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At the Bedside

How We May Become Detached from Our Patients and What We Can Do If This Happens

Edmund G. Howe

ABSTRACT

When clinicians provide clinical care or participate in ethics consultations, they may feel exceptionally painful emotions. When they do, they may distance themselves emotionally from patients and families. This distancing may harm these parties profoundly. It is therefore critical that clinicians avoid this distancing. In this piece, I present an approach that lies outside traditional practice that clinicians may use to try to avoid and even reverse this distancing, if and when they sense that this may be occurring. This approach may also benefit patients and families. It may increase their sense that their clinicians are working with them as allies to achieve their shared medical goals.

In introducing this issue of *The Journal of Clinical Ethics*, I shall discuss how we may best respond to patients and families when we become exceptionally emotionally distressed. In our medical training, we are taught to try to feel appropriate detached concern. This involves our, on the one hand, feeling empathy for our patients, but, on the other, remain-

ing sufficiently detached so that we can continue to be able to give our patients the optimal care that they need. Balancing these competing objectives may be difficult, and sometimes impossible. In some cases, for example, our emotional pain may overwhelm us. Then we are more vulnerable to becoming emotionally detached from our patients. Further, this detachment may occur even when we do not intend or want this to happen. It may occur automatically, outside our awareness, as if to protect us from painful feelings we could find too much to bear.

This detachment may greatly harm patients. It may hasten or even precipitate their death, as is most clear in the case of suicide. I present, therefore, an approach we may use to prevent this distancing from occurring. It may, in addition to stopping emotional distancing, possibly reverse it. It may result in patients feeling closer to us. Patients may see us more as allies, working with them to accomplish common medical goals, rather than seeing us as caring for them because this is just what we do.

This approach involves sharing our feelings with our patients when we feel overwhelmed, and disclosing too why this is. This makes our patients more knowledgeable about what is going on within us and, more importantly, unites patients and clinicians in searching for the best solutions together. Patients may feel greater closeness because we have been willing to share the angst we feel in these exceptional situations. Patients might see that we are distressed, already, in any case.

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There are other approaches we can use to try to reduce our emotional detachment from patients. Some are the same ways that we can use to try to avoid feeling burned out, as, for example, reducing our stress through activities such as meditation or jogging. These strategies, however, may not go far in enabling us to avoid emotional distancing and help us to continue to feel close to patients, and they to us. The emotions we experience when we treat some patients may simply be too much for us to bear. Then, consciously or unconsciously, we may distance ourselves from them to gain needed relief.

We may need another, better way to gain relief, as I will suggest. It may be uncommon, but it is not unprecedented, even though it lies outside and may go against traditional teaching. It may help us remain emotionally close to our patients when we perform the role of clinician or ethics consultant.

Two articles in this issue of *JCE* present cases that illustrate how emotional distancing can occur. From these cases I shall draw paradigmatic examples. The first article, "Ethical Challenges in Acute Evaluation of Suspected Psychogenic Stroke Mimics," by Alexandra J. Sequeira, Michael G. Fara, and Ariane Lewis, presents the case of a 47-year-old man who is admitted to the hospital complaining of 30 minutes of left-sided weakness.¹ If he is having a stroke, administration of tPA (tissue plasminogen activator) will be lifesaving, if it is administered in 4.5 hours. The patient's weakness comes and goes and may be psychologically caused. If he is not having a stroke, tPA poses only a small risk, but requires a high-acuity setting and significant use of resources. The hospital physician is uncertain, and may feel helpless. Feelings of uncertainty and helplessness are feelings I shall discuss as paradigms of the feelings that cause clinicians to emotionally distance themselves from patients.

The second article in this issue of *JCE* that I will discuss, "Deathbed Confession: When a Dying Patient Confesses to Murder: Clinical, Ethical, and Legal Implications," by Laura Ticknell, Anne O'Callaghan, Joanna Manning, and Phillipa Malpas, presents a case illustrating an emotion that may cause us to distance ourselves emotionally: *shame*.² The clinicians in this case may have felt shame and may have distanced themselves from the patient because they may have felt that they had to betray him and violate his confidentiality, although they had implicitly promised him that they would not.

Emotional distancing may protect us from pain that is caused by uncertainty, helplessness, and shame—and other painful feelings. This emotional distancing may occur automatically and wholly

outside our conscious awareness. Feelings of fear may exacerbate this distancing.³

The approach I suggest is to share the emotional pain we feel with patients, before we begin to distance ourselves from them. In response to powerful emotions, some clinicians may find themselves spontaneously crying in the presence of a patient. In doing this, clinicians may be acknowledging what the patient already knows they are feeling, but, by making their feelings explicit, they are including the patient, as though the patient was a member of their own family.⁴ This may bring patients and clinicians closer, which may be critically important to some patients, as I will discuss later. I will discuss the feelings of uncertainty, helplessness, and shame as paradigms. After discussing each of the feelings, I shall suggest how we might directly present these feelings to our patients, with a verbatim example.

UNCERTAINTY

Feelings of uncertainty may cause us to emotionally detach from patients, especially when the stakes are high.⁵ Clinicians who feel uncertain may respond sub-optimally in other important ways.⁶ We may, for example, conduct unnecessary tests.⁷ We may even, more ominously, discriminate among patients, based on their race.⁸

The case of the patient with left-sided weakness who may have been having a stroke, described above, left the physician feeling uncertain and perhaps even helpless. He could not resolve his uncertainty, but still had to act. He may have felt helpless because he had no way to discern whether the patient was really having a stroke. Fortunately, the stroke treatment would not have been fatal if the patient was not having a stroke. But often this is not the case. One example is when patients are suicidal. A second example is when infants are born so prematurely that it is almost inevitable that they will die, or, if they live, they will not "walk, talk, or relate" (as this is sometimes expressed). In both of these contexts, we may feel highly uncertain, and the stakes are irreducibly high. I shall use these two examples, patients who are chronically suicidal, and newborns who are extremely premature, to illustrate how we may be able to share our feelings of uncertainty with patients (and parents) to reduce the possibility we will distance ourselves emotionally from them.⁹

