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At the Bedside

Harmful Emotional Responses that Patients and Physicians May Have When their Values Conflict

Edmund G. Howe

ABSTRACT

One of the most difficult decisions a clinician may face is when, if ever, to decline what a patient wants, based on the clinician's own moral conscience. Regardless of what the clinician decides, the outcome may be deeply emotionally painful for both parties, and the pain may last. I will discuss this pain, how it occurs, and what we can do to try to reduce it before, during, and after a conflict arises. Approaches include explaining how we are like the patient or doctor, that no one is perfect, and that what we *do* is not who we *are.*

In this issue of *The Journal of Clinical Ethics,* several authors discuss the extent to which doctors should give their individual moral values priority over the moral values of patients or patients' family members, and, if doctors should do this, how they should do it. The articles focus particularly on the opinion that the American Medical Association's Council on Ethical and Judicial Affairs (CEJA) has written on these questions.[1]

The AMA opinion suggests that physicians continue to do as they have been doing, and continue to do now; that is, physicians should act in accordance with their deepest moral beliefs. If they do this, however, they should continue to inform patients and their families about the services they could expect to receive, but which their doctor won't provide, because of their doctor's individual moral beliefs. The doctor may refer patients to other care-providers, but, if doing this would compromise the doctor's moral convictions, the doctor still must tell patients how they can gain access to these services.

The latter two alternatives are especially controversial. Udo Schuklenk states in "Accommodating Conscientious Objection in Medicine—Private Ideological Convictions Must Not Trump Professional Obligations," in this issue of *JCE,* for example, "If you believe that abortion is akin to murder, it does not quite amount to a reasonable compromise that you should be obliged to pass a pregnant woman on to a colleague whom you know will commit what you consider a murderous act."[2]

BJ Crigger explains in "Thinking about Conscience," also in this issue of *JCE,* that controversies arose while the members of CEJA wrote the opinion.[3] She states that it can be expected, therefore, that many readers may disagree with it.

Indeed, this is the case. Schuklenk is a leading example. He asserts, for instance, that unjustifiable harm will result when physicians assign priority to their individual moral consciences. This, he says, would "subject eligible patients seeking help from a medical professional, *qua* professional, to the va-

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garies of this professional's idiosyncratic views of the universe." Schuklenk gives a chilling example of a harm he believes illustrates his contention: today in Italy, he asserts, "about 70 percent of gynecologists conscientiously object to performing abortion." He says that "this is arguably a major factor in the staggeringly high back street abortion rates in that Roman Catholic country."[4]

Schuklenk asserts further that the harm that can be brought about when physicians refuse to treat reflects a moral error on the part of the AMA. He cites Robert Baker, whom he regards as the "United States' pre-eminent historian of medical ethics." Baker, Schuklenk states, sees the AMA as an organization that "abdicated its role as moral conscience of the profession."

In the future, the AMA opinion might draw a distinction between objections that are religiously based and those that are morally based. In other contexts, this has led to discussion of whether a physician's religious views are "main stream" or are idiosyncratic.

Perhaps, in some instances, objections based on conscience shouldn't be accorded moral weight, an outcome that Schuklenk would favor. An example is patients who want to change their gender. Some physicians will not treat these patients, based on the physicians' moral and/or religious beliefs. To not treat them, however, may be as deeply problematic as not treating patients based on their gender, sexual preference, or ethnicity.

An important question any refusal to treat raises is: How this will affect the patient? It may be that, due to the risk of harm that such a refusal may cause, doctors who know that they will face such conflicts could choose, far in advance, to not enter fields where these problems will arise.

The present practice of physicians' refusing to treat, based on their own moral consciences, may not change in the near future. This is especially likely under the new AMA opinion. Still, there may be ways for physicians to better accommodate patients' decisions regarding treatment, based on physicians' own moral views, than they do now.

Physicians could initially regard their patients' values as having a moral weight that is similar to, or equal to, their own. As Martha Nussbaum wrote, following John Rawls: "The reasonable citizen does not try to enforce her own comprehensive doctrine through law, out of recognition of the burdens of judgment and a related respect for her fellow citizens."[5] Doing as Nussbaum suggests may reduce the burdens that acting unilaterally may bring. She notes that it might be reasonably expected that people will differ on important life matters and values; because of this, a Rawlsian social justice perspective, a spirit of mutual respect, would suggest that it is most reasonable for those whose views are in disagreement to propose "fair terms of cooperation."[6] Doctors who pursue maximally reconciliatory and accommodating ends may further three important values: treating patients with greater respect, reducing harm to themselves, and interacting with greater equality.

Patients and doctors who experience the moral impasses described in the AMA opinion may experience emotional or moral burdens as a result. Whether physicians decide to follow their own consciences or the moral views of their patients, there may be harmful, long term effects for patients and physicians. The most harmful emotional response patients and physicians may experience is shame: painful self-consciousness about inferiority, failure, and defeat.[7] Shame can be psychologically toxic[8] because it reduces self-esteem, and those who feel shamed may lose their capacity to enjoy life, sometimes for many years. Anthropologist Ashwin Budden states, "clinical theorists acknowledge that, in practice, shame is often difficult to detect, . . . because it gets buried in tendencies to withdraw, in language styles, and in distortions of memory, only to resurface in clinical symptoms, maladaptive behaviors, and somatic distress."[9]

The risk that shame will be hidden, remain buried, and then express itself in tendencies to withdraw are of special importance to this discussion. During moral disagreements on the ward between patients and doctors, for example, both may experience shame and then express it by withdrawing. They may then distance themselves from each other. If this distancing occurs during their initial discussions, it may prevent the parties from being able to share in decision making.

Many of us have witnessed or experienced extreme examples of this effect. I have written in these *JCE* pages, for example, of family members blocking the door to a patient's room or surrounding the patient's bed to protect the patient from clinicians, and of a grandmother who threw herself over her grandson's body to protect him from clinicians whom she knew had different moral views than her own. These examples represent patients' loved ones responding primarily with anger. In these instances, the greatest harm to them may be feelings of being isolated and alone. These memories may persist, and haunt them.

In light of the potential for these very bad outcomes, we might ask the following two questions: Should physicians give priority to their own moral

values? If they should, how should they go about doing this?[10] I will not provide answers, but rather will describe the most serious possible emotional harms to which patients and physicians may be exposed. I will suggest some ways in which other clinicians who observe these emerging negative effects may, both during the conflict and after, try to help.

Fortunately, we have clues as to how to best approach the challenging task of intervening that may help conflicting parties, or at least reduce some of the tension. Terri Traudt, Joan Liaschenko, and Cynthia Peden-McAlpine, in their article "Moral Agency, Moral Imagination, and Moral Community: Antidotes to Moral Distress," in this issue of *JCE,* present approaches that nurses in the intensive care unit (ICU) have used when they encounter moral disputes.[11] In this remarkable study, nurses report that they do not feel the degree of moral distress that might be expected, and most importantly for our purposes here, they describe why and how. Thus, in this article, I will discuss the shame that moral conflicts may engender and some approaches we may take to reduce incidents of shame for patients and doctors, on the wards and after.

