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At the Bedside

Edge-of-the-Field Ethics Consulting: What Are We Missing?

Edmund G. Howe

ABSTRACT

Ethics consultants' grasp of ethical principles is ever improving. Yet, what still remains and will remain lacking is their ability to access factors that lie outside their conscious awareness and thus still effect suboptimal outcomes. This article will explore several ways in which these poor outcomes may occur. This discussion will include clinicians' implicit biases, well-intentioned but nonetheless intrusive violations of patients' privacy, and clinicians' unwittingly connoting to patients and families that clinicians regard their moral values and conclusions as superior. I shall suggest several ways in which clinicians may seek to reduce these sources of bad outcomes or at least to do better when they occur.

In this issue of *The Journal of Clinical Ethics (JCE)*, in "The Work of ASBH's Clinical Ethics Consultation Affairs Committee: Development Processes Behind Our Educational Materials," Courtenay R. Bruce, Jane Jankowsky, Barbara L. Chanko, Ann Cordes, Barrie J. Huberman, Liza-Marie Johnson, Deborah L. Kasman, Aviva Katz, Ellen M. Robinson, Katherine Wasson, and George E. Hardart describe why they wrote the ASBH's latest guidelines for doing ethics consults as they did.¹ This new ASBH

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Study Guide provides edge-of-our-field guidance on how clinicians can best do consults. It presents this material in a way that is especially designed to engage readers, and thus, to maximize their learning.

Still, huge challenges remain. Patients and families may, for example, leave consults feeling wronged and even embittered. As a result, they may not only carry these feelings with them for the rest of their lives; they may not seek the care they need in the future, even though they know this may be harmful to them.² There are many reasons for such suboptimal outcomes. Persons' values, for instance, may differ, and when their moral preferences are not respected, they may feel angry. We should learn to respond more effectively, over time, due to such gains as those provided by the ASBH *Study Guide*. The guide urges us, for example, to always indicate explicitly to patients and families what we understand to be their views whether or not their views differ from our own.³ This task is fundamental.

Yet, regardless of the knowledge we have and the gains we make, there are some ways that we may be less likely to progress. These are the ways in which we don't know, for one reason or another, that we have caused another harm. Not knowing we have done this, we may not be able to correct the harm. I will consider such blind spots in this introduction to the summer 2018 issue of *JCE*. I will discuss three of the ways in which we may harm patients and families without fully knowing it, and I will also discuss ways in which we may try to do better.

I will do this in three sections. In the first, I will discuss how we may convey harmful, implicit biases without knowing it. We may not only not know

that this harm has occurred; we may defend ourselves if a patient confronts us with what we have done and how the patient has been affected. Defending ourselves only makes matters worse. Mutual hostility may escalate and soon dissolve our patient's trust in us and our relationship. Such a negative downward cycle can take place in response to all of the ways that we may harm patients that I will consider here. I begin with this example so that readers can use it as a paradigm for considering aspects of later examples I will provide. These aspects primarily include other ways that we may alienate patients without knowing it, and then react defensively when they confront us with how they feel.

In the second section, I will discuss two additional ways that we may harm patients profoundly, also without knowing the extent to which they have been harmed. The two examples I will discuss are built on concerns raised in other articles in this issue of *JCE*. One involves clinicians who violate patients' privacy. The other involves clinicians who share painful information that, while possibly true, may be unnecessarily hurtful, especially when the hurtful information is shared without softening it by placing it in context. Without placing the information in context, it may alter how patients see themselves, perhaps for the rest of their lives.

In the third section, the harm I will discuss particularly applies to clinicians who do ethics consultations, and applies whether the consults are formal or informal, as consults often are on the wards. The risk of harm occurs because we may, merely by taking on the role of ethics consultant, even informally, imply to a patient or family member without being aware of it that we view our moral insights as superior. The negative effect of evoking fear or resentment in a patient or family member may be much greater when we actually do believe that our insights are superior.

If patients or family members feel this fear or resentment, they may tend to respond in either of two ways. They may protest. This may be counterproductive. Their protesting may not succeed in getting them what they want, and the hostility they evoke may be painful for them and may cause those whom they confront to become even less flexible. Or, perhaps even worse, they may remain silent, but lose their trust in us, and, as a result, make suboptimal decisions. Either way, their outcomes, although hidden, may be poor, even catastrophic. I will suggest that, overall, we may do best to assign highest priority to maintaining our patients' trust and maximizing our relationship with them. If we do this, we may enable our patients and their family members, and also ourselves, to respond more insightfully

to ethical conflicts.⁴ In addition, everyone involved in making treatment decisions may be able to work more closely together, which may enhance the ultimate results.

IMPLICIT BIAS: WHAT IT IS; HOW IT WORKS

"Implicit bias" refers to the many ways we may demean others without knowing that we have done so.⁵ Implicit bias is broad and includes prejudices and stereotypes that can affect our judgments and actions subconsciously. Prejudice and stereotyping involve different parts of the brain, and thus different approaches may reduce each. For example, prejudice may be brought about by fear, may occur only once, and may be difficult to erase. Stereotyping is more cognitive and more alterable by new learning and experiences.⁶ Persons who have less status in a society are more likely to be the subjects of bias. Derald Wing Sue, an authority on implicit bias, states that while microaggression often involves race, it can go beyond race to the socially constructed identities that embody privilege such as income, social capital, religion, ableness, gender, and sexual orientation.⁷ Since, as medical professionals, we are much less likely to experience lesser status, it is particularly important for us to be aware of such slights so that we can avoid them. Unlike many more-privileged persons, we are at greater risk of inflicting harm because we may see ourselves—accurately—as not having conscious biases, or at least doing all we can to avoid them.⁸ With this commitment and source of professional and personal self-respect, we may be paradoxically less likely to be able to see that we may still have implicit biases that we can't detect, and that our biases may harm others, including patients and families. We may, in other words, feel exceptionally committed to regarding all of our patients as equal. This heightened commitment may, however, make us more blind to recognizing our limits in being able to do this. Thus, we may become defensive should we be criticized for having an implicit bias.⁹ When this occurs, our defensiveness may trigger reciprocal responses, overt or covert, in patients and families, and this cycle may continue and grow. As a result, patients and families may respond in either of the two self-injurious ways I described above. They may feel fear and resentment, and damaged trust. Having elucidated how implicit bias may occur in general, I will give some specific examples.

