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How Should Careproviders Respond When the Medical System Leaves a Patient Short?

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This issue of *The Journal of Clinical Ethics* offers a new feature: a public forum on bioethics conducted at Harvard Medical School. The first of these transcripts involves a new law in Massachusetts that provides more-universal medical insurance to residents of that state.¹ But, despite this new law, patients may still be left short. Marcia Angell, MD, one of the presenters in the forum, comments that trying to meet the needs of all Massachusetts residents may be like trying to squeeze blood out of a turnip. *What about inflation?* she asks. In every context, some patients will need more medical resources than they can get, raising difficult questions for careproviders:

- When — if ever — should careproviders limit the medical resources they give to some patients, so that these resources can be given to other patients?
- When — if ever — should careproviders game the system for a patient?
- When — if ever — should careproviders sacrifice their own needs to benefit a patient?

In my introduction to this issue of *JCE*, I will discuss what careproviders might best say to patients in each of these three circumstances.

TRIAGE

Two or more patients may sometimes need the same medical resource, such as an ICU bed, and when this happens, someone must decide who will get the resource. When two or more patients who need the same scarce resource have the same careprovider, the careprovider may have to decide who will get the resource, or may refer the decision to someone else. The example of the scarce ICU bed is, in fact, the most frequent kind of triage problem that careproviders face.²

When making a decision about which patient will be admitted to the ICU, careproviders will accord the most weight to medical considerations, but such decisions are always, to some extent, inherently ethical. Thus, perhaps the greater society should make the decision about who should be admitted to the ICU — and so perhaps who has the greater likelihood of living or dying. Often, however, for numerous reasons, society hasn't spoken,³ and careproviders make these triage decisions by default. It may be ethically preferable for careproviders to try to find an available ICU bed elsewhere, but what they should *do* isn't the question I will discuss. Rather, I will discuss what they should *say*.

In these circumstances, careproviders can choose to make a decision themselves, or they can let someone else make the decision. Referring the decision to another may be much easier, because they will be able to wholly ally themselves with their patients' interests. If they opt to make triage decisions themselves, however, it may be much more painful: they will have to tell their patient that they will make a decision that may compromise the patient's best interests, due to limited resources.⁴ Should careproviders divulge this, and, if yes, what is the best way to do this?

Before considering these questions, however, I would like to clarify that this ICU example is only one of many possible examples; careproviders constantly face situations like this. Researchers who have studied triage in the ICU report, for example, "this overarching priority [dilemma] trickles down to everyday priority setting decisions. This trickle-down effect causes everyday decision-making to become a series of moral stress tests for clinicians."⁵

HOW MUCH SHOULD CAREPROVIDERS TELL PATIENTS?

When a triage decision must be made, what should careproviders tell a patient? If careproviders say that they — or the hospital — must make a decision that will compromise the patient's best interests, the patient may strongly react; the patient may leave the hospital or bring forth an appeal. It may be easier for careproviders to refer making these triage decisions to others, but it still may be difficult for careproviders to continue to fulfil their commitment to the patients's best interests. For example, it takes substantial amounts of time to argue that one's patient should be admitted to the ICU. Also, most patients aren't aware that triage decisions are routinely made, and those making the decisions may become irate when they learn that patients are being informed. Given these difficulties, when the need for a patient to be admitted to the ICU is marginal, and it would be within the standard of care to admit the patient to the general ward, careproviders may prefer to make a decision to admit the patient to a general ward, not the ICU, rather than refer the decision to another — and not tell the patient that they did this.

If careproviders choose to make the triage decision themselves, they compromise, to some extent, their total and exclusive commitment to the patient. Should they tell the patient that they have made a triage decision? Doing this may completely impair the patient/careprovider relationship.⁶ Yet if they don't, they may add lying by omission to compromising their patient's best interest. Of course, this may be, like using therapeutic privilege, for the patient's own good.

Whether careproviders should make a triage decision is open to question, but, if they do, it may be that they should be fully honest about it. It may establish the kind of patient/careprovider relationship, based on trust, that can allow patients to transcend the negative response to the withholding of resources that they otherwise might have.