Patients Who Are Chronically Suicidal

When patients may commit suicide, we may feel especially uncertain because we (rightly) feel a need to be as certain as we can about how to best help

them. Feelings of uncertainty in such high-risk contexts are painful. Further, like all people, clinicians can be susceptible to irrational beliefs. Since the outcome of suicide is never inevitable, then, in theory, any suicide might be prevented. Thus, we may be vulnerable—in spite of knowing otherwise—to feel that we could have prevented a patient from taking his or her life, even when this isn't truly the case. When patients are chronically suicidal, if we hospitalize them against their will (or even just try to), it may harm them more than not doing it, over the longer run. Patients who are so hospitalized, for instance, may find it so traumatic that they choose to not see a mental health provider ever again.¹⁰ The trauma that some patients experience in the hospital may be greater if they are given medication by injection against their will. Patients who have been hospitalized and who are suicidal are more prone to taking their life in the month or so after they are released, perhaps reflecting the pain they report that they experience during hospitalization.¹¹

The effect on the patient/clinician relationship from even trying to involuntarily hospitalize such patients may be just as harmful to our patients, or even worse. Our relationship may, in some instances, be all that is keeping patients alive. When we treat patients who are chronically suicidal, we may be in a bind. On one hand, we want to help them do optimally over the long run. Yet, at the same time, we may accurately fear that if we don't hospitalize them immediately when their suicidal feelings increase, they may be at an increased risk of taking their life.¹²

There are other options. For example, we can meet more frequently with patients when they are more suicidal. One such patient and I agreed under these circumstances, for example, to talk by phone, initially, every six hours. We were then able to decrease the frequency. He has done well. But even waiting between such a patient's phone calls can cause us to feel highly uncertain. It still evokes fear. When we feel fear, it is likely to affect all that we do. For example, when we take an initial history from a patient, if suddenly the patient says he or she feels suicidal, our interaction may change, from that very moment. We may always have at the back of our mind the fear that this patient may take her or his life. As a result, we may change what we do in our therapy. We may spend less time seeking to give the patient the skills she or he will need over a longer time, and instead spend more of our time together asking the patient whether he or she feels suicidal.¹³

In addition, we may detach from the patient and not recognize that this detaching is occurring. We may rationalize decisions to distance ourselves as

being warranted for other reasons. For example, we may believe that the patient is exaggerating suicidal feelings to obtain more therapy than the patient is entitled to and needs. If we distance ourselves emotionally and share these thoughts with the patient, it may result in the patient feeling more suicidal.

This is an instance in which sharing our painful feelings may help us remain emotionally close with a patient. We can explain that the problem is within us. "I am emotionally torn," we might say, "because I want to help you in every way that I can, but at the same time the number of sessions we can have is, as you know, supposed to be limited. I feel so torn, not knowing what we should do." We can add, "If I thought I needed more treatment, this is something I can imagine that I would want to do for myself."

We could add that we know that the persons who will review the patient's need to have additional sessions may question and even turn down the request, and may do so because they believe the patient may not be suicidal, but is saying this to be able to have more therapy sessions. We could say that we suspect that may happen, because reviewers have responded in that way before. We can say that the last thing we would want to do is to respond in a way that would leave the patient feeling he or she must try to make the case that he or she is genuinely suicidal. We can say that if we feel the patient needs further sessions, we can imagine we would want to do whatever we could to do this. We can share this to make clear that we hurt and especially because we understand it to be the irresolvable nature of the patient's core plights. Sharing this may benefit the patient and our relationship, regardless of what we decide together at that time, or what we decide later, if we must decide this alone.

Since we may have to make a decision unilaterally, we should make this clear from the start: "I don't know now whether I will request more sessions. I will have to decide. I feel very torn and would like to discuss why with you. But I can imagine that if I were you, I might just want to say to me, 'So . . . decide!' Would you like me to share with you why my making this decision is so difficult for me?" As a result of saying this, as we face making the decision with our patient, we are more equal with the patient. The patient is more informed, and, to the degree that both parties are facing making a decision, greater *allies*. It may be that we will decide to not request more sessions. After our sharing our feelings and our plight, we still have to act independently, but we have disclosed this, and thus have involved our patient in the process, to the degree that we can.

When we don't distance ourselves emotionally from our patients, but stay emotionally closer to them, they may come to feel, over time, that they can find the kind of meaning they experience with us in interaction with others. It may be that, for some patients, the only way in which they can acquire a hope that they can experience a relationship with others is by first experiencing this openness and honestly with their clinician.

This process of sharing more with our patients may include sharing any rifts that come between us. If we can survive these rifts and still feel close to our patients, it may help them to be able to conclude that having a life of quality and meaning, shared with others, may be possible.¹⁴ An example may be helpful to illustrate how coping together with a patient, through such a rift, by talking it out, may be possible. This example also illustrates how subtle yet pernicious emotional distancing can be. I was seeing a patient who had felt chronically suicidal for years before I first saw him. A college rugby player, he had repeatedly reassured me that, as he hadn't taken his life, despite feeling chronically suicidal, he wouldn't. Rather, he often shared with me how important it was to him to share with me how much he wanted to die, since he had not been able to share this with anyone previously. Despite this reassurance, once as he was describing this wish in what seemed to be especially vivid terms, I panicked. I then asked him the customary question to screen for acute suicidality and the possible need for voluntary or possibly even involuntary hospitalization. He recognized this change immediately, and told me he felt angry. Hadn't he reassured me enough, he said, that he wouldn't take his life? I shared with him that I'd felt frightened, and said that I was sorry. I added that I was, in one sense, *glad*, because at least he now had a ground for believing that it might be that I genuinely cared. He had told me before that he had thought that all of the prior clinicians he had seen did what they did for the money. He said he was sorry he had scared me. This I took as an indication that he had an important strength: he could, I inferred from this, look at himself, see how he had affected me, and respond in a way that was optimal and most interpersonally appropriate. This indicates how such a rift may be talked out and resolved.

But there is more here to consider: my use of the word "appropriate." This is accurate, but at the same time reflects my judgment of this patient. Thus, in even my just thinking this, I may have moved from being primarily another person, to being primarily a clinician assessing a patient and judging his progress. Patients may sense this and find it infantilizing. When clinicians do this, we may con-

note to patients—rightly or wrongly—that we regard ourselves as superior, and this may quash the thread of a relationship we have with each other. This is an illustration of the subtlety with which we can distance ourselves emotionally from our patients, and possibly, as a result, end a meaningful relationship with them. It illustrates how we may never be able to not distance ourselves from patients as we treat them, since we must, at some point, view them objectively, for example, when we measure if they are getting better. The goal is, rather, aspirational and asymptotic. We can seek to relate with our patients as fellow humans; for example we will both experience death. Yet, as clinicians, we cannot but view them, in a sense, as our project, whom it is our task to make better. As this is the case, what can we do? We could share even this with our patients.