Examples That Illustrate Implicit Bias

I will begin with an example in which the person who was offended was an MD/PhD. This doctor, a person of color, was going with his wife to a

restaurant when a patron at the same restaurant assumed that he must be a parking attendant. She dropped her car key into his hand and didn't say a word. He reports that he felt flooded with feelings of inferiority and helplessness.¹⁰ Another example illustrating of such bias with people of color is the following. In an attempt to show they are not biased, some clinicians say they treat everyone the same; they may say that they are "color blind." Readers may wonder, how could this possibly be perceived as offensive? The answer is that some people experience this approach as negating the importance of their different race, ethnicity, and/or culture.¹¹ As with all behaviors that some people find offensive (assuming there are valid grounds for the offense), we should all regard the behavior as offensive. The example of "treating everyone the same" is particularly useful at this point, because it illustrates how implicit bias may lie outside our common knowledge and even lie beyond what we are able to imagine. Thus, it is important to scour the literature on this topic, when we can, to become better aware of what others may find demeaning, even though we would never intend to demean another person. Fortunately, there are many writings that may help us.¹²

Let me now add to the above example a bias that I have expressed in the past repeatedly. When I have met a person who seems clearly to be from another country, I have asked, "Where are you from?" I believed at those times that I was only expressing my genuine interest in the other person. This was not, however, what some perceived. Some feel demeaned by this, because, to them, it implies that I (and others) may see them as not fully American, but as "other."¹³ I ask readers to note what they feel as they read this. If you experience a strong feeling of disbelief, or even irritation, you can use this to better understand how we may be at risk of responding defensively when we are confronted by another person who is offended by a bias we have expressed. That is, if a patient or family member confronts us regarding an implicit bias we unknowingly expressed, we may be vulnerable to responding, at least nonverbally, in a way that is dismissive. As David Wing Sue notes, we may express our disbelief and that we feel wronged, not only verbally but with dismissive looks, gestures, and even tone of voice.¹⁴

We may make matters worse by telling ourselves, and telling the other person, that he or she is being overly sensitive.¹⁵ In such a situation, we may continue in our previously wrong inferences and conclude that the other person's reaction is not only unwarranted, but unfair to us. Such denial and an attempt to rationalize away the other person's response are common among people who are con-

fronted. My purpose is not to discuss when, or whether or not, in a specific situation or in situations in general, another person's taking offence is or is not justified. My purpose is to suggest that all of us should strive to see these responses, when they occur among our patients (and ourselves), as warranted and justified. It is necessary because only this will enable us to maximize the care we give to our patients and to grow as clinicians. Otherwise we can only sow seeds of distrust that will most likely undermine whatever we do that is beneficial.

It may be that, in some cases, others' "sensitivity" goes way too far. For instance, a colleague who teaches psychology described to me how she had shared an example in a class that came from the class textbook. The text said that customers may buy more cosmetics at a cosmetics counter if the salesperson, usually a woman, is attractive. She and the text posited that customers might buy more cosmetics from an attractive salesperson because they might want to look good as she does. To be maximally caring to the men in her class, the teacher said, "I'm sorry, you men may not be able to relate so well to this example." After the class, some students told her they were angry. They explained that what she said was offensive to them because there might be a transgender person in the class who had lived before as a woman. This student would have experienced as a woman what the teacher said he wouldn't be able to understand as a man.¹⁶

Regardless of how we respond to this example, if we wish to treat our patients optimally, we must respect their responses. That is, even if we are as aware as we can be, it is impossible to avoid what some may experience as a slight, as in the example just given. Informing ourselves is not enough, because we will miss some slights and may inadvertently cause harm. We must seek to avoid enacting these slights, if we can.

Another Way to Avoid Expressing Implicit Biases

If we could avoid expressing implied biases altogether, this would be ideal. Unfortunately, this is most likely impossible, because we have biases we don't know we have and may express them, even when we have the best of intentions and do all we can to avoid it. Further, what we say may have more than one meaning or an ambiguous meaning. Thus, in spite of our best efforts, we may still be offensive.¹⁷ But there is a way we may avoid this: we can limit this risk by becoming aware of exceptionally strong, sudden feelings we experience in response to something a patient says or does that goes against what we expected. If we can detect these feelings before we respond, we may be able to avoid express-

ing the surprise or other unusual emotion we may feel. If we express this feeling as it occurs, we may well express an implicit bias.

To illustrate how we may do this, here is another case that is particularly instructive. A father was visiting his daughter at her college for the first time since she had entered it as a freshman. He was White, and his daughter's roommate was Black. He took the roommates to dinner. Halfway through the meal, he said to the roommate, "I'm surprised. You speak so well. How did you come to speak so well?" She chose not to confront him. Whether or not people should confront those who offend them is, for many, a most difficult decision. It occurs more often for some people than others. Transgender persons confront this question, for example, when others speak to them using a pronoun that isn't their gender. If transgender persons state what they feel, they know that the other person might resent them. Especially if the other person is thin-skinned, the price paid for speaking up may be exceptionally dear.¹⁸ To return to the anecdote about the college roommates, it is clear that the father was racially biased. He believed that all or most Black people must speak in a specific, same way. That this is the case isn't my point. My point is that the father was surprised. That was the emotion he experienced first, as he acknowledged.

As this example illustrates, it may be possible to identify such feelings and so avoid the risk of expressing an implicit bias. It requires us to learn to identify such feelings as they occur. This goal is aspirational. It is not realizable in every instance. We can never, ever, always recognize biases that lie outside our awareness before we express them.¹⁹ In addition to increasing our knowledge of what our implicit biases may be, and putting ourselves more on the alert for spotting feelings like surprise that may come from these biases, and when we fail to recognize our biases and express them we must be willing and able to apologize in a way that gets through. How best to do this may be more complex than we imagine, so I will next describe how we may do this best.

Making Amends Once We Express an Implicit Bias

In our practices, we may not know we have expressed an implicit bias unless and until we see our patient's reaction. If we are able to detect this, we may be able, at that time, to make amends. Doing so may enable us to restore the patient's trust and preserve and maintain an optimal patient/clinician relationship. To notice whether a patient feels offended, we must be circumspect, able to detect even a split-second of a sudden downcast glance, for in-

stance, that a patient may show in response to what we have said. This may be the only clue that the patient offers. How can we discern whether we have offended a patient, and how can we apologize when we have? Some ways are better than others. I will discuss some of the better ways next.

Asking a Patient Whether the Patient Feels What We Think We May Have Seen

Seeing what may be a patient's negative response to what we have just said, we may ask, "I just thought I may have seen you respond to something I did or I said. Maybe you didn't. But if you were responding to something I did or said, please tell me. This is especially important to me if I, in any way, offended you. Please tell me this, but only if you want to. But please know that if I did offend you, this is the last thing I would want to do. If I did offend you and you tell me, I can not do this again."

