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When, If Ever, Should Careproviders Give Moral Advice?

Edmund G. Howe

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In this issue of *The Journal of Clinical Ethics*, in "Of More than One Mind: Obstetricians-Gynecologists' Approaches to Morally Controversial Decisions in Sexual and Reproductive Healthcare," Farr Curlin, Sira Dinner, and Stacy Tessler Lindau report that some obstetricians and gynecologists share moral views with patients. For instance, one doctor said, "I can't in good conscience tell [the patient] where to go" to get an abortion. Another said he may tell patients why he believes abortion may harm them.

The question of when — if ever — careproviders should share their own moral views with patients may arise in numerous situations. For example, many careproviders routinely tell their patients what they *should* do to maximize their health. Common examples are telling patients to stop or to reduce their drinking, to eat less, and to stop smoking.¹ Some patients consider these behaviors to be highly enjoyable, and thus *personal* choices regarding how they want to live their lives; as a consequence, patients may see this kind of advice from a careprovider as not only medical, but moral!

The "medical/moral" advice that careproviders give may go far beyond behaviors such as drinking, eating, and smoking. The doctor mentioned above, who tells patients about the harms of abortion, is an example; careproviders may go further in the advice they give their patients if they believe that they should always treat the *whole* patient, rather than just treating the "disease." Patients may agree: patients may feel offended, in fact, if they find out that their careprovider believed that he or she *could* have helped them by giving advice, but didn't.

Careproviders *and* patients, then, may believe that in some contexts careproviders *should* give moral advice, at least when it could significantly benefit a patient's physical or emotional health. But *should* careproviders share their moral views, and, if so, when? As articles in this issue of *JCE* illustrate, there is controversy regarding this question. Frank Chervenak and Laurence McCullough, in "Professional Responsibility and Individual Conscience: Protecting the Informed Consent Process from Impermissible Bias," answer emphatically, "No." They believe that careproviders who share their moral views may be a "peril" that could "undermine the profession of medicine from within." In contrast are the doctors mentioned above, who feel that they should share their moral views.

Edmund Pellegrino, physician and internationally renowned ethicist, writes in this issue of *JCE* that physicians must maintain their personal spiritual and moral integrity. He states, "Physicians opposed to abortion are morally entitled to refuse and give reasons for doing so clearly and honestly without demeaning the patient."² This would seem to support the tack taken by the first obstetrician-gynecologist mentioned above, who tells patients that it is not possible, "in good conscience," even to refer them to someone else.

Those who favor sharing their moral views may do so for a different reason; for instance, they may want to enhance a patient's autonomy, by enabling the patient to have additional views "on the table." These ob-gyns may want to maximally benefit the patient.

In this introduction, I will discuss whether careproviders should share medical-moral views, and, if they should, how far they should go. I will not describe what careproviders should do, nor where careproviders should "draw the line" along a medical/moral spectrum, with behaviors clearly related to patients' health — drinking, eating, and smoking — on the one end, and behaviors that may affect patients' emotional well-being — including almost any behavior — on the other. Instead, I shall discuss a third option that may enable careproviders to bypass having to make this kind of decision.

In this issue of *JCE*, David Kozishek and Elizabeth Bogdan-Lovis, in "Beliefs, Boundaries, and Self-Knowledge in Professional Practice Careproviders," write that it is possible for careproviders to avoid having to choose between "protecting patients' autonomy from the threat of paternalism" and "defending physicians' rights to follow the guidance of their conscience." Kozishek and Bogdan-Lovis suggest that careproviders may be able to go beyond having to choose between being morally neutral or expressing their moral views; they propose that careproviders can "re-imagine" their relationship with patients as one in which patients and careproviders are able to engage in a moral dialogue that is open and honest enough that careproviders don't have to be concerned with choosing to share moral views. The authors assert that this conceptual shift can replace careproviders' need to balance these two "competing rights" by providing "the moral space necessary" for patients and careproviders to have an "increased mutual understanding instead of resolution of conflicting principles." Is this view realistic? If it is, how could this best be achieved? These are the questions I will focus on in the following discussion.

