

# Microethics: *The Ethics of Everyday Clinical Practice*

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*Ethics is what happens in every interaction between every doctor and every patient.*

—Paul A. Komesaroff<sup>1</sup>

Over the past several decades, medical ethics has gained a solid foothold in medical education and is now a required course in most medical schools. Although the field of medical ethics is by nature eclectic, moral philosophy has played a dominant role in defining both the content of what is taught and the methodology for reasoning about ethical dilemmas. Most educators largely rely on the case-based method for teaching ethics, grounding the ethical reasoning in an amalgam of theories drawn from moral philosophy, including consequentialism, deontology, and principlism.

Using this approach, cases used for teaching tend to focus on extreme or unusual situations. For example, because truth-telling is widely regarded as a noncontroversial principle, case discussions tend to focus on exceptional situations where lying to patients may be ethically justifiable. Similarly, because informed consent is generally accepted as an ethical requirement, educators often prioritize unusual cases in which clinicians may reasonably treat patients without obtaining consent. Finally, traditional approaches to teaching medical ethics commonly emphasize controversies that generate media attention, such as debates about life-sustaining treatments, euthanasia, or abortion.

While recognizing the value and importance of principles to case-based ethics education, we suggest that this approach may fall short in capturing the full spectrum of ethical considerations encountered in clinical care. As Paul Komesaroff

has observed, “Crucial ethical issues [arise] in those clinical decisions which at first sight appear to be the simplest and most straightforward.”<sup>2</sup> To give one common example, anesthesiologists regularly obtain informed consent from otherwise healthy patients for routine low-risk anesthesia. Although the informed consent document typically lists “death” as a potential complication of anesthesia, few patients actually read the form, and anesthesiologists vary widely about whether they use the word “death” when they speak with patients. Some never do; some always do. Others customize their approach depending on whether the patient seems like the kind of person who would want to know all the details, versus someone who might prefer to know less rather than more. In our own work, we have found resident anesthesiologists to have remarkably little preparation or insight into how to navigate these and other ethical challenges in their conversations with patients.<sup>3</sup>

Relational judgments like these are rarely framed as “ethical” decisions. Yet these kinds of choices arise in everyday clinical encounters, and even seasoned professionals struggle with how to think about them. Bioethicist Rebecca Dresser collected an anthology of experiences from bioethicists who, like herself, had been diagnosed with cancer. Reflecting on comments from Arthur Frank, she wrote,

Doctors and nurses make ‘constant small ethical decisions [in their] everyday clinical work’, like whether to make eye contact with a patient or take seriously a patient’s complaints about treatment side effects. . . . Their choices have a major impact on patients and caregivers. . . . Concepts like beneficence and respect for persons are as relevant to these interactions as they are to conventional ethics concerns like decision-making about life-sustaining interventions.<sup>4</sup>

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In this article we hope to make a case for augmenting the focus of education in medical ethics. We propose complementing the traditional approach to medical ethics with a more embedded approach, one that has been described by others as “microethics,” the ethics of everyday clinical practice.<sup>5</sup>

To illustrate how these two approaches complement and contrast with the other, consider the case of a young college student who has discovered unexpectedly that she is pregnant and is considering whether to terminate the pregnancy. How might we approach this case in a class on medical ethics? Traditionally, we would recognize this as a case about the ethics of abortion. A number of relevant ethical questions would immediately come to mind for discussion:

- What is the moral status of a fetus?
- Does a fetus have independent “rights”?
- What are the ethical obligations or duties of a woman (or mother) to a fetus (or unborn baby)?
- What will lead to the best outcomes (benefits versus harms), all things considered?
- What are the best policies for preserving the moral fabric of our communities and society?

While these considerations are relevant to every person in society, the practitioners in the classroom are also likely to encounter this issue from a different vantage point, as clinicians sitting across from a young woman in this situation, helping her to decide what she should do. As Carol Gilligan’s work has shown, women faced with these decisions almost invariably see their choices in terms of conflicting responsibilities and relational needs rather than as moral imperatives.<sup>6</sup> Thus it would be unlikely (we hope!) that the clinician would engage in an abstract philosophical conversation about the ethics of abortion. Instead, the conversation would more likely center on a different set of questions, such as the following:

- Do you have a sense of what decision would leave you feeling that you had made the best decision, all things considered, and leave you with the fewest regrets later in life?
- Do you have faith or other convictions about this issue that might guide you?
- What do you imagine might be the impact of your decision upon others whom you care about?
- What do you envision might be the impact of your decision upon other practical issues in your life (school, job, relationships)?