Readers may note that in the words I used, I tried to ask this question in a way that leaves the patient feeling as unpressured about having to respond in any way that may be uncomfortable. I intend to make it as easy as possible for a patient to say in response, for example, "No, I wasn't responding to anything. You didn't offend me," whether or not this is the truth. Allowing a patient this freedom, to the degree we can, respects the patient to the greatest extent possible. This relieves the patient of some of the burden of having to decide whether to say what the patient may not want to say in response. The patient should not need to worry unduly about how we may respond to what the patient says or what we may most want to hear.

The importance of this special effort, more generally, exists in many other clinical interactions. It may be especially important, for instance, when we want to know if a patient is dying and wants to talk about his or her feelings regarding being terminally ill. Some patients will. Some won't. It may help to ask questions in a way that makes it easy for them to answer "yes" or "no." This technique and others have been insightfully discussed by clinicians who are especially skilled in caring for terminally ill patients. Marco Pino and colleagues suggest that in response to a positive response to the above question, we might say something like, "Are you able to share what's worrying you most at the moment?"²⁰ I would add only to this, "Are you able to share what's worrying you most at this moment, *if anything?*"

Generally, we can ask our patients if they have thoughts or feelings they would like to share with us, and, at the same time, make it clear to them that we realize they may not want to share their thoughts and feelings with us, at least not at the present time.

It is particularly important that we make it easy for our patients to respond, especially when the questions we are asking may be experienced as implicitly threatening.²¹

Saying "I'm Sorry"

If a patient shares that he or she feels offended, we should apologize. It is essential, though, that when we apologize, we do it in the right way. This is because what might appear to us to be an apology may be ambiguous and thus inadvertently may be offensive. Readers might want to test this possibility before reading further. To do this, readers could compare how they believe they would feel in response to these two different apologies: (1) "I'm sorry you feel hurt," or (2) "I'm sorry I hurt you." The first apology puts the "fault" more on the person who feels hurt and puts less fault on the person who did the hurting. The first apology may also imply that the person who is hurt is too or overly sensitive.

I would like to summarize this suggestion and add additional suggestions by quoting a psychologist, Harriet Lerner, who most richly instructs how to best apologize. She says that when we err, we are "apology challenged." She relates that she was at a friend's book signing, and she tried to be as supportive as she could be, but, to her friend, it didn't seem that way. Her friend confronted her with how she had disappointed her. When her friend told her this, Lerner felt enraged. She had tried to be as supportive as she could be.

After reflecting, however, she saw her reaction in a wholly different light. When her friend first said that she felt offended, Lerner felt totally blindsided. She thought this was unfair and felt extremely angry. Thus she said "*I'm sorry, but. . .*" She explains the error in initially responding in this way. She says, "Apologizing for the other's feelings—as by saying, 'I'm sorry *you* felt hurt'—rather than apologizing for our own behavior *is often worse than no apology at all*. It only deepens the original injury, but I did it anyway." (Emphasis added.) She continues that her friend "made herself vulnerable by sharing her anger and deep hurt. Whether I saw these feelings as completely valid *was irrelevant*. They were her feelings."²² (Emphasis added.)

"A wholehearted apology," Lerner continues, "means valuing the relationship and accepting responsibility for our part without a hint of evasion, excuse-making or blaming. . . . It's about 'investing in the relationship' and 'accepting the person you love as they are'. . . . This means 'to apologize for our part, even when the other person's feelings seem exaggerated, or they can't see their own contribution to the problem.'"²³ She concludes, "The good

apology requires that we take clear and direct responsibility for what we've said or done (or failed to say or do) without any ifs, ands, or buts and without bringing up the other person's crime sheet." This may require, she adds most insightfully, committing ourselves to not repeating what we have done, to correcting what we did, if possible, and even to listening "with an open heart" to the other's anger, and doing it "on more than one occasion."²⁴ Lerner's approach may fall short of achieving the authenticity we want between our friends and ourselves as we interact with them. It is open to question, however, whether authenticity and responding as Lerner suggests are mutually exclusive. This initial acknowledgment of another's hurt may clear the air and thus be a first step to discussion and reconciliation.

Lerner's last point about being willing to repeatedly bear another's anger is especially counterintuitive. We might instead respond to another's repeatedly expressing anger at us by stating we have had enough, but Lerner advises adamantly against this. Rephrasing her in terms of patients who feel offended, we should never say, "That's enough."²⁵ To truly and effectively apologize, we must do more than just say we are sorry. We must say it in the right way to undo what we have done, if that is possible. We must not repeat the offense, and we must let a patient vent his or her anger, even if the patient feels inclined to do this many times.²⁶

A last and more general point Lerner makes in regard to apologizing applies especially to clinicians who do ethics consultation: "We're hard-wired to seek justice and fairness. . . . Tendering an apology, however, can heal broken connections and restore trust" in relationships in which the result would otherwise be "impossibly tragic."²⁷

Impossibly tragic: Lerner does not exaggerate. Her statement that "We're hard-wired to seek justice and fairness" but that healing broken connections is what should count, should be taken literally by ethics consultants. She reiterates the overall priority that I urged at the beginning of this article, that clinicians who do consults should prioritize patients' feelings ahead of a more common and tempting priority: our ethical principles.²⁸ There is a risk, however, of which we should be continually aware: if we spare another our ethical objections, are we being patronizing or paternalistic?

SOWING DISTRUST IN OTHER WAYS

In this section I will discuss two additional ways that we may lose a patient's trust. Both involve not imagining sufficiently the negative effects that our action may bring about. The first is to violate a pati-

ent's privacy. The second is to give a patient a medical diagnosis in a way that may be accurate but may make it impossible for the patient to recover.

Searching a Patient's Social Media Accounts

In "TTaPP: Together Take a Pause and Ponder: A Critical Thinking Tool for Exploring the Private Lives of Patients," Leslie Kuhnle explores the ethical pros and cons of clinicians' using the internet to learn more about their patients and of their doing this without their patients' consent.²⁹ This practice is paradigmatic of other violations that clinicians may make and then misjudge or underestimate how their actions may affect their patients.