SHAME CAUSED BY MORAL INJURY

Moral injury may come about when our doing what is right is blocked by a person in authority (or by ourselves) in a high-stakes situation. The moral injury may create feelings of guilt, shame, and/or anger, and may result in "numbing."[12] This numbing may occur when patients and doctors reach a moral impasse that triggers doctors to make the kinds of decisions the AMA opinion considers. The increased distance between doctors and patients caused by this numbing may harm both of them, in the short run and in the long run.

In the short run it may prevent them from reaching an agreement, or at least from being able to maintain mutual respect and to genuinely care about each other. In the long run, it may dampen their capacity to experience joy in their lives. Of the emotions guilt, shame, and anger, it is shame that may be, by far, the most destructive.[13] For example, Bruce Bower notes, shame may "render individuals especially prone to moving from suicidal thoughts to actions" due to "self-hate triggered by extremely distressing experiences."[14] In their research on guilt and shame, Toni Schmader and Brian Lickel found that shame may cause persons to feel "ashamed," "humiliated," disgraced," and "embarrassed."[15] Practically, shame exists when people feel bad about what they or others have done and then believe that this reflects badly on what kind of persons they are. As experts in this area, Ulrich Orth, Matthia Berking, and Simone Berkhardt found, shame involves a "negative evaluation of a central aspect of the self. . . ."[16] "The self-esteem system," they continue, "reacts with a significant drop. . . ."[17] Schmader and Lickel state, more simply, that persons who feel shame feel that they are "somehow flawed."[18] Jonathan Shay states that when persons feel less good about themselves, it may "deteriorate" their "character."[19] People who experience shame infer that what they *did* (or that another did) reveals some immutable truth about who they *are*, at their core. This belief, as I shall explain, is always mistaken, and such erroneous inferences are sources of shame that we may be able to help others undo.

When we recognize the emergence of shame (or its existence after it occurs) we may be able to beneficially intervene. As noted above, persons may withdraw when they feel shame. Schmader and Lickel found that feelings of shame may predict "avoidance motivations . . . not . . . aimed at solving intergroup conflicts."[20] More than anything, then, we may be able to help prevent such avoidance and distancing from occurring, and, by doing this, allow patients and doctors, *together,* to have better results.

HOW SHAME MAY OCCUR WHEN MORAL CONFLICTS ARISE

Several harms may affect patients and doctors when a moral conflict arises. These harms may differ, and differ substantially, depending on whether doctors follow their own moral views, as the AMA opinion allows, or they deny their own moral views and go along with the views of their patients. In either case, patients and physicians may feel shame and be gravely harmed.

I will first discuss the shame that may occur when doctors adhere to their own values and do not assist patients in the ways that patients want. I will then discuss the harms that may ensue when doctors go against their own values to assist their patients. As a paradigmatic example of a moral conflict, I will use an example presented several years ago in *JCE*, in which the authors stated their belief that obstetricians should not attend planned home births, because they see home births as posing additional and unnecessary risks to infants.[21] This conflict illustrates the negative outcomes that may arise when there is an irreconcilable conflict in doctors' and patients' moral beliefs.

Moral conflicts like this are not uncommon, and it is not uncommon that they remain unresolved. In

this issue of *JCE,* Thaddeus Mason Pope and Kristin Kemmerling write, in "Legal Briefing: Stopping Nonbeneficial Life-Sustaining Treatment Without Consent," that these kinds of conflicts remain intractable to intensive communication and mediation in approximately 5 percent of disputes regarding medical futility.[22] Pope and Kemmerling discuss a law that was introduced in Virginia, but was not passed, which would have given a physician who holds moral views that are intractably different than the patient's 14 days to find another doctor to comply with the patient's request. A physician who could not do this in the allotted time could then impose his or her moral views on the patient. It is well worth imagining the pain that patients and loved ones would experience at this point.

That a physician would be given discretion not only in what she or he would choose, but also in finding another physician, illustrates how wide the gap may become between doctors' and patients' capacities to enact their moral views. It may suggest too the need for the AMA and other medical bodies to adopt more robust *limitations* in their guidelines to enhance uniformity in the U.S. states.

What might such limitations be? One is the extent to which patients and doctors have an existing relationship. Later in this article, I will consider the example of an obstetrician who is opposed to home delivery who is meeting with a pregnant woman for the first time. At the other extreme is the example of a doctor who has cared for a patient for some time and suddenly learns that the patient, who has come to be placed on a respirator, wants to discontinue it, knowing he or she will die, and the doctor objects to the discontinuation. In this second instance, the doctor could apologize to the patient for not having foreseen earlier that this situation could occur (if foreseeing it was possible), and then help the patient find another "route," one that might help the doctor avoid feeling morally complicit—a risk that Schuklenk has said that should, ideally, be avoided.

A further possible limit might be whether we should give different ethical weights to religious versus moral objections. The question would then arise whether a physician's religious objection is idiosyncratic; but even if a religious belief is "mainstream," some stances may remain unjustifiable, for example, refusing to treat a patient who wants to change gender.

A final consideration is whether the nature of doctors' specialties should make a difference, for example, psychotherapists. In these cases, therapists' moral objections may exceptionally affect and impair the care they provide their patients.

An underlying question in all of these examples is the extent to which all careproviders are capable of changing their moral views. A well-known way to change a negative bias, for example, is to personally get to know those against whom one has a bias. This may work well for therapists, for example. This raises another question for clinicians: when they don't know whether they can change their moral views, should they have their patients choose whether they would want to see another physician, or wait to see whether they, themselves, can change? The answer may depend on the extent to which the physicians' incompatible moral view is "reasonable" or not.

Harms to Patients and Doctors When Doctors Follow the AMA Opinion

Harms to patients. Many of the harms that arise when a doctor refuses to give a patient a treatment the patient wants are self-evident. As Schuklenk relates, women who are unable to find a doctor to perform an abortion may seek out an unsafe back street abortion. Another example would be that of a mother who chooses to deliver her infant at home without assistance and whose baby is then born with severe complications that would not have occurred if she had chosen a hospital delivery, assisted by her obstetrician. This could occur because, for instance, there are complications that arise during the birthing process that obstetricians using equipment available only in a hospital can treat, but could not treat with the more-limited equipment they could bring to a patient's home. Frank A. Chervenak and colleagues state, for example, that this is the main concern that underlies their opposition to attended planned home births.[23]

The last case is a "worst-case" example, as the mother's emotional pain may be greatly increased knowing she went against the advice of her obstetrician. Perhaps she disagreed with her obstetrician's assessment that delivery at home posed greater risks than a hospital delivery. She might have disagreed on empirical grounds, believing that the risks posed by a hospital birth should be the only value at stake. She might feel profound regret that she had heard her obstetrician's advice and disregarded it.