- What would those whom you love and respect think about this decision?
- What decision do you think would fit best with your sense of values and personal integrity?

We might characterize the traditional approach as “the view from the outside” and the microethical approach as “the view from the inside.” The view from the outside has the advantage of being accessible through theoretical analysis, generalizable, and consistent across cases. The view from the inside, the microethical view, is unique to each situation, arises spontaneously at a particular moment in time, and is created in the relational space between the participants. It is inextricably connected to the verbal and nonverbal ways in which we communicate, and it is directly applicable to the front lines of practice.

We emphasize that these two views are not contradictory approaches to an ethical dilemma. Rather, they are thoroughly complementary. A good ethical decision in any particular case must involve a dialectic between both perspectives. Our point is that traditional education in ethics has tended to equate only the view from the outside with “ethics,” whereas the ethical implications of the view from the inside, which augment the learner’s ability to integrate theory into everyday clinical encounters, remain largely unexplored and untaught. In our experience, exposure to and knowledge of both approaches foster the ability of clinicians to move dynamically between the two perspectives.

It is not surprising that clinicians commonly do not recognize the ethical elements underlying everyday clinical encounters. Few might immediately perceive that the choice of the anesthesiologist to use the word “death” in obtaining consent for a routine anesthetic or the choice of a clinician to use the word “fetus” rather than “baby” in counseling a young pregnant college student is an ethical choice that deserves recognition and reflection. In part, this is likely related to the fact that traditional ethics is often taught in isolation—a curriculum covered in a classroom during discrete hours without direct assimilation into the clinical learning environment. Learning to recognize and address these everyday ethical issues as they unfold requires training, practice, and intentional integration, an educational goal that requires the development and cultivation of “moral imagination”—that is, the ability to recognize the range of options available in how communication occurs and how decisions are made and the ability to appreciate the ethical valence in determining which choice is selected.

What is the best approach to educate clinicians about these ethical sensibilities and foundations? Consistent with theories of adult learning, we endorse a pedagogical strategy that features experiential learning with opportunities for practice, feedback, and reflection in a psychologically safe environment that closely simulates clinical encounters. Using a variety of realistic enactments involving common but challenging conversations, we invite clinicians to prac-

tice these conversations with improvisational actors who have been specifically trained to engage in unscripted enactments focusing on ethically laden issues.<sup>7</sup> These enactments are followed by facilitated feedback from the actors and by debriefing with the learning team. This provides a chance to collectively “look beneath” the conversations to identify and explore the embedded ethical issues that arise, often moment by moment and word by word, as the conversations unfold. Participants generally describe their experience as very realistic on both cognitive and emotional levels; indeed, the opportunity to reflect on and receive feedback about the encounter often leads learners to comment that they experienced the conversation as “more real than real,” as one of them once put it.

In this essay we focus on three themes of ethical consideration that we have found to arise frequently during conversations involving decision-making in the clinical encounter. Additional information about the pedagogy and efficacy of our Program to Enhance Relational and Communication Skills (PERCS) may be found on our website and in other publications.<sup>8</sup>

### **Respecting—and Constructing—Patient Values and Preferences**

The traditional autonomy model of decision-making in medicine can be simplistically described as a type of recipe: clinicians contribute the “facts” (the projected risks and benefits of the available medical options), while patients provide the “values” (based on their own preferences and ethical commitments). When these are combined, medical decisions emerge. Carl Schneider has cogently articulated the shortcomings of this model:

This task is hardly as simple as the schematic formulation makes it sound. Those “values” raise the most imponderable questions human beings ask. Because they are so hard to face, to formulate, and employ, those values are usually unexplored and undeveloped. . . . In short, patients will often lack what autonomists too readily assume—a set of preferences which are clearly defined, well-understood, and rank-ordered.<sup>9</sup>