To be more specific: How could share what we feel with a chronically suicidal patient? We could say, "I am terrified that you could take your life and I don't know at all what I should do. I may have to consult with others, and they may determine that I should hospitalize you, even if I don't agree. If they—or they and I—believe we must hospitalize you, even though we know you don't want this, please know I feel greatly sorry. We might do this even knowing how strongly you oppose it, because we believe this is necessary now to best insure that you don't take your life. If we decide this, we may be wrong, and I feel terribly bad now, knowing I don't know what is best for you." This example is greatly compressed for purpose of this illustration. In a real interaction, we should then ask the patient how she or he responds to this, and discuss it, if the patient wants to. Our hope is that even if, in the end, we disagree with the patient, that we have shared our feelings and the competing rationales might result in the patient's later having a greater understanding. This may allow a greater alliance with the patient than might otherwise be the case.

Extremely Premature Newborns

Infants who are born extremely prematurely may do well, or they may die or survive greatly impaired. Like the parents of such infants, clinicians may feel most uncertain about what to do.¹⁵ With the stakes as high as they are, our fear, too, is as high as it gets. Like parents, we may not know whether we should fully treat these infants.¹⁶ Some clinicians may believe, however, that in rare cases, we should make decisions on our own, without involving parents.¹⁷

That is, in rare cases when an infant who is born extremely prematurely will almost certainly die, or, if the infant survives, will be most severely neurologically impaired, some clinicians may not ask the

parents to be involved in making a decision whether to begin or continue to fully treat the infant, because the clinicians may see the infant as having an almost inevitably dismal and extremely poor prognosis, regardless of what is done.¹⁸ These infants will, the clinicians believe, die and/or not be able to talk, walk, or relate.¹⁹ With this exceptionally poor prognosis, the clinicians believe that to ask the parents to decide with them what they should do would be not only unacceptably misleading, but cruel. Asking parents to participate in making decisions could imply that there are real choices to be made, when there are none.²⁰

We can first talk with parents and indicate that we may decide that we should make decisions unilaterally because there are no real choices. On hearing this, parents, even when consulted fully from the outset, may feel enraged.²¹ There may be a case to be made that we could at least share with parents how badly we feel about this. When considering whether or not to say this, a consideration is that later parents may remember and value it.²²

We can also ask how far in explaining the bases of our angst we should go. If, having asked parents whether they want to know about how decisions will be made, and the parents say they would, we might ask them whether they want to know more about the questions staff will consider as they decide what they should do. If parents want to know more about this, we can share some of the ethical questions around how decisions should best be made. There are many; for example, making a decision could involve only neonatologists, only neonatologists and pediatricians, or both of these groups and obstetricians.²³ It could also involve nurses and other staff.

Then there are other questions: How many should be involved in making a decision? Should a decision be unanimous, or by a majority, or decided in some other way? If a decision is to be made by majority vote, should the voting be made anonymously?²⁴ These questions apply to decisions regarding extremely premature infants everywhere. Less-common questions are whether the parents want to know about the staff's shared pain, especially if the staff feels it must make these decisions unilaterally. When we struggle emotionally to answer these questions, we can take the initiative to offer parents the opportunity to discuss that—at the time, or later.

This may be seen as an extension of what we share when we cry with a patient, as I noted above. In the case of parents of an extremely premature infant, sharing our feelings may enable them feel that we are “side-by-side” with them.²⁵ As Norman Quist wrote, citing the pediatrician and psychoanalyst D.W. Winnecott in a past issue of *JCE*, “a sign of

health in the mind is the ability of one individual to enter imaginatively and yet accurately into the thoughts and feelings and hopes and fears of another person; also to allow the other person to do the same to us.”²⁶

If decision making will be shared with parents, we may seek to decrease any emotional distancing we may experience by going further than we would otherwise. Here is one example to illustrate how this might be done. With both parents present, prior to making any decision, we can ask them whether they want to discuss with us what they would want to do, if they have different views than we do. We could point out that having differing views is almost inevitable. If the parents want to discuss this, we can consider together how different values and decisions might affect the relationship that they have with us in the future. We might add that this may affect their infant, as well.

These discussions and the concerns expressed during the discussions may differ widely, depending on whether the parents are married and/or doing well, or are just hoping to do well. If the parents are married and doing well, for example, a key question to discuss with them might be, in addition to what might be best for the infant, what decisions may best allow their good relationship to continue to thrive and survive. If the parents aren't married, but one parent wants to be married more than the other parent does, there is a risk that the parent who wants the relationship to continue and grow may be tempted to go along with whatever the other parent wants, in the hope that this will increase the likelihood that the relationship will continue.

If we don't have these communication skills or don't have the time for these discussions, but the parents want this, we can contact others who have the skills and the time. Both of these initiatives—asking parents if they want to discuss making decisions and finding a way that they can, if they do—may directly offset emotional distancing, which may occur in this context if we have different views than parents.

When we decide by ourselves whether or not to include parents in making treatment decisions, to share our feelings, we might say, “What happens here may be close to unbearable for you. It is for me too, although to an infinitely less extent.” Expressing the feeling we have is depicted by Quist, who quotes Jerome Groopman. Groopman describes telling his patient, Maxine, that she has a disorder that may cause her death. “Maxine, sobbing, says to Groopman, ‘I don't want to die. . . . I didn't think it would happen so fast, so soon. I'm not ready to die.’ Groopman replies, ‘I don't want to lose you.’”²⁷

HELPLESSNESS

In the case of the patient who might have been having a stroke, discussed above, the physician making treatment decisions probably felt helpless. He had no way to discern whether the patient was having a stroke or had a conversion disorder. Helplessness is one of the most painful, if not the most painful, emotions we can feel. When we feel helpless, in any context, we may become emotionally detached. We may feel this in a wide variety of circumstances, as when a patient has an incurable cancer. Here are some less well-known examples of how clinicians who do not want to distance themselves emotionally may want to proceed.