Even when infants who are born at home do not experience problems, however, mothers (and fathers) who go against their doctor's advice may be affected by what the doctor said and did, as the doctor informed the parents, at least implicitly, that their decision to not deliver in the hospital was (in the doctor's view) morally wrong. Most of us believe that doctors commonly choose to enter medicine to help

others. These parents would also know that their doctor refused to help deliver their infant in a way that the doctor could have agreed to help. The parents would know, then, too, that their doctor refused to help when she or he could have agreed to help, even though the doctor knew that, in this instance, his or her refusal *could result in very serious harm to the infant*. And that this possible harm could have been prevented if the doctor had been willing to help deliver at home.

Given this, the parents' response may primarily be anger. This anger may in part, however, be due to their unconscious need to protect themselves from the more devastating feelings of self-doubt and shame that may result from knowing they willingly chose to go against their obstetrician's advice.

The parents may ever after doubt their capacity to make the best choices for their child, although they may have believed that they could do this before. This new self-doubt is the essence of shame. Said simply, the parents may lose respect for themselves and even feel self-loathing. Their self-doubt may cause them to place less value on what they want for their child, and themselves, in the future.

Such negative effects may underlie some points made in the articles in this issue of *JCE.* Schuklenk provides one excellent example:

> I have taught bioethics for a number of years in a large health sciences faculty. Invariably, among the dentistry students in any given year, there were a fair number of students who explained their choice of profession with their moral objections to abortion. However, *many also did consider it unprofessional to burden future patients with their personal convictions on this subject matter*." (Emphasis added.)

Armand H. Matheny Antommaria offers a second example in "Conscientious Objection: Widening the Temporal and Organizational Horizons," in this issue of *JCE:*

> Within this frame, the AMA opinion neglects the issue of physicians explaining the basis of their objections to patients. While discussing the basis may facilitate the mutual sharing of perspectives, some patients have objected to their physicians raising this issue or the way they presented it. One patient, for example, described her physician as launching into a lecture about her need to rethink things after having asked him to prescribe birth control pills.[24]

Doctors may make moral judgments like this and communicate that they believe that patients or parents are making less-than-optimal moral judgments. If they do not say this explicitly, they may imply it. They may even state this knowingly, in the hope of convincing parents or patients to comply with what the doctors believe is morally right. An example is that of a couple who had given birth to an infant with Tay-Sachs disease, and the child, just a few years later, was dying.[25] (Infantile Tay-Sachs is a rare genetic disorder that causes progressive deterioration of nerve cells and usually death by the age of four or five.) At every oral feeding the child was at risk of aspirating food into his lungs and then painfully coughing and quite possibly dying from a fatal lung infection. As it was, he coughed from saliva going into his lungs often while eating. The question arose whether he should have a feeding tube inserted, which would have allowed him to live a little longer, but, at the same time, in his doctor's view, would prolong his suffering.

The boy's parents wanted to have a feeding tube inserted to allow their son to live longer. The child's doctor told them that wanting this was selfish. In response, they changed their minds. They decided to let their child die, and reported that the doctor's telling them they were selfish was a critical factor in persuading them. (This may raise the general question of whether doctors should tell others that they are selfish. For example, obstetricians who are unwilling to attend planned home births might say this to parents who are considering it—that the parents are acting selfishly. If they do say this, they should "soften" it and place it in context by adding that they could imagine, if they were in the parents' position, that they might want what the parents want. If the doctors do say this, it must be genuine. Yet, it might be preferable, or even ethically mandatory, to say nothing like this at all.)

The answer to this question has been and presumably should be "no," even though, and despite the fact that saying this could, as in the above case, possibly enhance parents' and patients' autonomy. Why might this not be best approach and not be justifiable? A first reason is, of course, that the doctor's judgment may be wrong. Accordingly, parents and patients may respond with rage, although the parents in this case did not. A second reason—the one I am emphasizing—is based more on the emotional vulnerability of parents, patients, and most, if not all of us: our emotional vulnerability to feeling shame may not, in the vast majority of cases, "allow" it.

This risk to persons, as to these parents, may be increased due to the fears and doubts they already have. Their feelings may already be emotionally

"primed" to being harmed. They then may be exceptionally vulnerable to shame. I am reminded of this vulnerability in regard to research performed by Stanley Milgram in the early 1960s.[26] In the research, an authority figure told research participants, who had been brought in off the street, to administer increasingly painful shocks to a person sitting in a chair, when that person gave the wrong answer on a test. (The seated person was an actor who did not actually receive the intended shocks, but who did flail and scream when the research participants turned up a dial and pushed a button.) Milgram met with me and other medical students in the early 1960s. He pled with us to take to heart what his findings conveyed. He implored us, based on his findings, to never unthinkingly do harm just because we were told to do so by an authority.

The irony (to me, a very sad one) is that, based on this research, Milgram was later seen by many as morally flawed, when he had sought just the opposite. The reason for this later judgment is critical to our present concerns: that is, the research participants later indicated that they had gained self-knowledge from the experiment, namely that their capacity to harm another was much greater than they had known. Milgram came to be criticized for having changed the research participants' views of themselves without having forewarned them that this might occur. The research participants might forever experience shame, as a result. The feeling that they were less moral than they thought might be like the implicit feedback that parents might infer from their obstetrician's refusal to assist in their planned home birth. That awareness might be with them and haunt them for the rest of their lives.

Harms to physicians. Doctors who decide to go against a patient's wishes may be harmed as well. An example to illustrate this could again be obstetricians who say that they won't participate in planned home births. They may say this because doing so would pose, in their view, unnecessary and avoidable risks to a baby. Parents who want their doctor to attend a home birth may differ in how they interpret the studies regarding the relative risks to infants, and/or they may see other values as warranting some moral weight.

Obstetricians who feel they must turn down parents' requests may feel moral distress, especially if they came into medicine to help people. They would not be helping others, in the parents' view. These obstetricians might believe they will help more babies, overall, by furthering the degree to which parents agree to deliver their baby in a hospital. But these parents, rather than appreciating the obstetrician's viewpoint, might only feel (and express) their wrath. The doctors might feel shame because they did not succeed in convincing the parents to deliver in the hospital. Doctors often are—and should be—perfectionists in their work. Having this need is essential when they "work up" and treat patients. It may be necessary to save lives. But this tendency may extend too far. When it does, doctors may have unrealistic expectations that they can succeed perfectly. This erroneous belief is a flawed cognition that is most likely to result in persons coming to feel shame. They may also feel shame, believing that their colleagues will judge them, or even that they will be sued.

What might be the outcome of doctors' feeling they have failed? They may feel shame, and this shame may be "primed" by their feelings of fear. The obstetricians, like the parents, may defend themselves against their feelings of fear, consciously or unconsciously. In turn, the doctors may feel only anger toward the parents, and blame them, and their anger and blame may be, in part, their minds defending them from feeling shame. During ongoing discussions, these responses may make the doctors more rigid, and, over the longer run, make them more distant. Thus, their responses of shame may harm both patients and doctors. As we shall see, ICU nurses and other careproviders may be able to help doctors and patients avoid this.