HOW SHOULD CAREPROVIDERS DIVULGE THIS INFORMATION?

What might be the best way to inform patients? Whether careproviders have chosen to make a triage decision or not, they can say how sorry they are that, due to limited resources, the patient may receive less than optimal care.⁷ This simple statement is all-too-often omitted.⁸ When careproviders choose to make a triage decision, they can tell the patient why, for example, they and they alone can best decide what will benefit their patients, considered together, because they best know all of their patients' medical needs. Patients who are given this explanation may accept it.

Careproviders may then talk about the pain this causes them. They could say, for example, *My having to do this is killing me. I know your pain is much, much worse than mine, especially at hearing that the resources you need are limited. But this kills me anyway!*

To the degree that careproviders can feel pain and openly acknowledge it when they have to fill this decision-making role, they may acknowledge that patients and careproviders share this state of helplessness: the need to triage is outside the control of both. To acknowledge this may help some patients feel equal. Other patients may have a shift in how they feel: prior to this they may have felt they were sitting, as it were, opposite their careprovider, but now they may feel as though they are sitting side by side, two comrades united against a common enemy, namely the limited resources available.

The possible effect of this may be transforming, and it may enable patients to transcend the sense of loss, or even outrage, they might otherwise have felt for the rest of their lives, in response to being triaged. This possibility was expressed well by Hans Georg Gadamer, who said, in a more general context, "this whole process is only valid if it is reciprocal. Think of the humiliation when a greeting is not returned,"⁹ and "what we have here is something truly universal in which you and I are the same."¹⁰

WHEN SHOULD CAREPROVIDERS DIVULGE THIS INFORMATION?

Careproviders make these kinds of decisions every day, for example, whenever they choose to spend less time with one patient than they could, knowing that, as a result, they will be able to spend more time with another. These kinds of decisions are made so frequently that it is difficult to know when to disclose them to patients. I have two principal criteria that I suggest.

The first criteria for careproviders is, *Do you think the patient will see your making a triage decision as compromising his or her best interests?* One rationale underlying this criterion is that careproviders should not withhold information from patients.

The second criteria is, *Do you feel any anxiety in response to withholding information from a patient?* One rationale underlying this criterion is that what careproviders *feel* may, in some cases, be a better guide to what they should do than what they *think*. This is likely to be the case when a patient's feelings and his or her relationship with the careprovider are at stake.

On the other hand, careproviders may (like anyone else) rationalize how they would like events to turn out. As I mentioned above, it may be painful for careproviders to disclose to a patient that a triage decision has been made, whether the decision was made by the careprovider or not. Realizing this, careproviders may rationalize that it is appropriate to keep a triage decision secret.

But careproviders can also take into account whether — or to what degree — the triage decision makes a significant clinical difference. When the patient is placed at little risk by a triage decision, it may not be as important to divulge that such a decision was made — although the effect on careproviders of keeping any secret from patients — important or less important — is the same, oddly enough. It may be that, in making triage decisions, it is as theologian Paul Ramsey said: "*absolutely everything* is commanded which love requires, absolutely everything without the slightest exception or softening."¹¹

There is, finally, one more problem. Researchers report that, on a neurobiological level, manifested through neuroimaging, some of us respond more empathically to pain than others.¹² Similar to the rest of the population, some careproviders are probably more empathic than others. Careproviders who are interested in using the two criteria above may first try to imagine where, on a hypothetical scale for being empathic, they may be. Careproviders who rate themselves lower on the scale shouldn't feel discouraged, as they may be more effective in innumerable contexts when they are more objective than empathic. Many patients, if they had to choose, would prefer to have a careprovider who is optimally knowledgeable, rather than one who is less knowledgeable and more empathic.

But careproviders who see themselves as less empathic on this scale may be at a disadvantage using only the second criteria (how they themselves would feel about keeping a secret from a patient). These careproviders may try, systematically, to use the first approach more (whether patients could see making a triage decision as compromising their best interests). This approach requires careproviders to use their imaginations more than their emotions; careproviders might systematically place themselves, in their imagination, in the shoes of every patient they see who could be affected by limited resources. This exercise may enable them to compensate for the empathic capacity they may feel they lack, relative to other careproviders.