Subtle Examples That May Evoke Feelings of Helplessness

Helplessness may be very painful for clinicians because we need to feel certain and able to help in order to best treat our patients. There are some contexts, however, in which the opposite may be true. For instance, hospice clinicians can't save patients from dying, but they can help patients as they die, to an almost an immeasurable extent.

Hospice clinicians help their patients find and feel meaning in their life. In their last weeks and days, some patients find new meaning, and some find more than they ever had before. This new and greater meaning comes from mostly having deep or deeper interactions with others. Clinicians of all kinds can have these deeper interactions too. A patient may remember one word or even a gesture from us. One way to achieve this is to share our feelings when we feel helpless. We may, as clinicians, be not only prone to hiding painful feelings of helplessness, but to distancing ourselves from patients when we feel that way. An example that can be used as a paradigm to discuss this is the hospital physician in the case considered above, whose patient had left-side weakness, and may have been having a stroke. On the other hand, this patient might have had a *conversion disorder*, a psychologically caused condition whose cause can't be seen.²⁸ In cases like this, we may deal with our own pain at feeling helpless by blaming the patient. Thus, we may think or say with some disrespect that the patient's pain is all in the head. Most of us know by now not to do this. Yet this response indicates an emotional defense we have against the more painful feeling of helplessness, to which we are all still prone.

This response occurs especially when patients have symptoms for which we can find no bodily cause.²⁹ We may believe, irrationally, that if patients really wanted to, they could change. More often than

not, they cannot change, at least not on their own. Nonetheless, we distance ourselves. This error can occur when a loved one commits suicide. Afterwards, we may blame ourselves because we think we could have prevented it, if we were in the right place at the right time—but we weren't. We may believe only what we can see, and so, when we see patients with a psychogenic disorder, such as a conversion disorder, we may wrongly conclude that they can change by choosing to do so, just as we may wrongly conclude that because we might have been able to prevent a suicide, we not only plausibly could have, but should have.

The hospital staff caring for the patient with left-side weakness saw this psychogenic possibility and accepted the patient as he was, and didn't judge. We may experience feelings of helplessness when a patient has pain we can't fix, and then we may, in addition to blaming the patient, detach emotionally from the patient to even an even greater extent because we believe, to some degree, perhaps rightly, that the patient may be seeking drugs.

Another example is patients with anorexia nervosa. It may seem that they won't eat when they could and should. This may cause us to blame them and distance ourselves emotionally. The number of patients who die from this disorder is frightening. This risk emphasizes the importance of not distancing ourselves emotionally with these patients, but instead to increase our relationship with them. How might we possibly do this better? We might, when we feel helpless, share that information. In the next section I will discuss the possible, perhaps not so obvious, gains from sharing even these feelings.

Possible Gains from Sharing Feelings of Helplessness

I have presented the possible benefits of sharing the pain we experience with our patients. If we do this, we should always first share with our patients that we absolutely "get" that they are doing everything they can to get well. We may not know for sure that they are doing everything they can to get well, but we can assume they are, and say so. And when we do know for sure that they aren't, we can, transparently, explain our reasons.

The critical factor we must keep in mind when we do this is that there may be a reason patients are not doing what they can to get better. When we want to retain and preserve our relationship with such patients, we must recognize and make explicit that even if we don't know the reason they are not doing something to get better, we know that there *is* a reason, whether or not this is within their conscious control. When we share our angst at feeling help-

less, it is likely that our patients feel angst at feeling helpless, as well. It is critically important that we say we know that they lack conscious control, because doing this validates that there is nothing they can do, and indicates that we know this. Sharing our feelings of helplessness with patients before sharing our other thoughts may be necessary for patients to be able to be open to hearing our thoughts, and for the thoughts to be able to “go down.”

An example is patients who have a symptom such as pain, from which they get a so-called secondary gain, and they retain the secondary gain only if they keep the symptom. For example, the gain may be money that compensates the patient for an injury caused by another person. Compensation for the pain may continue only if the pain and the limitations it causes persists. How might we best proceed in these situations? The best approach is to prioritize our relationship with patients.³⁰ First, we can acknowledge why we feel helpless and how painful it is, and why we are sharing this with them. We can say that we imagine that they are in pain, even with this secondary gain, and that they are feeling much more helpless than we are. Thus, from the first moment we share this, the patients are not blamed, and, with the feelings we share with them, we are together, and less distant from one another in this way.

We may also help patients feel more equal by sharing with them how their symptoms may be outside their conscious control. Here I rely on the scientist Joseph LeDoux, whose empirical research explains how some information may get laid down in a person’s brain without the person knowing this is happening.³¹ For example, we may watch a frightening scene in a video for fractions of a second, too short for us to be able to take note of it. Our bodily processes, such as blood pressure and our heart rate, may, however, change at that moment, indicating we saw the frightening scene, even though we have no awareness that we did. We had a “fight or flight” response even when unaware that we had it. The memory, however, remains and may affect us.

Sharing our feelings of helplessness with such patients, and going the extra mile to explain why, may, over time, help them to get better, although why this happens is not yet known. There is another way to help patients fare better when they feel helpless that is not new, but is an enhanced old way. This approach was pioneered by psychiatrist James L. Griffith, who has since taught it to other clinicians to help patients who feel helpless on hospital wards.³² Griffith walks clinicians through sequential steps. First he asks them how they coped best in the past when they were in closely parallel, helpless conditions. For example, some clinicians who

feel burned out will do best through an activity such as jogging or gaining the help of others. Griffith seeks specifics. If clinicians say they were helped by others, he inquires, “Has this been a former mentor or a trusted friend to whom you can ventilate?” Likewise, we can seek to brainstorm with patients how they can implement a past choice that worked well.

What specifically might we say to patients when we want to share our feelings of helplessness? We might say, “I want to help you as much as I possibly can. Now, however, medically, I am helpless. Medicine has no way I can tell for sure whether you are [having a stroke/a conversion disorder/having the pain that you are]. For me it is terrible being helpless, and I can imagine, for you, your pain is many times this. Let me explain what we can still do under these circumstances.”