THE TWO TRADITIONAL ETHICAL OPTIONS

REMAINING NEUTRAL

When careproviders give moral advice, it may unintentionally serve to disrespect and harm patients. This is especially likely when the advice extends outside the usual scope of medical care. Accordingly, careproviders have conventionally believed that they should *not* share their own moral views. Chervenak and McCullough make this clear in the historical introduction to their article. The core deontological and consequential values underlying this traditional neutrality are generally well known. Careproviders who share their views may violate patients' vulnerability, caused by their illness. When careproviders do this, they also may impose their moral views on patients.

When careproviders share their moral views, they may strongly affect patients. Patients may not feel as free to make ethical decisions; for example, patients' decision making may be clouded by anxiety that they previously didn't experience. Their anxiety may be due to new uncertainty or even new guilt. Or patients may feel offended when careproviders share their own moral views; some patients may feel so offended that they won't return. The loss of the patient-careprovider relationship may be *most* critical. Worse still, patients may generalize this negative feeling to all careproviders and avoid other careproviders whom they need to see for other pressing medical reasons.

In addition to these arguments, there are other, more subtle concerns that careproviders should also recognize. First, even when careproviders have exceptional medical knowledge and experience, *these* sources of exceptional expertise *don't* enable them to have better "ethical answers." This is equally true of experts in ethics, who have exceptional skill in ethical *analysis*. This skill doesn't enable them, *either*, however, to determine which of two *reasonable* ethical outcomes is better. This conclusion is, I believe, self-evident from how ethicists typically respond. That is, even the most skilled ethicists often reach different conclusions. There is a reason for this discrepancy: ethics, as a discipline, provides no method for deciding which of two reasonable ethical answers is more morally valid.³ For this same reason, it may be problematic for careproviders to share their moral views with patients. The preferable ethical course for careproviders may be to leave moral decisions *entirely up to patients*, as Chervenak and McCullough suggest.

Second, even though careproviders' moral advice may, *in general*, be sound, it may not apply to *any individual patient*. It may not be possible to understand any *one* patient well enough to be able to give advice that "hits the mark." This may be the case, in part, because when persons make moral decisions, they take into account innumerable conscious and unconscious experiences. They may make decisions much as persons fill in a crossword puzzle,⁴ that is, they don't rely solely on logic, but also use their intuition. Careproviders may use this understanding of how decisions are made to benefit patients. They can assure patients that they, alone, are the best qualified to make moral decisions for themselves. Patients may not have previously considered themselves as "best in the world" at anything, and careproviders can help patients by imagining a strength that the patients have, and then sharing this with patients. I will discuss this further below.

Third, when careproviders give patients moral advice, it may be degrading to patients if it appears that the careproviders see patients as less deep and complex persons than they are. Gabriele Marcel experienced this when he was working for the Red Cross in France during World War I. He identified missing persons and informed their families. Families contacted him daily, asking him if he had any information about a French soldier or another person. "Nothing," Marcel wrote, "could have immunized me better against the power of effacement possessed by the abstract terms which fill the reports of journalists and historians of the war."⁵

There is evidence that some patients resent careproviders when they give moral advice, even to quit smoking.⁶ Thus careproviders should think twice before giving advice, *even when patients ask for their moral view*. I recall a time that I didn't hesitate to share my views, and I still regret it. A patient, an adult, told me that he had spoken "harshly" to his parents, and asked me if I thought what he'd said was "cruel." I thought that if I hesitated, the patient would think that I was hedging, and this would be worse than whatever I said. Well, it wasn't. I said, "Well, *yes!*" and the patient was floored. He is still my patient, but my responding as I did remains a source of distrust to this day.