Harms to Patients and Doctors, Even When Doctors Go Along with What Patients Want

Harms to patients. Using this same example, if parents deliver at home and their baby is harmed because they did, the parents may feel profound regret. Further, even when their baby is fine, if parents know their obstetrician disagreed with their choice to birth at home, they may feel new and unprecedented self-doubt regarding their capacity to make moral judgments regarding their child. On the other hand, if their physician attends the planned home birth, the parents still may be harmed. Knowing that their doctor has agreed to help, against his or her own values, the parents may still experience new self-doubt. More than this, perhaps, the physician may feel guilt and anger toward the parents. The physician may even feel shame. The physician may, as discussed previously, then become distant. This distancing may harm the parents more than it does the doctor. The doctor may, for instance, withdraw due to feeling shame and then dread further interactions with the parents.

A recent study reports the frightening possible adverse effects of this kind of distancing on some

patients.[27] In this study, psychiatrists' charts were reviewed to see whether there were signs suggesting that doctors were distancing themselves from their patients. A positive correlation was found between doctors' write-ups that indicated signs of distancing and the likelihood that a patient would end his or her life. This study dramatically and sadly shows the possible increase in negative outcomes when doctors distance themselves. If physicians feel shame, the risk that they will knowingly or unknowingly distance themselves increases. It is patients who will most likely suffer when this happens.

Harms to physicians. When values conflict, doctors may choose not to act on their own beliefs. They may do this primarily to not impose on patients the negative outcomes that could occur. Obstetricians might attend planned home births for this reason, for example, even though they oppose home delivery. They might do this to decrease the risk to a newborn, even though the obstetricians feel that it is morally wrong for parents to allow such risk to their baby. Obstetricians could also attend home births, despite having opposing views, because they want more than anything to preserve the patient/physician relationship. They might realize—and realize rightly—that this end, especially over the long run, is more important than any other.

To illustrate the costs to physicians' emotions that such a decision may bring about, I will go somewhat "far afield" to discuss a conflict that parents of children who are subjected to bullying at school may undergo. The parents may believe that they have no choice but to report the bullying to the school authorities, but their child may plead with them not to report it. Parents who are placed in this bind may find it excruciating. If the parents do not report the bullying, it may continue, whereas if they do report it, their child may lose trust in them.[28] This example may mirror, in an important way, the moral bind that physicians find themselves in when they have to decide whether or not to follow their own moral views. If, for example, they go along with the views of parents or patients, when those views conflict with their own, the feeling that they are doing wrong may not "go away."[29]

Physicians in these circumstances may feel resentment, and they may feel numb and distance themselves from the patient. This may be very harmful to the patient; as noted above, distancing has been found to be a risk for suicidal patients. Clinicians' moral struggles in treating suicidal patients may be much like parents' struggles when they must decide whether to report that their child has been bullied. Clinicians who treat suicidal patients may have to decide whether to hospitalize a suicidal patient involuntarily. The responses of suicidal patients are complex. They (like most or even all of us) may be more emotionally vulnerable than we suspect.

This is illustrated by a fellow physician and friend who gave me permission to tell her story. In fact, she urged me to do this so others might know what occurred with her, and how it could occur with others. She was taking a medication that was well known for producing a "suicidal side-effect." She suddenly noticed that she felt suicidal. She knew that this was a side-effect and sought help. The doctor whom she saw did, she said, "everything right." She told him that she was quite sure she wouldn't take her life, but even as she said that, she felt that she would. She said she knew it, but to succeed in taking her life, she couldn't tell the doctor about it. She felt driven to take her life and to lie to him, even though, especially as a doctor, she knew that her feeling suicidal was nothing more than a side-effect, and thus, if she could stay alive for long enough, the side-effect would go away. Thankfully, she did not take her life.

But her experience shows why clinicians who care for these patients may feel in such a bind when a patient doesn't want to be admitted to the hospital. The angst of physicians in this situation is, in some ways, akin to that of obstetricians who try to decide whether to attend a planned home birth. They may feel highly conflicted and feel angst, regardless of which way they choose. They may have no escape from feeling shame because, no matter what they choose, they may erroneously believe that somehow they should have been able to do better.

It is no wonder that two highly renowned psychiatrists, John Maltsberger and Dan Buie, refer to what clinicians may feel toward some suicidal patients as "counter transference hate."[30] This feeling is not, of course, what the clinicians would want to feel or believe that they should feel. Doctors who have individual moral beliefs that strongly clash with their patients' moral beliefs may feel that they are in a similar bind. They may feel shame, distance, and dread, regardless of what they choose to do.

Given this, what might be an optimal approach for physicians to take when they first meet a patient with whom they anticipate they may have a moral conflict? Here is a generic example. A physician might say, "Good morning Ms Alfred, I am Robert Jones. It is a pleasure to meet you. I am taking the opportunity to meet and talk with you this morning, as I do with all new patients, to introduce myself and to say, briefly, a few things about myself and my practice. My approach may or may not be

different than what you've experienced, but I hope you will feel at ease and comfortable. I want you to know that although I am speaking first this morning, this is most likely the only time that the conversation will be about me, unless you ask a direct question. Okay, I assume that since I practice [XXXX], that you are here for that reason?"

After Ms Alfred responds, the doctor could say: "The relationship that I have with you is most important to me. I hope it is a relationship we will build together, based on trust and open conversation. This is part of the reason I am introducing myself. I want you to know that if you choose to be my patient, I will always endeavor to provide you the very best medical care I can. Since I have only a general understanding of why you are here, nothing that I say is in response to or in judgment of you personally, except for my expression of building a relationship based on trust and open communication. I sincerely hope that you hear me in that way. In the interest of trust and openness, I must explain that if you are seeking a physician-partner who will provide [YYYYY], I will not be your best choice. You may not have come here for that reason. I will say more, if that is a conversation you want to have, but this is completely up to you. I want to be clear that my reasons for my practice choices may be mistaken and wrong, but this is the best I can do. And, since I value your trust above all else, I wanted to begin by disclosing this. I hope I have not put you on the spot or caused you to feel uncomfortable, although I understand this conversation risks doing just that. If I did, I sincerely apologize. What happens next is completely up to you. I am happy to discuss any of this with you—or none of it, if that is your choice. You are welcome to stay, but I will understand if you decide to leave. Whatever you decide, I want you to find a physician whom you can trust and with whom you feel most comfortable. Shall we go on?"[31]

This is one optimal interaction when meeting a patient for the first time for physicians who do not feel, in good conscience, that they can offer a particular health service. Further consideration of what might be optimal approaches in other situations when conflicts may arise—for example, when a patient and physician already have an established relationship—may lead to better outcomes.

APPROACHES THAT MAY ALLOW BETTER RESOLUTIONS

Limiting Occurrences of these Impasses

One possibility that is preferable is for doctors to take measures to reduce the likelihood that such conflicts will occur. Some of the authors published in this issue of *JCE* discuss this; for example, Antommaria relates an argument made by Holly Fernandez Lynch, that state licensing boards should be responsible for compiling and publicizing lists of physicians who are willing to provide particular treatments and of physicians who refuse to provide the treatments, and for assuring that there are a sufficient number of willing physicians.[32] This approach may or may not ultimately be optimal. It could, it would seem, help limit the problem that Schuklenk brings up in the paradigmatic negative example he uses of women who undergo back street abortions in Italy and other Roman Catholic countries that outlaw the procedure.