SHAME

Another article in this issue of *JCE* that I want to discuss is “Deathbed Confession: When a Dying Patient Confesses to Murder: Clinical, Ethical, and Legal Implications.” Ticknell, O’Callaghan, Manning, and Malpas present the case of a terminally ill patient who confesses that, decades before, he performed “several contract killings” as a gang member. The medical staff is torn. They want to respect their patient’s confidentiality—as they do for all of their patients—but they also want to help the families and loved ones of those who were killed, to help give them closure, in case they don’t know what happened to their loved one. The staff are faced with conflicting duties: to respect their professional and personal implicit promise to the patient, and to help others. They may distance themselves emotionally from the patient, as a response. This kind of conflict exists in many contexts in medicine, and I will now consider conflicts in similar contexts and suggest what we may do in response.

Similar Contexts

As they cared for the former gang member, now a patient, the medical team may have felt anticipatory shame. That is, they may have felt shame at merely wondering whether they should renege on their promise to protect the patient, as breaking this promise would violate their deepest moral beliefs. To reduce the pain of this shame, they may have emotionally detached themselves from him.

In regard to this and similar cases, it may be best to first consider an ethical possibility that may warrant priority over all other moral frameworks and principles: that this patient, notwithstanding what he did in the past, may be worst-off. If so, perhaps

meeting his needs should be the first priority for the team, unless another competing interest is especially compelling; for example, in this case, the needs of his victims' loved ones might be given priority. To put this metaphorically, it may be that the bully needs us more than the bullied. And this may pertain, whether or not the patient knows this.

Why? This patient may be so blocked off or emotionally numbed by what he has experienced that he now feels no needs, even though he may still have them, and at some level is hurting. He may, for example, feel totally and abysmally alone. This may be the kind of a rock-hard emotional defense that some people show when they have complete denial. People may, on the other hand, feel neither the need for caring from others nor regret. Yet we never can know this. Some patients, for example, do not say so much as a word to a new clinician, even after seeing the clinician for weeks. The clinician may sit with the patient, silently, day after day. Then suddenly the patient talks to the clinician. And weeps.

Some therapists work with incarcerated patients who will never go free, since they are serving a sentence with no possibility of parole. With therapy, the patients, who may be bitter and want nothing for years, may come to find, to their surprise, that even though they are confined in prison for the rest of their life, there is still much meaning in life, and that they want to live. The reason for this? It may be the relationship they have with their therapist.

These ethical considerations support giving due moral weight and ethical priority to the patient who had been a gang member, regardless of what he had done. But whether we can actually "get there" ethically or emotionally is discussed in the next section. The need to help others who have done wrong, and the shame this may cause when others' interests are in conflict, may appear in many guises. This occurred for me, most painfully, when a patient came into my office in extreme emotional distress. He had done something wrong. He was no longer a danger to others, but we both knew it was likely that one of us would have to turn him in. He turned himself in, and now, long after, he is finally well.

The painful angst I experienced was as strong as I have ever felt for a patient. I imagine the staffs' feelings around the former gang member were as painful. I still wonder whether I should have said something to my patient such as, "I expect that it may be that one of us should turn you in. I feel terrible about the thought of doing this. I feel this in part because I care so much for you, as I hope you know. I wouldn't have known about this if you hadn't told me. I fear that since this is the case, I should turn you in, but I am too chicken. I lack the courage

to be willing to follow through with this thought." The fear is greater and the stakes are higher when others are in danger, or when others may be helped by our actions.

Another patient caused me similar, although less intense, angst because I thought (rightly or wrongly) that I knew him better than I actually did. This patient had taken a medication with a known side-effect, causing him to imagine harming others. I could have and perhaps should have called in the police, or at least should have said I would do this unless he admitted himself to the hospital. I did not call the police, perhaps because I imagined my ability to predict his future behavior was greater than it was. But thankfully, his impulses to do harm went away and he, too, has since done well.³³

A more ominous example is that of an adolescent boy on a school bus, who shared, when riding home with a fellow student, that he felt like killing his teacher. His fellow student reported this to the school principal. The principal sought the advice of the school guidance counselor. The counselor consulted two different mental health professionals who differed radically in their recommendation. One thought an in-house evaluation at the school might suffice to clarify that the student did not pose a genuine risk. The other thought that any action short of immediate hospitalization and evaluation of the student would run an unacceptable risk. The guidance counselor and the principal decided to conduct an evaluation in-house, and it was determined that the student did not pose a risk. He said he had not really meant the threat. Those who met with the student, like the members of the team who cared for the former gang member, worried over their determinations greatly.

How might we help our patients, whether or not we violate their confidentiality or some other duty owed to them? Our chief task may be, at all costs, not to distance ourselves emotionally from them. I shall now discuss how this might best be done.

Sharing Despite Ethical and Emotional Reservations

There are two issues that make it difficult or implausible for us to treat some patients. We may have ethical or emotional objections that are so strong we cannot realistically expect to treat them effectively. In this last section, I shall address these two objections, and how to help our patients if we have these objections and want to overcome them.

Ethical objections. Throughout time, people have seen wrongs as warranting punishment and have sought revenge. Thus, retribution remains a rationale underlying our laws, even today. Emotionally, too, we may crave revenge. As clinicians, we

may have these feelings, notwithstanding what our professional oaths urge us implicitly to think and say. We can use ethical analysis to assess and determine how these general guidelines should best be applied. This may be the most that ethics has to offer. If we do this in an attempt to discern what *other clinicians* should do in these instances, we will have a tough row to hoe. This is because our ethical views and emotional convictions may differ from other clinicians', and thus make it hard or even impossible for us to do what we conclude they should do.

Do people who have committed wrongs, such as the patient who murdered, have free will at the time? What of those who murder for pay? Is there any line we could and should reasonably draw? If these persons have free will, to what extent do they have it, and should this matter? Even if these people knew at the time what they were doing, and did these things deliberately, is there a place in our society to forgive them, or, if not, for us as clinicians to forgive them? These questions are irreconcilably controversial and complex. It may be that this disagreement and complexity shouldn't matter to us, as clinicians. Our duty to help all patients, as our oaths urge and require us to do, may, morally, be quite right in these instances.