GAMING THE SYSTEM

Studies report that it is not uncommon for careproviders to game the system to help their patients. In one study, for example, 28 percent of the careproviders interviewed reported that they exaggerated the severity of a patient's symptoms; 24 percent said they had changed a patient's diagnoses; 10 percent said they had

recorded nonexistent signs and symptoms to help a patient.¹³ Many careproviders say they do this because their professional obligations require it.¹⁴ Careproviders may do these things more often in managed-care settings.¹⁵ Gaming may or may not be ethically justifiable in any context, but if gaming is ever justifiable, the argument in its favor is stronger, obviously, in some cases than in others.

Such an instance may be, in general, when a new medical policy has just been adopted, and at the present its relative benefits and burdens are not entirely clear. For example, some years ago a policy was adopted to discharge newborn infants and their mothers more rapidly after delivery.¹⁶ Some careproviders who feared that some of these newborns could be unduly harmed by the new policy tried to game the system, and found reasons to keep the new mothers — and so their infants — in the hospital longer.¹⁷

In general, it is the majority ethical consensus, by far, that careproviders should not game the system.¹⁸ A primary concern is that if careproviders game the system it may seriously and fundamentally undermine the medical system itself. Instead, the majority consensus is that careproviders should try to change the system if they feel it does undue harm or is unjust.

I have heard from several careproviders who want to help patients who need home oxygen but can't afford it. When patients' oxygen levels are low enough, they may be able to qualify for assistance. The careproviders tell me that they advise their patients to exercise before their blood is drawn, to lower the level of oxygen in their blood. (There is now some evidence, however, that oxygen may not be as helpful as careproviders once believed.)¹⁹

In circumstances like this, the first choice careproviders make is whether to game the system. Their second choice is deciding what to tell a patient if they decide they won't game. A third choice may be whether to give a patient the name of a careprovider who *will* game the system (if known). This is legally safe. Many careproviders who admit that they game the system say they fear being caught; in one study, 57 percent of the careproviders who admitted that they gamed the system to aid patients said that they feared being prosecuted for fraud.²⁰

It may be easier for patients to accept that their careprovider refuses to game the system than it is to accept that their careprovider is willing to make a triage decision that may affect the patient's best interests. Careproviders who refuse to game can tell patients quite credibly that they won't do it because it is immoral. Even though patients won't benefit, they may respect their careproviders more. Still, careproviders who won't game may be obligated to tell patients even when patients don't know to ask. Part of their ethical obligation — if not their professional obligation — is an implicit promise to help patients as much as they can. Since careproviders have more knowledge about gaming, perhaps they are obligated to tell patients that they will not game, but there are careproviders who will — and perhaps help patients who are interested find them.

Careproviders who educate patients about gaming the system may decrease the amount of injustice in the system, because patients who know that the system can be gamed will no longer have an advantage over patients who don't. (The same arguments apply, to an extent, to informing patients about triage decisions.) Patients may react strongly upon learning that the system can be gamed, but that their careprovider won't do this because it is wrong — they may try to find a careprovider who will game the system.

Beyond this, it may be morally inconsistent for a careprovider to tell patients that he or she could game the system but won't because it is wrong: by telling patients that the system can be gamed, the careprovider may in fact further the values that he or she opposes. This is the case to an even greater extent if a careprovider gives patients the name of a careprovider who will game.

Beyond ethical concerns, careproviders who game the system may, as I mentioned above, be emotionally harmed by a fear of legal liability. Even when careproviders won't game, they may be vulnerable to feeling emotional pain: they may feel guilty that they did not help a patient, whether or not this is irrational. But there may be an optimal way for careproviders to tell patients that they won't game the system, that will lessen these hurtful feelings, for both parties.