SHARING MORAL VIEWS

Careproviders may enhance patients' autonomy and benefit them by giving patients new food for thought. Such advice may be literally lifesaving. An example is when careproviders tell patients that they should stop or reduce their drinking.⁷ Patients who drink too much risk losing their marriage, job, and even their life. Careproviders may tell patients to stop or cut back on drinking even in an ER setting,⁸ *even when careproviders have no prior patient/careprovider relationship and have little time*. It is obvious that drinking strongly affects patients' health, but careproviders may be able to give advice that is less concerned with physical safety but may still benefit patients greatly.

For example, what if the philosopher Martin Heidegger had met with his physician prior to deciding to join the Nazi Party? That Heidegger made this and similar choices later harmed his reputation and, for many, the significance of his work.⁹ Let us suppose that Heidegger's physician saw Heidegger's choice as immoral, gave him advice, and thus enabled Heidegger to change. The physician could have regarded this advice as affecting Heidegger's emotions, and, although it would have been outside the scope of "usual medical care," it would have benefited Heidegger immensely.¹⁰

ATTITUDES CAREPROVIDERS MUST ACQUIRE AND CONVEY

Kozishek and Bogdan-Lovis propose that careproviders and patients can acquire the ability to talk about moral issues openly. I recommend, to accomplish this, that careproviders acquire and convey certain *attitudes*. These attitudes can be best modeled by imagining an ideal family, since family members tend to care for one another to an exceptional degree. Ideally, family members share experiences spontaneously, and don't have first to ask what is ethically justifiable. This is what Kozishek and Bogdan-Lovis propose. Is such spontaneity possible for careproviders? I offer an experience of my own in this regard.

I saw a patient who had been in the intensive care unit recovering from a brain infection. During this time, his wife and children hadn't been able to visit him. When I saw him, he had recovered and was making

plans to return home. He told me he planned to stop and visit an old friend whom he hadn't seen in many years on his way home. When I heard this I winced, because I imagined how his wife and children might feel if they learned that he hadn't come home directly to them, and I told him this, spontaneously. "Thanks," he said. "I'd never thought of that."¹¹ He went home directly, and later told me that he was *very* glad that he had.

I spontaneously told the patient what I thought. This anecdote conveys how careproviders who want to establish a re-imagined relationship might respond to patients. When I winced at hearing the patient's original plan to visit a friend rather than go right home, I responded to "just a feeling." Careproviders who would like to respond to their patients as a member of an ideal family might do this, too. The three most important attitudes that careproviders can adopt are best exemplified by how ideal parents would respond.

First, children need to know that their parents unconditionally love them and that, *regardless of what they do*, their parents won't abandon them. Ideal parents may be the *most* loving when their children are at their very *worst*. Careproviders may have to do this, too. In the next section I will provide an example of how careproviders can go the extra mile for patients.

Second, children need their parents to see their strengths. How might ideal parents do this? Let us suppose, here, that a child wants to join a baseball team but his (or her) parents anticipate that the child will be, by far, the worst player on the team. The parents could say before their child joins the team, "You know, we are proud that you want to be on the team. Even if you are the worst player on the team, we will be proud. In fact, if you are, we will be *even prouder* of you than if you are the best player." "Why?" the child might ask, "Why might you be even *prouder*?" "Because," the parents might say, "if you are the *best* on the team, that would be easy. What is much harder is to be the worst, but to still play!" In the next section, I will describe an intervention in which careproviders can tell patients about a strength they have.

Third, children need to know that parents know and respect that they have *different* values. This may be most difficult for parents, because they have the competing interest in "instilling" in their children good moral views. Consider, however, this instance. An adult daughter comes to her parents and tells them she's pregnant. Suppose that her parents believe that she might be considering an abortion. How, ideally, might they respond? They might say, even if they oppose abortion, "We know that with *your* strengths, you will do well *whatever* you decide. Please tell us any way we can help." Why might parents say this? Because this may be the only way they can expect to be able to maintain open communication with their child when she needs their support.

