

Harvard Medical Labcast

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Medicine and Morality

How do doctors resolve ethical dilemmas hidden in everyday patient care?

Robert Truog

Interviewers: Stephanie Dutchen, David Cameron

[MUSIC PLAYING]

STEPHANIE DUTCHEN: Let's start it like that.

DAVID CAMERON: Hi, everybody!

DUTCHEN: Hello. Is that loud enough?

CAMERON: I like that.

DUTCHEN: Hello, and welcome to the June 2015 Harvard Medical Labcast. This podcast is brought to you by Harvard Medical School's Office of Communications in Boston. I'm Stephanie Dutchen.

CAMERON: And I'm David Cameron.

DUTCHEN: In this episode, David tells us about a new test that can trace your entire viral infection history from a single drop of blood.

CAMERON: And in today's conversation, Stephanie speaks with Robert Truog about the everyday ethics of doctor-patient interactions. Stephanie, can you tell us a little bit about Bob Truog?

DUTCHEM: Sure. Bob is a Harvard Medical School professor at Boston Children's Hospital. And he's the director of the HMS Center for Bioethics. He's done work in so many fascinating areas that it was hard to pick just one for our podcast.

CAMERON: So what are some examples?

DUTCHEM: Oh, clinical ethics, research ethics, public policy, questions like, can you do research on someone who comes into the ER and can't give informed consent? Or how do you negotiate end of life in the pediatric intensive care unit? Or should physicians participate in capital punishment? Or if there is a public health emergency and a shortage of ventilators, do you take one patient off life support to make room for another patient who has a better chance of survival?

CAMERON: So these are pretty big questions.

DUTCHEM: Right. But actually, Bob was keen to talk about the less splashy issues, the sort of ethical decisions that doctors and nurses make every day that they may not even be aware of -- the words they choose when they talk to patients and families, the way they frame conversations and the conscious and unconscious biases they may have. He calls it microethics.

CAMERON: Microethics. That's a new one. OK. Well, that sounds interesting. Let's hear what he has to say.

[DINGING]

DUTCHEM: So Bob, thank you so much for joining us today.

ROBERT TRUOG: Oh, it's my pleasure.

DUTCHEM: Now, you're a pediatrician and an anesthesiologist by training, correct?

TRUOG: That's right.

DUTCHEN: So how did you get into bioethics?

TRUOG: Oh, well, that's a good place to start. I think my interests have gone back a long way. But they really crystallized when I began practicing in the pediatric intensive care unit at Boston Children's Hospital. And I found that as we went from bed space to bed space -- remember, this was 25, 30 years ago -- there were just so many ethical issues that came up: the difficult choices that parents were facing for their children, what was permissible for us to do, what was necessary for us to do.

These were all just wide-open questions, and I found them absolutely fascinating. And so about a year into it, I decided to do some graduate work in philosophy and see if I could start to sort some of these questions out, at least in my own mind. And that led really to what has become a lifelong interest for me in bioethics.

DUTCHEN: Interesting. Do you remember what some of the questions or issues were that you would encounter when you were going from bed to bed?

TRUOG: Yeah. I mean, I think one that is, in some ways, commonplace now, but was really novel and difficult at the time, was for children who were not doing well with the treatment, let's say, children with cancer, for example, or those who had perhaps suffered a near-drowning incident: When do you decide that it would be better to stop the use of life-sustaining treatment and allow them to die? And how we might think about that. What factors would go into those decisions, the roles of parents? And in making those decisions, what were the role of committees in bringing in people from outside the clinical team to help us think about them? These were all new at the time and really fascinating issues for me.

DUTCHEN: Yeah. It doesn't sound like those are easy issues to grapple with. Did you have a lot of guidance?

TRUOG: Not really at the time, no. And I think that the place that I looked for guidance was in moral philosophy. But certainly, there's a lot more that goes into these decisions than just philosophical reflection.

DUTCHEN: Like what?