Dresser elaborates on this from the perspective of bioethicists who have experienced cancer:

At times, work in [bioethics] conveys the impression that seriously ill patients and their families would be in good shape if clinicians would only do things like give patients the proper information, respect patients’ choices, and follow advance directives. We can assure you that this is not true.<sup>10</sup>

Applying our individual preferences to treatment decision-making wasn’t always simple. Few of us had confronted medical choices like this before. As John Robertson observed, “most of us are first-time players with no training.” We weren’t always sure which option was most consistent with our overarching values and goals.<sup>11</sup>

If bioethicists who have spent careers pondering these matters cannot call upon a discrete, coherent value set to guide their medical decisions, should we routinely expect the average patient to be able to do so? Whereas traditional ethics holds that clinicians must *elicit* patient’s values and preferences, an emerging literature suggests that clinicians must go further and help patients *construct* their values and preferences in the context of their present medical situation.<sup>12</sup>

As Ronald Epstein and Ellen Peters have observed, many patients do not use a purely rational approach when making complex medical decisions.<sup>13</sup> Antonio Damasio suggests that so-called rational decision-making is merely an overlay that functions on top of deeply engrained emotional predispositions that are composed of visual, tactile, and visceral images, memories, and feelings.<sup>14</sup> Previous experience (“my dad had that procedure and died from it”) or primal intuitions (“doing something is better than doing nothing”) may trump rational decision-making when patients face overwhelming decisions. Finally, some decisions force patients into what might best be described as “choiceless choices”—impossible situations in which they must choose between equally unacceptable options, such as near-certain death or mutilating surgery.<sup>15</sup> And of course, it is not only patients who struggle with their values and beliefs in the face of complex medical decisions; clinicians face the same dilemmas.<sup>16</sup>

Since the notion that patients bring a well-formed and easily accessible set of values to these decisions is oversimplified, the ethical challenge for clinicians is to assist patients in making choices that are as true as possible to the patient’s authentic self. This involves using skillful means to elicit the patient’s core values and helping the patient translate them into the medical context.

While theoretically straightforward, this approach compels clinicians to recognize their enormous responsibility and influence in shaping patients' decisions. This power must be understood and used respectfully and judiciously. It also compels clinicians to develop greater awareness of the ways in which their own biases and ethical proclivities shape how they guide patients in making decisions. Sometimes clinicians are conscious of how they frame certain choices, but most often these biases are expressed unconsciously, such as in presenting the preferred option first or discussing the preferred option in terms of the chances of success rather than the risks of failure. Tone of voice, body language, and eye contact may unwittingly signal clinicians' biases and influence the patient's decision making.<sup>17</sup>

There is evidence that physicians sometimes deliberately manipulate their power to yield the decision that they believe is correct. In a study of critical care physicians, for example, one physician described how he differentially used the word "suffering" to describe patients for whom he thought care should be withdrawn, but never for patients in situations where he thought treatment should continue. When challenged, physicians in this study tended to deny that these techniques were ethically problematic or even a form of persuasion. Rather, they insisted that they were merely "informing" the patients.<sup>18</sup> It may be that these practitioners were unaware of their biases, or perhaps they were aware but unfazed that they were influencing patient decisions.

Recent work by Richard Thaler and Cass Sunstein has generated discussion about when it may be appropriate to consciously "nudge" patients into making "good" decisions that seem objectively to be in their best interest.<sup>19</sup> While some examples may seem straightforward (persuading a patient to stop smoking), other examples are more controversial (persuading a patient to change her diet in ways that involve giving up foods she loves). The line between permissible persuasion and unethical manipulation is not always clear, and slippage occurs easily. One group, for example, has recommended that clinics "show videos of children who have suffered from not being vaccinated" to encourage parents to accept vaccination.<sup>20</sup> Regardless of how one might judge these efforts to persuade, our point here is that all of them raise important ethical questions that are symbiotically illuminated through both the traditional and microethical perspectives.