That clinicians use the internet to learn about patients without first asking for permission, or even saying that they would like to do this before doing it, may be more common than we might expect. And this practice may be increasing. Kuhnle states, for example, that, according to one study, 94 to 97 percent of the psychology graduate students surveyed had engaged in patient-targeted googling (PTG) of at least one of their patients in the preceding year. Kuhnle presents a case in which members of a medical team distrusted information that a patient's family member gave them. Concerned that "something fishy" was going on, the team members googled the patient to learn more. What they found was unsettling, and they requested advice from their ethics committee. Kuhnle reports that the American Psychiatric Association's (APA's) Ethics Committee holds that clinicians should engage in PTG only to promote a patient's care and well-being, but that clinicians should consider how doing this might influence treatment and the therapeutic relationship. We might ask whether the APA committee's view is much too broad: its requirement for "care and well-being" could be used to rationalize almost anything.

In this regard, Kuhnle lists 10 contexts in which clinicians who engage in PTG activities have been seen as clinically and (presumably) also ethically justifiable. These include suspected "doctor shopping," patients who respond evasively to clinical questions, patients who make improbable claims about their personal or family history, and even patients who make inconsistent statements regarding themselves or their family. The examples raise a common concern: they accept that clinicians might google patients under such circumstances, *even though doing so might place them at odds with their patients*.

Doing this always risks creating a highly suboptimal result. For this reason, I have urged clinicians to give priority to patients' feelings, rather than to even justice and fairness. Here is a common, hypo-

thetical example. I have a patient who greatly exaggerates. This is not at all uncommon for persons, in general. All of us may tend to do it in one way or another; for instance, we may tend to minimize our contribution to something we have done wrong, hoping that it makes us look less blameworthy in another's eyes. Those who exaggerate may mostly want others to see them as better. This may be my patient's predominant need. If I support my patient with the positive regard he seeks, his exaggerating over time may diminish. Given this example, we might question the APA committee's criteria. Consistent with the APA criteria, I could google my patient who greatly exaggerates without his permission, so long as I believe that in some way, he (or someone else) would, in net, benefit.

This example suggests the importance of seeking diligently to imagine and anticipate ways in which our patients may be adversely affected by our actions, as, for example, was considered above in the discussion regarding clinicians' recognizing their feelings of surprise. The strongest argument that can be made to justify googling our patients is that the patients made this information about themselves public when they shared it on social media; therefore, their privacy has not been violated when we google them without their consent.

While this argument is logically valid, it may be clinically shortsighted—in the same way that it is shortsighted for clinicians who have expressed an implicit bias to insist that the only thing that "counts" is their intent. In both instances the logic may be right, but how patients feel and respond may not conform to this logic. To best meet our patients' needs, we may have to start where they are, and work with them from there. This is the case even when a patient responds in a rare and singular way.³⁰

A second example involving privacy counter-sinks this point. It involves patients' charts. Often there are professional guidelines to be followed, but it may be, as when making a decision whether to look at a patient's posts on social media, we should do what most respects the patient and preserves our patient/clinician relationship. A specific example is a person who has questions about her or his gender identity. This may include what the person should or should not do, and he or she may not want any part of the discussion in the medical record.

In some cases, transgender persons may not want some of the clinicians they see to know about their gender identity. An example of such a clinician is, for instance, one they would go to for a sore throat. (I use the word "persons" rather than "patients" because some transgender persons feel strongly—as perhaps all of us should—that they do not have a

disorder. This is consistent with the reasoning presented above, that we should respect a patient's feeling that he or she has been offended by an expression of implicit bias.) What should clinicians do when they see a transgender person who wants to discuss concerns regarding gender identity, but doesn't want anything about this in the medical record? Here, we don't have to imagine or anticipate whether this is important. This person's privacy is of the utmost importance to him or her, and this person will have to decide with whom to share this information for the rest of her or his life. Accordingly, with transgender persons, we may want to ask when we first meet what, if anything, they would want us to write in their chart. If they want us to say nothing, we may be faced with the question considered more than once in this article: Should we place these persons and their feelings first, or should we give greater priority to what we may see as our usual professional obligation? In this regard, I recall a clinician who faced making just this choice. The clinician decided to write nothing in the chart about what she and the transgender person she saw had regularly discussed.³¹

Our analysis has focused to this point only on what we should anticipate and *not* do. It may be better to anticipate what we could do that might be additionally beneficial for our patients. I think of a clinician who tries to imagine what may be most helpful when he first sees a patient who has been raped. He takes two steps initially. One has some precedent, the other does not. First, he asks the patient whether she feels fearful being alone with him in the room—roughly similar to asking any patient with a clinician of the opposite sex whether the patient wants someone of the same sex in the room. Second, he asks the patient whether she feels fear in response to his *smell*, as the rapist's smell may have been so strong that an odor even somewhat similar may trigger a terrifying, flash-back-like response.³² This example indicates what we should seek to imagine, anticipate, and possibly do to maximally respect and support our patients' needs and feelings. We should seek to imagine what they might need, even if and when it has not occurred to them.

Sharing Information That May Change How Patients See Themselves

In Andrew Clark's "Psychiatric Diagnoses and Informed Consent," in this issue of *JCE*, he asks how clinicians should communicate psychiatric diagnoses to their patients.³³ He states that the assumption that clinicians should inform patients of their diagnostic conclusions may be "reasonably valid" in traditional medical fields, but that psychiatric di-

agnoses often may be "different in kind." Psychiatric diagnoses," he states, may "pose an even greater risk to the patient than the treatment itself."

In the last issue of *JCE* I discussed related ethical questions: Should we always seek to determine whether aged patients who come in for a routine exam have early dementia? And if they might: Should we always inform them of it? I suggested that, in some cases, we might consider describing the pros and cons of having testing, thus helping patients to make a fully informed decision whether they would want the testing. The concern underlying this approach is analogous to the harm that concerns Clark: learning a diagnosis of early dementia may profoundly impair patients' capacity to enjoy their life from that moment on.³⁴

Clark uses the example of a diagnosis that he believes could pose a comparable risk, that of borderline personality disorder (BPD). Many patients may benefit from knowing that they have this diagnosis; learning this may, for example, help them better understand some difficulties in living they may continue to have, such as frequent mood shifts or becoming easily angered. These difficulties may make it harder for them to keep jobs and friends. It may be helpful to patients to hear why they have had problems and what they may do to make their lives better. For other patients, however, as Clark contends, this diagnosis may be devastating.³⁵ I recall a patient who had done well in school and had many friends until, in her early adult life, she experienced a profound trauma. After this she trusted no one and often became angry. A clinician diagnosed her as having BPD. She felt extreme shame and protested mightily: "I was mentally healthy before this occurred," she said, "and I became as I am now only after this trauma. Thus, I don't have a borderline personality disorder."³⁶ Accordingly, to avoid or at least minimize the risk of alienating our patients to the point that they might not be willing to see us—or anyone else—there are approaches we can use to minimize the likelihood of this happening. This may be a risk only for one or a few patients in a practice, and so it is a good example of how we might alter our practice to avoid needlessly negatively affecting even only one patient.