There are two other examples that are useful to further illustrate this approach. The first is that of a Jehovah's Witness patient who needs immediate surgery but is unwilling to accept blood. Some surgeons may be willing to operate under this condition. Others are not. If, then, hospitals surveyed surgeons beforehand to find out who would be willing to operate and who would not, it may save patients' lives. In the future, hospitals could quickly locate surgeons who are willing to do this kind of surgery.[33]

Another example that may be more commonplace is that of internists who are attending physicians. Some of these doctors feel an exceptional commitment to the sanctity of life, and may not be willing to give sedative meds to patients who have decided to go off a respirator and end their lives. The sedative meds may spare patients from suffering due to air hunger, but the meds may also reduce the patients' respiratory drives, so that the patients will die when they otherwise might have survived for some time off a respirator.[34] Attendings who are opposed to giving sedative meds for this reason may come onto a ward on which such a terminal event has already been arranged. These doctors may feel that they have no other moral choice than to order that the terminal event be stopped, at least until they can review the decision themselves, and then seek optimal arrangements so that the meds can be administered by another doctor.

The result of this postponement may be, of course, catastrophic. The patient and family may have been preparing themselves for this end, only to have it be most traumatically delayed. To try to help prevent this from occurring, hospitals might have policies in place to help avoid it. If such a terminal event is planned, for instance, the hospital could take special precautions to ensure that the attending doctors coming newly onto the ward will know this well in advance.

In the same way that hospitals can set new policies based on conflicts that occur, members of ethics committees (and all careproviders) should be aware that their work may not end when an ethical conflict has been resolved. Like these hospitals, they may want to ask, once a conflict has ended, how in the future such a conflict might be prevented.

Intervening When We Encounter a Conflict and Sense Others May Be Experiencing Shame

The dilemmas that nurses and others may encounter on an ICU ward are easy to imagine. Doctors may, for example, believe that further treatment is futile, but the patient and family may have the opposite view. This may be more likely now that physicians in some hospitals have policies "backing them" in making this determination. Of course clinicians may also, at the far other extreme, want to keep a patient alive at all costs, and this too may cause nurses and others no end of moral distress.

What the ICU nurses report in the article by Traudt, Liaschenko, and Peden-McAlpine in this issue of *JCE* is remarkable. The authors report that, generally, the nurses do not feel moral distress, and the authors report on the approaches the nurses use that may help the nurses fare as well as they do. The approaches may help any careprovider encountering similar conflicts. We may use these approaches to try to defuse the kinds of warring interactions we have been considering. We may not enable the various parties to a conflict to agree on a desired outcome, but we may be able to mitigate the residual rancor that otherwise could occur. This especially might be indicated, for the reasons I have given above, when we see that patients or physicians who are in conflict are feeling shame.

The Nurses' Approaches

The authors of this study summarize the nurses' approaches in this way:

> The nurses consistently approached the moral issues embedded in their daily work in a caring manner with a primary focus on loyalty to their patients and a willingness to challenge hierarchies. They held themselves accountable for their actions and did not fail to act because of either external or internal constraints. The practices of (1) self-awareness, including accountability for self and one's skill, and (2) advocacy fostered their ability to work through these constraints.

Several key aspects of this summary warrant discussion. I shall use some of the nurses' own words to convey what they did. One ICU nurse says of her colleague, "I want her to know I've got her back." The foreknowledge and assurance that a colleague will be on our side may be more critical than anything else in these situations. This is because it may go a long way to help us to feel safe, and we are then able to attend more fully to our patients. Our thoughts and feelings will be less distracted by our own concerns. Such unconditional trust in another can help a patient or careprovider overcome shame, if that person has come to feel shame during or after a warring interaction. Seeking out another with whom we feel safe and being able to share a feeling of shame may provide immediate and long-term emotional relief. A community with whom we can debrief and find support can be the most important asset careproviders can have.

Another ICU nurse describes how she goes beyond caring for herself to feel greater empathy for others. "Sometimes," she said, "I think we've been through this so many times, but it's always that person's first time, so just go in, not being all-knowing. . . . I try to put myself in that family member's shoes and not say too much. Not to give too much advice, but rather just empathize with how hard this must be." Empathizing as much as we can in such situations is critically important. As psychiatrist Jodi Halpern notes, citing research results, "when doctors attune to patients' cues nonverbally patients communicate emotionally laden topics and give fuller histories."[35] When we encounter a patient or careprovider who is feeling shame, our nonverbal expressions may show that we believe that we are like the person we see before us, in the most essential ways. We know that we are like the person feeling shame, regardless of what that person has done.

Conveying that we know we are "like the other" is most important in enabling another to overcome shame and then model this acceptance in turn, becoming similarly unconditionally accepting of him- or herself. How then might we do this initially within ourselves? One way is to seek to identify, somewhere within ourselves, feelings that are similar to the ones the other person may be experiencing. Granted, when the other person has behaved exceptionally badly, this may be extremely difficult. Still, though, I believe that it is possible to do this. A hideous example would be a mother who, like Euripides's Medea kills her children to gain revenge on an unfaithful husband; or a father, who kills his children to gain revenge on an unfaithful wife. These parents later feel the profoundest regret. This does happen.

Such desire for revenge is not a feeling with which most of us would want to identify. We might

believe that these parents are not like us. We may see them as sociopathic or as evil, but, in any case, not as persons worthy of dignity and respect.

But when we feel that others—patients or care-providers—are different from ourselves, our efforts may be limited in the degree to which we can help them. Still, it is most likely that we will be able see some trait we have in common. Who among us has not, for example, felt some feeling, at least somewhat like revenge, when wronged by another? There is some evidence that the desire to retaliate may be more common in those with obsessive traits, but who living among us is without these traits—or at least vulnerable to having them when we have been bested by the wrong influences, or too much stress?[36] Experiencing this kind of feeling, even if it is fleeting, may be vivid enough for us to realize that we and the person who is feeling shame are similar.

It may be difficult to identify with another when we feel we can't find any common frame of reference. I recall in this regard, for instance, a time I interviewed a couple whose toddler had died when left alone in a swimming pool for what must have been little more than an instant. I interviewed them much like the doctor who interviewed my suicidal colleague: I did it "by the book." I asked all the right questions and left no key part of the history unexamined. Only years later did I wince when I recognized in a moment of epiphany how I had so absolutely failed to ever ask myself how these parents might have felt at that time—and indeed, perhaps felt always thereafter. I felt shame. I recognized that I hadn't stopped to try to imagine within myself their intolerable and unimaginable pain.