### **Self-Awareness and Management of Clinicians' Values and Biases**

Beginning with the work of Amos Tversky and Daniel Kahneman, an extensive literature now documents how conscious and unconscious biases may influence decision-making.<sup>21</sup> Research with the Implicit Association Test has confirmed their power.<sup>22</sup> Physicians with an implicit bias favoring white patients, for example, have been found to be more likely to recommend optimal treatment for white patients than for black patients who present with similar acute

symptoms of myocardial infarction.<sup>23</sup> Another example relates to professional affiliations and identity: Obstetricians and pediatricians involved with the care of pregnant women and their fetuses differed sharply on which factors associated with fetal congenital abnormalities would justify termination.<sup>24</sup>

Biases like these are deep, pervasive, and often unrecognized; there is surely no easy way to eliminate them. However, we have found that opportunities to practice as part of a learning team improve clinicians' recognition and insight into their biases. In one of our PERCS workshops, for example, an experienced specialist in maternal-fetal medicine counseled a pregnant patient and her partner (as represented by our professional actors) about whether to undergo amniocentesis to confirm whether suggestive ultrasound findings correctly indicated that the fetus had Down syndrome. When the pregnant woman asked the clinician whether she would recommend the amniocentesis, the clinician replied, "Yes, I would have the amnio. Information is always good." In response, one actor replied, "[But if we don't do the test and do not have the information], then the decision is out of our hands. If we do the test, then it's like we're playing God." In the subsequent debriefing, the physician discovered that she had a strong—and unconscious—bias that "information is always good." Through debriefing and reflection, she came to realize that others could hold different but equally reasonable and coherent preferences. Personal insights such as these can be a powerful tool for helping clinicians gain greater awareness of both the ethical content embedded within their routine communication and their personal biases. Such insights help clinicians to more skillfully guide patients in constructing their preferences around medical decisions.

The traditional mainstream view in medical ethics is that counseling by clinicians should be value neutral.<sup>25</sup> That is, clinicians should never let their personal values enter into the counseling process. We appreciate the importance of giving patients the full range of options and allowing patients to choose freely among them. But these biases do exist. In our workshops, we ask learners to consider whether optimal patient counseling is best achieved through an artificial and unachievable veil of value neutrality or through efforts to identify and perhaps disclose biases.

To begin, we raise the question of whether value neutrality on the part of clinicians is even possible. Perfect value neutrality requires what the philosopher Thomas Nagel described as "The View from Nowhere," a hypothetical stance from which one might make ethical judgments untainted by any personal history, values, or beliefs.<sup>26</sup> Regardless of whether even the hypothetical stance is theoretically possible, no human being can claim such unbiased wisdom. But if this is true, then asking clinicians to counsel patients from a position of value neutrality is unrealistic.

Some would still argue that clinicians should try their best to be value neutral insofar as they are capable. A question we commonly explore in our workshops is whether

patients would be better served if clinicians were instead committed to being more transparent and forthcoming about their experience and perspectives. Perhaps clinicians should express—rather than try to repress—their known value biases up front, rather than pretending that these biases can or should be completely concealed during the conversation. For example, the maternal fetal medicine specialist described above might now consider beginning some conversations about whether to recommend amniocentesis by stating, “Before we discuss your options, I would like you to know that I tend to come at these decisions from the perspective that more information is generally better. As we move forward in deciding what you want to do, I recognize you may not share this view.”

One area where questions about self-disclosure often arise is when a patient asks a clinician, “What would you do if you were me?”<sup>27</sup> We have conducted research that sheds light on how clinicians respond to this question when it arises in the context of counseling a patient or family regarding withdrawal of life-sustaining treatment.<sup>28</sup> In a scenario involving a young boy who had been involved in a near drowning accident, actors in our workshop were coached to ask, “What would you do if this were your child?” Clinicians demonstrated a wide range of responses: some concealed personal values (for example, “To be honest, my opinion about this is irrelevant. This is your decision.”); others shared their values but qualified them as personal (“I would tend to think about your situation as follows, but this is purely my personal opinion. . .”), while some believed that offering their experience was potentially helpful and instructive (“I’ve seen lots of patients in this situation, and based on my experience, I think it would be best if you . . .”).

Our approach in teaching has not been to identify any one of these as the ideal or even the best approach, but to explore the unique situational and relational elements present in each conversation that might make any response more or less constructive. Again, the educational strategy is to identify and discuss the ethical issues at stake, to offer helpful ethical principles from which to guide the conversation, but not to give clinicians specific rules for how to interact with patients and families.