As discussed in regard to triage, careproviders can begin by expressing regrets, and then explain why they believe that they can't game. Should they decide to do this, the challenge is to be fully honest. Carepro-

viders may want to say they will not game because it is a matter of moral conscience, when in reality part of their concern is fear of being prosecuted (even when the possibility that this might happen is extremely remote). It is morally acceptable in almost every case for careproviders to choose not to do things for a patient that causes them fear — among other reasons, if they do something that causes them fear, they may come to resent the patient, and this may destroy their relationship altogether. In this situation, a fully honest disclosure might be: *I don't want to game the system — partly due to personal moral scruples, partly because I don't want to be caught breaking the law — and, really, it might be hard to say which is stronger!* Sharing this openly and honestly may preserve the sometimes profound positive outcomes that a trusting patient/careprovider relationship can achieve.²¹

SACRIFICING PERSONAL INTERESTS

A third way that careproviders may respond when medical resources are deficient is to sacrifice their own personal interests to better meet the needs of their patients. A classic example is when careproviders risk death to care for patients during an epidemic.²² In the early years of the HIV epidemic, careproviders feared caring for patients with HIV. If a pandemic were to occur, to what extent would careproviders be willing to sacrifice their own interests — and those of their families? Mitigation plans for these kinds of catastrophes commonly include how best to distribute the services of careproviders who are available.

Yet careproviders could, in these conditions, refuse to assist. They would know that their loved ones could become infected, and, in these extreme conditions, they might choose to stay with their family members to protect or care for them, rather than attend patients. Such potential conflicts between meeting patients' needs optimally or meeting our own needs, also arise daily in clinical situations due to limited medical resources. Conflicts may involve such small acts as a careprovider deciding whether to call a patient after work, at the end of the day, to inquire how the patient has fared on a new medication.

Careproviders who make phone calls for this and other reasons may benefit patients far more than might be imagined. They may significantly motivate patients to better manage any number of chronic illnesses such as diabetes that may cause very serious additional medical problems such as blindness and death.²³ Careproviders' phone calls have even been reported to help patients who have problems involving substance abuse and adolescents who are suicidal,²⁴ both of whom are among the most difficult patients to treat. The most common conflict, however, is when a patient requests an intervention that a careprovider, due to conflicting personal feelings, doesn't want to provide.

For example, patients may ask careproviders to give them exceptional medications, diagnostic tests, or referrals to specialists.²⁵ These exceptional measures will probably provide greater benefit, but are more costly than routine measures. Careproviders may want to avoid them, in part to hold down costs, but also because they fear that others who have greater responsibility for minimizing costs will criticize them for "caving in to patients' demands." In many cases careproviders could agree to patients' requests for medical reasons, but, in fact, careproviders often agree for personal reasons.²⁶ Patients may exert extreme emotional pressure on careproviders to comply with their wishes, over time. As one cardiac surgeon stated, "I think what's more of an urgency rating score is the guy who stamps his feet."²⁷ At a certain point — and this is different for every careprovider — we may choose to grant patients' requests over and against our own personal wishes to avoid discomfort.

When situations arise in which careproviders can benefit patients by making self-sacrifices, and they are aware that this is the conflict they face, they should answer the same questions discussed above:

- Should careproviders ever self-sacrifice? If yes, when?
- If careproviders can help a patient by self-sacrificing, but choose not to, for whatever reason, should they tell the patient?

The second question can be extended. Suppose a careprovider decides to tell a patient that she or he *could* self-sacrifice — but *won't*. Should the careprovider go further? Should the careprovider tell the patient

that he or she would make the same self-sacrifice if the patient was a family member? It may sound absurd to even ask this last question, because no matter how nicely it is stated, it sounds contemptuous, but it is very often the truth. For example, it is not all that unusual for a careprovider to bypass usual channels to reach another careprovider when a family member has an urgent medical need. As I will discuss below, some patient populations will only do well when their careprovider is absolutely honest with them, and tells the truth to this degree.

Further, as I stated above, when careproviders disclose information to patients, they help to decrease the advantage that informed patients have over uninformed patients. Or, careproviders could decide that they will disclose this kind of information to patients only when patients ask about it; for example, a patient may say, "I bet you would do this for me if I were a member of your own family. You would do this for your family, wouldn't you?"

As in the discussion about triage decisions above, careproviders may be able to use how they feel in a situation to understand what they should do. If they can identify a painful feeling because they did not do something for a patient that they could have, they can use this feeling to infer the possibility that they have not met the patient's needs to the greatest extent possible, because it conflicted with meeting a need of their own.

