider “standard medical care.”

Given the rise in popularity of “alternative” treatments that can be acquired over the counter (or in this case, purchased on the internet), questions arise about the safety of these products, which are not subject to the same regulatory oversight as drugs approved by the U.S. Food and Drug Administration (FDA). Mr. J is convinced that colloidal silver is benefitting his wife and should be continued. Palliative care practitioners recognize that at times, interventions benefit a patient’s
loved ones as much (or more) than the patient him/herself. Could staff allow Mr. J to continue giving the supplement to Mrs. J based on this rationale? That is, even if the colloidal silver wasn’t actually helping her, if it didn’t harm her, and gave Mr. J a sense of control and belief that he was helping her, could this justify allowing him to continue giving it? Such a decision requires considering potential harms. Setting aside the concern about aspiration if the supplement was given by mouth, could the colloidal silver harm Mrs. J?

Hadrup and Lam (2014) categorize silver as “non-essential to human physiology,” although humans are exposed through contact with silver coins, tableware, jewelry, dental fillings, and fish consumption. Mr. J’s confidence that silver will protect his wife from contracting pneumonia is likely informed by information presented on websites and other sources touting silver as an anti-bacterial and anti-inflammatory agent. While it is true that silver compounds are used topically to treat wounds, there is no evidence that ingesting silver can treat or prevent systemic infections. Negative effects have been seen in animal studies at higher doses (for example, hypoaactivity, altered blood values, enlarged heart, and immunological effects). It could also interfere with how other medications are absorbed. Hadrup and Lam calculated a “tolerable daily intake” of 2.5 micrograms per kilogram per day. Perhaps the fact that no skin discoloration is noted provides some evidence that Mrs. J has not received toxic doses, since excessive silver exposure manifests through a blue-grey skin discoloration. However, from this review, it appears that ingesting colloidal silver presents more potential harm than benefit.

This information appears to support the clinicians’ decision not to order colloidal silver for staff to administer. But what about taking action to prevent Mr. J from giving it to his wife on his own? Allowing him to do this “on record” would likely be prohibited by the Code of Maryland Regulations for long-term care facilities. But what if he gives it when staff are not in the room? What should staff do if they suspect this? If Mr. J were caring for Mrs. J in their own home, he could very well give her over-the-counter supplements without the knowledge or approval of the health care team. Would a health care provider raise concerns about negligent care or elder abuse in such a situation? This question could provide a threshold for considering how much staff should oppose Mr. J’s actions in dosing his wife with the supplement. Since the current goal of care is to prolong Mrs. J’s life, including attempting CPR if needed and treating her aggressively if she developed pneumonia, it seems appropriate that the clinicians recommend against her getting anything orally. Thus, if Mr. J was found to be dosing his wife by mouth, that might warrant more active opposition from staff. While a risk of aspiration from comfort feedings might be allowed if the goal of care were to maximize her pleasure and quality of life, since the colloidal silver isn’t intended to increase Mrs. J’s comfort or pleasure, but merely to appease Mr. J in his belief that it’s providing her benefit, there’s less justification for not opposing his actions here. Also, if he were dosing through the feeding tube, this might have implications for how facility staff manage and oversee her care.

The clinical team should explain their reasoning to Mr. J for omitting the colloidal silver from Mrs. J’s plan of care in a way that he is best able to understand. Perhaps other alternative/complementary interventions could be explored for Mrs. J that Mr. J might find meaningful, such as aromatherapy or music therapy. How should staff proceed if they suspect Mr. J is giving the colloidal silver to Mrs. J by mouth despite being told not to do this? Given the depiction of Mr. J having a volatile temper, “policing” or directly confronting him is ill-advised. Mrs. J appears comforted by her husband’s presence, so banning him from her bedside would deprive her of this (and would be logistically challenging to implement). Ultimately, the clinicians have to evaluate the degree of actual harm they think Mrs. J is exposed to. If they conclude that Mr. J’s actions are too great a threat to Mrs. J, or to others in the facility if he is unable to control his anger, options include involving Adult Protective Services, seeking guardianship for Mrs. J to replace Mr. J as his wife’s health care agent, or pursuing an involuntary discharge of Mrs. J based on inability of the facility to meet her welfare and needs, or concern that the health of individuals in the facility are endangered by her continued stay (MD Code Health-General §19-345). Ideally, the process of ethics consultation would uncover a less drastic resolution to this situation. For example, a behavioral contract could be negotiated between Mr. J and staff to establish expectations of their interactions. Sometimes the “difficult” family member is simply one who has not felt heard, understood, or respected. Other times, family members cross lines and staff to establish expectations of their interactions. Sometimes the “difficult” family member is simply one who has not felt heard, understood, or respected. Other times, family members cross lines and staff to establish expectations of their interactions. Sometimes the “difficult” family member is simply one who has not felt heard, understood, or respected. Other times, family members cross lines despite best efforts of staff to work with them to do what’s best for the patient. All the stakeholders in this case deserve consideration of what’s best for Mrs. J and what reasonable accommodations look like in meeting her goals of care.