### Managing Medical Information

Clinicians communicate medical information to patients and families every day. Some skeptics of informed con-

sent have claimed that patients can never be fully informed, since there is no way for clinicians to communicate all of the information, experience, and nuance that would be necessary for a fully informed consent.<sup>29</sup> Even if this is true, however, it is still reasonable to ask what would constitute an adequate level of information to count as an ethically acceptable informed consent process.

Consider again the problem of whether the word “death” should be uttered during the routine consent process for low-risk anesthesia. If the actual risk of death is roughly one in one hundred thousand,<sup>30</sup> does routine disclosure of this risk expose large numbers of patients to needless anxiety, even causing some patients to forego beneficial surgery because of fear? Is it sufficient to provide an option by saying, for example, “There are rare serious risks associated with anesthesia; I would be happy to describe them in more detail if that would be helpful to you”? If the word “death” is to be included, might the risk be framed nonnumerically, by analogy, such as “The risk of death from your anesthetic today is roughly comparable to the risk involved in your driving to the hospital this morning”?<sup>31</sup> In our workshops, anesthesiologists come to recognize that the informed consent process is much more than a mere form that requires a signature. As they reflect on how to better serve the unique needs of each individual patient, they learn that the process is relational in nature and replete with microethical choices in how they decide to communicate and manage information.<sup>32</sup>

With regard to how medical information should be shared with patients, Epstein and Peters ask, “Can less be more?”<sup>33</sup> They propose that information, like other medical interventions, should be dosed according to each patient’s needs and circumstances. Should a patient with a suspicious lung nodule on a CT scan be told about an incidental benign liver cyst? Should a patient with panic disorder be informed about a borderline long QT interval and associated risk for cardiac arrest? Should patients be informed about incidental genomic findings of uncertain significance?<sup>34</sup>

Perhaps most challenging is whether information may ever be withheld from patients for therapeutic reasons. Whereas the placebo response is defined as a positive effect from a theoretically inert intervention, the nocebo response is a negative effect from a similarly inert intervention. A recent study of informed consent for patients being prescribed finasteride to treat benign prostatic hypertrophy found that omitting information about sexual dysfunction reduced reported adverse sexual effects from 44 percent to 15 percent.<sup>35</sup> Can we justifiably omit information about a side effect that

would usually be considered essential if data show that the information triples the likelihood that patients will report having experienced the effect? Alternatively, might it be best to say to patients, “I can give you information about side effects associated with this medication, but you should know that if I tell you about them, it is significantly more likely that you will experience them. Would you like me to tell you?” Or might this circuitous disclosure actually magnify the nocebo response if the patient chooses to be informed?

We share the three themes described above as representing ethical considerations that we have commonly observed in our educational programs, but we recognize the unresolved tensions that exist between them. If clinicians are commonly unaware of their biases, how can they support patients in authentically constructing their values and preferences? Similarly, how can we accurately titrate information when the values and preferences of patients are in active flux and evolution? Indeed, clarity about how to resolve these tensions will likely be found at a more conceptual and theoretical level, illustrating the dynamic interplay between the inside and outside perspectives. Augmenting traditional ethics teaching with a focus on the microethics of daily practice can bring greater awareness and tangible meaning to the myriad of ethical moments that shape clinicians’ interactions with patients. At the same time, grounding microethical teaching in traditional ethics principles and deriving from theory new solutions to the unresolved tensions of daily practice can help clinicians evolve their practice in principled ways.

We call upon medical educators to consider expanding the scope of medical ethics teaching, bringing within it experiential learning techniques designed to elucidate and explore the microethical dimensions of everyday clinical practice and to help clinicians to fully recognize that medical ethics must be more than just a theoretical exercise in solving ethical dilemmas. In this regard, the words of Komesaroff ring as true today as they did almost twenty years ago: “We must not allow ethical debate in medicine to be restricted to discussions about embryo experimentation or life support systems, to the neglect of the actual, vital decisions that characterize our everyday work. Let us instead return to the living, ethical core of medicine—both as it is and as it ought to be.”<sup>36</sup>

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