As an example, I recall a time that I chose not to self-sacrifice for a patient, which I regret even now. A patient had a problem involving drug abuse and missed his appointment with me. I considered calling him immediately, but didn't. Even though I didn't call, I continued to feel anxious that I hadn't. At the time, the patient was experiencing cravings, and there is data suggesting that my calling him may have made a difference in his outcome. In fact, the patient did relapse, but now is doing better.

My point is not that I should have called (whether I should have is now clinically a very controversial debate).²⁸ My point is that the painful feeling I experienced when I decided not to call could have alerted me that the call might have met my *own* needs. I was fully aware that, to succeed with the patient, I should begin wherever the patient was at that time.²⁹ But I rationalized and told myself that the patient should take responsibility for his own problem. While this was true in one sense, it was not true in that the patient lacked the skills he needed to do this on his own, at that time.

In any case, there are a number problems with self-sacrificing; for example, even when the degree of self-sacrifice is small, careproviders may feel resentment toward a patient afterward, and this resentment may deprive them of the capacity to relate well with the patient. One careprovider stated, for example, "[I am] not the sort of moral saint who could carry out a self-sacrificial life without exhibiting bitterness and resentment."³⁰

Given that some careproviders know that they could self-sacrifice and will not, why even consider disclosing this to a patient? Why take truth-telling to this degree? The overriding answer is: *It is the truth.*

Careproviders may be able to be honest about who they are, as fellow humans, with patients. This may be particularly important to patients, should they end up without medical resources they need. When careproviders tell patients they won't self-sacrifice, the effect on patients may not be as bad as might be imagined; in fact, the effect might be just the opposite. For example, I have shared this kind of painful truth with patients on more than one occasion, usually involving my challenging another careprovider who has made a determination regarding the patient. In these instances, the patient might have benefited if I was successful in challenging the determination — for example, the patient might have received increased monetary gain for her or his illness. I should add that, in all of these instances, it would have been most unlikely that I would have been able to change the determination, as sole dissenter — the majority view would almost surely have prevailed.

I have sometimes said to a patient in these situations: *I could challenge this determination, but I can vividly imagine the exceptional stress I will feel if I do. Thinking about it, I really don't want to do this. I'm sorry.* Surprisingly, the patients have not become angry, walked out, or sought another careprovider. It is as if they appreciated and perhaps even were moved by my candor. In one way or other, they offered me their support! One patient, for example, reversed roles and gave me counseling: he said, "People have to make decisions whether they are right or wrong. If they are wrong, that's just how it goes."

As I mentioned above, it may not be a net good for careproviders to consider making such sacrifices because they end up resenting the patient, which will harm the relationship with the patient, and harm the patient. This resentment may be outside the careprovider's conscious awareness, and be insidious. In my very limited experience, the most important benefit in disclosure has been the gain in the quality of the relationship that patients and careproviders experience. Such improved emotional engagement may be exemplified by the response of the patient I described above, who decided to offer me some counseling. The increased engagement may occur in response to self-disclosure; perhaps the disclosure has a leveling effect, as I previously said.

On the other hand, some careproviders might want to disclose to a patient that they could help, but won't, as a way to relieve their own guilt feelings — almost as an unfaithful spouse might, confessing to a marital partner after an affair. Given these complexities, what should a careprovider say to a patient who says, "You would do this for me if I were a member of your family!"?

I have had this experience, as have many others; for example, when a patient is a person who feels exceptional agony when alone, and wants the careprovider to be available night and day. When a patient who felt this way said to me, "You would do this for me if I were a member of your family!" I said, *Yes, you're right. I would be available to a family member as you want me to be available to you, just as you say.* Whenever this occurs, responding honestly to the patient is critically important to the survival of the relationship and its subsequent thriving.

This is where I have chosen to draw the line in my own practice: I do not tell patients that in some instances I will not self-sacrifice unless they ask me. In this way I may be treating my patients less than equally, as my patients who don't ask me about this won't know.