TRUOG: Like what? Well, like what are religious views about the particular pathways that we might take? And then there's a lot of things that have come out of social science research now that isn't really about ethics, but about how human beings make decisions in real life, and the factors that come into that. And so I think that bioethics has really become enriched over that time period, from what it was at the beginning.

DUTCHEN: Yeah. So you certainly have used what you've learned in your own clinical practice. But now you've also turned to teaching.

TRUOG: Right.

DUTCHEN: Will you talk more about that?

TRUOG: Yeah. You know, I think some people are inclined towards philosophy more than others. And I'm one who does enjoy it. But I recognized that that wasn't going to be enough. And one of the times that occurred to me was about, oh, I don't know, maybe 10 or 15 years ago, when we were beginning to use simulation as a way of educating our medical students, residents and fellows in the ICU.

We were recognizing that when parents would come back and talk to us, maybe months or even years after they'd had a child in the ICU, whether that child survived or not or did well, very often the parents had little memory about the medical details of what happened

during that time. But they would often have very vivid memories, even word for word memories, of things that somebody said to them at a particular moment.

DUTCHEM: Oh, wow.

TRUOG: And sometimes those were beautiful moments. Somebody said something that just was absolutely the right words at the right time. And they found it comforting and reassuring. But there were also memories they had that were, frankly, very, very painful, I mean, sometimes searingly hurtful. And oftentimes the clinician wasn't even aware that they said something like this. And yet, it was a memory that the parents would carry with them really forever.

And so the idea we had was, along with this spirit of simulation and creating environments where we can practice, where no one will get hurt, was to recreate these difficult conversations in health care. And there are so many of them; challenging, difficult conversations. And giving our trainees an opportunity to practice those conversations in an environment that's safe and where they can get feedback in a way that really will give them insight into what they did well and what they can improve on.

And that became the basis of a lot of work. But it also was the basis for me coming to think about ethics in a different way.

DUTCHEM: Now, I think when a lot of us think about bioethics, medical ethics, we think of these big issues, right? The ethics of end of life care, the ethics of big data and privacy. But it sounds like a lot of what you're focusing on in this teaching work is the everyday ethics, situations where people might not even be aware that there are ethical issues in what they're discussing.

TRUOG: Absolutely. Yeah. We've kind of latched onto this term "microethics" as a way of talking about the ethics of everyday practice. And you're so right. When people think

about medical ethics, they immediately gravitate towards these huge decisions, like abortion or euthanasia. And those are important, and those are interesting to talk about.

But I think what so many doctors and nurses and other clinicians don't often recognize is that there's little ethical decisions that are built into almost every interaction they have in the course of a day. And our work has been around making these clinicians more aware of the choices they're making, because the choices are often happening at an unconscious level. They're not even aware that they're making them. And then to think a little bit more deeply about how one choice might be better or worse in a given situation than another.

DUTCHEN: Now, in your classes and your workshops and your consortium meetings, what are the sort of things that you're trying to help people become more aware of? And what are some of the skills that you're hoping that they'll be able to build to take with them into these conversations?

TRUOG: Right. So I think there are several levels that we're operating. And many of the issues have to do with the biases that we bring to these conversations. Some of the biases are conscious. They're ones that we know about. And many are unconscious, and we're not even aware that we're bringing them in.

If we talk about our conscious biases, one of the gold standards that has been taught is that we should be value neutral when we talk to families. And I'm not so sure that that's actually the right way to go about it, because if you come into a conversation, and you have strong views about what the right thing to do is, and then you try to hide those views, it can be very confusing for the patient that you're talking with.

DUTCHEN: Because if they try and hide a bias, they can leak out in ways that a patient can pick up on?

TRUOG: Yeah. It's not the way that we normally interact with each other. I mean, when you're having a genuine conversation with another person, you're not pretending that you don't have views about things. And so I think it forces us into a false kind of interaction that really isn't us at our best, and not what we really owe to patients that we're talking with.