In regard to questions involving free will, we might consider the case of Leslie Van Houten, one of the women who committed murders at the direction of Charles Manson.³⁴ At the time of the Manson trials, Margaret T. Singer, a clinical psychologist, was widely viewed as a leading expert on cults and on how people could be brainwashed by them.³⁵ The brainwashing used by cults, Singer said, surpasses even those that enemies use during wartime. Cults, for example, flood new members with love and, at the same, time keep them isolated and away from all those they know. A particularly pathognomonic characteristic that cult members tend to show and that mark them as possibly brainwashed is how they respond to questions of all sorts with the same answer. They tend to respond with Johnny-one-note answers, as it were, suggesting that they are like a needle on a phonograph record stuck in one groove, able to play only one snippet of melody over and over. Singer testified at Van Houten's trial that when Van Houten repeatedly stabbed her victim, she had been brainwashed by Manson and thus at that time was not able to freely choose what she did.³⁶

This example is only one among hundreds, and may be anomalous. Still, it indicates how having free will may not be as self-evidently unequivocal as we might think. Our inner judgement may be absolute in some cases, and difficult to shake, but our awareness of people like Van Houten and Singer's

view of them may make it more possible when we treat them to give them more the benefit of the doubt.

Moving from the question of free will; in the case of the patient who committed murders as a gang member, the staff decided what to do primarily by weighing and balancing the pros and cons of maintaining his confidentiality. This is a more traditional moral framework, weighing various ethical principles. The staff instead might have accorded priority to maintaining the quality of their relationship with the patient, following an ethics of care. This moral framework could have produced a profoundly different outcome, as illustrated by one of its advocates, Nel Noddings, who once stated that she would lie, at any time, for her son. Her special relationship with him, she said, required this response.³⁷

In using an ethics of care, we may see ourselves as owing greater loyalty to our patients, overriding other, competing moral values, much as Noddings saw her chief priority as being caring toward her son. Utilitarianism is another ethical framework, which, in theory at least, one can use to quantify an ethical response. That is, with this approach, one can seek to add up numbers to determine an ethical response, which makes it an approach that is easily defended. For that reason, it may be overused.

Put most simply, we are at risk of opting too readily to make ethical decisions on the basis of utilitarian calculations and consequences when other values, not based on consequences, should prevail. These values may not be easily quantified and easily defended, such as respecting persons and being just. Other frameworks that emphasize relationships are among those that might prevail.

If, in the case of the patient who had killed many others, the medical team used more of an ethics-of-care approach, their analysis might have been different. They might have placed more moral weight on respecting the patient's confidentiality, and, on the basis of his being, beneath it all, one of the worst-off, as already mentioned.

Emotional objections. Even if we can ethically come to terms with what patients like these have done, we may still not be able to move beyond our emotional responses to them. We may *feel*, for example, repugnance, or feel that they are evil. Whether there are people who are evil, or whether evil is a description of what people do, may be, like free will, a philosophical question that will remain and never reflect a consensus.³⁸ There are ways, though, we can reduce these feelings, if we want, so we are able to treat these patients. To assist clinicians who feel emotions like repugnance, based on their patients having "done evil," I shall present three approaches we can use.

A first approach begins with the awareness that these patients may have gone through past experiences that we haven't and quite literally, perhaps, couldn't even imagine. I think of a young person who survived after an ambush of everyone on a bus, in another country. He survived because he lay hidden and wholly silent under the dead bodies of others. Much later, as an adult, he committed a crime in the United States, when, he says, he "was triggered" in response to another's actions. Another example is a person who, as a teen in another country, was captured with his family and was told by his captors that he was to kill his family, or the captors would kill them all. We may not easily be able to fathom, much less imagine, what some of our patients have experienced. Even if they have not undergone exceptional stress, they may be more vulnerable to profoundly upsetting reactions to the smallest of stresses, and in that way differ greatly from most other people. For example, in some people, the bones that form the skull and surround the brain may be unusually fragile, such that a blow to the skull is much more likely to shatter the skull. In forensic settings this is referred to as eggshell skull. It may be a genetic condition.

A second approach to reducing our repugnant feelings toward some patients is to imagine, as best we can, tendencies within ourselves that mirror those we see in these patients. We widely, if not universally, have a tendency to see those traits that we least like in ourselves as not there in us at all, but as existing in others. We project the traits we abhor to others. None in us, but only in them. For example, I can identify within myself the feeling of wanting revenge. I see this because I know that when I hear that others who have hurt me have, in some way, fared not as well as they could, inside I feel the glimmer of a gloat. If we are, to this extent, able to see how we are like these patients in this way, we may be able to feel empathy and relate, to a degree, sufficiently for us to be able to treat and help them.

A third approach, urged by Paul Ricoeur, may help us to "slice through ethical Gordian knots."³⁹ Ricoeur had profound losses and pain during the Holocaust. Still, he supported only going forward and doing good. What mattered to Ricoeur was not the act that was committed, but the suffering of the victim. Thus, what counts is not what happened, but what one still can do. Ricoeur's focus, then, was on relieving and preventing further suffering. Likewise, we can take this same approach, reasoning that if he and so many others *could* do good—and *did*—so can we. But merely clearing these ethical and emotional impediments to be able to help patients like

the former gang member, however, will not help us to go far enough to help our patients, or to even reach them at all. To do this it may be necessary for us to somehow convince patients that we really care about them. This may mean that to reach some patients, we must do more than we usually would.

An approach that may do this as much as any other is to share the emotional pain we are feeling. This has been found to reach patients in other exceptional contexts, such as patients who feel emotionally empty, when others do not. The best argument for such emotional sharing was made by the psychiatrist Hugh Mullan.⁴⁰ He suggested that, for patients to change in the ways they want, therapists must be themselves and discard the emotionally distancing aspects of the therapeutic role. Mullan "eschewed" a "mechanized, linear view of the person." He believed that psychotherapy is, in essence, the "life-changing emotional meeting between vulnerable humans (both patient and therapist) who communicated one with another."⁴¹ More concretely, he believed that, to help patients change, therapists must change themselves. The patient's change, he thought, "is *contingent* on change in the therapist."