Some patients will not feel resentment even when careproviders do share this kind of information with them, for example, patients who are homeless or those who are presently incarcerated. I have had the extreme good fortune to talk with some careproviders who are exceptionally effective in enabling these patients to transform and find new meaning in their lives. The careproviders are able to reach the patients, form relationships with them, and, based on the relationships, enable the homeless and incarcerated to find unprecedented meaning in their lives. The careproviders say they have been able to do this by being absolutely authentic, or honest, with these patients. The careproviders say that their success includes telling patients, when they ask, the truth about what they and others feel about the patients.

It is possible that the patients who ask, "Would you sacrifice more for your family than you would for me?" want, more than anything else, to know if their careprovider will tell them the truth. Patients who don't ask may not want to know; they may prefer to avoid the ugly human truths that can be made explicit with total candor.

It is possible that the absolute candor that persons who are homeless or imprisoned may require in a relationship with a careprovider exists in all of us, wholly out of our consciousness. Here is an account that suggests this.

I was seeing a teenager who, in a fit of anger, smashed out all of the windows in his father's car with a sledgehammer. He said his family had told him that they thought his doing this was both crazy and wrong, and he asked me if I agreed with them. Perhaps unwisely, I said "Yes." He became very angry and stormed out. He refused to see me again. After some time had passed, though, he called, saying he wanted more than anything to take his own life, so didn't know why he was calling me. He agreed to resume treatment. He didn't take his life and is now doing well. Why did he call? Perhaps it was because of my previous honesty.

Some final points. In the situations described above — triage, gaming, and self-sacrifice — rather than making decisions about disclosure, careproviders could ask patients what they want. They might say,

- *Due to limited resources, other patients' competing medical needs may have to be considered against yours. Would you want me to tell you more about this, if this was going on now? or*
- *Sometimes careproviders game the system for patients, or they may be willing to stretch — or even distort — medical findings to benefit patients. Would you want me to tell you if this was possible, even if I, myself, was not willing to game the system? or*

- *In some instances, careproviders can go beyond the present standard of care, and that may possibly benefit a patient. Would you want me to tell you when this is a possibility, even when it isn't something I myself would offer?*

The downside to asking is that patients may well say, "No, I don't want this information." They may say this not because it is the truth, but because they sense that saying "Yes" would be painful for the careprovider or for themselves. They may want to protect their careprovider, as I mentioned previously.

Finally, what happens if a careprovider takes one of the initiatives I've described and it *bombs*? What if a careprovider says one of the things I've suggested, and the patient objects? There are ways that a careprovider can help. First, express regret: *I'm sorry that I am only able to offer you somewhat less than full treatment*, or, *I'm sorry that I'm not willing to game the system*, or, *I'm sorry I won't be available for you as much as you'd want me to, when other careproviders might*.³¹ When apologizing, a careprovider should be particularly careful not — even implicitly — to give a patient some (false) excuse. It may be overwhelmingly tempting to make an excuse in this situation, but doing this may undo all the careprovider has gained from telling the whole truth.

Second, careproviders should validate the patient's responses. *Of course you feel hurt and angry. I would feel this way if I were you, too*. Third, a careprovider should ask, *Is there a way — anyway that you can think of — that I could still possibly make amends? Perhaps even something I could do differently when I see someone else?*

It may be that what the patient asks for is not be possible. Still, the careprovider asked, and what the patient suggests may be possible.

I end this section with another example. Several years ago, I failed to free myself up to go to a patient's funeral. The patient's husband, whom I'd treated with her, told me when the funeral was, and then said, "I know you're busy, please don't come." I didn't, and it turned out that the husband was crushed. I called him later and acknowledged how bad I felt for not attending the funeral. I also said that this would not happen in the future; I would make it my priority to go to the funerals of patients. This was how I made amends. Saying all this, particularly making and expressing this amends, I believe, enabled us to get back to where we had been.

CONCLUSION

Political innovations, such as those now taking place in Massachusetts, will result in more patients receiving the care they most need. Still, careproviders will most likely continue to face many difficult ethical choices when resources are limited.

Careproviders may want to tell patients more in these situations than they customarily have said in the past; in regard to self-sacrifice, I have suggested that when careproviders share that they *could* help, but *won't*, the results may be paradoxical: some patients may respond by wanting to reassure their careprovider that if they are human in this way, it is okay with them.