This may be the case also for careproviders. If careproviders do share their moral views with patients, patients may choose not to share their medical concerns with physicians in the future, but share with someone else instead. Given this risk, how can careproviders not share their moral views, but, at the same time, help patients change their moral views? In the next section I will consider how careproviders can do this by only asking questions.

If careproviders acquire these attitudes, they will treat patients more like their own family members. This may be a degree of commitment that many careproviders do not want to establish, but it may be necessary, to establish the kind of re-imagined relationship that Kozishek and Bogdan-Lovis describe.

SPECIFIC INTERVENTIONS

When careproviders have a strong relationship with their patients, they may be able to benefit the patients to a greater extent, because patients may be much more likely to listen to and reflect on what their careproviders say. An example of this is when careproviders gave patients advice that they should lose weight. Some patients viewed their careproviders positively or negatively — not on the basis of what their careproviders said — but on the basis of whether they thought that their careproviders felt empathy toward them.¹² If there is a strong relationship, careproviders may be more able to preserve relationships with patients should they give advice and the patients feel offended. Careproviders can't know in advance how patients will respond. Thus, the only way is to "minimize damages" when they give advice by trying, beforehand, to form strong relationships. Sometimes, however, careproviders do not feel empathy for their pa-

tients.¹³ When this happens, perhaps it is not possible to establish the kind of relationships these patients need. The interventions I describe below don't require careproviders to always feel empathy, however, careproviders can use them at any time, including when they don't feel as empathic as they might want.

GOING THE EXTRA MILE

The first intervention involves careproviders taking an opportunity to go the extra mile for patients. Careproviders can imagine and then take the opportunity to do more than might be expected, from taking slightly more time to benefit a patient or acting as a patient's advocate. An example of an intervention that is not particularly burdensome is to knowingly accept some amount of greater stress to benefit a patient in a way that is not essential to his or her care. I think of a junior staff member who told me of the stress he experienced whenever he chose to "lobby" his attending on behalf of his patients. Some patients might conclude that they would do without the benefit if the junior staff member was not there to lobby for them.

An example of an intervention requiring somewhat more burden is for careproviders to make themselves more available by giving patients their home or cell phone number. I remember, in this regard, being at a dinner with a careprovider who took a phone call from a patient and missed the main course and dessert. She told me that she gave her patients her cell phone number because she thought that this gave them better care. I have considered her effort to be the state of the art ever since.

A third example that requires a great deal of burden is when careproviders go against their professional boundaries to serve patients. A careprovider may have the opportunity to do this, for instance, when a medical service can't schedule a new appointment for a patient for months, because it has an extremely long waiting list. Careproviders in this situation may get better results for such patients by contacting the service themselves. They may tell the service that unless the service can "fit the patient in" sooner, they fear that it could become grounds for a patient to bring a suit, because health problems that could be prevented with an earlier appointment might ensue. This may cause the service to make an earlier appointment.

All three of these interventions would be things that careproviders would do for members of their family.

To make extra efforts like this, careproviders first must be able to imagine them. They can do this by trying to imagine, with every patient, what they would do if the patient were a member of their family. Beyond this, there is a more radical intervention that careproviders should habitually perform: if they imagine something they would do — but won't or can't — they should explain to their patients why they won't or can't. Doing this conveys to patients, even when careproviders don't feel particularly empathic, that they are committed to patients, at least to this extent. This is what they would do for their families.

There are downsides to going the extra mile. First, opportunities may simply not exist for some patients. Second, when careproviders do go the extra mile, they may not be able to tell some patients what they have done, as some patients may suspect that their careprovider is merely trying to impress them, and it is not possible to strengthen the relationship in this way. Third, the strain making extra efforts may cause careproviders to resent patients, consciously or unconsciously. Such resentment can easily occur outside our awareness. I recall, for example, a time that one of my patients acted badly and, as a result, spent the night in jail. I remember feeling only "good" when I learned he would be released after only one night. Afterward, it dawned on me that I could have easily tried to call the patient while he was in jail. I would have done this for a family member. In retrospect, I believe that I didn't call because I unconsciously felt angry. As a result, I was not there when the patient needed assistance most.