In treating these patients, feeling emotional pain is inevitable. Whether or not we decide to respect their confidentiality, they are likely to be harmed by our distancing ourselves from them.⁴² How might we best avoid that? We might begin by saying what may be most important to them: that we will strive mightily to put their interests first, but there may be limits to what we can do, that we should have foreseen, but didn't. We might say:

If we come to decide to not respect your confidentiality, and violate it to benefit another person, you may understandably hate us and not want to speak to us again. But please know that I, just saying this, feel greatly torn, even though I know that my pain is very much less than yours. Regardless of what our staff decides to do, you may feel deeply hurt, even livid in response to my telling you that we are even considering this. Please know also, that even though I know you may be feeling this way, I would like and hope very much to stay with you and work with you after this, regardless of what we or the staff decide, if this is at all what you would want. You needn't decide this now, and at any time you could change your mind.

CONCLUSION

When we have painful feelings that our patients evoke in us, we may emotionally detach from them.

I have discussed how we may seek to avoid this by sharing directly with patients the pain we feel. Disclosing this pain extends to the wider population of all patients, and includes what we share when we cry with patients.

I think of an illustration made by Elvin Semrad, a revered psychiatrist at Harvard.⁴³ A resident was crying because, he said, a patient wasn't doing at all well. "Let him see you as you are now," Semrad, said, in essence. The resident then "confessed his distress and helplessness to his patient, and told her he desperately wanted to help her, but did not know how."⁴⁴ She, then, did better.

MASKING

Details in the cases have been altered to protect the identities of patients and family members.

NOTES

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1. A.J. Sequeira, M.G. Fara, and A. Lewis, "Ethical Challenges in Acute Evaluation of Suspected Psychogenic Stroke Mimics," in this issue of *The Journal of Clinical Ethics* 29, no. 3 (Fall 2018).

2. L. Tincknell, A. O'Callaghan, J. Manning, and P. Malpas, "Deathbed Confession: When a Dying Patient Confesses to Murder: Clinical, Ethical, and Legal Implications," in this issue of *The Journal of Clinical Ethics* 29, no. 3 (Fall 2018).

3. M.C. Nussbaum, *The Monarchy of Fear* (New York: Simon & Schuster, 2018); K. Kozłowska, P. Waler, L. Mclean, and P. Carrive, "Fear and the Defense Cascade: Clinical Implications and Management," *Harvard Review of Psychiatry* 23, no. 4 (July-August 2015): 263-87.

4. J. Fox, "'Notice How You Feel,' An Alternative to Detached Concern Among Hospice Volunteers," *Qualitative Health Research* 16, no. 7 (September 2006): 944-61.

5. M.J. Dugs, M.H. Freeston, and R. Ladouceur, "Intolerance of Uncertainty and Problem Orientation in Worry," *Cognitive Therapy and Research* 21, no. 6 (1997): 591-606.

6. Portnoy and colleagues note, "our findings provide preliminary evidence that physicians' perceptions of patients AA [ambiguity aversion] may influence physicians to adopt paternalistic practices and to forgo communicating with patients about scientific uncertainty . . . and involving them in decision making. This might paradoxically and counterproductively increase patients' uncertainty. . . ." Emphasis added. D.B. Portnoy et al., "Physicians' Attitudes about Communicating and Managing Scientific Uncertainty Differ by Perceived Ambiguity Aversion of their Patients," *Health Expectations* 16 (2011): 362-72, 369.

7. E.P. Tubbs, J.A. Elrod, and D.R. Flum, "Risk Taking

and Tolerance of Uncertainty: Implications for Surgeons," *Journal of Surgical Research* 131, no. 1 (March 2006): 1-6.

8. B.A. Cunningham et al., "Physicians' Anxiety Due to Uncertainty and Use of Race in Medical Decision-Making," *American Public Health Association Medical Care Section* 52, no. 8 (August 2014): 728-33.

9. L. Diamond-Brown, "The Doctor-Patient Relationship as a Toolkit for Uncertain Clinical Decisions," *Social Science and Medicine* 159 (2016): 108-15.

10. D.T. Chung, C.J. Ryan, and M.M. Large, "Commentary: Adverse Experiences in Psychiatric Hospitals Might Be the Cause of Some Post Discharge Suicides," *Bulletin of the Menninger Clinic* 80, no. 4 (Fall 2016): 371-5.

11. M. Olfson et al., "Short-term Suicide Risk After Psychiatric Hospital Discharge," *JAMA Psychiatry* 7, no. 3 (November 2016): 1119-26. See also T.P. Ho, "The Suicide Risk of Discharged Psychiatric Patients," *Journal of Clinical Psychiatry* 64, no. 6 (2003): 702-7.

12. Patients may take their life in the hospital. As one psychiatrist says, however, this could be prevented by keeping every patient in restraints, but then few might get better.

13. "The suicidal patient who for long periods of time remains mute is particularly prone to become the target of projected countertransference hate." J.T. Maltzberger and D.H. Buie, "Countertransference Hate in Suicidal Patients," *Archives of General Psychiatry* 30 (May 1974): 625-33, 629.

14. "We must expect collisions and *withstand and contain* . . . their impact on the relationship. . . ." L. Havens, "The Best Kept Secret: How to Form an Effective Alliance," *Harvard Review of Psychiatry* 12 (2004): 1256-62, 1258.

15. M.R. Mercurio, "The Ethics of Newborn Resuscitation," *Seminars in Perinatology* 33, no. 6 (December 2009): 354-63.

16. Statistical predictions regarding how an infant will do may be inaccurate because existing studies have excluded infants who were given only palliative care. P.D. Murray, D. Esserman, and M.R. Mercury, "In What Circumstances Will a Neonatologist Decide a Patient is Not a Resuscitation Candidate?" *Journal of Medical Ethics* 42 (2016): 429-34. In this study, of 490 practicing neonatologists, 25 percent responded "yes" when asked if a unilateral DNAR (do not attempt resuscitation) would be permissible based solely on neurological prognosis.

17. Clinicians may believe that medical expertise and experience necessarily bring about ethical expertise, but this may not be the case. Thus, a more senior clinician who may be a department chair may too much determine a staff's decision. Likewise, staff members may not fully share their different views because they don't want not to offend the friends they will be working with the next day and days.

18. In the U.S., when clinicians feel they cannot provide futile care to a child, they generally offer parents the opportunity to try to find other hospitals that will. A. Park, "When Parents and Doctors Disagree on What Futile Means," *Time* (24 July 2017): 17-8, 17.

19. The severity of an infant's status when she or he can't talk, walk, or relate is subject to different responses. In my own experience, some parents love such children

as much or more than any child who has these capacities.