Albert Camus wrote in *The Plague* about a physician, Dr. Bernard Rieux, and his anguish under the conditions of a plague. Camus wrote, "What's true of all the evils in the world is true of plague as well. It helps men to rise above themselves."³² This may be so; when resources are limited, as they are during a plague, it may also bring out the very worst in people. But in the more everyday circumstances of scarce resources, careproviders may have a unique opportunity to relate to their patients without the usual barriers. Careproviders may be able to openly acknowledge their shared helplessness and even vulnerability. By acknowledging more openly the stark realities that confront them, careproviders may be able to establish a connection with patients that they, or their patients, have not had before.³³

NOTES

1. This public discussion perhaps exemplifies Alvin Gouldner's claim that, in general, as persons become more educated they become increasingly committed to the collectivity as a whole. A.W. Gouldner, *The Future of Intellectuals and the Rise of the New Class* (New York: Continuum, 1979), 65. To the degree that this commitment has occurred or will occur, most persons in ethics would not only celebrate this vision, but consider its emergence long overdue.

2. The most common in-patient triage decisions in U.S. hospitals involve access to intensive care. J.C. Moskop and K.V. Iserson, "Triage in Medicine, Part II: Underlying Values and Principles," *Annals of Emergency Medicine* 49, no. 3 (March 2007): 282-7, p. 282.

3. Physicians' decisions affect almost 80 percent of what care patients get. M.K. Wynia, D.S. Cummins, and J.B. Van Geest, "Physician Manipulation of Reimbursement Rules for Patients," *Journal of the American Medical Association* 283, no. 14 (12 April 2000): 1858-65, p. 1858.

4. There are obviously problems when any persons make potentially life-and-death decisions for others. See, e.g., R.M. Veatch, "Who Should Manage Care? The Case for Patients," *Kennedy Institute of Ethics Journal* 7, no. 4 (December 1997): 391-401.

5. N.A. Walton et al., "Priority Setting and Cardiac Surgery: A Qualitative Case Study," *Health Policy* 80, no. 3 (March 2007): 444-58, p. 454.

6. R.M. Veatch and C.M. Spicer, "Futile Care: Physicians Should Not be Allowed to Refuse to Treat," *Health Progress* 74, no. 10 (December 1993): 22-7, p. 23.

7. For a discussion of this see A. Fiester, "Viewpoint: Why the Clinical Ethics We Teach Fails Patients," *Academic Medicine* 82, no. 7 (July 2007): 684-9.

8. Ibid.

9. H.G. Gadamer, *Hegel's Dialectic*, trans. P.C. Smith (New Haven, Conn.: Yale University Press, 1976), 64.

10. Ibid., 72.

11. Emphasis Ramsey's. D.H. Smith, "On Paul Ramsey: A Covenant-Centered Ethic for Medicine," *Second Opinion* 6 (November 1987): 107-27, p. 89, citing P. Ramsey, *Basic Christian Ethics* (New York: Charles Scribner's Sons, 1950), 89. Ramsey argues, according to Smith, that "Jesus's commandment to love shows me how I ought to be related to each and every one of the many other persons with whom I come in contact," p. 109.

12. M.J. Banissy and J. War, "Mirror-Touch Synesthesia is Linked with Empathy," *Nature Neuroscience* 10, no. 7 (July 2007): 815-6.

13. Wynia, Cummins, and Van Geest, see note 3 above, p. 1861. See also R.M. Werner, G.C. Alexander, and A. Fagerlin, "Lying to Insurance Companies: the Desire to Deceive among Physicians and the Public," *American Journal of Bioethics* 4, no. 4 (2004): 53-9.

14. Wynia, Cummins, and Van Geest, see note 3 above, p. 1859.

15. Ibid.

16. M.J. Maisels and T.B. Newman, "Jaundice in Full-Term and Near-Term Babies Who Leave the Hospital within 36 Hours: The Pediatrician's Nemesis," *Clinical Perinatology* 25, no. 2 (June 1998): 295-302.