To help reduce the risk of harming a patient with a diagnosis of BPD, for example, we could ask the patient if she or he wants to diagnose her- or himself. We can do this by reading the nine criteria that making this diagnosis involves and seeing if the patient meets at least five of them.³⁷ We might state in advance that the name of the diagnosis is unfortunately most misleading, and, that, personally, we would totally change it if we could. Making this

statement, and perhaps more importantly, taking the time and effort to convey this information, may soften the impact of a diagnosis of BPD sufficiently that the patient will continue to see us, or someone else, for treatment.

Patients may, as Clark rightly says, make their own meaning of their diagnoses. They similarly may be most profoundly harmed by a clinician telling them that they are manipulative or attention seeking.³⁸ This may turn them off from seeing a clinician who could help them, and they may come to see themselves as having nothing to offer others, much less themselves. Accordingly, when we suspect that we know a patient's maladaptive psychodynamics, we should try to imagine ways in which we can share this information, if we think it will help, in a way that will not harm the patient. This may be accomplished by first placing what we will say in context, indicating to the patient our personal stance toward them, one that is highly supportive and caring. For example, if the patient expresses a concern about interacting with others, we might begin by saying something like: "It's clear that you care greatly for other people. You may be having the same problem that many other people do, who also care exceptionally for others. They expect that others will treat them as they would treat others. When others don't treat them this way, they may feel baffled, and not know how to respond."

This kind of context-establishing statement often is true—or if it is not, the patient will surely have other strengths that we can note. With this initial expression of support we may better succeed in allying ourselves with the patient, and asking whether he or she would want to explore together why others may react as they do, in ways that the patient has said is distressing.

The critical goal is, once again, to prioritize remaining our patient's ally above all else. This aspiration is nowhere better expressed than by the psychologist Marianne Amir, who says, "The aim of the health care team should be to create a secure environment of unconditional trust that patients can rely on to mediate between their inner world and the outside reality—an environment similar to that of maternal holding."³⁹

CONVEYING TO PATIENTS AND FAMILIES THAT THEIR MORAL BELIEFS ARE INFERIOR

In Grattan T. Brown's "Medical Futility in Concept, Culture, and Practice," in this issue of *JCE*, the author discusses what might be appropriate ethical limits for dual liver-kidney transplants.⁴⁰ He looks,

for example, at "pretransplant illness severity," and asks whether this intervention should be warranted if, say, due to a patient's medical condition, even with a dual transplant, the patient would only live at most three months.

Brown also seeks to explore this question from a wider perspective by looking at what clinicians regard as futile in other contexts. He considers, for example, a baby with complex medical needs whose parents wanted to care for him at home. They knew the burdens and the benefits of doing this because they had cared for their deceased daughter who had the same genetic disease. Brown asks whether the baby's clinicians should have allowed this. The cases that Brown presents highlight the ethical question of futility. My purpose is not to assess what should count in making this determination, but to consider how these decisions should best be made.

In answering this question, I would suggest that it may be that we can do no better than consult some guidelines offered by a leading expert on conducting mediation, Autumn Fiester. She suggests that we should loosen and widen the criteria by which we make such moral judgments as futility. First, she says, it makes sense to do so. Second, practically, if it makes sense and we are able to do it, we will be able to reach more judgments that are in agreement with our patients and their families. This possibility is particularly important, Fiester suggests, when patients' or families' positions initially differ from our own. She provides two steps by which we can do this. She presented these steps and a list we all can use at a workshop at the 2017 meeting of the American Society for Bioethics and Humanities (ASBH). Fiester has published these steps and the list, and they are readily available.⁴¹

At her workshop at the ASBH meeting, Fiester challenged all of those attending to imagine positions that patients and families might hold that were the most opposite to the positions that clinicians hold dear. Fiester presented a list of ethical dilemmas that were common, yet posed the greatest ethical conflicts with patients and families that are likely to be confronted at the present time. She elicited some examples of patients' and families' views that the attendees said they most opposed. With this list, Fiester put forth a plausible argument for each, making these views seem not so unreasonable at all. In unearthing the sound values that might be underneath the positions that clinicians at this workshop might have adamantly opposed, she tried to convey that such views, often seen as groundless, were actually views that reasonable persons might reasonably have. Fiester's goal was to show that, with the loosening of our more fixed ethical convictions, we

may be more open to hearing and accepting patients' and families' initially seemingly wholly differing positions. Stated differently: Fiester encourages us to assess our implicit ethical biases to discern whether the values we hold, that may lie hidden, are as sound as we assume they are.

We must, she says, "dethrone" the moral commitments we may have that, even subliminally, we may take to be more "objective, absolute, and universal" than they are.⁴² Readers might want particularly to attend to the use of the word "subliminally." These are beliefs that we may hold outside of our conscious awareness, and, as they are unknown, may be more beyond our conscious control than our other beliefs would be. If, as with implicit biases, we deliberately attempt to consider and re-assess what may lie outside our awareness, we may have greater success. Fiester puts this challenge to us when we engage in ethics consultations: "Can clinicians provide a moral justification for the stance taken by each individual stakeholder in the conflict? If not," she says, "they have more to do."⁴³

To help us to do this, Fiester presents a list that she calls the Bioethical Positions Inventory (BPI).⁴⁴ This list of prevalent moral views and opposing views is a tool to assess one's own personal, normative commitments on contemporary bioethical issues and debates. With this initial self-understanding, we can work to create a values-based defense for any position that is in conflict with our own. Fiester writes, "I believe this two-step exercise—first identifying one's own positions and reflecting on the ethical rationale that undergirds them and defending the antithetical positions held by others—protects CECs [clinical ethics consultants] from values hegemony and what I elsewhere call the 'weaponizing' of moral principles."⁴⁵

To illustrate the kind of counterpositions Fiester takes, here is an example from the article she refers to (that actually involves "weaponizing" in its title). She considers the case of Mrs. Dee, from Nancy Dubler and Carol Liebeman's book, *Bioethics Meditation: A Guide to Shaping Shared Solutions*.⁴⁶ This case raises questions similar to the case Brown describes, of the baby whose parents wanted to care for him at home. Mrs. Dee's clinicians see maintaining her life as futile, whereas her loved ones wholly disagree. Fiester points out that the reasons underlying the loved ones' position may be more valid and have more moral weight than those of us who do ethical consults may customarily see and accept.