UNDERSTANDING AND COMMUNICATING A STRENGTH

Leston Havens is a psychiatrist who has directed the training of Harvard psychiatric residents for decades. He has pioneered approaches that careproviders can use to establish strong relationships, even when there is no prior relationship and little time.¹⁴ Once grasped, Haven explains, these steps can be "accomplished with surprising speed."¹⁵ In general, careproviders must first try to "meet the patient." Careproviders must "seek simply to think, feel, and experience what is happening as the patient is thinking, feeling, and experiencing it."¹⁶

The first of these steps is to understand. This enables patients to see their careproviders more as an ally. If careproviders can then share with their own moral view, patients may be more likely to see the careprovider as trying to help them. One way in which careproviders may be best able to understand patients is to scan their own experience to find a feeling like theirs. For example, I once was trying to understand the feeling of a patient who wanted to die. I was able to recall being on a whale watch ship near Maine, when I felt such extreme nausea that I thought, if this doesn't stop, I want to die.

Once a careprovider understands, the next step is to share the understanding with the patient. As Havens says, this "understanding must be *communicated back to the patient* for the alliance to begin. . . ."¹⁷ Careproviders can then check whether they truly understand; this also conveys to patients that careproviders want to understand. A good way to see if careproviders understand is to self-disclose. This is an unusual intervention, but it can have exceptionally positive effects.¹⁸ Self-disclosure may be particularly important when the patients are from a minority culture, because they may especially want to know that their careprovider is a "real person" before they develop trust.¹⁹ There are many different types of disclosures that careproviders can make; they might disclose a feeling that echoes the patient's experience. Careproviders might say, for example, "When I was in a situation like yours, I felt scared, especially because I, too, didn't know how things would turn out for me."²⁰ Self-disclosure may be particularly beneficial because it may enable patients to "normalize" what they are experiencing.²¹ The effect may be quite profound, as illustrated in this case. A patient avoided doing something he'd needed to do for years and now had crippling anxiety as a result. He felt depressed and suicidal, particularly because he knew he had brought this all on himself. I assured him (at greater length than related here), "I do this too. And then I feel enraged at myself that I've caused my own problem." When I finished, the patient smiled. "Until now, I've seen you as someone who had it all together," he said, "and believed I could never be like you. Now I know I *can*."

The third step that Havens suggests is to help the patient find a strength. Havens writes, "The widespread concentration on pathology . . . is not only demoralizing, but *it deprives clinicians of an ally*."²² He and a colleague write elsewhere, "The patient needs to feel that the two of us, together, with our *strengths*, are facing this predicament."²³ Careproviders can *always* find such strengths. To best do this, careproviders may find it helpful to ask themselves what they imagine their patients are trying to achieve.

An example illustrating how careproviders can always find a strength is a patient I saw who felt inordinately emotionally attached to inanimate objects. I realized that this patient had exceptionally warm relationships with all of the members of her family. I said, "Of course! How could this *not* be! You have the most exceptional capacity to empathize. This is why, I think, that you have such exceptionally close relationships with your husband and children. Your capacity to care has simply spilled over!" The patient said that she was now able to see herself as gifted. Moreover, for the first time, she felt *equal*. She has flourished. Whenever persons have vulnerabilities, they also have corresponding strengths.

ASKING, NOT TELLING

Recent advances in medical knowledge indicate that the best way to treat persons who drink to excess is *not* to tell them what is "wrong with them," rather, careproviders should ask patients what they see as the pros and cons of their drinking.²⁴ This same approach also has been used successfully with patients who have what might be called "highly destructive" moral or religious views. Most importantly, this approach has enabled patients in these situations to make not only new choices that were beneficial to them, but choices that were still within what *they* viewed as *their own* moral or religious framework.