17. For a contemporary view, see L. Goulet, A. Fall, and D. D'Amour, "Preparation for Discharge, Maternal Satisfaction, and Newborn Readmission for Jaundice: Comparing Postpartum Models of Care," *Birth* 34, no. 2 (June 2007): 131-9.

18. See, i.e., E.H. Morreim, "Gaming the System: Dodging the Rules, Ruling the Dodgers," *Archives of Internal Medicine* 151, no. 3 (March 1991): 443-7.

19. M.L. Nonoyama et al., "Effect of Oxygen on Health Quality of Life in Patients with Chronic Obstructive Pulmonary Disease with Transient Exertional Hypoxemia," *American Journal of Respiratory and Critical Care Medicine* 176 (2007): 343-9.

20. Wynia, Cummins, and Van Geest, see note 3 above, p. 1862.

21. See, as an example of the meaning that a relationship with a careprovider can create, L. King, "On Being a Doctor: The Veil," *Annals of Internal Medicine* 145 (2006): 932: "His hand grabs mine and closes on it with surprising strength. 'No. Don't leave.' . . . He is not alone after all. At least not while I am with him."

22. O.P. Grell, "Conflicting Duties: Plague and the Obligations of Early Modern Physicians Towards Patients and Commonwealth in England and the Netherlands," *Clio Medico* 24 (1993): 131-52; J.D. Arras, "The Fragile Web of Responsibility: AIDS and the Duty to Treat," *Hastings Center Report* 18, no. 2 (April-May 1988): S10-20.

23. S.M. Donahoe et al., "Diabetes and Mortality Following Acute Coronary Syndromes," *Journal of the American Medical Association* 298 (2007): 765-75.

24. J.A. Burlinson and Y. Kaminer, "Aftercare for Adolescent Alcohol Use Disorder: Feasibility and Acceptability of a Phone Intervention," *American Journal of Addiction* 16, no. 3 (May-June 2007): 202-5; G. Vaiva et al., "Effect of Telephone Contact on Further Suicide Attempts in Patients Discharged from an Emergency Department: Randomized Controlled Study," *British Medical Journal* 332, no. 7552 (27 May 2006): 1241-5.

25. R.A. Bell et al., "Unmet Expectations for Care and the Patient-Physician Relationship," *Journal of General Internal Medicine* 17, no. 11 (November 2002): 817-24.

26. S.A. Keitz et al., "Behind Closed Doors: Management of Patient Expectations in Primary Care Practices," *Archives of Internal Medicine* 167, no. 5 (12 March 2007): 445-52; R.L. Kravitz et al., "Direct Observation of Requests for Clinical Services in Office Practice: What Do Patients Want and Do They Get It?" *Archives of Internal Medicine* 163, no. 14 (28 July 2003): 1673-81.

27. Walton et al., see note 5 above, p. 451.

28. "This model . . . is in contrast to the abstinence model that has long dominated the substance abuse field. . . ." D. Fisk, D. Sells, and M. Rowe, "Sober Housing and Motivational Interviewing," *Journal of Primary Prevention* 28 (2007): 281-93, p. 290. See, in this regard, C. Strong, "The Neurobiology of Free will and Drug Addiction," *NeuroPsychiatry* 8, no. 7 (July 2007): 1ff.

29. D. Fisk, J. Rakfeldt, and K. Hefferman, "Outreach Workers Experience in a Homeless Outreach Project: Issues of Boundaries, Ethics and Staff Safety," *Psychiatric Quarterly* 70, no. 3 (Fall 1999): 231-46, p. 239.

30. J. Stuart, "A Virtue-Ethical Approach to Moral Conflicts Involving the Possibility of Self-sacrifice," *Journal of Social Philosophy* 35, no. 1 (Spring 2004): 21-33, p. 24.

31. Fiester suggests that if this relationship can't be established, careproviders should refer the patient to another. See Fiester, note 7 above, p. 688.

32. A. Camus, *The Plague*, trans. S. Gilbert (New York: Random House, 1991), 125.

33. Fiester states, "Because the patient has no other support people with him . . . , the only individuals with whom he has a relationship are the members of the treatment team, and they must assume this role." Fiester, see note 7 above, p. 687. See also King, note 21 above.