First, Fiester notes, there is the sanctity of all human life, which we all value. It is hardly a new proposition that this value exists, but, nonetheless, it should be recognized and given due respect. More

significantly are two values we might not so readily see. (1) Mrs. Dee's loved ones see her continuing to live as not being futile. This is of no small worth; we take others' sensibilities into account in many ethical contexts. We do this, for example when we debate how much moral weight we should give to views that differ on the basis of cultural relativity. The main difference between opposing views may be the different populations' moral sensibilities.

(2) In some contexts, we have begun to consider the interests of others, besides patients, when we haven't before (or only a few of us have). For example, medicines for children with rare, serious diseases may be scarce, and some have suggested that a last criterion to use in deciding which children should get a limited medicine is the interests of the children's *other siblings*. At the 2017 ASBH meeting, two different presentations proposed giving new and greater moral weight to the competing needs of others as well as patients. The first involved mature minors. The second involved greatly medically compromised infants, like the baby Brown mentions in his article. In both cases in the two presentations, the patients' families were not so well-off.⁴⁷

Fiester's second counterproposition that supports according more validity to family members' views on maintaining a patient's life is intriguing. Might it not be that if Mrs. Dee were conscious and competent, and asked about her preferences, she would most likely say that she wants whatever is most important to her family members, not what is most important to her. This may mean that deferring to what Mrs. Dee would say is truly the best way to respect her autonomy. Fiester states, "Reaching beyond the limits of what an advance directive could possibly reveal about a patient's deepest moral commitments, Pat [Mrs. Dee's adult son] asserts that his mother would not want to forego or withdraw life-sustaining therapy if her family needed her to continue with it. This might be framed as a principle of staying alive for the sake of others, and there is a great deal of intuitive plausibility to it."⁴⁸

Readers may or may not see this argument as having ethical merit. Fiester notes that she knows many people might disagree. The question we might best focus on here is not whether Fiester is right or not. It is how we might be blind sided by views we have that may not be optimally insightful because they lie outside our conscious awareness and thus outside our conscious control.

In this regard, we may trigger patients' and family members' automatic, oppositional reactions merely by presenting ourselves as an ethics consultant. This may occur even when we only informally offer an ethical view. An immediate loss of trust may

be triggered should we in some way hint or even unintentionally just imply that we regard our moral views as superior or more enlightened.

Fiester's urgings may help us to see and avoid these results. Merely asking ourselves whether we are inadvertently conveying the impression that our moral views are superior may alter how we interact with others, so that we should avoid even just using verbal tones that could convey this impression. If so, the gain maybe most substantial: it may enable us to make ethical decisions *with* our patients to a greater extent than may have been possible previously.

CONCLUSION

In this article, I noted how the authors of the ASBH's new *Study Guide* have furthered our field. I addressed how we may progress still further by recognizing the ways in which we may lose the trust of patients and families without realizing it. I discussed implicit biases as a paradigm for how this can occur outside our awareness and how negative feelings can escalate if we offend patients and their family members and they confront us. I explored three other specific examples in which we may lose our patients' trust: undervaluing their privacy, undervaluing how our sharing their diagnoses and psychodynamics may affect them, and not seeing how believing that our moral views may be superior may offend patients and family members and move them to try to effect the best end result by no longer seeking to work with us.

I offered some possible remedies for these destructive, although unintentional, behaviors. These involve looking for feelings like surprise, not seeking outside information about our patients without prior permission, not sharing potentially negative feedback with patients without discussing what it *doesn't* mean first, and doing all we can to try to insure that patients don't see us as believing that our own moral values are superior.

I suggested that clinicians may seek to imagine ways they might benefit patients, even when the patients may not know what it is that they want or need. (One example of this was asking rape victims about the male clinician's smell.) The most controversial of these suggestions—and the one that we may most want not to accept—is loosening many of the moral views we now have. Perhaps we should not do this. It may, however, be worth considering.

I offered a number of points from the work of Autumn Fiester; the last point may involve respecting patients to the greatest degree, by asking what they would want for their loved others if they could

still speak. Fiester's ground for this is compelling. She asks, "Wouldn't most parents at no physical cost to them want to help their children? Wouldn't parents want to do much more?"⁴⁹

DEDICATION

To Rick. And to Leslie, his wife, and our managing editor, who pursued with Rick the best care possible, some of her insights from their experience often finding themselves into this journal's pages.

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I would like to thank Norman Quist for his careful reading and insightful comments on this article.

NOTES

1. C.R. Bruce, J. Jankowski, B.L. Chanko, A. Cordes, B.J. Huberman, L.-M. Johnson, D.L. Kasman, A. Katz, E.M. Robinson, K. Wasson, and G.E. Hardart, "The Work of ASBH's Clinical Ethics Consultation Affairs Committee: Development Processes Behind Our Educational Materials," in this issue of *JCE* 29, no. 2 (Summer 2018).

2. "Therapists who are unaware of their biases and prejudices may unintentionally create impasses for clients of color, which may partially explain well-documented patterns of therapy underutilization and premature termination of therapy among such clients." D.W. Sue et al., "Racial Microaggressions in Everyday Life: Implications for Clinical Practice," *American Psychologist* 62 (2007): 271-86, 271. Preventive efforts may also help. See, i.e., T.V. Cunningham, L.P. Scheunemann, R.M. Arnold, and S. White, "How do Clinicians Prepare Family Members for the Role of Surrogate Decision-Maker?" *Journal of Medical Ethics* 44, no. 1 (January 2018): 21-6.

3. The ASBH has consistently urged this. In *Addressing Patient-Centered Ethical Issues in Health Care*, it asks readers, for example, when considering how they would respond to (what they refer to as) a "difficult" patient: "What can you imagine about his perspective or the reasons for his behaviors and interactions?" *Addressing Patient-Centered Ethical Issues in Health Care* (Chicago, Ill.: ASBH, 2017), 69. Previously, ASBH advised, "Reconstruct the case from the patient's perspective," in *Improving Competencies in Clinical Ethics Consultation* (Glenview, Ill.: ASBH, 2009), 39.