So one of the things that we're exploring in the workshops and the trainings that we do is whether under some circumstances it may be permissible, even preferable, for the clinician to go into a conversation and own their views, their values, their preferences, and say to the family, "I happen to think about the issue this way. Let me explain the options to you as best I can. But I would encourage you to talk to my colleague, who I know has very different views about what people should do in this situation."

DUTCHEN: Now, that's assuming that you're aware of the bias that you have. It sounds like that's not always the case.

TRUOG: Right. And I think the much more difficult problem are the unconscious biases that we will bring into these conversations. There was one example I'll just share with you, because it was such an "aha" moment, I think, for all of us who were in the room. There was a very experienced specialist in maternal fetal care. And we were practicing with actors the conversation that she has many times a week, which is about whether a woman should get an amniocentesis to confirm some findings that were seen on ultrasound.

And at one point, our actor-patient asked the physician, "What would you do if you were me?" And the physician said, "Well, I would, of course, have the amniocentesis, because information is always good." And the actor -- and this is where actors can be so talented and so helpful -- she said, "Well, but if I don't have the information, then I don't have to make a choice. And if I have to make a choice as to whether I'm going to terminate this pregnancy, then how am I not going to feel like I'm playing God?"

And the conversation went on. And then at the end of it, we were debriefing it and talking about what had gone on. And for the physician, this was such an insight, because she really does carry the unconscious bias that information is always good. And so really for the first time in her long career, she saw that for some people, that's not necessarily true. And I think that will forever change how she has these conversations.

And I'll tell you, it was an "aha" moment for me, too, because I'm exactly that kind of person, as well. I always assume that we would all want more information. And it changed. By even not being in the conversation, but by watching her have that conversation, it was an incredibly insightful moment for me also.

DUTCHEN: So what are some other skills or choices that clinicians make when they're having these kinds of everyday difficult conversations with their patients?

TRUOG: One place where I think clinicians are making ethical decisions on the fly, moment by moment, is often in the way that decisions either get framed or the words that are used to describe the decision. So by framing, for example, if I'm talking to somebody about a procedure that I think they should have, I'll say something like, "Most of the time, this procedure is successful." If it's a procedure where I'm thinking it's probably best if they don't have this, I'll say, you know, "There's about 30 percent of the time that this really doesn't go very well."

Now, both can be factually correct. And yet, just by framing it one way or the other, I'm going to have enormous influence over the decision that this patient is going to make. And it's not that that's necessarily a wrong thing to do. I think that patients do look at us for advice and recommendations. But we should at least be aware that it's happening. And most of the time it's happening at a completely unconscious level.

Another example is the way that word choice will often show up. And an example that I often use, if you think about a clinician who's counseling a woman, let's say, possibly about termination of pregnancy, the words that you use are going to be incredibly

powerful in that context. Do you just talk about a woman or a mother? Do you talk about a baby or a fetus? I've watched clinicians ask, for example, "Does your baby have a name yet?" Which, of course, is a powerful way of personalizing the pregnancy.

For many clinicians, these will just come to their lips automatically. And I think, there again, just being aware that it's happening is the first step towards thinking about ways that we might do it better.

DUTCHEN: So earlier, you mentioned the epiphany that someone in one of these workshops had when she realized that not everyone agreed with her that more information was better. And then you also described the power that word choice can have. It sounds like a part of these discussions is an empathetic understanding that the person you're talking to might not be on the same page as you.

TRUOG: Right. So I think that's a very important consideration. And on the one hand, we have to acknowledge the enormous power that doctors and nurses and other clinicians have in that relationship, that very often, we're helping patients navigate territory that they are completely unfamiliar with, they've never thought about. And the way that we choose to guide them through the conversation is going to have a powerful impact on the decision that they made. And we need to be very careful about paying attention to that power and recognizing the appropriate limits to that power.