Our task, then, is to stop, and at least, like the second ICU nurse, to ask ourselves what it must be like to be the other person, even if we can't ever really know. The paradox is this. Even if we only try to do this, the effort, in and of itself, may generate empathy. Of course, to do this and succeed may hurt. Leston Havens, a psychiatrist known for his exceptional work with patients who have schizophrenia, often spoke of how hard this work was for him, and that it should be hard for others. To empathize, he said, *could* and *should* be painful.[37] The approaches described above by the two ICU nurses are, in large part, nonverbal, but may be, however, most important. Systems within our brains may tabulate others' nonverbal responses separately from verbal responses, perhaps to indicate to us the degree to which we should trust what is or isn't "said."[38]

The second nurse's approach was not to make statements, but to ask. Rather than confront patients and family members with views they might have been missing, she asked them questions. This seems an ideal way to evoke change by genuinely promoting new thinking that avoids making others feel defensive. We can imagine that the nurse could steadfastly continue to ask questions until she felt that her task was done. Asking is a common approach, used for the same purpose, in psychotherapy. Therapists might seek to promote growth by asking, for example, "Could it be that . . . ?" Leston Havens, however, cautioned against therapists using such approaches routinely or repeatedly. Making such comments repeatedly, he said, is "risky: There is much to say for this, but unless it includes spontaneity the result is to deaden. . . ."[39] The point is that we cannot expect to achieve optimal rapport with patients by responding with rote phrases. The phrases may be empathic and help build our relationship with patients, but unless they reflect authentic concern, they may cause patients pain. Our responding by rote may cause patients to feel infantilized.

We might consider the nurses' approaches as similar to those of clinicians who do mediation. Just a brief look at some of the approaches mediators have used, that they have reported in *JCE,* will make this comparison more clear. One example is Edward Bergman's approach.[40] He, like the nurses, emphasizes steadfast advocacy. When an institution has implicitly supported a questionable policy, for example, he seeks to involve the institutional or departmental representative responsible. This may facilitate, at the very least, he says, feuding parties' having a greater understanding afterward.

Autumn Fiester also emphasizes asking.[41] She says, for example, that the questions she asks may unearth overlapping interests "despite what may be chasms of distance between stakeholders' differing initial positions." This may bring out new, shared truths without inadvertently driving stakeholders to become more firm in their original positions. When we wish to help those in disagreement to find common moral ground, however, Feister warns, we "must not come to any party's defense." This is because it may appear that the intervener is being judgmental. "Calling the speaker on what he or she has said may be implicitly "shaming."[42]

Haavi Morreim notes that the exact wording of questions is important. We must avoid expressing an implied criticism, but rather, we should frame our question as "an inquiry born out of genuine curiosity."[43] Morreim, like the ICU nurses, stresses the importance of expressing empathy. An honest expression of empathy for doctors, she says, such as recognizing the difficult position they are in, may enable them to feel more open. In addition, she de-

clares, it may help them to realize, and then possibly share, how distraught they are, and even their regret at having, in part, precipitated the situation.[44]

How might these approaches "work" in the conflict we have been discussing, an assisted planned home birth? Looking to respond to an obstetrician who does not want to encourage a home birth, we might say, "It sounds like you really want, above all else, what is best for the baby. It must be excruciating for you that the parents don't see this as you do." As Edward Bergman says, this may not solve the problem. It may, though, help the obstetrician and the parents end up feeling better toward each other and not feeling shame.

Approaches We May Use after these Deliberations

After a conflict has ended, patients and doctors may feel residual shame for the reasons outlined above, but the shame may remain hidden, even to them. They may, for example, feel and express it only as anger. We may still be able to help both parties reduce their shame by asking them if they would like to discuss their experiences with us. If they will, there are three key approaches that we should keep foremost in our minds. All are implicitly what the ICU nurses and mediators do. These approaches have even been used effectively with those among us who revile themselves more than perhaps any others: as mentioned above, mothers (and fathers) who kill their own children.[45] These parents may later feel that they have no reason to live. How might they be helped to feel again that there is, or may be, some quality to their lives that will make living worthwhile? These are the same approaches that may help patients and doctors overcome the shame they feel.[46]

Among all of those we have considered who may most need these approaches are parents who disregard their obstetrician's advice against home birth, only to have their child encounter serious problems that could have been prevented in the hospital. The first approach is to enable them to feel trust. They must know that those with whom they will share their shame will not judge them. This approach requires us to really feel that we are like those we hope to help, as discussed above. As Brené Brown states, having researched this endeavor for years, "Find someone who loves you, not despite your vulnerabilities but because of them."[47]

This may seem like a big reach for any nurse or physician outside a therapeutic relationship. Further, if we haven't previously "tested" a friend or colleague, sharing information that they might judge negatively might be a gamble. Still, I hope that most of us have someone like this. I have been astonished, in this regard, often, by the degree to which just one colleague's unqualified support can offset, and sometimes even wholly reverse, the despair that shame may create. One of the ICU nurses who is quoted states this implicitly when she says of her colleague, "I want her to know I've got her back."

As Jodi Halpern states, an individual can quickly shift from shame to regain a much better sense of self, given the right interpersonal circumstances.[48] As Brené Brown put it, speaking of herself, "Shame dissipated the minute I realized that I wasn't alone—that my experience was human."[49] Shame is a painful self-consciousness about inferiority, failure, and defeat.[50] When a trusted person lends his or her support, it may prevent the shame from becoming entrenched. Shame that is not helped may bring about a type of posttraumatic disorder, one that reflects the absence of a possible recovery.[51]

What might a colleague say to a person that conveys such unconditional support? Perhaps the colleague could say something like, "You did the best that you could. There is nothing more that you could have done in this situation." This may mean not only that the colleague couldn't have done better, but also, on a deeper level, it may mean that the person who is feeling shame couldn't have done better given the limits of the situation, or given how that person saw the situation at the time. A quintessential assumption we must make to be able to help others is that people do the things they do not because they are bad, but because they got something or other wrong. Then, whatever that thing was that they got wrong, perhaps that can be corrected. This belief must come from what might be called faith, although it is not necessarily a faith that is religious. That is, it cannot be concluded from what we can see. We can, though, perhaps, choose to have this attitude.