4. This is a biologically based, likely outcome recently presented by Daniel Kahnemann. D. Kahneman, *Thinking, Fast and Slow* (New York: Farrar, Straus, and Giroux, 2011). Basically, when people feel calm and supported, they may think more constructively, because their brain is less geared for a fight-or-flight response. See, also J.A. Soodalter et al., "Affective Science and Avoidant End-of-Life Communication: Can the Science of Emotion Help Physicians Talk with Their Patients About the End of Life?" *Patient Education and Counseling* 101, no. 5 (May 2018): 960-7. A factor that may make it harder for us to accept how we might harm a patient is knowing that if we of-

fended this patient, we most likely may have harmed many others over the course of our career. Accepting this may be especially painful. One example is to learn at mid-career that giving a patient a simple reassurance in the immediate aftermath of a disaster, such as saying, "You will be okay," may actually make the patient more tense. Uniformed Services University of the Health Sciences, "Psychological First Aid/Helping Victims in the Immediate Aftermath of Disaster," *Courage to Care*, January 2005, a fact sheet for clinicians available from this author.

5. Micro invalidations "negate, or nullify the psychological thoughts, feelings, or experiential reality of members of marginal groups." K.L. Nadal et al., "Microaggressions toward Lesbian, Gay, Bisexual, Transgender, Queer, and Genderqueer People: A Review of the Literature," *Journal of Sex Research* 54, no. 4-5 (2016): 488-508, 490. See also Sue et al., "Racial Microaggressions in Everyday Life," see note 2 above; A. Weber et al., "Subtle and Severe Microaggressions among Racially Diverse Sexual Minorities," *Journal of Homosexuality* 65, no. 4 (2018): 540-59; T. Devos and M.R. Banaji, "American=White?" *Journal of Personality and Social Psychology* 88, no.3 (March 2005):447-66; P.J. Sawyer et al., "Discrimination and the Stress Response: Psychological and Physiological Consequences of Anticipating Prejudice in Interethnic Interactions," *American Journal of Public Health* 102, no. 5 (May 2012): 1020-6. Implicit aggression can be measured. See A.G. Greenwald, D.E. McGhee, and J.L. Schwartz, "Measuring Individual Differences in Implicit Cognition: The Implicit Association Test," *Journal of Personality and Social Psychology* 74, no. 6 (June 1998): 1464-80; S.R. Torres-Harding, S.L. Andrade, Jr., and C.E. Romero Diaz, "The Racial Microaggressions Scale (RMAS): A New Scale to Measure Experiences of Racial Microaggressions in People of Color," *Cultural Diversity and Ethnic Minority Psychology* 18, no. 2 (April 2012): 153-64. Implicit biases can start early. See M.P. Renno and K. Shutts, "Children's Social Category-Based Giving and its Correlates; Expectations and References," *Developmental Psychology* 51, no. 4 (2015): 533-43. They can also be, at least somewhat, overcome. See K. Schumann, J. Zaki, and C.S. Dweck, "Addressing the Empathy Deficit: Beliefs about the Malleability of Empathy Predict Effortful Responses When Empathy is Challenging," *Journal of Personality and Social Psychology* 107, no.3 (September 2014): 475-93.

6. D.M. Amodio, "The Neuroscience of Prejudice and Stereotyping," *Nature Reviews: Neuroscience* 15, no. 19 (2014): 670-82. I wish particularly to thank L.T. Madeline Teisberg, DO, for insights on implicit bias which she presented in "Are We Better Than Robots?" psychiatry grand rounds presentation, Walter Reed National Military Medical Center, Bethesda, Md, 28 February 2018.

7. Sue et al., "Racial Microaggressions in Everyday Life," see note 2 above, p. 271.

8. Unconscious processes may shape judgements often in invalid ways. A.G. Greenwald and M.R. Banaji, "The Implicit Revolution; Reconceiving the Relation Between Conscious and Unconscious," *American Psychologist* 72, no. 9 (2017): 861-71, 868.

9. Sue et al., "Racial Microaggressions," see note 5 above, p. 271.

10. R.E. Montenegro, "My Name is Not Interpreter," *Journal of the American Medical Association* 315, no. 19 (17 May 2016): 2071-2, 2071.

11. Sue et al., "Racial Microaggressions in Everyday Life," see note 2 above, p. 272.

12. *Ibid.*, 276-7.

13. *Ibid.*, 277.

14. *Ibid.*, 273.

15. Nadal et al., "Microaggressions," see note 4 above, p. 491.

16. There are many such examples. All warrant respect. For example, some women who have had a bilateral mastectomy resent it when a clinician questions them if they say that they don't want breast reconstruction. M.T. Brown and J.A. McElroy, "Sexual and Gender Minority Breast Cancer Patients Choosing Bilateral Mastectomy without Reconstruction; 'I Now Have a Body That Fits Me,'" *Women & Health* 58, no. 4 (April 2018): 403-17.

17. C.K. Boscardin, "Reducing Implicit Bias through Curricular Interventions," *Journal of General Internal Medicine* 301, no. 12 (2015): 1726-8.

18. *Ibid.*, 1726.

19. Sue et al., "Racial Microaggressions in Everyday Life," see note 2 above, p. 272.

20. M. Pino et al., "Engaging Terminally Ill Patients in End of Life Talk: How Experienced Palliative Medicine Doctors Navigate the Dilemma of Promoting Discussions about Dying," *PLoS One* 11, no. 5 (31 May 2016): 9. See also in this regard, M.L. Fang, J. Sixsmith, S. Sinclair, and G. Horst, "A Knowledge Synthesis of Culturally-and Spiritually-Sensitive End-of-Life Care: Findings from a Scoping Review." *BioMed Central Geriatrics* 16 (18 May 2016): 107.

21. The specific words used are not important, but what is important is to not inadvertently place pressure on patients to say more than they want to. We might say in response to a patient's declining this invitation to talk, for example, "Well, that's okay. Maybe later." Even this, however, may place unnecessary pressure on a patient.

22. H. Lerner, "The Power of Apologizing," *Psychotherapy Networker* 42, no. 2 (March-April 2018): 40-7, 43.

23. *Ibid.*, 43-4.

24. *Ibid.*, 46-7.

25. We may also respond to patient's anger more effectively. Fiester states, for example, that anger is a reactive emotion, and thus a key to helping angry patients is to find its source. She says that with effective technique, anger can be abated in less than a minute by identifying and then describing patients' concerns. A.M. Fiester, "What Mediators Can Teach Physicians about Managing 'Difficult' Patients," *American Journal of Medicine* 128, no. 3 (2015): 215-6. Fiester notes that some clinicians are better able to do this than others. This presents an additional challenge, to decide when and how we should withdraw from a situation and seek the help of someone else.

26. We may find that bearing such patients' anger is easier if we keep in mind that if the other person is speaking, he or she is, at least, not shut off. Listening may be the beginning of a future relationship that will improve.