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CALENDAR OF EVENTS
Winter 2018

JANUARY

22 (4-5:30PM)
Clinical Ethics Case Consultation Webinar: Tips and Pitfalls, sponsored by the Center for Medical Ethics and Health Policy at Baylor College of Medicine. Visit: events.houstonmethodist.org/webinar-bioethics.

26 (10A-12N)
Meeting of the State Advisory Council on Quality Care at the End of Life, executive conference room at the Office of Health Care Quality in the Bland Bryant Building, Spring Grove Campus, Catonsville, MD. For campus map/directions, visit: https://health.maryland.gov/ohcq/Documents/MapofSpringGrove.jpeg.

FEBRUARY

8-10

28 – March 2

MARCH

1-4

2
Pellegrino Seminar on the Philosophy of Medicine, Georgetown University, Washington, DC. Visit: http://www.event.com/d/gtqkny/4W.

APRIL

12-13

13-14

13-15

13-15
Examining the Foundations of Medicine and Religion, Union Station Hotel, St. Louis, MO. Visit: www.medicineandreligion.com.

16-18
Intensive Bioethics Course, Houston, TX (see Jan 22 event above for sponsorship and contact info).

RECURRING EVENTS


January 22- Speaker: Eric Dishman, Director, All of U.S. Research Program on Precision Medicine (Zayed)

February 12- Speaker: Juan Mendez, JD, Professor of Human Rights Law In Residence, Washington College of Law (Feinstone Hall)

February 26- Speaker: Anne Barnhill, PhD, Assistant Professor, Medical Ethics and Health Policy, Perelman School of Medicine, University of Pennsylvania (Feinstone Hall)

March 12- Speaker: Christine Mitchell, MTS, MS, FAAN, Executive Director, Center for Bioethics, Harvard Medical School (Hutzler-Rives Memorial Lecture; Zayed)

March 26- Speaker: Hilde Lindemann, PhD, MA, Professor of Philosophy, Michigan State University (Feinstone Hall)

April 9- Speaker: David DeGrazia, PhD, M.Stud, Professor of Philosophy, George Washington University & Senior Research Fellow, Department of Bioethics, National Institutes of Health (Feinstone Hall)

April 23- Speaker: Kathleen Meert, MD, FCCM, Chief, Division of Critical Care Medicine, Professor, Department of Pediatrics, Children’s Hospital of Michigan (Hutzler-Rives Memorial Lecture; Zayed)
The Maryland Healthcare Ethics Committee Network (MHECN) is a membership organization, established by the Law and Health Care Program at the University of Maryland Francis King Carey School of Law. The purpose of MHECN is to facilitate and enhance ethical reflection in all aspects of decision making in health care settings by supporting and providing informational and educational resources to ethics committees serving health care institutions in the state of Maryland. The Network attempts to achieve this goal by:

- Serving as a resource to ethics committees as they investigate ethical dilemmas within their institution and as they strive to assist their institution act consistently with its mission statement;
- Fostering communication and information sharing among Network members;
- Providing educational programs for ethics committee members, other healthcare providers, and members of the general public on ethical issues in health care; and
- Conducting research to improve the functioning of ethics committees and ultimately the care of patients in Maryland.

MHECN appreciates the support of its individual and institutional members. MHECN also welcomes support from affiliate members who provide additional financial support.