Another approach we might consider is to communicate that, regardless of what the person has done, no one can be perfect. Shame tells you, Brené Brown says, that "you're not good enough and you should have known better."[52] And so, "You're officially a prisoner of . . . perfecting. . . ."[53]

The crimes of parents who kill their children are immense. But even those crimes may be seen as stemming from human imperfection. This is why, therefore, if we want to help people with their shame, we must see vulnerability as something that we all share, regardless of the shame's source, and, indeed, its resulting extent.[54]

The third key approach is to help patients and careproviders who feel shame to distinguish between what they do and have done, and who they

are. *What they have done is not who they are.* It is their behavior. Brown states that, knowingly or unknowingly, we attach our self-worth to what we do.[55] If things don't go well, she says, we focus on what we have done and lose sight of who we are.[56]

If we are in a therapeutic role with a person who feels shame, we could work with the individual to try to discover, with that person, a new coping skill that the person needs and may lack. When we want to help a person who feels shame, we must, however, believe that, no matter what the person has done, she or he warrants the same respect we give to ourselves. This is because how each of us feels will affect the other. Havens may have said this best: "both minds indirectly affect the other . . . both minds will forever be changed. There is no other way. At the end of the interview, . . . two slightly different people emerge from the office, whether they are aware of this fact or not."[57]

For some of us, this may be impossible. For others, this conviction of mutual and identical worth will readily come. Is it possible that we can change our attitude, so that we can see this underlying good in others, that is necessary to help them overcome shame? Viktor Frankl would say "yes." He speaks of those in Nazi concentration camps who were comforted when other prisoners gave away their last pieces of bread. He says that they may have been few in number, but they offered proof that everything can be taken from us except for one thing: "the last of the human freedoms—to choose one's attitudes in any given set of circumstances."[58]

Such a change in attitude can't easily be inferred from ostensible evidence. This basic goodness underlying and within all of us, even when wholly hidden, can be difficult to infer from the behavior, for example, of a serial killer sociopath. That could be, however, a choice that we make.[59] Some of us come by this naturally. Others can *choose* to see those "worst among us" in this way.

The AMA opinion on physicians' exercise of conscience may reflect the possibility that clinicians may have values that they can't—and perhaps that they shouldn't—overcome. Conflicts arise because this may be as true for patients' values that they can't—and perhaps shouldn't—overcome. The challenge is for us to do what we can. This may be for us to help both parties feel as emotionally unscathed as they possibly can.

CONCLUSION

My introduction to the articles in this issue of *JCE* has primarily examined the emotional effects of doctors following (or not) the AMA opinion on physicians' exercise of conscience and the feelings of patients who will be affected as well. I have also addressed some of the ways that before, during, and after we encounter these conflicts, we may optimally respond. The most toxic emotion addressed that may come about due to these conflicts, for both patients and doctors, is shame. Patients may feel, like the participants in Milgram's research, that they are less morally sound than they believed they were. Doctors may feel that they should have done better, and then distance themselves from their patients.

I have discussed how, when we observe this shame, we may best proceed. Aside from exploring ways to prevent these conflicts from arising, we can assure patients and doctors who are affected that we are just like them, assure them that no one is perfect, and tell them that what they *do* is not who they *are*. We must to believe that those we try to help are, indeed, good.

NOTES

1. "Opinion 1.1.7 Physician Exercise of Conscience," *Code of Medical Ethics* (Chicago, Ill.: American Medical Association, 2016). The opinion appears in full in figure 1 in BJ Crigger, S.L. Brotherton, P.W. McCormick, and V. Blake, "Report by the American Medical Association's Council on Ethical and Judicial Affairs on Physicians' Exercise of Conscience," in this issue of *JCE,* 27, no. 3 (Fall 2016).

2. U. Schuklenk, "Accommodating Conscientious Objection in Medicine—Private Ideological Convictions Must Not Trump Professional Obligations," in this issue of *JCE,* 27, no. 3 (Fall 2016).

3. BJ Crigger, "Thinking about Conscience," in this issue of *JCE,* 27, no. 3 (Fall 2016).

4. This example has exceptional meaning for me. The first rotation I took during my internship right after medical school was in obstetrics and gynecology. This was at Harlem Hospital in New York City and was before *Roe v. Wade*. The doctors on this service agonized at this time over how far they could go within New York State's laws to provide women abortions. They wanted to do this to the extent that they could, because they were all too aware of what was occurring and would continue to occur if they didn't. They knew that "backstreet" attempts, as Schuklenk states, would occur. As a result of this, more women would have uterine infections and then, perhaps, lose their capacity to conceive, and some might possibly even die.

My second rotation was in pediatrics. Here, children came in with lead poisoning caused by their eating flakes of lead-based paint within their homes. The treatment for this was to give them three shots of what is called a chelating agent three times in 24 hours to remove the lead from their blood. This meant that the children would get one such shot—from a painful, large-bore needle—at 2 a.m.

every night. After the first night, the children would *know.* Thus, they would stay awake until 2 a.m. every night thereafter, dreading this event. They would often, hearing a nurse and me coming, spring from their bed and run. I spent many nights, therefore, with a nurse, chasing them around the ward at that hour.

They would then be cured, but only until they ate lead paint again at home again. Then they would return to the ward for a retreatment four months later.

Thus, to be able to help these women and children maximally, I concluded, clinicians would need the help of the law to allow abortion and to outlaw lead-based paint. Therefore, I then applied to law school.

5. T. Brooks and M.C. Nussbaum, ed., *Rawls's Political Liberalism* (New York: Columbia University Press, 2015), 4.

6. Ibid., 24.

7. A. Budden, "The Role of Shame in Posttraumatic Stress Disorder: A Proposal for a Socio-Emotional Model for DSM-V," *Social Science & Medicine* 69 (2009): 1032-9, 1033.

8. D.J. Robinaugh and R.J. McNally, "Autobiographical Memory for Shame or Guilt Provoking Events; Association with Psychological Symptoms," *Behaviour Research and Therapy* 48 (2010): 646-52, 651.

9. Budden, "The Role of Shame," see note 7 above, p. 1036.

10. Crigger asks the second question this way: "If physicians, being individual moral agents as well as members of an ethically freighted profession, should sometimes be able to follow personal conscience in the conduct of their professional lives, how are they to do so in a responsible, ethically acceptable way?" Crigger, "Thinking about Conscience," see note 3 above.

11. T. Traudt, J. Liaschenko, and C. Peden-McAlpine, "Moral Agency, Moral Imagination, and Moral Community: Antidotes to Moral Distress," in this issue of *JCE,* 27 no. 3 (Fall 2016).

12. J. Shay, "Moral Injury," *Psychoanalytic Psychology* 31, no. 2 (2014): 182-91, 182.

13. T. Schmader and B. Lickel, "The Approach and Avoidance Function of Guilt and Shame Emotions: Comparing Reactions Self-Caused and Other-Caused Wrongdoing," *Motivation and Emotion* 30, no. 1 (March 2006): 43-56, 54. See, also, U. Orth, M. Berking, and S. Berkhardt, "Self-Conscious Emotions and Depression: Rumination Explains Why Shame But Not Guilt is Maladaptive," *Personality and Social Psychology Bulletin* 32, no. 12 (December 2006): 1608-19; J.T. Maltsberger et al., "Traumatic Subjective Experiences Invite Suicide," *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 39, no. 4 (Winter 2011): 671-93.

14. B. Bower, "Over the Edge: What Leads a Person to Move from Thinking About Suicide to Taking Action?" *Science News* 189, no. 1 (9 January 2016): 22.