27. Lerner, "The Power of Apologizing," see note 22 above, p. 47.

28. Fiester asserts that we are all too prone to under-

estimate the “unwitting, involuntary role” that our deeply held beliefs play in performing ethical analysis, and that, in clinical ethics, we are therefore “quite unaware of how our unarticulated conception of the good drives our agendas.” A.M. Fiester, “Teaching Nonauthoritarian Clinical Ethics: Using an Inventory of Bioethical Positions,” *Hastings Center Report* 45, no. 2 (2015): 20-6, 21, https://repository.upenn.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1077&context=bioethics_papers.

29. L. Kuhnel, “TTaPP: Together Take a Pause and Ponder: A Critical Thinking Tool for Exploring the Public/Private Lives of Patients,” in this issue of *JCE* 29, no. 2 (Summer 2018).

30. J.E. Sabin and J.C. Harland, “Professional Ethics for Digital Age Psychiatry: Boundaries, Privacy, and Communication,” *Current Psychiatry Reports* 19 (2017): 55.

31. See “OpenNotes—Patients and Clinicians on the Same Page,” <https://www.opennotes.org/>.

32. For an appreciation of the significance of smell, see G. Rowley and J. Hurdle, “‘Here Was America’s Dad on Top of Me,’” *New York Times*, 13 April 2018. The person who was sexually molested reports remembering the smell after 36 years.

33. A. Clark, “Psychiatric Diagnoses and Informed Consent,” in this issue of *JCE* 29, no. 2 (Summer 2018).

34. A colleague states openly, for example, how she dreaded the possibility that she might later have early dementia. She hopes that, if she does, she can end her life before she loses her capacity to do this.

35. See D.W. Blak et al., “Attitudes Toward Borderline Personality Disorder: A Survey of 706 Mental Health Clinicians,” *CNS Spectrum* 16, no.3 (March 2011): 67-74; D. Chartonas et al., “Personality Disorder: Still the Patients Psychiatrists Dislike?” *British Journal of Psychiatry* 41 (2017): 12-7.

36. For a most poignant and memorable depiction of the harms caused by the stigma of psychiatric diagnoses, see E. Kupersanin, “Tragic Experience Leads Senator to Battle Stigma,” *Psychiatric News* (18 June 2000): 14.

37. American Psychiatric Association, *Desk Reference to the Diagnostic Criteria from DM-5* (Washington, D.C.: American Psychiatric Publishing, 2013). The present approach to establishing psychiatric diagnoses as presented in the above reference has recently been strongly questioned on several grounds, among them that similar symptoms often exist in multiple disorders. See, i.e., B.N. Cuthbert, “The NIMH [National Institute of Mental Health] Research Domain Criteria (RDoC): New Concepts for Mental Disorders,” *Psychiatric Times* 34, no.5 (May 2017): 1, 8, 12-6. See, also, P. Tyler, “What are the Borders of Borderline Personality Disorder?” *Acta Psychiatrica Scandinavica Supplementum* 379 (1994): 38-44.

38. A.M. Fiester, “The ‘Difficult Patient Reconceived: An Expanded Moral Mandate for Clinical Ethics,” *American Journal of Bioethics* 12, no. 5 (2012): 2-7, 3.

39. M. Brezis, Y. Lahat, M. Frankel, and A. Rubinov, “What Can We Learn From Simulation-Based Training to Improve Skills for End-of-Life Care? Insights from a National Project in Israel,” *Israel Journal of Health Policy Research* 6, no. 1 (6 November 2017): 48, citing A.M.

Kalemkerian, “Run for Your Life: The Reaction of Some Professionals to a Person with Cancer,” *Journal of Clinical Oncology* 21 (2003): 3696-9, stating that she was referring to Donald W. Winnicott, the British pediatrician and psychoanalyst.

40. G.T. Brown, “Medical Futility in Concept, Culture, and Practice,” in this issue of *JCE* 29, no. 2 (Summer 2018).

41. A.M. Fiester, “Avoiding Values Imposition in Clinical Ethics Consultation,” 19th Annual Meeting of the ASBH, 20 October 2017, Kansas City, Mo.

42. Fiester, “Teaching Nonauthoritarian Clinical Ethics,” see note 28 above, p. 20.

43. Fiester states that the first step is to locate one’s own positions to “dethrone” the moral commitments that one might mistakenly take to be “objective, absolute or universal.” *Ibid.* A plausible additional argument for us not regard our own ethical conclusions as objective and absolute is experimental findings that suggest that our moral views may be affected by substances such as serotonin. M.J. Crockett, L. Clark, M.D. Hauser, and T.W. Robbins, “Serotonin Selectively Influences Moral Judgment and Behavior through Effects on Harm Aversion,” *Proceedings of the National Academy of Sciences of the United States of America* 107, no. 40 (5 October 2010): 17433-8. Scientists studying the worm *C. elegans*, which in this regard has the same genes that we do, have found that cells in its brain may pump out serotonin to the brain’s “sprinkling system” of nerves, as opposed to this occurring only at nerve junctions, and this may alter the worms’ behavior. C. Bargmann, “Using Fixed Circuits to Generate Flexible Behaviors,” David Packard Lecture, Uniformed Services University of the Health Science, 3 May 2018, Bethesda, Md. If our brains work in this same way, as is likely, ethical views that we have may vary somewhat depending on when and whether our serotonin brain pumps have been active.

44. Fiester provides the Bioethical Positions Inventory, that consists of 15 common ethical positions with views that oppose them as a “useful pedagogical vehicle for teaching nonauthoritarian ethics.” Fiester, “Teaching Nonauthoritarian Clinical Ethics,” see note 28 above.

45. Fiester, “The ‘Difficult Patient’ Reconceived,” see note 38 above, p. 5.

46. A.M. Fiester, “Weaponizing Principles: Clinical Ethics Consultations & the Plight of the Morally Vulnerable,” *Bioethics* 29, no. 5 (2015): 309-15. The case of Mrs. Dee is from N. Dubler and C. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* (Nashville, Tenn.: Vanderbilt University Press, 2011), 312.

47. E.K. Salter, “Conflating Capacity and Authority: Why We’re Asking the Wrong Question in the Mature Minor Debate,” 19th Annual Meeting of the ASBH, 19 October 2017, Kansas City, Mo.; K. Miller and M. Aulisio, “The Heart of the Matter: Reframing the Best Interest Standard in Choosing Technology-Dependent Life for Neurologically Devastated Children,” 19th Annual Meeting of the ASBH, 19 October 2017, Kansas City, Mo.

48. Fiester, “Weaponizing Principles,” see note 46 above, p. 314.

49. *Ibid.*