Destructive religious views might lead patients to refuse lifesaving treatment because they feel that they should be punished; or they may lead patients to "disown" an adult child because the child is gay, or to stay in a marriage with a partner who beats them. How is it possible to help patients with these beliefs? Griffith and Graby write, "The most useful questions are often those in which the clinician in essence lends . . . to the patient the clinician's [insights] . . . by embedding them within questions."²⁵ More specifically, careproviders can ask patients indirect questions, for example, "What do you think *God* would think in response to what you are doing?" or "What do you think you would do if you *didn't* think that God had this view?"

Here is an example of how such indirect questions may be beneficial. A patient I saw was feeling despair after her mother died. She felt this way, she said, because she believed she could never be even "half the person" her mother had been. I asked, "What would *your mother* say about this?" She responded, suddenly brighter, "Oh, *she* would strongly disagree with me. *She* would say that I am just as worthy as she is, because I, too, have a wonderful family and friends."

I was almost moved to tears by her account of her mother's wisdom, and I told her so. She said, "Maybe I'm not such a failure after all."

CONCLUSION

In this introduction I've pointed out extremely strong reasons that careproviders should *not* share their moral views with patients. On the other hand, I've also pointed out that if careproviders do share their views, they may enhance patients' autonomy and benefit them. Whether or not careproviders do this, and the degree to which they may help patients depends on whether they have a prior, strong relationship with their patients.

To foster strong relationships, careproviders may have to treat patients almost as they would treat members of their own families. I have also indicated how careproviders can establish such relationships: going the extra mile — or telling patients why they can't or won't go the extra mile, understanding patients, telling patients about a strength that they have, asking patients questions about their moral views.

What should careproviders do? The last word on this should be Lester Havens's. He states that our patients need us "to risk being extended in how we think and how we work . . . if we are careful to follow the patient, and do not attempt to lead, we can afford to venture beyond the familiar."²⁶

NOTES

1. L.I. Solberg, M.V. Maciosek, and N.M. Edwards, "Primary Care Intervention to Reduce Alcohol Misuse/Ranking Its Health Impact and Cost Effectiveness," *American Journal of Preventive Medicine* 34, no. 2 (February 2008): 143-52; K.I. Pollak et al., "Empathy Goes a Long Way in Weight Loss Discussions," *Journal of Family Practice* 56, no. 12 (December 2007): 1031-6; T. Pilnick and T. Coleman, "'I'll Give Up Smoking When You Get Me Better': Patients' Resistance to Attempts to Problematised Smoking in General Practice (GP) Consultations," *Social Science and Medicine* 57, no. 1 (July 2003): 135-45; J. Litt, "How to Perform Effective Smoking Cessation Advice in Less than a Minute Without Offending the Patient," *Australian Family Physician* 31, no. 12 (December 2002): 1087-94.

2. E.D. Pellegrino, "Commentary on 'Of More than One Mind'," in this issue of *JCE*.

3. An example of this is the conflict between the values of the sanctity of life and of relieving a patient's suffering. These premises are well summarized in A.L. Caplan and E.J. Bergman, "Beyond *Schiavo*," *The Journal of Clinical Ethics* 18, no. 4 (Winter 2007): 340-5; and A. Fiester, "Mediation and Moral *Aporia*," *The Journal of Clinical Ethics* 18, no. 4 (Winter 2007): 355-6.

4. S. Hack, *Evidence and Inquiry* (Malden, Mass.: Blackwell Publishers, 2001), 84.

5. G. Marcel, *The Philosophy of Existentialism* (New York: Citadel Press, 1963, written in 1947), 199.

6. Pilnick and Coleman, "'I'll Give Up Smoking When You Get Me Better,'" see note 1 above; K. Treadway, "The Code," *New England Journal of Medicine* 357 (2007): 1273-5.