20. Parents may, on the other hand, be allowed to decide that only one of a set of twins will be resuscitated. M.J. Bizarro and M.R. Mercurio, "Selective Resuscitation in Premature Twins: An Ethical Analysis," *Journal of Perinatology* 29, no. 7 (July 2009): 479-82; A. Hurst et al., "Tough Decisions for Premature Triplets," *Pediatrics* 137, no. 2 (February 2016): e20153804, doi:10.1542/peds.2015-3804.

21. Clinicians may tend to underestimate the meaning that many parents find in holding their baby, even though they know that soon the baby will die. Clinicians also may tend to underestimate the quality of life of an infant and its parents when the infant is more severely impaired. A. Janvier, K. Barrington, and B. Farlow, "Communication with Parents Concerning Withholding or Withdrawing of Life-Sustaining Interventions in Neonatology," *Seminars in Perinatology* 38 (2014): 38-46, 43.

22. D. Nuzum, S. Meaney, and K. O'Donoghue, "The Impact of Stillbirth on Consultant Obstetrician Gynaecologists: a Quantitative Study," *British Journal of Obstetrics and Gynaecology* 121, no. 8 (July 2014): 1020-8.

23. B.T. Edmonds et al., "Comparing Obstetricians' and Neonatologists' Approaches to Periviable Counseling," *Journal of Perinatology* 35 (2015): 344-8.

24. M.R. Mercurio, "The Role of a Pediatric Ethics Committee in the Newborn Intensive Care Unit," *Journal of Perinatology* 31, no.1 (January 2011): 1-9.

25. Parents may ask their clinician, "What would you do?" Clinicians who routinely respond, "I can't say," may want to reconsider this. Some patients value greatly hearing their clinician's view. Clinicians' not sharing this may also lessen patients' trust in their relationship. Janvier, Barrington, and Farlow, "Communication with Parents," see note 21 above, p. 41.

26. N. Quist, "The Paradox of Questions and Answers: Possibilities for a Doctor-Patient Relationship," *The Journal of Clinical Ethics* 14, no. 1/2 (Spring/Summer 2003): 79-87.

27. Ibid.

28. P.I. Rosebush and M.F. Mazurek, "Treatment of Conversion in the 21st Century: Have We Moved Beyond the Couch?" *Current Treatment Options in Neurology* 13 (2011): 255-66.

29. A conversion disorder that is likely to evoke clinicians' anger is when a patient has blindness. The patient may still somehow step around obstacles that clinicians purposefully place in the way to help them make this diagnosis. F. Scarpina et al., "Explicit and Implicit Components of the Emotional Processing in Non-organic Vision Loss: Behavioral Evidence About the Role of Fear in Functional Blindness," *Frontiers in Psychology* 9 (10 April 2018): 494 doi: 10.3389/fpsyg.2018.00494. eCollection 2018.

30. I have observed that therapists may disclose their emotions to a greater extent to patients who have dissociative disorders. (These patients experience disconnection and lack of continuity in their thoughts, memories, surroundings, actions, and identity, escaping reality in involuntary and unhealthy ways.) This may be because

therapists must offer more of themselves to be able to reach and help these patients.

31. J. Le Doux, *Anxious* (New York: Viking, 2015). See also J. LeDoux, R. Brown, D. Pine, and S. Hofmann, "Know Thyself: Well-Being and Subjective Experience," *Cerebrum* (January 2018): 1-15; http://www.dana.org/Cerebrum/2018/Know_Thyself_Well_Being_and_Subjective_Experience.

32. J.L. Griffith, "Hope Modules: Brief Psychotherapeutic Interventions to Counter Demoralization from Stressors of Chronic Illness," *Academic Psychiatry* 42, no. 1 (February 2018): 135-45.

33. M. Chapman, "A Review of Violence Risk Assessment for the General Clinician," *Psychiatric Annals* 47, no. 9 (2017): 449-53.

34. N. Meredith, *The Manson Women and Me* (New York: Citadel, 2018), 126-32.

35. A. O'Connor, "Margaret Singer, a Leading Brainwashing Expert, Dies at 82," *New York Times*, 7 December 2003, <https://www.nytimes.com/2003/12/07/us/margaret-singer-a-leading-brainwashing-expert-dies-at-82.html>.

36. K. Faith, *The Long Prison Journey of Leslie Van Houten* (Lebanon, N.H: Northeastern University Press, 2001).

37. N. Noddings, *Caring*, 2nd ed. (Berkeley, Calif.: University of California Press, 2003), 56-57.

38. R. Simon, "Should Forensic Psychiatrists Testify About Evil?" *Journal of the American Academy of Psychiatry and the Law* 31, no. 4 (2003): 413-6.

39. P. Ricoeur and D. Pellauer, "Evil, a Challenge to Philosophy and Theology," *Journal of the American Academy of Religion* 53, no. 4 (December 1985): 635-48. For a discussion of Ricoeur's views at this time, see S. Paulika, "How Should We Respond to 'Evil'?" *New York Times*, 27 June 2016, <https://www.nytimes.com/2016/06/27/opinion/how-should-we-respond-to-evil.html>.

40. F. Wright, "Personal Reflections on Hugh Mullan: Existential Group Therapist," *International Journal of Group Psychotherapy* 62, no. 1 (January 2012): 23-42. In a similar approach called "presentness," the emphasis is on "mutual reverie and moments of spontaneous responsiveness on the part of the therapist." R. Lazar, "Presentness: an Intersubjective Dimension of the Therapeutic Act," *American Journal of Psychotherapy* 54, no. 3 (Summer 2000): 340-54.

41. Wright, "Personal Reflections," see note 40 above.

42. For a study reporting that shame uniquely predicts avoidance and distancing, see T. Schmader and B. Lickel, "The Approach and Avoidance Function of Guilt and Shame Emotions: Comparing Reactions to Self-Caused and Other-Caused Wrongdoing," *Motivation and Emotions* 30, no. 1 (March 2006): 43-56.

43. M.L. Good, "Elvin V. Semrad (1909-1976): Experiencing the Heart and Core of Psychotherapy Training," *American Journal of Psychotherapy* 63, no. 2 (2009): 183-205.

44. J.T. Maltzberger, "Treating the Suicidal Patient: Basic Principles," *Annals of the New York Academy of Science* 932 (May 2001): 158-68, 160-1.