DUTCHEN: Yeah. So you didn't have a lot of guidance when you were getting started. Now it sounds like people who are in the Harvard community or perhaps elsewhere have increasing resources available to them to navigate this kind of everyday conversation that they're having with their patients. What is the future of all of this as it continues to grow, do you think?

TRUOG: Well, I think at a couple of levels. First of all, experiential learning is becoming recognized correctly, I think, as much more powerful than didactic learning. And so we are fortunately, I think, moving away from the idea that you learn by

lecturers, and you learn much better by experience. More specifically, with regard to the fact that I teach ethics, I think we're recognizing that those big picture ethical dilemmas, that we started the conversation with, are important, and we are teaching those things.

But that used to be exclusively what we taught. And so now we're building in more opportunities to think about microethics, to practice the difficult conversations, and to learn from them. They're both valuable. They're both important, but I think we need to bring both into the curriculum, where they haven't been there before.

DUTCHEN: Never too early and never too late to learn it either?

TRUOG: Yeah. I think that's really true. I think that's really true.

DUTCHEN: So who do you hope will think about these kinds of skills and issues?

TRUOG: Well, we're certainly building it into the medical student curriculum now, as well as the curriculum for residents and fellows. How do you bring new ways of thinking to more senior faculty, I think is an interesting challenge. One way that we found valuable is to invite senior faculty to participate in our workshops and share the wisdom of their many years of practice. And that serves two purposes.

First of all, almost all of them do have a lot of wisdom to share. But in addition, by having them in the room, they can begin to see that they have something to learn, as well. And it gives them an opportunity to see other ways of doing things, where they would not otherwise be exposed.

DUTCHEN: Are there people outside the medical community who can learn this, too? I mean, I'm thinking about patients.

TRUOG: I think another important facet of looking at ethics, in general, and the patient-physician relationship, in particular, in this new way, and hopefully with podcasts like

this one, is to educate the public a little bit about what's going on in those conversations. The patient is always the other half of this conversation and is often on the more vulnerable side of that conversation.

And I think to have a greater appreciation of the dynamics of what's happening and of the ways that choices are being presented by the doctors and nurses they're talking with, I think it'd help to empower patients and help them to make better choices for themselves and for their own lives.

DUTCHEM: I think that's a really empowering message that we can send to patients, to families of patients, to doctors, nurses, and everybody who's thinking about going into those fields. Thank you so much for sharing your thoughts with us today.

TRUOG: Oh, thank you so much for the opportunity.

DUTCHEM: It's been a pleasure.

[BELL RINGING]

DUTCHEM: And now for this month's abstract.

[DRIP]

CAMERON: What is in a single drop?

[DRIP]

Well, when it comes to your blood, a vast historical record of every virus you ever crossed paths with. It's all there. The problem is that using traditional methods, if you want to know if you have a specific virus, you have to run a specific test. HIV, Hep C, each requires its own assay.

Now Stephen Elledge, a geneticist at Harvard Medical School and Brigham and Women's Hospital, reports in the journal *Science* that he and his colleagues have developed a platform called VirScan that can determine past exposures to more than 1,000 strains of virus from 206 different species, all from a single drop of your blood. What's more, the test only costs \$25.

Now, the test is currently only available as a research tool. But it has obvious clinical benefits for patients down the road. VirScan can also give a tremendous boost to epidemiological studies. Researchers could test populations of patients who have particular autoimmune diseases or cancers, to see if viruses are contributing to these conditions. As Elledge himself admits, there are applications to this that he and his group haven't even dreamed of yet.

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DUTCHEN: This podcast is a production of Harvard Medical School's Office of Communications. Thanks to our producer, Rick Groleau. To learn more about the research discussed in this episode or to let us know what you think, visit HMS.harvard.edu/podcasts. You can also follow us on Twitter, where our handle is @HarvardMed, or like us on Facebook.

Now we'd like to leave you with a thought by Walter Gilbert. "Why do we do basic research? To learn about ourselves."

END OF INTERVIEW