15. Schmader and Lickel, "The Approach and Avoidance Function," see note 13 above, p. 47.

16. Orth, Berking, and Berkhardt, "Self-Conscious Emotions," see note 13 above, p. 1609.

17. Ibid., 1615.

18. Schmader and Lickel, "The Approach and Avoidance Function," see note 13 above, p. 54.

19. Shay, "Moral Injury," see note 12 above, p. 182.

20. Schmader and Lickel, "The Approach and Avoidance Function," see note 13 above, p. 55.

21. F.A. Chervenak et al., "Planned Home Birth in the United States and Professionalism: A Critical Assessment," *The Journal of Clinical Ethics* 24, no. 3 (Fall 2013): 184-91. For a general discussion of the contexts obstetricians confront today, see L. Diamond-Brown, "The Doctor-Patient Relationship as a Toolkit for Uncertain Clinical Decisions," *Social Science & Medicin*e 159 (2016): 108-15.

22. T.M. Pope, "Legal Briefing: Stopping Nonbeneficial Life-Sustaining Treatment without Consent," in this issue of *JCE,* 27, no. 3 (Fall 2016).

23. Chervenak et al., "Planned Home Birth," see note 21 above.

24. A.H.M. Antommaria, ""Conscientious Objection: Widening the Temporal and Organizational Horizons," in this issue of *JCE,* 27, no. 3 (Fall 2016).

25. "Death of a Child: Losing Adam," *NPR Driveway Moments 2,* K. Thompson, producer, 2004.

26. N.J. Russell, "Milgram's Obedience to Authority Experiments; Origins and Early Evolution," *British Journal of Social Psychology* 50, pt. 1 (March 2011): 140-62.

27. L. Westgate, B. Shriner, P. Thompson,and B.V. Watts, "Evaluation of Veterans' Suicide Risk with the Use of Linguistic Detection," *Psychiatric Services* 66, no. 10 (October 2015): 1051-6.

28. A poignant, fictional example is that of August, a child born with exceptional facial features, who is bullied. He refuses to tell his parents and plans to not return to school. "You're going to have to tell Mom and Dad why," Via, his older sister, tells him. "Via, it's okay," August says. "I know what I'm doing. I've made up my mind." P.J. Palacio, *Wonder* (New York, Knoff, 2012), 114-5.

29. Moral convictions may run deep. Consider, for example, Antommaria's example in "Conscientious Objection," see note 24 above. He asks, "How should the owner of a physician practice respond, for example, to a nurse or medical assistant who generally administers injections, but who objects to administering depot medroxyprogesterone acetate (DMPA, a long-acting contraceptive injection drug—Depo-Provera)?"

30. J.T. Maltsberger and D.H. Buie, "Countertransference Hate in the Treatment of Suicidal Patients," *Archives of General Psychiatry* 30, no. 5 (May 1974): 625-33.

31. This hypothetical introductory conversation was written by Norman Quist as we were discussing, on 26 August 2016, how physicians might best respond if they knew that they might have a conflict when first meeting a patient. I am exceedingly grateful to Norman for sharing not only this passage, with which I concur, but for making numerous other comments and suggestions that have added greatly to this article.

32. Antommaria, "Conscientious Objection," see note 24 above.

33. For another approach to this ethical conflict with Jehovah's Witness patients, see A. Pena, "Preventing the Predicable," *American Journal of Bioethics* 15, no. 1 (2015):

72-4.

34. R.D. Truog, D.W. Brock, and D.B. White, "Should Patients Receive General Anesthesia Prior to Extubation at the End of Life?" *Critical Care Medicine* 40, no. 2 (February 2012): 631-3.

35. J. Halpern, *From Detached Concern to Empathy* (New York: Oxford University Press, 2001), 93.

36. People with more obsessions and/or compulsions tend to be more prone to feeling a desire for revenge. Who among us lacks obsessional thinking or compulsive feelings? R. Fatfouta and A. Merkl, "Associations between Obsessive-Compulsive Symptoms, Revenge, and the Perception of Interpersonal Transgressions," *Psychiatry Research* 219 (2014): 316-21.

37. ". . . when an interviewer and a patient meet, their minds meet and interact . . . it is critical to understand the clinical gremlins that arise. . . ." L. Havens, "Approaching the Mind in Clinical Interviewing: The Techniques of Soundings and Counterprojection," *Psychiatric Clinics of North America* 30 (2007): 145-56, 144.

38. The importance of nonverbal interactions cannot be overstated. Parts of the brain may specially process these responses. C.D. Frith, "The Social Brain?" *Philosophical Transactions of the Royal Society B: Biological Sciences* 362, no. 1480 (April 2007): 671-8.

39. L. Havens, "The American Impact on Psychoanalysis," *Psychoanalytic Quarterly Dialogues* 14, no. 2 (2004): 255-64, 259.

40. E.J. Bergman, "Identifying Sources of Clinical Conflict; A Tool for Practice and Training in Bioethics Mediation," *The Journal of Clinical Ethics* 26, no. 4 (Winter 2015): 315-23, 320.

41. A. Fiester, "Contentious Conversations Using Mediation Techniques in Difficult Clinical Ethics Consultations," *The Journal of Clinical Ethics* 26, no. 4 (Winter 2015): 324-30, 329.

42. Ibid.

43. E.H. Morreim, "Story of a Mediation in the Clinical Setting," *The Journal of Clinical Ethics* 27, no. 1 (Spring 2016): 43-50, 47.

44. Ibid., 45.

45. See, e.g., S.H. Friedman and P.J. Resnick, "Child Murder by Mothers: Patterns and Prevention," *World Psychiatry* 6, no. 3 (October 2007): 137-41, and D.G. West, S.H. Friedman, and P.J. Resnick, "Fathers Who Kill Their Children: An Analysis of the Literature," *Journal of Forensic Sciences* 54, no. 2 (May 2009): 463-8. For an example of how a therapists may work with such patients effectively, see M. Manjula, C.R. Chandrashekar and Filicide, "Extended Suicide: An experience of Psychotherapy with the Survivor," *Indian Journal of Psychiatry* 56, no. 2 (April-June 2014): 194-6.

46. Brown summarizes research on how to treat and overcome shame in lay language in B. Brown, *Daring Greatly* (New York: Avery, 2012).

47. Ibid., 80.

48. Halpern, *From Detached Concern to Empathy,*" see note 35 above, 117.

49. Brown, *Daring Greatly,* see note 46 above, p. 81.

50. Budden, "The Role of Shame," see note 7 above, p. 1033.

51. Ibid.

52. Brown, *Daring Greatly,* see note 46 above, p. 63.

53. Ibid., 64.

54. Ibid., 35.

55. Ibid., 63.

56. Ibid., 64.

57. Havens, "Approaching the Mind in Clinical Interviewing," see note 37 above, p. 56.

58. V.E. Frankl, *Man's Search for Meaning* (Boston: Beacon Press, 2006), 65-6.

59. Simone Weil wrote, "at the center of the human heart, there's a longing for an absolute good. . . . The needs of a human being are sacred. . . . Whenever people are lonely and turned in on themselves, wherever there is sadness or ugliness, there are privations that need remedying." S. Weil, "Draft for a Statement of Human Obligation, 1943," in *An Anthology,* ed. S. Miles (New York: Grove Press, 1986), 202, 207, 210.