7. Solberg, Maciosek, and Edwards, "Primary Care Intervention to Reduce Alcohol Misuse," see note 1 above.

8. R. Asseltine, "The Impact of Screening, Brief Intervention, and Referral for Treatment on Emergency Department Patients' Alcohol Use," *Annals of Emergency Medicine* 50 (2007): 699-710.

9. Heidegger spoke to a friend "at the turn of 1931-2," and this friend then recorded in his diary that Heidegger was becoming a National Socialist, like his wife. "I would never have believed it," the friend comments. R. Safranski, *Martin Heidegger*, trans. E. Osers (Cambridge, Mass.: Harvard University Press, 1998), 227.

The theologian Reinhold Niebuhr said, "One of the most fruitful sources of self-deception in the ministry is the proclamation of great ideals and principles without any clue to their relation to the controversial issues of the day." R. Niebuhr, *Leaves from the Notebook of a Tamed Cynic* (New York: Harper & Brothers, 1930), 191-2, cited in D.R. Davies, *Reinhold Niebuhr: Prophet from America* (New York: MacMillan, 1948), 13.

10. Heidegger had a "physical and mental breakdown" in the spring of 1946. He said that he had "broken down" at the "'inquisitional hearing'" in December 1945. Safranski, *Martin Heidegger*, see note 9 above, p. 351.

11. It may be interesting to note here that some persons who have damage to their brains may tend to make decisions more on the basis of utility than on other values. They may, for example, take *less* into account their own or others' feelings, much as this patient did in this case. M. Koenigs et al., "Damage to the Prefrontal Cortex Increases Utilitarian Moral Judgments," *Nature* 446 (19 April 2007): 908-11.

12. Pollak et al., "Empathy Goes a Long Way in Weight Loss Discussions," see note 1 above. Some patients might assume this, for instance, if they saw that their careproviders were themselves overweight.

13. Should careproviders take time when a patient in the hospital dies to "formally mourn"? See Treadway, "The Code," see note 6 above.

14. L.L. Havens, "The Best Kept Secret: How to Form an Effective Alliance," *Harvard Review of Psychiatry* 12 no. 1 (2004): 56-62.

15. *Ibid.*, 57.

16. L.L. Havens and S.N. Ghaemi, "Existential Despair and Bipolar Disorder: The Therapeutic Alliance as a Mood Stabilizer," *American Journal of Psychotherapy* 59, no. 2 (2005): 137-47, p. 138.

17. Emphasis is in Havens. Havens, "The Best Kept Secret," see note 14 above, p. 56.

18. S. Knox and C.E. Hill, "Therapist Self-Disclosure: Research-Based Suggestions for Practitioners," *Journal of Clinical Psychology* 59 (2003): 529-39, p. 529. I am indebted to my daughter, Chelsea Howe, for referring me to work by Clara Hill.

19. *Ibid.*, 535.

20. *Ibid.*, 530.

21. *Ibid.*, 531.

22. Havens, "The Best Kept Secret," see note 14 above, p. 57.

23. Havens and Ghaemi, "Existential Despair and Bipolar Disorder," see note 16 above, p. 142.

24. This is known as motivational interviewing. It is now used in numerous fields. See, e.g., B. Everett et al., "Pragmatic Insights into a Nurse-Delivered Motivational Interviewing Intervention in the Outpatient Cardiac Rehabilitation Setting," *Journal of Cardiopulmonary Rehabilitation and Prevention* 28, no. 1 (January/February 2008): 61-4.

25. J.J. Griffith and L. Graby, "Brief Psychotherapy at the Bedside: Countering Demoralization From Medical Illness," *Psychosomatics* 46, no. 2 (March - April 2005): 109-16, p. 111.

26. Havens, "The Best Kept Secret," see note 14 above, p. 61.